Dear Care and Support Provider,

Care and Support Provider Update: 7th May 2020

In today's update there are some key information to share with you:

- Testing Update
- An amended financial template
- Escalation Policy
- Training and Education Programme V4

NEW – More Testing in Southport

We are pleased to be able to announce that the Military Unit will be back in Southport on the 12th, 13th and 14th May. At this time, we do not know when Southport will appear on the system as an option, but we just wanted to let you know so you can watch out for it.

You can refer staff as an employer on the Employer Referral Portal as detailed in communication to you last week or people can self-register by submitting their details to https://self-referral.test-for-coronavirus.service.gov.uk/ where they will be able to add more people from their household.

Other information about Testing

The access to COVID-19 testing is currently being developed and the following information is aimed to support homes who would like to arrange testing for staff and residents, we will update this information as guidance and pathways for testing change.

Currently testing is in place for residents being admitted from hospital to care homes, this testing should take place even when the resident does not display any symptoms of COVID-19 whilst in hospital.

There is currently no pathway for testing residents who do not have symptoms when they are admitted to a care home from the community.

If you have more than one resident with symptoms of COVID-19 then you should report this to the community infection control team using these details:

Community Infection Control Team can be contacted on 0151 -295-3036 -or if out of hours Public Health England Health Protection Team Cheshire and Merseyside –out of hours on-call 0151 434 4819

They will be able to pass on details of residents that require swab testing to the North West Public Health England team who will arrange swab kits to be delivered to the care home.

Financial Template

It has come to our attention that the template we sent out to you this week had an error where some of the cells where incorrectly locked. Please accept our apologies

for this. The correct template has been sent to you and can also be downloaded on the Care Providers webpage (Care Home Updates).

Escalation Policy
As you are aware during the past couple of weeks, the health and care system has been developing the Escalation Policy, which is below. This policy is to let you know what wrap-a-round support you can expect from the health and care system should you experience a disruption to your service.

Education and Support Programme – Version 4
We hope that you have been finding the Education and Support Programme helpful for you and your staff. We appreciate that it is currently a really busy time for you but if you get chance, please have a look and share with your staff as the education and support within the programme has been identified as potential areas you may need either now or in the future.

Version 4 of the Education and Support Programme for care Homes can be found here

COVID 19 Response Escalation Policy for Care Homes:

(Care Homes have been sent this document. If you are downloading this from the website and would like the embedded documents, please email Jayne.vincent@sefton.gov.uk)

As part of the response Health and Social Care have formed a Care Homes Cell which includes representatives from Local Authority, CCG, and Community Health Care Providers (Mersey Care and Lancashire Care NHS Trusts). Part of the Cells function is to provide Market Oversight, Share Intelligence and to offer reactive and proactive integrated wrap around support to the Care Homes in Sefton.
The policy sets out how the Health and Social Care system will support providers to maintain a safe, effective and quality service during the Pandemic. What the system will do should service be disrupted. If a provider believes they are at risk of failing to deliver a service they should in the first instance following procedures set out in their own Business continuity plans and secondly raise concerns with the Local Authority Contracts and Commissioning team using the following e mail address contractsandcommissioning@sefton.go.uk

Summary

Risk of Service failure			
	Enacted own Business Continuity Procedures		
		notify Council through contractsandcommissioning@sefton.go.uk	
			Tools available: Enhance Community

			Provider Offer, Emergency PPE Supply, Staffing support, End of Life Support, Hospital admission and discharge protocol

Aims and Principles to Escalation Policy:

- The health and well-being of Service Users is maintained
- The needs and welfare of Service Users are safeguarded
- Effective communication and information sharing exists between all affected and interested parties
- Legal and contractual requirements are adhered to
- System failures and enforcement issues are managed effectively
- Ensure protection and support in place for community staff to support care homes (such as PPE, social distancing and reduced footfall)
- Understand capacity within the service and the amount of resource available to support care within care homes.
- Support capacity management within the service lines
- Implement reactive offer in time to meet anticipated surges in demand to critical services

Hospital Offer:
Acute NHS Services will continue to support frail older patients admitted to hospital through Frailty offers. Discharge process will be followed as set out in the COVID 19 Response discharge policy [
The community gerontology and frailty service offered by the acute Trusts will immediately suspend routine face to face Care Home consultations in view of social distancing measures.

1. The Trust (LUHT) will offer, between the hours of 08:00 to 17:00, daily support with an emergency phone advice line with a Geriatrician available for advice for GP/ Community Matron and NWAS for all patients in care homes for who hospital admission is being considered.

N.B. This is applicable to Care Providers in South Sefton only at this time.

2. This will provide decision making support for patients in the following ways;

a. Decisions as to whether it is appropriate to convey a patient from a Care Home to the ED or whether remaining in the care home for treatment (palliative or active) would be in the patients best interest s

b. Advice on ceilings of care

c. Advice on complex clinical issues and symptom management

The Single Point of Contact for this service will be telephone Number 07464518716, the helpline will be staffed by Geriatricians with expertise in Community and Frailty services. In LSCFT referrals will be received in to the Single Point of Access and virtually triaged by clinical specialists. It is expected that all potential conveyances to the acute Trust from care homes will be discussed prior to NWAS conveyance during the hours of operation with appropriate discussion to identify if the situation relates to a COVID or NON COVID presentation

Community Health Care provision:
identified responsibilities include:

- Care Home Model
- Developing COVID reactive response model
- Offer and visibility of lost closures and re-opening to understand capacity

- Roll-out of Attend Anywhere
- District Nurses (DNs) deliver care to the residential care homes with the requirement of care delivery for Nursing homes being EOL care and Complex wound/ complex catheter care.
- Care Delivery for DNs within Care homes will be aligned to national guidance and more reactive approach to care delivery with no or very little proactive care.
- In response to COVID-19 the DNs will be appropriately equipped and supported to deliver on EOL care for those patients in residential care who are deemed to be in the last days and hours of life, in line with locally agreed pathways.
- Community Matrons/Frailty practitioners. The CM/Frailty service is also aligned with National guidance and delivers on reactive/supportive care in the care homes. They will continue to triage all referrals and perform a full clinical examination on deteriorating patients to establish whether symptoms are reversible and commence treatment as necessary. CMs or where Hospice and Acute providers have been directed will also support the implementation of ACPs DNACPR as appropriate on both COVID and non-COVID patients.

Enhanced offers are available from Mersey Care in the South Sefton area and Lancashire Care in the North Sefton area as follows. Please note core business as usual services will be maintained during normal working hours and out of hours arrangements in place to ensure continuer service.

Community Services	What are they doing for care homes differently?
District Nurses	District Nurses (DNs) deliver care to the residential care homes with the requirement of care delivery for Nursing homes being EOL care and Complex wound/ complex catheter care. Care Delivery for DNs within Care homes will be aligned to national guidance and more reactive approach to care delivery with no or very little proactive care. In response to COVID-19 the DNs will be appropriately equipped and supported to deliver on EOL care for those patients in residential care homes who are deemed to be in the last days and hours of life, in line with locally agreed pathways.
Community Matrons/Frailty	The CM/Frailty service is also aligned with National guidance and delivers on reactive care in the care homes. They will continue to triage all referrals and perform a full clinical examination on deteriorating patients to establish whether symptoms are reversible and commence treatment as necessary. CMs or where Hospice and Acute providers have been directed, will also support the implementation of ACPs DNACPR as appropriate on both COVID and non-COVID patients. The delivery of care home support in both Liverpool and South Sefton is underpinned by an MDT approach with GP/ Community Geriatrician/ CM/ DN and other specialist nursing input. Supporting Care Homes with admission avoidance.
Specialist Palliative Care	The community specialist palliative care team will act as coordinators to both the acute, domiciliary and care home setting, these will work closely with CMs, Frailty, GPs and DNs delivering and coordinating EOL care and symptom control. The team is working corporately across Liverpool and South Sefton to ensure capacity and capability across the footprint

Single Point of Contact (SPC)	This will be key where all Care home referrals will come through and triaged as per patient need, referrals will then go to community nursing teams where the most appropriate clinician will be identified.
Medicines Management Team (MMT)	Support is required from MMT in relation to national guidance and local policy in relation to prescribing/ administration/ distribution of COVID and non-COVID patients medication, and systems for ensure availability of EOL meds and carer administration
IV Team/ 02 Therapy and respiratory team	This specialist input also has to be considered as a part of the COVID offer however as not all these services are delivered by MCFT then this needs to be highlighted and a wider system discussion needed.

The ICT will proactively work with the care home sector to support the reduction of spread of COVID-19 by advising and reinforcing the implementation of national and local guidance. This will include:

- Clinical and operational support to care homes via the Community Hub
- Provide single point of access to support COVID-19 related decision making in care homes
- Revise Advanced Care Plans (ACPs) and Do Not Attempt Cardio-Pulmonary Resuscitation (DNAR) agreements to prevent avoidable conveyance to acute hospitals.
- Coordinate the assessment of new service users requiring ACP where the preferred place of care is the care home setting.
- Conduct daily calls to those care homes identified as high intensity users of NHS111, Primary Care and AED, with the aim of avoiding unnecessary ambulance conveyances and potential hospital admissions.
- Support care homes to ensure they are equipped to accept new residents including those who may have tested positive for COVID-19
- Reduce the potential spread of COVID-19 by aligning District Nurses and Community Matrons with care homes (zoning) to reduce the number of care home residents/care homes that clinicians come into contact with. This is very important to reduce viral spread.
- By using remote video consultation that our community nursing teams and care homes have access to and providing the expert advice and support that the care home staff require at this time of isolation.

End of Life support offer

A program of Care Planning and review of all Care Home residents will be rolled out.
There are a range of clinical models to achieve proactive end of life care planning within all care homes, though the proposed model (s) has considered sufficient organisational and system support to enable contact to be made with each care home and facilitate discussion to identify

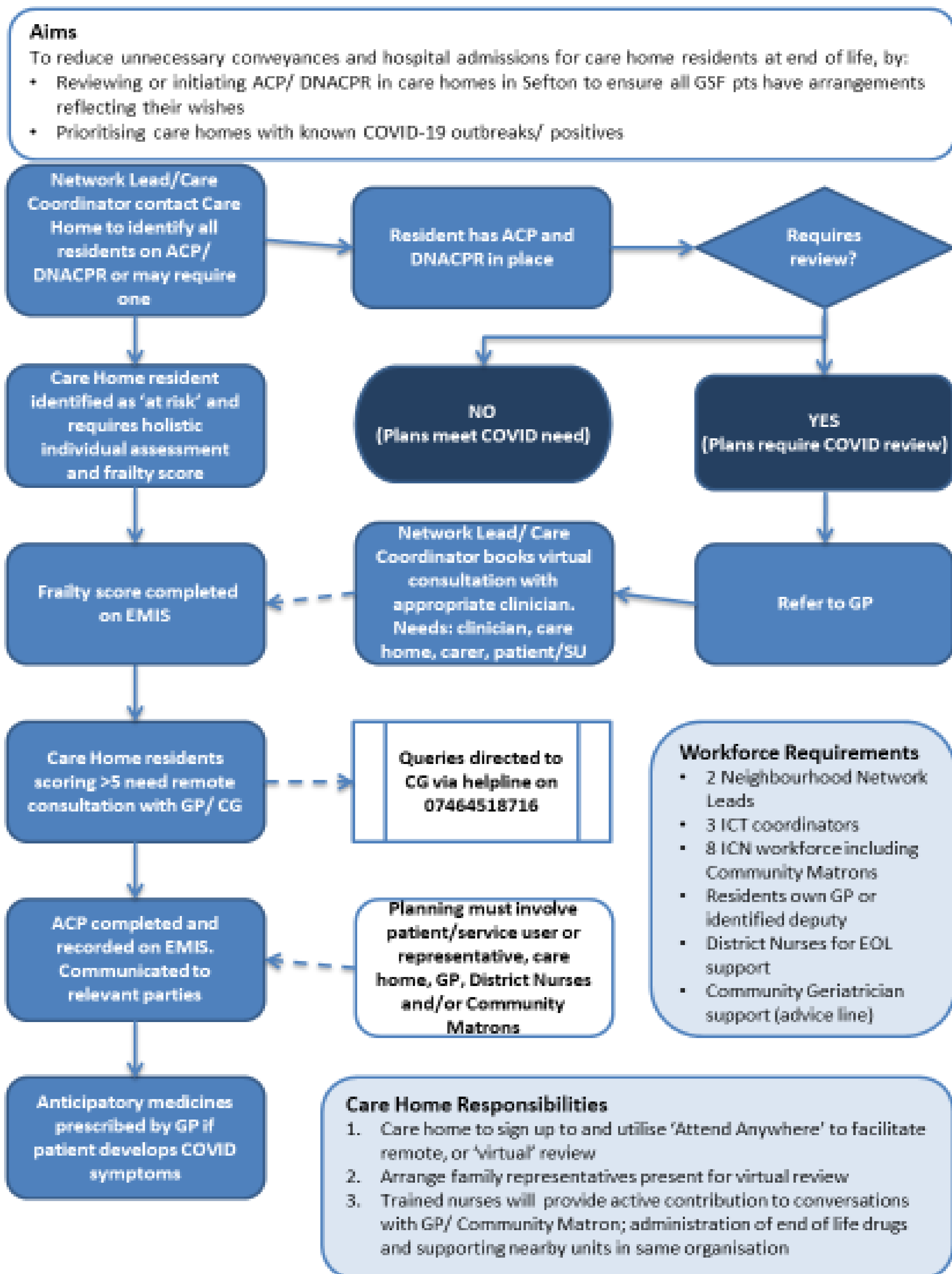
1. Care home residents with a current Advanced Care Plan (ACP) or Do Not Attempt Resuscitation (DNACPR) arrangements which meet individual needs during the crisis

2. Care home residents with a current ACP or DNAR arrangement which will not meet individual needs and,

3. Care home residents who do not have any ACP or DNACPR arrangements in place however these may be required during the COVID-19 crisis.
4. Advising and supporting Homes in Verification of Death as per RCN Covid-19 Guidelines

The following Summary of Support available to you from the Health and Social Care system can be found here:
End of Life Summary Offer .docx

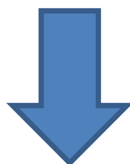
Integrated Care Home Support COVID-19 pathway:



Care Homes Escalation Flowchart Nursing Staff Failure

Escalation process for concerns with Nursing staff availability in Nursing Homes during the COVID 19 outbreak

1. The Local Authority or CCG become aware that there is a lack of available Nursing Staff at Nursing Home in Sefton.



2. Local Authority contractual discussion with Home regarding steps taken in line with their business continuity plan. Safeguarding referral made for residents.

3. Home still unable to source nursing staff

4. The Local Authority Quality Team to support providers in identifying potential Merseyside Nursing Agencies to both support and share with the Care Homes to ensure the Home is fulfilling their contractual requirement and not self-limiting in their choice of Agencies.

5. The Local Authority may submit a request for redeployment of staff from the CCG

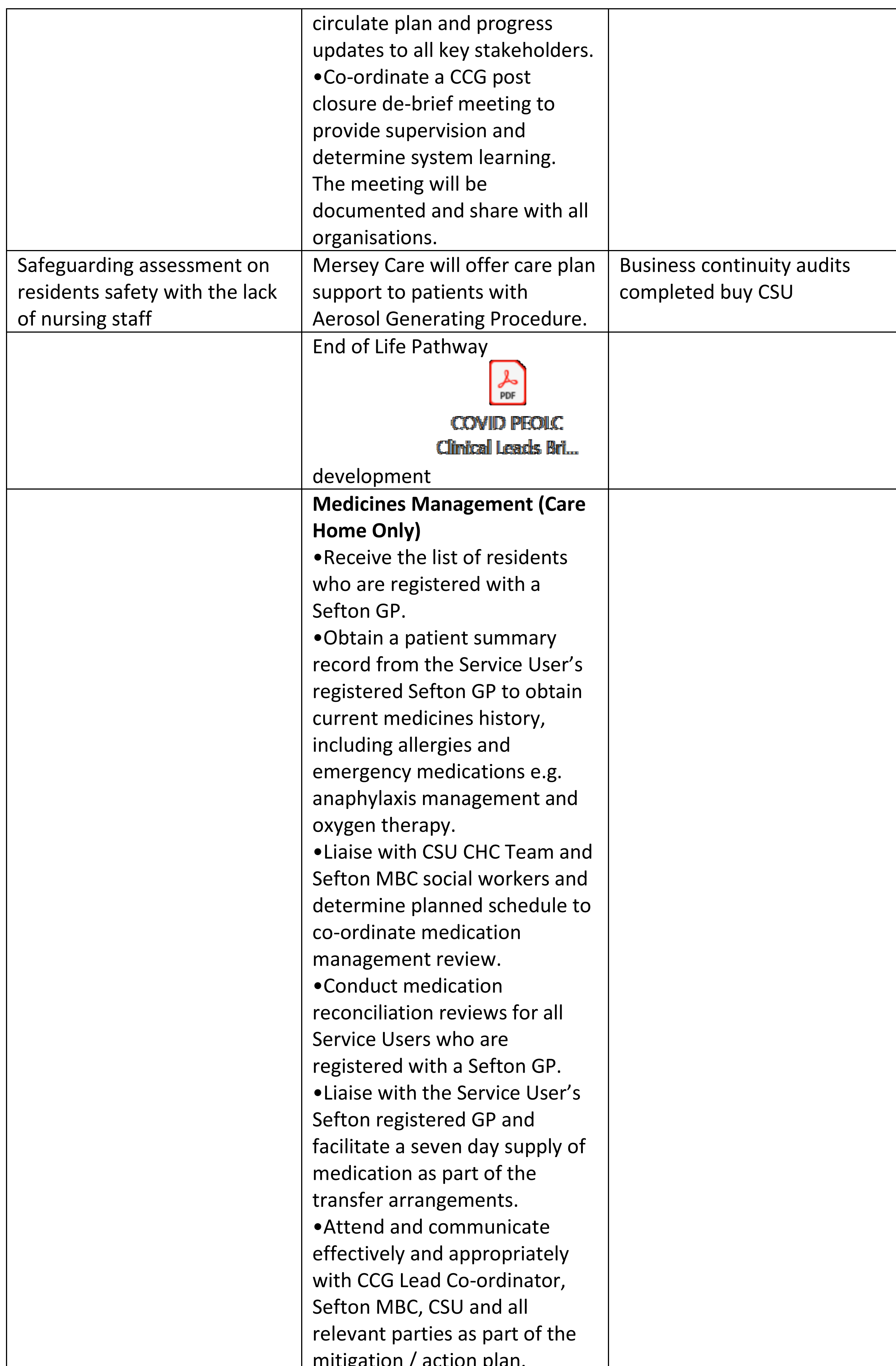
6. Under a joint policy and process, the Local Authority and CCGs would enact their 'Provider Failure' Policy should the Home be unable to provide safe and clinically effective care. The CSU would support as appropriate with both any closure of a Home and subsequent decant of residents. Safeguarding of resident ongoing care overriding consideration. Permanent residency of choice considered in medium term care plan.

Summary Roles and responsibilities of Council, CCG and CSU:

Local Authority	CCG	CSU
Enact Contract Management triggers to ensure homes have executed all business continuity measures to maintain staffing levels Ensure the Homes have discussed with Community Providers to ensure access to clinical advice and support Support Homes by ensuring they have approached a broad number of Agencies across Merseyside and are not self-limiting their options May request a redeployment of staff request to the CCG	Support Local Authority with clinical advice and support for the Homes	Oversight of Governance process for requesting mutual aid Enact Contract Management triggers to ensure home have executed all business continuity measures to maintain staffing levels for Homes contracted to provide placements for CHC and FNC funded residents
Enact Contract Management triggers to ensure home have executed all business continuity measures to maintain staffing levels Sefton MBC hold the lead commissioner role for Care Home Providers across the borough of Sefton. It would be anticipated that under normal circumstances Sefton MBC would take the lead role in co-ordinating a Service / Care Home Provider closure plan following advice guidance and actions as directed by CQC and or Sefton MBC legal services. The CCG will work jointly with Sefton MBC to facilitate safe transfer of Service Users. Sefton MBC will hold the overarching transfer plan.	Utilise Mutual Aid mechanisms to source support. The CCG Lead Co-ordinator will act as the central point of contact for the CCGs health response as part of any potential / intended closure of a care home or domiciliary care provider. This will facilitate appropriate communications across the partnership including: Sefton MBC, CCGs, NHS England, Commissioning Support Unit (CSU), CCG Medicines Management, NHS Commissioned Providers CCG Lead Co-Ordinator will; •Notify Continuing Health / Complex Care senior managers immediately either in person or by telephone with confirmation in writing (email) using Delivery and Read receipt facility. Staff passing information to and from CSU Continuing Health / Complex Care Team must ensure that it has been received.	Oversight of Governance process for requesting mutual aid •Identify a lead person to liaise and co-ordinate response with local authority and CCG Lead Co-ordinator. •Provide the CCG Lead Co-ordinator with an up to date list of Service Users who are funded by the CCG areas and their funding status, including CHC, FNC, S117 and Joint Funded packages of care, and agree those to be reviewed by CSU. •Using a dynamic purchasing tool and local intelligence provide a snap shot Nursing Home availability list and alternative domiciliary care provider across the local economy. This will be provided within 3 working days from the date the CSU were first notified of the planned closure. •Liaise as required with Sefton MBC social workers to co-

	•Notify CCG Safeguarding Service where the closure is linked in any way to adults at risk of harm or abuse under section 42 safeguarding enquires (Care Act, 2014). •Notify CCG's Accountable Officer / Chief Nurse, providing a briefing for the relevant CCG Governing Body •Notify CCG Head of Communications •Notify CCG Head of Medicines Management •Ensure that Sefton MBC are notified of all relevant and appropriate health representatives to be included within the delegate list for Sefton MBC led multi-professionals meetings (CCG Meds Management, CSU CHC / Complex Care Senior Managers, Designated Nurse safeguarding Adults). •Obtain from the patient database (currently available via the CSU) a list of CCGs funded resident details inclusive of Name, Date of Birth and registered GP if applicable, to notify neighbouring CCG Chief Nurses of Service Users placed / packages of care where funding accountability lies with that CCG and provide the CCG Medicines Management Team a list of the CCGs funded resident details inclusive of Name, Date of Birth and registered GP. •In the case of domiciliary care providers notify the Director of Nursing of the relevant NHS Commissioned Community Provider to request they put in place mitigation and co-ordination of patient reviews. •As required and in the case of clinical safety concerns have been highlighted within a	ordinate the process of Service User reviews. •Liaise as required with NHS Community Providers to co-ordinate the process of reviews of all health funded Service Users in their own home. •Provide a comprehensive list of any specific care needs by patient which would need to be considered as part of an transfer arrangements / requirements e.g. mobility, oxygen, specialist equipment, for inclusion within overarching multi-professionals transfer plan. •Provide most recent audit report/plan (applicable to Nursing Homes only). •Attend and communicate effectively and appropriately with CCG Lead Co-ordinator, Sefton MBC, CCG Med Management and all relevant parties as part of the mitigation / action plan. Arrange to prioritise the closure •Communicate in a timely manner with Service Users / relatives and advocacy services facilitating choice of alternative care placement, taking into account CQC / CCG / Sefton MBC communications and restrictions in relation to confidentiality. •Provide a list of residents reviewed and confirmed provider name and proposed place of destination for inclusion within the multi-professional's transfer plan (applicable to Care Homes only). •Liaise with the alternative domiciliary care provider to enable safe transfer of packages of care.

	nursing home, discuss support and mitigation with the Director of Nursing of the relevant NHS Commissioned Community Provider. •Notify Primary Care Programme Lead. •Ensure that all relevant CCG and CSU partners are invited and are able to contribute at the Sefton MBC multi-professionals meetings. To enable staff to prioritise unplanned closure over routine activity. •Provide regular updates to the Chief Nurse and other membership of the CCG as appropriate e.g. Chief Officer, CCG Governing Body, Head of Communications, CQC. • Co-ordinate and take responsibility for the delivery of the health related actions as part of the multi-professionals care home transfer plan, which will be contributed to by other health professionals e.g. Medicines Management, CSU, Integrated Equipment Stores, Local Authority, NWAS. Where applicable with NHS Community Providers. •Liaise as appropriate with Community Equipment Stores in relation specific health related equipment e.g. beds, pressure relieving equipment, bed rails and bumpers, bariatric / specialist equipment and ensure systems are in place to repatriate after transfer. •Provide ongoing support as part of the planning process to all CCG / health staff, across all agencies involved. •In conjunction with Local Authority formulate and deliver a final overarching multi-professionals care home transfer plan (Appendix 7) and	•Update records to note the new location to enable reviews of appropriate residents in their new place of residence. •Co-ordinate post transfer reviews for all individuals in receipt of 100% health funding transferred to an alternative domiciliary care provider via NHS community provider.



	circulate plan and progress updates to all key stakeholders. •Co-ordinate a CCG post closure de-brief meeting to provide supervision and determine system learning. The meeting will be documented and share with all organisations.	
Safeguarding assessment on residents safety with the lack of nursing staff	Mersey Care will offer care plan support to patients with Aerosol Generating Procedure.	Business continuity audits completed buy CSU
	End of Life Pathway PDF COVID PEOLC Clinical Leads Bri... development	
	Medicines Management (Care Home Only) •Receive the list of residents who are registered with a Sefton GP. •Obtain a patient summary record from the Service User's registered Sefton GP to obtain current medicines history, including allergies and emergency medications e.g. anaphylaxis management and oxygen therapy. •Liaise with CSU CHC Team and Sefton MBC social workers and determine planned schedule to co-ordinate medication management review. •Conduct medication reconciliation reviews for all Service Users who are registered with a Sefton GP. •Liaise with the Service User's Sefton registered GP and facilitate a seven day supply of medication as part of the transfer arrangements. •Attend and communicate effectively and appropriately with CCG Lead Co-ordinator, Sefton MBC, CSU and all relevant parties as part of the mitigation / action plan.	

	•Provide Service User specific medication requirements as part of safe transfer arrangements e.g. emergency medicines and oxygen to be included within the overarching multi-professional's transfer plan. •In the case of Service Users who require oxygen therapy, ensure a supply of prescribed oxygen is available and systems and processes are in place for ongoing prescription and delivery in the alternative placement from the home oxygen provider. •Liaise with the Primary Care Programme Lead to communicate change of residence, to the Service Users registered GP. Request allocation for GP where Service Users would be deemed out of area for the Service Users current registered. •Make arrangements for appropriate staff from the Medicines Management Team to be on site on the day of the closure to facilitate: seven day supply and MARs charts transfer with each Service User; emergency medication provided with guidance to NWAS / LA transfer team; appropriate oxygen therapy in place for specific Service Users; all extraneous medication including controlled drugs are appropriately destroyed. 7.4.4 Head of Communications •Liaise across with Sefton MBC communications to determine an effective communication strategy and responses for publication from the CCGs. •Liaise and communicate with the CCG Lead Co-ordinator as	

	part of the on-going process and support all internal / external communications.	
	Primary Care Programme Lead Support information requests from CCG Medicine Management to the Service Users registered GP e.g. Patient Summary, Notification in change of residence, Notification of any resident being placed out of area.	
	CCG Safeguarding Service •Provide specialist oversight in relation to any ongoing section 42 safeguarding adult enquiries. •Provide specialist safeguarding advice in relation to mitigation plans and undertake tasks as required within this plan.	
Safeguarding assessment on residents' safety with the lack of nursing staff	Joint working in relation to residents who are in receipt of fully funded CHC package and FNC	

Safeguarding

The Local Authority will continue to receive and respond to safeguarding concerns raised in accordance with the Care Act 2014 s42 and s44 statutory requirements in a timely and proportionate manner in the context of the pressure providers are under.

PPE Supply disruption:

PPE Support.docx