Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	22 April 2020
Executive Member	Councillor Eleanor Wills, Executive Member (Adult Social Care and Health
Clinical Lead	Dr Ashwin Ramachandra, CCG Chair
Officer of the Single Commission	Jessica Williams Director of Commissioning
Subject:	**OUT OF HOSPITAL CARE**
Report Summary:	This report describes the principles and pathways that will operate across Tameside and Glossop to support people to remain out of hospital, both in a personal residence and in a care home.
Recommendations:	Strategic Commissioning Board is recommended to: (i) Agree the principles set out in the report (ii) Approve the use of the DHAC19 service to support people living in Tameside and Glossop residential and nursing homes.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	*No Investment required*
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Microsoft Teams is currently being deployed free of charge across the local systems. The request in this paper is not asking for any additional money to change the way of working. However this change in practice/method if sustained long term is likely to result in unquantified savings as the need for face to face contacts reduces.
Additional Comments This paper explains the	

	principles and framework the CCG will be working within to ensure due diligence and assurance for working practices under COVID19. There are no financial implications.
Legal Implications: **(Authorised by the Borough Solicitor)**	
What is the evidence base for this recommendation?	This approach aligns with national guidelines.
Is this recommendation aligned to NICE guidance or other clinical best practice?	This approach aligns with national expectations to reduce face to face contact and to reduce the risk of patients attending hospital when they would be more effectively supported at home. It aligns with the Greater Manchester Out of Hospital approach.
How will this impact upon the quality of care received by the patient?	The approach will enable patients to receive appropriate individualised care during the COVID-19 pandemic.
How do proposals align with Health & Wellbeing Strategy?	The approach supports the commitment to personalised care and providing support to people at the End of Life and their families.
How do proposals align with Locality Plan?	This aligns with Ageing Well and our ambition to support people to be cared for in their usual place of residence.
How do proposals align with the Commissioning Strategy?	It supports effective use of acute bed capacity.
Recommendations / views of the Health and Care Advisory Group:	Whilst not discussed through HCAG the approach has been supported by CCG Chairs, Tameside and Glossop Ageing Well Lead, the Pandemic Resilience GP Leads, the LMC and representatives from Tameside and Glossop Integrated Care Foundation Trust.
Public and Patient Implications:	Whilst not discussed due to current situation the outcome of the proposal is in line with public expectations around dying in usual place of residence.
Quality Implications:	This paper aligns with national guidelines and raise no additional quality implications. Individual services will continue to be managed in line with the CCG contract arrangements which include representation for Nursing and Quality.
How do the proposals help to reduce health	This will support people equally but will not specifically reduce health inequalities

inequalities?	
	This will support people equally according to need.
What are the Equality and Diversity implications?	No additional safeguarding implications
What are the safeguarding implications?	
	No additional IG implications
What are the Information Governance implications?	
Has a privacy impact assessment been conducted?	No
Risk Management	There are no specific risks associated with the principles and pathways.
Access to Information :	The background papers relating to this report can be inspected by contacting
	 Telephone: 07855469931
	 Email: Elaine.Richardson@nhs.net

1. INTRODUCTION

1.1. The majority of patients with COVID-19 will have mild symptoms and will be able to care for themselves at home. There will however be a significant number of patients who contract moderate or severe illness from COVID-19 requiring primary or secondary care input.

1.2. Some people are at increased risk of severe illness from COVID-19. This includes those who are:

1.2.1. Aged 70 or older (regardless of medical conditions)

1.2.2. Under 70 with an underlying health condition (i.e. anyone instructed to get a flu jab as an adult each year on medical grounds)

1.2.3. Pregnant

1.3. Most patients presenting with symptoms of COVID-19 can be assessed and managed remotely. When face-to-face assessment is required, this will need to be managed either through use of designated sites (whether within practices or as separate locations) or through home visiting services.

1.4. National guidance is being received on a daily basis for all sectors within the health and social care economy. In addition Greater Manchester has put into place a Hospital Cell and an Out of Hospital Cell to identify opportunities to 'do once' across the ten Localities to improve efficiency or promote consistency.

1.5. This paper confirms the principles of Out of Hospital Care and describes an enhanced service for Digital Health.

2. PRINCIPLES OF OUT OF HOSPITAL CARE

2.1. The following principles underpin the ability to support people to remain out of hospital.

2.2. We will always treat people with respect, dignity and in line with their own expressed wishes and choices.

2.3. All care plans and decisions will be made on an individual basis and in discussion with patients and their families/carers.

2.4. For those lacking Mental Capacity, due reference to the Mental Capacity Act will be made.

2.5. The registered practice remains the prime provider of general medical services during core hours (Monday to Friday 08:00 to 18:30) and the Primary Care Access Service out of hours.

2.6. In line with the 'Guidance and standard operating procedures General practice in the context of coronavirus (COVID-19) Version 2', remote consultations will be used where possible.

2.7. The use of video consultations will facilitate triadic consultations between the patient, carers, and clinicians. These will be particularly important when discussing care plans and agreeing optimal care in line with wishes of the patient.

2.8. Where the patient and family are unable to use video technology or the use of such technology would prevent an appropriate assessment a face to face consultation will take place.

2.9. The development of Advance Care Plans and Statements of Intent with people at the End of Life are developed through face to face consultations which have previously been direct

but in the current circumstances may be undertaken through video consultation in line with the above.

2.10. The additional community health support provided to people in the neighbourhoods through the ICFT Intermediate Tier Services (ITS) will continue e.g. District Nursing and Palliative and End of Life care.

2.11. The Individualised commissioning of specialist health care support through home based funded nursing care packages and placements in Nursing Homes will continue.

2.12. Home based packages of social care and residential care placements will continue according to need.

2.13. The Digital Health service which supports residential and nursing homes through remote monitoring and advice and manages GP admissions to the Tameside and Glossop Integrated Care NHS Foundation Trust will remain in place with enhanced additional medical expertise and capacity. To differentiate the Digital Health offer during the COVID-19 pandemic from the service previously commissioned the team will now be referred to as the Digital Health Acute COVID19 service (DHAC19).

3. OUT OF HOSPITAL PATHWAYS

3.1. Whilst the availability of health care is dependent on clinical need it is recognised when people live in a residential or nursing home their access to support can be managed differently by virtual of the 24/7 presence of care staff. For this reason the following pathways have been differentiated by the home circumstances of the individual.

3.2. The pathways below operate across the whole cohort of patients regardless of any confirmed or suspected COVID-19

People in Residential or Nursing Homes

3.3 This pathway aligns with the commitment below in the 'Admission and Care of Patients during COVID-19 Incident in a Care Home (V1.0) Official Guidance.'[1]
'*We want to support Care Home Providers to protect their staff and residents, ensuring that each person is getting the right care in the most appropriate setting for their needs.,*

3.4 DHAC19 will enhance the service provided to care home residents by provide proactive monitoring and support across all residents in addition to the urgent care support provided to an individual when their condition causes concern.

3.5 The DHAC19 support model has the following aims:

3.5.1 To support personalised care of residents in nursing and residential homes using the best available clinical and care data;

3.5.2 To enhance the quality of clinical decision making through the use of proactively collected core resident data from the care homes using a 'Core COVID-19 Data App' in combination with acute clinical data;

3.5.3 To expand capability with additional senior clinical decision makers to support on-scene clinical and care staff in planning and delivering optimal care;

[1] https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes

3.5.4 To support system efforts to ensure the resilience of care homes during this period and that these efforts are co-ordinated;

3.5.5 To work collaboratively as a cross sector multidisciplinary clinical team for the benefit of residents and colleagues. When DHAC19 identify the need for additional support this will be provided by the registered GP supported by the ICFT ITS.

3.6 DHAC19 will underpin care pathways which ensure that wherever possible residents will receive optimal care in their care home based on their assessed clinical needs. It will also facilitate a planned pathway in which the resident may require a diagnostic test without admission (e.g. radiological investigation following injury) to guide their subsequent care back in the care home.

3.7 The Emergency Department (ED) and care pathways within the hospital sector are evolving in response to COVID19 pandemic demand. ED is becoming an area for rapid assessment and resuscitation of patients and direct admission pathways are being put in place to wards and the Stamford Unit to avoid ED. DHAC19 will support the direction of patients to locations within the hospital where specialist teams will provide the care required. The transfer of residents from care homes to the ED will only occur in those situations where this is immediately necessary and in which every other alternative has been exhausted.

3.8 DHAC19 will:

3.8.1 Be the first point of contact for care homes requiring clinical advice and support for the care of a resident.

3.8.2 Provide advice to care homes on immediate and longer term management of residents.

3.8.3 Manage any escalation of care for a resident to hospital for further diagnosis and management.

3.8.4 Agree on a plan of care for a resident at home including supportive, palliative and end of life care. Where discussions need to take place with the resident and family regarding a new or amended advance care plan (including resuscitation arrangements) this will be managed by the registered GP.

3.8.5 Undertake a daily review of core data provided by care homes for each resident through the Core COVID-19 Data App via a central dashboard to proactively identify residents by the following characteristics

- RAG acute illness status
- COVID symptoms
- Onset of delirium

3.9 The availability of systematically collected baseline minimum data for all residents to supplement real time clinical data will considerably enhance the quality of remote real time clinical decision making. During the pandemic it is particularly important that baseline data is recurrently updated given the vulnerability of care home residents. The Core COVID-19 Data App is key to this and it is intended that the App will be fully deployed by end of April 2020.

3.10 This data will be used in one of two ways:

3.10.1 Proactively to identify residents who may be deteriorating (RAG rated RED initially) and for whom there is no clear evidence of an advance care plan in place. These patients will be notified to their GP to prompt advance care planning ideally before the need for a crisis intervention.

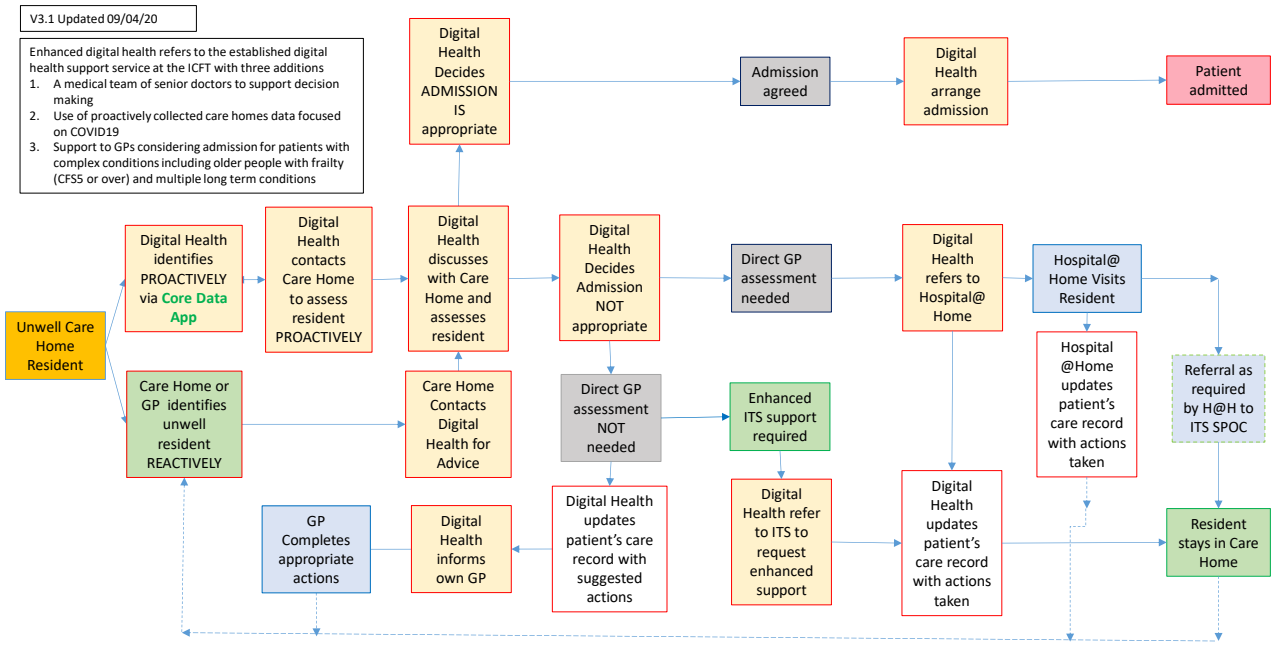
3.10.2 Reactively to add contextual information to support decision making for care home residents and to advise both the care home and attendance GP and/or care at home team of the optimal steps to take to support the care of the resident in the event of an acute event (illness or injury).

3.11 When residents become ill DHAC19 will ensure that where appropriate people are transferred to the hospital and where support in the care home is the clinically appropriate option additional services will be involved as necessary.

3.12 When required DHAC19 will use Triadic consultations via video link between the patient and carers, Digital Health clinicians and the GP.

3.13 The following pathway demonstrates how DHAC19 will work with a patient's own GP, the Hospital at Home visiting service and the Intermediate Tier Service to deliver optimal care.

Enhanced Digital Health Acute COVID-19 Team-GP Triage CARE HOME support pathway algorithm



3.14 When discharge from an inpatient bed occurs the ICFT discharge team will liaise with DHAC19 to ensure an effective discharge.

People living in their own homes

3.15 The Registered GP will manage appointments remotely when possible but will see patients in the practice or at home as clinically necessary.

3.16 When additional ITS community support is required the practice will refer to the ICFT as usual.

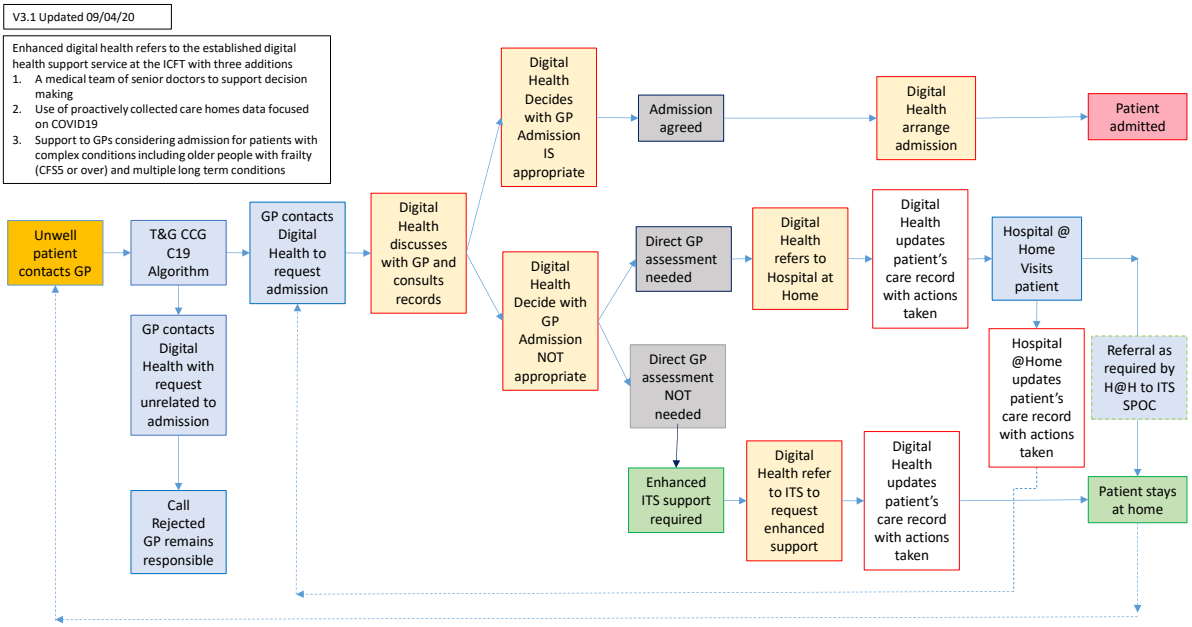
3.17 When discharge from an inpatient bed occurs the ITS will be engaged through the discharge team and the registered GP will support as clinically necessary.

3.18 When a potential need to admit to the ICFT is identified GPs will continue to contact DHAC19 prior to admission to discuss. A joint decision between DHAC19 and the GP requesting admission will be made. If the decision is to admit the responsibility for the care will transfer to the ICFT during the period of admission. If the decision is not to admit the ongoing responsibility of the care will remain with the registered GP with support from the

ITS and a Home Visiting service that will enable patients to receive prompt home visits 24/7.

3.19 The following pathway demonstrates how DHAC19 will work with a patient's own GP, the Hospital at Home visiting service and the Intermediate Tier Service to deliver optimal care.

Enhanced Digital Health Acute COVID-19 Team-GP Triage RED admission pathway algorithm



4 RECOMMENDATIONS

4.3 As set out on the front sheet.