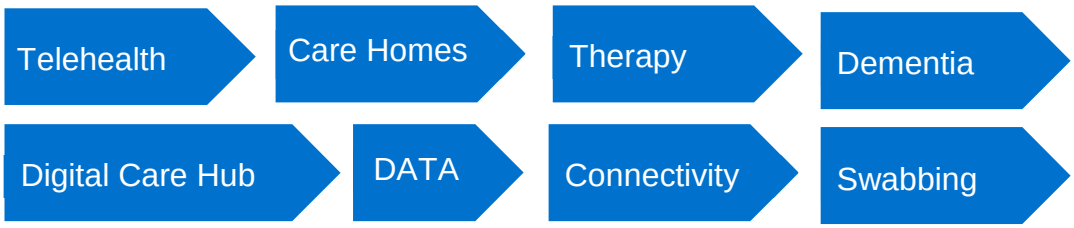
NHS
Bradford District and Craven
Clinical Commissioning Group

Friday 5th June 2020

Care Home Edition 1

Care@Home newsletter

Supporting people living with frailty and experiencing escalating needs during Covid-19



The Care@Home work stream is leading on the organisation of our COVID-19 response for care homes and the frail elderly at home in Bradford district and Craven.

We are working with key NHS, local authority, VCS and independent sector partners to keep as many of these patients at home as possible and are working directly with care homes to support them in a different way for the next few months.

We are introducing practical pathways for managing people that get sick in care homes, and frail elderly who get sick in their own homes - with covid, or non-covid related illness.

If you have any feedback about this newsletter or suggestions for articles to include, please contact Walter O'Neill - Walter.ONeill@bradford.nhs.uk

Attached is a Win Zip file containing all the attachments associated with this newsletter.

In this newsletter:

1a. Accessing Speech and Language Therapy

MAY 2020

AIREDALE AND BRADFORD
Speech and Language Therapy referral information for Digital Care hub

NHS Bradford District Care NHS Foundation Trust

Airedale and Bradford Speech and Language Therapy working together

NHS Airedale NHS Foundation Trust

This guide is to enable timely referral to Speech and Language Therapy services for people with suspected Dysphagia or Communication Difficulties, including those with or recovering from COVID-19

Q. What issues might be presenting?

- *Difficulties with swallowing; coughing whilst eating or drinking; chest infections*
- *Changes to voice*
- *Difficulties expressing self*
- *Difficulties understanding*

Q. Who can be referred to Speech and Language therapy (SALT)?

Residents where there is :
Significant/ new concern around eating drinking and swallowing safety
Significant/ new concern around voice quality
Significant/ new concern around communication (expressive/ receptive skills)

⇒ Active Covid-19 OR Post Covid-19 recovery (including recent hospital discharges)
⇒ Non-Covid conditions linked to issues with e.g. Swallowing problems, COPD, Post Stroke/Head Injury, Cancer, Progressive neurological conditions, Dementia

Questions to ask before referring:

Has the resident been referred to SALT previously?
Is there feeding /communication advice from SALT in place? What IDDSI levels were recommended for food and drink?
Has the resident also been referred to a dietitian?
Are these swallowing/ communication issues new or has there been gradual onset?

Q. How do I get support from SALT or refer a resident?

You can contact the SALT team for advice and support directly during normal working hours on the contact details below:
Bradford - 01274 221166
Airedale, Wharfedale and Craven - 01535 293641

GPs can refer the patient via SystmOne.
- Bradford **IDCR SALT Adults e-referral**
- Airedale **ANHST Referral Gateway**

Once the referral is received it will be triaged and assigned as urgent or routine

Referral forms are available on the Airedale website or by phoning 01274 221166 (Bradford) and can be emailed securely to the appropriate services :
Bradford: Fax-HPK.Admin-Hub@bdct.nhs.uk
Airedale : agh.therapyservicesadmin@nhs.net

1b. Accessing Community Therapy Services

MAY 2020

NHS Bradford Teaching Hospitals NHS Foundation Trust

working together

Bradford and Airedale Therapy Care Home Bulletin

NHS Airedale NHS Foundation Trust

Airedale and Bradford Community Therapy Services Preventing Deconditioning Pathway for Nursing and Residential Care Homes

The community therapy teams consists of occupational therapists, physiotherapists and therapy assistants who provide rehabilitation to people in their own homes. They are able to support and advise people at risk of

Q. What is deconditioning?

Deconditioning refers to generalized weakness or loss of strength because of lack of muscle use, which can happen due to bed rest and inactivity during hospitalization or illness. It results in functional losses in such areas as mental acuity, strength and the ability to manage activities of daily living including walking and other activities the person enjoys.

Q. Who can be referred to community therapy teams?

Residents who:

- At high risk of falls
- Have deteriorating strength and mobility
- Have problems with fatigue
- Are struggling to manage daily living activities they can normally do

Q. How do I get support from a community therapy teams?

Care homes in can refer directly to the team by emailing

Craven - craven.crt@nhs.net
Bingley - bingley.crt@nhs.net
Keighley/Ilkley - airewharfe@nhs.net
Bradford - bth.ot.physionorth@nhs.net

GPs can refer directly to the team by;
- Airedale via the ANHST Referral Gateway on SystmOne

Top tips to help residents who are at risk of deconditioning

- Aim to maintain residents current levels of ability—continue to encourage patients to 'do what they can' when washing and dressing and other functional tasks.
- Encourage patients to mobilise frequently—even if it is only a few steps.
- If residents are unable to mobilise, try to get them to stand on the spot and count to 10 or complete some sit to stand exercises.
- Encourage residents to keep moving their arms and legs when in bed and in their chair.
- Try to set up and engage residents in a simple chair based exercise group.

Contact Details

Craven	01756 701703
Bingley	01274 322037
Keighley/Ilkley	01943 885153
Bradford North/Central /South	01274 322071/ 435250/ 276435

1c. Accessing Community Dietetic Services

MAY 2020

COVID-19 AIREDALE AND BRADFORD DIETITIANS Emergency Adult Malnutrition Management Pathway for Nursing & Residential Care Homes

NHS Bradford Teaching Hospitals NHS Foundation Trust

working together

Bradford and Airedale Dietitians Care Home Bulletin

NHS Airedale NHS Foundation Trust

Redeployment during the current pandemic has enabled us to provide an emergency, temporary community dietetic service for people at high risk of malnutrition, including those with or recovering from COVID-19

Q. Why is nutrition important for a resident with Covid-19?

- Loss of appetite and reduced dietary intake is common with Covid-19
- Breathing difficulties can increase energy requirements, loss of muscle mass and weight loss
- Overweight or obese residents are still at risk of undernutrition and slower recovery
- Some residents may require nutritional supplements, which a Dietitian can advise on

Q. Who can be referred to a dietitian?

Residents at **HIGH RISK OF MALNUTRITION: MUST Score 2 +**
OR no weight/MUST score possible but significant concern due to recent unintentional weight loss &/or loss of appetite

⇒ Residents could be underweight, normal weight or overweight with significant weight loss and/or poor appetite
⇒ Active Covid-19 OR Post Covid-19 recovery (including recent hospital discharges)
⇒ Non-Covid conditions linked to weight loss e.g. Swallowing problems, COPD, Post Stroke/MI, Cancer, Progressive neurological conditions, Dementia

Q. How do I get support from a dietitian or refer a resident?

You can contact the dietitian for advice and support directly
Bradford - bradford.dietitians@nhs.net
Airedale, Wharfedale and Craven - airedale.dietetics@nhs.net

You can also ask the residents' GP or community nursing team to refer the patient via SystmOne. **Once the referral is received a Dietitian will contact you by telephone to provide advice and support for the resident.**

Top tips to help residents who are at risk of malnutrition

- Fortify foods with cream, cheese, butter and sugar where appropriate
- Use fortified milk in drinks and on/in food (4 tablespoons skimmed milk powder per 1 pint full fat milk)
- Offer high energy and protein options at meal and snack times
- Support eating little and often, offer 3 meals plus 2-3 snacks
- Offer nourishing drinks 2-3 times per day e.g. milky coffee, malt drinks and home-made milkshake (see recipe overleaf)

For more information please go to the following websites:
https://www.bda.uk.com/resource/malnutrition.html
https://www.malnutritiontaskforce.org.uk/resources-and-tools/self-screening-pack
https://www.malnutritionpathway.co.uk/carehomes

Contact Details
Bradford dietetic office: 01274 365108, **Airedale dietetic office:** 01535 294854

Collaboratively produced by Bradford Nutrition and Dietetic Services (Bradford Teaching Hospitals NHS Trust) and Airedale Nutrition and Dietetic Services (Airedale NHS Foundation Trust)

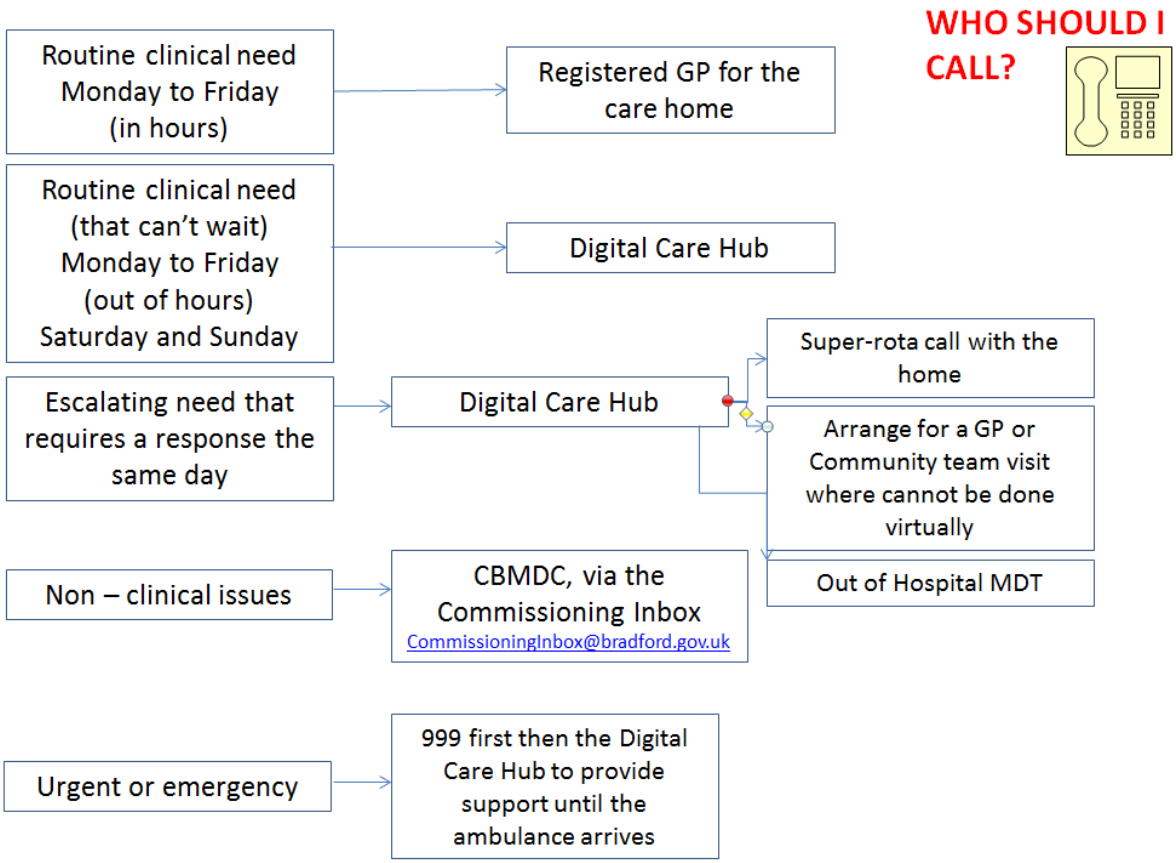
2. Digital Care Hub – responding to escalating health needs for care home residents

What new support is available during COVID-19

- Digital Care Hub for all care homes 24/7 (also called Telemedicine or Immedicare)
- Super-rota of clinicians 8am-12am 7 days per week
- Out of Hospital Multi-disciplinary team 8am-8pm 7 days per week

What is still in place

- Still have your regular GP for all routine medical queries
- Community matrons and district nurses still in place to support homes
- 111 and 999



When should I use Telemedicine to call the Digital Care Hub?

- For any resident where there is an unplanned clinical concern, for example their condition may have worsened, their needs escalated or they require clinical advice or care the same day.

<u>What support does the Digital Care Hub offer?</u>

- 24/7 video enabled access for care home staff and residents to qualified healthcare professionals

- The initial call will be answered and triaged by a call handler and transferred to a nurse
- If needed, calls can be passed to the Super-rota, or multi-disciplinary team – GPs, Consultants and practitioners from across our local providers who are experts in care of the elderly, rehabilitation, A&E, Palliative care, Older People, Mental Health and End of Life care.

3. Data from our Digital Care Hub for April 2020

Following the expansion of the Telemedicine service into 124 Bradford District and Craven care homes to support our response to the Covid-19 pandemic, we have just received the first return of data (April 2020) regarding;

- Numbers of contacts - 319 consultations were conducted across the District
- Call response times - average time to answer across all contracts was: 2 minutes 50 seconds
- Onward referrals
    - For residential homes: 78% were not onward referred; 14% referred to a GP
    - For nursing homes: 70% were not onward referred; 27% were referred to a GP
- Overall, 79% of all consultations that would have called a GP were not referred to a GP

It is still early days and there were a lot of new installations to care homes at the end of April so we expect numbers of contacts to increase significantly in May. The data shows that care homes need this type of clinical support, which often can be managed without any onward referral to primary care.

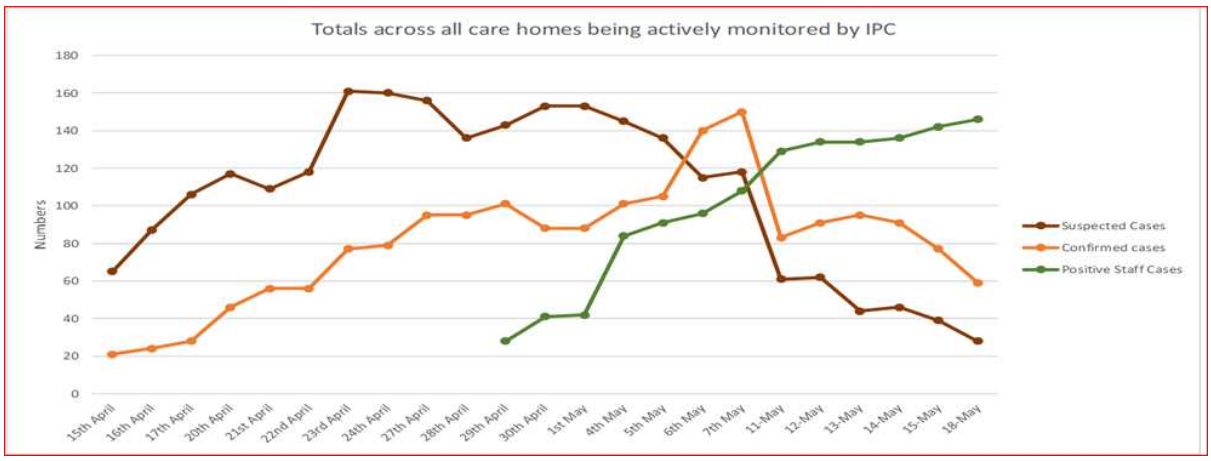
Please continue to work the Care@Home workstream on refining the Digital Care Hub pathway and we will in turn continue to challenge the system to give the best results.

4. Falling Covid-19 Rates in Care Homes

Bradford Local Authority Data from Care Homes on COVID positive patients (20th May 2020)

Since the implementation of the Bradford Care Homes Resilience Plan (30thApril) the overall number of suspect and confirmed cases in care homes being monitored has reduced by 64% from 241 to 87, and in the 2 weeks since 30th April there have been 45 more deaths in total from the homes being monitored compared to 61 in the previous 2 weeks.

This indicates that the spread of infections is being controlled by measures put in place and the likely continued rise of mortality is a result of the high rates of infections when measures were put in place. However, maintaining the measures is important to continue to bring the rate of infections and mortality down to minimal levels.



5. Care home connectivity

Good internet connectivity is key to accessing care through the Digital Care Hub. To support care homes seeking to enhance their connectivity, NHSX and NHS Digital have negotiated and published on the NHSX website a range of internet connection offers with telecom companies. This is complemented by two new pieces of guidance; choosing an internet connection for your care home and how to use digital services in your care home.

Please consider taking these opportunities to enhance connectivity in your home during this period when a strong digital connection is the route to a range of specialist, high quality clinical care.

6. COVID-19 System Roles and responsibilities care home swabbing pathways for Bradford

Controlling the spread of infection through better testing for care home residents for COVID-19 status

This COVID-19 System Roles and responsibilities care home swabbing pathway for Bradford (Craven not included as NYCC have adopted a different approach) summarises the roles and responsibilities for each organisation and provides a pathway of the following scenarios where testing is required.

1. Discharge of new and existing 'residents' going in to a care home setting from hospital
2. Admission of individuals in to a care home from community setting (Bradford only)

3. Point of Outbreak - residents that are symptomatic in a care home setting at the point of outbreak (Pillar 1)
4. Subsequent testing of residents for ongoing and post outbreak (Pillar 2)

See WinZip items; 6.0 Bradford districts Care Home Swabbing Pathways and 6.1 Care Home swabbing pathways Provider Forum PresentationMay2020

7. Guidance for care homes supporting people with dementia who walk with purpose

The COVID-19 pandemic is presenting many new challenges for people who live in care homes and for staff. This new guide is for care homes supporting people with dementia who "walk with purpose" and;

- **have, or are suspected to have, COVID-19**
  - Public Health England guidance is to isolate people, providing care in a single room.
- **do not have symptoms of COVID-19.**
  - isolation in one room is not required, but 'social distancing' rules still apply.
- **People who are 'extremely clinically vulnerable' and shielding**

Much of the advice will be helpful for other health and care settings, including;

- Ideas to achieve co-operation with isolation and social distancing.
- Who to contact: help is available from NHS services, City of Bradford Metropolitan District Council and North Yorkshire County Council.

The aim is to keep everyone else in the care home safe and minimise the spread of infection.

See WinZip items; 7.0 Bradford-Craven-walking-with-purpose-guide_1.0

Open forum – Zoom call reminder

If you have questions, issues, challenges or something to share about 'supporting people with frailty during COVID-19 - the Bradford approach, join Dr Sara Humphrey and the Care @ Home work stream on Tuesdays from 12.30pm to 1.30pm in an open forum Zoom call.
You can join the Zoom meeting using this link.

- Meeting ID: 829 3087 9157
- Password: 863891

Think: **Telemedicine**

Do you feel unsure or need advice or support for a resident?

"if in doubt, call us now"

- Falls
- Chest Infections
- Skin Complaints & Wound Care
- Urine Infections
- Diarrhoea
- Breathing Difficulties & Breathlessness
- Increased Confusion
- Dehydration
- Medication
- Nausea & Vomiting

Remember - you can call us 24/7 with any health-related concern, not just these highlighted above.

ANY EMERGENCY

Always contact 999 first then the Hub for support until paramedics arrive e.g. Cardiac chest pain, suspected stroke, severe head injury or loss of consciousness.

involve

NHS Airedale NHS Foundation Trust

In partnership with Airedale NHS Foundation Trust and Involve