South West Academic Health Science Network

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COVID Oximetry @home Webinar 2

2 December 2020
16:30-18:00

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Welcome

The webinar will be starting at 16:30

Please remain on mute to reduce background noise

Use the Zoom chat function to submit questions

Please note this webinar is being recorded

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Welcome

Anita Randon
Director of Programmes, South West AHSN

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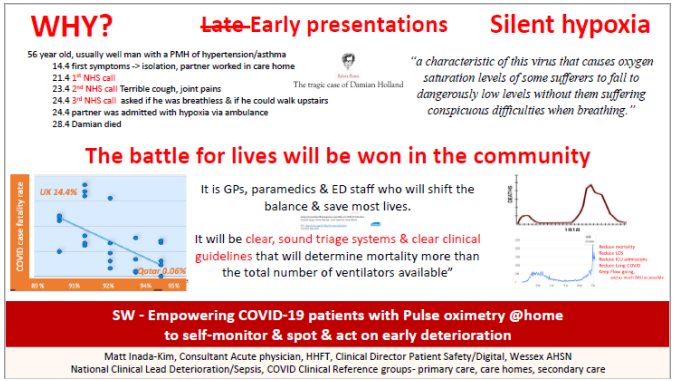
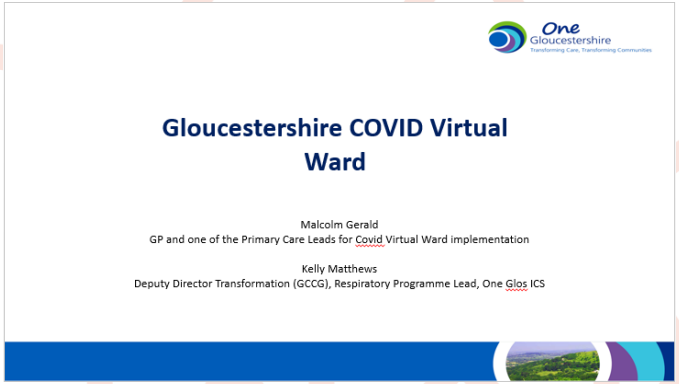
Where were we then?



COVID Oximetry @home webinar 1
4 November 2020

- 8 first wave pilots highlighted importance of monitoring and identifying for 'silent hypoxia'
- Oxygen sats <92% high predictor of mortality if not identified early

- No national mandate for Oximetry @home services
- Approximately 20 services live nationwide



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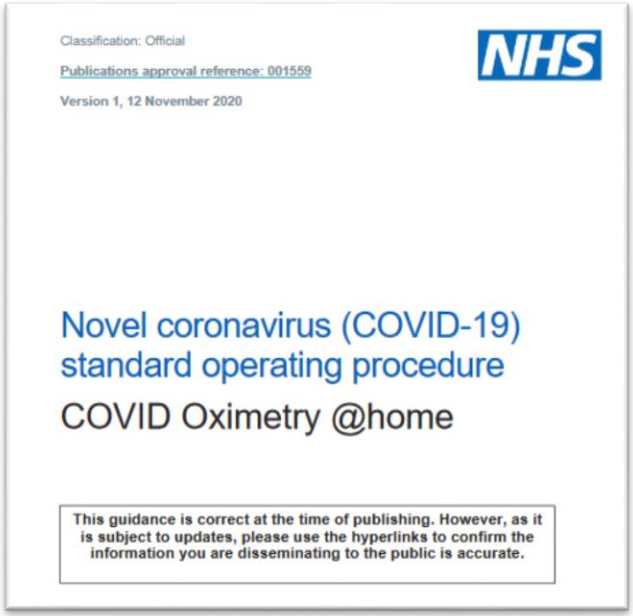
Where are we now?



Classification: Official

Publications approval reference: 001559

Version 1, 12 November 2020

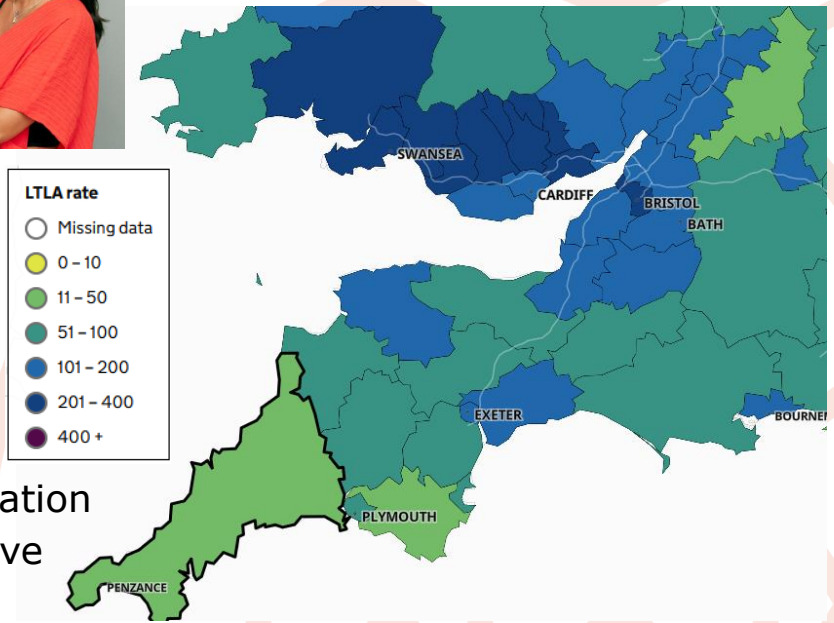
NHS

Novel coronavirus (COVID-19) standard operating procedure

COVID Oximetry @home

This guidance is correct at the time of publishing. However, as it is subject to updates, please use the hyperlinks to confirm the information you are disseminating to the public is accurate.

Vaccine hopes increased but roll out and efficacy still not certain and likely to be lengthy



13 Nov 20 - 27 CCGs Referrals ‘active’. 15 pre-mobilisation

20 Nov 20 - 107 of 135 CCGs pre-mobilisation or active

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Where are you now? - Poll

Please click on the on-screen poll

We'd love to know how people are getting on with COVID Oximetry @Home services

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Agenda

1	Welcome	Anita Randon, Director of Programmes
2	Volunteers and oximeter distribution	Emma Easton, Head of Voluntary Partnerships
3	Evaluating Oximetry @ home	Hayley McBain, Evaluation Lead
4	National Institute for Health Research & UCL evaluation next phase	Naomi Fulop, Professor of Health Care Organisation and Management
5	Learning Disabilities Mortally Review (LeDeR) COVID-19	Mark Tucker, Learning Disability and Autism Programme Assurance Manager & SEND Lead
6	Integrating the RESTORE2 Rollout with Remote Annual Health Checks for people with LD	Jamie-Lee Cosgree, Primary Care Liaison Nurse
7	Discussion and Q&A, including key clinical considerations for pulse oximetry	Alison Tavaré, Primary Care Lead
8	How to stay connected	Anita Randon, Director of Programmes

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Q&A

Please post questions in the chat

We'll have a Q&A session after the presentations

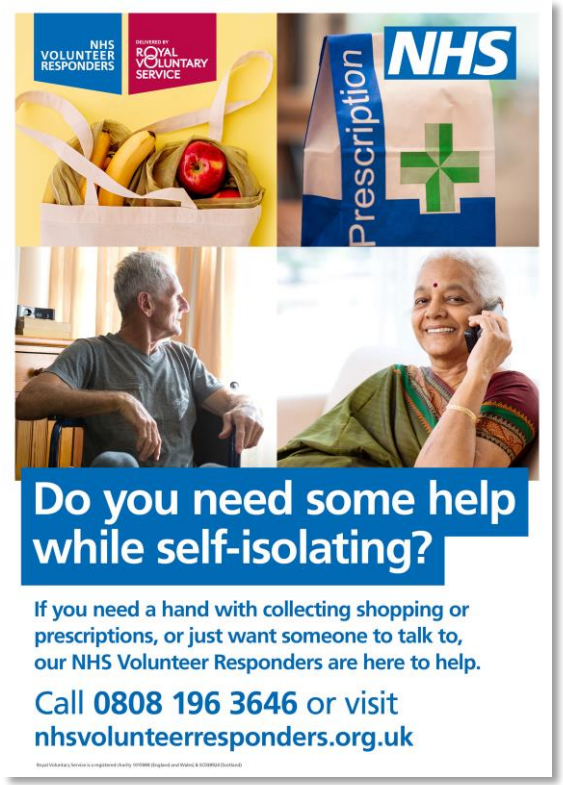
NHS Volunteer Responders and Pulse Oximetry

2nd December

Emma Easton, Head of Voluntary Partnerships

NHS England and NHS Improvement

What are the aims of the scheme?



The NHS Volunteer Responders scheme aims to:

1. Provide protection to those clinically vulnerable to the Covid-19 pandemic
2. Enable more individuals to step forward to support the NHS through micro-volunteering opportunities.
3. Increase capacity within the local healthcare economy and respond to 'real-time' needs in the system.

The programme will continue until at least 31 March 2021

Over 1.15m tasks have been completed by volunteers to date

Support available

Volunteer Responders support vulnerable individuals through one of the following roles:

Community Response Volunteer / Community Response Plus

This role involves collecting shopping, medication or other essential supplies for someone who is self-isolating, and delivering these supplies to their home.

NHS Transport Volunteer

This role involves transporting equipment, supplies and/or medication between NHS services and sites, it may also involve assisting pharmacies with medication delivery.

This role could be used to deliver and pick up pulse oximeters.

Patient Transport Volunteer

This role supports the NHS by providing transport to patients who are medically fit for discharge or to transport patients to medical appointments.

Check In and Chat Volunteer / Check in and Chat Plus

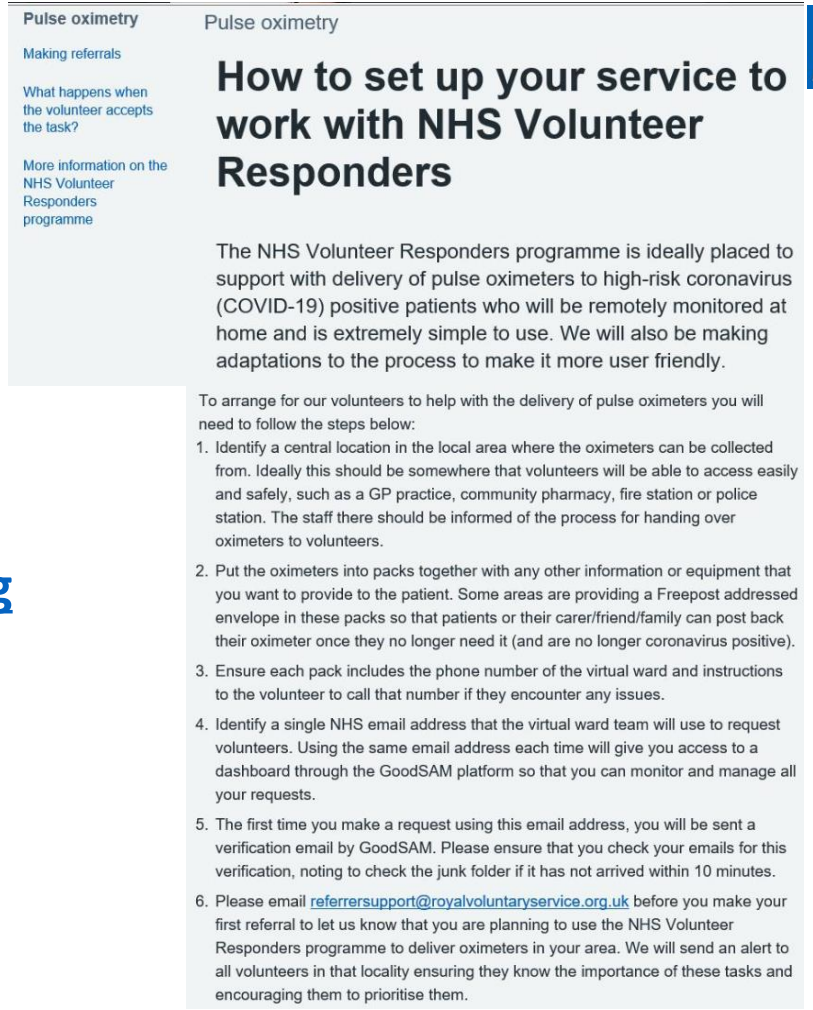
This role provides telephone support to individuals who are at risk of loneliness as a consequence of self-isolation.

How to get set up

Supporting <u>delivery</u> and <u>collection (where needed)</u> of pulse oximeters

Pulse Oximeter Fact Sheet: https://nhsvolunteerresponders.org.uk/pulse-oximetry

6 steps for setting up your service to work with NHS Volunteer Responders



Pulse oximetry

Making referrals

What happens when the volunteer accepts the task?

More information on the NHS Volunteer Responders programme

Pulse oximetry

How to set up your service to work with NHS Volunteer Responders

The NHS Volunteer Responders programme is ideally placed to support with delivery of pulse oximeters to high-risk coronavirus (COVID-19) positive patients who will be remotely monitored at home and is extremely simple to use. We will also be making adaptations to the process to make it more user friendly.

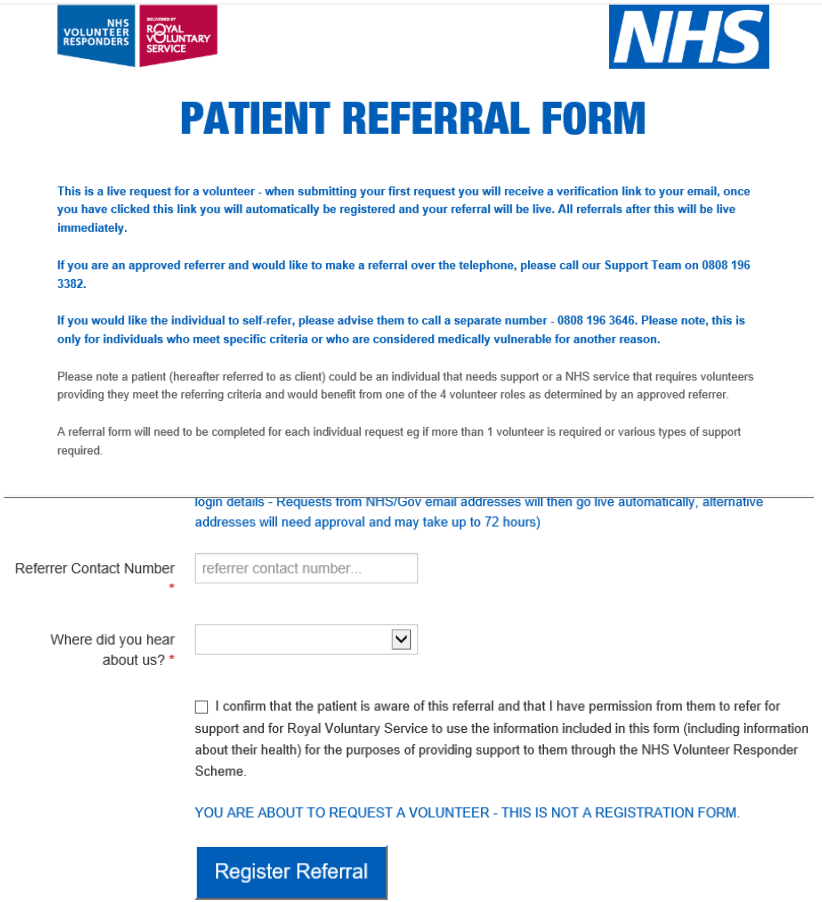
To arrange for our volunteers to help with the delivery of pulse oximeters you will need to follow the steps below:

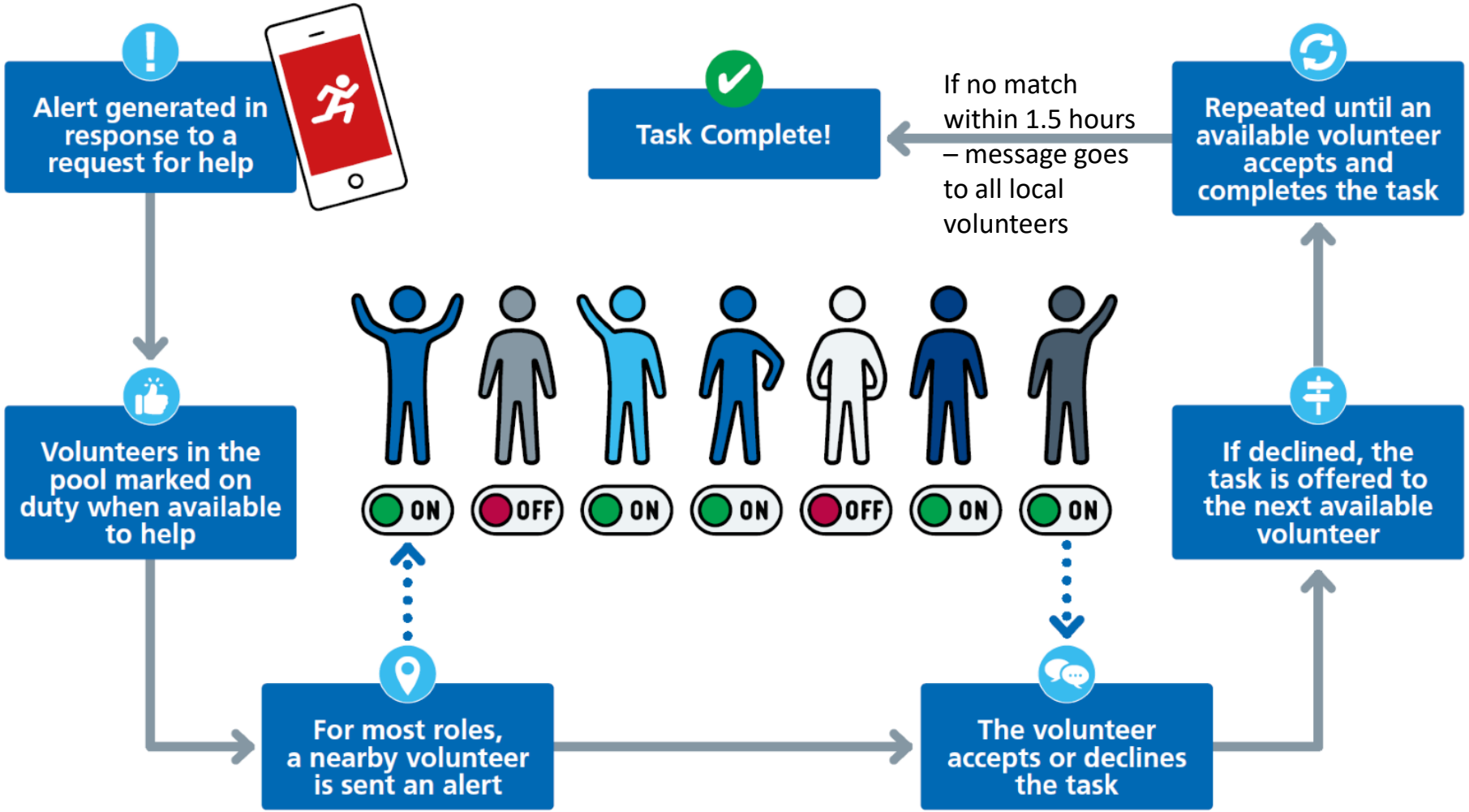
1. Identify a central location in the local area where the oximeters can be collected from. Ideally this should be somewhere that volunteers will be able to access easily and safely, such as a GP practice, community pharmacy, fire station or police station. The staff there should be informed of the process for handing over oximeters to volunteers.
2. Put the oximeters into packs together with any other information or equipment that you want to provide to the patient. Some areas are providing a Freepost addressed envelope in these packs so that patients or their carer/friend/family can post back their oximeter once they no longer need it (and are no longer coronavirus positive).
3. Ensure each pack includes the phone number of the virtual ward and instructions to the volunteer to call that number if they encounter any issues.
4. Identify a single NHS email address that the virtual ward team will use to request volunteers. Using the same email address each time will give you access to a dashboard through the GoodSAM platform so that you can monitor and manage all your requests.
5. The first time you make a request using this email address, you will be sent a verification email by GoodSAM. Please ensure that you check your emails for this verification, noting to check the junk folder if it has not arrived within 10 minutes.
6. Please email referrersupport@royalvoluntaryservice.org.uk before you make your first referral to let us know that you are planning to use the NHS Volunteer Responders programme to deliver oximeters in your area. We will send an alert to all volunteers in that locality ensuring they know the importance of these tasks and encouraging them to prioritise them.

Making referrals

Once a patient is identified as needing an oximeter, organisations should complete the online

Patient Referral Form to request a volunteer: Link to form: [https://www.goodsamapp.org/nhs referral](https://www.goodsamapp.org/nhsreferral)




Alert generated in response to a request for help
Volunteers in the pool marked on duty when available to help
For most roles, a nearby volunteer is sent an alert
The volunteer accepts or declines the task
If declined, the task is offered to the next available volunteer
Repeated until an available volunteer accepts and completes the task
If no match within 1.5 hours – message goes to all local volunteers
Task Complete!
ON
OFF
ON
ON
OFF
ON
ON

Completing the task

1. Volunteers will phone the contact number on the referral form to clarify details. E.g. pulse oximeter collection location and patient's address for delivery.

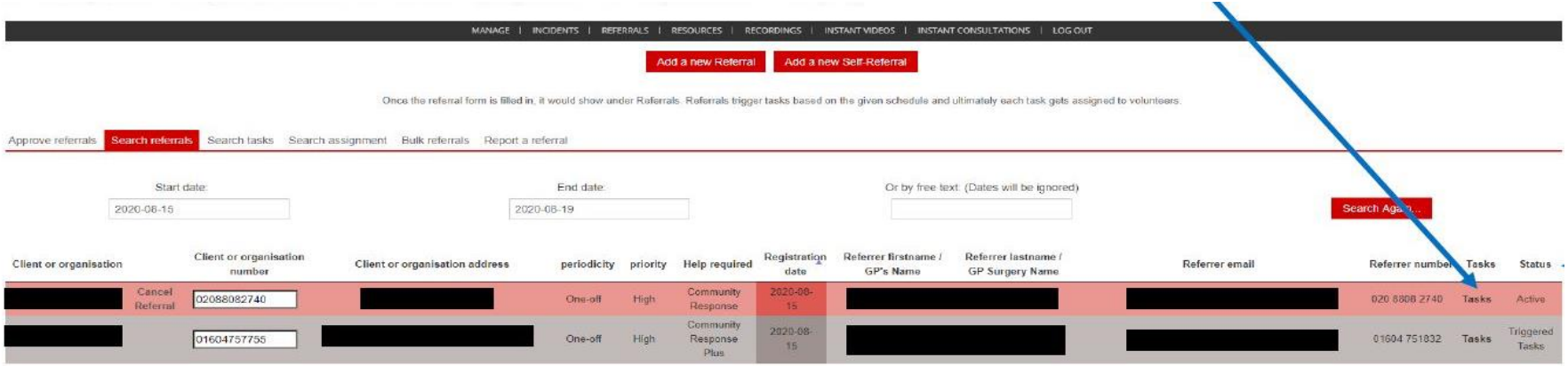
2. Volunteers will arrive at pulse oximeter collection location. Identification will be shown and pulse oximeters collected.

3. The volunteer will deliver oximeters to patient's address by posting through the letterbox if possible or they will leave it on the doorstep, knock and step back at least 2 metres and check that someone retrieves it from the doorstep before leaving.

4. If volunteers encounter any difficulties, they will contact the number of the virtual ward or the central Support Team.

Other important things to know

- ✓ Please make sure you let us know before you start using the service so that we can disseminate communication to all volunteers locally (email referrersupport@royalvoluntaryservice.org.uk)
- ✓ Service operational 7 days a week, tasks live from 09.00 – 18.00 (call centre support available 8am-8pm)
- ✓ We recommended that referrals are completed **early in the day where possible**.
- ✓ Referrals made **late** in the day **may not picked up until the following morning**.
- ✓ Please monitor your dashboard and have a 'back up' plan just in case - COVID Oximetery @Home SOP states: *Particular care needs to be given to ensuring reliable arrangements are in place for same day oximeter distribution to patients, and their subsequent decontamination and reuse.*



Further information

You can find more information about the programme, including FAQs, at www.nhsvolunteerresponders.org.uk

Data reports, case studies and the latest communications resources - including posters and social media graphics - are available on the NHS Volunteer Responders COVID-19 Future NHS workspace. Local authorities, NHS colleagues and other referrers can ask for access to the workspace by emailing NHSVolunteerRespondersCOVID-manager@future.nhs.uk

Any further questions about the programme: england.covid-communities@nhs.net

Thank you!

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Evaluation and Learning: COVID Oximetry @home

Dr Hayley McBain, Evaluation Lead

Why do evaluation?

Demonstrate programme impact

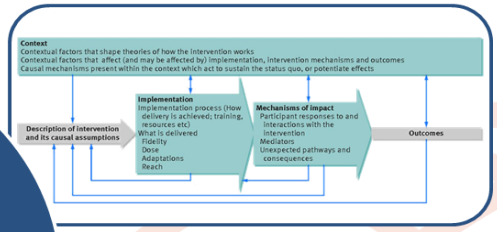
- Support future commissioning
- Prove impact to funders

Improve programme design and implementation

- Learn from mistakes and make changes

Types of evaluation

- diagnostic accuracy
- patient-reported outcome measures
- clinical measures of disease severity or disability
- behaviour
- physiological measures
- user satisfaction and acceptability
- health and social care resources



Economic analysis level	App...	
Basic.	Budget impact analysis.	Estimated yearly budget impact for years 1 to 2. Data may be collected to inform future economic analyses.
Low financial commitment.	Cost-consequence analysis.	Estimated costs and benefits. Sensitivity analysis results.
	Budget impact analysis.	Estimated yearly budget impact for years 1 to 5. Sensitivity analysis results.
High financial commitment.	For DHTs with health outcomes funded by the NHS and Personal Social Services, a cost-utility analysis should be done using NICE's guide to the methods of technology appraisal as a reference case.	Estimated incremental cost-effectiveness ratio. Sensitivity analysis results.
	For DHTs funded by the public sector with health and non-health outcomes, or for DHTs that focus on social care, a cost-utility analysis should be done. If this is not possible, a cost-consequence analysis may be acceptable. The analysis should be done using developing NICE guidelines: the manual as a reference case.	Estimated incremental cost-effectiveness ratio (cost-utility analysis) or estimated costs and benefits (cost-consequence analysis). Sensitivity analysis results.
	Budget impact analysis.	Estimated yearly budget impact for years 1 to 5. Sensitivity analysis results.

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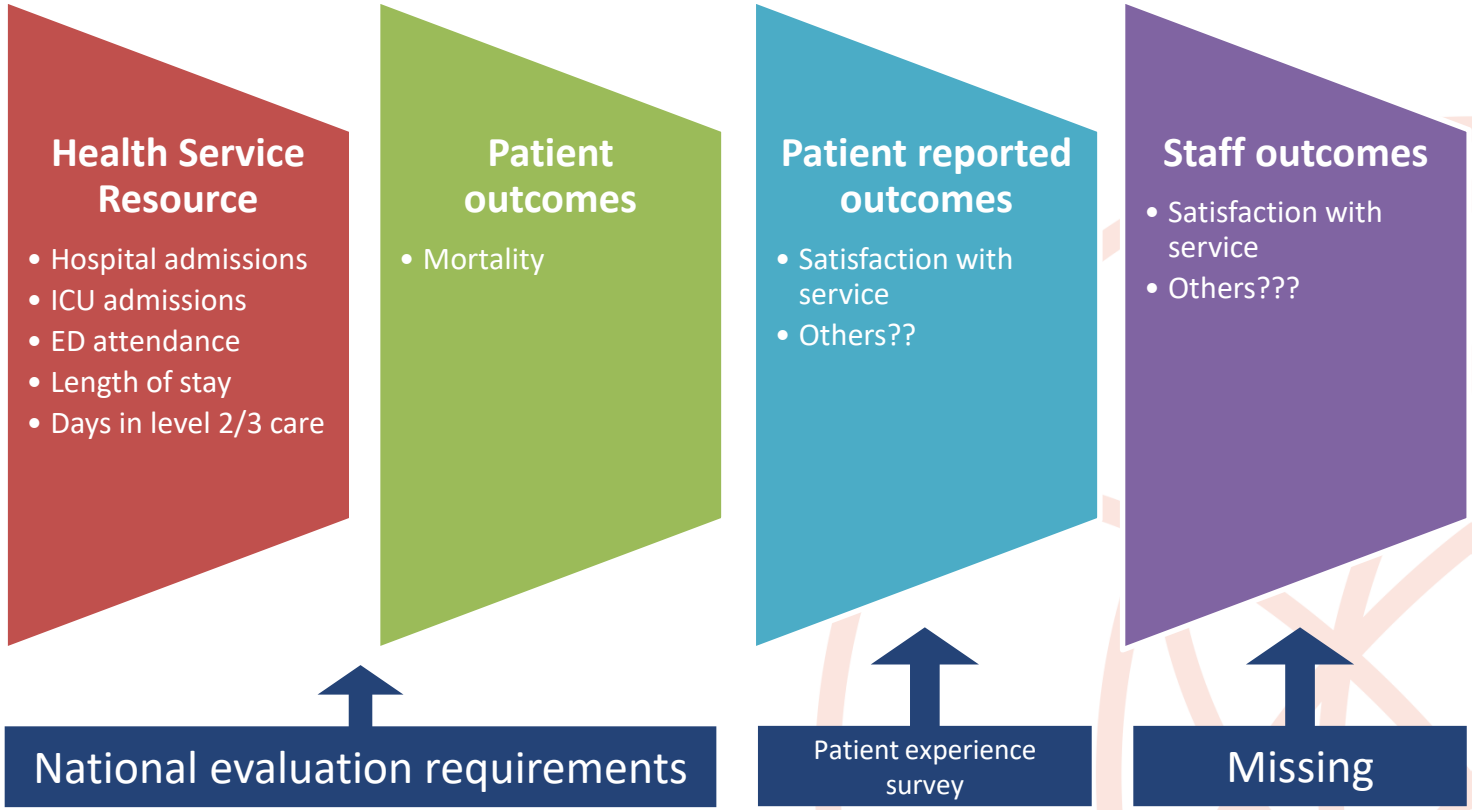
Outcome + economic evaluation



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Process evaluation – national evaluation

Implementation

- How?
  - Who is doing the delivery?
- Fidelity
  - How many oximeters are in use?
  - How many patients are onboarded?
  - How many onboarded receive an oximeter?
- Reach
  - Are those entering the service those who it was intended for?

Mechanisms of Impact

- Mediators
  - Outcomes by technology

Context

- Occupation
- Home circumstance

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Process evaluation – patient experience survey

Implementation

- How?
  - Who is doing the delivery?
- Fidelity
  - How many oximeters are in use?
  - How many patients are onboarded?
  - How many onboarded receive an oximeter?
- Reach
  - Are those entering the service those who it was intended for?
- Barriers and enablers to:
  - Recording the reading (patient)
  - Self-efficacy:
    - Recording the reading

Mechanisms of Impact

- Mediators
  - Outcomes by technology

Context

- Occupation
- Home circumstance

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Process evaluation – what's missing?

Implementation

- How?
  - Who is doing the delivery?
- Fidelity
  - How many oximeters are in use?
  - How many patients are onboarded?
  - How many onboarded receive an oximeter?
  - Do patients self-monitor and seek help?
- Reach
  - Are those entering the service those who it was intended for?
- Adaptations
  - What adaptations are being made to service in different settings?
- Barriers and enablers to:
  - Using the oximeter (patient)
  - Recording the reading (patient)
  - Help-seeking (patient)
  - Implementing the service (settings, services
  - Self-efficacy:
    - Using the oximeter
    - Recording the reading
    - Help seeking

Mechanisms of Impact

- Mediators
  - Outcomes by technology
- Unexpected consequences
  - Patient anxiety

Context

- Occupation
- Home circumstance

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Problem: [Clearly articulate the problem the project is trying to solve. Include "who, what, why, where, when, and how" in your statement.]

Goal: [What is this project trying to accomplish? The answer to this question is the solution to your problem statement.]

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Assumptions	Activities	Outputs	Outcomes
[What are the conditions which your project needs to succeed? These conditions already exist and likely cannot be changed.]	[Activities are the actions that are needed to implement your project and achieve your outcomes.]	[Outputs are the tangible and direct products or results of your project activities. Make sure your outputs have activities and resources associated with them.]	[Outcomes express the results that your project intends to achieve if implemented as planned. Outcomes could relate to patients, staff, organizations or systems during or after the project, but must be as a consequence of the project activities. It is important to remember that these outcomes must be within the scope of the projects' control or sphere of reasonable influence.]
Resource [Identify the resources you need to deliver your project, this could be staff (paid and in-kind), equipment, materials.]			**Impact** [Impact is what you hope to achieve as a consequence of attaining your outcomes. Your project may have a less direct influence on impact, or maybe beyond the timeframe of your project].

Logic Model for [insert name of project]

RSET rapid service evaluation team

BRACE Rapid Evaluation Centre

COVID Oximetry @Home

[Remote home monitoring]

RSET and BRACE evaluation

Professor Naomi Fulop

University College London

FUNDED BY NIHR | National Institute for Health Research

Team and funding

- Naomi Fulop (UCL, RSET)
- Cecilia Vindrola (UCL, RSET)
- Manbinder Sidhu (University of Birmingham, BRACE)
- Chris Sherlaw-Johnson (Nuffield Trust, RSET)
- Theo Georghiou (Nuffield Trust, RSET)
- Holly Walton (UCL, RSET)
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- Jenny Bousfield (RAND, BRACE)
- Jo Ellins (University of Birmingham, BRACE)
- Steve Morris (University of Cambridge, RSET)
- Pei Li Ng (UCL, RSET)

For more info contact: n.fulop@ucl.ac.uk

Acknowledgement:

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The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR, NIHR, NHS or the Department of Health and Social Care.

Phase 1 evaluation: remote home monitoring models during first wave pandemic

- **Rapid systematic review** – preprint available here

  https://www.medrxiv.org/content/10.1101/2020.10.07.20208587v2

- **Rapid evaluation of 8 sites operating remote home monitoring during 1st wave**:
  - typology of models / Implementation / staff experience / use of data / patient numbers and impact / staffing models and costs

  → **Lessons learned for winter 2020-2021**

  - Slide set summarising findings:

  https://www.nuffieldtrust.org.uk/files/vw-evaluation-final-slideset-for-dissemination-12th-oct-2020.pdf

  - Preprint publication:

  https://www.medrxiv.org/content/10.1101/2020.11.12.20230318v1

- Not able to determine effectiveness or patient experience

What will we look at in phase 2 evaluation?

Work stream 1: the impact of CO@H

Work stream 2: Economic analysis

Work stream 3: National study of implementation, patient and staff experience

Work stream 4: In-depth case studies of implementation, patient and staff experience

Work stream 1: How is CO@H associated with mortality and use of hospital services?

- **National area level analysis (available aggregated data)**
  - Changes in Covid hospitalisations & mortality, after implementation
  - Accounting for area characteristics, dates of implementation, levels of uptake, vaccinations(?), etc
- **Step-down model readmissions (HES data)**
  - Changes in Covid readmissions - frequency and patient characteristics
  - Accounting for above factors, also person characteristics, prior admission
- **Covid admissions (HES data)**
  - Changes in characteristics of Covid-admitted patients, after implementation
  - Includes impact on hospital experiences eg LOS

Work stream 2: Economic analysis

- **Cost analysis**
  - Implementing CO@H at study sites
    - Staff and non-staff costs
  - Running the CO@H sites
    - Staff and non-staff costs
  - Treating patients whose health deteriorates
    - Including ED and outpatient visits, and inpatient stays including ICU stays
- **Cost-effectiveness analysis**
  - Costs (as above)
  - Outcomes measured in terms of mortality and quality-adjusted life years
- **Budget impact study**
  - Local and national cost impact of the rollout of the CO@H programme
- **Data:**
  - Bespoke cost collection tools from study sites (costs of implementing and running CO@H)
  - Proposed National Dataset (hospital use, mortality)
  - Published data (quality of life)

Work stream 3: National study of implementation, staff and patient experience

Aim: To explore the experiences of those setting up and delivering CO@H and those receiving CO@H at a national level

Staff surveys: A national survey with staff who have been involved in implementing and delivering CO@H. The survey will focus on capturing information about the service, experiences delivering CO@H, training and support received, impact on workload, perspectives on patient engagement, and barriers and facilitators.

Patient and carer surveys: A national survey with patients and carers who have received CO@H. The survey will focus on demographics, questions about service received, patients' experience of receiving CO@H, patients' engagement with CO@H, and barriers and facilitators.

Work stream 4: In-depth case studies of implementation, patient and staff experience

Aim: to analyse implementation of CO@H and staff experiences of delivering the service and patient experiences of care in a sample of 12 sites purposively sampled by geography/setting/model type/mechanism for remote monitoring.

Staff interviews: semi-structured interviews with staff from sites who implemented CO@H during waves 1 and/or 2 of the pandemic. Interviews will focus on capturing data relevant to implementation incl the factors acting as barriers and enablers. We will aim to carry out interviews with **3-4 staff members at each site** (including lead, staff delivering the service and staff with data knowledge).

Patient interviews: semi-structured interviews with patients will focus on documenting their journeys of remote home monitoring, their experiences of being ill and monitored at home, experiences with escalation and discharge, and recommendations for improving these models. We will aim to recruit 6 patients per study site, including patients who received the service, and if possible, those who withdrew and those who declined.

How we would like you to be involved

National

- Sending out patient and staff surveys (to be returned to research team)
- Providing aggregate data on patient nos./outcomes, staffing & costs

Case studies (if selected as one of 12 sites)

- Supporting with recruitment for the patient and staff interviews

Once the study has finished, we aim to provide individual site feedback on our key findings from the patient survey

For more information about the study please contact Prof Naomi Fulop n.fulop@ucl.ac.uk or Pei Li Ng pei.ng@ucl.ac.uk

Mark Tucker

Learning Disability and Autism Programme Assurance Manager and SEND Lead
NHS England and NHS Improvement South West

2nd December 2020

People with a Learning Disability & Coronavirus

- PHE analysis of data on deaths during first wave of Covid-19
- University of Bristol analysis of 206 LeDeR reviews in similar period
- South West region actions

PHE findings

- **Number of deaths:** 623 deaths equates to 240 per 100,000 deaths : > double rate for general population (104 per 100,000 deaths).
- **Age at death:** learning disability population die significantly younger than general population. Majority of deaths in 55 to 64 yr olds. General population deaths concentrated in age groups over age 75.
- **Place of death:** 82% died in hospital, compared with 63% in the general population. (Note 77% in UoB report).
- **Community-based care:** COVID-19 accounted for 53% of deaths of adults with a learning disability receiving community-based social care. This level of additional mortality is similar to that seen in residential care.
- **BAME:** Death rates higher for men, people from BAME groups, people living in areas of greater socioeconomic deprivation and older people. The number of deaths of people with a learning disability from all causes for white groups rose by 1.9 times but rose by 4.5 times for Asian / Asian British groups and 4.4 times for Black / Black British groups.
- **Out of hospital deaths of adults:** where the learning disability status of the deceased was recorded, 2.4% were adults with a learning disability. GPs in England recognise only 0.57% of adults registered with them as having learning disabilities. So adults with learning disabilities were over-represented by almost 4 times among people dying in hospital from COVID-19. The disparity was larger in younger age groups.

University of Bristol Review of 206 deaths in first wave (LeDeR)

The University of Bristol analysed 206 deaths of people with a learning disability, **163** with COVID-19 and 43 from other causes, to enable learning / help understand reasons for increased deaths during the pandemic and implement changes. All occurred between 2nd March and 9th June 2020. Represents about 1 in 4 of all people notified to LeDeR at that time who had died of COVID 19. **Thirty three (20%) of the COVID-19 deaths were those of people with Down's Syndrome.**

Key findings

- **Age at death: About half of deaths were of people aged 50 – 69 (gen population half over 85).** Indicates that age thresholds for shielding people from COVID-19 would disproportionately disadvantage people with a learning disability.
- **Place of death:** 125 (77%) people with a learning disability who died from COVID-19 **died in hospital**, compares to 63% in general population who died from COVID-19, 60% of people with a learning disability whose deaths were reviewed in 2019 and only 46% of the general population in 2018.
- **Normal place of residence:** 57 (**35%**) people with a learning disability who died from COVID-19 **lived in a residential care home** and 40 (25%) in supported living; those with Down's Syndrome: 16 (48%) lived in residential care and 29 (88%) lived in some sort of care setting. settings (Of all adults with a learning disability known to GPs, only 11.6% live in residential care homes), Of those for whom we know the probable source of infection, **half are thought to have caught the virus from staff or other residents in their home.**. At least 14 (42%) of those with Down's Syndrome caught the virus in a residential home.
- **Existing conditions:** All of the people in the sample had existing medical conditions most frequently impaired mobility, respiratory conditions, high blood pressure and obesity. Those who died from COVID-19 were slightly more likely to have an existing respiratory condition than those who died from other causes.
- **Shielding:** 16 (7%) of the people who died from COVID-19 had received a letter advising them to shield because of extremely clinically vulnerable status. A further 11 (5%) were shielding despite not receiving a letter. **The majority of those who were shielding were supported by external paid carers**.

Key findings (continued)

- **Infection control:** 21 (27%) people who died from COVID-19 are thought to have **contracted the virus during a previous hospital stay** for an unrelated condition.
- **Social distancing:** was **impossible for some** who relied on close contact with carers for everyday care.
- **PPE:** A small number of problems with supply - particularly where people lived in their own homes or with families.
- **Deterioration:** 18 (11%) of those who died from COVID-19 experienced a rapid deterioration in health following a period of apparent improvement. **Concerns were raised about the lack of tools and equipment to detect deterioration in primary and community settings**.
- **COVID-19 symptoms:** top three symptoms in those who died from COVID-19 were **difficulty breathing** (127/78%), **a cough/'chesty**' (104/64%) and a **fever** (93/57%). No one reported a loss of sense of taste or smell.
- **Access to timely and appropriate healthcare:** 45 (28%) of the people in the sample who died from COVID-19 had **problems accessing the care they needed**. Problems included responsiveness of NHS111, difficulty accessing COVID-19 testing and lack of access to specialist learning disability services. People struggled to access tests. NHS 111 was unable to tailor services for people with a learning disability
- **Hospital treatment:** of those who died from COVID-19, 124 (76%) received treatment in hospital 14 (9%) had had any treatment in ITU or critical care (10% gen population). The **majority of those who died from COVID-19 were treated with antibiotics** (113/69%) and / or oxygen (99/61%). 25/15% received mechanical breathing support or ventilation (similar to general population).
- **Reasonable adjustments:** **were not made for 29 (18%)** people in the sample who died from COVID-19. They would have benefited from learning disability services whilst in hospital, more personalised care and/or being accompanied by family or carers.
- **DNACPR:** **133 (82%)** of those who died from COVID-19 **had a DNACPR decision in place**. Reviewers felt that the majority (96/72%) of these were correctly completed and followed – **37 (28%) were not**. Several reviewers noted that frailty or **'learning disabilities' were given as rationales** for a DNACPR decision for people who had died from COVID-19. Several reviewers also noted that the DNACPR decision had **not adhered to the mental capacity act**.

Key action areas

- **Identifying deterioration in health**
  - Staff in care homes, carers and front line clinical staff need to be trained in recognising deterioration using tools such as NEWS2 and RESTORE2™
  - Virtual COVID wards should be rolled out and use of pulse oximetry made routine
- **DNACPR**
  - It should be reinforced that a learning disability is never a basis for a DNACPR and all DNACPRs must be decided in line with the Mental Capacity Act
  - 'Learning disability' should never be cited as a reason for death in MCCD
- **Diagnostic overshadowing**
  - Hospital passports should be used across systems to communicate health needs of people who are autistic and those who have a learning disability
  - GPs should use their own judgement of individual risk around shielding and social isolation to consider how people with a learning disability with 'moderate risk' comorbidities are best advised to remain safe.
- **Reasonable adjustments**
  - All mainstream services should know how to and then make reasonable adjustments for people with a learning disability – learning disability liaison nurses are key to support this
  - Testing including reasonably adjusted testing needs to be readily available for people with a learning disability and their carers
  - PPE needs to be readily available to unpaid carers

https://www.gov.uk/government/publications/covid-19-deaths-of-people-with-learning-disabilities

What we are doing in the South West

Spotting when people are getting more unwell

- **Restore 2 & Restore Mini** training to social care staff – soft signs & actions to take
- Trial & spread – **piloting Pulse Oximeters** – project team set up and links to Oximetry at Home.
- Compiling **new national policy documents** to help hospital staff spot the signs that somebody with a learning disability is getting more unwell.
- Our Acute Trusts all had provision for people with a learning disability during first wave – North Bristol Trust were exceptional in increasing number of Acute LD Liaison nurses but all linking Acute to community
- **Hospital Passports** have been promoted & am aware that many of the CLDTs have been targeting people to make sure people have these.

What we are doing in the South West

DNACPR and learning disability as a cause of death

- Continuing to remind doctors that a learning disability is not a reason not to try and resuscitate someone making sure GPs look at all DNACPR decisions and make sure they are right for the person.
- Funding provided to Somerset CCG to develop training & resources to promote Advanced Planning for people with a learning disability – including **DNACPR** which was a particular problem for Somerset during Wave 1
- Supporting the introduction of Medical examiners to make sure doctors use the right words on death certificates.
- Supporting reviewing training for staff working in health and social care.

What we are doing in the South West

Winter – Flu vaccination

Developed and published:

- A Learning Disability **Flu Campaign Toolkit**
- Professional's **grab pack & webinar** – 3 RNLDs (BSW, Devon & Cornwall) worked together to develop a Flu Pathway and with our Immunisation & Screening lead ran a webinar to Community Learning Disability teams (CLDTs).
- **Awareness video** featuring actors with learning disabilities from Misfit Theatre Group - **Flu vaccination: Just don't let anything stop you**

As of November 6:

- 100+ unique flu comms toolkit downloads
- 30+ unique Grab Pack downloads

The awareness video has been live for a month, (published 19 Oct 2020), and as of 18 Nov 2020 it has received 3,778 unique views. High traffic rates via Facebook (over 40%) indicating good social sharing.

What we are doing in the South West

Annual Health Checks (AHC) push

- Toolkit with guide to patient risk stratification (Social & Clinical vulnerabilities) published & promoted widely.
- Linked closely to all flu messaging i.e. capitalise on attendance for the vaccine and schedule AHC.
- Majority of areas have clear, strong strategies. Proposal under production for CCGs to support push with Primary Care and lead commissioners.
- Learning Disability Collaborative – WEAHSN & NHSEI developing quick guide videos for Primary Care teams alongside delivering regular webinars to people, families, social care staff & NHS staff.
- Call to Action and Funding to support CCGs increase uptake of AHCs will be launched w/c 30th November

People with a Learning Disability & Coronavirus

- PHE analysis of data on deaths during first wave of Covid-19
- University of Bristol analysis of 206 LeDeR reviews in similar period
- South West region actions

- **Impact on People with a Learning Disability**
- **Covid has magnified exiting health inequalities**
- **We have a plan**
- **Early identification**

Together **we can make a real difference to the lives of people with a Learning Disability in the South West**

NHS England and NHS Improvement

Integrating the RESTORE2 Rollout with Remote Annual Health Checks

Plymouth Community Learning Disabilities Team

What is RESTORE2?

- Recognise Early Soft signs, Take Observations, Respond, Escalate.
- Teaching those with the most hands on care. The people who know them best.
- Gives a tool of communication with medical systems. A universal language.
- A tool to safeguard with COVID19 restrictions. Virtual wards etc.

What are the problems?

- COVID19- AHC first quarter data shows 57% less people got their AHC. (Devon CCG, 2019/2020)
- LeDeR outcomes, particularly in residential settings. 1/3 in residential settings (50% for individuals with Down's Syndrome) and a quarter in supported living.
- Higher risk cohort.
- Clinical risk vs oversight.

Remote Annual Health Checks

- Shielding patients.
- Digitally excluded population.
- Fast changing systems can be complicated and inflexible
- Population concerns, less likely to self present.

Risk vs Priority

Priority Category	Support setting	AHC Intervention
Low	Nursing/ Residential setting, 24/7 carers.	Use AHC tools to complete majority of AHC remotely. Only having face-to-face consultations where triggered in HAP.
Moderate	District nurse daily calls, Package of care in place in the community. Involvement of external agencies. BAME individuals (If multiple comorbidities please classify as high priority)	Use AHC tools as appropriate, send out to individuals to fill in and send back before an AHC to see what areas could be targeted during AHC. Face-to-face may be required to complete all information. If individuals can use technology the virtual appointment may be explored if appropriate.
High	No social or health care package in place for support. Support calls only, minimal health interventions/ practitioners involved.	Will require a face to face appointment for full physical examination.

Utilising RESTORE2 numerics

- Collection of baselines.
- Understanding of ‘unique wellness’
- Tool for remote monitoring (virtual wards, AHC etc.)
- Recognises deterioration sooner, even without the NEWS2 score.
- Recognition of asymptomatic conditions such as silent hypoxia.

Current Feedback

- Found it helpful when talking to the doctor, using terminology they now understood.
- Feel more listened to and able to recognise changes in baseline to escalate when they may have waited before.
- Found the training easy to follow, NHSE videos have been really valuable for reference.
- Each service using same tool in their own unique routine.

Desired Outcomes

- Improve confidence and competence of those who know directly support individuals with complex health needs.
- Increase and help facilitate remote annual health checks for numeric collection and monitoring.
- Improve the clinical outcomes of individuals in supported living residence in light of COVID.
- Improve communication between health and social care services.
- Reduce the number of preventable deaths of individuals with learning disabilities.

Part of The AHSN Network

South West Academic Health Science Network

West of England Academic Health Science Network

Discussion and Q&A

Chaired by Alison Tavaré

Please post questions in the chat

We'll share the chat transcript with the post webinar materials

Pulse oximetry: a finger-tip guide

Am trying to measure oxygen saturations but can't: why?

- Patient not been still for few minutes?
- Hand not flat on chest or table?
- Cold hands?
- Nail varnish?
- Device: app or watch?

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Pulse oximetry: a finger-tip guide

Oxygen saturations of 94%

- Is this accurate; should it be repeated?
- The device cost about £25 can I trust it?
- The patient has known COPD what difference does this make?
- The patient has pigmented skin does this make a difference?
- Is the patient acutely unwell?
- Could this be COVID?
- Could this be silent hypoxia?
- Could this be acute illness not related to COVID?

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Survey

We'd love to hear your feedback: we'll use this to help plan future webinars and where the South West and West of England AHSNs can support you

https://www.surveymonkey.co.uk/r/COVIDOXATHOME_2_December2020

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Where can you connect to learning and sharing events?

Nationally the AHSN Network have convened a rapid learning and sharing network to support the pilot sites, and the development of a COVID virtual ward toolkit available on the FutureNHS collaboration platform.

- If you currently have access to this platform, log on and click on 'My Workspaces', then 'Find a Workspace' and search for 'National Patient Deterioration Forum'. Once access is granted, click on the 'COVID 19 Virtual Ward Toolkit'.
- For those not on FutureNHS, you can register if you have an NHS email address. Register for an account here (using your NHS email address) and request access to the National Patient Deterioration Forum. Once access is granted, click on the link in the forum for COVID 19 Virtual Ward Toolkit.

Locally, we have these regional webinars (we will let you know future webinar details) and there are Wednesday morning webinars for those in the South West part of the region.

Connect with us

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