

Written evidence submitted by The Queen's Nursing Institute (DEL0152)

The Queen's Nursing Institute is a registered charity founded in 1887, originally to train District Nurses. Today we offer a wide range of support to all nurses who work in community settings, including care homes, those who work with the homeless, school nurses and many other specialists.

The charity operates a Community Nursing Executive Network (CNEN) for directors of nursing (and their deputies) in community healthcare provider organisations and they were asked to submit their observations for this Inquiry.

In addition we asked all Queen's Nurses to submit their observations for this Inquiry.

The QNI reintroduced the prestigious title of Queen's Nurse in 2007 and today there are over 1300 Queen's Nurses working in all community healthcare settings in England, Wales and Northern Ireland.

Almost all of the 25 individual submissions below are from Queen's Nurses or from members of the Community Nursing Executive Network. We have highlighted some of what we believe are the key issues they raise in the main text, **in bold**. Key issues vary from one piece of evidence to another, which is to be expected given the diverse settings and geographical locations described, but include:

- Mobile technology – the potential of and lack of in some teams
- Access to testing for Covid-19
- Anxiety about the supply and correct use of PPE – conflicting advice
- How to maintain social distancing in a hands-on profession.
- Mental health of nurses, patients and families
- Lack of visibility for community nurses in the media, policy
- Improved motivation and morale in some teams
- Pressure of rapid discharge from hospital of very unwell patients
- Increase in end of life cases with rapid deterioration
- Large caseloads placing strain on nursing teams
- Anxiety about deferred care and illness
- Concern about take up of childhood immunisations
- The burden of supporting care homes
- Increased self-care among some patients and families
- Challenges posed by caring for people with dementia.

For more information about the work of the QNI visit www.qni.org.uk .

Primary Care

In the Mid Bedfordshire Primary Care Team we feel proud of the response and team effort demonstrated by all staff. They are working long hours, going over and above to meet the needs of the patient population, supporting each other and maintaining the team morale. Care continues to be delivered as it should, with the patient at the centre of everything that we do. We are working to the same high standard that we were before, and will be after the pandemic.

The Primary Care team is supporting hospitals to discharge high patient numbers to free up beds.

These patients are medically fit for discharge but are discharged rapidly for any issues to be addressed once home. As a result :

- We are seeing a reduction in discharge information, staff visit blind and find on arrival
- Visits are longer in length as there are often complex issues to resolve
- Community teams are referring patients for care packages and bridge the gap until this can commence
- The equipment to support early discharge has not been sourced by discharging hospital
- All patients discharged from hospital are treated as suspected Covid 19 for 10 days. This means two members of staff are required to attend each visit for donning and doffing

Caseload sizes have increased with an estimated one third of the caseload being treated as positive or suspected Covid 19. All patients are contacted and screened for symptoms prior to a visit so the right level of PPE is worn.

We have seen an **increase in End of Life care at home**, we suspect that this may, in part, be due to our palliative patients not wanting hospital admission, patients would prefer to stay at home as local hospices have restrictions on visiting times and numbers of people who can visit. Elderly frail population appear to be becoming unwell and deteriorating rapidly, it is not known if this is due to Covid-19.

Community staff have supported their colleagues in Residential Care Homes to deliver nursing care to residents, this is to reduce footfall and risk of infection as well as supporting the care staff with delegated responsibilities. The community nurses continue to visit once a week and telephone the residential homes weekly between visits to offer advice and support. Any issues are triaged and residents visited if further support is required. Community staff have also offered advice around infection control and the use of PPE.

Community staff now have access to and a plentiful supply of PPE, there has **been anxiety amongst staff driven by the changing advice on what level of PPE to wear**. Staff have stated that they feel disconcerted by images shared globally of varying levels of PPE worn in other areas / countries and images in the media of colleagues in the acute areas. As a manager it has felt important to give advice promptly as PHE's advice has changed and to reiterate that we are following guidance from public health.

To manage the increased demands of the service, caseloads have been RAG rated, however there are not many visits that can be reduced or postponed, we are seeing high acuity and a high proportion of palliative patients.

To meet the increased demand staff are working collaboratively with other services, they are thinking creatively and finding new ways to work. As a Team Lead it has been exciting to watch the teams find creative solutions and encourage them to work in new and different ways. They are using technology to maintain social distancing. New staff are being taught on the job as classroom based training is postponed.

The teams are supporting each other and working well as a team. **The morale is good, staff are keeping calm and carrying on**, there are good days and bad and as one staff member feels low or is having a bad day the team are supporting them and lifting them back up.

They have supported each other as staff have become symptomatic themselves, ensuring those who live alone are contacted daily and have what they need.

I feel that the **role of community nursing has not been represented in the media**, that we remain a hidden workforce, the team know their patients well and are best placed to deliver holistic, patient centred care, helping patients to stay at home and stay safe. Thank you for asking for contributions and information from Community Teams.

Queen's Nurse
Team Lead, Mid Bedfordshire

Community Services and Discharge Workstream

I am currently leading the community services and discharge workstream, feeding into the the North East and Yorkshire Out of Hospital Cell as part of the regional Covid-19 ICC response

The issues being raised by community service providers currently are:

- There has been a **substantial increase in the requirement for end of life care for covid-19 patients being nursed at home**. The issue emerging is around the relative short end of life pathway and patients dying much more quickly than expected. This is resulting in **nurses needing much more support psychologically**;
- Another issue is the **increase in pressure ulcers** from patients who have been shielding or who have not been having their routine community nursing visits – the fear is that there will be a huge increase in demand for TV input once normal service has resumed
- Finally, there is a need for **respiratory management education** amongst community nurses, GPNs care home nurses etc., who are finding themselves caring for many more respiratory patients than would be normally on the caseload.

Queen's Nurse
Deputy Director of Nursing
NHS England & NHS Improvement – North East and Yorkshire

Challenges facing community nursing during Covid-19 pandemic

Delivering community nursing care across both a city and rural community the nursing services have faced a number of key issues:

Reducing access into care home facilities – residents within the care home settings are being attended to by the community nursing services because they have a defined nursing need. This may range from the administration of life sustaining medication / treatment, complex wound care

through to the administration of palliative care drugs. For many community nurses the requirement of effective PPE to support enhanced infection control procedures has been challenging with each individual care home having individual requirements and expectations however these have been managed and through effective communication and support from CCGs and local councils.

Innovations such as the **use of technology** to advise whether visits are required and escalation of care have proven effective however the assurance of the underpinning knowledge for the care home staff has proven difficult to achieve to allow effective delegation of some tasks. There is a fine balance required under professional accountability and expectation that care home staff are indemnified through their own insurances / registration.

Accessing Covid 19 symptomatic patients in their own homes. The vast majority of patients who are Covid-19 positive have remained at home and self isolated. For some of these patients the attendance by the community nurse to undertake the range of nursing duties has been problematic. Where possible treatment has been delayed or the patient has been instructed on self management and an electronic system has been used to identify patients to ensure they are contacted regularly so that treatment can be reviewed either virtually or through visiting once they become asymptomatic.

For those patients unable to self-care and covid 19 positive a clear schedule of visits had to be devised so that chances of cross contamination between patients was greatly reduced. Staff access to PPE and alcohol gel was paramount at this point. Staffing levels – already depleted through national shortages within community were also stretched as visits arranged to prevent mix of “hot and cold” patients being seen.

Support of shielding patients - through the information supplied by GP services those vulnerable patients who are shielding but require community nursing services have been prioritised for first appointments (cold) to prevent contamination. With the option of self care and reduced visiting offered to all patients, very few have declined continued community nurse input.

Increased support of care homes - the requirement and expectation placed upon the services that community nursing can monitor and provide immediate responses to an increased number of deteriorating patients has been very problematic. Advice with regards to symptom relief and control has been made available and assistance given to carehomes in identifying the speed of deterioration, however this form of case management has required a rapid redesign of team structure and identified the lack of investment placed on the national development of community nursing services over the years.

Queen's Nurse

Lead Practitioner – Clinical Service Development
City Health Care Partnership, Hull

Reinvented the telephone as a means of communication using Microsoft Teams (MST) – significantly reduced number of emails. Does mean always available though.

Staff have been able to **focus on their clinical roles** as much of the data collection and other distractions not required. We want to maintain this “new normal”. Anxiety that we will just go back to “business as usual” and lose these new-found freedoms and improved working.

Morale significantly improved:

- Morale was the highest seen in a long time
- Good team spirit
- Functioning well as a team
- Working as a team
- Staff have stepped up
- Kindness
- Comradery
- Generally, morale was good
- More staff coming into work than not
- Wanting to be part of the NHS drive
- Upbeat
- Pulling together
- Morale is high
- Morale good in the area and people are reflecting on this.

Reviewed our **discharge to assess** process – reduction in bed occupancy and fill rates. Impact on community services as more acutely unwell patients being discharged. Increase in numbers of community deaths and rapid deterioration.

Number of staff shielding but many still contributing by **working from home**. Improved attendance at meetings using MST. Also reduced frequency of meetings so will continue to review so not meeting for meetings sake. Reduced email traffic as make a quick call using MST. Some areas lower than usual **sickness** outside of Covid-19 cause.

Band 7s usually office based and not in uniform, staff appreciated their visible presence and in uniform – solidarity. Changes in meetings enabled senior staff to increase visibility in clinical areas and support patient and staff groups. Staff stepping up – noted particularly with band 6 team leader staff so will continue to develop them. Had been over-protective before but proven they are up to working at this level.

Within **forensic services** move to intelligence led practice rather than routine – rub down searches, room searches and testing. Fewer incidents as patient opportunities to bring contraband in reduced.

Challenges around resuscitation – conflicting advice from resus council and PHE and impact then around FFP3 mask supply and fit test training as went with resus guidance re chest compressions being an aerosol generating procedure.

Patients miss face to face input; increase in numbers of patients self-harming. Trying to reduce with resource packs for psychological support, imagery work, distress signatory work and activities. Initial risk as stopped face-to-face training – managing violence and aggression, resuscitation

particular high risk. Now starting to reinstate in small groups with staff wearing PPE as they would in ward areas. However, this is voluntary and online training also available.

Recruitment – removed a lot of bureaucracy and now much more streamlined and speedier. Final year students being brought into clinical areas has helped with numbers, and mentoring more readily available.

Communications – much improved. As working in a command and control mode having real time meetings and communications. Clear escalation – Clinical Reference Group to Gold then back out to divisional meetings all in same day. Real ward-board working. Supported by daily briefings from Chief Executive to all staff which frontline staff have really appreciated.

Overall improved staff relationships – all in it together. Plus, national support for NHS, put pride back into roles. Had introduced staff huddles so on hold due to social distancing but will restart when possible alongside staff meetings.

PPE – steep learning curve. Identifying aerosol generating procedures (AGPs) – re-siting a naso-gastric tube. The whole debate around CPR – are chest compressions an AGP. Became very emotive within our Trust with the decision being taken that for inpatient areas they were which then meant we had to train a significant number of staff in the wearing of FFP3 masks. Alongside this then is the issue of supply as staff are trained to a specific mask and so when stocks of different types come in they are not appropriate for use unless they are re-fitted which is a drain on a small team.

Big ask of **IPC teams** – widened remit. Been very difficult for our IPC team as having to support guidance which ordinarily they would not accept – reuse of PPE. They have felt compromised whilst understanding the requirement. Timing of guidance – usually Friday afternoon so then **worry over weekend and trying to implement on Monday**. Lot of pressure on the IPC team – and expectation to deliver rather than support. Health and safety have not been in the forefront and when asked have been slow to come forward.

Handover using MST for community teams – much improved, staff not struggling to get back in time or missing as out on visits

Staffing levels much improved – staff redeployed, caseload cleansing, patients wanting to self-manage and promoting. Redeployed staff had insight into colleagues' roles so improved understanding and working relationships.

Queen's Nurse
Associate Director of Nursing
Nottinghamshire Healthcare NHS Foundation Trust

Community Nursing

Need focus on admission avoidance not just acute capacity. Consider reducing hospital capacity to enable support to models of care in the community through collaboration, partnership working and shared skills. Cohorting elderly patients, managing the spread of infection and the benefits of people receiving care in their own homes should all be looked at in this context.

Focus of services on recovery, rehabilitation and support with functional decline. Taking a Multi professional approach to care, highlighting the need for joined up care that reduces duplication and focuses on public health needs for prevention and recovery. **Continue to encourage the public to access services through the correct routes** e.g. use of pharmacy, minor injury units etc. Evaluate the benefits of more remote/virtual working, e.g. musculo-skeletal services. Certainly at SHFT we would be keen to be involved in any planned research and have some resources to support this.

Deputy Director of Nursing, Southern Health

Community Urgent Response Team

I am an advanced nurse practitioner (ANP) in a community urgent response team. We offer a two hour response, previously to both discharges from hospital and admission avoidance, to help people stay at home. We are a mixed team of ANPs, carers, therapists and registered nurses.

The team has now been split into two, with therapists undertaking the Discharge to Assess (D2A) care stream, and we are undertaking admission avoidance work.

The ANPs were also first to be trained as swabbers – initially we undertook community swabbing, but that then ceased. We are now **undertaking swabbing in care homes for symptomatic patients**. My understanding is that more people are being trained up to swab and from next week the plan is to swab all patients in care homes, jointly with the Army who will swab all the staff. We have been asked to train the new swabbers, who are apparently therapists, **who have never done this type of thing before**.

We are also continuing with our caseload, seeing frail usually elderly people at home. We normally have a consultant geriatrician working with us one day a week, but he has not been around since the start of Covid-19 (being off sick for 2 weeks initially with suspected Covid). We can always contact him by telephone if we need to.

We are managing our caseload; therapists are referring into us if needed once they have done a D2A assessment. On the **plus side barriers are being broken down** – fast track funding is being approved without us having to jump through hoops, therapists are working as one with a rota that tells us who to access on that day, social care are working remotely but available on the phone.

There has been **useful guidance on Covid-19** from NICE, <https://www.nbmmedical.com/>, and the RCGP. End of life care has been highlighted as an area that needs to be considered re availability.

The **swabbing in care homes is upsetting**, particularly as a lot of the patients have dementia, and it is difficult to explain to them what we are doing, and obtaining their consent. I know I am doing this in their best interests, and try just to get it over with as quickly as possible, it is not a pleasant procedure.

There are **varying practices in care homes re PPE** – we are always observing re infection control measures, and trying to support and explain how they might be able to improve their practices. In the same day we may be swabbing in care homes, and then visiting a frail elderly person at home. Should we be doing this? Of course we take all measures and wear PPE.

GPs are virtually all not visiting, but phoning us and asking us if we can go and assess. This is not what we are commissioned for, but of course we will do it for the patient. Should we be looking after the top 2% frailty patients in a holistic thorough manner that GPs are finding difficult?

Re **end of life care** - there are discussions around how to manage the provision of anticipatory medications to maximise availability for all which look useful, but will require whole changes of mindsets which may be challenging for some.

Masks are such a barrier to communication, and we cannot hug people any more – I'm finding this hard as a nurse.

Queen's Nurse

Advanced Nurse Practitioner, Nottinghamshire

Community/District Nursing and Care Homes

1. Focus on acute hospital care should have been matched with the same level of preparation and preparedness for community health and care. Hospital services here have thankfully not experienced unmanageable levels of hospital admissions as yet.
2. Care Home outbreaks seem to have caught everyone out. We deployed community nurses and carers to support residents in residential care where hospital admission was not required, which was the majority of residents.
3. Working between command and control and holding pattern is really tough, we are all struggling with loss of contact and connection.
4. PPE and the right PPE advice for community care settings. We need better evidence for the complexities for delivering care in the community.
5. In domiciliary care the use of RAG to prioritise caseload, using hot and cold teams and resting staff has given us good resilience. Same approach in nursing, including basing specialist nurses in generic teams, has worked really well.
6. Great examples of **innovation around self-care** e.g. wound care self-management packs.
7. Tech could be extraordinary in managing our way into a new rhythm of care provision.

8. Our community citizens and business response has been magnificent. Keeping it going will be the trick, especially in light of point 10.

9. Cancer care - we are still doing OP, operations and SACT but over split sites to maintain safe social distancing. Opportunity for innovation here.

10. Future issues will be in **late diagnosis in cancer and other LTCs (long term conditions)**. We are likely to see rise in poorer prognosis and increased EOLC (End of Life Care) needs over the next 3-5 years. Other challenges will be in **mental health** services as people respond to trauma, either related to experience in caring and treating or personal experiences relating to finance, jobs, loneliness, isolation, substance misuse, homelessness etc.

11. Leadership is everything and we have great confidence in our leaders.

Queen's Nurse (name supplied but withheld on request).

District Nursing

- Impact on District Nurse education & already fragile position of our future pipeline of qualified district nurses
- Capacity to deliver IMC services during COVID recovery within existing resources
- Capacity and knowledge to deliver respiratory rehab at scale post Covid diagnosis/treatment
- Psychological safety of community workforce
- Necessity to redeploy returners/students to community to cope with the projected scale & duration of need for out of hospital services.

Queen's Nurse

Director of Nursing

Locala Community Partnerships

District Nursing

I am aware that my local **community nursing teams are actively supporting and working whole shifts in Nursing Homes** to cover staff who are off sick. This has had an impact on the service they can usually deliver, with their caseloads being triaged according to urgency. As a result those patients deemed to be less urgent are being asked to undertake their own dressings etc.

These are vulnerable often isolated individuals whose only contact with services is via the community nursing teams. A visit is never as simple as a quick dressing - yet they are being denied care, whilst NHS staff are supporting private nursing homes.

Local nursing agencies are actively looking for work, yet have not been approached. I feel this is an imbalance and should be addressed.

Queen's Nurse

Clinical Nurse Specialist, Rowcroft Hospice

District Nursing

I would like to give some examples of things I have experienced as a District Nurse through the Covid-19 pandemic.

I have found it incredibly hard to keep up with the changing information particularly surrounding PPE. This has made it difficult to convey information to staff and has increased anxiety at times. We have followed Public Health England guidance at all times. I have felt that this information has not kept up with the feelings of community staff and their patients. It is difficult to explain why we only started to wear PPE to patients sometime after they had already started self-isolating. I think the way that PPE has been sourced and provided across the country has been very poor.

The use of PPE by other members of the multidisciplinary teams has also caused problems. **GPs have told us that they felt we should be wearing more PPE which has been very difficult to deal with** as we are following national guidance but their comments make members of our teams feel vulnerable as they are made to feel they are not adequately protected. A consistent approach across all services would have been much better.

We have had difficulties at times with **doctors not wanting to go out and see suspected or confirmed patients.** There have also been difficulties with GP surgeries which, whilst reducing their workload, have seemed quite happy to have referred things to District Nursing that did not meet our criteria. Patients who were self-isolating (but not housebound) were frequently referred. Thankfully we have had many conversations which have resulted in a reduction in these types of referrals and patients have been attending surgeries or practice staff have visited them at home. Many practice staff have been very willing to support our DN teams and take on visits.

There has been an increase in families willing to provide care or do simple tasks, as they do not want too much contact in the house. However this will raise the problem if these people then start to go back to work or refer these things back to the DN's in the future as the workload could increase rapidly. I think it has **highlighted to many that they can self-care and I hope that we can build on this to promote more self-care in the future.**

We have facilitated discharges very quickly, although this has resulted in poor communication in some instances where DNs have not been informed of drug changes or that syringe drivers were in situ. I have also been concerned that family members who were admitted with suspected Covid-19 symptoms were sent home to self-isolate with family members who were unable to adequately care for them. I feel that **sometimes people were discharged so quickly there was not adequate assessment of the home environment and this has put families at risk.** This has been particularly challenging when the patients then refuse to accept any community care and their other family support live too far away to travel to support them.

All the DN teams have adapted to using mobile technology. They are all able to have handovers remotely and are now fully using their mobile technology for patient care. I think this is a positive step for the long term running of DN services

Staff that have been redeployed have been very supportive at a time when they must be very anxious about leaving their own workload. We have made changes to support their induction into new areas of work.

I think **volunteer groups that set up rapidly have been very helpful** to vulnerable patients at home. Some people were left in great difficulty as their carers pulled out for various reasons very quickly so these support groups have been invaluable in providing shopping, food etc. These groups would be a very welcome support to communities even after this pandemic.

I think the amount of work and adaptation that has been needed in such a short space of time has been phenomenal.

Queen's Nurse
District Nurse

District Nursing

I am a community nurse team leader in the south west. During the Covid-19 pandemic we have encountered the following issues:

PPE the guidance for what to where and when was slow to come out, we then were given supplies of gowns, surgical face masks aprons and gloves, but told to only wear this when we had a patient with either suspected or confirmed Covid-19. This then changes three weeks later to wear PPE when within 1 metre distance of vulnerable patients; gowns were taken to the acute settings. We then found carers who were issued one mask per shift! Not per client! I raised this and with some care agencies and this was changed.

GP surgeries appear to have been given a separate set of instructions to ourselves and this has raised concerns when we have to visit the surgeries. We have had difficulties in **obtaining various controlled drugs** and supplies such as dressings. Staff have been **redeployed without adequate training**, this was raised and training put in place.

As community nurses we do feel that we continue to be second rate compared to secondary settings especially regarding staff being unable to be tested for the virus despite having clear symptoms.

Community Nurse Team Leader, Virgin Care

District Nursing

Very few nurses and clinicians working in community have been given a smart phone to use at work. I find this astonishing in this day and age given the following potential benefits:

- Groups chats enabling safer **lone working**, building team support, making people feel included and safe, the team is an effective system (we have used Whatsapp on our own phones for this and although not ideal (we don't use identifiable info) it has been transformational for the team communication and team dynamics.
- Maps, finding addresses, knowing where you are (you can share your location through a few taps on a group chat)
- Accessing your calendar and any appointments, reducing wasted time, making appointments or meeting arrangement easy
- Accessing the electronic roster and knowing who else is on duty with you, lone working +safety of staff
- more efficient of time
- Reduced mileage due to having information more easily available, not having to drive to access all of the above, being forewarned about journeys not being necessary
- The whole team is informed of any road closures, delay to handover, staff members needing to go home sick, enabling reorganising of the day/handover/visits instantly
- The BNF (safer patient care) and google at your fingertips
- Input mileage from your car into expenses website.
- Access to emails, intranet, policies =safer patient care
- Access to the local apps, electronic staff records, NHS safeguarding guide, Gather App, Skype
- Staff feeling valued and being given the equipment to help them do their job effectively, I would argue this aids retention of staff and shows we are a service that people should work for.
- Some staff do have smart phones but no data included.
- Community Trusts need to bulk purchase data and hardware to obtain competitive prices.
- Phones may be expensive but what is the unmeasured cost of not having the above things in place for community staff?
- We have managed to **embrace video calls for nursing handover, virtual ward meetings and across health and social care and university links**, which has freed staff up /created opportunities for conversations that didn't happen before (we are starting GP, DN weekly discussion next week for few minutes each Monday regarding local care home for example) in these last few weeks, the next amazing step could be more changes with technology.

Queen's Nurse

Lead District Nurse, Purbeck Locality, Dorset

Community Tissue Viability Nurse Specialist

Within the county of Wiltshire the provision of leg clubs is undertaken independently by PCN led services and those more traditionally guided and subscribing to the Lindsay Leg Club Foundation.

As a community tissue viability specialist I have seen the benefits to both the physical and social health of patients through community leg clubs. **I would like to ask how these can be supported in the coming future as social distancing goes against the social health aspect of this provision of care.**

These services are vital in providing consistent, evidenced based care and play a huge role in engaging patients and families in treatment. With the CQUIN CCG11- Assessment, diagnosis and

treatment of lower leg wounds set for 2020/21 - the continued safe provision of these essential services needs to be considered carefully.

Queen's Nurse
Tissue Viability Lead
Wiltshire Health and Care

Integrated Wound Care Project

Positives are self-care but not always enough people with the skills to facilitate this.

Nurses being stopped and asked to prove in writing that they are doing essential travel! Lack of understanding about community nursing: do the police know that not all nurses work in a hospital?

PPE: different messages communicated by primary care and NHS trust in the same geographical location. This causes anxiety and doubt about the information being given. Need one message across health and social care

Access to testing: a number of nurses who had symptoms early on still don't know if they had Covid-19 – again this causes anxiety

Queen's Nurse
Clinical Project Lead, Integrated wound care project

A Community MS Nurse Specialist

I am a Community Multiple Sclerosis (MS) Nurse Specialist - as a service we have stopped face to face visits in order to protect our clients but continue to support as many as we can by phone: **clinics have been moved to telephone clinics.**

We sent out shielding and self-isolating letters to all clients meeting the criteria within the first month. We have a small percentage of patients who need to shield due to their medications or current Health needs.

With more complex patients we have worked with the District Nurses (DN) to assess medication regarding symptom management and we are able to co-ordinate via telephone. We use the DN mobile and put it on a speaker to enable the patient to also participate in feeding back any issues - we have been working well together and **I would hope that this practice would continue post lock down when we are not able to co-ordinate joint face to face visits.**

At this time the MS team are relying on community teams, carers, who are still visiting our clients to be our eyes and ears and this link is so invaluable in maintaining patient care and safety especially for our more vulnerable and high risk patients.

Our Clinical Psychologists have looked on the internet to review sites to help support patients and team members, manage mood etc., which is helpful and we can print off for those patients without internet access.

There is potentially much more we could do and it **is identifying those who are isolated and alone or in vulnerable positions** have access to the support they need.

Other issues are those patients not currently receiving their MS Disease modifying medications as these reduce patients' immune systems and it may mean that **they may need to seek alternative less effective treatment at this time.**

Teamwork across all Health, Social care and voluntary sectors has never been more essential and I hope that this continues to work effectively moving forward.

Queen's Nurse
MS Specialist Nurse, Frimley Health NHS Foundation Trust

Dementia Care and the Pandemic from a General Practice Perspective

Mission Dementia is a quality improvement project available to view on the GPNEN site, www.gpnen.org.uk . It proposes that General Practice should lead dementia care, co-ordinating the complex care required to manage this illness from pre diagnosis to end of life.

Our locality has worked on this premise building great working relationships with patients, their families, voluntary agencies, secondary care, community mental health teams, hospices and adult services, and this has placed us in a good position to cope during the pandemic.

There are two key issues to highlight from Mission Dementia prior to the pandemic. One is **the value of memory cafes** supported not just by the voluntary agencies but General Practice. This has enabled us to keep our patients and their carers on the radar without them coming into surgery. Early problems have been identified and small issues have been dealt with promptly avoiding crisis and unnecessary GP appointments.

Covid-19 has provided an unexpected way of addressing this as our professional and peer support gatherings have had to stop; memory matters courses for those newly diagnosed have been suspended and yet **the need of this cohort of patients and their families remains the same.** As a nurse in general practice I have had to find new ways of working to support this vulnerable group. The work done through Mission Dementia has been extremely helpful.

We have a **weekly Zoom memory café** supporting people with dementia and their carers. As well as the surgery input, we are supported by Dementia UK and Andover Mind dementia advisors. More people want to join but either to not have the technology or they cannot use it and the skills are not available to support them with this remotely.

People with dementia and their carers who became friends at the cafes have been offering each other support by phone and facetime. I have been able to connect people where permission is given, and carers who have lost their love one have stepped forward to see if they can offer support by phone.

My role has been to connect with people living with dementia and those with mild cognitive disorder **by phone** if they cannot use other methods. Most people are glad of phone support and are coping very well. Several safeguarding issues have been highlighted and referred on speedily. Connections built across the health and social interface have proved beneficial. Good relationships continue remotely from the surgery with older people's mental health teams.

I have accessed through <https://www.futurelearn.com/> some excellent award-winning courses about dementia for carers and this resource should be highlighted as a future alternative to memory matters courses.

It will interesting to measure as we pass through this **crisis if our intervention has provided the necessary support to prevent general practice being overwhelmed with dementia related issues on return to normality**. Hopefully our community support groups will be able to restart at some point but I feel we have identified other methods which will help us support more people keeping them on the radar, out of the surgery setting and reduce emergency consultations and crisis.

Queen's Nurse

Community Dementia Practitioner

I work as a Community Dementia Practitioner within a Community Trust supporting those living with dementia in the community to ensure they receive the appropriate care and support to live a healthy and as independent a life as possible throughout their illness to the end of life. The team do not work within a mental health team and are separate to memory clinic services, our aim is to support patients and families throughout their illness not just at diagnosis or when behaviours change.

We have been undertaking **well-being telephone calls with all of our families to ensure they have adequate support**, especially those without a package of care to ensure that someone is fetching their shopping and medications. We have been able to undertake these calls either working remotely or within our usual office area. It is far more difficult to undertake an assessment by telephone as you cannot determine the family dynamics or assess the environment for risks.

As a team we were informed that all of our patients would fall into the vulnerable category and that we should be having conversations with all of the families to ensure that they had an **emergency plan in place to ensure continuity of care**, should the carer become sick. Also, particularly for those in the more moderate to advance stages, to discuss DNACPR and register them on coordinate my care. It is extremely difficult to discuss resuscitation status over the telephone as families often have not thought of this or discussed it. We have therefore had at least one **telephone call with each family before sending some information regarding planning your care ahead** and the Coordinate my care system before we then actually discuss the status and complete the CMC record. Once we have had the conversation we obviously document and write to the GP to inform them. We are a team of 2 and have found this to be an extremely exhausting and emotionally draining role to undertake at this time, our caseload is 144.

An example of where this has not supported a patient's death occurred last week. The gentleman had no family therefore I had spent several phone calls with the solicitor power of attorney to discuss CPR status and obtain a decision. This was duly recorded in our records, on CMC and the GP written to. When the gentleman actually aspired and paramedics were called to the house both

Matron and GP who were on duty were working remotely and could not access the CMC record with the LPA details. Therefore our office had to be contacted for details so that the solicitor could be contacted again to confirm the previous decision. **If we are going to work remotely in the future we must ensure that all computer systems can talk to each other and that staff can access them remotely.**

During the crisis our patients and carers have experienced **great isolation and increase to their caring roles affecting their stress levels**. Many of our carers are elderly themselves and have had to increase their caring roles with little or no respite as the day centres closed. Due to a fear of the virus and **the lack of PPE for social care staff** many carers have also reduced the package of care they receive increasing their caring burden.

For **example**, one couple in their 80's care for their 64 year old son with advanced early onset dementia. Usually their package of care includes 4 days a week respite at a day centre, with QDS visits when he is at home. He is hoisted for all transfers and for pad changes has to use a standing hoist. As the day centre has closed he is now home all day. The elderly couple have taken on the 2 mid-day carer calls to reduce the number of visitors to the house, but it can take them up to 1 hour to undertake the pad changes at lunchtime and 5pm. When the carers do attend in order to socially distance they stay upstairs and therefore are unable to monitor the quality of care being given. Due to staff sickness they have had new carers occasionally, who do not fully know the needs of their son. **This is obviously having a great strain on them physically and emotionally**. This week their son has developed a moisture lesion, the prescription for dressings has not been able to be filled by the chemist for 48 hours. To actually receive their son's normal medication also took three trips queuing at the local pharmacy shop as not all of the medication is available at once (they do not have the delivery service because this has proved to be unreliable in the past and they have not received the correct medication). The GP is continuing to allow only 1 month supply of medication so they will have to repeat these visits to the pharmacy again next month.

This case study highlights several of the issues for those living with dementia:

- Closure of day centres and no follow up support for example by telephone to check the carers are managing
- Families fear of the virus and lack of social care staff PPE, also that these staff have to travel on public transport has led many families to reduce their care package to reduce the risk of infection
- GP surgery's still insisting on issuing only 1 month supply of repeat medication when chemist shops do not have the full stock and this involves queuing several times to obtain the full prescription
- The elderly and those with dementia are usually unable to use electronic / computer devices and so are not able to access the online information or arrange shopping on line
- Those who can access computers have had great difficulty proving to the supermarkets that they are in the vulnerable category and need home delivery.
- Those with dementia often will say that they are managing when in reality they are not. Without home visits or regular telephone contact it is difficult to assess the level of carer stress
- Families who have moved in with an elderly person often did not realise previously how much care was required and how emotionally stressful it can be for all involved.
- For those caring for more mobile family members with dementia it is extremely difficult to get them to understand social distancing and why they can't leave the house or see family members.
- Increased physical and emotional stress for the carers

Going forward how are we going to open day centres and respite facilities for families? Once the lockdown is loosened the children and grandchildren will return to work, those living and caring for those with dementia will again have a reduced support network that will lead to poor quality of life for those with dementia. The government had previously promised action to sort out social care now is the time to review how we provide this care and emotional support to those living with a dementia diagnosis.

Queen's Nurse
Community Dementia Practitioner
Hounslow & Richmond Community Healthcare NHS Trust

Children's Paediatric Services

I work for the community services in children's paediatric services. We are a multidisciplinary service and within this I specialise in children with eating issues and sleeping. These services have been classed as tier 3 and at the most tier 2 and therefore a colleague and I have been allocated for redeployment.

I understand the pressures of differing areas but there has been **no awareness of the anxieties of the families we are working with**. Especially for the children who are now in lock down, not sleeping causing the whole family to be awake for 18 hours or more, mainly due to anxiety. Along with the children who only eat one specific brand of food and maybe only a couple of food types where the parents have been unable to get this food then refusing to eat anything. These children are especially at risk of hospital admission for tube feeding.

I am very concerned that **work that is being stopped now will have a major impact on children and families for far longer than the covid19 crisis**. During this time will increase the risks within families from domestic violence due to the children sleep deprivation and the impact this has on the rest of the family or food deprivation and the impact hospitalisation has especially given the current visiting rules for children's wards.

Queen's Nurse
ICAN Community Nurse

Family Nurse Partnership

I am a family Nurse (FN) which is normally a home based, therapeutic service delivered to young families (women 19 and under) working with them from approx. 12 weeks of pregnancy until their child is two years old. Clients are normally visited weekly or fortnightly for approx. 1-1.5 hours and visits cover a range of topics and FN's liaise with every other organisation/ service that works with young people.

From early on in the pandemic we have carried out socially distancing walks with clients. Particularly important in this population in which there are **high levels of domestic abuse**, we walk with client and child, but not partners. We have been able to think of strategies to stay safe and plans for an exit if that is needed too. We have found that clients are receptive to walking out with us, for some

it has triggered traumatic memories and for others it is a genuinely novel experience as anxiety has prevented them going out, however with few people around and with the support of their nurse they have had increased confidence.

We have been able to adapt materials, particularly around play and stimulation for children with references to nature, splashing through puddles etc.

We also FaceTime clients. During lock down, I have recruited three clients and have found that by adapting my communication skills I have learnt a lot about my clients and are able to provide a high level of emotional support.

We wear PPE if we need to enter a client's house to weigh a baby, or because we are concerned for the safety of the child or mother. Clients seem to see past the barrier.

My clients' age range is one in which **poor mental health and high adverse childhood experiences (ACE)** means that developing a strong level of trust is essential and I believe by this adaptability we have been able to continue to provide a therapeutic relationship.

This is our experience. I think we may continue to use FaceTime/Skype for occasional visits in the future as it appears to be another useful vehicle for connection with this vulnerable group.

Queen's Nurse
Family Nurse, East Oxford Health Centre

Children's Community Nursing

Challenges

- PPE availability- has been generally good within our Trust but sometimes '**just in time**' as certain pinch points develop related to challenges around different brands and types of mask being available and the need to fit test for each. Fit testing has been problematic with a high fail rate using bitrex but improved with portacount device
- Patient supplies ensuring on-going supply of consumable items for every day clinical care need eg. ventilation circuits, tracheostomy tubes, enteral supplies. Standard deliveries have been delayed due to the focus on PPE – especially those related to respiratory management
- **Differing guidance** from National bodies re –resuscitation. This has been especially challenging around children where the need to deliver respiratory support is essential and sometimes the only intervention required.
- IT support when more staff working from home VPN / Server capacity inadequate and frequent connectivity issues – always addressed by local IT Team but frustrating and interrupting fluidity of clinical work.
- **Bereavement support / funeral arrangements difficult** when usual services not open. Families have struggled to cope when children have died from non-Covid related illness.
- The emergency planning process within our Trust has been really helpful but can be slow escalating certain issues up and responses do not always match the needs of the breadth of different children community nursing services adequately. Sometimes decisions have had to

be made to response to clinical needs using informed, pragmatic problem solving before a response comes back

- Our Community Children's Nurses work in partnership with education and social care and the differing guidance across these areas has been confusing i.e. re PPE when working in partnership with Special School Schools. This has led to some tension with social and education colleagues and anxiety for staff across the services where different levels of PPE are worn by different organisations.
- **Conflicting evidence** around some AGP i.e. for placement of NG tubes, chest compressions etc
- Some apparent inequity for NHS staff who struggle to work i.e. due to childcare issues. Our Trust guidance is to take A/L /unpaid leave when others in the country in other professions are furloughed and may be able to receive 80% of their pay.

Positives

- Use of video conferencing
- Setting up differing ways of Staff Development / Training - use of video's / Skype
- Empowerment of children and their families to self care.
- Communication within the organisation improved with more video calls
- Different way of working developed eg Children's Continence Team implementing telephone clinics with positive impact as parents are at home to support interventions.

I am incredibly proud of the CCNs who have continued to deliver essential care and want to ensure our challenges are included.

Queen's Nurse

Interim Head of Children and Young People's Specialist & Community Nursing
Sussex Community NHS Foundation Trust

School Nursing

Delivering the universal and targeted healthy child programme 5-19 during the pandemic and beyond: how to achieve an appropriate balance between coronavirus and 'ordinary' health and care demand.

The 'ordinary' **work of the school nurse involves early identification and support for children and young people around safeguarding issues** – CSE, violence, risk taking behaviours, gang related issues among others. The ability to provide early intervention, support and identification of issues has been severely impacted by this crisis as face to face contact has been substantially reduced. The work force has been depleted over a number of years and will need increased numbers to enable the inevitable demands once this crisis moves to the next phase.

'Ordinary' work involves school nurses routinely phoning a parent/carer to discuss a child's identified health concerns however recently the conversation soon turns into a COVID conversation and practitioners are needing to support parent/carer's over their anxieties.

Ordinary work of directly seeing Yr 9 following the completion of a health needs assessment has had to be **curtailed completely due to social distancing and school closures**. Therefore we have been unable to complete this element of important work. This means that the individual needs of young

people are unable to be identified and supported and local and population data that is usually used to inform local, spending, resources the JSNA is unable to be gathered.

Usual service delivery has been altered due to COVID. Usual provision, at this time of year, would involve some of our practitioners extensively delivering a variety of health promoting activities however this promotion is now all taking place via different **digital platforms and communications**.

A huge challenge has been to engage extensively enough with the local population to ensure needs are being highlighted and referred in as schools, children and family centres, local authority groups are closed.

Meeting the **wave of pent-up demand** for health and care services that have been delayed due to the coronavirus outbreak

School nurses have not been able to deliver our usual “transition” work for year 6 students going into high school, due to the rapid and unforeseen closure of schools. Therefore we are envisaging higher levels of anxiety around changing schools. More staff will be required to assess and meet this need with the earliest intervention being a priority.

During the summer term it is normal to receive a higher level of referrals linked to exam stress and anxiety. This hasn't happened this year. However these students may potentially now have **even higher levels of anxiety as a result of COVID fears and concerns that they would have “forgotten” everything that they had learnt at school**. This could lead to higher referral rates when schools re-open. We will need to utilise not only the learning from innovations initiated during this period, i.e. digital consultations but also more staff will be required to be available and visible to schools and young people to aid assessment, identification and support for issues.

Increased demand for emotional health and wellbeing support for children, young people and families could overwhelm already depleted services.

Meeting extra demand for mental health services as a result of the societal and economic impacts of lockdown.

- Use of the digital platform i.e. ChatHealth and parent line text messaging service, the use of WhatsApp for holistic health assessments and Looked after children annual reviews, Zoom or Microsoft Teams for meetings with Parents, carers. Has been very effective
- We have assisted children, young people and families by providing schools with up to date information about mental health and wellbeing activities which they could adopt/try through weekly newsletters to schools.
- Schools have been provided with links to local support services and online activities. Updated weekly
- Many teams are providing a duty nurse, available on the phone for young people and parents/carers, Monday to Friday.

However **not all school nurse teams have access to smartphones/digital platforms** to enable this work.

Supporting mass testing and vaccination once they become available. This would be an effective use of school nurse time, however they would need to have increased resource to ensure that the needs of the young people are still being met.

How to ensure that positive changes that have taken place in health and social care as a result of the pandemic are not lost as services normalise.

- There has been some really good use of technology across school nursing and partner agencies. As a result we have experienced training sessions via Webinars and social care meetings via secure log ins. This will release time from travelling that can be used to see young people and needs to continue.
- There has been positive feedback about the use of WhatsApp videos/ telephone consultations, however we need to be mindful that not all young people and families can access this technology due to lack of for example phone credit, Wi-Fi, or a private and confidential space to speak in. Additionally some young people are not comfortable with phone/video consultations and would prefer face to face interactions.
- This is a great opportunity to expand our service provision due to our recent experience of using technology which will expand the choice for our service users. For example – we are looking at being able to deliver; new parent talks and continence workshops via a virtual route as well as face to face.
- This has been a great opportunity to quickly introduce new ways of working and shown us that it can be done quickly without losing quality of care. We need to examine all the feedback and evidence from school nurses/community nurses around the country and ensure that any refresh of guidance, standards and procedures reflect these new ways of working.

Assistant Director Universal services. Compass

Executive Lead Officer, School and Public Health Nurses Association.

Occupational Health Nursing

Occupational health advice does not seem to be at the fore within any of the PHE strategies, which is disappointing, the involvement of public health professionals is obvious but OH nurses and physicians have skills which other public health professionals lack.

OH advice and support for all workplaces including small, medium and large enterprises will be crucial to support an **effective return to work** once lock down eases. We can assist with regards to policy development for a new way of working including:

- Covid19 policies including safety plans which consider public health and safety issues as people return to work;
- Ensuring there are robust work and health related policies which focus on the specific needs of the organisation including, but not restricted to, infection control, mental health, sickness absence, alcohol and substance misuse;
- A tailored support and advisory service available to managers, individuals and groups of workers – what is appropriate in the NHS will not be be totally applicable to other sectors such as manufacturing, engineering, construction, leisure and transport sectors.

Queen's Nurse

Occupational Health Nursing

As an occupational health nurse based within an acute trust I know that we give excellent care and support to all of our staff. They have access to the OH services and can talk to someone about any of their concerns.

We have direct access to virologists, microbiologists and infection control specialists. Staff can access the latest advice in terms of risk due to their exposure to Covid-19. There has been access to covid-19 testing for some while. They also have access to a wide range of mental health support including psychologists, counselling and meditation plus there is a lot of national support offered to the NHS.

This is not the case for health and social care within the community. They do not have occupational health support. They do a challenging job in difficult circumstances. Throughout this time none of the staff have had the same access to support that we give to our staff. They are poorly paid. May not have access to sick pay which also means they may have continued to work when they had early symptoms or equally didn't want to feel that they would let their clients down. Many of these care and support staff also develop very close relationship with their clients and to care for them and to watch them die - their loss has been immense. It can be like losing a family member in some cases.

Access to local mental health support just is not available. Who do these staff turn to? They have to find their way through the minefield to find the right support when they unwell and this is a challenge. Many staff have felt abandoned. If they couldn't access the most basic of equipment (PPE) then they certainly haven't had access to any additional emotional or practical signposting or support.

Many work for care homes and businesses which are private companies. Covid-19 has shone a light on what is an unequal access to support services for staff because of the structure of our care system.

We always need well trained and caring staff to work in the community to keep patients out of the acute hospitals but in reality the staff and the patients felt they were abandoned.

I am aware that there are lots of national campaigns available but as we know not everyone listens and then when they need that particular resource they forget anything they may have heard in the past. Occupational health services should be available to all employees

Queen's Nurse
Occupational Health Nurse Manager
Southampton

Occupational Health Nurse for one of the largest Police Forces in the UK

Occupational Health (OH) was overlooked in preparing for and managing this pandemic.

Occupational health, have access to a lot of the working population, both private and public sector, including, but not limited to: NHS, Police, Councils, manufacturing and construction industries. Our Professional Bodies and societies were able to move quickly to compile advice to workers who should be shielding, self-isolating or taking extra precautions, and my organisation moved quicker than the NHS letter system. This was only achieved by personalities within our department banging on the Chief Constable's door to say 'please let me help'. I have heard anecdotally that this was the same in other organisations. So not only were we overlooked from a government level, but also from an organisational level.

Meeting the needs of rapidly discharged hospital patients with a higher level of complexity

Occupational health can have a part to play with a number of areas. We assess fitness for work, using our skills to support people back to work in a supportive fashion is **likely to see people returning to work sooner**. As identified, individuals, once discharged from hospital have more complex care needs and may have developed long-term health complaints due to the complications of their infection. However once they have stabilised using occupational health skills for their workability **will lighten the burden on GPs**.

Supporting mass testing and vaccination once they become available

Our organisation, like many have delivered occupational vaccination programs, we therefore deliver antibody screening, and vaccinations, this can be recorded through a national database or through labs recording the result centrally to ensure results of this are not disjointed. There are many OH providers who can offer this to smaller companies who don't have their own in-house service. Administering the antibody test (once available – whether it be a point of care test or blood test for lab analysis) and administering vaccinations to our working population will see more workers return to work and stay at work, and see a greater impact on our economy.

Meeting extra demand for mental health services as a result of the societal and economic impacts of lockdown

Supporting workers with mental health complaints is already a large part of many OH work, therefore using this to help support workers during this time. Offering online resources to individuals through free subscription. Improving access to support is imperative; many occupational health services have been used as an assessment service allowing recommendations to be made to support someone in the workplace. However, allowing regular contact with those struggling, offering practical advice, can be delivered through existing OH services One major advantage of this being delivered through workplaces, is that individuals will feel safer returning to work, if they have access support through work. Also improving funding and resources through organisations such as Remploy to support those working (or furloughed) during this difficult time.

Queen's Nurse
Occupational Health Nurse Advisor

The Queen's Nursing Institute

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