COVID-19 - guidance for community settings

Health Policy team
This page provides guidance for paediatric community settings. Service resumption in the context of COVID-19 is first covered, followed by case studies of innovation in community settings that have been submitted by members. The final section is operational guidance that signposts to other useful documents.

This guidance has been produced with the British Association for Community Child Health (BACCH).

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Community paediatric services' response to COVID-19

Community paediatric services have developed some excellent innovations in the face of the enormous challenge posed by the COVID-19 outbreak, including: utilising telemedicine tools to continue seeing patients; introducing new infection control procedures to reduce risk to clinician and patient; and working in new ways with colleagues from other professions. For more inspiration see the section on community settings case studies, below.

As in other services, community paediatrics has not been able to function at full capacity
which has increased waiting lists. There is concern about clinician workloads as attention turns towards service resumption.

It is also likely that infection control measures will have to remain in place for the foreseeable future, especially for the most clinically vulnerable patients and families, contributing to the complexity of assessment and care.

COVID-19 remains a great risk to population health. As attention turns to how we can best provide community paediatric services in the next months and years, the RCPCH and BACCH are working to support teams to develop services with the approach of Reset, Restore and Recover.

**Reset, Restore, Recover**

The RCPCH has developed three principles to underpin its approach to the planning and delivery of healthcare for children and young people, in the context of the COVID-19 pandemic.

These are outlined below with extra information related to community paediatrics.

1. **Reset**: Planning children’s health services should be underpinned by data and evidence so that innovation and new models of care that meet the needs of children and young people are maintained. The following have been developed by the RCPCH:
   - The RCPCH QI Central hub features a collection of COVID-19 resources.
   - Our CYP Engagement team are working to gather the views of children and young people on their experiences of services during COVID-19, and what new innovations they’d like to see kept moving forward.
   - The team have also compiled a directory of research studies on children and young people’s views and experiences of COVID-19.

2. **Restore**: Delivery of children’s health services should be restored so that all children and young people receive high-quality, safe and effective care in every setting, ensuring timely diagnosis with a particular focus on supporting community services. There should be no diminution in facilities and adherence to current standards must be maintained.
   - We know that COVID-19 has not affected everyone equally, as the most vulnerable families, children and young people have been hit hardest by the pandemic. The work of community paediatricians will be crucial in addressing this.
   - Working with colleagues at a system level will be more important than ever, to ensure that community paediatric services receive appropriate resources and support. The RCPCH and BACCH will continue to advocate for community services in the wake of the COVID-19 pandemic.
   - RCPCH Ambassadors is the College’s local advocacy network of members who work with their Integrated Care System/Sustainability and Transformation Partnership to raise the profile of paediatrics and child health services in their system. Find out more on the webpage and submit an application to become an Ambassador. Please be aware that responses from the team are subject to delay due to focus on COVID-19.

3. **Recover**: The paediatric workforce should be recovered, bringing paediatricians back to children’s services and their training pathway, including sharing new ways of working with a focus on wellbeing.
The RCPCH Impact of COVID-19 tool collects information from services regarding service capacity and staffing, among other questions. If you’re registered you can see weekly responses and overall national level results. This data may be helpful when planning your service recovery, and will help us as a College to demonstrate how COVID-19 has affected the community paediatric workforce.

Many services have a renewed or greater emphasis on workforce wellbeing as a result of the COVID-19 outbreak. It is important that this continues into the future; for example, maintain regular online service briefings and team meetings, and if you’re a leader try to keep an emphasis on wellbeing in your communication with staff. The RCPCH COVID-19 Wellbeing Hub is a useful source of resources and inspiration.

Further resources for resuming community child health services are available on the BACCH website.

Community settings and COVID-19: case studies

As attention turns to how we can best provide community paediatric services in the next months and years, it is important to reflect on recent changes and to share what has worked well – especially those innovations that will continue to be used for the remainder of the pandemic and beyond.

Thank you to the services that have submitted their innovations and experiences so far. Instructions on how to submit yours are in the next section.

Remote consultations and prioritisation of clinical activities, Community Paediatric Service United Lincolnshire Trust

The problem posed by COVID-19

Due to significant redeployment of staff in community paediatrics (~70%), it became extremely challenging to maintain all core clinical activities.

All core clinical activities in community paediatrics were therefore ceased from the 30th of March until further notice (for review at the end of April). Routine new referrals (e.g. including referrals for ADHD and Autism) and routine follow up activities were put on hold for the exception of those deemed to be of urgent clinical priority.

The solution

We identified those that were deemed to be of clinical priority through triage system and risk assessment as follows:

1. Urgent referrals (developmental regression and severe developmental delay)
2. Repeat prescriptions for patients where the GP has declined share care arrangements
3. Urgent telephone advice to families
4. Remote follow up consultation for ADHD patients on controlled medication as this was deemed clinical priority
5. Adoption/fostering medicals, particularly where there are approved adopters and
A COVID-19 Triage guidance and Standard Operating Procedure (SOP) was developed to describe the procedure to be followed to continue to provide these services above that are deemed to be of clinical priority via remote consultation, ensuring continuity of care to the most vulnerable children in the current COVID-19 pandemic. This SOP incorporated guidance for telephone and video consultations.

The Core Principles of the COVID-19 Triage guidance and SOP were:

- To identify quickly those that are of urgent clinical priority.
- To keep children out of direct contact within the healthcare system, unless essential.
- Use of telemedicine and other non-direct care, when appropriate.
- For the majority of our patients deemed as high clinical priority to be assessed by telephone or video consultation rather than face to face.

Additional short 10-15 minutes telephone advice clinics were set up to address any patient concerns and to give medical advice by the community paediatric team, in response to patients’ queries related to their care under the community paediatric service during the COVID-19 pandemic.

The benefits of all the above were as follows

Benefits for patients

- No requirement to travel
- Supported social distancing policies
- Reduced the risk for siblings accompanying parents to clinics during school closures
- Ensured continued monitoring of health condition and attendance to urgent medical advice

Benefits for staff

- Supported social distancing policies
- Supported clinicians that fell under the high risk group to work from home.

Benefits to service

- Clinicians that were not deployed into acute clinical care safely maintained priority clinical activities, in line with the reduced clinic capacity.
- Ensured continued monitoring of patients’ health conditions that are of clinical priority

How the solution will be incorporated into new ways of working

The plan is to continue to prioritise the urgent clinical cases as we open up our routine referral assessment pathways and other routine follow ups. We will use the COVID-19 ULHT Triage guidance in community paediatrics that we developed to ensure timely identification, attention to urgent cases and grading of all new referrals to community paediatrics.
We are continuing to use remote consultations successfully to address our backlog following our staff return to the department.

Lessons learned

We will continue to identify and prioritise urgent clinical cases within our workload.

We will also continue to provide additional 10-15 minute telephone advice clinics to address urgent patient-initiated medical advice between scheduled appointments.

All telephone calls should be triaged by the community paediatric secretaries, as some patient concerns that are non-clinical can be dealt with by the secretaries. This includes concerns related to scheduled appointments, nature of appointments, overdue appointments and the process for new referrals. Secretaries then escalate clinical requests to the clinicians, such as those regarding medication change, repeat prescriptions where GP does not share care, and for medical advice.

We will continue to use email to support the patient-initiated telephone advice and ADHD medication titration and stabilisation.

While remote consultations will continue, we plan to see the child safely face to face where there is a need to do physical examination.

Contact for further information

For more information on this case study, email: folasade.johnson@ulh.nhs.uk

Helping families to self manage glue ear at home, Cambridgeshire Community Services NHS Trust

The problem posed by COVID-19

During COVID-19 no grommet operations have been available for children with persistent hearing loss secondary to glue ear (also known as Otitis Media with Effusion, OME).

The solution

A research project was set up by Cambridge Community Services (although ENT services wanted it to be set up as a service and not a project) to send a set of bone conduction headphones to all children with glue ear. Their parent/teacher received a small microphone and the Hear Glue Ear app. The headphones do not require any programming by an audiologist, but work to send sound as a vibration directly to the cochlear (simply by passing the ear drum which has fluid built up behind it).

The headphones can then either be 1) bluetooth connected to a small microphone worn by a parent/teacher to enable the child to hear better, or 2) the headphones can be bluetooth connected to the free Hear Glue Ear app for speech and language enrichment through audiobooks, songs and listening games. Speech and language therapy can also be delivered through the app, and it has a hearing game to help parents monitor their child’s hearing at
The study was fast tracked as part of the COVID research initiative and enabled clinicians to see how families coped with being sent equipment and simply followed up remotely by telephone or video consultation.

**How the solution will be incorporated into new ways of working**

Before COVID-19, children waited 12 months on average for a grommet operation and were deaf during that time. This method of self management by the family is a solution that many ENT, audiology, paediatric and speech and language services are now keen to adopt - especially because in 2018 NHS England announced that they would fund fewer grommet operations. In Cambridge the ENT and audiology services are speaking to commissioners.

**Lessons learned**

The study is still continuing so we will be able to learn more. Initial findings seem to suggest that families are able to self manage glue ear at home and possibly more effectively in the community. Children can potentially be better supported while they have a temporary deafness from glue ear.

**Contact for further information**

For more information on this case study, email: hearglueear@gmail.com

**Rapid access community clinics, Nottingham Children's Hospital**

**The problem posed by COVID-19**

Our service runs approx. 1700 general community paediatric clinics per year in the community at 12 locations seeing approximately 2000 new patients and 10,000 follow up patients per year. We are part of an integrated service with the hospital based service so see a combination of general paediatric problems amenable to being seen in a community setting as well as the developmental problems more typically seen in community paediatrics. Children are seen within a community clinic near to their home as far as possible.

At the beginning of lockdown all our clinics were closed face to face, with telephone review offered instead for all those due to be seen. However there were a number of both new and follow up patients booked where face to face assessment seemed essential e.g. new patients where physical examination seemed essential, or follow up patients needing blood tests, weighing, measuring or blood pressure checking. At this point in the pandemic opportunities for any of this to be done in alternative settings e.g at hospital or in primary care were limited.

**The solution**

We set up two rapid access clinics each week at our child development centre – a stand alone building on a hospital site, which acts as a base for many of our community children's services. All other face to face activity in the building had ceased and most staff were
working from home. The building was made safe for use by removing many of the soft toys and furnishings to facilitate cleaning, and a one way system through the building established.

The clinics were staffed by health care assistants who greeted families, went through screening questions before admitting the family and then carried out the usual clinic support roles. Community paediatric consultants covered the clinic on a rota basis, joined by community paediatric trainees (when they returned to our services after having been seconded in the acute phase of the pandemic to front line services).

Children were booked into the clinic at short notice in a number of different circumstances:

1. New patients where information in GP referral letter indicated physical examination/tests at first appointment seemed necessary and urgent
2. New patients who had had telephone assessment that identified the need to be seen as above
3. Follow up patients where telephone review identified the need for physical examination/tests

From April to Mid June (10 weeks) we ran 19 clinics, offering appointments to 5-9 children each clinic. 89 attended, 17 were not brought and 3 cancelled and rearranged. The majority were judged as having needed the urgent appointment once they had been seen. Most needed further tests or referrals and 80 of them required ongoing involvement and arrangements were made to see in their local clinic after lockdown lifted.

**How the solution will be incorporated into new ways of working**

The idea of having the ability to see new patients in the community quickly had been one we had previously considered. Our waiting lists in the community are generally around 8-12 weeks, which are similar to hospital colleagues but we do also have rapid access clinics run by the general paediatricians in the hospital.

Therefore when referrals to our single point of access for general and community paediatrics need urgent assessment (e.g. for developmental regression) they are generally initially seen in a hospital rapid access clinic, before being passed on to a community colleague if necessary. Where ongoing community paediatric involvement is deemed likely from the referral information it would seem more appropriate for them to be allocated to a community paediatrician from the outset. We are therefore now considering whether we should retain some of the rapid access slots within the community paediatric service, once our usual clinics start to open up.

**Lessons learned**

We learnt that we were able to identify, through referral letters or telephone triage, children who required urgent assessment that could be offered in a community setting. We will further analyse the clinic data recorded from this time, together with assessment of referrals coming into our single point of access for general and community paediatric out-patients to decide whether a rapid access community clinic would be a useful addition to the range of clinics we offer.
Submit your case study

We are collecting case studies on how community paediatric services have adapted to COVID-19 – from telemedicine to closer working with colleagues from other professions, we want to hear about your service’s action and experience. Case studies will be published in the previous section on this community settings guidance page.

Submit your case study by clicking on the button below, which will take you to our easy online form. The form asks for:

- Your Trust or service name
- Description of the problem posed by COVID19 (max 1500 characters)
- Description of the solution (max 1500 characters)
- Description of how the solution will be incorporated into future ways of working (max 1500 characters)
- Lessons learned (max 1500 characters)

You are also asked to provide a contact email address, so that a member of the team can let you know if/when your case study will be published on this page.

Thank you for helping to share ideas, innovation and valuable information across community paediatrics.

Submit case study

Operational guidance: Minimising potential exposure to COVID-19 for patient and practitioner, while keeping children safe

Community clinics

- In addition to those face to face appointments that have continued throughout the pandemic for some children (child protection, LAC etc), face to face appointments may be clinically required for other referrals, particularly for new patients.
- The clinic environment must allow adherence to social distancing in clinic rooms and in waiting areas with appointments timed to facilitate this. The centre should be cleaned to a standard that minimises infection and have hand sanitisers or hand washing facilities for patients. The centre should only have play equipment that can be cleaned comprehensively and easily or is disposable, such as pencils and crayons. Appropriate PPE must be available for staff.
- If your service requires patients to wear PPE beyond what they can be reasonably assumed to possess, such as coverings in addition to non-medical grade face masks, then the service should provide this.
Continue to use telemedicine tools as much as possible where clinically appropriate. This may include telephone consultations or similar, depending on the resources available. RCPCH QI Central features online resources for setting up and running successful video consultations.

For England, more information about virtual assessments, using digital technology for patient support and essential face to face care is available in the NHSE/I COVID-19 Standard Operating Procedure for Community Health Services. Section 2.5 focuses on healthcare settings.

**Home visits**

- Clinicians should consider whether visits are necessary and, if so, use telemedicine tools as much as possible. This may include telephone consultations or similar, depending on the resources available. RCPCH QI Central features online resources for setting up and running successful video consultations.
- For England, the NHSE/I COVID-19 Standard Operating Procedure for Community Health Services notes that screening questions should be asked before each home visit. Visits must also be prioritised according to guidance, (see ‘England: Priorities for community health services’, below), and cohort considerations should be made. Section 2.4 of the Standard Operating Procedure focuses on home visits.
- When considering whether visits should be conducted as planned, clinicians should also consider their own safety and the safety of the other children that they provide care for.
- For Scotland, guidance is available from HPS COVID-19 Information and Guidance for Social or Community Care and Residential Settings. Section 1.10 ‘Home visits/care at home’ notes that health and social care staff should defer visits to self-isolating people if possible. If visits are essential, staff must comply with all infection control procedures and the use of bank/agency staff must be avoided wherever possible.
- The guidance is complemented by the Scotland National Clinical Guidance for Nursing and AHP Community Health Staff during the COVID-19 pandemic. This document is geared towards nurses and AHPs, but is relevant to the work of community paediatricians as part of an integrated approach that utilises the skills of all community professionals.

**Educational settings**

- For children and young people with education, health and care plans (EHCPs), PHE guidance on vulnerable children and young people states that these should be risk-assessed by the school/college to decide whether children and young people need to be offered a school place to meet their needs, or if they can safely have their needs met at home. If necessary, this could include carers, therapists or clinicians visiting the home to provide essential services.
- There is further information regarding special schools and colleges in the guidance.
- For children in alternative provision (AP) settings, guidance states that AP settings are staying open throughout the COVID-19 outbreak, as significant numbers of children in AP meet their definition of vulnerable (having a social worker and/or an EHCP).
- Clinicians working in AP settings should work with management to minimise infection risk to children and young people while ensuring that their needs are met. The PHE guidance published 14 May on safe working in education, childcare and children’s social care settings.
covers childcare settings and schools including special schools.

- **SEND risk assessment guidance** has been published by the Department for Education (DfE). This document does not explicitly refer to health services but notes the health and wellbeing risks to the individual as a result of COVID-19 and the temporary closure of educational services.

- **Guidance on supporting children and young people with SEND as schools and colleges prepare for wider reopening** is available from PHE.

- **Guidance for Scotland concerning COVID-19 school closures** similarly notes that school, early learning and childcare (ELC) settings may stay open for children of key workers and vulnerable children (defined as those in receipt of free school meals, children with additional support needs and at-risk children).

- The Northern Ireland Department for Education has **advised that special schools will stay open**, as these children fall within the definition of vulnerable children.

### England: Priorities for community health services

- NHS England has published **guidance on the restoration of CYP services**. This states that the majority of services should undergo partial or full restoration.

### Scotland: Priorities for community health services

- **National Clinical Guidance for Nursing and AHP Community Health Staff during the COVID-19 pandemic** is geared towards nurses and AHPs, but is relevant to the work of community paediatricians as part of an integrated approach that utilises the skills of all community professionals.

- Section 5 contains guidance specific to the care of children and young people, and Annex 4 outlines priorities of care in the community for health visitors, family nurse partnerships, school nurses, children’s community AHP services, district nursing services, general practice nursing, specialist nurses, learning disability and mental health nursing, adults community AHP services.

### Mental health, learning disabilities and autism

- NHSE/I has **guidance for clinicians who have had limited contact with people with a learning disability or autism**, which outlines an approach to supporting people with a learning disability and people with autism throughout the COVID-19 outbreak, and links to further resources.

- The national mental health and learning disability and autism teams and NHSE/I have set up a COVID-19 response cell. The cell has limited relevance to CYP but may be useful to be aware of. More information is available in their **update from 15 March 2020 (PDF)**.

- The cell has guidance: **Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages** (PDF), published on 25 March 2020.

- The guidance outlines general principles. These are that people with mental health needs, a learning disability or autism should receive the same degree of protection and support as other members of the population; providers may need to make difficult decisions in the context of reduces capacity and increasing demand; providers should consider both physical and mental vulnerability; partnership working is crucial; digital technology is an essential tool to maximise delivery; and providers should bear the
longer-term impact of the COVID-19 outbreak in mind, and seek to minimise changes that impact on the capacity of the system in the long term.

- The guidance then discusses a range of considerations, such as funding, cohorting and additional considerations for community-based teams.

**Notes on this guidance**

- **According to PHE**, the UK is currently in sustained transmission. The provision of direct clinical care requires the appropriate use of PPE irrespective of the symptom or test status of the child. PPE guidance for different contexts is available from the PHE website and relevant to the UK. Table 2 and table 4 are of most relevance to community settings.
- Where available, existing guidance is signposted from Scotland, Wales and/or Northern Ireland.
- While hospice settings are outside the scope of this section, we recognise that some community paediatricians may lead on this work. Clinicians are advised to make appropriate policies in conjunction with others in their locality, such as hospice staff and the local authority.

This guidance has been produced with the British Association for Community Child Health (BACCH).

[Logo: British Association for Community Child Health]

**Latest updates on this page**

Updates in this version (published 24 July)

- Case studies: Helping families to self manage glue ear at home, Cambridgeshire Community Services NHS Trust case study added
- Case studies: Remote consultations and prioritisation of clinical activities, Community Paediatric Service United Lincolnshire Trust case study added

Updates in version published 7 July:

- COVID-19 and Community Settings: case studies, Nottingham Children’s Hospital case study and Submit your case study sections added.

Updates in version published 23 June:

- Link to RCPCH Ambassadors added.

Updates in version published 22 June:
• Reset, Restore, Recover section added.
• Operational guidance: edited and updated with new links.