NPHET 8th May 2020
Community Capacity and Resumption of Community Services (Post-COVID-19)
Proposal to establish a Community Capacity Working Group

1. Community Capacity – Scope

The community covers primary care services, services for older people, palliative care, specialist disability services, social inclusion and those accessing mental health services.

2. Context - Community Services and COVID-19-19

The situation in primary care broadly reflects that in the acute sector in terms of a fall-off in presentations at GP surgeries and a scaling back or halting of many community services to enable resources to be deployed as part of the response to COVID-19.

At the same time, essential services, including respite care and home care, for both specialist disability services and older people, have been maintained, albeit at a reduced level of service, as part of a process of prioritisation, with services identified into four baskets or levels ranging from must do/critical to lower priority/desirable.

It should also be noted that the COVID-19 pandemic has had a particularly significant impact on more vulnerable groups in the community, including older people who are more medically vulnerable to COVID-19, particularly those living in long-term-residential care including older people, those with a disability and mental health.

3. Service Innovation

Changes in **work practices and new methods in the delivery of services** have been introduced in the wake of the COVID-19 pandemic, and some of these innovations, introduced in a time of such extreme upheaval in the Health Service may be maintained in the long term. These include the enhanced use of technology systems (both administrative CRM and eHealth/ePrescribing initiatives); telehealth and assistive technology, greater integrated working across the sector; COVID-19 Response Teams in CHOs; and developments of clinical, palliative care and infection prevention supports and infrastructure. These innovations were essential to address long standing clinical governance, integrated multidisciplinary teams and infection prevention expertise/infrastructure challenges in the community.

There has also been the development of **alternative community support services**, such as the ALONE model and the Local Authority Support Framework which involves the HSE at local fora, as well as the utilisation of voluntary supports.

Subject to evaluation and review, there is now an opportunity to develop and incorporate such innovations into the community sector over the longer term. In this respect, it should be emphasised that the thrust of many, if not all, of the service innovations has been on finding ways to care for people at home or in their local community, which is of course the core vision of Sláintecare.

4. Challenges

There are a number of challenges facing the community as we seek to resume services. Most notably:

Availability of staffing – staffing pressures relate to redeployment of staff to various aspects of the COVID-19 response, absence related to illness/isolation, additional staff requirements to support additional infection prevention, surge requirements, vulnerability to COVID-19 or the challenge of childcare.

Testing/Contact Tracing – there remains a need to ensure that the testing system is on a firm footing, but once this been achieved it may then be necessary to consider whether the use of HSE staff is the most effective use of resources over the longer term.

Infection Prevention and Control - it will be necessary to enact more long-term changes in terms of physical and environmental changes to accommodations/health facilities while also introducing behavioural adaptations of patients and staff to ensure social distancing is adhered to, PPE is available and properly used as required etc. The requirement to comply with infection prevention and control standards is likely to lead to a reduction in efficiency as for example, group work becomes more difficult.

5. Next Steps

A Community Capacity Working Group to encompass primary care, social care, mental health and social inclusion leads from both Department and HSE which will include relevent clinical expertise will be established to develop a high-level plan for the phased resumption of services and associated capacity requirements for the community. This high-level plan will be operationalised having due regard for the advice of the Office of the Chief Clinical Officer of the HSE and the need to achieve an integrated approach between acute and non-acute services.