The Experience of Managing Covid 19 in Social care in London

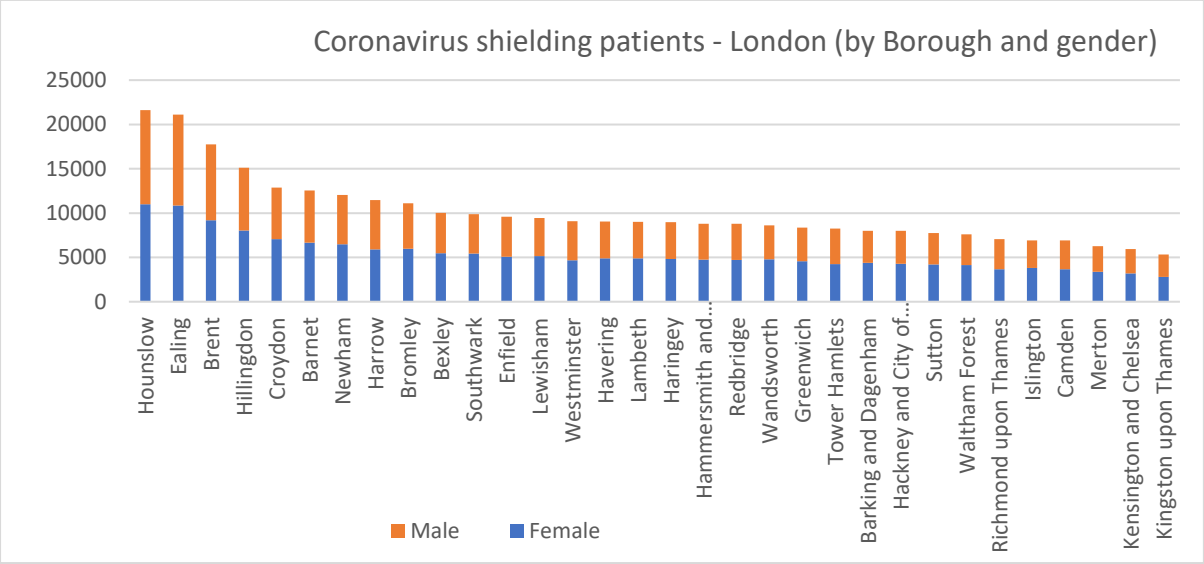
Purpose: this report describes the experience of social care teams across London through the initial phase of the Covid 19 pandemic from March 2020 – June 2020. It summarises the context for social care, the experience of both staff and clients through this period and sets out recommendations that build on the learning and experience gained throughout.

1. Background and Context

The Covid 19 pandemic has posed an unprecedented challenge to the social care sector in London.

At the beginning of the pandemic in London, social care teams across the 33 London Boroughs were providing care and support to 150, 000 London residents across a mixture of care settings. As part of a policy to protect the NHS and to free up capacity within hospitals to manage the expected surge, discharge procedures were radically overhauled in March 2020[i] and, as a result, 6500 people were discharged from hospitals into the care of local social services teams from 26th March - 12th June 2020, which equates to 25% of the care home capacity in London being filled over a 10 week period. This is against a national backdrop where, in the first half of March, the number of patients discharged to care homes was higher than in the previous year and the proportion of hospital discharges to care homes increased throughout March, with a reduction in discharges by the end of the month.

These former patients required a variety of care settings, from nursing homes through to community support at home and, in addition to providing this support at unprecedented levels, care staff were also required to take responsibility for a significant proportion of 'shielding' residents – those identified by NHSE or clinicians as being at greater risk for contracting the virus and therefore asked to remain at home, with support from local teams, for an initial 12 week period. In some Boroughs, there are over 20 000 shielding people identified as requiring support[ii].



The pandemic has presented an extraordinary challenge to a care workforce already under extreme pressure. The decision to protect NHS services and to ensure adequate provision within a clinical hospital setting, whilst understandable, had consequences for the teams delivering services outside that setting. In the strategic context, this decision was modified as the pandemic developed, when it became clear that the level of infection and the mortality rates being suffered within care homes was leading to tragic outcomes for many residents.

At the outset of the pandemic, the majority of infections were identified within a clinical hospital setting. In the week ending 20th March, 4% of those confirmed as dying from Covid 19 nationally were care home residents. The figure had grown to 31% in the week ending April 17. At the peak of the pandemic within care homes (which took place later than the peak within hospitals), nationally 44% of weekly fatalities occurred within care home residents. The recently published Laing & Buisson report on total excess deaths resulting from the pandemic estimates 57% will have been care home residents[iii].

Care homes in London were particularly badly affected by the crisis. The surge in London came earlier than in other areas, and the changes in policy which have assisted other areas in protecting care homes more effectively (such as the increased availability of PPE and testing for care homes) therefore came relatively late to London's care homes and care workforce. The result was that deaths in care home residents in London have been proportionately higher than those outside London[1], with the possible exception of the north east of England. It appears that 4.7% of all of those resident in London care homes (1654 people) had died from Covid-19 by 15th May 2020 *(figures include care home residents transferred to hospital)* and, of the 1394 care homes in London, 45.6% had been infected by Covid, with 635 outbreaks recorded in the period to 31st May 2020[2].

In addition to the requirements to support the shielded population and to manage rapid discharge into care settings, social care teams have also had to manage the ongoing social challenges created by the pandemic. This is in the context of our diverse populations and the clear disparities in the risk and outcomes of Covid-19 on people living in deprived areas and people from Black and Minority Ethnic groups (BAME).

These challenges include supporting families through the closure of support services for those requiring non-residential care; managing the ongoing domiciliary care of non-Covid vulnerable people without adequate PPE and with reduced staffing numbers; supporting vulnerable households and children through the extraordinarily stressful experience of being confined to a domestic setting and providing ongoing support to families in crisis. Finally, social care teams worked alongside council colleagues as part of the whole council response in areas such as rough sleeping and food distribution.

There have been some excellent examples of collaborative working between NHS and social care colleagues strategically and locally, ranging from regional joint work on demand and capacity modelling to some local solutions to move forward on PPE and

[1] The Health Foundation (2020)
[2] Public Health England (2020)

testing ahead of national responses. However, the pandemic period has nonetheless represented an extraordinarily difficult and tragic moment for care clients and their families, as well as for the staff and commissioners of social care.

2. Impact of Covid 19 on the Social Care Workforce

Access to PPE and testing has been a major challenge throughout the pandemic in London. There were major problems within the national supply chain for PPE at the beginning of the pandemic and, as London was earlier than many areas to reach the peak of infections, many of the supply-chain problems were felt most acutely in the capital.

Initially, as the majority of infections were in a clinical setting in March 2020, PPE and testing for NHS staff was prioritised. This meant that often staff in care homes or in home care settings were working without PPE and without knowledge as to whether either they, or their clients were infectious. Over the course of the pandemic, locally-led arrangements and pan-London procurement solutions, with boroughs working together, helped to bring more reliability and organisation into the system, and represent a potential model of practice moving forward in the space of PPE and testing.

Nationally, the mortality rate amongst social care staff and healthcare workers has been a focus of national remembrance. The impact on social care staff have been particularly acute. The death rate in social care calculated as 23.4 deaths per 100,000 for males and 9.6 deaths per 100,000 females, compared to 10.2 deaths per 100,000 men and 4.8 deaths per 100,000 women for healthcare workers[iv].

Whilst these figures will change as the pandemic progresses, Covid 19 has had a significant impact on social care staff, and further research will be required to understand how to mitigate this risk in future.

3. The London Response in Social Care

Policy guidance was issued by central government on 19th March 2020 setting out a revised process for discharge that was intended to protect and free-up capacity within hospitals to deal with a rapid increase in presentations with suspected Covid 19

> *"Implementing these Service Requirements is expected to free up to at least 15,000 beds by Friday 27th March 2020, with discharge flows maintained after that."*

There was also a commitment that the NHS Covid-19 budget will take responsibility for the ensuing costs:

> *[Adult Social Care will] "Take the lead contracting responsibilities for expanding the capacity in domiciliary care, care homes and reablement services in the local area paid for from the NHS COVID-19 budget."*

In addition, specific requests were made of social care teams in order to assist with the management of the pandemic. Social care was asked to work as part of a team of organisations coming together to protect the NHS. Chapter 5 of this policy summarises the requests made of social care in this period.

In addition to the responsibility to take on care costs for additional people discharged from hospital, social care was also asked to take responsibility for supporting the shielded population in their homes.

The shielded population is distributed across London unevenly, as would be expected, but the result was that some boroughs assumed responsibility overnight for providing support to over 20 000 additional people, many of whom would have had no previous contact with social care. The complexity of providing support to shielded residents was immense, as their support needs are often varied and fall outside the traditional world of social care, and there was the added complexity of maintaining infection-free contacts without access to PPE, despite the additional risk to this group of individuals.

Across London, social care teams mobilised to protect and support their local populations, working collaboratively with colleagues in the voluntary and community sector, deploying local volunteer assets as well as drawing down on the local knowledge and insight about specific communities and support requirements that is a key part of social care provision.

In addition to the requirements detailed in the March revised discharge policy, social care teams across London implemented:

1. **Integrated Discharge Hubs**, bringing together expanded multi-disciplinary teams to manage rapid discharge with standard care packages followed by a review within 1-2 weeks. This was resource intensive.
2. **Community Support Hubs**, working with the voluntary sector locally to provide support to the shielded population including social support such as assistance with dog walking, shopping, prescription collection etc
3. **Proud to Care –** an initiative from boroughs working together to recruit into ongoing vacancies in the care workforce to meet growing demand on the sector
4. **Rapid Response Units,** to provide support to care homes and the frail elderly population through the pandemic
5. **Collaborative procurement of PPE** to meet the needs of social care staff

The appendices attach reflect just a few of the case study examples of borough responses and collaborations across local authorities and the NHS.

Financial support was made available to care homes from local authorities, to meet the increasing and unexpected costs, and other examples of innovative work took place across health and care in London in order to develop systems of discharge and support to care homes. **A key element of future planning will be to make sure these developments in discharge and Mental Health support to care homes, for example, become embedded for the future in all settings**.

Detailed borough level preparation took place to free up capacity to ensure that the peak predicated hospitalised population could be discharged and thus new patients admitted. This was a huge task. It involved re-providing care for many existing

recipients in conjunction with the care sector, voluntary organisations, charities and their families and creating step down facilities to support Covid positive residents and protect care homes. A huge range of facilities from hotels to hospices, to charity retreats and conference centres were lined up. The actual experience that this was lower doesn't diminish the huge effort to be ready for the higher level.

The acceptance by the NHS that resources directed via them would be used to pay for higher levels of discharge was essential – as it remove the usual debate and argument about responsibility and payments, thus enabling focus on action. However, an ongoing risk presented by the crisis is that, as evidence shows, care and support tends to be 'overprescribed' at the point of hospital discharge and a sense in London that rapid discharges led to some people being on the wrong pathway, without sufficient support to rebuild their strength and capacity, thus leading to a drift into needing long-term care that could have been avoided and the associated costs of this.

4. Analysis

Social care in London was placed in a particularly challenging position through the pandemic. Many of the changes in policy that have benefited other areas nationally (such as greater access to PPE and testing within the care workforce, the changes to discharge protocols for suspected Covid+ patients and the development of effective isolation protocols within care homes) were developed as a result of learnings from the London experience, as the first region to experience the surge in NHS demand through the peak.

Staff across London have worked collaboratively with each other and with NHS colleagues to manage the effects of the pandemic, and have taken time to reflect and learn from the experience in order to be in a stronger position for the future.

The London response was heavily data-led, and effective local collection of timely data was able to support relationships with care providers and to identify and flag challenges as they appeared in the analysis. London data collection led to initial concerns about the impact on care home residents being raised in March 2020. Nationally mandated systems cut across this.

Social care has been, historically, less well understood by the public than many of the health-focused professions. The lack of knowledge presented a challenge at the outset of the pandemic, with decision-makers often unaware of the principal role of care homes as places of residence (people's homes) and social interaction; and therefore often unsuitable and unequipped to apply the same infection control approaches as used in hospital settings.

The pandemic has magnified a range of ongoing realities that we face in dealing with the care home sector. Composed of independently run organisations, and operating with serious public funding constraints, this is a highly fragile sector; and the success or failure of these organisations has a direct impact on the lives of residents and the scale of demand faced by the NHS (the hospital sector in particular deals with the consequences or insufficient pandemic preparedness).

Any changes to the delivery of care home support, including segregation, infection control measures associated with staffing levels, restricting movements and pay and the provision and use of PPE, has a direct impact on the costs borne by providers, which will need to be passed on to funders, whether in the public sector or self-funders. These extraordinary costs have, rightly, been recognised and provided for within the NHS; and we must ensure the same arrangements are extended to the care sector.

This, at its essence, requires a commitment to allocate resources to prevent infection – in care homes and elsewhere – otherwise we will continue to invest in expanded hospital capacity to deal with the avoidable consequences of disease. A more preventative approach has the potential to avoid demand in the NHS, and to safeguard the wellbeing of some of London's most vulnerable people.

This period has led to a rapid increase in understanding of the reality and value of single pathway approaches to care, where organisations work together as part of a co-ordinated system in a local setting.

The recommendations below aim to build on that new understanding to create a pathway model for treatment and care than ensures that people and staff are equally protected and prepared to manage either a second wave of infections or endemic Covid 19 in the local population.

5. Recommendations

It is hoped that a **wider understanding of the nature and requirements of care settings**, the importance of **building effective partnerships for care**, alongside the treatment that the NHS provides, the **value of local community assets** in meeting people's needs will all be products of this extremely challenging period, and will form the basis of an ongoing response to endemic Covid 19 within our community.

In addition, the experience demonstrates the need for **a radical change to the financially precarious situation social care operates within.**

The recommendations below address these requirements and should form the bedrock of a regional approach **both in the management of a second wave** and as part of an **improved, integrated model of health and care management** across the region

5.1 Parity throughout the pathway

That the same principles of infection control and prevention are applied throughout the length of the care pathway, meaning that care homes, supported living and Homecare staff are able to protect those they care for to the same level as is proposed within the hospital setting

In practice this means…

- Ensuring that care homes and home care staff are able to provide safe, infection-free spaces for vulnerable people. This will include training care home staff in clinical observations for at-risk residents, agreeing infection controlled pathways and ensuring the availability of the appropriate level of PPE to manage infections risk (ref: https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes

- Zoning care homes in line with current clinical practice, and prioritising testing and PPE for homecare workers. This includes a clear national strategy on testing and re-testing for staff and residents.

- A new financial model for Care Homes, with teams potentially increasing in size, in line with the increases in the acute sector teams, and new patterns of staffing and rotation in order to minimise cross-infection

5.2 Planning and Delivering Together

That a single plan is built up for each ICS / STP, jointly with local authorities, and within a timeframe that allows the space for collective reflection which is meaningful at borough level, and signed off by the appropriate bodies within regional and local government, and the NHS, to agree a practical, deliverable framework to manage Covid on an ongoing basis

In practice this means…

- Colleagues in health, the voluntary and community sector and our local communities working together at borough level to build up effective system-wide, place-based responses. We recognise that we all work best where we plan and deliver together.

- All parties within a local area should come together to determine and agree an appropriate and practical response which draws on relevant local assets and knowledge across the whole system – a dialogue of equals.

5.3 Protecting People to Protect People

Testing and PPE to be available to those providing care in any setting (eg care homes, homes, supported living facilities for learning disabilities etc). These settings should be considered alongside hospitals and equally in the allocation and prioritisation of protective resources, due to the vulnerable nature of the residents and the need to ensure that people can be safe and protected in their own homes

In practice this means…

- Creating local, system-wide deployment of PPE and regular testing, which recognises the importance of all care and residential settings

- Ensuring that staff are protected both inside and outside the care setting, to minimise the risk of transmission from care settings into the community and vice versa

- Recognising that, as care homes and residential settings provide long-term care to vulnerable people, their needs for protective equipment and testing are likely to remain high and acute for a significant period of time (potentially longer than the acute hospital setting) and planning accordingly

- Understanding the demographic profile of the social care provider workforce, including age and ethnicity, to mitigate risks associated with COVID-19 in view of the evidence of higher mortality rates amongst this workforce.

- Valuing the social care workforce through better remuneration and improved access to career pathways into e.g. nursing and social work

5.4 Building strong and sustainable Places

Increasing the social care workforce and drawing upon existing and new local community assets to support those who are vulnerable, shielding or providing support to the shielded population within local areas.

In practice this means…

- Expanding the social care workforce to meet the additional requirements of the shielded population, the newly vulnerable as well as their existing clients

- Working in partnership with the voluntary and community sector to develop new and existing community assets to maintain people's independence and reduce risk and pressure within the care and health sector

- Working at 'place' level to tackle wider determinants of health and connect socio-economic recovery with our workforce challenges

5.5 Funding for the Future

The costs of managing the pandemic and protecting local people will add significant pressure to local authority budgets. The requirements detailed in this paper, including additional PPE, additional staffing, effective infection control and zoning will all lead to increased costs. In the NHS, these costs will be born centrally and distributed. For local government, the question as to how these costs will be met in a way that in the reality of the significant local challenges areas face, and the existing fragility of the current model needs to be addressed.

In practice this means…

1. Using the structure of the BCF (as the existing mechanism) to invest in providing additional support to social care in a way that is proportionate to that provided to the NHS in each area

2. Working with Care Home providers to assess the viability of vulnerable homes (recognising that some may not survive) and to ensure continuity of safe and good quality provision for residents

References

[i] HM Government (2020). COVID-19 Hospital Discharge Service Requirements. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/880288/COVID-19_hospital_discharge_service_requirements.pdf

[ii] Nuffield Trust (2020). Chart of the week: How many people in your area are being 'shielded' from coronavirus? https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-how-many-people-in-your-area-are-shielding-from-coronavirus

[iii] Health Foundation (2020). Care homes have seen the biggest increase in deaths since the start of the outbreak. https://www.health.org.uk/news-and-comment/charts-and-infographics/deaths-from-any-cause-in-care-homes-have-increased

[iv] Office for National Statistics (2020). Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered up to and including 20 April 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregistereduptoandincluding20april2020#deaths-involving-covid-19-among-health-and-social-care-workers

Note: This paper was authored by Claire Kennedy, Co-Founder and Managing Partner, PPL in collaboration with LondonADASS, based on conversations with DASS colleagues across STP/ICS sub-regions