Leaders' Committee

NHS Collaboration

Item no: 6

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Summary

This report updates the Leaders' Committee on discussions in respect of the potential for future pan-London collaboration with the NHS. Specifically, it seeks comment on the propositions for a more comprehensive and accelerated move towards closer collaboration and influence across the health and care system which had been emerging prior to the Covid pandemic, what learning can be taken from the period of the pandemic to date in relation to future collaboration and Leaders agreement for London Councils to push forward further senior member and officer level discussions with the intention of reporting to Leaders' Committee a final package of proposals for consideration.

Recommendations

Leaders' Committee is asked to:

1. Comment on the emerging propositions intended to accelerate improvements in health and care system, specifically the recovery of out of hospital and community care, through closer collaboration with the NHS in London as summarised by this report.
2. Note that London Councils will take forward senior level member and officer discussions to refine propositions for discussion with the NHS in search of an agreement for a more comprehensive and London-wide approach to collaboration across the London health and care system.
3. Note that a refined proposition will be reported to Leaders' Committee later in the year.

NHS Collaboration

Background

1. Leaders' Committee in October 2019 discussed a report on the new opportunity to make London wide progress in the improvement of health and care services through faster integration and increased local leadership.

2. This report sets out emerging conclusions from member and officer discussions between October 2019 and March 2020, when progress of discussions had been due to report to Leaders' Committee. Those discussions had been progressed on the basis of identifying areas where a concerted, London-wide approach to borough leadership of integration could improve health and care provision in London, including how to maximise investment of new funding for primary and community care, for example.

3. The work which had been due to report to Leaders' Committee in March was paused while the NHS and boroughs mobilised the emergency response to Covid. While the Covid pandemic and emergency response has disrupted health and care in very many ways, the pre-Covid work remains the potential foundation for deepening and strengthening integrated working. Furthermore, as London enters a period of recovery, there is an opportunity to also build on what has been learned during the pandemic in terms of closer collaboration between the NHS and boroughs.

4. Therefore, this report describes –

    - The conclusions of pre-Covid work involving borough members and officers in relation to accelerating health and care integration in the context of the NHS Long Term Plan.
    - Early learning points from the Covid emergency in respect of joint work with the health system.

- Areas for further discussion with NHS leadership in London in order to bring back to Leaders detailed propositions for closer joint working at borough, sub-regional and pan-London levels.

Opportunities in the NHS Long Term Plan

5. The NHS Long Term Plan sets out a number of commitments which will have an effect on boroughs' individual and collective ability to influence improvement to health and care systems in London. These commitments remain a part of the NHS long term strategy.

6. In particular, it is clear from the Long Term Plan that the NHS recognises the critical role local government has to play in:
   - shifting the emphasis of health and care towards earlier intervention and out of hospital care;
   - breaking down the barriers between health and care services through new budget pooling and joint/single commissioning arrangements; and
   - returning the health system to a long-term sustainable financial footing.

7. Three specific Long Term Plan commitments stand out as ones which will impact on the nature of collaboration with boroughs. Those commitments relate to delivering closer and more formalised joint working at the sub-regional (Integrated Care System) level, the bringing together of delivery partners at the borough (Integrated Care Partnership) level and development of multi-disciplinary population health focused Primary Care Networks. At each level, there is a clear opportunity to develop more systematic closer working between boroughs and the NHS.

Pre-Covid – Developing the Collective Borough Perspective

8. Following the Leaders' Committee in October 2019, work was intensified to develop more concrete proposals for borough leadership on collaboration. Discussion with NHS London senior leaders continued, specifically through ongoing senior level discussions which include the CELC Lead Advisor for Health, NHS London Region, GLA and PHE.

9. To accelerate the officer level discussions, London Councils led work to develop a local government perspective on pre-Covid collaboration arrangements and the key parts of a possible local government proposition for how collaboration with the NHS should evolve in the short to medium term as the Long Term Plan is implemented. Those discussions drew upon experience in boroughs across London, including through meetings with a range of officer leads such as Chief Executives, Directors of Adult Social Services and Directors of Public Health.

10. The aim of all discussions had been develop clear propositions which boroughs and the NHS could agree to which will enable an improvement in health outcomes for Londoners, create a more sustainable health and care system addressing fundamental health and care challenges in London, including –
    - Reducing demand on GPs and cutting waiting times for appointments.
    - Reducing demand on other community and acute services.
    - Earlier intervention to head off future service demand pressures, for instance by acting to increase the number of children that are school ready.
    - Developing a more cost-effective balance of provision for those on the border between health and care.
    - Enabling the quicker delivery of new primary care estate which meets the needs of the future, more joined up primary care offer.
    - Creating better links to local government services that help maintain personal well-being, such as employment support, housing or leisure.

11. The pre-Covid emerging proposition were based on five core priorities –

    1. **Establishing enhanced pooled funding arrangements at a borough level across a significant number of boroughs** to allow investment in shared priorities such as prevention and earlier intervention.

    2. **Creating a clearer role for boroughs in the development and implementation of PCNs in London**

3. **A consistent commitment to borough leadership of each borough-based ICP board**

4. **A consistent London framework which articulates the potential future roles of Health & Wellbeing Boards and ICPs to emerge.**

5. **An overall "local by default" model of planning, performance management and delivery**.

Recovery from Covid - Journey to a New Health and Care System

12. In April 2020, the NHS took the first steps in the process of rebuilding health care services in the wake of the Covid epidemic, building upon innovation adopted during the first phase of the epidemic and addressing challenges such as estates, digital and workforce that pre-date the covid-19 epidemic. NHS leaders have been issued a set of recommendations by NHS England for restarting of non-covid-19 services, as set out in a letter on the second phase of the NHS response to covid-19.

13. The NHS's organising principles underpinning its approach to acute care recovery is to ensure hospitals are resilient in advance of a potential second wave on infections and ensure people feel safe when attending or working in health and care settings. For example, the NHS has noted that A&E attendances had fallen from 12,000 a day to 4,000 at the lowest point during lockdown, with the numbers rising to roughly 7,000 a day in recent weeks. This illustrates a concern that Londoners are not accessing essential heath services through concern about the risk of infection by attending health settings.

14. The London Health and Wellbeing Board Chairs' Network held a special meeting on 11 June 2020, at which Sir David Sloman, Dr Vin Diwakar and Martin Machray presented for NHS England London on the acute recovery planning process in the Capital, and answer members' questions.

Harnessing Learning from the Covid Pandemic

15. Although the Covid emergency slowed the pace of the London Councils' led work, the pandemic has shone a light on the unique power of borough, place, based working. London's Directors of Adult Social Services have rapidly produced a report describing the experience of social care teams across London through the initial phase of the Covid 19 pandemic from March 2020 – June 2020. The 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. The full report is **attached** as Appendix 1 and details key findings from an adult social care perspective, which are informing thinking in relation to health and care recovery.

16. Therefore, as the NHS moves forward with its acute recovery planning, which involve, in some case, complex reforms, London Councils has worked with borough Chief Executives and Directors of Adult Social Services and have identified a number of issues for incorporation into how the Capital builds back out of hospital and community care, including –
    - The efficient and rapid delivery discharges ensured London hospitals did not breach acute care capacity. However, across London there were examples of this being achieved with increased risk to care homes and care home residents, and so there will need to be lessons learned in order to minimise risk in discharge decisions.
    - Detailed and intelligent market insight was vital in order to predict market stability. Locally-led analysis was more insightful than centrally driven.
    - Joint modelling of care home supply and demand and mitigation planning for supply side disruption or failure, for instance through multi-tiered mutual aid agreements and access to emergency regional support through hotel accommodation, was essential in giving assurance and confidence to the system and in ensuring discharge flows could be maintained.

- Shielding many thousands of Londoners with the supply of food, medicines and wider wellbeing support, helping many people remain healthy at home. These interventions relied heaving on good local partnership working and les so on centralised mechanisms and approaches.
- The development and upscaling of virtual and remote services, including social and primary care services.
- The emergency relocation of over 3000 rough sleepers in order to shield this group from Covid and avoid further pressures on hospitals.

17. The London Councils' London Health Board Leaders were invited to and participated in a pan-London workshop with senior NHS leaders on 14 May 2020. This workshop explored some of the key learning to date and allowed members to lead a discussion in respect of the borough view on the London approach to recovery.

Out of Hospital and Community Care - Building Back Better through Collaboration

18. Learning from the pandemic highlights the clear interdependencies between acute sustainability and resilience and the delivery of effective out of hospital and community care, in the broadest sense of the many interventions which kept vulnerable Londoners healthy out of hospital.

19. In parts of London, boroughs and health partners are developing place-based recovery plans for out of hospital and community care. However, this work is moving at a mixed pace and does not come the same degree of clarity at the London level of how out of hospital and community care will form a key part of the long-term recovery and resilience of London's hospitals.

20. London Councils members and officers, with CELC lead advisors and London DASS leads, are in ongoing discussions with senior NHS leadership in London in respect of a collaborative approach to the recovery of health and care across the City, specifically 1) how boroughs and the

NHS move forward in the short term transition and longer term recovery, and 2) the learning factors boroughs and the NHS should prioritise in out of hospital and community care.

21. Seen together, the proposals emerging from the pre-Covid work and the Covid learning suggest that London boroughs and NHS partners might approach the recovery of out of hospital and community care on the basis of the following principles –

a) **Out of hospital and community care is critical to sustainability and resilience of the acute system**; each borough and CCG plan should be aggregated to create the ICS and London plan for building back better the future offer.

b) **Pandemic learning is embedded in short term transition/2nd wave plans**; notably in relation to discharge arrangements, financial flows to pay for discharge in care and market stability, joint modelling and planning, care home support and testing.

c) **Establishment of enhanced pooled funding arrangements at a borough level** to allow investment in shared priorities such as prevention and earlier intervention; and to enable the enhancement of the role of working with local VCSE partners including in social prescribing, mental health, supporting the shielded population and managing the wider determinants of health.

d) **A Senior Borough Officer or Political Leader, possibly the Council Leader or Chief Executive, to co-chair each borough-based ICP board and a multi-disciplinary model of building for the future**, including two-way lines of support between ICS and local Chairs at the leadership level and mainstreaming of all relevant professional leadership into out of hospital and community care planning.

e) **A consistent London framework which articulates the role of Health & Wellbeing Boards**, recognising their statutory

responsibilities in overseeing local plans and critical importance of Joint Strategic Needs Assessments which reflect the Covid experience. This can dovetail with borough ICP leadership to help offer a consistently good quality fit to ICS in a form that suits different communities.

f) **The renaming of PCNs in London to become "Local Care Networks" (LCNs)** with a defined role for local authorities in each borough to co-lead their development.

g) **An overall "local by default" model of planning, performance management and delivery** based on the Covid learning in respect of demand and capacity insight and planning. This will need to bring into scope the wider system, including NHS and social care provision. Joint work across at the place and ICS level will be critical.

22. These core principles remain draft and in development. However, the view of Leaders will shape the approach to the next phase of discussion with health partners.

The Next Phase of Engagement

23. The political and officer discussions have now reached the point where the next steps will be to refine the proposals and seek and agreement on a pan-London approach with NHS London. To reach that point, the following steps are likely to be undertaken –

- Further discussion between the London Councils' London Health Board representatives with the key borough Chief Executive leads, including the CELC Lead Advisor.
- Meetings with NHS London to discuss integration at all three levels and the development of PCNs.
- The London Health Board on 30 June 2020 will also provide a platform for a political level discussion in respect of how the Capital takes forward the health and care recovery. The outcome of discussion at the London Health Board will be shared with Leaders' Committee on 7 July 2020.

24. The outcome of these discussions will be reported to Leaders' Committee with any propositions that emerge for a more comprehensive strategy for collaboration in improve health outcomes and service effectiveness across the whole health and care system.

25. In parallel, London Councils officers, with CELC leads and Directors of Adult Social Care, will continue to work with the NHS to enable pace and joint focus on out of hospital and community care recovery planning.

Recommendations

Leaders' Committee is asked to:

- Comment on the emerging propositions intended to accelerate improvements in health and care system through closer collaboration with the NHS in London as summarised by this report.
- Note that London Councils will take forward senior level member and officer discussions to refine propositions for discussion with the NHS in search of an agreement for a more comprehensive and London-wide approach to collaboration across the London health and care system.
- Note that a refined proposition will be reported to Leaders' Committee later in the year.

Financial Implications for London Councils

None

Legal Implications for London Councils

None

Equalities Implications for London Councils

None

Appendix A

The Experience of Managing Covid 19 in Social care in London

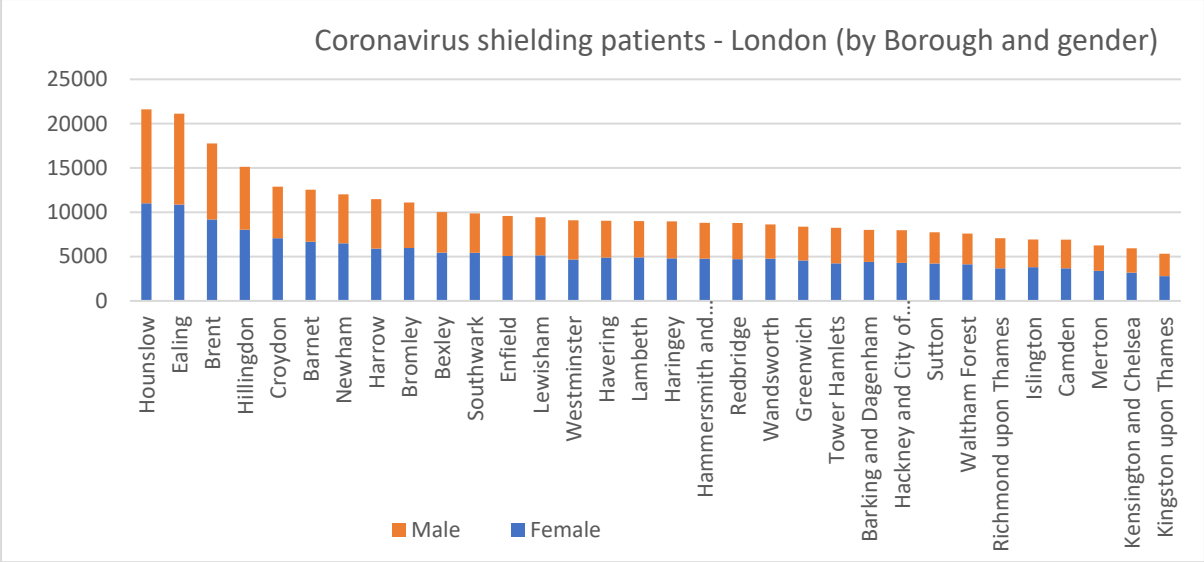
Purpose: this report describes the experience of social care teams across London through the initial phase of the Covid 19 pandemic from March 2020 – June 2020. It summarises the context for social care, the experience of both staff and clients through this period and sets out recommendations that build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

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

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 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

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

Appendix B

Social Care Paper Appendices

Hospital discharge & surge planning (LB Tower Hamlets)

A core challenge related to pandemic planning was the expected surge in demand for acute health care, and the additional pressure this would place on social care services to support timely discharge in order to keep hospital beds effectively utilised.

The Government published new national service requirements for hospital discharge on 30 March, directing all hospitals to establish an 8am-8pm, 7 days a week discharge service to facilitate the discharge of all medically optimised patients.

To help meet this challenge, an Integrated Discharge Hub was established at the Royal London Hospital within the space of a week to speed up the process of discharging nonemergency patients from acute care into residential or home-based care. The Hub draws together a multi-disciplinary team of social work, nursing, Occupational Therapy, Physio and Brokerage professionals from across the partnership. Standardised packages of care are offered at the point of discharge, followed by a more personalised review and care package one - two weeks following hospital discharge.

Over 300 patients have been referred through the service since the end of March, with just over 50% of these Tower Hamlets residents. 90% of patients have been successfully discharged home with care and support, with the remaining 10% discharged to nursing and residential homes, supported accommodation, and newly commissioned step-down facilities. 25% of patients have been discharged the same day, and over 50% within one day, a significant improvement in performance compared to historical discharge times.

Capacity is generally holding up well. Significant progress has also been made on finalising and integrating the homeless and rough sleepers discharge pathway.

Case Study Example of Community Response Hub Working (LB Merton)

One of the first actions taken by the Council was to work with the Merton Voluntary Services Council to set up a response hub, known as the Merton Covid-19 Community Resource Hub; the Hub takes inward bound calls directly from residents, or via other voluntary sector organisations, requesting support with things such as shopping, dog walking and isolation. It is staffed by a combination of council staff redeployed from elsewhere in the Council, mainly from libraries.

Over 1,400 individual contacts and subsequent referrals to the voluntary sector for follow up and action had been made with the Hub. Support given from the voluntary sector include practical tasks such as shopping, befriending and small grants given along with debt advice. It has been so successful that we are working with the voluntary sector to keep the hub going as a one stop shop for the voluntary sector in Merton with one number and email for the voluntary sector.

The Government has established a shielding process whereby the NHS has identified a cohort of very vulnerable people on the basis of pre-existing medical conditions and has advised them that they should remain at home for 12 weeks. Councils have been given the responsibility of contacting residents in their areas who fall within this group in order to ascertain whether they require any assistance.

The Government has set up direct food deliveries to any shielding resident who requires them, but these packages are a standard offer and do not pick up on dietary or religious requirements. These requirements are meet locally via the Community Response Hub.

Merton has been given the names of 6,950 people living in the borough and has set up a shielding hub in order to contact all the people on the list and provide them with assistance if required. Around 16% require ongoing support whilst shielding and are likely to continue to need support for some time afterwards too. The Council has also established arrangements with community pharmacists to ensure that people can have their prescription medicines delivered to their homes and a coordinated voluntary offer means that residents have access to other support such as taking food and other items into people's homes, cooking and dog walking.

As per the above we have worked with the voluntary sector to also provide practical support to include practical tasks such as shopping, befriending and small grants given along with debt advice.

Case Study Example of scaling up Proud to Care North London to a pan-London approach (North Central London DASSs)

The Councils of Barnet, Camden, Enfield, Haringey and Islington have a well established joint adult social care programme , focused on sub regional priorities to support an excellent adult social care workforce and sustainable care home market.

As part of the workforce priority they developed the Proud to Care North London website with local care providers, to promote care as a great sector to work in. The site provides a free local jobs board, local recruitment events, a range of information on training and development opportunities, including apprenticeships, information for business, and real-life stories.

In March, they launched a recruitment campaign to support their local sector during Covid19. To streamline the process, they piloted a simple survey in place of job applications, and worked with teams in each borough to market

the offer and develop a local screening and matching service to their key providers. Where needed, candidates were offered ESOL assessments and support. From this short pilot over around 3 weeks, there had been 123 applicants and 45 job offers by the end of May.

Following the success of the North London pilot, London rapidly set up the 'Proud to Care London' campaign from early April. Ofsted redeployed staff to support the process, including DBS checking. The campaign – a partnership between councils across London has benefited from an astonishing amount of free advertising, including locally led advertising campaigns, including e-newsletters, twitter, facebook, and on council websites, supported by influencers such as Sadiq Khan, NHS London and the Fire Brigade tweeting directly or re-tweeting posts. Free advertising has been offered by 4 major recruitment sites (Reedonline.co.uk, CV Library, Talent.com, Zip Recruiter), digital advertising spaces from Clear Channel UK and JC Decaux and on some of the massive electronic boards at locations around London.

This saw 823 people register in the first week and over 2,000 by mid-May, demonstrating that Londoners want to work in care;- interestingly around 1 in 2 had previous care experience and there was a high proportion (around 1 in 3) of younger applicants, which is generally a demographic the care sector finds difficult to recruit.

Proud to Care, a recruitment approach for social care workers, including workforce development resources, and a portal for social workers. Proud to Care is now a regional programme, and helped support care homes to ensure safe staffing levels during the pandemic.

Case Study Example of active local partnership to support infection control and testing (LB Bexley)

Recognising the impact that the COVID status of staff was having on care home resilience Bexley decided to target the initial scarce COVID-19 testing slots made available to Adult Social Care, to care home and home care providers.

This response to testing has been an exemplar of partnership working locally. The Director of Public Health is the designated lead for testing for London Borough of Bexley. A multi-agency Testing Task and Finish Group has been set up to address the challenges in this area and continues to steer the work.

- Testing pre-discharge from hospital and prioritising our allocation of testing slots to care home and domiciliary care staff was facilitated in Bexley, ahead of the change in government guidance. This was possible only through the invaluable support towards testing extended by Lewisham and Greenwich NHS Hospital Trust (Queen Elizabeth Hospital).
- Guidance and flow-charts on the pathways to testing for Care Homes was developed and circulated and the Mobile Testing Unit has been set up in Bexley two days a week for the past 3 weeks. Bexley has been one of the top performers in London in terms of the number of tests done at the Mobile Testing Unit.

- This facilitated the familiarisation and adoption of the national testing portal pathways when they came on-line for Care Homes, with alternative local arrangements in place for specific situations.
- Further work is underway to facilitate testing of asymptomatic essential workers, and on training in this area for Care Homes and other settings.

Providers are particularly concerned about access to testing and it is clear that we need to continue to prioritise enabling easy access to testing for residents and staff on a regular basis. Bexley are already taking a proactive local approach to testing people with learning disabilities and mental health needs in supported living settings, recognising that these are not included in other testing schemes.

Case Study Example of building on partnerships and collaborative procurement of PPE to meet the needs of social care staff (LB Brent and NWL)

Initial challenges to accessing PPE over the first eight weeks were significant, however supply issues are now being better managed, with for the most part Local Authorities filling gaps. This presents increased costs to providers and to local authorities, one Council estimated the predicted annual cost of PPE as £6m. Access to PPE is critical to infection control and hugely important as it impacts staff morale, confidence and anxiety.

The purchase and distribution of PPE by Brent Council started on the 27th March, with Brent being the first borough to distribute PPE directly to all providers. The national Care Homes Support plan returns that were completed directly by care home providers at the end of May reflected that 100% of Brent respondents to the care home survey reported they felt they had sufficient PPE and recognised the local support provided.

This local good practice was able to feed into wider STP/ICS partnerships. The North West London (NWL) Health & Care Partnership, made up of 30 system partners across local authorities and the NHS, had a pre-existing workstream to tackle practical and clinical support into care homes. This workstream included quality in care homes, primary care, community and pharmacy support as well as testing, education and training. The partnership was able to quickly respond to pandemic challenges, for example, with the creation of a new supply chain for NWL to provide emergency PPE stock to all care home (& home care) providers. The West London Alliance was also able to scale up its PPE procurement from a sub-regional partnership to securing supplies across London.

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