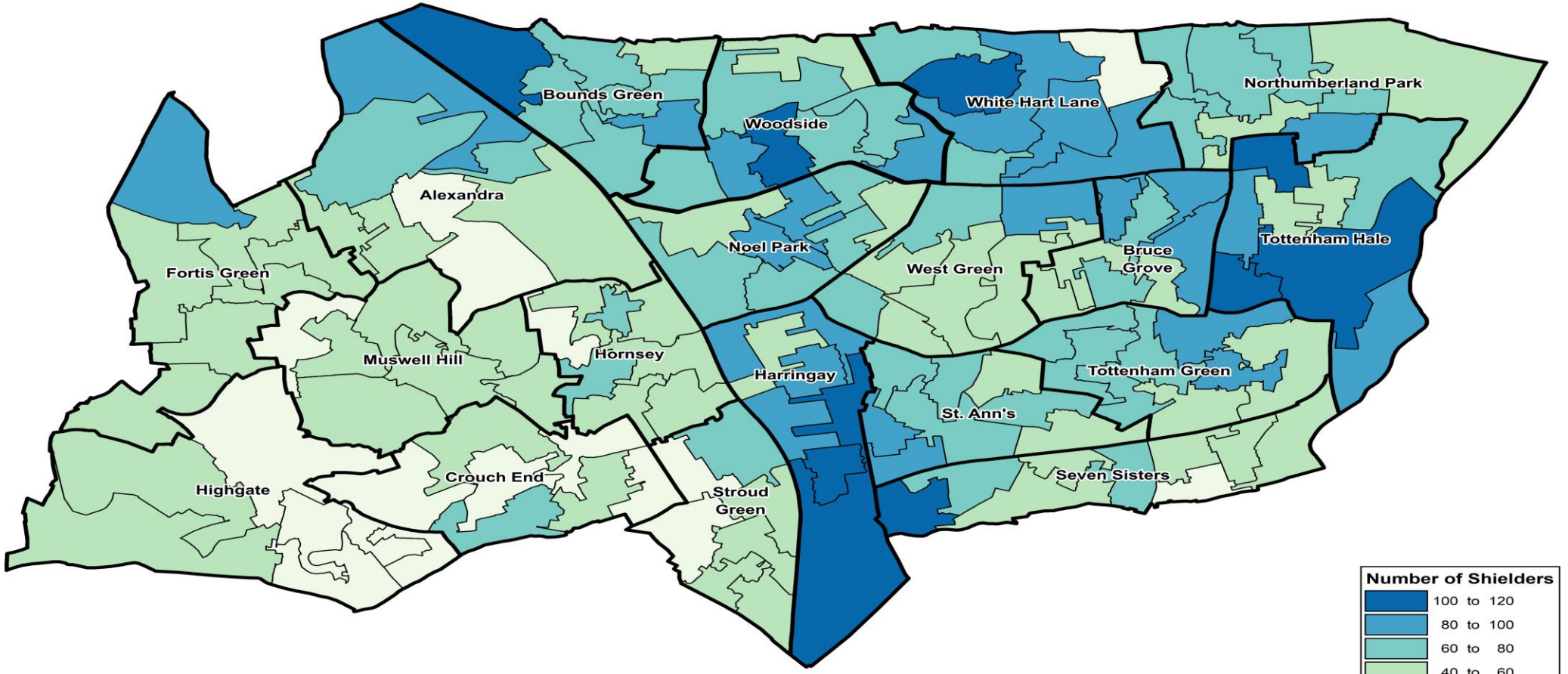
Adult Social Care – Service Delivery During Lockdown

Adults and Health Scrutiny Panel: 21 September 2020

1) Support for Shielded and Vulnerable Groups

NHS Shielded List (9,308 Individuals) – this map shows the number of households in the borough, by ward, with shielded residents.



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1) Support for Shielded and Vulnerable Groups

Ensuring that shielded and other vulnerable residents were supported during lockdown was a key priority for the Local Authority and resource from across the organisation was flexed to meet demand. As part of this **ASC supported the Connected Communities team** fielded requests for support from shielding residents.

Over 2,400 Shielders have been spoken to, triaged and offered information, advice, guidance and support from Connected Communities workers. Over half (53%) don't require support, the remaining got the support they required (as at 17/7/20).

The number who say they are **in need of essential supplies** is updated daily in a file received from Government. Connected Communities phone **all** these **within 2 working days**.

In May, CC helpline received 364 (19%) calls from self-identified shielders. Nearly all of these had a **question about food** compared to 62% of all calls. Over 540 medication deliveries – all made by DBS checked local volunteers working with Community Pharmacy through Connected Communities and local organisations such as Public Voice

Age breakdown of those **self referrals** shielding who **needed supplies** at 19/6/20 was :

- **37% age 65+**
- **56% aged 18-64**
- **7% children**

100% of **those shielding** who were in need of supplies had a **food package delivered** by the next day latest or on the **same day.**

Proactive calls to people in the shielding list who said that their basic care needs were **Not being met.**

2) Adult Social Care – Response and Changes in Service Delivery

A number of changes in service delivery were made from mid-March onwards **to flex capacity to meet new demand** created by COVID-19 and lockdown arrangements. These included:

- **Reablement Service (CRS) led the way in supporting C19 patients back to their homes**.
- The reablement service remodelled to increase capacity (**they doubled the number of hours from 600 to 1300)** by recruiting new carers and changing rotas.

- **Intermediate Care: Developed and Implemented new models of care with Health Partners at Osborne Grove & Prothero House –** new intermediate bedded care capacity to support the surge in very poorly people leaving hospital admission who are not well enough to go home.

- **Hospital Discharge: Supporting Haringey's most vulnerable residents, who have had C19, home from hospital** - New hospital discharge guidance has meant ASC have had to totally reconfigure Hospital Discharge Teams, with Brokerage to create **new discharge Hubs at NMUH & Whittington** to meet the surge in patients and enable fast discharge – including moving to an **7 day service model**. **ASC were managing double the number of discharges they usually manage in a week.**

- **Supporting Family Carers;** A staff volunteer group supported by FRT, working in partnership with the CCG has contacted family carers to carry out **welfare checks** to **over 600 households**

2) Adult Social Care – Response and Changes in Service Delivery

- **Mental Health Services** worked in close partnership with the Trust, CCG and voluntary sector to offer people support. **The Recovery College and Locality teams** reached out and offered support by regularly telephoning people.

- **Wellbeing hub run by MIND** offered a more intense support to those who may be struggling on their own and feel very isolated.

- **Clarendon College** is leading on the developing a virtual Safe Haven (a virtual crisis café) and looking to develop on line courses for learners.

- Locality based Mental Health teams introducing **'anytime anywhere' an online platform to conduct virtual visits** to people. All MH teams are linking up with Community Connectors to ensure vulnerable people can receive regular food parcels.

- **Day Services Reconfiguration** – Day services have moved to an **outreach model** that not only support service users but have been instrumental in supporting **food deliveries**. Community team staff are assessing new referrals, reviewing and providing **support to people with complex needs**, their families and carers via regular phone calls.

- **Mental health reablement** is in development to facilitate hospital discharge using local MH providers.

3) Monitoring Impact on and Performance of Service During Lockdown

We use the London **ADASS Market Insight Tool** to monitor COVID-19 activities to produce Live daily SITREP reports on Capacity, Workforce, Clients and PPE stock from bed based and home care providers.

Adult Social Care – Covid-19 (Coronavirus) Metrics

Demand and Capacity – Increase in Duty Emergency Request for Additional Support

Safeguarding monitoring – numbers and abuse types trend e.g. Domestic abuse

Assessment and reviews – monitoring incoming numbers and completion rate

Council data sets linked to healthcare – **HealtheAnalytics** which supports admissions and discharges from hospitals – Transfer of care monitoring report. It also assists in identifying and supporting vulnerable individuals.

Capacity Tracker

Built in partnership with NHS, local authorities and care home providers

A jointly established **capacity tracker** provides daily monitoring reports on placement vacancies from care home, community, hospice and acute who accept Covid-19 patient's

4) NCL and Planning for a Second Wave

Summary of Demand:

- **Currently nearing 'normal' non-COVID non-elective** (NEL) admissions for Haringey
- **Anticipate c. 10% increase in NEL demand into winter in hospital** without a 'COVID Wave II peak' – this is the normal winter variation compared to the summer
- If it occurs, **COVID Wave II may add up to a further increase to NEL admissions at 'peak COVID'** – but its effect is likely to be time-limited over several weeks. Modelling is evolving so it should be noted that working assumptions are developing.
- **This assumes there is no decrease in non-COVID NEL admissions** – although this is what happened in Wave I COVID

Plans for Winter and COVID Wave II

Plans for winter and COVID II are currently being developed and evolving with partners, including:

- **Nursing Rapid Response** to avoid hospitalization
- Additional **nursing and social care input into acute SPAs** and to support people at home
- Short-term **intermediate care beds**
- Additional intensive **24-hour packages of care** to facilitate timely discharge.
- Increased **Re-ablement Capacity**
- **Flexibly use of social care/OT workforce** to turn-up capacity when required in key areas
- **Enhanced Health in Care Homes model** in response to Government guidance and will consider our options about strengthening the model for winter

4) NCL and Planning for a Second Wave

(Continued)

- **Care Sector Support Workstream -** practical interventions (in partnership with LBH & CCG): Inc PPE, advice and guidance, testing etc.
- **Support those more vulnerable, including shielded patients, as we move into autumn and winter.** This includes information about flu vaccinations, that the NHS 'is open for business' and reaching out to vulnerable communities and groups.
- **Review and address System-wide need for short-term intermediate care and rehabilitation bed needs across NCL** ahead of winter.
- **Business Continuity arrangements to support responsiveness -** Adult Social Care and Community/Acute Health Partners are all currently reviewing and updating.
- **ASC Covid-19 Response and Resilience Group** provides weekly scrutiny and oversight on KPIs, planning, risks and actions required to enable this and escalate as required to relevant workstreams, local and NCL partners and LBH Gold.