Agenda

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 25 SEPTEMBER 2020 AT 10.00 AM
REMOTE MEETING VIA MICROSOFT TEAMS. THE MEETING CAN BE WATCHED LIVE VIA HTTPS://COUNCILMEETINGS.CAMDEN.GOV.UK.

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MEMBERS

Councillor Tricia Clarke, London Borough of Islington
Councillor Pippa Connor, London Borough of Haringey
Councillor Alison Cornelius, London Borough of Barnet
Councillor Lucia das Neves, London Borough of Haringey
Councillor Linda Freedman, London Borough of Barnet
Councillor Osh Gantly, London Borough of Islington
Councillor Christine Hamilton, London Borough of Enfield
Councillor Larraine Revah, London Borough of Camden
Councillor Edward Smith, London Borough of Enfield
Councillor Paul Tomlinson, London Borough of Camden

Issued on: Thursday, 17 September 2020

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The Committee is allowed to discuss some items in private, although this does not happen often; any such items will be discussed, as far as possible, at the end of the meeting. The live meeting will be paused and public speakers will be asked to leave the remote meeting

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- Ensure you have read the report(s) before the meeting.
- Ensure that you are located in an area where you are unlikely to be disturbed.
- Ensure that your broadband connection is sufficiently stable to join the meeting. If your connection has low bandwidth, you might need to ask others using your broadband connection to disconnect their devices from the broadband for the duration of the meeting. If the does not help, you may wish to try connecting your device to your router using an Ethernet cable.
- Ensure that your background is neutral (a blank wall is best) and that you are dressed appropriately for a meeting held in public.
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- Join the meeting promptly to avoid unnecessary interruptions.
- Mute your microphone when you are not talking. If you are an officer or a deputee, please turn off your video when not speaking in order to reduce bandwidth.
- Only speak when invited to do so by the Chair.
- When speaking for the first time, please state your name.
- Keep comments, questions and other contributions brief and to the point.

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[1] Participants are defined as members of the committee; other councillors who seek to address the committee; officers advising the committee or presenting reports; any external partners / third-parties invited to address or advise the Committee; and deputees (including any member of the public with speaking rights).

- If referring to a specific page on the agenda, mention the page number.
- The ‘chat’ function must only be used by committee members to indicate a wish to speak, to indicate that they are having a connection issue or to make a request for a formal vote. It is not to be used for conversations and should be used in an appropriate and professional manner at all times.
- Once you no longer need to participate in the meeting, please leave the call; you can still watch via the public video stream if you wish. Once the Chair closes the meeting, all remaining participants should leave the call promptly.

Exempt or confidential items

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
25 SEPTEMBER 2020

THERE ARE NO PRIVATE REPORTS

PLEASE NOTE THAT PART OF THIS MEETING MAY NOT BE OPEN TO THE PUBLIC AND PRESS BECAUSE IT MAY INVOLVE THE CONSIDERATION OF EXEMPT INFORMATION WITHIN THE MEANING OF SCHEDULE 12A TO THE LOCAL GOVERNMENT ACT 1972, OR CONFIDENTIAL WITHIN THE MEANING OF SECTION 100(A)(2) OF THE ACT.

AGENDA

1. ELECTION OF CHAIR

To elect a Chair for the remainder of the 2020/21 municipal year.

2. ELECTION OF VICE-CHAIRS

To elect two Vice-Chairs for the remainder of the 2020/21 municipal year.

3. GUIDANCE ON REMOTE MEETINGS HELD DURING THE CORONAVIRUS NATIONAL EMERGENCY

To agree to conduct the meeting in accordance with Camden's procedure rules for remote meetings.

4. TERMS OF REFERENCE

(Pages 9 - 10)

To note the Committee's terms of reference.

5. APOLOGIES

6. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Members will be asked to declare any pecuniary, non-pecuniary and any other interests in respect of items on this agenda.

7. ANNOUNCEMENTS

Broadcast of the meeting

The Chair to announce the following: 'In addition to the rights by law that the public and press have to record this meeting, I would like to remind everyone that this meeting is being broadcast live by the Council to the Internet and can be viewed on our website for six months after the meeting. After that time, webcasts are archived and can be made available upon request.

If you have asked to address the meeting, you are deemed to be consenting to having your contributions recorded and broadcast, including video when switched on, and to the use of those sound recordings and images for webcasting and/or training purposes.'

Any other announcements

8. DEPUTATIONS

(Pages 11 - 12)

A Deputation has been received from NCL NHS-Watch requesting JHOSC to scrutinise the service changes and impact due to the pandemic.

9. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

10. MINUTES

(Pages 13 - 18)

To approve and sign the minutes of the meeting held on 31st July 2020.

11. NORTH CENTRAL LONDON UPDATE ON THE IMPACT OF COVID-19 ON CARE HOMES

(Pages 19 - 92)

This report provides an overview of the impact of Covid-19 on Care Providers and the support NCL have provided during the pandemic.

12. BARNET, ENFIELD, HARINGEY (BEH) SUB GROUP MINUTES (Pages 93 - 98)

To ratify the minutes of BEH NCL JHOSC Subgroup meeting 25th June 2020

13. WORK PROGRAMME (Pages 99 - 104)

This paper provides an outline of the 2020-21 work programme of the North Central London Joint Health Overview & Scrutiny Committee.

14. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

AGENDA ENDS

The date of the next meeting will be Friday, 27 November 2020 at 10.00 am in Conference Room, Enfield Civic Centre, Silver Street, Enfield EN1 3XA.

North Central London Joint Health Overview and Scrutiny Committee (JHOSC)

Terms of Reference

1. To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;

2. To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;

3. To respond to any formal consultations on proposals for substantial developments or variations in health services affecting the area of Barnet, Camden, Enfield, Haringey and Islington and to decide whether to use the power of referral to the Secretary of State for Health on behalf of Councils who have formally agreed to delegate this power to it when responding to formal consultations involving all the five boroughs participating in the JHOSC;

4. The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;

5. The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and

6. The joint committee will aim work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people.

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Deputation from NCL NHS-Watch to the Joint Health Overview and Scrutiny Committee, North Central London. 2 September 2020

Government took wide-ranging but time-limited powers earlier this year to combat covid-19. Among the changes made were significant alterations to health service configuration, including making almost all GP services digital, ceasing open access to A&E without prior agreement by NHS 111, halting most acute elective treatment and the redirection of services to different sites. Emergency powers allowed this to be done without the statutory public consultation that would otherwise have been required.

At the end of April, Sir David Sloman, NHS E London, wrote to senior health officials in London setting out the intention to keep many of these changes in place on a permanent basis. He included a cryptic phrase 'new approach to consent through systematic deliberative public engagement e.g. citizens juries'. The whole tone of this document expresses a concern 'not to waste a good crisis' and to hurry into being without adequate statutory consultation changes which are on the bucket list of health planners. This unpublished document was leaked to the HSJ and can be found at

.https://healthcampaignstogether.com/pdf/Journey%20to%20a%20New%20Health%20and%20Care%20System%2024th%20April%202020%20REVISED%202.pdf1

Public accountability matters because the NHS is ours and we need to hold to account those who exercise a stewardship role on our behalf. JOHSC is the main institution of local public accountability for health, and we therefore urge you to do the following.

- Require North London Partners to set out the changes that have been made in services under the emergency powers and state whether there are plans for reversion or for keeping the changes into the future.
- For those changes that are proposed as permanent, please ask them to set out how they will meet their statutory obligations for public consultation.
- Since many of the current changes will have serious implications for health inequalities (eg digital by default), please ask to see a detailed health inequality impact assessment of their proposals.

Sue Richards, on behalf of NCL NHS-Watch

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THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 31ST JULY, 2020** at 10.00 am in Remote Meeting via Microsoft Teams.

MEMBERS OF THE COMMITTEE PRESENT

Councillors Tricia Clarke, Pippa Connor, Alison Cornelius, Linda Freedman, Larraine Revah (substitute member) and Edward Smith.

MEMBERS OF THE COMMITTEE ABSENT

Councillors Lucia das Neves, Osh Gantly, Alison Kelly and Samata Khatoon

ALSO PRESENT

Councillor Paul Tomlinson

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the North Central London Joint Health Overview and Scrutiny Committee and any corrections approved at that meeting will be recorded in those minutes.

MINUTES

1. ELECTION OF CHAIR

Members agreed to elect a Chair for the duration of the meeting and to defer the election of a Chair for the 2020-21 municipal year to the 25th September meeting.

Councillor Pippa Connor (LB Haringey) was nominated to chair the meeting and this nomination was seconded. There were no other nominations.

RESOLVED –

(i) THAT Councillor Pippa Connor be elected chair for the duration of this meeting.

(ii) THAT the election of Chair of North Central London JHOSC for 2020-21 be deferred to the 25th September 2020 meeting.

2. ELECTION OF VICE-CHAIRS

Members agreed that the election of Vice-Chair(s) should be deferred to the 25th September meeting.

RESOLVED –

THAT the election of Vice-Chair(s) be deferred to the 25th September 2020 meeting.

3. GUIDANCE ON REMOTE MEETINGS HELD DURING THE CORONAVIRUS NATIONAL EMERGENCY

The Guidance was noted.

4. TERMS OF REFERENCE

The Terms of Reference were noted.

5. APOLOGIES

Apologies were received from Councillor Alison Kelly (LB Camden), Cllr Lucia das Neves (LB Haringey) and Councillor Samata Khatoon (LB Camden). Councillor Khatoon was substituted for by Councillor Larraine Revah.

6. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Councillor Cornelius declared that she was a Barnet Council appointed member of the Eleanor Palmer Trust, and served as its Vice-Chairman.

7. ANNOUNCEMENTS

Councillor Pippa Connor conveyed her thanks to Councillor Alison Kelly, the outgoing Chair of the Committee, for her hard work in scrutinising and engaging with health services throughout North Central London.

8. DEPUTATIONS

There were no deputations.

9. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no notifications of urgent business.

10. MINUTES

Consideration was given to the minutes of the meeting held on 13th March 2020.

Councillor Linda Freedman noted that her first name had been omitted from the attendance list.

Councillor Alison Cornelius said that her declaration of interest should be amended to clarify that she was a council-appointed trustee of the Eleanor Palmer Trust.

With regard to the care homes item, Councillor Cornelius noted that members had requested a list of care homes in the North-Central London area by borough and had not been provided with one yet. She asked that this be provided forthwith.

RESOLVED –

THAT the minutes of the meeting held on 13th March 2020 be approved, subject to the amendments above.

11. NORTH CENTRAL LONDON SYSTEM RESPONSE TO COVID-19: NCL TEMPORARY SERVICE CHANGES MADE IN RESPONSE TO THE PANDEMIC

Consideration was given to a report from North London Partners in Health and Care.

Mike Cooke (Independent Chair of the North London Health and Care Partnership) and Frances O'Callaghan (Accountable Officer for North-Central London Clinical Commissioning Groups) presented the report to the Committee. Mr Cooke highlighted that, although it had been a very challenging time for the health service, he had been impressed by the joint working between local authorities and the NHS.

Ms O'Callaghan outlined that, given the unprecedented emergency situation that coronavirus had placed the health service in, there had needed to be changes in service delivery which could not go through the normal consultation process. Clinical assurance had been obtained for changes through the NCL Clinical Advisory Group. As conditions changed and various services were going to be returned to normal, this would need to be cleared with the Clinical Advisory Group.

Key points that officers highlighted in their introduction to this item were:

- Urgent cancer treatment was continuing;
- Some services were being delivered digitally – but officers were aware of the 'digital divide' and the problems this caused for access;
- Critical care was focused on UCLH and North Middlesex Hospitals.

Members asked what the recommendations for the future based on the experience of the pandemic would be. Ms O'Callaghan said that recognising the interdependence between health and social care was an important one. The importance of mutual aid between different parts of the health service was another important lesson learnt.

In terms of social care, important issues were the need to make available testing slots for social care workers and the need for mutual aid to ensure that enough PPE was available in the right places for the appropriate staff.

Members queried the decision-making process behind releasing patients into care homes, as there was public concern that some of those patients had coronavirus and so contributed to the spread of Covid-19 in care home settings. Mr Cooke said that he did not believe this had happened to a significant degree in North Central London. Releasing patients into the care of care homes was an operational matter but, in order to avoid the spread of coronavirus, patients who were being discharged into care homes were sent to a ward in St Pancras Hospital where they could be monitored for Covid-19 symptoms.

The Acting Chair, Councillor Pippa Connor, asked that more information about the release of patients from hospital into care homes be provided for the Committee when it considered the care homes item at its 25 September meeting.

ACTION: North London Partners

There was a discussion about delays in other treatment which were occurring during the Covid-19 pandemic period. Several members raised particular concerns about screening, about elective surgery and about dialysis. Officers said that the infection needed to be under control and that patients needed to feel safe when they were coming into hospital. When this had been achieved, then the health service could move towards tackling the backlog that was emerging with regard to other treatments and appointments. Mr Cooke said that there was a London Transition Board, which included a representative from London Councils and from the Mayor's Office, which was looking into the recovery from the pandemic period.

With regard to minimising visits to A & E over the last few months, where the matter could be dealt with by other means, members were informed that people were being advised to ring 111 before they visited A & E. Members said that it was important that there was clinical triage for these calls, rather than relying on telephonists without medical qualifications. They also asked whether there had been engagement with the public about the use of 111 to minimise use of A & E. Mr Cooke informed the meeting that there had been engagement with a sample of Londoners who had been selected via a process led by the Mayor's Office.

There was a discussion about digital consultations by GPs. It was noted that some GP practices had been conducting telephone consultations where necessary and appropriate prior to the pandemic striking, and this might be a method that older patients felt more confident with – rather than online digital processes.

There was a discussion about the service variations mentioned in the report. Members noted the importance of separate coronavirus and non-coronavirus pathways in hospitals. Where possible, this was being done; however, many older hospital complexes did not have the building layout that made this possible.

Moorfields and Chase Farm were now better able to deal with non-coronavirus cases separately than before.

Concern was voiced about the long-term effects on the health of some people who had had Covid-19. Officers acknowledged that this was a fast-developing field and said there would be a multi-disciplinary approach taken to rehabilitation. Members said they would welcome further information about this as it developed.

It was noted that Great Ormond Street Hospital had dealt with a disproportionately large number of child patients during lockdown, and there was now a re-opening of some children's services in UCLH and North Middlesex. The paediatric beds in Barnet General remained closed. A decision would be taken on re-opening them in September.

A member asked what was happening with regard to the LUTS clinic, a matter on which the Committee had received a number of deputations from concerned patients over the past few years. Ms O'Callaghan said she would liaise with the relevant officer (Richard Dale) about providing a written update on the topic.

ACTION: Frances O'Callaghan / Richard Dale

With regard to maternity services, officers said that a limited homebirth service had been reinstated in May. Councillor Clarke asked that more information be provided about this and how the restoration of the service was developing.

Members queried the disproportionate impact of coronavirus on BAME communities. Councillor Smith said that, in Enfield, there was particular concern about the number of deaths and serious illnesses that had occurred among the Somali community in that borough. Members also made reference to the impact on the health workforce, particularly as many health workers were from BAME backgrounds.

Ms O'Callaghan said that Dr Fenton's study on the impact of Covd-19 on ethnic minority populations was being reviewed and that NCL health partners were working on implementing the recommendations. She added that health bodies would be encouraging the take-up of the flu vaccination among their staff.

Members expressed concern about the mental health impact of the pandemic. Ms O'Callaghan said some good work was being done on this, and that a triaging system was used to direct patients to a specialist section at St Pancras so that they did not need to go to A & E.

Members asked that a report be provided at a future meeting updating members on the impact of Covid-19 on health services and on developments flowing from this. Councillor Connor would liaise with officers about this paper.

RESOLVED-

(i) THAT the report and comments above be noted;
(ii) THAT a report come to a future meeting of this Committee on the impact of Covid-19 on the NCL health system on developments flowing from the pandemic.

12. DATES OF FUTURE MEETINGS

It was noted that the dates of future ordinary meetings would be:

- Friday, 25th September 2020
- Friday, 27th November 2020
- Friday, 29th January 2021
- Friday, 26th March 2021

It was also noted that a special meeting would be arranged for early September to consider the orthopaedic services review.

13. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

There was no other business.

The meeting ended at 12:20pm

CHAIR

Contact Officer: **Vinothan Sangarapillai**
Telephone No: **020 7974 4071**
E-Mail: **vinothan.sangarapillai@camden.gov.uk**

MINUTES END

North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC)	London Boroughs of Barnet, Camden, Enfield, Haringey and Islington

REPORT TITLE

North Central London Update on the Impact of Covid-19 on Care Homes

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE** 25 September 2020

SUMMARY OF REPORT

This report provides an overview of the impact of Covid-19 on Care Providers and the support NCL have provided during the pandemic. The report begins by giving an overview of the size of the care home market, and the characteristics of care home residents.

The report provides data showing how care homes were affected by Covid-19, and shows, with reference to an After Action Review, what lessons were learned during the first wave.

The report concludes by detailing the next steps NCL are taking to ensure care home providers are sufficiently supported and prepared for current challenges and potential future waves.

Contact Officer:

James Fox
Senior Policy and Projects Officer
London Borough of Camden
James.fox@camden.gov.uk
020 7974 5827

RECOMMENDATIONS

1. To consider and note the report.

- Appendix A – JHOSC - Update on the Impact of Covid-19 on Care Homes
- Appendix B – Enfield Friends and Family report.
- Appendix C – NCL After Action Review
- Appendix D – NCL After Action Review Data Pack
- Appendix E – NCL After Action Review Literature Review

APPENDIX A

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

JHOSC – Update on the impact of covid-19 on care homes

25th September

BARNET LONDON BOROUGH

ENFIELD Council

ISLINGTON

Haringey LONDON

Camden

Scope

The presentation will cover

- Background to support to care providers
- Summary data
- After Action Review with care providers
- Examples of support provided so far and our next priorities

Background – size of the care home market

- 223 Care Quality Commission (CQC) registered homes across NCL, with 5,732 beds:
  - 40 Nursing Homes (2311 beds)
  - 177 Residential Homes (3009 beds)
  - 6 Nursing & Residential Homes (412 beds)
- 73% of beds are in Barnet and Enfield
- 82% of NCL care homes are rated as good or outstanding (Mar 20)

	Barnet		Camden		Enfield		Haringey		Islington	
	# homes	# beds	# homes	# beds	# homes	# beds	# homes	# beds	# homes	# beds
Nursing & Residential Home	2	213	0	0	2	144	1	5	1	50
Nursing Home	17	886	4	282	10	609	2	149	7	385
Residential Home	63	1298	7	177	68	1051	31	368	8	115
Total	**82**	**2397**	**11**	**459**	**80**	**1804**	**34**	**522**	**16**	**550**

Background – outputs of 2019 joint care homes review

APPENDIX A

Residents within our care homes are the frailest people living outside of hospital. The “average” resident is 85yrs old, has at least 6 long term conditions, is on at least 7 medications and will have a combination of physical frailty, disability and mental health needs. We need to ensure that we provide pro-active health care to enable people to live well within their home.

We presented the below principles to JHOSC in March and provided an update on support for the care provider in a few areas of focus: workforce (recruitment, progression and training); access to clinical advice and expanded end of life care services. Today’s presentation focuses on how we have supported care homes (and other providers) through the covid pandemic.

Summary data on impact of covid-19 and care provider response

APPENDIX A

As with other areas covid-19 had a devastating impact on our care home population. We have provided a more detailed dataset undertaken as part of the After Action Review with Care Providers to Members of JHOSC.

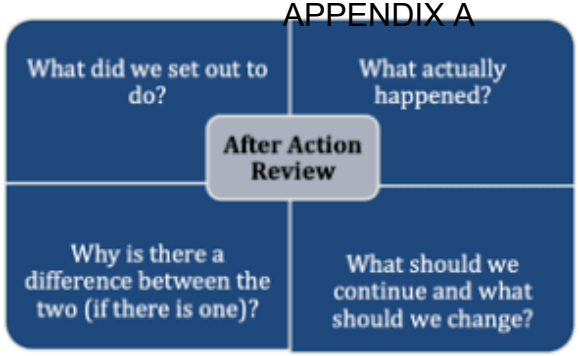
Some of the key figures are:

- Around 60% of care homes had an outbreak (2 or more confirmed cases), with the vast majority of these being in March and April. Extra care and supported housing providers also experienced outbreaks.
- Between 6th March and 12th June we recorded 365 deaths from covid-19 of care home residents. There was no statistical difference in the level of deaths of care home residents by NCL borough or with London.
- There was significant workforce absence, at times of over 25%, (e.g. from suspected infections) for care providers during March and April.

Care providers generally responded to covid-19 with great fortitude. During this period we found providers were able to retain and recruit staff (though of course workforce absence was higher than a usual period); care providers quickly, and often ahead of guidance, implemented changes such as cohorting of staff and residents; increased procurement and use of PPE; reduction of staff moving between providers and much more. Providers supported other parts of the system through embracing digital, supporting speedier and remote discharge planning and through close working with health services, including EOLC.

To recognise and spread this innovation we are developing case studies of good practice by our care providers.

Learning from wave 1:



Due to the huge impact covid-19 has had on residents that receive care services we developed a robust After Action Review to explore how we had responded as a system and what we could learn.
The review has 3 phases that are summarised below:

1. Discovery

- Data analysis
- Friends and family feedback
- Care provider workshops
- Literature review

2. Plan

- Identified draft action areas
- Refined with system partners
- Overseen by steering group
- 38 draft actions identified

3. Do

- Embed actions locally and across NCL
- Continue to shape, refine and innovate

*An After Action Review (AAR) is a discussion of an event that enables the individuals involved to learn for themselves what happened, why it happened, what went well, what needs improvement and the lessons learnt. The AAR seeks to **understand** the expectations of all those involved and provides **insight** into events and **behaviours** in a timely way with the learning leading to personal awareness and **action.***

(Steve Andrews, September 2008)

We have agreed that as a system we will formally implement a joint programme of work between NHS and Councils to continue strengthening integrated work with care providers at a borough and NCL level. This will support continuous improvement and learning as well as implementation of the action plan from the review.

Overview of support to the care sector during covid-19

APPENDIX A

- We worked closely together, particularly across adult social care, public health and NHS partners. We formed new joint programmes of work and enhanced relationships with care providers to help us respond.
- The documents below set out in the detail the support provided to the care sector:
  - ❑ Council and local system support to care homes are summarised in the care home support plans, which were published in May. Full reports on Council websites or summary link here
  - ❑ The CCG also published summary of system support to care homes to its Governing Body later this month, which will be shared with JHOSC members once published
  - ❑ We have also recently conducted an After Action review of how we worked with care providers in NCL and we have shared the findings with JHOSC Members

Areas that we developed new or remodelled approaches:

Infection Prevention & Control and Personal Protective Equipment	Testing	Recruitment, skills and workforce wellbeing	Advice and guidance	Relationships with residents, family and friends
Safeguarding vulnerable residents	Access to clinical support	New discharge teams	Commissioning of care	Use of digital technology

Personal Protective Equipment (PPE)

1st: Providers use own supply chains

2nd: Providers access borough stocks

3rd: Boroughs access NCL system supply

Enablers

Daily calls from LA to providers
Clear escalation processes
Mutual aid between providers, LAs and NHS
Support to understand guidance
Robust supply chain management
NCL system for stock levels and usage
Financial support to care providers

How we responded to wave 1:

The process above helped maximise the total supply chain and ensure that there was strong local oversight.

Each LA established PPE hubs with clear reporting mechanisms with providers. LAs took delivery of the first tranche of national supply in w/c 24th March which were then distributed to providers. LAs and the NHS established an NCL hub and mutual aid arrangements early in the pandemic.

Nevertheless, there were some issues with supply of some items in late March and early April in particular, for example, with shortages of masks and gloves.

This approach meant we were able to respond to the guidance around sustained transmission (huge increase in use of PPE) and by 31st July the 5 LAs had distributed over 5m items to care providers free of charge.

We developed a PPE usage model developed to understand likely demand in different care settings and have trained providers on how to use PPE safely and to identify when specialist PPE is required (e.g. FFP3 masks)

Next steps:

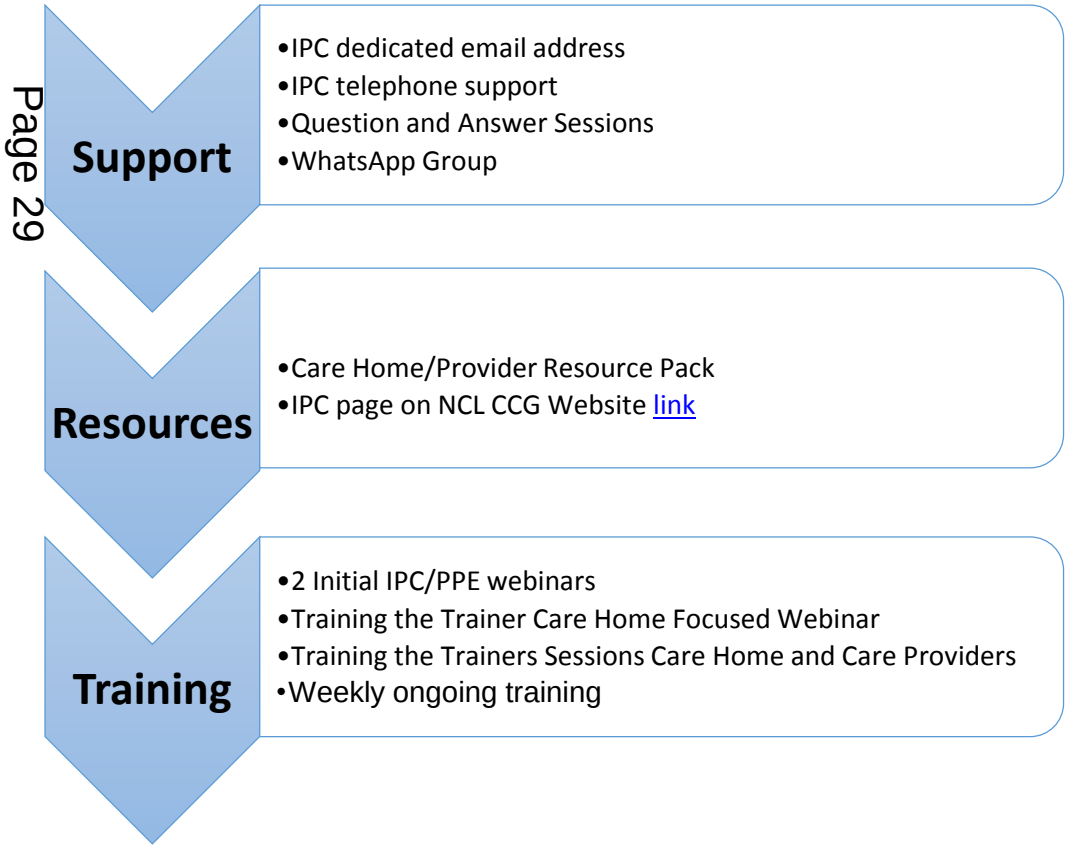
Analysis of supply chains and cost of PPE to ensure best value for money for commissioner and care provider

Ensuring safe stock levels and distribution for winter

Care Home/Provider Infection Prevention & Control (IPC) Support

How we responded to wave 1:

- NCL CCG established a programme of integrated infection control prevention support working with the local health and care system, Local authorities, public health and providers across North Central London.
- The aim of the programme was to provide consistent support to local care providers throughout the COVID-19 pandemic.



- The most requested area for information and guidance from the inbox and helpline related to PPE (46%) with cleaning and testing the other areas with over 10% of contact activity.
- IPC seminars in phase 1 had a total of 905 staff attended from various care providers
- The Chief Nursing Officer England request to offer IPC training to all care homes across NCL was achieved by the set timescale.
- The total number of staff attending the Train the Trainer webinars held to date is approximately 440 staff across 172 organisations.
- Survey feedback on the webinars indicated that 92% of respondents rated the training as good or excellent and no ratings were poor or very poor.
- Coordinated work with Public Health and Adult Social Care to support care providers with visitor policies
- Care providers also access there own IPC training. Where care homes have not accessed NCL training this is usually due to confidence in their own offer.

Next steps:

- Support remains in place with weekly webinars, question and answer sessions and access to direct expert IPC support
- Review IPC support ahead of winter and promote good practice amongst providers

Testing of residents and staff of care providers

APPENDIX A

How we responded to wave 1:

Within NCL, we started widespread staff antigen testing for care providers (along with NHS and other key workers) from early April

- Nationally, care homes can access testing (Pillar 2) testing via an online government portal. All care homes can register to request regular testing. The vast majority have registered but not all have received regular tests yet.
- We've used local tests re-directed from Pillar 1 capacity for NHS staff to support testing in care homes and extra care / supported living settings from May 2020 to date, as directed by local DsPH, where there are gaps in Pillar 2. Over 100 care home / supported living settings have been supported through local Pillar 1 capacity to date.
- Pillar 1 capacity is not sufficient to cover all gaps in the Pillar 2 offer, so DsPH have prioritised accessed based on need and risk.
- All residents are tested before discharge from hospital and before admission to a bedded care provider. This commenced in late April.

Next steps:

- We have developed a proposed covid + pathway to ensure no-one covid + is admitted to a bedded care provider. This will go live from 1st October
- We will continue to prioritise local capacity in relation to the national offer
- We will continue to support and train care providers around testing
- We will explore antibody testing for staff of care providers – though this will not change how we practice care, PPE and IPC

Service area	Antigen* National offer (Pillar 2)	Antigen Local offer (Pillar 1)
Care Homes	All care homes (as of early September) can register for weekly staff and monthly resident testing via national portal	Have used Pillar 1 capacity to support testing in care homes as directed by DsPH
SL / Extra Care	Govt is making one round of testing available for extra care / supported living schemes but we don't know when this will be in place.	Have used Pillar 1 capacity to support testing in supported living and extra care as directed by DsPH

*Antigen testing shows whether a person has covid-19. Antibody testing shows whether a person has been infected in the past.

Clinical Input to Care Homes

APPENDIX A

How we responded to wave 1:

- Initial challenges organising primary and community care support to care homes given covid-19 challenges
- Strengthened dedicated care home clinical support teams (new team established in Barnet)
- In response to 1st May letter from Nikki Kannani (NHSE/I) we confirmed a named clinical lead for all care homes and alignment between primary care networks and care homes.
- All boroughs establishing delivery of weekly ‘check in’, to review patients identified as a clinical priority, with input from community services, including end of life care and pharmacy as required
- Focused digital support, including NHS mail (90%+ care homes have access), provision of remote monitoring equipment, online consultations etc
- In depth support for providers managing outbreaks coordinated between public health, social care and health providers

Next steps

- Develop a sustainable commissioning model for the future
- Review out of hours provision for each care home
- Refine the weekly “check in” model for mental health and learning disability homes
- Ambitious digital programme to strengthen remote monitoring; information sharing and tools for care planning

Workforce

How we responded to wave 1:

- Worked with Skills for Care to establish a whatsapp group for care managers to support sharing and peer support with clinical support to respond to queries
- Programme of webinars to support learning and key skills and respond to provider queries
- Peer support groups established for care providers
- Development of workforce wellbeing pack for care providers and NCL Together in Mind https://togetherinmind.nhs.uk/ to provide access to emotional, wellbeing and therapeutic support
- LAs supported care providers to respond to staffing challenges
- NCL LA Proud to Care Programme established as part of the London social care pandemic response and saw over 800 NCL residents express interest in working in care – locally boroughs match residents to care job opportunities https://www.proudtocarenorthlondon.org.uk/

Next steps:

- The care workforce has proved to be extremely resilient through the pandemic – we need to continue to support and demonstrate we value this workforce in the same way as NHS staff are recognised
- Care is a growing sector so continuing to focus on recruitment and progression pathways to develop good jobs in care
- Review our new covid-19 workforce initiatives with care providers to ensure we sustain areas that support and continue to innovate

Flu Vaccinations for Care Home Residents and Staff

1. Vaccinating those most at risk of complication as a result of contracting influenza will be prioritised across NCL. This includes those from the care home setting
2. Care home residents can receive a vaccination from their registered GP, Community Pharmacy or Housebound provider (District Nursing)
3. Care home staff can receive a vaccination from their registered GP or Community Pharmacy
4. The approach to vaccination will differ depending on the existing arrangements within each borough – but all will aim to complete vaccinations by November
5. NCL CCG will be collecting information via a care homes vaccination tracker which will detail the number of care home residents, number vaccinated and date this occurred
6. NCL CCG will follow up with GP Leads aligned to each care home to ensure vaccination has taken place in a timely manor and information submitted for assurance purposes

Next steps

- The After Action Review action plan will be finalised and embedded in the plans of boroughs and the NCL Joint Care Providers Workstream
- We will ensure care providers form a core part of NCL system winter plans, including
  - demand and capacity modelling to ensure we have the right services in the right place
  - establishing a covid + pathway to protect residents of bedded care providers
  - continuing to provide enhanced support around IPC, PPE and testing
  - delivery of NCL's largest ever flu vaccination programme
  - programmes supporting workforce development and wellbeing, digital and remote monitoring that provide parity of access to care providers, alongside NHS partners
  - strengthening care provider input into system work, including through supporting the NCL care provider reference group
  - ensuring we hear from residents using care services, their families and friends

Questions

For more information regarding this presentation please contact Richard.elphick@camden.gov.uk and / or Meena Mahil m.mahil@nhs.net

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Adult Social Care Quality Assurance
Covid 19 ‘Lockdown’ Friends & Relative Feedback Report

Produced by London Borough of Enfield Adults Safeguarding Team, in partnership with Independent Quality Checkers.

July 2020

Part of the NCL Care Providers After Action Review

ENFIELD Council

Here’s what our Quality Checkers say

Findings

79 residents friends and family contacted across 7 homes.

Each home had feedback from at least 5 relatives, one had the majority of contacts (45 relatives). Homes included residential care; nursing care and one supporting people with learning disabilities and one supporting older people and people with learning disabilities . Findings varied by home.

The majority of respondents felt that the care provided has been of high quality and communication with the home was good.

74 communicated with their loved one during the lock down period by phone , video calls and garden visits

5 did not communicate during the lock down period and felt this was due to poor communication with the provider

5 felt the provider did not provide enough updates during the lock down period

5 found it difficult to contact the provider during the lock down period

7 did not or were unsure if their loved one was well supported during the lock down period

27 felt the provider could have done more to support communication between them and their loved one – this ranged from actions like facilitate more visits – to concerns and challenges around making telephone contact

Quotes

Yes, [relative] is coping well and says 'It is the best hotel [relative] has stayed in!) I think [relative] will be even happier when visiting is permitted to be on a more regular basis.

I think the situation was managed very well by the home.

We did feel the homes shouldn't have had to accept hospital admissions because of risk of cross-infection to existing residents.

Staff were excellent at keeping our family informed. I do wonder whether our [relative] deteriorated during lockdown, not at any fault of the staff, only the circumstances of not been able to have a visit.

My mum felt very lonely during the lockdown. The garden visits have helped with this, but I still feel the home could do more by taking the residents out into the community on a more regular basis. (even if only for a walk)

She tested Covid positive and during this we were updated more frequently.

I thought the visiting regime was quite strict at the start but have since come to understand the reasons behind the rules.

Videos sent to us of our [relative] walking and dancing

Will provider eventually accommodate visits inside?

Proposals

Resident recommendations

- Head phones for residents to be able to have calls with relatives
- Big screen tablet so video calls are easier
- Key workers filming residents doing activities to be sent to relatives
- Families to be able to upload and send messages to residents where phone calls and face time was not possible
- Regular emails / calls from provider giving update information on residents wellbeing
- Information about covid testing to be shared with family and friend contacts
- Named contact at the home to be given to family and friend contacts

Quality Checker Recommendations:

- Headphones – better for dementia residents to be able to concentre – loved ones who did not use headphones said the residents struggled to understand where the voices were coming from
- Home whatsapp group – can buy cheap phone – free sim card – use home wifi to send it
- WIFI booster – no wifi in rooms
- 4g tablet – loved ones said video calls maybe easier with a bigger screen!

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North Central London

A rapid review of learning from the Covid-19 pandemic

Across Care Homes, Domiciliary Care, Supported Housing and Extra Care

A collaboration between NEL, NCL CCGS and the NCL Local Authorities

Summary of learning

A rapid review of learning from the Covid-19 pandemic across Care Homes, Domiciliary Care, Supported Housing and Extra Care

Overall Project Context

Nationally, around 40% of covid-19 deaths have been of care home residents, whilst a significant proportion will also be people accessing other forms of care such as home care, Extra Care and Supported Housing. It is therefore important to ensure that effective health and social care to this population is essential to delivering a population health needs driven approach. This project has been established by the Local Authority on behalf of all system partners across North Central London to:

- learn lessons from providers about what happened compared to what they expected during the initial surge
- identify what resources, processes and initiatives have been developed over the pandemic period so we understand what is working well and less well now.

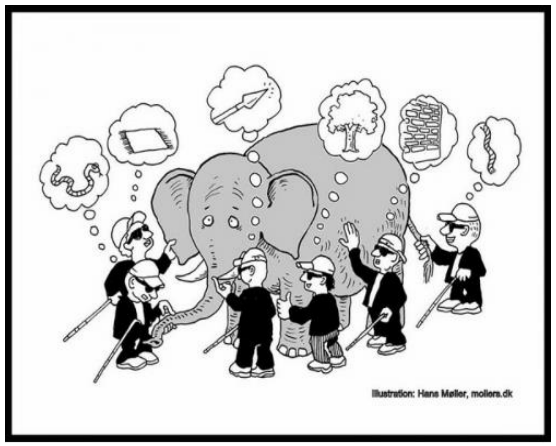
This will help inform recommendations of what to maintain, what to change and what we may need to do in the event of a second wave.

The key elements of the project include:

1. **Insights**
   - Data analysis
   - Review of literature review and evidence of good practice
   - Feedback from social care providers, Councils and NHS partners via existing forums and small workshops to generate insight **through the delivery of six After Action Reviews (AARs)**
2. **Recommendations**: Development based on insight and iterate with system partners
3. **Agreed next steps:** A workshop of key system partners

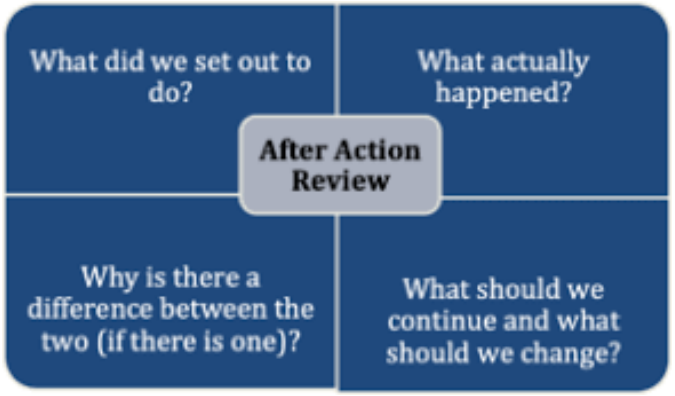
The After Action Reviews (AARs) were facilitated by **Jan Annan**, Head of Improvement and Service Transformation and **Nita Bull**, Improvement Manager, at NEL Commissioning Support Unit.

After Action Review (AAR)



*An After Action Review (AAR) is a discussion of an event that enables the individuals involved to learn for themselves what happened, why it happened, what went well, what needs improvement and the lessons learnt. The AAR seeks to **understand** the expectations of all those involved and provides **insight** into events and **behaviours** in a timely way with the learning leading to personal awareness and **action***

(Steve Andrews, September 2008)



Total 43 participants:

15 from Care Homes
6 from Supported Housing
16 from Domiciliary Care
6 from Extra Care

Overall Summary

This project was a collaboration between the CSU and Richard Taylor-Elphick, the Adult Social Care Programme Lead, on behalf of all North London Councils.

The review was designed and delivered within a 3 week period in order to rapidly capture learning and to facilitate and enable all stakeholders to learn together what elements they wish to maintain and embed, identify and share innovations and to consider planning for the anticipated second wave based on learning from the first wave.

Six After Action Reviews (AARs) took place in July 2020.

Key themes included the following areas:

- **Covid-19 Guidance**
- **Clinical-related/infection control**
- **Workforce/ staff support**
- **Care provision**
- **Provider Organisation responses**
- **System working**
- **Innovations shared**

Findings: Key Themes 1

Covid-19 Guidance

- **The National Guidance** wasn't specific to each care setting. All participants felt that it wasn't clear, wasn't simple, it wasn't concise and coming from different organisations, Local Authority digested information was differently interpreted across Local Authorities, information overload and time consuming to process and manage.
- Some larger organisations identified key individuals to read the daily guidance, make sense of it and prepare organisational bespoke information to their staff.
- Participants would have preferred a co-ordinated approach to the synthesis of national information from Public Health England (PHE), Local Authority (LA), NHS and CQC.

Clinical-related/infection control

- **Access to clinical advice and support** was reported to have been withdrawn at the point of lockdown which led carers to attempt to provide a broader aspect of health support in the absence of access to clinicians; access to clinical/medical and community services support was reported as variable.
- **Familiarity with PPE:** community care providers generally do not use PPE in their daily care provision (excluding residential settings) and therefore had to learn and become familiar with a new way of working quickly.
- **Access to PPE**: there was no system-wide co-ordination of procurement/provision of PPE and acute trusts had the priority for receiving PPE. Community Care Providers felt anxious and concerned about putting staff and clients at risk and took it upon themselves to source PPE and in some cases bought from Ebay, Screwfix and other outlets to source what was required, such as gloves, visors, masks, aprons and suits. As this was not part of usual equipment purchasing for non residential care provision, there was no budget for PPE and many experienced inflated prices when trying to purchase. Some received PPE from the Local Authority.
- **Access to testing:** at the beginning there was no access to testing and therefore if staff had symptoms they had to self-isolate, not work and not provide care provision, not knowing if it was covid-related. This still remains an issue.
- **End of Life Care**: importance of supporting End of Life Care and access to medication – there is the opportunity to further develop protocols.

Findings: Key Themes 2

Workforce/staff support

- **Staff absence:** was variable due to the impact of Covid-19 and some had specific arrangements with agencies in order that they could allocate staff to one setting and prevent staff from moving between services. Some services struggled as staff were sick or had shielding/sick family members, others had limited sickness levels, reported as due to early implementation of use of PPE.
- **Remote leadership**: many management staff reported working remotely to ensure continuity on operational oversight with the carers continuing.
- **Online training**: many services established online learning opportunities for staff, including induction following virtual recruitment.
- **Staff welfare:** managers experienced an increase in the need to support staff psychologically, due to fear of contracting the virus. Many set up regular check-ins with staff virtually and face to face (socially distanced) such as in car parks.

Care provision

- **Promoting digital inclusion:** was of the utmost value, access to devices, online activities, helping service users with devices and media e.g. iPads, Face Time, to support service user engagement with activities, personal health, and family – as well as to access clinical support.

Findings: Key Themes 3

Provider organisational responses

- **Short term contracts for agency staff** made it easier to ensure carers were going to designated service users and protected staff/service users.
- There are opportunities to refine **Business Continuity Planning** as significant experience was gained during the pandemic.
- **Sharing practice/innovations:** further opportunity to share best practice across providers as a group e.g. individual social stories.
- **Identifying when to respond to emerging issues:** Services seemed to identify for themselves when to stop visitors to care homes in order to keep staff/residents safe, this was at the end February/early March before lockdown. Some care homes were looking at the international picture and locking down before the formal UK lockdown.

System working

- **System-co-ordination:** community care providers were expecting the system to lead and support.
- **National Care Home Forum:** to encourage all care homes to participate for shared learning and networking.
- **Stakeholder involvement in discharge:** care providers and in particular care homes reported that they were not included in discussions about care pathways and managing rapid hospital discharges; they felt they were directed to take patients from hospitals and would have liked more supporting guidance and collaborative discussion around safe discharge with appropriate patient information as well as support when unable to take an individual.
- **Supporting people to stay in the community:** the importance of community services and their role in keeping people in their place of residence with the necessary support as appropriate was recognised.
- **Information:** posters/handouts for staff could be managed system-wide.

Innovations shared

- Organisations set up car pools to facilitate staff accessing clients.
- Arranging cohorts of staff and clients to reduce infection transmission.
- Care homes set up isolation rooms/areas for covid-positive residents.
- Innovation of dedicated staff managing calls with relatives for continuity, – consider a co-ordinated approach to maintaining communication with relatives/clients.
- Designing activities that could be undertaken online or via devices.
- They set up WhatsApp group for rapid communication.

Proposed recommendation areas

The provider workshops have informed various recommendation areas that will be developed into a set of actions.

- In preparation for a second wave, NCL may wish to develop a coordinated approach to PPE with the aim to ensure all providers are clear of their responsibilities and able to access sufficient supply.
- There are clear discharge pathways for residents that include covid testing before they leave hospital and a clear approach for residents that are covid positive.
- National and local testing capacity is coordinated in a way which is clear for staff and resident groups and prioritises access to higher risk groups.
- Community care providers, should be integral to planning for the second wave alongside acute and community trusts, CCGs and the LA. Recommendations from this work should be co-owned with care providers, Councils and the NHS.
- Collaboration to ensure community providers are not receiving duplication or conflicting communication and guidance. Consideration may be given to Local Authority to manage on behalf of all system partners.
- Supporting and enabling consistent access to clinical advice and support.
- Safeguarding: system of oversight on safety issues as a result of residents/their families rejecting care or of clients returning to their families during lockdown.
- Developing new mechanisms to ensure we hear from residents and families about their experience of care.
- Increase in communication from providers to residents and families which has been made easier through the use of technology and a time when there has been more communication than normal levels.
- Access to iPads/devices for activities at home and to maintain a client's network and access to health and care services as an area for further development.
- Prior to Covid-19, organisations worked independently, during Covid they developed networks and ways of sharing information. CCGs/Local Authority to explore how this can be further developed, supported and embedded to create a network of support and communication across all community care providers.
- Further consideration to appropriate mechanisms to support staff recruitment, retention and staff welfare.
- Infection control: training, support and guidance developed as part of business as usual going forward.

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Summary of Data Analysis for the NCL After Action Review

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Acknowledgements

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Care Homes

Data quality notes: Not all beds are occupied. Although the majority of health or care service users are placed in care homes within NCL, some are placed outside of the region. Care home residents are a mix of Council funded residents, health funded residents and self funders. There are a wide range of providers of care in care homes, including Councils, trading companies, the VCS, independent providers and major national groups

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Setting the scene

- There are 225 CQC registered care homes across NCL, with almost 6,000 beds in total:
  - 85 in Barnet with 2,600 beds
  - 11 in Camden with 460 beds
  - 80 in Enfield 1,800 beds
  - 33 in Haringey with 490 beds
  - 16 in Islington with 560 beds
- Some care homes provide support for older people, while others provide specialist support and residential care for learning disability, mental health or substance misuse. Official statistics aggregate all care home providers together.

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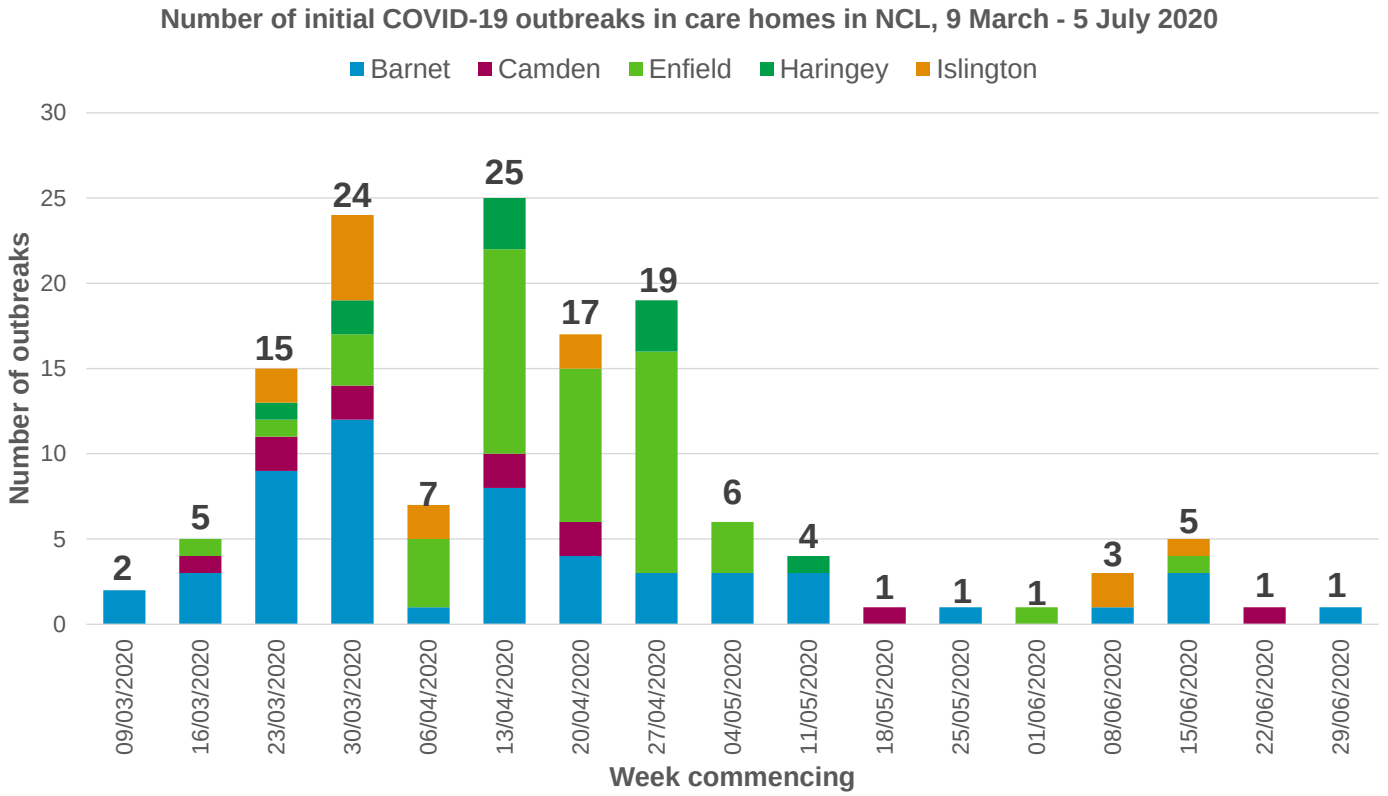
Outbreaks of COVID-19 in care homes in NCL



Note: This dataset is derived from reports to Public Health England. Any individual care home will only be included in the dataset once. If a care home has reported more than one outbreak, only the first is included in this dataset. This dataset contains no indication of whether the reported outbreaks are still active or have been resolved.
Source: Public Health England Dataset 9 July 2020

- This figure presents the timing of the first outbreak in care home, by borough in NCL. We can see that first outbreaks in care homes peaked in the week of 30 March and 13 April.
- Although outbreaks have declined in May and June, some care homes continue to have initial outbreaks.

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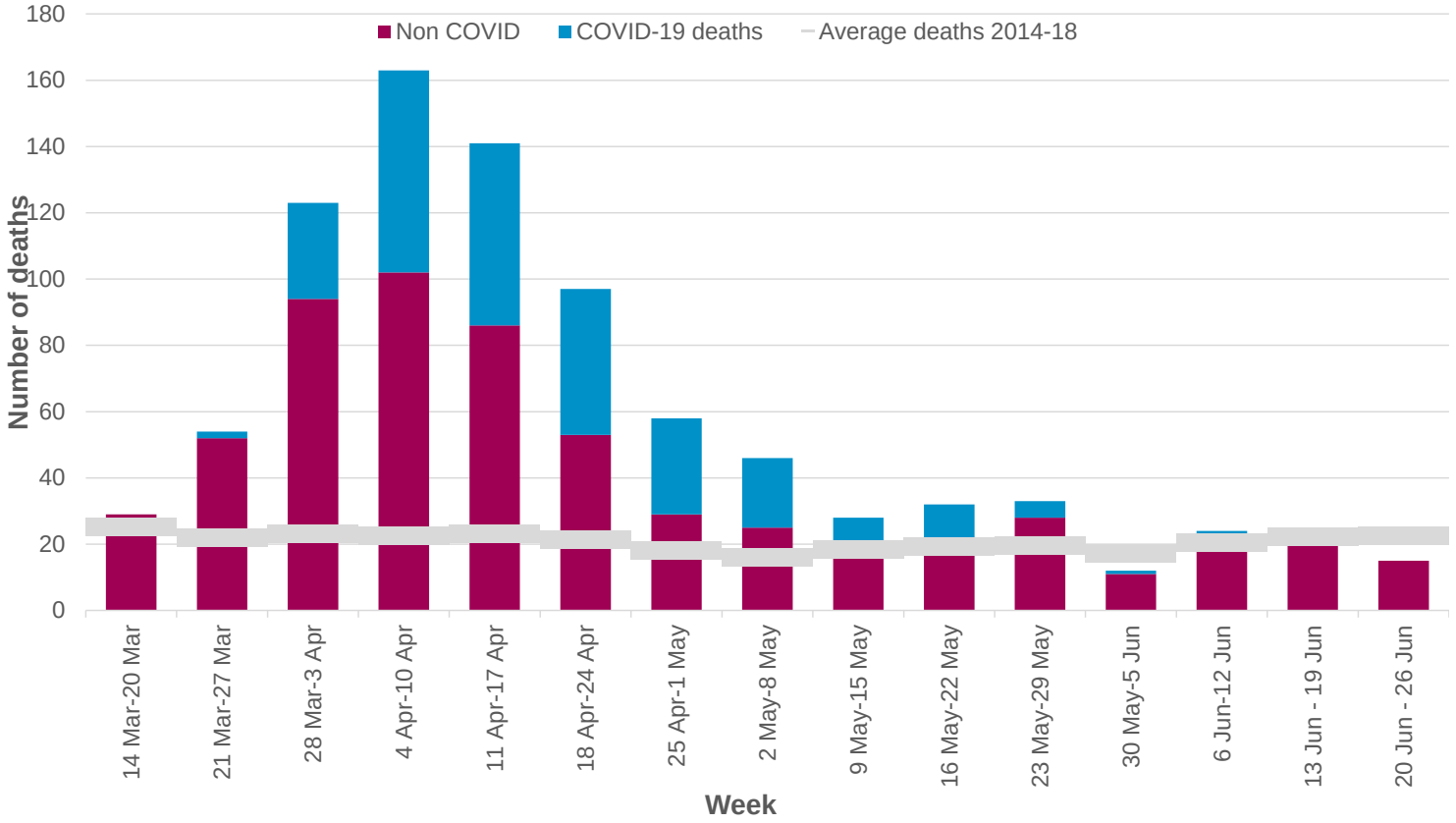
Excess deaths in care homes, NCL

Deaths by cause of death (weekly numbers) for deaths that occurred in care homes from 14 March to 26 June 2020 but were registered up to 4 July 2020, compared to average deaths 2014-18



Source: ONS

- In NCL between 6 March and 12 June 2020, there were 365 COVID-19 related deaths of care home residents and 651 non-COVID-19 related deaths.
- There have been 267 excess deaths in care homes between 14 March and 26 June 2020 in NCL, compared to average deaths from 2014-2018.
- Deaths not involving COVID-19 have also been elevated during this period.

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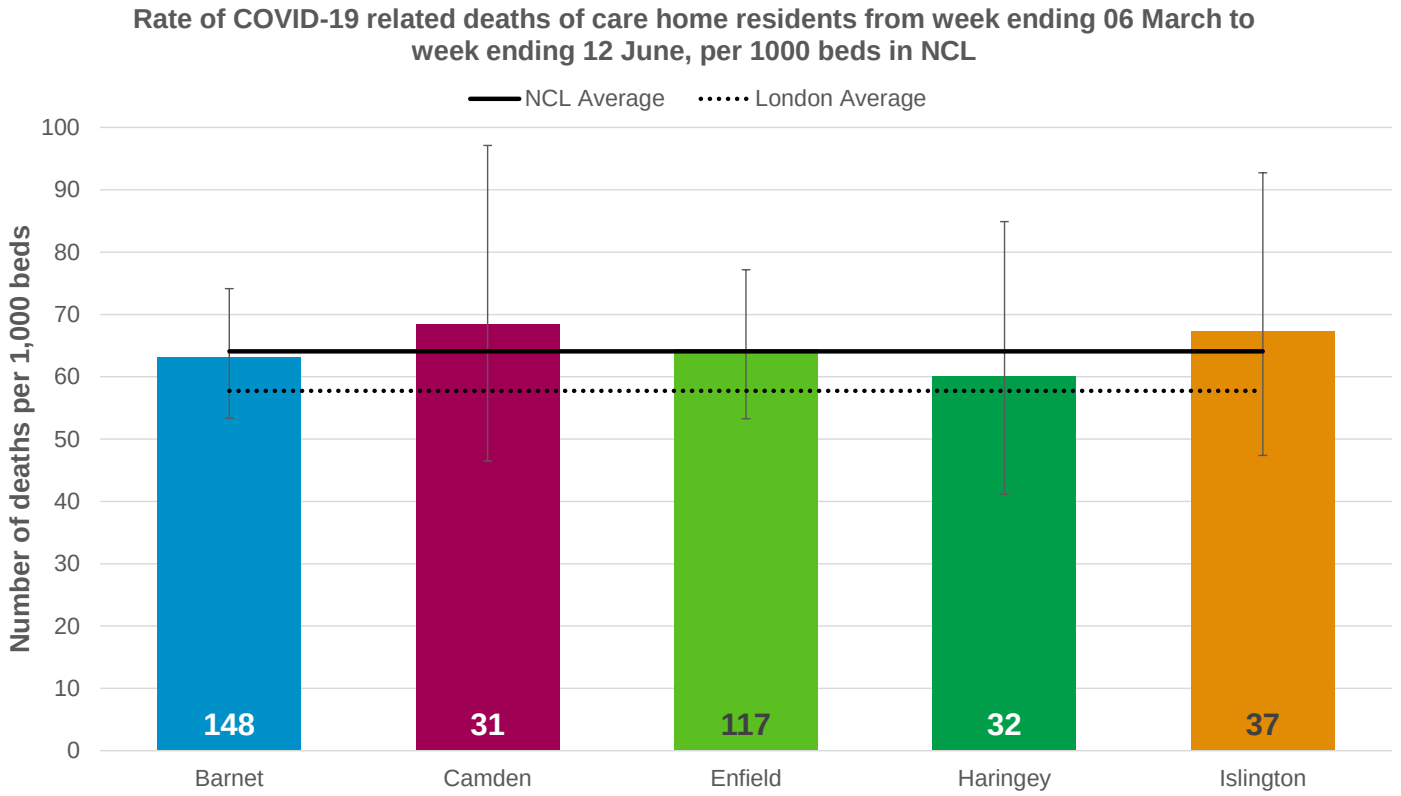
Rate of COVID-19 related deaths of care home residents, by borough



Note: Not all beds are occupied. Figures are for weekly deaths, involving COVID-19 of care home residents, occurring from week ending 6 March 2020 to 12 June 2020, registered up to 20 June 2020
Source: ONS, 03 July 2020

- When standardised by number of care home beds in the borough, there are not significant differences by borough in rate of COVID-19 deaths among care home residents or in the rate of COVID-19 deaths in care homes by borough.
- The NCL average is not significantly different to the London average.

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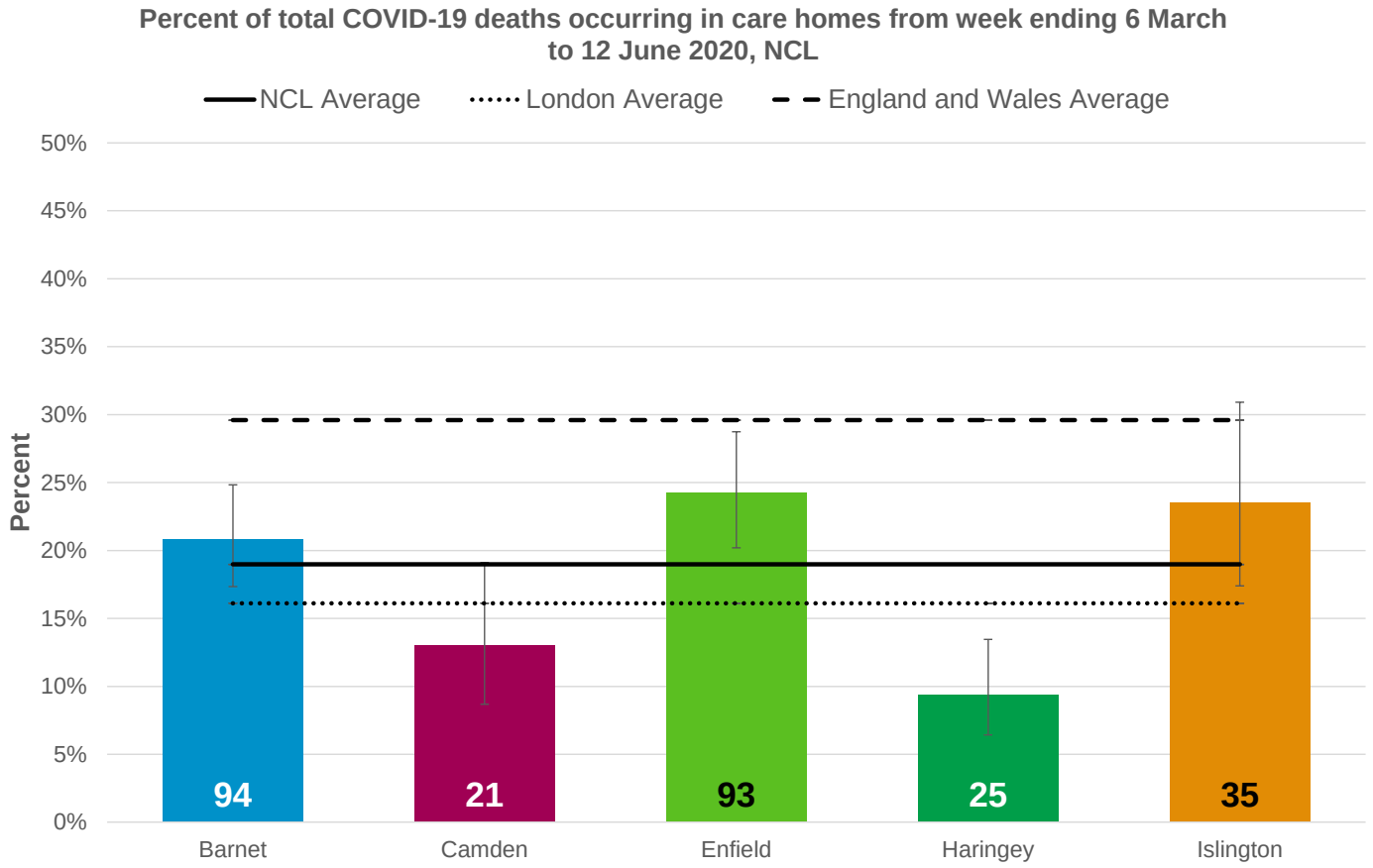
Percent of COVID-19 deaths that occurred in care homes



Source: ONS Death registrations and occurrences by local authority and health board

- Overall in NCL, 19% of total COVID-19 deaths in this period occurred in care homes, a significantly higher proportion than the London average (16%) but significantly lower than England and Wales (30%).

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Other Service Types

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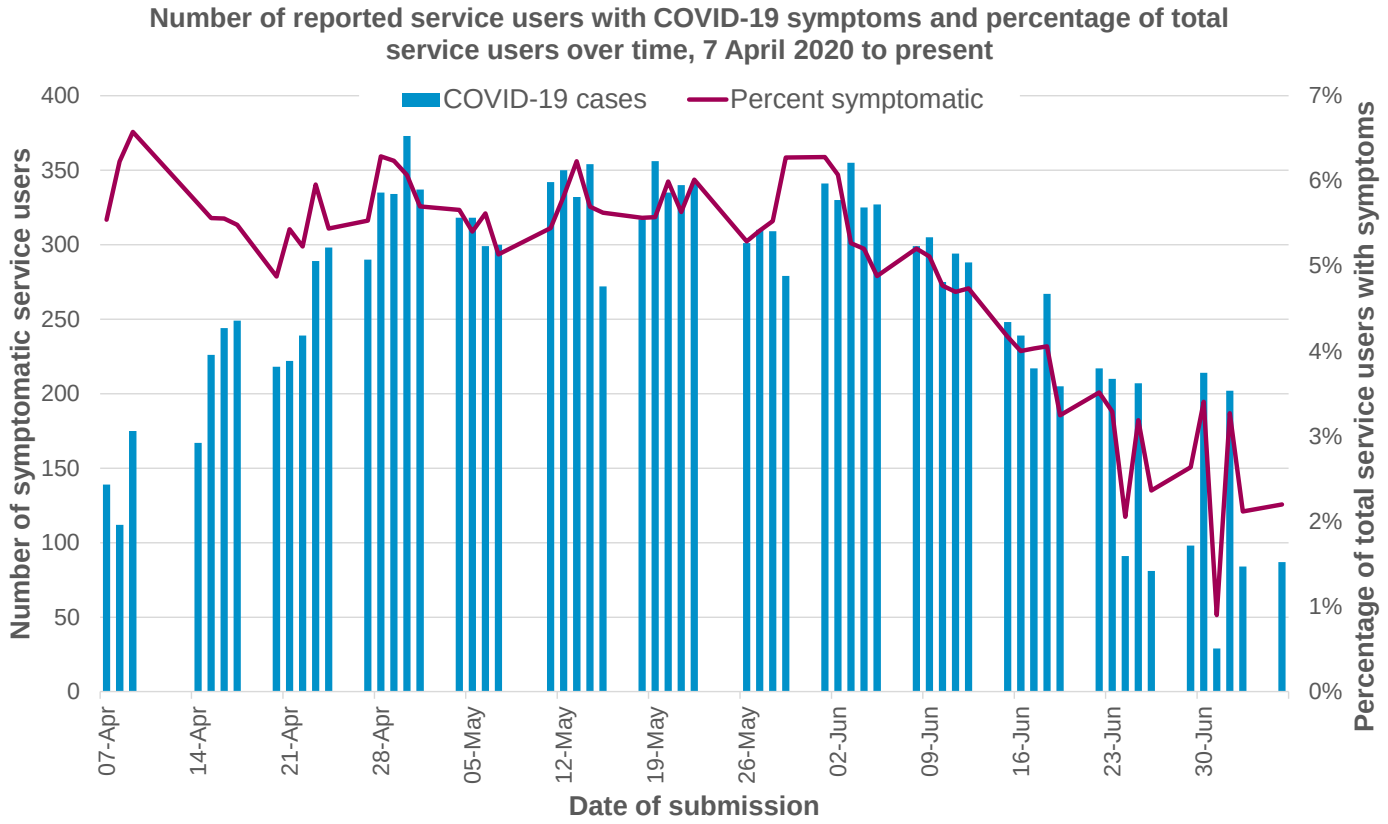
Symptomatic service users: Home Care



Note: This is compiled of self reported data from service providers as reported through the ADASS Market Insight Tool. Data quality is affected by response rate. Not all service providers report every day. These are not official statistics and should not be used as such.
Source: ADASS Market Insight Tool

- An average of 88 home care providers reported to MIT on a given day across NCL.
- Proportion of reported service users reported as having COVID-19 symptoms was between 5-6% for April and May, but has declined to 2-3% in recent weeks.

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Supported Living

- It is difficult to collect information on Supported Living providers as many of them are not CQC registered. Based on local knowledge, there are around 240 providers across NCL:
  - 102 in Barnet
  - 21 in Camden
  - 39 in Enfield
  - 27 in Haringey
  - 53 in Islington
- There may be some overlap between boroughs, so the total number may be slightly smaller than 240.
- Supported Living services take a variety of forms, including housing support and specialist support for a variety of issues, including learning disability, mental health or substance misuse.

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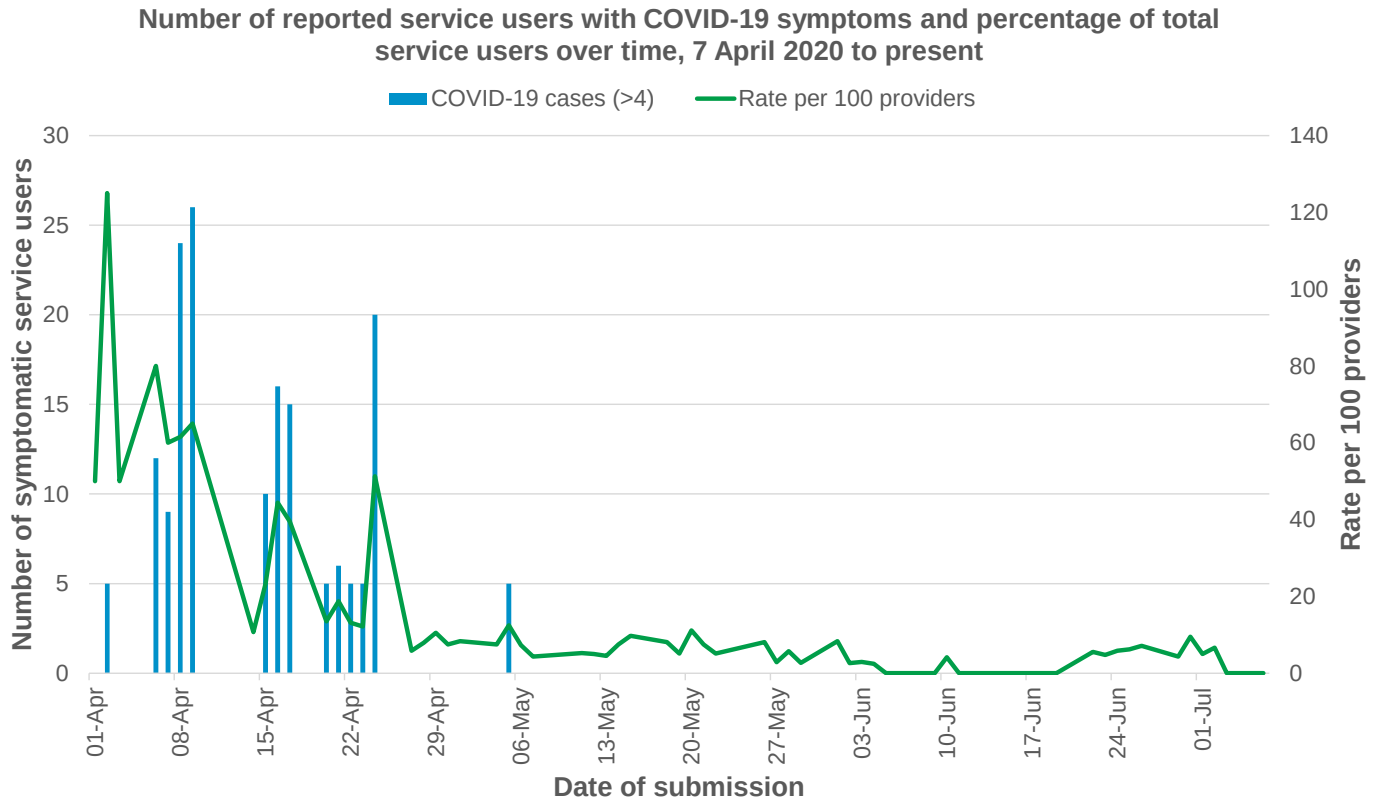
Symptomatic service users



Note: Where reported number of symptomatic service users was less than 5, data is not included in the chart. This is compiled of self reported data from service providers as reported through the ADASS Market Insight Tool or via internal reporting mechanisms. Data quality is affected by response rate. Not all service providers report every day. These are not official statistics and should not be used as such.
Source: ADASS Market Insight Tool; Internal Islington, Camden and Barnet Council Data

- Based on reports from a total of 55 providers across NCL, there is a clear impact of COVID-19 on service users, with up to 26 symptomatic service users reported on a single day in early April.
- We do not have a denominator for services from Barnet or Camden to help control for variation in reporting here. In addition, because reporting to Barnet was at will and not in a structured manner, this may only capture a very small proportion of Barnet supported living providers. Therefore we have included number of responses as a denominator.

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ASC Workforce

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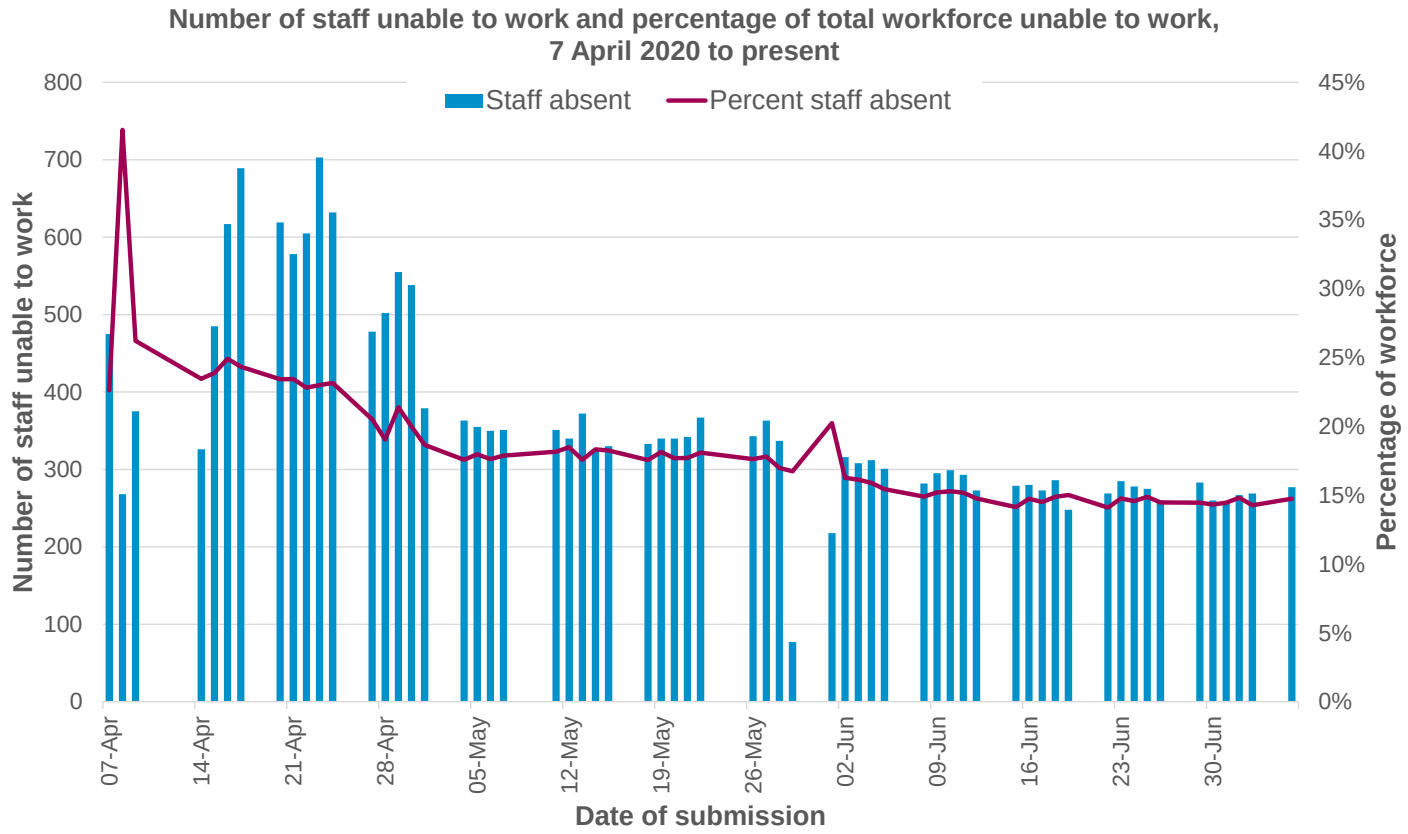
Workforce: Care Homes



Note: This is compiled of self reported data from service providers as reported through the ADASS Market Insight Tool. Data quality is affected by response rate. Not all service providers report every day. These are not official statistics and should not be used as such.
Source: ADASS Market Insight Tool

- The impact of staff absence on the care home workforce in NCL has been higher than the impact of the total workforce. In early April, staff absence peaked at above 25%.
- Staff absence has been declining consistently over time, to below 15% in recent weeks.

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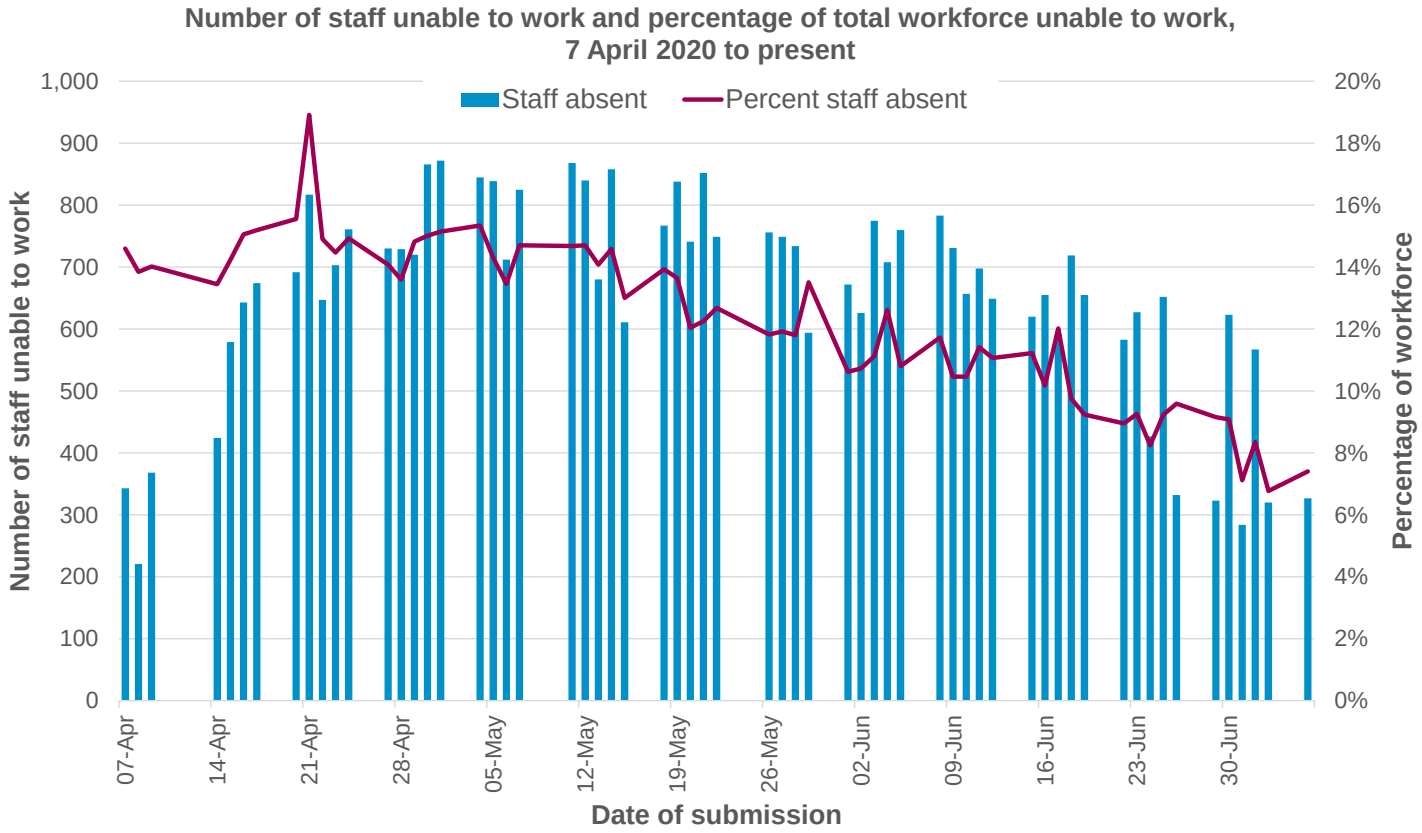
Workforce: Home Care



Note: This is compiled of self reported data from service providers as reported through the ADASS Market Insight Tool. Data quality is affected by response rate. Not all service providers report every day. These are not official statistics and should not be used as such.
Source: ADASS Market Insight Tool

- The impact of staff absence on the home care workforce in NCL peaked in early April, with around 20% of staff unable to work.
- Staff absence has been declining consistently over time.

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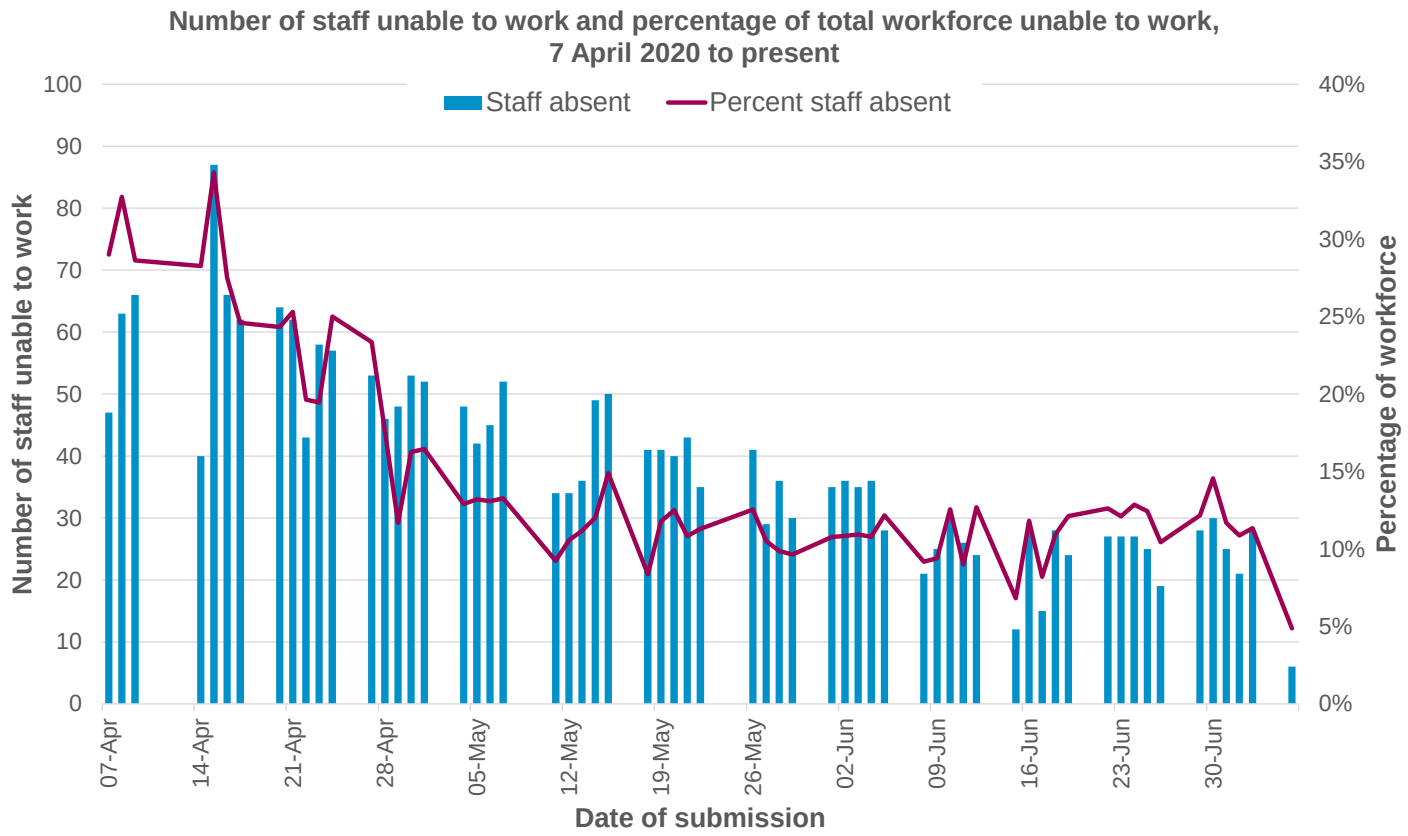
Workforce: Supported Living



Note: This is compiled of self reported data from service providers as reported through the ADASS Market Insight Tool. Data quality is affected by response rate. Not all service providers report every day. These are not official statistics and should not be used as such.
Source: ADASS Market Insight Tool; Internal Islington and Camden Council Data

- Because both Camden and Islington collected numerator (number of staff unable to work) and denominator (total number of staff needed) we are able to examine the impact of COVID-19 on a sample supported living providers in NCL (Camden and Islington have about 30% of supported living providers in NCL).
- As with other social care providers, the supporting living workforce was hit hard by COVID-19, with more than 20% of staff unable to work in most of April.

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Data Sources

- Public Health England "COVID-19: number of outbreaks in care homes – management information"
  - This dataset is also published weekly by PHE and reports on reported suspected or confirmed outbreaks of COVID-19 in care homes. Any individual care home will only be included in the dataset once. If a care home has reported more than one outbreak, only the first is included in this dataset.
- ADASS Market Insight Tool
  - Information is collected via daily self-reports from CQC registered ASC service providers, including care homes, with information on COVID-19 symptoms among staff and service users as well as hospitalisations, deaths and PPE stock.
  - Advantage in that it provides more information on ongoing outbreaks in care homes.
- Anecdotal/Internal reporting
  - Many adult social care teams have close relationships with the providers in borough and may be collecting information on suspected cases through internal reporting methods.
- ONS "Deaths involving COVID-19 in the care sector, England and Wales"
  - This presents a holistic picture of the care sector, but is published on a lag and the most recent data is up to 12 June (published 3 July) with no announced publication date for the next round.
  - This is the most complete picture of deaths of care home residents, but the challenge is the lag in publication and that we don't know when the next publication date is or how regularly it will be updated.
- ONS "Death registrations and occurrences by local authority and health board"
  - This dataset is published weekly by ONS and reports on deaths by local authority and place of occurrence. You can chose to look at either date of death registration or date of occurrence of death. Occurrence is more intuitive, so suggest we use that approach.
  - This table is updated weekly. The challenge is that it only reports on number of deaths in care homes, not deaths of care home residents in other settings.

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Findings from a Rapid Literature Review to support the After Action Review of Social Care during COVID-19 in North Central London

July 2020

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Methods

This rapid literature review aimed to identify examples of good practice from around the world in reducing the impact of COVID-19 in social care settings. I searched for relevant English language material in the public domain using Google Scholar, limited to papers published in 2020. These papers could include literature/systematic reviews, original investigations, commentaries, editorials, letters to the editor, working papers, or any published material relevant to the topic at hand:

> What policies and practices were put in place by social care providers during the COVID-19 pandemic and what effect did these practices have on slowing the spread and impact of the disease on their populations?

240 abstracts were found to review following searches of various related key words (COVID-19 AND any of the following social care, care homes, nursing homes, residential homes, residential care, supported housing, supported accommodation, domiciliary care, home care, assisted living). Another search was conducted for papers meeting the following key words (COVID-19 AND social care AND any of the following: learning disability, physical disability, substance misuse, dementia). A number of papers considering health-based mental health services were identified but excluded as beyond the scope of this review. Papers considering mental health effects of social isolation or mental health of social care services users were retained.

Results

79 papers have been retained for further analysis. Broadly, these papers consider the following topics:

- Non-residential adult social care services, such as home care, supported accommodation and informal caregiving arrangements.
- The impact of clinical interventions in care homes with most focusing on palliative care interventions.
- Coordination of care between health and social care systems, whether in regard to rehabilitation, discharges or how the system is organised.
- The experiences of service users with specific primary support reasons including dementia, learning disability and other disabilities.
- The impact of loneliness and social isolation, with many considering the benefits of technology to mitigate these effects.
- Analysis from long term care settings (including nursing and residential homes) by focusing on specific policies or strategies including testing or considering the impact of characteristics of the residential care setting on COVID-19 outcomes.
- The experience of the workforce is captured as well.

These papers reflect experiences from 18 different countries as well as several papers with a regional or global perspective, although the majority (38 papers) are from the USA or UK.

The papers include 27 commentaries/perspectives, 17 original investigations (with some still in pre-print), 9 editorials, 9 letters to the editor or correspondence and 6 literature or systematic reviews (again, with some still in pre-print). The remaining 11 papers include brief reports, other reports and working papers. These varying types of papers result represent varying quality of evidence.

Findings

The International Long-Term Care Policy Network (ILTCPN) at London School of Economics has been collating and presenting relevant research related to long term care (social care) during the COVID-19 period. Researchers at this network are also maintaining a living document of international examples of measures to prevent and manage COVID-19 in care home settings, which was last updated on 11 May 2020 (1). This document is built from country reports published on the ILTCPN website. They outline the key policies in care homes as follows:

1. Policies to support care homes in preparing for outbreaks
    a. National taskforce to coordinate response
    b. Information systems that monitor outbreaks in care homes and link care homes to supplies of PPE, additional staff and medication
    c. Develop guidance and deliver training for all care home staff
    d. Preparation of rapid response teams
    e. Measures to reduce care home occupancy
    f. Ensure care homes are supported in assessing the feasibility of effective isolation in their current buildings
    g. Considering reviewing and updating advance care directives
2. Measures to prevent COVID-19 infections in care homes
    a. Measures to restrict visitors
    b. Measures to ensure staff do not bring infection
    c. Measures to ensure new or returning residents do not bring infection
    d. Measures to monitor potential infections
3. Measures to control and manage infection
    a. Measures to ensure access to healthcare and palliative care
    b. Deploying army or fire services to support care homes

   c. Measures to maintain staff availability and wellbeing
4. Measures to compensate for the impact of physical distancing on residents

In this review, we follow this useful outline, primarily focusing and building on key policies covering points 2 – 4. We also include examples of international practice, and more examples can be found in the ILTCPN review (1). It is important to note that while policies are described, very few studies have conducted evaluation of the impact of any of these policies on outcomes at this point. It is also important to note that many studies referenced are still in pre-print and evidence is constantly evolving.

Preventing COVID-19 infections: Restricting Visitors

In four countries (Austria, Hong Kong, Israel and South Korea) there have been policies put in place to implement isolation for all residents within care homes to prevent the spread of COVID-19. Many more countries have put rules in place to restrict visitors to care homes (1). The risk of lack of family visits to residents' wellbeing and vulnerability to abuse and neglect has been highlighted (2) and there have been calls to ask residents and their families for their well-informed preferences before imposing these isolation measures indefinitely (3).

Following revised Dutch guidelines to begin allowing visitors to nursing homes following lockdown during the COVID-19 period, a study found that nursing homes reported sufficient to good compliance with local guidance and a positive impact on wellbeing of residents. No new COVID-19 infections were reported during this time (4).

Preventing COVID-19 infections: Ensuring staff do not bring infection

Larger and more crowded nursing homes have been found to have comparatively more cases (5, 6, 7). One hypothesis for this association is that larger care homes have more staff and more movement between units (8). Staff movements are a particular challenge in controlling spread in this sector, as highlighted in a literature review from the Centre for Evidence-Based Medicine at Oxford (9).

One study identified an association between COVID-19 cases and the number of staff not working in direct care roles and suggested these staff may be less likely to wear PPE and more likely to work across multiple locations (10). Use of PPE is a key aspect of Infection prevention and control in care homes and other social care settings. An English study identified PPE challenges around a lack of eye protection and face masks as an important risk factors for COVID-19 spread in care homes (10).

Three countries report travel restrictions for care staff, 3 report restrictions on staff entry into care homes and four countries have shared examples of ensuring staff only work in one care home (1). Both Taiwan and Hong Kong also report having taken steps to prevent cross-over of staff between settings (11, 12). This approach is echoed by a commentary from June 2020 that suggested US States needed to limit the number of facilities visited by staff in a two week period to prevent spread across facilities (13). Some facilities even house staff on site (13, 1).

Other infection control methods are also key to preventing COVID-19 infections in care homes. In an early commentary published in March 2020, US researchers encouraged nursing homes to implement infection control practices and education of staff (14). Internationally, basic infection prevention and control (IPC) measures have been key in preventing the spread of COVID-19 in care homes and basic IPC measures such as hand hygiene and environmental decontamination were highlighted in the CEBM review (235). An additional source highlighted the importance of air flow in care home rooms to prevent infection and made suggestions for improvement (15).

Building on lessons learned from SARS, Taiwan has implemented strict IPC measures in their care homes, including universal vaccination, daily temperature checks and adequate PPE and IPC training (11, 16). Similar measures have been implemented in Hong Kong, as well as discouraging talking during meal times and regular cleaning of the environment (12, 17).

Preventing COVID-19 infections: Ensuring new or returning residents do not bring infection

8 countries report quarantine for people discharged from hospital, whether in a separate facility or in a single room for up to 14 days. In Spain, adapted hotels and other facilities have been used as quarantine and rehabilitation facilities following hospital discharge (1). In a proposed approach for resource allocation, researchers in the United States suggested that without access to timely and reliable testing, nursing homes not be required to accept discharges from acute care (18).

Two countries report testing residents following discharge from hospital (1) and Singapore has reported that, on discharge from hospital, nursing homes requested letters from hospitals to certify absence of COVID-19 (19). In Hong Kong, although COVID-19 testing is not required, new residents and newly discharged residents from hospitals are bathed immediately and body temperature is monitored twice a day for one week (12).

Preventing COVID-19 infections: Measures to monitor potential infections

An ILTCPN living systematic review of evidence in long term care settings last updated on 29 June 2020, primarily focuses on evidence of impact on long term care facilities, highlighting the concentrated impact on this group (20). However this review does stress the importance of testing, as symptom-based strategies in this sector may be misguided due to high proportions of asymptomatic staff and residents identified in care homes during systematic screening. This finding was echoed by the literature review from CEBM and a number of additional studies or commentaries reviewed highlighted high numbers of asymptomatic staff and residents (9, 21, 22, 23, 24) and a number of commentaries and editorials echoed the call for testing to be a focus of infection control at care homes (2, 8, 25).

Internationally, testing has been a key part of the response to COVID-19 with many countries implementing systematic symptom monitoring and testing (1). Mobile testing units have been reported in Slovenia and France (1, 26). In one useful case study, a French nursing home reported the results of a testing programmed on 28 May 2020. Building on American recommendations to test all staff and residents following a confirmed case, followed by repeated weekly testing of all previously negative residents until there are no new cases detected for 14 days. This study confirms this approach as, of 38 residents who tested positive, 36 were diagnosed at baseline and two at day 7 (27).

Guidance from the ECDC Public Health Emergency Team in May 2020 called for prompt testing of any identified symptomatic residents and if confirmed, comprehensive testing for all residents and staff. If the facility is in an area with ongoing community transmission, they recommended regular testing (weekly and comprehensive) of staff even if a case has not been identified (28).

Control and manage infection: Isolation measures

An important consideration for care homes is what to do after a positive case has been identified or a resident develops symptoms. Identification and isolation of symptomatic cases has been found to help reduce resident-to-resident and resident-to carer transmission (29). Several organisations have provided detailed guidelines, including the ECDC Public Health Emergency Team in May 2020 (28).

9 countries report, wherever possible, isolating symptomatic residents in a single room or separate part of the facility while 9 report isolating residents with possible COVID-19 in risk zones or cohort isolation (1). This can be challenging due to shared rooms and a lack of ensuite bathrooms can result in difficulties establishing effective cohort isolation in care home settings (5, 8, 30).

Other countries are removing residents who test positive into quarantine centres or other accommodation (1, 31, 32, 33). However, an editorial in the Journal of the American Geriatrics Society warned that the relocation of care home residents can be traumatic and lead to difficulties in contact tracing when asymptomatic patients are identified (34).

A report from Taiwan highlighted the particular experience after a nurse at a nursing home tested positive for COVID-19. Staff and residents in the facility were immediately tested and all residents were moved to a nearby hospital and quarantine facility to prevent further spread while the facility was disinfected. Contact tracing was implemented and monitored and there were no subsequent positive tests (16).

In Singapore, all patients with symptoms are referred to acute hospitals to rule out the virus. If in the nursing home, patients are isolated in negative pressure rooms and tested once if clinical suspicion is low. “If there is significant concern, some patients may even be subject to a repeat swab before transfer to a general ward.” Authorities made plans to establish wards for cohorting of patients but had not yet needed to use these plans as of May 2020 (19).

Whatever approach is taken, it is important to consider the impact of these measures on the well-being and dignity of residents, especially residents with compromised cognitive functioning (35). When restrictive isolation practices are in place following admission to the care home or from hospital the principles of person-centred care must be implemented (36).

Control and manage infection: Ensuring access to health care

COVID-19 has greatly increased the speed at which telemedicine initiatives have been rolled out in care home settings. Five countries reported steps to expand telehealth visits from healthcare providers in care home settings, including in the US by the federal government waiving some requirements for practitioners to perform in-person visits (1, 31).

In a Letter to the Editor, French physicians outlined procedures at their hospital, highlighting the use of telemedicine to provide initial consultations in care homes and daily follow ups. They highlight that telemedicine can contribute to managing the crisis without exposing additional staff to the virus (37). Telemedicine consultations were also a cornerstone of the response in the Occitanie Region of France (26).

A report comparing differing practices of telemedicine in the UK, USA and Australia highlighted key differences influenced by geographical challenges (countries with more rural populations are more advanced in telemedicine practices). Generally, Australia invested more money into telemedicine at the start of the pandemic while the UK (excluding Scotland) were slower in implementing telehealth solutions (38).

Several editorials lauded the expansion of telemedicine services into social care settings (39, 40, 41), and in an early commentary published in March 2020, US researchers suggested that telemedicine would become the default for care homes (14). An editorial in JMIR Aging highlighted the opportunity COVID-19 has presented to further improve use of technology in care homes even further, through increased use of electronic medical record systems and use of technology for end of life planning and information sharing between nursing home staff and families (42).

However while this is very exciting, a literature review into the impact of COVID-19 on people with intellectual disability highlighted the urgency to rethink and facilitate the provision of care to people with intellectual disability to adjust to these changes as they require a workable level of IT literacy and technology needs to be accessible to people with cognitive impairments (43). This challenge was echoed in a commentary from clinicians within a learning disability care setting in the United Kingdom (44).

Control and manage infection: Palliative Care

The provision of palliative care in care homes is an important consideration, and three countries reported some form of guidance in this area (1). Although one review of international COVID-19 palliative care guidance found that most guidance addressed early physical symptom management in COVID but not symptoms toward the end of life (45), there are several published reviews of palliative care procedures. A commentary from Switzerland signposts to guidance on palliative care in COVID-19 (46) and encourages the following:

- Palliative care settings should give the option to patients whether they wanted to be cared at home or continue to be cared for in nursing home,
- Facilities should plan ahead and make prescriptions for drugs that would alleviate symptoms if patients gets COVID-19
- Measures must be put in place for families to say goodbye to the resident in a safe way if care homes are closed to visitors. This recommendation was echoed by the Norwegian Geriatrics Society that, following a case by case assessment, nursing homes may provide an exemption for family members to visit if their loved one is expected to die within a short time (47).

A separate rapid systematic evidence review focused on how palliative services continued to be delivered during a pandemic and stressed that palliative and hospice care should be part of the national and local planning (48). A review of palliative treatment for nursing home patients in Norway compiled a useful review of interventions (47).

Due to limitations in staffing, some social care staff may find themselves performing palliative care procedures they are unfamiliar with. One paper suggested telehealth could be an effective way to provide support to these staff members (25).

Advance Care Planning has also been a challenge in the COVID-19 period but is essential, especially in care home settings. In the Netherlands, every newly admitted resident to care homes establishes preferences around resuscitation, hospital admission, ICU treatment and an Advance care plan (33). The ILTCPN policy review also contains an example from Germany (1).

Control and manage infection: Referral system between hospitals and care homes

Although there have been some positive examples of coordination between health, social care and other public services (25) there have also been calls for improvement in this area (49). An example from China of providing emergency medical care and a referral system between hospitals and care homes is provided in the lLTCPN policy review (1) and there are several examples of good practice from France, although both still need to be formally evaluated.

French physicians highlighted the success of a strategy in the Occitanie Region of France where the geriatrics department and nursing homes worked closely together, with hospital staff redeployed to a team dedicated to supporting nursing home staff and residents (26). A COVID-19 support platform for care homes was established with a 7 day hotline to train and answer questions from doctors

from care homes. A hotline was also established at another French hospital to support decision of appropriate level of care for older people in care homes. The hospital also established a dedicated follow-up pathway and a dedicated COVID+ palliative care department (50). They found that majority of calls received were to help determine the level of care required and only 11% of calls from care homes required transfer to hospital (50).

A report from Italy suggested that recovered patients awaiting a negative test result be discharged into hotel rooms and using telemedicine for monitoring within those rooms (51).

Several American teams have proposed coordination approaches with different measures suggested for care home and hospital coordination (18, 52, 53). Key suggestions included infection prevention and control measures and education within care homes, continual testing and contact monitoring with increased surveillance and coordination as cases increase. Between surges, it was recommended that care homes prioritise advanced care planning with all patients (52, 53) and robust communication channels between care homes and A&E doctors (53).

A May 2020 commentary in the UK suggested that COVID-19 had provided new opportunity to redesign pathways that better reflect the patient journey from home to hospital and back again. Where rehabilitation services are fragmented or siloed or narrowly focussed on hospitals, there is an opportunity to put services in primary care and the community centre-stage, and to engineer better collaboration with agencies outside healthcare rehabilitation services (49). The authors also discussed how the pandemic response has highlighted the efficacy of remote communication, which must now be scaled up (49) and even where face-to-face delivery of rehabilitation is able to restart, remote delivery is an opportunity for more efficient delivery (49).

Control and manage infection: Managing staff availability and wellbeing

There have been several published findings from surveys of care home staff. From the US, administrators reported particular concerns around availability of PPE, staff shortages and resident health and safety (54). UK staff have called for better financial support, improvements to the PPE supply chain, regular and efficient testing, and accurate clinical information on hospital discharge. Respondents also highlighted the need for support when facing staffing shortages and for psychological support (55). Clinicians within a learning disability care setting reflected that they have been unable to give clear and consistent advice to patients and their families, that integration with other services improves staff morale and that anxiety is high in both staff and patients (44).

Staff providing home care support (in the US, called direct care staff) are essential sources of support for adult social care service users. A commentary in the US from June 2020 highlights the challenges facing these workers. In the US, 48% of direct care staff earn less than a living wage and have limited resources to fall back on in an emergency situation (56). Authors call for training, higher wages and wrap-around services to meet the needs of direct care staff to protect them from financial and health exposure due to COVID-19 (56). One editorial highlighted that the expanding use of technology in the sector could lead to a better offer of more flexible online training opportunities for social care staff (42).

In the ILTCPN policy review, 2 countries reported plans for government taking over funding or running of care homes, 5 reported plans to provide retention bonuses to staff, 5 plans to recruit recent graduates and health students and 6 plans for recruitment of staff that are new to the sector. There are also reports of loosening staff regulations and providing psychological and other support to staff (1).

Measures to compensate for impact of physical distancing in care homes

Technology has also proved to serve an essential purpose for social care service users in maintaining social connections between people who use services and their families. This benefit was explicitly highlighted in six commentaries and editorials (13, 14, 57, 58, 59, 60).

Two commentaries stressed that increased reliance on technology in this way would require additional investment in ensuring long term care facilities had sufficient technological infrastructure and training to support residents and staff (14, 58). One report from the Netherlands found that about 60% of older patients have been able to use video calling and health professionals report that many patients are more resilient than expected (61). In the long term, the expanded use of technology could lead to the use of other apps and technologies to support resident well-being (58).

To further support improved communication between the care homes and families, one commentary suggested assigning staff members as primary contacts for families (57) while another editorial suggested a social work approach to interacting with residents, families and staff to emphasise “the process of communication as central to the quality of work” (62).

Although in general, the quality of evidence for the majority of interventions for social isolation and loneliness is generally weak (63) there are several examples of ideas to mitigate the effect of isolation and social distancing in care homes, such as wearing name tags (64), letter writing, window-greetings or drive by greetings, singing to residents who are standing on a balcony (65). Family members can also assist with the arranging delivery of essential items and sending activities like books and puzzles (65). In Hong Kong, although family visits were restricted from 23 January 2020, relatives were able to leave necessities to residents at care homes at the main entrance.

A report from the US on a telephone outreach programme where medical students phone care home residents once per week received feedback that the programme was deeply appreciated by residents while also improving wellbeing of the student volunteers (66).

BEYOND THE CARE HOME

Impact of COVID-19 on service users

People who use adult social care services are particularly vulnerable to COVID-19. As highlighted in previous sections, isolation and the disruption to services caused by COVID-19 can be particularly upsetting for people with dementia or intellectual disabilities. Two reports emphasised the need for clear and tailored education programme for older people to inform them about COVID-19 (16, 67).

Several editorials have highlighted our gap in knowledge about the impact of COVID-19 on people with disability (68, 69) and have called for further research and data collection.

A June 2020 commentary from Ireland argues that we need, more than ever, to assert the personhood of people with dementia and provide more comprehensive support for people with dementia including reinforcing the health messages of washing hands and social distancing (70). The Northern Health & Social Care Trust developed a practical 'how to' booklet for carers and care staff to understand potential changes in the behaviour of people with dementia by providing a framework and examples on how to provide support to these vulnerable groups (71).

A study from Canada identified for the first time that social distancing imposed on people living with dementia has multiple impacts on well-being of people living with dementia and their family members and/or care partners (72). Many of the stresses and anxieties identified in this study, including reported increase in neuropsychiatric symptoms, could potentially be mitigated through

health system innovations. There is evidence that tablet based interventions can benefit cognition and self-perceived quality of life for people living with dementia (72).

A commentary from China echoed the challenges of isolation and banned visitation and group activities on care home residents with dementia. National organisations in China released recommendations on how to provide mental health and psychosocial support and provided free counselling services for people living with dementia and their caregivers (73). The authors encouraged a multidisciplinary approach to providing mental health support to people with dementia and a variety of methods, such as online relaxation or meditation exercises and telephone hotlines (73).

The use of WhatsApp to provide mental health counselling for older people has been reported in Brazil, Ireland and Lebanon (60, 74, 75). Initiatives by NGOs to support older people and their carers have been reported in Lebanon and Portugal (60, 75).

Volunteers

Although many countries shut down volunteer programmes within care homes during the COVID-19 period, there are still opportunities for volunteers and community organisations to support social care service users. In both the UK and US, volunteers were essential to delivering food to isolated older people (25, 32). One commentary suggested that quality volunteer engagement requires coordination between local authorities and CCGs and suggested a rapid training programme for volunteers (25).

Non-Residential Services

Adult social care services can take many forms beyond care homes. Given that some non-residential adult social are services have shut down during the pandemic, consideration needs to be given to supporting family members who are providing care in the absence of these services.

Several commentaries have published ideas for alternative methods of care provision and many rely on the types of technology discussed in previous sections (65, 76).

In the UK, direct payments are believed to increase service users' choice and control over their social care service provision. A similar approach in the US, called self-direction, is discussed in a commentary from June 2020 as being beneficial during the COVID-19 period as it allows service users increased flexibility to increase or reduce reliance on agency staff as family caregivers may be more or less available during the COVID-19 period. In the US, many states are increasing self-directed budgets, benefit limits and/or rates to encourage use of self-direction (77).

Finally, a provider of supported living in the UK has published a commentary outlining their experience and the interventions they implemented to prevent spread of COVID-19 in their facilities including not using agency staff, ensuring access to PPE, providing safe transitions into supported living from the community and hospital, accelerated recruitment, and access to technology (78).

GUIDANCE

Internationally, guidance for nursing care guidance has been published by numerous organisations (see: https://ltccovid.org/resources/). Several commentaries urged co-production of guidance with social care staff (41, 79, 55) and one commentary from the UK called for technology to be used more effectively to ensure effective dissemination of revised guidance (25).

A report from Taiwan emphasized the benefits of a clear chain of command for guidance dissemination, from central government to local governments and then to care institutions (11).

Locally in North Central London, the flow of guidance followed a similar chain of command, generally from national government to local public health and adult social care teams, who then communicated with local care institutions.

Locally, the Camden and Islington Council Public Health reactive team summarised and cascaded at least 42 pieces of guidance to Adult Social Care stakeholders between 20 March and 13 July 2020. These documents were received from a number of sources, including the Department of Health and Social Care (DHSC), Public Health England (PHE), NHS Digital and other stakeholders. These guidance are summarised in Appendix 1.

Other local public health teams in North Central London also established strong relationships with local care providers and prioritised cascading information to their adult social care teams. In Haringey, a weekly briefing was sent from the DPH to care homes. In Barnet all advice to care settings was sent from within the Adult Social Care team, but they worked in close collaboration with Public Health to make the national guidance more user friendly and the public health team held webinars for care providers.

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Appendix 1. Summary of content of guidance circulated to ASC providers by Public Health

Date and Title of Guidance	Summary of content/updates
20 March 2020 Guidance for local government	• The creation of a taskforce to bring together senior experts from across key sectors – including resilience, local government, public health and adult social care fields – who will assess Local Resilience Forum (LRF) plans and provide support and advice to ensure they are robust. • Guidance to assist staff and employers in addressing coronavirus in a hostel or day centre environment.
20 March 2020 Ethical framework for adult social care	The bulk of the document examines ethical values and principles and the associated actions and best practice when considering and applying them
20 March 2020 Guidance on residential care, supported living, and home care	• Identifies steps care home providers can take to maintain services working in partnership with the LA, primary and community health care • Explores what to do if a staff member is concerned they have COVID-19 including stay at home advice • Clarifies how care homes can minimise the risks of transmission for example reviewing their visiting policy • Outlines what to do if a resident has symptoms of COVID-19, for example thinking about isolation precautions and offering guidance on wearing personal protective equipment • Identifies the steps the NHS can take to support care homes • Outlines current government support and the steps local authorities can take to support care home provision • how to maintain delivery of care in the event of an outbreak or widespread transmission of COVID-19
20 March 2020 Hospital Discharge Service Requirements	The guidance outlines actions to be taken immediately by all NHS trusts, community interest companies and private care providers of acute, community beds and community health services and social care staff in England. It involves altering their discharging arrangements and provision of community support. It also sets out requirements around discharge for health and social care commissioners (including Clinical Commissioning Groups and local authorities). The guidance must be adhered to from Thursday 19th March 2020. The update from 19 March added a cover letter and patient information leaflets (on admission and on discharge).
20 March 2020 Guidance on social distancing and for vulnerable people	This guidance provides advice on: • People who are considered to be at increased risk of severe illness from COVID-19 • What social distancing means in practical terms • How to get assistance with foods and medicines whilst social distancing • What you should do if you have a hospital or GP appointment whilst social distancing • Visitors, including those providing care for you, whilst social distancing • How to look after your mental wellbeing whilst social distancing

	Updates as of 20/3/20: • Translated versions of this guidance has been published here
23 March 2020 Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from COVID-19	This guidance is for people, including children, who are at very high risk of severe illness from coronavirus (COVID-19) because of an underlying health condition, and for their family, friends and carers. It is intended for use in situations where the extremely vulnerable person is living in their own home, with or without additional support. This includes the extremely clinically vulnerable people living in long-term care facilities, either for the elderly or persons with special needs
27 March 2020 British Geriatric Society - Care Home Guidance	Guidance about what to do about wandering residents, and frail residents
30 March 2020 Social care provider resilience during COVID-19: guidance to commissioners	This guidance note is for local authority commissioners. It is designed to summarise pressures on social care providers arising from COVID-19, and to put forward ways in which commissioners can alleviate these pressures.
3 April 2020 Coronavirus (COVID-19): admission and care of people in care homes	Received from DHSC How to protect care home residents and staff during the coronavirus outbreak.
13 April 2020 Coronavirus (COVID-19): Prevention and control for step down in hospital, home, residential settings	Received from PHE Further advice on appropriate infection prevention and control (IPC) precautions for stepdown in hospital or discharge to home or residential settings
21 April 2020 ASC Guidance index page	Received from DHSC To simplify sourcing information relevant to the social care sector, a new collection page has been created on gov.uk bringing all the guidance relevant to them together into one place
21 April 2020 Coronavirus (COVID-19): guidance for people receiving direct payments	Received from DHSC Advice for people who buy care and support through a direct payment, as well as local authorities, clinical commissioning groups and those who provide care and support.
22 April 2020 Information and resources in relation to COVID-19 and dementia from the Dementia Clinical Network	Two resource packs with information and resources in relation to COVID-19 and dementia. Please note this is not NHSE/I guidance.
24 April 2020 COVID-19: how to work safely in care homes	Received from DHSC Updated guidance on 23/04/2020: added posters for putting on and taking off PPE.
24 April 2020 COVID-19: guidance for stepdown of infection control precautions within hospitals and discharging	Received from DHSC Updated on 23/04/2020: added clarifications of testing capacity and strategy and re-ordered the page for improved readability.

COVID-19 patients from hospital to home settings	
27 April 2020 COVID-19: how to work safely in domiciliary care	Received from PHE A resource for those working in domiciliary care providing information on the use of personal protective equipment (PPE).
27 April 2020 COVID-19: how to work safely in care homes	Received from PHE Updates include: Information on PPE simplified, flowchart removed, PPE for COVID-19 currently recommended for all care homes during sustained COVID-19 transmission, further text changes and additional FAQs added.
28 April 2020 Coronavirus (COVID-19): reuse of medicines in a care home or hospice	Received from DHSC Standard operating procedure on how to run a safe and effective medicines reuse scheme in a care home or hospice during the coronavirus outbreak.
6 May 2020 COVID-19: number of outbreaks in care homes – management information	Received from PHE Weekly number and percentage of care homes reporting a suspected or confirmed outbreak of COVID-19 to PHE by local authorities, regions and PHE centres
6 May 2020 Number of deaths in care homes notified to the Care Quality Commission	Received from ONS Provisional counts of deaths in care homes caused by the coronavirus (COVID-19) by local authority
7 May 2020 Coronavirus (COVID-19): guidance for people receiving direct payments	Received from DHSC Advice for people who buy care and support through a direct payment, as well as local authorities, clinical commissioning groups and those who provide care and support.
8 May 2020 Domestic abuse safe accommodation: COVID-19 emergency support fund	Received from MHCLG This prospectus provides prospective bidders with information on how to apply for funding and how the assessment process will work.
11 May 2020 Dedicated app for social care workers launched	Received from DHSC A new dedicated app for the adult social care workforce in England has been launched to support staff through the coronavirus (COVID-19) pandemic.
14 May 2020 Coronavirus (COVID-19): getting tested	Received from DHSC Update to guidance on 14 May: Amended wording on what to do if a care home suspects a resident has coronavirus symptoms and how to test care home residents and workers. Added updated version of the visual guide to adult social care testing
20 May 2020 Infection prevention and control guidance	Received from Public Health England Appendix 2 has been added which provides visual, best practice resources on PPE, handwashing, hand rub and management of body fluids
21 May 2020 Coronavirus (COVID-19): informing DHSC of the death of a worker in social care	Received from DHSC How local authorities and social care providers can tell DHSC about the death of an employee or volunteer in social care.
21 May 2020	Received from Home Office

Coronavirus (COVID-19): bereavement scheme for family members of NHS and health and social care workers	Information for non-EEA national family members and dependants of NHS workers and independent health and social care workers who have died as a result of contracting coronavirus (COVID-19).
29 May 2020 Coronavirus (COVID-19): looking after people who lack mental capacity	Received from DHSC Updates have been made to the main guidance attachment, in particular to the 'Emergency public health powers' section. The format of the attachment has also been changed to ensure it's accessible. 3 new attachments have been added to the page: additional guidance, annex A and an easy read.
1 June 2020 COVID-19: management of staff and exposed patients and residents in health and social care settings	Received from PHE *UPDATED* Updated in light of the test and trace guidance and added guidance for risk assessment of staff in the event of PPE breaches.
5 June 2020 PPE portal: how to order emergency personal protective equipment	Received from DHSC The PPE portal can be used by social care and primary care providers to order and receive critical coronavirus (COVID-19) personal protective equipment (PPE). Providers who can use the service will receive an email invitation to register.
7 June 2020	Received from NHS England and NHS Improvement Care Home Resource Pack
9 June 2020 Speech: Health and Social Care Secretary's statement on coronavirus (COVID-19): 5 June 2020	Received from DHSC Health and Social Care Secretary Matt Hancock gave the 5 June 2020 daily press briefing on the government's response to the coronavirus pandemic.
9 June 2020 COVID-19: personal protective equipment use for aerosol generating procedures	Received from PHE Guidance on the use of personal protective equipment (PPE) for aerosol generating procedures (AGPs).
10 June 2020 Adult Social Care Infection Control Fund	Received from DHSC Sets out the infection control measures that the infection control fund will support, including information on the distribution of funds and reporting requirements
10 June 2020 Coronavirus (COVID-19): guidance for people receiving direct payments	Received from DHSC Q&As have been updated with new examples, information on PPE, testing and flexible uses of direct payments. Two new documents also added - easy read version, and most important things to know
18 June 2020 COVID-19: guidance for households with possible coronavirus infection	Received from PHE Added easy-read guide.
19 June 2020 Coronavirus (COVID-19): reducing risk in adult social care	Received from DHSC NEW: A framework for how adult social care employers should assess and reduce risk to their workforce during the coronavirus pandemic.

19 June 2020 Steps to take following the death of a person who worked in adult social care in England	Received from DHSC NEW: Actions for local authorities and social care providers following a coronavirus (COVID-19) related death of an employee or volunteer in adult social care.
7 July 2020 The Health Service and Social Care Workers (Scrutiny of Coronavirus-related Deaths) Directions 2020	Received from DHSC Directions to NHS trusts and NHS foundation trusts in England to ensure the scrutiny of deaths of health service and adult social care staff from coronavirus (COVID-19).
10 July 2020 COVID-19 prevalence survey	Received from PHE This pilot study provides the first estimate of the extent of COVID-19 infections among domiciliary care workers in England
10 July 2020 Coronavirus (COVID-19): reducing risk in adult social care	Received from DHSC Easy read added
13 July 2020 PPE portal: how to order emergency personal protective equipment	Received from DHSC Visors can now be ordered through the portal

MINUTES OF THE BARNET, ENFIELD & HARINGEY NCL JHOSC SUB GROUP
THURSDAY, 25 JUNE 2020

Councillors: Pippa Connor (Chair) (Haringey), Lucia das Neves (Haringey), Alison Cornelius (Barnet) and Linda Freedman (Barnet)

BEH.1 APPOINTMENT OF SUB-GROUP CHAIR

AGREED:

That Councillor Pippa Connor (Haringey) be appointed as Chair for the meeting.

BEH.2 APOLOGIES FOR ABSENCE

An apology for absence was received from Councillor Clare de Silva (Enfield).

BEH.3 DECLARATIONS OF INTEREST

Councillor Connor reported that she was a member of the Royal College of Nursing and that her sister worked as a GP.

BEH.4 QUALITY ACCOUNTS - GUIDANCE

AGREED:

That the guidance for overview and scrutiny committees from the Department of Health on the consideration of Quality Accounts be noted.

BEH.5 BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST - DRAFT QUALITY ACCOUNT

The draft Quality Account for Barnet, Enfield and Haringey Mental Health Trust was presented by the following:

- Amanda Pithouse – Executive Director of Nursing;
- Dr Mehdi Veisi – Executive Medical Director;
- Shila Mumin – Head of Effectiveness; and
- Caroline Sweeney – Deputy Director of Quality Governance.

It was noted that the trust had a new board of directors. In addition, the trust's executive team had been reviewed. The new Trust Strategy had been developed with service users, carers, staff, partners and other stakeholders. As part of its development, focus groups and executive roadshows had been undertaken. Four key themes had been identified within the new strategy:

- Excellence;
- Empowerment;
- Innovation; and
- Partnerships.

The trust had been inspected by the Care Quality Commission (CQC) in September 2019 and rated as "good". However, some areas were identified as needing improvement, including safety. The trust had 7 "must do" and 58 "should do" actions arising from the inspection. Ahead of the inspection, the trust had developed 10 "Brilliant Basics". These were both strategic and clinical.

Six specific and quantifiable quality priorities had been set for 2019/20. These included improved access to beds. This had been increasingly challenging but a new 15 bed ward had been opened which had assisted the Trust in addressing the issue.

The Sub-Group considered the Quality Account as follows:

(i) It commented that the patient experience had only been highlighted in the latter parts of the Quality Account. It also felt that the earlier passages of the report could be made more accessible as they currently appeared "corporate" in nature. It was noted that a lot of feedback on services had been received and that this had come from a range of sources. It was felt that this should be disaggregated so that it was possible to determine the level of response from service users. Ms Pithouse acknowledged that there was a need to make the Quality Account more accessible and present data in a more meaningful way. In particular, looking at data over a longer period could provide a clearer picture of trends;

(ii) Ms Pithouse stated that the trust aspired to improve all of its services and had been disappointed by the rating of inadequate by the CQC for community based mental health services for adults. This required timely access to services and many mental health trusts found this challenging. Work was in progress to address this including developing more effective working relationships with partners, such as the Police;

(iii) There was some variation in the quality of work by crisis teams across the trust. The good practice in some areas needed to be spread across the trust and action was being taken to reduce variation;

(iv) It was noted that there were particular challenges in improving environments for patients. Some in-patient accommodation was still not fit for purpose although new accommodation would shortly be opened in Haringey;

(v) Provision for Child and Adolescent Mental Health Services (CAMHS) was also being addressed, with work starting on new premises at Chase Farm shortly;

(vi) Dr Veisi commented that a large amount of the content of Quality Accounts was prescribed but the trust would nevertheless try to make the document more accessible. One option might be to provide an easy read version for lay people. In respect of beds, the trust had increased the number of these by 34 in the last six months. The trust was currently addressing the findings of the CQC report. As part of this, it had commissioned an independent review of the Crisis Care pathway and this had made 10 recommendations. Some work had been delayed by the pandemic but this had now been resumed. The Sub-Group requested further information on the 10 recommendations that had been made in respect of the Crisis Care pathway;

(vii) In answer to a question, Ms Pithouse stated that all of the money that had been obtained from the redevelopment of the St. Ann's site had now been re-invested and was not sufficient to finance sufficient additional beds to meet demand. The trust wished to address this and was putting a plan in place. A case was being made to NHS England for funding. Dr Veisi commented that the trust had invested

in improvements to make accommodation safe. Some was beyond repair but would nevertheless not be allowed to become derelict;

(viii) Dr. Veisi reported that the trust was working to address demand for community based services. Action that had been undertaken recently included the establishment of a place of safety at the Dennis Scott Unit in Edgware, staff being located in Accident and Emergency units and establishment of a 24 hour crisis line. In addition, the trust had been appointed to run the crisis line for north central London. It was likely that there would be increased demand for services as a consequence of the Covid-19 pandemic, including referrals for Post-Traumatic Stress Disorder (PTSD), depression and anxiety. Direct engagement with service users had been reduced as a result of the Covid-19 pandemic but the shortfall was being made up digitally;

(ix) The Sub-Group noted that the trust was part of a network of mental health service providers where learning could be shared and was continually looking to collaborate with others. In addition, it also looked at practice in other countries;

(x) The trust was an integral part of Child and Adolescent Mental Health Services (CAMHS), together with local authorities. Access to services was increasingly through digital means. This was not by default but by choice;

(xi) Sub-Group Members highlighted that the staff survey had indicated that bullying and aggression was an issue. Ms Pithouse stated that it was the focus of specific attention. Engagement would be taking place with staff and external assistance would be procured through the use of a “cultural thermometer”;

(xii) In respect of recruitment and retention, Ms Pithouse reported that this was particularly challenging in respect of nursing staff. Nursing was often not perceived as an attractive career option. However, the pandemic may have changed this view. Work to address recruitment and retention was taking place across London and the NHS as a whole. One particular challenge that the trust faced was that its staff did not receive inner London weighting;

(xiii) In response to a question regarding whether staffing issues impacted on the safety of in-patients, Ms Pithouse stated that the majority of deaths of patients took place in the community. In addition, some patients were very frail. Any death was a cause for concern and the data was analysed. However, current figures did not indicate anything that was unusual and were within normal levels of variation. Dr Veisi reported that mortality reviews took place every two weeks and all cases were looked at. It was likely that there would be an increase following the pandemic and this would be a national pattern;

(xiv) In respect of EU nationals, the status of all of those who worked for the trust had been addressed. The cost of visas required for employees of the trust was likely to be large though and this would be a challenge for the whole of the NHS;

(xv) In respect of incidents of patient restraint, Ms Pithouse reported that this was looked at on a weekly basis. There were particular hot spots where incidents were more common and these were being addressed. Challenging behaviour nevertheless remained an issue and could impact on recruitment and retention. It

was particularly difficult to recruit to posts in the Intensive Care Unit (ITU) as the work was often very stressful;

(xvi) The Sub-Group noted that collaboration on learning and staff development was taking place with Camden and Islington Mental Health Trust and opportunities had been put in place for nurses to work across the two trusts;

(xvii) In respect of patient experience feedback and the lack of QI compliance in collaboration, it was noted that that work to address this was now being stepped up. Engagement with patients had not stopped though and it was now actually simpler due to enhanced use of IT. It was agreed that the wording of this section would be simplified;

(xviii) It was noted that there were currently 25 peer support workers in the and the intention was to increase this by 15 and to make peer support available in all in-patient wards. Preventing violence and aggression was a specific priority within this programme;

(xix) Sub-Group Members highlighted the low response to the Community Mental Health Survey. Dr Veisi commented that this was a national survey. Permission needed to be obtained for information from patients to be shared and the trust was looking at ways in which participation could be made easier;

(xx) In respect of the interface with Haringey Council, Ms Pithouse stated that the reason why this was referred to as a challenge was unclear. It was possible that this referred to delayed transfers of care. Sub-Group Members commented that there was no section on what had gone well and what was challenging in respect of Barnet;

(xxi) In respect of why there were more complaints from Haringey service users, Ms Pithouse felt that environmental issues could be a factor which the opening of new accommodation would hopefully address. Staff attitude was the single biggest reason for complaints. It was an area that was currently being reviewed by the Trust and a report was due to be submitted to the Board in July. Complaints reports could be shared with the Sub-Group;

(xxii) The Sub-Group suggested that more regular reports on progress by the Trust might help to increase awareness amongst Members of its work and achievements. It was agreed that officers would liaise to see how this could be progressed; and

(xxiii) It was noted that the trust also delivered community health services in Enfield and that physical health would be a particular priority in next years Quality Account.

The Sub-Group thanked officers from the Trust for their kind assistance.

AGREED:

1. The further information be shared with the Sub-Group by the Trust on the ten recommendations that had been made in respect of the improvement of the Crisis Care pathway; and

2. That proposals be developed for more frequent communication between the Trust on current developments and progress with Members of the Sub-Group.

BEH.6 NORTH MIDDLESEX UNIVERSITY HOSPITAL - DRAFT QUALITY ACCOUNT

The Sub-Group noted that the Trust had advised that further work was being undertaken on their Quality Account and it would now not be ready until the autumn.

Cllr Pippa Connor
Chair

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE Work Programme 2020-2021	
REPORT OF Committee Chair, North Central London Joint Health Overview & Scrutiny Committee	
FOR SUBMISSION TO NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 25 September 2020

SUMMARY OF REPORT

This paper provides an outline of the 2020-21 work programme of the North Central London Joint Health Overview & Scrutiny Committee.

Local Government Act 1972 – Access to Information

No documents that require listing have been used in the preparation of this report.

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RECOMMENDATIONS

The North Central London Joint Health Overview & Scrutiny Committee is asked to:

a) Note the contents of the report; and
b) Consider the work programme for the remainder of 2020-21.

1. Purpose of Report

1.1. This paper provides an outline of proposed areas the Committee might choose to focus on in the rest of 2020-21. This has been informed by topics highlighted previously by the JHOSC and through a review of key health and care strategic documents that impact on North Central London. The Committee is asked to consider the list of topics highlighted in Appendix A, as well as any other areas of interest, and use these to populate the committee work programme for the remainder of the municipal year.

2. Terms of Reference

2.1. In considering topics for 2020-21, the Committee should have regard to its Terms of Reference:

- To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;

- To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;

- To respond to any formal consultations on proposals for substantial developments or variations in health services across affecting the areas of Barnet, Camden, Enfield, Haringey and Islington and to decide whether to use the power of referral to the Secretary of State for Health on behalf of Councils who have formally agreed to delegate this power to it when responding to formal consultations involving all the five boroughs participating in the JHOSC;

- The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;

- The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and

- The joint committee will aim to work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people

3. Appendices

Appendix A – Items to be considered for the 2020/21 NCL JHOSC Work Programme

REPORT ENDS

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Appendix A – Items to be considered for 2020/21 NCL JHOSC work programme

Item	Purpose	Lead Organisation
General Practice as the foundation of the NHS: improving health and wellbeing	Update of new roles of GPs to improve residents' health and wellbeing, by embedding other health care professionals including social prescribing, pharmacists into GP practices and examples of how this will improve care	NCL
Tackling inequalities through prevention and early intervention	A report covering NCL's focus on prevention and early interventions to improve the health and wellbeing of residents, including wider determinants of health and preventable health issues.	NCL
Digital GP paper	Maximising the amount of space available for people who need it. Not moving everything to digital	NCL
Integration of health and care	Updating on actions and following up from previous items in March and June. Including update and NCL CCG	NCL
Finance	A report to respond to address funding and finance issues.	NCL
Screening and Immunisation	NCL partners to confirm focus and scope.	NCL
Children and Young People - integrating care for children and young people	A report on work across NCL through the paediatric integrated network with examples of how this is improving care for children and young people	NCL
Temporary changes to Paediatric services	An update to respond to concerns around the closure of Paediatric Services at the Royal Free and UCH.	NCL
Continued Emergency and/ or Recovery Planning	Updating on plans for emergency planning and recovery planning	NCL

Timetable of meetings

27th November (Enfield)
29th January (Haringey)
26th March (Islington)

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