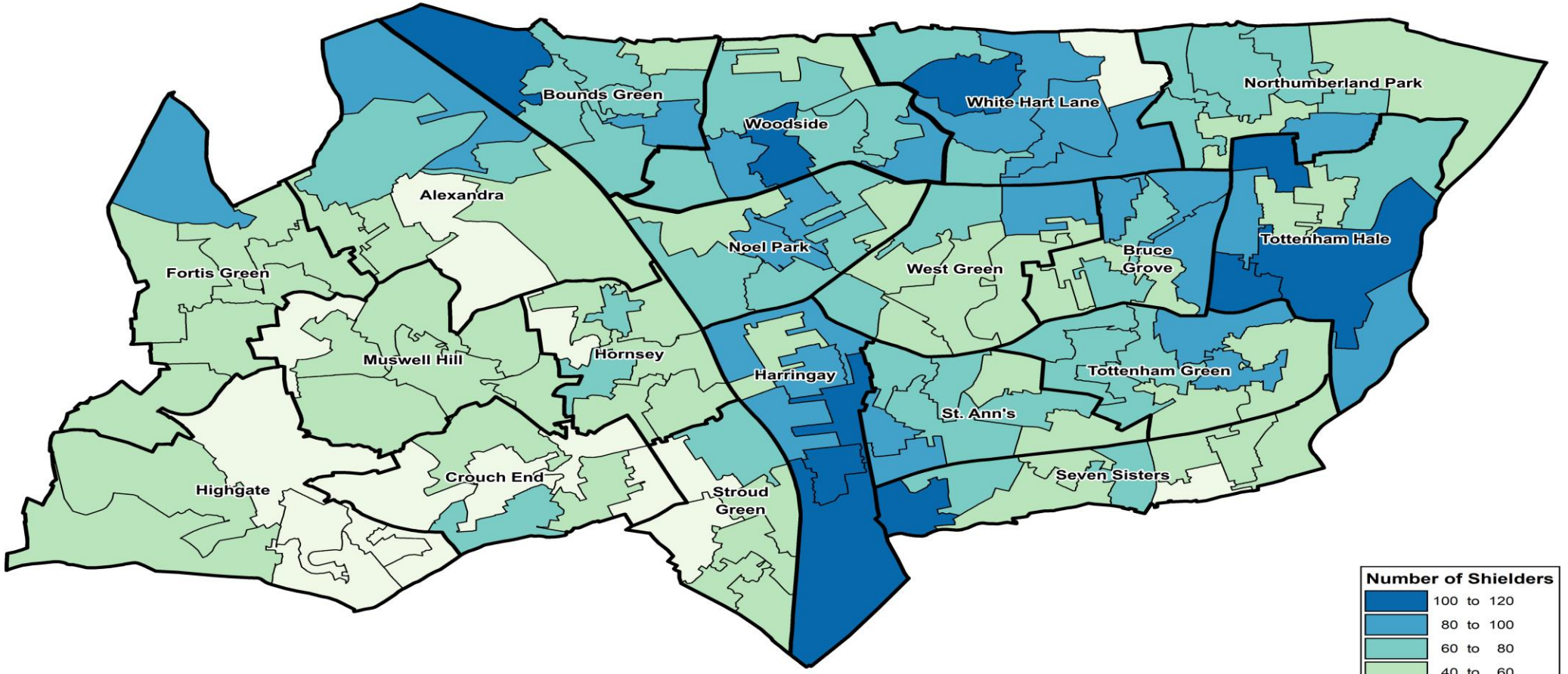
Adult Social Care:
Responding to Covid Wave 1
Preparing for Winter and Covid Wave 2

Responding to Covid Wave 1

1) Support for Shielded and Vulnerable Groups

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



Produced by Business Intelligence
© Crown copyright. All rights reserved 100019199 (2020)

1) Support for Shielded and Vulnerable Groups

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3) Monitoring Impact on and Performance of Service During Lockdown

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

Adult Social Care – Covid-19 (Coronavirus) Metrics

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

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

Assessment and reviews – monitoring incoming numbers and completion rate

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

Capacity Tracker

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

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

Learning from Wave 1 and Preparing for Winter and Covid Wave 2

Learning & Improvement Focus following Wave 1

- **After Action Reviews** carried out with each **Integrated Discharge Team (IDT) across NCL** and the **Care Market** following the first C19 wave

- Acute, Community and LA partners an LGA/ECIST **gap analysis self assessment and** IDT leads **gap analysis returns from all partners.** (Focused around the high impact change principles for discharge – see slide 10)

- **Peer partner visits carried out within** Integrated Discharge Teams in Acutes to review and share good practice

- **Joint Action Plan** on areas for improvement drawing in all learning from AAR, Gap Analysis and peer review process.

- **Implementation of action plan and monitoring** at local IDT meeting in progress

NCL Discharge Principles – A Framework for Improvement

The NCL system rapidly mobilised the National Discharge Requirements for Covid and this has led to some variation in operating practices. NCL partners agreed that new ways of working across IDTSs should be underpinned by a common set of discharge principles that all IDTSs will meet. To build on existing best practice, the High Impact Change Model has been updated to reflect the current Covid priorities in NCL as outlined below (main Covid changes highlighted in blue). This approach was subsequently embedded as a requirement into the new national hospital discharge and policy guidance.

1: EARLY DISCHARGE PLANNING AND SAME DAY DISCHARGE

An expected discharge date should be set in 48 hours of admission and communicated to partners.
To maintain flow during the Covid period all patients are to be discharged on the same day from an acute or community hospital.

2: MONITORING & RESPONDING TO SYSTEM DEMAND AND CAPACITY

System partners provide real-time information on system demand and able to respond timely way. This data informs system demand and capacity modelling and future planning.

3:MULTI-DISCIPLINARY WORKING

MDTs work together to coordinate discharge around the person to maximise outcomes. Planning is based on joint triaging, processes & protocols, shared responsibilities and communication.

4: HOME FIRST

Should be the system mind-set. It means always prioritising and if possible supporting someone to return home before considering other options

5: FLEXIBLE WORKING PATTERNS

Where it will help to deliver the "right care, right time, right place". SPAs and Brokerage will be operationally 8-8pm 7 days a week as per current national guidance.

6: TRUSTED TRIAGING/ASSESSMENT

Partners should undertake holistic strengths-based triaging/ assessments to avoid duplication & speed up response times. so that people can be discharged in a safe and timely way.

7: ENGAGEMENT & CHOICE

Early engagement with people who are using services, their families/carers is vital so they are empowered to make informed decisions about their future care. During the COVID-19 pandemic, patients will not be able to wait in hospital for their first choice of care home. This will mean a short spell in an alternative care home and the care coordinators will follow up to ensure patients are able to move as soon as possible to their long term care home.

8: IMPROVED DISCHARGE TO CARE HOMES

Partners should work together to improve outcomes for care home residents and ensure smooth hospital discharge into care homes. All patients will be tested 48hrs prior to discharge to a care home.

9: LAST PHASE OF LIFE

Ensuring wherever possible patients die in their preferred place.

10: HOUSING & RELATED SERVICES

Effective referral processes and good services which maximise independence are in place to support people to go home. Housing needs and options are addressed early in discharge planning.

Care Sector Support - Key programme areas

- **Immediate/ongoing**
  - Implementing guidance
  - Operational issues
  - Work in progress
- **3 – 6 months**
  - Sustainable and long term support
  - Strategic proposals and decisions

NCL Covid+ Pathway: “bridging pathway”

In order to protect residents of care homes and other bedded care units (extra care and supported housing) from Covid outbreaks, **any patient on a P3 pathway (Nursing or Residential Care Home) who tests (or remains) Covid+ on day of discharge from the acute trust, will be temporarily moved to a P2 bed (intermediate Care Bed) until they are no longer infectious* and/or until a COVID- test is returned**. At this point they will be transferred to their Pathway 3 destination.

* Exceptions: Rarely, some patients will repeatedly test positive but no longer be infectious. This will be confirmed by clinical assessment in hospital or P2 unit in order to facilitate discharge to a care home.

Please note:

- As these patients will be on a **planned P3 pathway**, there should usually be a P3 destination agreed on discharge from the acute.
- We expect an average **length of stay** of 7 days in a P2 bed. Our modelling suggests there will be approximately 6 patients at any one time across NCL on this “bridging” pathway.

Haringey Plans for winter and a Second Wave

Summary of Demand:

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

Plans for Winter and COVID Wave II

Plans for winter and COVID II are currently being agreed with partners, but are evidence based on previous winters and Wave I:

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

Haringey Plans for winter and a Second Wave

(Continued)

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