Agenda Item 6

HEALTH AND WELLBEING BOARD – 24 SEPTEMBER 2020

CORONAVIRUS (COVID-19) IMPACT AND RESPONSE OF THE LOCAL CARE SYSTEM

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Purpose of the Report

1. This report advises the Health and Wellbeing Board on the impact of the Coronavirus (COVID-19) within the County and the response of the County Council and the local care system. The report also considers how the health and care system may develop as a result of the pandemic.

Recommendations

2. The Health and Wellbeing Board is asked to note the report.

Background

3. Coronaviruses are a family of viruses common across the world in animals and humans. Covid-19 is the illness seen in people infected with a new strain of coronavirus not previously seen in humans and began in Wuhan Province in China in December 2019. The first case in Leicestershire was reported on March 6th with cases reaching a first peak in mid-April.

Health and Social Care Impact and response

Health

4. The initial phase of the NHS response to covid-19 commenced on 30th January with the declaration of a Level 4 National Incident. Following the World Health Organisation's declaration of a global pandemic on 12 March, on 17th March, the NHS initiated what has been described by NHS England and Improvement as the fastest and most far reaching repurposing of NHS services, staffing and capacity in its 72-year history.

5. This response has been unprecedented and necessary to deal with is one of the biggest international challenges faced in a generation. In Leicester, Leicestershire and Rutland (LLR) the total number of confirmed cases stood at 3762 as at 7th September. Sadly 536 LLR residents have lost their lives, either in LLR hospitals or elsewhere.

6. The need to adapt and respond to the COVID - 19 pandemic has permeated all aspects of NHS services. To control the spread of the virus and protect patients, it was necessary to temporarily redesign how some services are

accessed and provided or, in some cases, pause services in the interests of protecting patients and staff, to focus on the anticipated demand to support covid-19 cases.

7. This work has been coordinated across Health and Care services via the Health Economy Strategic Coordination group (HESCG) and the Health Economy Tactical Coordination group (HETCG). These groups, and the individual cells reporting to them, have met at least weekly since the pandemic began and continues to do so as the system heads into what is predicted to be a difficult winter period.

8. On July 31st, the third phase of the NHS response to covid-19 was launched, with a reduction in the UK's overall covid alert from four to three, signifying that the virus remains in general circulation with local outbreaks likely to occur, as seen in parts of Leicester, Leicestershire and Rutland.

9. The expectations outlined for phase 3 include:

    - Accelerating the return to near-normal levels of non-covid health services
    - Preparation for winter demands, alongside continuing vigilance in light of further covid-19 spikes locally
    - Doing both the above in a way that takes learning into account from the first covid-19 peak

10. The HESCG continues to oversee this phase and are working system-wide to ensure the three priorities outlined above are delivered in a safe manner, both to protect staff and patients. This includes building on newly-introduced service delivery models, such as digital primary care services, to ensure that patients have a wide range of access points into health and care services.

Ongoing incident management

11. At the time of writing the UK Government covid-19 Alert level is level 3.22. Arrangements for incident management have been maintained, ensuring the NHS is in a strong position to respond to changes in the prevalence of covid-19 and the impact on NHS services. The joint working, particularly between health and social care, has supported more holistic approaches to decision – making, enabling rapid action to be taken to resolve problems, and in many cases creative solutions to long-standing challenges.

12. The NHS will continue to work closely with local authority colleagues as they develop outbreak plans. Close working with public health colleagues is essential to understand the prevalence of covid-19 and the potential for further 'local hotspots.

13. This will include surge exercises to test the system ability to manage different scenarios over the coming months in addition to the normal surge planning events such as winter flu and bad weather.

14. Underpinning everything is the infection, prevention and control (IPC) position of NHS England which aims to ensure that no patient or staff member should catch covid-19 in NHS healthcare facilities.

15. Like the general population, the NHS will be operating in a world with covid-19 for the foreseeable future.

16. For patients there are now requirements when attending hospital sites to wear face coverings. Visiting restrictions remain in place, but we will review them. NHS Trusts fully acknowledge the difficulties and distress this has caused but we need to continue to protect patients and the public.

17. All sites are undertaking risk assessments and audits to ensure they meet the rigorous standards for infection control and social distancing.

PPE

18. In LLR, the NHS has faced some challenges with the availability of PPE as was the case nationally. At times stocks of items ran low and it took some time before the supply process worked effectively.

19. Mutual aid within the NHS in LLR and with neighbouring Trusts in other areas resolved the situation when necessary but was clearly not sustainable. Once the national supply chain was working effectively, including a central portal for ordering, the situation has largely been resolved but maintaining vigilance on stocks and supplies is essential going forward.

Care homes

20. The joint working arrangements between health and social care has ensured robust support is available to care homes.

21. During the earlier stages of the outbreak it should be acknowledge that there were some significant challenges facing care homes including: discharge of patients without a negative covid test, the availability of appropriate isolation facilities for caring for covid-19 infected patients, clinical support, shortages of PPE and resilience of staff and the impact of staff sickness.

22. To support care homes, health and social care have now established processes for the safe discharge of patients to care homes and support arrangements to ensure resilience in homes in response to staff shortages, for example. Training on Infection Prevention and Control and clinical leads to support care homes.

23. The joint working between health and social care to support care homes will continue as will ongoing monitoring of care home resilience.

Testing and tracing

24. The test and tracing service ensures that people who develop symptoms can be tested to find out if they have the virus, and also includes targeted asymptomatic testing of NHS and social care staff and care home residents.

25. It also helps trace close recent contacts of anyone who tests positive and, if necessary, notifies them that they must self-isolate at home to help stop the spread of the virus.

26. Tests are carried out at the testing centre set up at Birstall Park and Ride and through Mobile Testing Units (MTUs), visiting various sites around Leicester, Leicestershire and Rutland. UHL staff can also have the test at UHL.

27. Whether symptomatic or not, all non - elective patients are given the test at the point of admission and elective patients are tested within 72 hours of being admitted.

Service recovery and restoration

28. As stated above, the initial response was the need to deal with covid-19 related patients, and the action taken, including the cancellation of non-elective treatments and procedures, reflects this.

29. Within phase 3 a ‘safe re-start’ of services stood down or reduced during the initial phase will be undertaken.

30. In line with the aim that no patient or staff member will catch covid-19 in our hospitals. The following are key areas of action and priorities:

    – Covid treatment capacity: maintaining critical care infrastructure (workforce, estates, supply, medicines) that enables readiness for future covid demand, and managing the separation of covid and non-covid patients.

    – Re-starting non-covid urgent care, cancer, screening, and immunisations, identifying the highest risk services that have had the most impact in terms of population health. This includes recovering service waiting lists and delayed referrals.

    – Services have been prioritised including cancer, maternity, cardiovascular disease, heart attacks and strokes, mental health. There has clearly been an increase in the number and length of time people are waiting and the system is building a complete picture of the impact of this as an anticipated increase in GP referrals takes place.

    – Addressing new priorities: the impact of covid-19 on public health including identifying additional needs due to the pandemic and considering health inequalities. This specifically includes responding to the clear evidence to have emerged on the disproportionate impact of covid-19 on the BAME community. We also anticipate increased demand for mental health

services and support due to the economic consequences of covid-19 such as increased unemployment for example.

- Staff capacity and wellbeing: including capitalising on new ways of working, considering staffing ratios and moving the current expanded workforce to a sustainable footing.

- Working jointly with LRF partners through the Health and Wellbeing Board. Using national resources (wellbeing apps) and support for resilience and counselling.

- Working closely with BAME colleagues within the NHS workforce to ensure we understand their concerns and respond to them. BAME colleagues must have the reassurance and confidence to feel safe carrying out their work. A programme of risk assessments and listening exercises has been undertaken and through the HWB specific resources have been developed for BAME staff.

Social Care

31. In response to the pandemic and in accordance with legislative changes and government guidance for local authorities, Adult Social Care services have been reviewed and amended to enable continued service delivery. A covid-19 Recovery Group is in place with senior managers and business partners to oversee and lead the recovery and escalation process.

32. This involves planning and actions in place to embed new ways of working, enacted during this phase of the emergency, to restore prior services where appropriate, and to future proof service delivery where this can benefit both people who use our services and staff.

Impact on services

Provider market

33. Enhanced support for care homes and domiciliary care providers continue to be in place to provide advice and information, financial and practical support where appropriate. Daily contact and data collection continue to be undertaken to track activity and operational issues as they emerge. Regular provider forums are held, and bulletins issued to keep communication live and up to date.

34. Community and day services, and short breaks building-based services, have been closed or significantly reduced because of social distancing and infection control measures, but services are being provided where needed in people's homes and to support access to some daily community activity and virtual

support. Recovery plans and individual risk assessments are underway for the reopening of services where appropriate. Care staff have been redeployed to support home-based care and carer support.

Hospital Discharge

35. Hospital discharge continues to be a significant area of focus with new Discharge Guidance issued in March 2020 to cover the Covid-19 emergency period of 19 March –31 August and revised guidance issued on 24 August to be in place from 1 September. The requirement for timely discharges remains and post discharge support for up to six weeks for recovery/reablement packages will be funded by the NHS.

36. The Home First pathway will be utilised to support timely discharge and plans are emerging to effectively resource this offer jointly with the Clinical Commissioning Groups (CCGs) to maximise the opportunity for recovery and reablement post discharge in line with the revised Hospital Discharge Guidance.

Case management demand

37. There continues to be an increase of mental health and safeguarding referrals to teams reflecting the anxiety and uncertainty of the current situation. Access to Health support is still limited and yet to return to normal access levels.

38. People who have received post-discharge support in the emergency period (19 March-31 August 2020) remain Covid-19 funded. Reviews are to be undertaken to ensure that people are in the most appropriate setting for recovery and that their support is maximising their opportunity for increased independence. Those that are not eligible for continued health funding following review will transfer to the appropriate funding stream with a deadline of 31 March 2021 to complete this backlog.

39. Following the changes made to services during Covid-19, individual reviews are being undertaken for working age adults to look at the future Community Life Choices provision to promote enablement and progression to more opportunities for independent living.

Prevention Services

40. Adult Social Care and Public Health services have been co-ordinating and aiding the 25,000 clinically vulnerable people identified as requiring shielding in Leicestershire, working closely with district and volunteer services to provide safe and well checks and practical support where needed. This support has now ceased, with arrangements in place to pick up any further requirements through local outbreak planning.

Workforce

41. Most staff continue to work from home, with limited office based activity based on individual risk assessments and service priorities .

42. Face to face visits have resumed where appropriate with Personal Protective Equipment (PPE) as needed. IT and digital solutions are in place to support productivity.

43. There has been a decrease in general absence rates and Covid-19 related absence is currently at less than 1% across the department.

Finance

44. There has been a significant financial impact on adult social care which could be potentially in the region of £13.5m including:

    - Care providers have been supported by the end of July with around £3m for additional costs being incurred and £11m in an advance payment to support business cashflow.
    - £6.5m of the Infection Control Fund passed directly to care providers.
    - Changes in the level of demand from the service users for commissioned services.
    - The cost of hospital discharges is estimated to be £4m by end of July which will be funded by the NHS Covid-19 Discharge Fund.
    - The costs of the new discharge arrangements from 1 September 2020 are yet to be determined
    - Delaying planned changes to services for example moving service users from residential care to supported living.
    - Loss of income from service users for commissioned services
    - Additional cost of PPE is estimated to be around £700,000 for services provided by the Council.
    - The continued Covid-19 demands look likely to extend beyond this financial year and could increase again should infections rates increase and restrictions reinstated.

Opportunities

45. Significant practice and service delivery changes have been implemented in a very short space of time. New ways of working have been adopted and many services have been re-organised.

46. People in receipt of services have experienced a different set of service interventions and in some cases, this has had a positive impact on them which has led to opening discussions with providers about alternative models of care. Service users will be enabled to self–serve when finding out information and undertaking basic assessments to support their independence and are enabled to digitally engage with our services.

47. Delivery of preventative approaches to shielding vulnerable people with district councils and the voluntary sector has demonstrated an ability to share data and information, integrate service offers and provide a model of countywide and localised delivery.

48. Improved joint working with health partners delivering integrated services has been experienced as staff have worked together to respond to Covid challenges. This has enabled timely hospital discharge and reduced delayed transfers of care.

49. Digital solutions will be the first point of call where they can be effectively utilised to prevent, reduce, and delay people's pathways into social care, or where they can be effectively utilised to meet care needs. Our working processes should prioritise digital solutions where they save staff time and money, and our service user records and data will be fully integrated with health as part of the place-based approach.

Challenges

Integrated pathways of care

50. Hospital discharge support has seen an increase in Adult Social Care resources to support rapid discharge and commissioning of health funded packages. If this increased level of responsibility and activity is to be sustained there will need to be an agreed discharge model with partners going forward that aligns to the Adult Social Care principles of promoting independence and care in an ideal setting.

51. Our Home first pathway is currently reliant upon temporary funding sources being supported by BCF and Ageing well funding.

52. The new Hospital Discharge guidance supports the Home First principles and makes clear that this should be resourced effectively to enable DTA at home as the default option.

53. The Department will need to ensure that appropriate and effective jointly commissioned support is available to fulfil this requirement.

54. Transition of the hospital discharge emergency support packages to the appropriate funding authority will need to be carefully managed to ensure that people have the right level of care post recovery and that they receive a financial assessment for ongoing social care support to agree their contribution to the costs. People will have been in receipt of free services for an extended period including those who would normally pay the full cost of their services.

55. From the 1 September 2020, the Continuing Healthcare assessment will be reinstated. The risk of increased health and social care long-term funding, if not carefully managed with joint agreement, is significant. Weekly planning meeting with partners have been set up to oversee this process and ensure that the back log is completed by 31 March 2021.

Provider Sustainability

56. The current provider market has been a key focus of Adult Social Care support as the availability of good quality, safe and affordable services is vital to ensure need can continued to be met. Recruitment, training, management and emergency planning, funding and access to PPE has been put in place. However, it is likely that the sector will continue to require support for some time to come. In addition, the effect of the pandemic on the sector has been to reduce occupancy rates within care homes which may impact on the financial sustainability of some care homes.

57. Domiciliary care providers have maintained and, in some cases, increased capacity but continue to struggle to recruit and retain staff. As hospital demand and activity increases and community referrals return back to pre Covid levels it is likely that domiciliary care services will see demand outstripping capacity. This maybe compounded by changes in the expectations of families and the way the public use care services with less focus on residential services.

58. The system needs to recognise the joint responsibilities and interdependency of available and good quality social care support for all pathways of care to achieve the outcomes for people who use health and social care services. Joint commissioning of services ensures that this can be delivered as a system. Integration of care pathways needs to support the system-wide outcomes for people that leads to resilience, good health and wellbeing.

Local Picture

59. The Council started receiving granular data on pillar 2 cases in late June. Since then Leicestershire had reduced its rate of infection from twice the national average to below the national average.

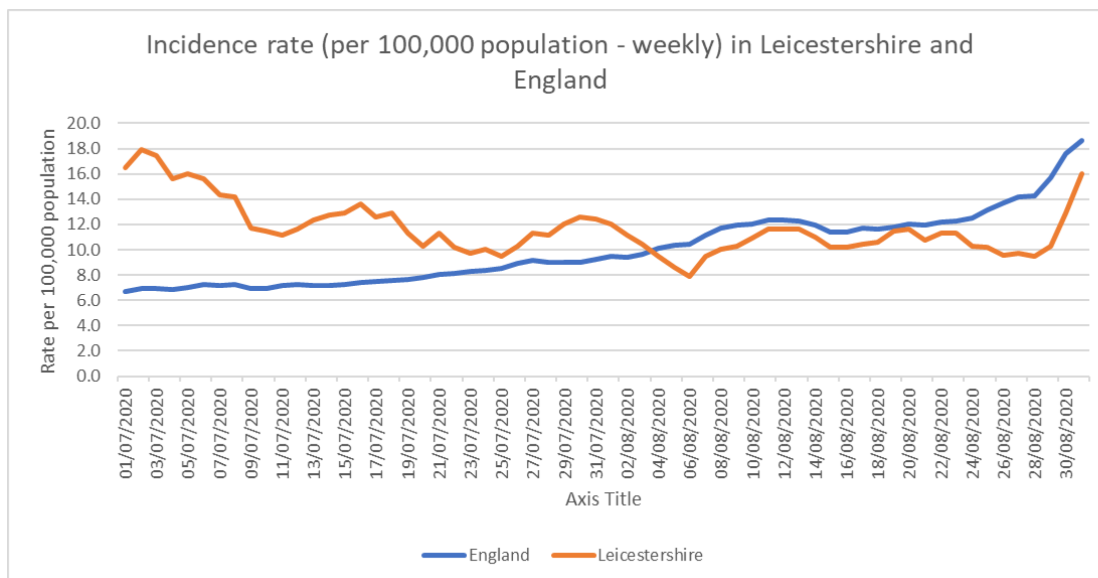
60. The figure below shows that going into July, Leicestershire's seven day rate of infection per 100,000 stood at about 16/100,000 compared to a national average of around 7.

61. Through July and August, the national average rate has been slowly rising whilst the Leicestershire rate has, overall, decreased. The Leicestershire rate went below the national average in early August and has remained below that since.

62. To achieve that against a background of the high rates in Leicester during lockdown, the higher rates in Oadby and Wigston at that time, and a subsequent surge in cases in Melton, is testament to the work of Health and Wellbeing Board member organisations across Leicestershire.

63. Within the County, there has been good joint working across districts and County Council to coordinate the response. Through jointly targeted communications, engagement with the local population and the deployment of increased testing, we have shown that it is possible to control the virus locally.

64. There has been, though, a sharp increase in cases both locally and nationally in recent weeks, with the local rate doubling in the first week of September.



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Equalities and Human Rights Implications

65. There are no equalities or human rights implications arising directly from the recommendations in this report.

66. The pandemic of the covid-19 virus has required the Council and other partners to be flexible and responsive in the way in which it delivers its services and performs its functions. The Council's Corporate Equalities Board, together with Departmental Equality Groups will play a key role in monitoring the impact of any changes.