Comisiwn Bevan Commission

Care Homes facing the Next Covid-19 Wave: Learning from the past to inform actions

A Bevan Commission report informed by a Round Table Event, under Chatham House Rule

November 2020

Introduction

This paper builds upon discussions by the Bevan Commission on matters relating to Care Homes more broadly and the impact and implications of Covid-19. The need to focus on short term actions was identified to help inform the most urgent decisions and necessary changes. To further inform their discussions a Round Table Event, based upon Chatham House Rule, was held on 8 September 2020, attended by invited representatives drawn from the Care Home sector, NHS, local government and the third sector. Five Bevan Commissioners attended as Chairs for event and the breakout sessions.

The event focused upon, '*what **short-term actions** needed to be taken so that Care Homes can, going forward, avoid the excess deaths experienced at the outset of Covid-19, whilst also meeting the wider needs of residents and their relatives'*. The context for this was the possibility of a second wave of Covid-19 impacting on Wales in the future, which is even more relevant now as we see cases rise significantly. The key actions identified by the Bevan Commission aim to help contribute to the ongoing effort by many to improve care in homes through Covid-19. It reinforces much of the work already underway. In particular, the guidance set out in the most recent Care Homes Plan[1] by Welsh Government and the recommendations contained in Welsh Government commissioned 'Rapid Review for Care Homes in Relation to Covid 19 in Wales' [2], to ensure Wales takes the necessary steps to overcome Covid-19.

Summary: Key actions

1. Strategic and operational leadership and two-way communication with all parties (including residents) should continue to be strengthened across Health and Social Services for the safety and viability of Care Homes.

2. Increase access to support to Care Homes through staff redeployment, support to train staff and providing shared services.

3. Ensure rapid access to Test Trace Protect (including repeated testing to detect asymptomatic infection levels), for staff and residents is maintained.

4. Ensure planning for future care needs are based on individual needs and circumstances with personalised care plans, particularly in reducing isolation and ensuring that care plans are not subject to 'blanket policies'.

5. Establish/continue home visiting Multi-Disciplinary Teams.

6. Keep under review the applicability and adherence to procedures and guidance for in-house care of residents (including those with Covid) and the process for transfers to/from hospital.

7. Maximise efficacy of existing networks to share ideas and find solutions together.

Round Table Format

The Round table event heard first from speakers providing different perspectives from Care Homes, General Practice and Health Boards. Subsequent discussions were focussed through three breakout sessions, each considering a particular theme:

Breakout 1: Experience, Engagement and Connectedness.

What would improve the experience, engagement and ‘connectedness’ within a Care Home (including end of life care)?

How do we maximise rights to personal contact and information, reducing loneliness and social isolation at an individual and Care Home level?

Breakout 2: Quality, Governance and Accountability.

How do we ensure that people in Care Homes receive safe, high quality care, who is accountable and what governance is needed to sustain it?

Breakout 3: • Meeting particular needs.

What changes might be needed to ensure particular needs- such as the residents with dementia, mental health needs or learning difficulties, as well as the needs of the staff-were met?

The Breakout Groups

Although each breakout group was allocated a particular focus, in reality there was considerable overlap between the three groups as discussion clustered around issues such as respect for personal autonomy, responsibility, the financial (and operational) fragility of the sector and system preparedness. There was a recognition that the country has been facing an unprecedented situation with regard to Covid 19 with a rapidly changing environment as it evolved requiring immediate actions at scale and pace..

It was important to learn from experiences to date to ensure that, moving forward, we adopt robust policies and practices to secure the safety and wellbeing of both residents and staff.

During discussions, many participants emphasised the need for a balanced approach in relation to matters such as the management of infection risk versus people making choices to see relatives etc. The following sets out the consolidated output across the groups which was used to inform the final key actions.

i. Autonomy

- The issue with regard to Covid 19 and Care Homes is not merely about protection but also about the individual's quality of life. There were reports of social isolation creating real distress and severely aggravating underlying mental health issues. Going forward there is a need for Local Authority and NHS Community leads and NHS hospital managers to be better at listening to and acting on the concerns of those living in Care Homes as expressed by the resident or by their personal representative, and also of those working in them. People living in Care Homes need 'agency' and not just seen as the passive recipients of decisions about them being made by others.

- Local Community clusters need a single point of contact (preferably a manned telephone number) for residents, their advocates and staff to contact directly with concerns. This single point to contact should be established, reporting directly to the Cluster lead, with a log of issues raised and actions taken.

- At the outset of the Covid 19 crisis, there was a general acceptance of the necessary restrictive measures. Over time, however, residents and relatives recognised the need for a more balanced approach-especially, as Covid 19 shows no sign of disappearing in the short to medium term. That balance has two core elements. Firstly, recognising that many people want to make informed decisions on the amount of risk that they wish to be exposed to, for example, if a married couple wish to visit each other, even if one has been diagnosed with Covid 19. Secondly, a flexible and quick response to local

conditions that allows protective measures to be rapidly increased and subsequently de-escalated.

- With regard to end of life support, it was vital that all planning was tailored and specific to individual needs and not in any form collectively based on factors such as age, or disability.

- Training in Advanced Care Planning for staff was important and there should be a coordinated drive to ensure training is delivered across Wales.

- Some care home residents were concerned that they were being seen as second-class citizens in terms of the ability to access health care within primary and secondary care. That concern should to be recognised and explicitly alleviated by NHS Wales.

- We advise that the revised NHS Wales guidance on CPR decisions is used as a benchmark against which Care Inspectorate Wales audits decision making across social care.

ii. Variation in system quality, response and accountability

- During the initial Covid 19 crisis, (especially during April/May 2020), there was variability in the quality of Covid 19 care in Care Homes and also in their ability to access medical services, equipment and support. Variation also existed between geographical areas within Wales in terms of adequacy of response, staff availability etc and the lack of a whole system response to local problems.

- The inability to identify a single person in a locality with responsibility and ultimate accountability to Welsh Government, for ensuring the safety of the Care Home sector was highlighted. There is a need for a clearly designated strategic and operational leadership across health and Social Services at all levels: National (Welsh Government) local (Local Authority/Health Board/Regional Partnership Boards) and community levels (Clusters). Those individuals should have responsibility and accountability for working with Care

Home providers at an operational level to ensure the safety and wider wellbeing needs of the Care Home residents are met.

- One of the ways the efficacy of such leadership could be monitored is by a review of the actions taken against the log of calls to the dedicated call line (as suggested above).

- Some Care Homes experienced difficulty (especially at the outset of the Covid 19 crisis) accessing a range of services including; general practice, mental health assessments, specialist end of life support and access to equipment such as syringe pumps. Some homes have had an excellent service, but others have not, and overall service provision has been inconsistent (in practical terms this felt like a post-code lottery). This linked back to concerns over governance and identifying who is actually responsible for ensuring Care Homes receive such support when requested.

- There was a general view that in the longer term the GP contract needs to change to ensure greater consistency and support is provided to Care Homes than is currently the case. In the short term, Health Boards (and clusters) needed to have in place contingency plans that ensured access to GP support to all homes. Given that the availability of primary care would vary from practice to practice depending on factors such as staff illness etc, those plans needed to be flexible enough for one area to draw on the resources of another if required and should also include outreach support from secondary care.

- At the time of the Round Table (early September) the testing regime appeared to still have a problem in relation to turnaround times. A safe, efficient and reliable testing system including the possibility of retesting was seen as being crucial for the wellbeing of both staff and residents. We are aware WG and PHW are monitoring this closely and welcome the improvements made.

- A number of those present felt Care Homes should be represented at cluster meetings given their importance to local community service provision.

- We recommend that each cluster requires care homes in its locality to elect at least two representatives and their alternates, preferably from different care homes, to attend cluster meetings and that these representatives are required to report back across the sector in that area.

iii. Communication

- Communication (on PPE, access, testing etc) needs to be clear and concise. On many occasions, participants from the Care Sector felt this had not been the case and was often fragmented and difficult to follow. This had been compounded by a tendency of public agencies to consider all Care Homes as the same, despite huge variations in size, whether they are single ownership or part of a large group. Smaller homes may need more support, as they are unlikely to have the infrastructure to respond readily to complex and changeable guidance/instructions.

- Communication to the Care Home sector has come from various sources and was at times confusing. It needs to be consistent and concise and sensitive to the differing nature of homes across the sector.

- The guidance for Care Home resident's attendance at A&E/hospital and subsequent discharge to Care Homes should be clear and consistent across Wales. We endorse the work being undertaken to ensure that Welsh Government guidance is adopted, particularly the use of 111 to plan transfer of non-urgent cases in an effort to avoid long waits.

- There was a need and an opportunity to enable the care home network to share and adopt ideas and good practice and help and support each other Wales wide.

- We commend the initiative of the current WhatsApp group formed amongst Care Home owners and staff and other social medial platforms.

iv. System Fragility

- The care sector in general and Care Homes as part of it could be characterised as complex and fragmented. There are 1264 care homes in Wales, providing over 26,000 beds, delivered across some 420 separate providers. Over 360 of these are single providers, with some having as few as 30 places. Most, (but not all) Care Homes are privately owned. The sector is regulated through Welsh Government's registration and inspection processes, but not managed in the sense that no single body or individual has overall responsibility for ensuring it operates efficiently, that it remains viable, or that residents are kept safe from the threat of Covid 19.

- The NHS relies on the capacity of the Care Sector to allow the discharge of a large number of patients from hospital beds. Therefore, if the sector (or even a part of it locally) collapses due to either financial or operational problems there would be a serious knock on effect on NHS capacity and of course on the people involved. The additional financial support provided by Welsh Government to the sector is both recognised and welcome.

- The fragility of the staffing situation within the Care Home sector was also highlighted as an issue with many low paid, transient and often undervalued staff who played a key role in keeping people safe and well. The recruitment and retention of staff was also an important factor in the long-term stability of the sector.

- We encourage the WG to proceed as rapidly as possible with promotion of training and registration of Care Sector staff to ensure appropriate assessed training and to raise the profile and standing of those working in the service.

The Future

Covid-19 has significantly exacerbated the financial problems the sector faces, to which the Welsh government had already put in financial support measures in recognition of those issues. If the continued prevalence of Covid-19 leads to a further fall in occupancy, further support is likely to be required.

Addressing the issue of the operational and financial fragility of the care sector is essential for the long-term viability of social care in Wales. These, alongside issues such as the recruitment and retention of significant numbers of care staff and the funding implications of an increasing demand for social care, predated Covid-19 but will become even more pressing in the future. The Bevan Commission recognises both the significance of this and the difficult and complex issues it raises and it intends to undertake further analysis on these issues and the options over the coming months.

In the meantime, taking account of wider views, the Bevan Commission has identified the following actions as important in helping to ensure learning is assimilated, acted upon and continues to inform future care across Wales.

Key Actions

1. Strategic and operational leadership and two way communication with all parties including residents should continue to be strengthened at national, regional, local and community levels for the safely and viability of care homes. This should include GP Clusters, with responsibility and accountability for the strategic development of the Care Home sector as a critical asset and working with Care Home providers at an operational level to ensure that the needs of the Care Home residents are met safely and consistently. This requires digital connectivity to maximise remote connection for use by staff and residents.

2. Increase access to support to Care Homes through staff redeployment, support to train staff and providing shared services from Health Boards, local

government, and in particular from General Practice and mental health services. This includes procedures to support volunteer training*, providing access to shared services and facilitating cross boundary working to enable NHS staff to be deployed to Care Homes as required, whilst taking steps to minimise any infection risk from moving staff between areas.

3. Ensure rapid access to Test Track, Protect (including repeated testing to detect asymptomatic infection levels), for staff and residents is maintained. Care Homes must be able to access Testing with rapid results within 24 hrs to allow infection to be isolated and staffing maintained safely.

4. Ensure planning for future care needs are based on individual needs and circumstances with personalised care plans, particularly in reducing isolation and ensuring that care plans are not subject to 'blanket policies'. Whilst Advanced Directives and/or Powers of Attorney should form part of the overall planning, they should not be unduly emphasised. In the initial outbreak attempts to get such directives in place at pace, gave some residents and their relatives the impression that the Care Home residents were being 'abandoned'. To help reduce isolation and facilitate visiting and family connections schemes such as 'Safe Rooms'** with appropriate cleansing protocols should be considered and introduced.

5. Establish/continue home visiting through Multi-Disciplinary Teams (MDTs) based upon clinical and social care staff who can visit Care Homes to conduct face-to-face assessments and physical examination of residents as needed.

6. Keep under review the applicability and adherence to procedures and guidance for in-house care of residents (including those ill with Covid) and the process for transfers to/from hospital.

This should include some of the Occupational Health approaches to making Care Homes more normal for residents including the introduction of Red, Amber and Green Zones *** and considering the use of 'Nightingale field hospitals' as step-down facilities if required.

7. Maximise efficacy of existing networks to share ideas and find solutions together. Existing networks, such as the Care Forum Wales WhatsApp group to spread ideas, find solutions and encourage improvements adopted pan-Wales. This can enable rapid responses to operational queries and share up-to-date information 24/7).

* Training extra volunteer staff to work temporarily within the social care sector (which might also increase interest in this being a permanent occupation) – noting the success of such training in Freetown, Sierra Leone, of the "Ebola Academy" run by the UK Military and MSF which, over 6 weeks, trained a few thousand Sierra Leonean volunteers.

** A Safe Room is one with external access for relatives and an internal access for residents, with the room separated into two by a clear plastic or glass panel to prevent physical touching or aerosol spread. Heated tents were used by at least one Care Home, but many Care Homes have suitable small rooms which open onto their garden which would be more suitable.

*** The introduction of Red, Amber and Green Zones replicates the successful approach by at least one major operator during Ebola in West Africa to sustaining commercial operations in an area of very high Ebola prevalence. How might it work? The Red area is for deliveries and for staff coming to work. The Amber area is for those who work in the home but do not come into direct contact with residents, or are awaiting entry to the Green area. Entry to the Amber area is via a gateway where temperature, symptoms and contact and travel area checked. The Green area is for those, including Residents and their staff who with a high degree of certainty do not have Covid-19. Rapid testing, whilst in the Amber Zone, should support this system. Green Zone participants would not normally wear protective clothing other than when undertaking specific procedures.

References:

1. Welsh Government (2020) *Care Homes Action Plan: Summary of Progress*. Issued 7th October 2020. Available at: https://gov.wales/care-homes-action-plan-summary-progress-html

2. Boulton J (2020) *Rapid Review for Care Homes in Relation to Covid 19 in Wales July-September 2020*. Available at: https://gov.wales/sites/default/files/publications/2020-10/rapid-review-for-care-homes-in-relation-to-covid-19-in-wales.pdf.