Updated Review of Covid Learning

Paper prepared for consideration by

London Borough of Ealing

by

Ealing Reclaim Social Care Action Group (ERSCAG)

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Updated Review of Covid Learning in the London Borough of Ealing July 2021

Introduction

In August 2020, drawing on public materials provided by Ealing Council staff and elected officials – especially the discussions held at relevant Council committee meetings[1] - Ealing Reclaim Social Care Action Group (ERSCAG) prepared a "Review of Covid Learning". ERSCAG believed that it would be helpful in advance of any national and/or local inquiry to have brought together useful local lessons from the pandemic response to date. The paper (see Appendix) was briefly discussed at the Council's Health & Adult Social Services Standing Scrutiny Panel (October 2020).

This current paper updates that earlier review, taking into account the learning in Ealing from the last twelve months of the pandemic.[2] In the interim, government has decided to establish a national inquiry in 2022.[3] ERSCAG believes that local insights into developments on the ground should form part of that inquiry and indeed may have some relevance for current local and national debates around the question of reforming the social care system generally.

Learning in relation to residential care

ERSCAG believes that the learning from the pandemic suggests that:

1. NHS policies should formally recognise that discharges to residential care should not occur without proper infection testing and controls to ensure that infections are not inadvertently transmitted onwards.[4]

[1] See ERSCAG/Council exchanges in 2020 - 26 March, 12 June, 3 and 13 July; on care home deaths specifically 22 June, 10 and 17 July; and discussions at Health and Wellbeing Board 7 July and Adult Social Care Scrutiny Panel meeting 22 July 2020.

[2] Since the August 2020 review paper, ERSCAG has also attended all the committee meetings of both the Adult Health & Social Services Standing Scrutiny Panel and the Health & Well Being Board.

[3] Hansard parliamentary report dated 12 May 2021 in speech by Prime Minister: *"I can confirm today that the Government will establish an independent public inquiry on a statutory basis …..I expect that the right moment for the inquiry to begin is at the end of this period, in Spring 2022".*

[4] In 2020, the Guardian reported (29 May) that the Department of Health & Social Care 2 April guidelines on discharge from hospitals said "Negative tests are not required prior to transfers/admissions into the care home". A Freedom of Information request made by a local reporter learnt (email dated 29 July 2020) that, of the 119 patients discharged to care homes in NW London (not necessarily Ealing) between 1 March/15 April 2020, only 32 were tested.

2. The NHS/Local Council should maintain the potential of something akin to the 'step down' measures introduced locally and early on, to facilitate effective discharge & end delays in discharges from hospital.

3. It proved beneficial to have a single GP practice covering a large number of nursing home residents across the Borough since it allowed for an early identification of common problems.[5] It was also good that the Council took early control over care home issues (eg provision of PPE, privileging supplies, infection control measures etc). The Council also monitored closely the long-term viability of local provision (even negotiating closure of some care homes to new admissions when necessary). Prior to a return to the 'status quo ante' the Council should consider which of the powers and administrative measures that facilitated cooperation across and between care-homes (and between relevant statutory bodies – NHS/CQC/CCG etc.) during the pandemic should be retained over the longer term?

4. Efforts should be strengthened to ensure that anyone residing in a care home merely because they are awaiting the provision of alternative accommodation is speedily re-housed.

5. The experiences of voluntary take-up of vaccinations in care-homes and by care-home workers – and regular testing - should be tabulated to monitor the nature of any vaccine hesitancy and the difficulties posed in extending vaccinations and testing to all care-home workers (eg the practical challenges of different work rotas). Is there more advice to be shared between care home providers and the Council? (The imminent introduction by government of compulsory vaccinations may also throw up additional issues to be monitored).

ERSCAG noted that, throughout the pandemic, the privatised and highly fragmented nature of care-home provision created particular challenges that the Council has had to overcome. In the August review, we noted a range of national research studies[6] which suggested that - post pandemic – Councils should use their experiences on the ground to (re) assess issues such as:

[5] **https://www.theguardian.com/world/2020/apr/22/without-a-plan-its-not-going-to-stop-care-homes-fear-worst-yet-to-come-covid-19** includes an interview with Dr Anna Down, a doctor with the Argyle practice in Ealing working with 1000 nursing home residents.

[6] For example, see data from ONS cited in August 2020 ERSCAG review which revealed that nationally there were more covid-19 cases in care homes that hired temporary staff; care homes that did not offer staff sick pay also had higher rates of infections; and the movement of staff between homes is seen as a potential vector for infection.

- Is there an optimal size for care-homes?
- Is Ealing receiving adequate extra funding to cover pandemic related costs, and continuing costs post-pandemic, for being a net receiver of residential/nursing home placements?
- Is frequent movement of staff between residential care-homes problematic and, if so, what counter-measures should be introduced?
- Is there any correlation between the quality of care provided by care-home managers and their use of temporary staff, staff training, the status, pay and working conditions offered their care workers?
- How can Ealing Council – as a London Living Wage employer for its own directly employed staff – promote the LLW as a basic minimum requirement for all care-home staff?

Learning in relation to domiciliary care

ERSCAG believes that there are a number of lessons arising from the pandemic that are useful to improving the Council's long-term work of supporting adult social care provision in the Borough. For example:

1. The Council should maintain (and regularly publicise) their emergency response contact number for social care users who fall ill, or whose PAs/carers fall ill, at short notice.

2. The Council introduced a variety of support networks for those shielding (to help with transport, shopping etc). The Council should evaluate how the various networks operated and consider if and how they might be retained post-pandemic?

3. The Council monitored the number and level of domiciliary care packages throughout the pandemic but future funding decisions should consider: (a) the importance of providing the LLW for all domiciliary carers; (b) the likelihood of increased demand for care packages if, as studies suggest, residential care appears a less attractive occupation in future, and the possible impact of people experiencing 'long Covid' and qualifying for social care support.

4. Closer contact and regular coordination of efforts between the Council and domiciliary care agencies evolved during the pandemic to monitor the latter's operational methods, financial resilience and sustainability.

Should the Council consider retaining these responsibilities over the longer term and what are the implications of greater Council oversight?

5. The pandemic required outreach to the Personal Assistants and carers employed by Direct Payment Users (for PPE supplies/vaccination arrangements etc); are the current administrative arrangements/ communication tools adequate, if a similar need were to become necessary in future? What additional support should the Council be able to offer Direct Payment users in future – for example, regarding recruitment/training of PAs?

6. There were examples of excellent liaison between all the relevant statutory bodies – do any of these have implications for future work on domiciliary care? For example, did the GP (and central NHS) records clearly note which of their patients were housebound (and unable to reach vaccination centres)? Are all carers registered as such with their GPs even if their caring work is carried out in a different Borough to where they are NHS registered? Is there any useful learning about the need for clearer divisions of work between the Council and the NHS (eg for those moving between Direct Payment and Continuing Healthcare packages) and the Council and the Care Quality Commission (eg oversight of domiciliary care agencies)?

Learning in relation to day-care services

It is difficult for ERSCAG to say much in relation to the learning regarding the provision of day-care services since there has been no systematic reporting on such services at the Council committee meetings we regularly attended.

We understand that the Michael Flanders Centre in Acton, and Cowgate Centre in Greenford remain closed and, as of June 2021, the Scrutiny Panel was given no dates for their re-opening. Relevant voluntary organisations have been supported by the Council to fund placements so that staff could set up outreach and sessions on zoom, allowing service users and carers to learn IT skills and enjoy art, exercise and healthy living sessions at home on a regular basis. However, in terms of the quality of life of day-care users (and the importance of meeting friends, following regular routines, and respite for carers), the provision of 2/3 hours a week is totally inadequate when compared to the 3 or 4 days a week of day care provided pre-covid.

It is not clear from the public record what is happening to these service users and their carers - how are they managing? are their carers able to provide extra care at home and is this to the detriment of their own health or well-being? Even with the gradual reopening of day-care centres, voluntary groups have reported substantially reduced attendances, due to continued fear of the virus in group situations or on public transport. This in turn puts at risk the financial viability of some service providers with the possible closure or downsizing of centres. Continued Council support remains vital as the services, and their clients, continue to adapt to the evolving situation.

One important lesson from the covid period would appear to be the value of the Council keeping disaggregated statistics about its day-care users. National reports[7] show that virtually every aspect of daily living has been devastated for people with learning disabilities: loss of friendships, erratic health care and checks, anxiety and mental health breakdowns, as well as the closure or partial closure of centres and projects. But do we know what this means at the local level: how many people in Ealing with special needs were hospitalised or died of covid;[8] are vaccination take-up rates monitored along these lines; how have needs changed in the intervening period - what are the consequences for transition services and young people in special education moving to adult services and what will happen to supported employment projects which relied on employment in the hospitality, retail and catering sectors, given that many employers must be under pressure to withdraw from the schemes.

Learning in relation to social care more generally:

ERSCAG has only drawn on publicly available material, so there are probably many areas of the Council's response to the pandemic that we are unaware of, and which would benefit from more reflection. We can at least note:

1. More work might be done to improve communications:
    a. Communication tools already available (regular Council bulletins; outreach in different languages, work via third parties etc) were well used; but additional tools might have helped.

[7] See reports by Inclusion London: Abandoned, Forgotten & Ignored (June 2020), and most recently the Association of Directors of Adult Social Services (ADASS) https://www.adass.org.uk/media/8647/adass-rapid-learning-review_ld-autism_may-2021_recs_v9.pdf.

[8] For national concerns (people with learning disabilities five times more likely to be hospitalised, and eight times more likely to die of covid), see British Medical Journal https://doi.org/10.1136/bmj.n1701 (15 July2021)

b. Social care users reported the need for more clarity about who to address their many questions to at different stages of the pandemic (supplies of PPE, shielding situation, vaccinations etc). To avoid 'pestering' overworked staff, a better coordination of the information effort could be developed.
c. Are the contact details of all social care recipients/their carers/ available centrally to the Council to facilitate easy circulation of relevant information? In the light of the pandemic, does any such central resource need up-dating?
d. Are there any particular communication needs that need further consideration (for example deaf-blind residents, or those not digitally connected)? Those in receipt of social care and in routine contact with the Council should be encouraged regularly to check their files have accurately recorded their "preferred method of communication".[9]
e. Can other channels of communication be opened up? Regular updates sent to local Councillors/MPs/domiciliary care agencies etc. could all ensure that accurate information gets to as many people as possible, and people get the reassurance they need. For example, Councillors at the HSC Scrutiny Panel meeting (10 February 2021) suggested a regular Q&A sheet to help them answer questions from the public & reduce staff workloads.,

2. In our August paper, we noted that there seemed to be "*a need to have a clearer division of responsibilities and/or better coordination between national and local government decision making; clearer division of responsibilities and/or better coordination between the NHS/local Council's public health services; and better, and more timely, disaggregated and localised data*". Certainly, early on in the pandemic, it appeared that many problems arose in Ealing because of decisions made elsewhere (about hospital discharge policies, PPE supplies, contact and trace etc). More recently, the devolution of issues like contact tracing to local public health efforts seems to have ensured a much more effective response: local community/linguistic/and geographic know-how proved invaluable in compliance efforts. It would be important to record early problems in the division of work between national and local authorities, and their solutions, for any eventual national review or inquiry that is instituted.

[9] This suggestion arose at a June meeting of ERSCAG's Direct Payment User Group with Ealing staff members.

3. It would also be important to record – and try to maintain – the many excellent initiatives introduced in response to covid, but of much longer-term value. To take just one example: Northwick Park appointed a specialist nurse to help care for Learning Disability patients on the wards during the pandemic. Such a post facilitated communications between NHS/social care professionals and people with learning disabilities/their families/carers, thus facilitating hospital admissions, care and subsequent discharge. This measure is beneficial to all concerned, reflects well on the cooperative links built up between health and social care practitioners and, as with many other similar measures, should be considered a positive long term change to be maintained post-covid.

4. Government has claimed[10] in relation to the Brexit transition and care workers from the EU that "*we do not anticipate the end-of-transition will have an immediate impact on workforce supply".* This is not the experience of Direct Payment users in Ealing who have heard both of Personal Assistants who have already resigned and domiciliary care agencies that report a loss of staff who are EU nationals. The Council needs to monitor such issues closely and if appropriate, consider intervening in national policies (on work visas, immigration policies, workforce monitoring, pay & condition issues for care workers etc) that create practical problems on the ground.

5. The Council is currently undertaking an Integrated Equality Impact Assessment which presumably will hold extensive lessons for the provision of Council services, including social care, in future. The June 2021 Health & Well Being Board meeting noted that the findings of this project would feed into the future HWB Board strategy for 2022-2027 and the Council plan more generally. People in receipt of social care, and the social care workforce, are likely to be disproportionately represented in the various characteristics covered by the Equality Act (gender, race, age, disability etc) as well as in socio-economic deprivation indices. ERSCAG assumes that recommendations will include issues such as disability and racial equality training for staff? Is the Council able to access relevant disaggregated statistics, or does it need to devote more resources to such work? See earlier comments under day-care services – national reports reported the number of

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/957124/gov-resp-to-hscc-rep-on-asc-funding-and-workforce-web-accessible.pdf

covid-related deaths for people with learning difficulties, do we know the statistics for Ealing?

6. ERSCAG understands that Healthwatch Ealing is working on a BAME Inequalities Research Project. Mention was specifically made to them intending to review "the patient experience" of Ealing Hospital but it would be important that they also look at any differential experiences on grounds of race within social care.

APPENDIX – August 2020 REVIEW

This document is attached since some of the earlier footnotes/sources may still be of interest

Review of learning post-covid in Ealing

Paper prepared for consideration by
London Borough of Ealing by
Ealing Reclaim Social Care Action Group (ERSCAG)
As of August 2020

Ealing Reclaim Social Care Action Group (ERSCAG) has been in regular touch with Council staff and elected officials about the impact of covid 19 on social care provision locally.[11] This is our write up of the learning to date.

1. Learning in relation to residential care

1.1: The NHS's discharge policy from hospital: The NHS issued (19 March 2020) a default status of "discharge home today" which led to people being discharged across England from hospitals to care-homes without testing.[12] Mitigating measures were subsequently taken, but in future, these must be in place prior to discharge. Most obviously, no-one going into a care-home setting should be discharged by the NHS without testing to ensure that they are free of the virus.

1.2: Intermediate steps – the creation for patients leaving hospital of step-down measures at the Mary Robinson unit for patients discharged with a positive covid diagnosis and/or community transition beds at Manor Court Nursing Home are vital. These measures help counter any 'bottleneck' when patients are ready to be discharged from hospital but not ready to go to a care home setting (given the high risk for all other care home residents).

1.3: Early warning signals: Ealing benefitted from early warning signals – for example, nearly 1000 Ealing nursing home residents are catered for by one single GP practice (the Argyle Care Home Service). This factor ensured that, in Ealing, it was quickly spotted that residential care provision – which is extensively privatised and therefore highly fragmented - was facing severe problems.[13] Presumably the Argyle Road surgery can continue to perform this role in future for nursing homes in Ealing, but the Council may also want to look for additional early warning mechanisms: similar to the Argyle coverage (more coordination efforts with other GP hubs; an openness to 'whistleblowers'[14])?

1.4: Other measures: Care-homes – see initiatives such as the Joint Care Home Resilience Plan/Care Homes Cell – need continued support from the multi-disciplinary groups set up to respond to the first wave:

- To provide regular (currently weekly) contact from the Council for advice on infection control, with more frequent contact for individual care homes as need be;
- To maintain Council support for assistance with timely and adequate supplies for PPE/testing/privileging of supplies etc;
- To ensure advice & support in discharging people out of care homes speedily if they are only awaiting alternative accommodation;[15]
- To negotiate closures of care homes to new admissions when necessary;

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[11] See ERSCAG/Council exchanges 26 March, 12 June, 3 and 13 July; on care home deaths specifically 22 June, 10 and 17 July; Health and Wellbeing Board, 7 July; and Adult Social Care Scrutiny Panel meeting 22 July.

[12] The Guardian reports (29 May) that the Department of Health & Social Care 2 April guidelines on discharge from hospitals say "Negative tests are not required prior to transfers/admissions into the care home". A Freedom of Information request made by a local reporter learnt (email dated 29 July) that, of the 119 patients discharged to care homes in NW London (not necessarily Ealing) between 1 March/15 April, only 32 were tested.

[13] https://www.theguardian.com/world/2020/apr/22/without-a-plan-its-not-going-to-stop-care-homes-fear-worst-yet-to-come-covid-19, which includes an interview with Dr Anna Down, a doctor with the Argyle practice.

[14] See for example May 12th, the Daily Telegraph's International Business Editor quoted from an email received from a cardiologist: "*We discharged known, suspected and unknown cases into care homes which were unprepared, with no formal warning that the patients were infected, no testing available, and no PPE to prevent transmission. We actively seeded this into the very population that was most vulnerable…..We let these people die without palliation. The official policy was not to visit care homes — and they didn't (and still don't). So after infecting them with a disease that causes an unpleasant ending, we denied our elders access to a doctor — denied GP visits — and denied admission to hospital. Simple things like fluids (and) effective palliation like syringe drivers, withheld.*"

[15] Early in the pandemic, ERSCAG notified Adult Social Services of individual care-home residents in this situation.

- To ensure oversight of the long-term viability of all local providers and have measures in place for speedy intervention as and when necessary;
- And to distil any lessons learnt elsewhere[16] which could usefully be applied here in Ealing in respect of: the need to reduce the movement of staff between care-homes: the optimal size of care-homes; the importance of minimising the use of temporary staff; and the correlation between the quality of care on the one hand, and the status/pay/working conditions of care-workers. Ealing may of course also have useful experience to share with others.[17]

1.5: Outstanding questions on residential care which probably still need to be addressed/resolved by the Council:

a. Did any *individual* care-homes have a very worrying - or positive - experience in terms of deaths, levels of infection, extent of staff turnover - and what consequences and learning should follow on from this?
b. Does the Council need to maintain a higher level of contact/control over care-homes in the longer term, and what does this mean in terms of privatisation of care home provision and out-sourcing of Council duties?
c. Were the informal arrangements for joint working between the Care Quality Commission and the Council adequate during this emergency period? What changes, if any, are needed to their respective statutory powers for any future waves of infection?

2. Learning in relation to domiciliary care

2.1: Emergency service: For people receiving support from Personal Assistants or carers coming into their homes from the outside, the pandemic was (and still is) an extremely frightening time. At meetings[18] service users have reported that they found it reassuring to be reminded that the Council has a statutory duty to provide support if an individual's Direct Payment User's service fails, but expressed concerns about how this works in practice. Does an emergency service really exist and will it be maintained post covid? If domiciliary care users are to be able to access services 24/7, the emergency service needs to be:

- better known;
- properly maintained and adequately staffed;
- capable of signposting people onto vital services (eg a list of accredited care agencies if current care arrangements are at risk of failing);
- and be monitored routinely to ensure it is adequately resourced.

2.2: Communications: Frequent and clear communications with service users are essential. It cannot be assumed that everyone will have access to social media, so a variety of mechanisms need to be used. The regular Ealing Council bulletins are helpful; more regular outreach by phone would be appreciated; and communicating via third parties (voluntary groups, faith groups, care agency staff, local press and radio etc) is also important. Councillors/MPs should engage in active outreach to those in their wards/constituencies to encourage people with problems or needing information to get in touch via them.[19] There are also individuals and groups with particular needs – some for example may need material in languages other than English, deaf-blind residents must not be excluded from vital communications etc.

2.3: Shielding arrangements: Recipients of social care are disproportionately found amongst the 'shielding' category of Ealing residents. Many expressed appreciation for various Council covid initiatives, and the hope is that these measures (examples below) would be maintained, given the potential for future waves of the pandemic:

- Ealing Together
- Ealing Covid 19 mutual group
- Extended taxicard arrangements
- Privileging for PAs and others helping with shopping
- Supermarket priority delivery slots etc.

The Council may well want to do its own evaluation of how these and other similar services performed, but from the perspective of users, it seems that the very existence of these additional support mechanisms, and their forms of operation, were much appreciated and should be maintained for the foreseeable future. Small local voluntary groups often have much

[16] Data from ONS revealed that nationally there were more covid-19 cases in care homes that hired temporary staff; care homes that did not offer staff sick pay also had higher rates of infections; and the movement of staff between homes is seen as a potential vector for infection. Liverpool Council has also produced a new report on the in-sourcing of social care.
[17] For example, the Proud to Care London efforts to support care home staff recruitment may be a model for elsewhere; the West London Alliance work with the NWL Health was cited positively in the April 2020 government action plan.
[18] ERSCAG organised meetings with Direct Payment users (3 June and 5 August), having previously developed a case-study paper about the kinds of issues facing those in receipt of domiciliary care (February 2020).
[19] ERSCAG encouraged individual residents to contact local Councillors/MPs and informed them of follow up given (see April/May/June 2020 ERSCAG newsletters).

to offer to ensure that older people and those with disabilities can live lives as independently as possible as we all move out of the pandemic.

2.4: Care packages: In a very welcome step, Ealing chose not to exercise the power of easement granted Councils under emergency legislation.[20] Assessments and re-assessments of care packages are very worrying times for care-users, and even before covid 19 there was a widespread fear that these processes were being used to try and reduce Council expenditures.[21] These fears are all the more likely in the future. Already ERSCAG has received accounts of people being told that they may face reductions in their care packages, or who report receiving misleading information from Council staff regarding easements. The Council must monitor closely the number and level of care packages supported pre- and post-covid, and look at staff training, to ensure that the burden of handling the post-covid financial burden does not fall disproportionately upon those Ealing residents least able to cope.

2.5: Day-care provision: MENCAP nationally carried out a survey of service users and found that 69% of people with learning difficulties had their social care cut during covid 19.[22] ERSCAG has no way of estimating what this has meant at the local level but we do understand that the specialist support given by groups such as MENCAP Ealing was maintained throughout the pandemic (albeit often at the end of a phone/zoom call rather than face-to-face). However, we also understand that these services are now at risk precisely at a time when people with learning difficulties and their carers are beginning to feel safe enough to benefit from day-care services again.

2.6: <u>Outstanding Questions in domiciliary care</u> for consideration by the Council:

a. What is the learning (if any) about the ideal oversight of care provision to individual users and private care agencies? Infection control and the provision of PPE and other supplies - difficult enough for the care home sector - is all the more so when different agencies have domiciliary clients in the same road, when several visits to the home occur during one day, or a series of different carers are involved.
b. The Council has taken steps to monitor the financial resilience and sustainability of care-homes: do any steps need to be taken with regard to domiciliary care agencies and/or Direct Payment arrangements? Examples include: greater flexibility in covering the extra costs associated with infection control & disability related expenditures; more advice (upon request) for Direct Payment users regarding recruitment/training measures; more transparency and sensitivity regarding (re)assessments once 'normality' returns.[23]
c. Nationally, concerns were expressed about the use of temporary staff, pay and conditions for staff, and the links between these factors and rates of infection in care homes (see earlier). Is any of this relevant to the domiciliary care experience in Ealing and should the Council/Adult Social Care Scrutiny Panel ask for a report into the longer term implications of covid for domiciliary care, given that it was in crisis before the pandemic?

3. In relation to social care more generally:

It is clear nationwide that a number of early problems arose in relation to the supply-chains for PPE, testing, and monitoring the impact of centrally made decisions around discharge/care-home safeguards etc. The situation now regarding testing is still far from satisfactory. Many of the problems arose in Ealing because of decisions taken elsewhere. In future, there is a need to have a clearer division of responsibilities and/or better coordination between national & local government decision making; clearer division of responsibilities and/or better coordination between the NHS/local Councils' public health services; and better and more timely disaggregated and localised data.[24] What is Ealing Council doing to ensure that this learning is built in systematically to the response to any future waves of the pandemic? This learning would all be useful if any national review/inquiry is ever instituted.

[20] ERSCAG hopes that this practice will be retained even if the parliament renews these emergency powers in the Autumn.
[21] Social Care System in Crisis: The human story in Ealing, ERSCAG report, February 2020.
[22] See MENCAP press releases 10 and 20 August 2020 (www.mencap.org.uk)
[23] See earlier reference to February paper from ERSCAG highlighting many problems in social care – what really is the level of unmet need in the Borough and shouldn't the whole charging system be overhauled?
[24] eg An early awareness/understanding of covid's impact on BAME communities was crucial given Ealing's demography.