January 2018 PIPP-0118-C

Pandemic Influenza briefing paper: Community health care and social care

Issue:

1. **This paper sets out a framework of options to augment community health care and adult social care sectors response to an extreme influenza pandemic.**

Action required:

1. **Board members are asked to:**
   - **COMMENT on the content of the paper**

1.0 PURPOSE

The purpose of this paper is to set out a framework on key considerations and options to augment community health care and adult social care sectors response to an extreme influenza pandemic.

The majority of the detail in this paper will not be replicated in any publically available documentation and this must be borne in mind when sharing this paper beyond its initial intended audience. This paper is to be presented to the Chief Medical Officer (CMO), the Chief Scientific Advisor (CSA) and the Chief Nursing Officer (CNO).

A number of biological caveats also need to be considered, including the uncertainties around how and when a future pandemic may present, and the population age / risk groups who may be most affected. Additional caveats are set out and explained within the paper where relevant.

This paper is current as of January 2017. It is authored by the DHSC pandemic influenza team, DHSC Community and Transformation team with policy responsibility for Adult Social Care and NHS England, and considers both community health care and adult social care. Input has been sought from key contributors in NHS England, DHSC and partner organisations; this engagement will continue through the development of the service and local government facing guidance.

This paper can be read in parallel with the paper produced by NHS England for CMO, CSA and CNO as part of work stream 1 which focusses more on acute and primary care surge and triage.

This paper, and all data within it, refers to England only. Children's social care is out of scope of this work stream and this briefing paper. It is being considered as part of the Department for Education's sector resilience planning.

[DN: A key next step is to develop implementation plans for the suggested actions. This will include assessing what levers the national level has, including emergency powers and current legislation. Additionally, further work is required on decision making, including how/who does the prioritisation of services, balancing the clinical need against resource availability.]

2.0 INTRODUCTION

The provision of **social care** in England is a combination of state and self-funded provision for around **1.1 million** people receiving long term care a year. It provides **personal and practical support** for adults who need help with daily activities and is used by a variety of people, including the elderly and those with learning or physical disabilities. Most people receiving formal care are **supported by the state**, but there is a significant proportion who **pay for and arrange their own care**

The majority of long care term users are in **community settings.** A range of statutory, voluntary and private organisations provide adult social care services in England. These services are commissioned locally through Local Authorities.

Most **community health care** also takes place in people's homes or community settings. Around **15.4 million** people in England use community health services to manage their **long term conditions**, in partnership with primary and secondary care. These include diabetes, chronic obstructive pulmonary disease, coronary heart disease, arthritis and asthma.

There is an increasing emphasis on **personalisation of support** to enable people to remain and be cared for in their own homes and communities. Care at home remains a key part of the range of services to meet some users' needs. Community health care providers, alongside adult social care providers, are a key part of keeping patients out of hospital, by providing preventative services and/or on-going support, ensuring patients can be discharged. In an influenza pandemic, hospitals will need to treat only the most seriously ill, increasing pressure on community care services.

Community health care providers and social care providers are aware of, and are in regular contact with, many **vulnerable individuals** in the community. Such individuals might be either more vulnerable to, or more affected by, pandemic influenza. Other individuals, not normally perceived as vulnerable, may become so in the setting of a pandemic, e.g. single parents with young children, and adults living alone who may be remote from family.

Annex A provides additional detail on the current position of adult social care and community health care.

Services provided **vary dramatically** across England, with difference in both provision and patient need. In recognition of this, this briefing paper provides options for responding to an influenza pandemic rather than a set model to follow.

3.0 CURRENT CHALLENGES

3.1 Adult Social Care

Adult social care comprises a wide range of (non-clinical) personal and practical care and support for adults of all ages: older people and working age adults with physical disabilities, learning disabilities, or physical or mental illnesses, as well as support for their carers. The "settings" for care include an individual's own home (domiciliary care), day centres, residential care homes and nursing homes.

There are a range of well documented challenges facing adult social care. These include demographic challenges with the growth in population of England, driven largely by increasing numbers of older people. The number of people aged 75 and over is expected to increase by 70% between 2015 and 2039 (ONS), with life

expectancy increasing. There is also wide variation in performance, quality and practice across the country.

There are specific barriers, constraints and pre-existing challenges that may constrain national government and local adult social care commissioners and providers in developing a co-ordinated response to an extreme influenza pandemic. These include:

- **Variability in the strength of council and provider relationships:** Where local provider forums exist, the relationship tends to be stronger in being able to manage business as usual issues as well as respond to crises. However, up to a third of areas do not have an active provider forum.
- **Health care and social care interaction:** The relationship with health is sometimes unclear at local level; which can be compounded where NHS England regions and local areas and clinical commissioning groups (CCGs) don't align with local authority regions or Local Resilience Forum (LRF) boundaries. All of this can make joined up local response planning more challenging
- **Identifying and co-ordinating capacity:** It can be very difficult to identify where additional capacity exists, particularly from domiciliary care services, and co-ordinate any available capacity. There are associations for both domiciliary care and care home providers but the coverage is incomplete.
- **Statutory Vs independent providers:** There can be tension between statutory sector organisations and services and the independent sector, e.g. access to information. Independent providers feel that they are sometimes treated on a 'need-to-know' basis. Additionally, for independent providers, it can be difficult to know who to speak to in a council, other than their direct commissioners. There is a need to share contact details across all sectors/providers.
- **Regulatory, contract and process adherence:** Even in crisis situations contracts remain in place. LAs and providers will aim to work flexibly but there is a risk of a contract adherence mentality which could cause tensions and obstruct delivery of the response (e.g. taking out of area referrals). There will also be some providers who feel unable to be flexible because of concerns that their quality rating may be negatively affected.
- **Identifying self-funding providers and service users:** It is a challenge to maintain a current record of individuals who self-fund; there is a need to ensure that providers flag them to the Local Authority. Additionally, an increasing number of providers are only working with self-funders and therefore have very little, if any, contact with local authorities.

3.2 Community Health Care

Community health care is provided by a range of healthcare professionals, such as district nurses, community physiotherapists, rehabilitation and health visiting teams.

The way community health services are commissioned means that there is a great variation in provider size, type and level of spend. This includes NHS organisations such as community trusts, integrated trusts (i.e. the community provision is an aspect of an acute or mental health trust), independent providers, community interest companies and third sector providers. Community health services are commissioned via block contract by CCGs. Local Authorities also commission community health services to fulfil their public health commitments; e.g. health visiting, sexual health services and others.

Table 1. Examples of community health care services

Assistive Communication Service	Diabetes support teams	HIV nursing	Phlebotomy
Stroke Support Service	District nurses	Homeless health	Podiatry
Breastfeeding Support Service	End of life care (adult and children)	Looked after children	Rehabilitation
Falls Prevention service	Bone health service	Physiotherapy	Respiratory
Children community nursing	Family Nurse	Nutrition and dietetics (adult & Children	School nurses
Neuro-rehabilitation	Health visitors	Occupational therapy (adults & children)	Sexual health
Continence services	Heart nurses	Oral health promotion	Speech therapy (adult & children)
Dementia specialist nurses	Child Healthy weight team	Parkinson's support units	Stoma care
Stroke support	Tissue viability	Walk-in centres	Audiology
COPD	Continuing healthcare	Geriatrician	Hospital avoidance services
Immunisation	Integrated community care	Minor Injury Units	

As with adult social care, community health care also faces a number of challenges. Whilst local areas are driving improvements to community health care through new care models and Sustainability and Transformation Partnerships, these challenges could constrain planning for a co-ordinated response to an extreme influenza pandemic. These include:

- **Increasing demand** – as with the rest of the NHS demand in community health care is rising, due to a variety of reasons, including an increase in activity and acuity. Any plans for emergencies will need to recognise the current pressures as a starting point.
- **Limited data on services provided and who is using them** - The lack of data available on community health services is a known problem. DHSC are

working with NHS England and NHS Digital to resolve this, by developing a Community Services Data Set, due to flow data from February 2018.

- **Poor communication with adult social services** – Although community health services support patients alongside social care, communication is often poor between the two, although this does vary nationally. This will be particularly challenging in an influenza pandemic as additional pressures arise.

This paper largely considers physical healthcare, however it is recognised that a significant amount of mental health care is provided in the community. It has been recognised that fever (for example, that associated with influenza infection) has the potential to exacerbate mental health conditions, such that patients could become more unwell, or cease to take medicines. Separate work will be needed to consider both inpatient and outpatient mental health care, and integrate this into wider existing arrangements.

Plans to augment the ability of social care and community health care to respond to an extreme influenza pandemic should recognise pre-existing challenges common to the NHS and recognise the sectors ongoing ability to cope and respond to crises such as provider failure and seasonal winter challenges.

4.0 IMPACT ON DEMAND AND CAPACITY

In the event of a future influenza pandemic the number of people in the community requiring support, either as a direct result of influenza or because of underlying conditions, is expected to increase. This will have repercussions on community health care and social care sectors. Increases in demand may be as a result of:

- increased numbers of people cared for in the community who might normally be cared for in hospital but, due to overall increases in acuity and activity leading to shortages in acute capacity, are leaving hospital and have to be cared for at home or in the community, (this includes both acute patients whom the hospitals can no longer support and patients who could be cared for in the community if systems were in place in that location),
- existing community health care and adult social care service users having increased levels of need due to influenza infection,
- informal carers becoming ill and /or needing to take on a higher level of caring responsibility, so requiring support, and
- previously well individuals now needing support at home or in the community as a result of the pandemic.

As well as increased demand, the demographic profile of those employed within the community health care and adult social care sectors means that a higher than average proportion of the workforce has personal caring responsibilities. This,

alongside sickness rates, will reduce the capacity of community health care and adult social care.

Current planning assumptions predict that this pressure is likely to be sustained for several weeks, possibly with more than one peak.

Impact on Adult Social Care

Initial analysis and modelling of the impact on the adult social care workforce suggests that in the event of an influenza pandemic, a large number of staff would be absent from work for periods of time. This could be directly through illness, or due the need to provide childcare in the event of school closures, etc. A reasonable worst-case scenario for the English population would be that 20% of staff would be absent in the peak weeks, though small organisations (5-15 staff) should plan for absence levels nearer 30-35%. An additional 10 to 15% absence rate might be expected in the event of school closures[1].

Applying these rates to the social care sector (they are broadly in line with the assumptions included in NHS England's Operating Framework for Managing the Response to Pandemic Influenza[2]). This would mean nearly 300,000 of the adult social care workforce being absent (from a total of 1.4m) [approx. 231,000 FTE roles], or 500,000 [or approximately 392,000 FTE] roles in the event of school closures. Nearly 10% of care home providers and around 15% of domiciliary care providers have fewer than 10 staff and so ought to plan for an even higher level of staff absence as described above[3].

These estimates represent only a severe scenario; depending upon the particular characteristics of the pandemic strain, different age groups will be affected differently. For example, a flu strain which impacted older people particularly strongly might cause greater pressure in managerial and senior adult social care roles as the age profile in these role tends to be higher than in care workers more generally.

5.0 WHAT CAN BE DONE NOW TO PREPARE FOR A PANDEMIC?

This paper outlines a framework that can be followed in the event of a severe pandemic. Whilst the nature of the pandemic has a number of variables (e.g. clinical attack rate, hospitalisation rate, effectiveness of countermeasures), there are some actions that can be taken now to improve and increase the speed of community health care and adult social care response to an influenza pandemic.

- **Local Resilience Forums:** Ensure all LRFs have a pandemic influenza plan which reflects the severity of the reasonable worse-case scenario and

[1] https://www.gov.uk/government/publications/spi-m-publish-updated-modelling-summary
[2] https://www.england.nhs.uk/ourwork/eprr/pi/
[3] https://www.nmds-sc-online.org.uk

considers the breadth of organisations in their area including community health care and adult social care.

- **Voluntary and charity sector:** Identify the sort of help the public could provide in an influenza pandemic, to help coordinate spontaneous volunteers rapidly.
- **Local Providers:** Ensure all areas have an active social care provider forum, and that LRFs/Local Authorities are aware of the total market provision, including private providers who only work with self-funded service users/patients. Build relationships with these providers to make communication in an emergency smoother. The Care Providers Alliance and ADASS could have a role to play here.
- **Plan how to identify service users/patients/vulnerable individuals:** work with providers to develop a shared method to identify all service users and patients in an area, including those who are self-funding. If data governance allows, identify those who are receiving support from more than one provider. E.g. Camden Community Care currently maps postcodes of their patients using an app that could potentially be shared with social care providers.
- **Establish what 'vulnerable individuals' means in a pandemic situation:** early findings from the ADASS survey identified a discrepancy between what local authorities and central government consider 'vulnerable individuals'. Clarifying this ahead of any emergency would be beneficial.
- **Reduce the number of minor but frequent challenges:** E.g. work with housing providers to increase speed of establishing key safes which can impede discharge from residential care to the home environment.
- **Consider how to support childcare to maintain the workforce**: As a significant proportion of the workforce of community health care and adult social care have caring responsibilities, early consideration on childcare support in the case of an emergency would be beneficial.
- **Regulation in Health and Social Care**: building on ongoing discussions with the CQC, DHSC could build on existing social care provider failure communications arrangements to include the cascade of messages about temporary regulatory easements ahead of an influenza pandemic. DHSC could also invite CQC to develop and publish a framework document to provide reassurance to providers and commissioners on what these easements will mean for them. Decisions to make apply such easements will be intelligence led and draw on either existing DHSC winter or LRF escalation systems.

6.0 RECOMMENDATIONS FOR SERVICE RECONFIGURATION

[DN: This section will be supplemented with further findings from ADASS work in January and early February.]

Surge capacity is already required on a regular basis when organisations experience localised short term pressures (e.g. during periods of cold weather) and organisations can use their business continuity plans as starting points to identify their priority services for an extreme pandemic. NHS organisations have business continuity, major incident and pandemic influenza planning and response arrangements.

However this will need to be reviewed in light of the extended duration of an influenza pandemic and the wider geographical impact and as such a flexible framework within which to operate is essential. Local decisions will need to be taken based on services provided and patient profile as to what the priorities are. These may also change during the pandemic or period of surge.

A key element of changing service provision will require a change in risk appetite. The Care Quality Commission (CQC) has agreed that it will adopt a 'pragmatic not bureaucratic' approach to regulation in a pandemic. Taking a flexible and risk-based approach, and making a national statement on possible regulatory easements, the CQC could provide reassurance to providers and commissioners who feel unable to be flexible because of concerns that their quality rating may be negatively affected. Additionally, the CQC recognises the need to take a geographically-variable approach, as the pandemic impacts different parts of the country in different ways.

Community health care and adult social care providers and the CQC recognise there may need to be a short-term, localised trade-off between responding to a severe pan flu situation and maintaining quality. It is agreed that safety should never be compromised.

The remainder of this document highlights the options suggested by providers and stakeholders of social care and community health care, including examples to aid local decision making. There is a focus on mutual support and maximising share resources.

6.1 Options for prioritising care

In order to prioritise and reconfigure community health care services and adult social care, a clear understanding of the consequences is required. Prioritisation of the different elements of services could be based on the following categories:

- *Preventative: long-term prevention/minor* – e.g. Stop Smoking (CHS); housing adaptations
- *Preventative: quality of life* e.g. Podiatry; re-ablement services (helping users to develop the confidence and skills to carry out daily living activities and other practical tasks themselves and continue to live at home)
- *Preventative but necessary: keeps people out of hospital* e.g. Respiratory, rehabilitation care, diabetes care; re-ablement and telecare

- *Life critical* e.g. PEG medication; social care outcomes a, c and d (in below list)

The table below suggests which community health care services could be considered critical and those that could be stopped or reduced. Many of these services have a number of different elements, some of which will be more critical than others. Individual providers will be expected to prioritise within their own services. Annex A provides an example deep dive into one service, District Nursing.

Table 2. Possible prioritisation of community health care services

Services that could potentially be reduced	Services that have critical elements
• Children's Integrated Targeted Services • Community Heart failure • Continence • Immunisation • Health screening • Nutrition & Dietetics • Occupational Therapy • Phlebotomy • Podiatry • Musculoskeletal physiotherapy • Respiratory • Speech and Language Therapy (SALT) • Sexual health • Stop Smoking • Tissue Viability/ leg ulcer service • Preventive services – e.g. smoking cessation	• District nursing • Integrated care teams • Walk in centres • Minor injury units • Palliative/ end of life care • Discharge teams • Children's health • Safeguarding • Admission avoidance services • Diabetes care • PEG medication • HIV/AIDS support • Bereavement visits

Access to community health care is not necessarily 24/7, and hours vary across providers and areas, creating an additional challenge during periods of increased demand. Organisations should consider whether they can extend their operational hours, or link to other services (such as out of hours general practice) in order to ensure the best possible care and maintain patients in the community.

In social care local authorities make an assessment of whether an individual requires state funded care based on whether their need/s:

- arise from or are related to a physical or mental impairment or illness,
- make them unable to achieve two or more specified outcomes (see below),
- as a result of being unable to meet these outcomes, there's likely to be a significant impact on the adult's wellbeing.

Outcomes

a. managing and maintaining nutrition, such as being able to prepare and eat food and drink
b. maintaining personal hygiene, such as being able to wash themselves and their clothes
c. managing toilet needs
d. being able to dress appropriately, for example during cold weather
e. being able to move around the home safely, including accessing the home from outside
f. keeping the home sufficiently clean and safe
g. being able to develop and maintain family or other personal relationships, in order to avoid loneliness or isolation
h. accessing and engaging in work, training, education or volunteering, including physical access
i. being able to safely use necessary facilities or services in the local community including public transport and recreational facilities or services
j. carrying out any caring responsibilities, such as for a child

When considering how to prioritise and reconfigure adult social care, the list of outcomes above will be a useful starting point. It may be that in an extreme influenza pandemic, only those needs that arise from physical or mental impairment of illness would be prioritised. Alternatively, only those services supporting outcomes a, c, and d would be considered essential.

6.2 Options for altering service provision:

- **Delaying/pausing services:**
  - Reducing some services would be inconvenient, but not life threatening e.g. podiatry
  - Decisions will need to be made about how long it is possible to delay delivering a service. For example, sexual health services, both planned and walk in, could be realigned to release nursing staff – but this would then potentially move the risk to unplanned pregnancies (if patients were unable to access emergency contraception through other routes) or to sexual health outbreaks. Aspects, however, would have to be ring-fenced and maintained – such as HIV support.
  - Community occupational therapists, some physiotherapists and some aspects of speech and language therapy (SALT) could be delayed/ reduced – to potentially enable an increase in chest and respiratory physiotherapy in the community rather than in other settings; swallow therapy may be an essential SALT service to maintain
  - Children's community nursing, particularly end of life care or care for complex needs (such as those with tracheostomies or requiring PEG feeding) will need to be maintained

- Patients from rehabilitation wards could potentially be discharged to home earlier than usual to enable others to be admitted. This could be patients from the community or as a step down from acute care – if appropriate and sufficient staff were available.
- Patients may have to be kept in bed, rather than supported to get up and back in bed in the morning and evening, to help limit the number of visit and reduce the number of visit requiring more than one member of staff.

- **Reducing number of visits:**
  - There will be a need to reduce duplicative visits from domiciliary care and community health services. This will require good communication between NHS services and social care providers. It may be possible for district nurses to delegate simple nursing tasks to social care providers if they have been given suitable training. There is already evidence that the reduced supply of community nursing and access to primary care has resulted in some low level clinical tasks being built into the work of home care workers.
  - Map how many services a patient/service user is receiving, and consider whether tasks could be delegated from one to the other to make best use of resources and reduce infection risk. For example, the community care provider in Camden uses an application to map their caseloads. Depending on data sharing difficulties, this could be combined with other service providers.
  - Some housebound patients may receive two to three visits per day from health and care workers. These would need to be prioritised to be maintained to ensure the patient didn't deteriorate and need admission to acute care.
- **Increase in some services:**
  - Some services e.g. phlebotomy, may need to be maintained (or even increased) to help reduce pressures in other settings.
  - Whilst some of the preventative elements of respiratory and heart failure services may be reduced, there is likely to be an increase in acute support/admissions avoidance.
- **Remove patient choice:**
  - Patients may no longer have a choice on the date or time of their visits or appointments.
  - In the short term patients may have limited, if any, choice on the residential service they access.
  - Reordering visits so they are in geographical order or care workers going straight to a visit rather than via a place of work may help reduce staff travel time, increasing capacity.
- **Increased use of technology**
  - Increase use of phone or video triage to identify patients who can be kept in the community (including those who need a visit vs those who need phone advice) and those who have to go back to hospital.

- Online consultations or near patient samples.

6.3 Options for staffing

- **Re-deploying staff**
  - It may be possible to move staff from an aspect of community care provision to something else if a service is stopped/ reduced. Additionally, it may be possible redeploy acute staff into the community should that be deemed the most effective approach for that area. However, there is no benefit in stopping a service if those staff cannot be sensibly re-deployed to other roles, for example community nursing staff may be better able to move into alternative roles than therapy staff.
  - It may be possible also to release clinically trained staff in CCGs or elsewhere to resume clinical roles in the community. This would only be possible through local conversations and discussions and an understanding of individual staff skills and capabilities. CCG-employed pharmacists have been supporting discharges in some acute trusts by supporting medicines provision to patients.
  - Children's community health services require specialist training so many nurses may be unable to or hesitant to treat children for even basic health care.
  - Many GPs practices employ health care assistants; these could support community health care but it would need to be clear what role they could have.
- **Training and upskilling**
  - Additional training may be needed to ensure any redeployed staff were confident and competent to act in different roles.
  - Training should be rolled out sooner rather than later in a pandemic to ensure valuable patient care time can be maximised during a peak
  - Some specialist services don't do basic care and therefore they may need upskilling again. There is a need for nurses not to become too specialised and have regular refreshers of core competencies. In 2009, community nurses had to be re-trained to do interventions and this caused a lot of anxiety.
  - It would be helpful to have a list of tasks/competencies that will be needed in a pandemic.
  - Basic training in mental health first aid (MHFA) and palliative/end of life care would be beneficial to all community based staff, as well as staff coming into support organisations
  - A basic nursing skills refresher course would also be valuable
- **Bringing in staff from other sectors**
  - Other sources of staff could include qualified nurses returning to practice, dental nurses, reservists, student nurses and medics (this raises a

question of delegation and indemnity), allied health professionals, or even veterinary nurses.
    - These staff groups would require a variety of registrations, training and supervision depending on their skills and experience
    - It may be useful to have access to the list of registered nurses. Many businesses hire nurses e.g. airlines, cruise ships. In addition, there are many nurses who are no longer practicing, working in other organisations. There could be a public request for these staff to support community health care, through returning to nursing and/or working for community health care providers on a temporary basis. This raises the issue of indemnity, which the draft Pandemic Influenza Bill is aiming to address.
- **Portability of staff**
    - The impact of the pandemic may vary geographically over time; therefore it would be beneficial to allow staff to work for different providers, depending on levels of need.
    - Additionally, staff may need to move location to care for family but still be able to work for short periods of time.
    - One possibility would be a national agreement to allow staff to work wherever they are needed. This would require careful management to ensure certain geographical areas do not become depleted of staff.

6.4 Options for facilities

- **Open additional beds**
    - In response to the increase in palliative and end of life care, empty, non-funded beds in hospices could be opened if staff could be identified and funding made available.
    - This will only be possible if sufficient staff, with the correct skills are available, or with rapid training.
- **Trusted Assessor Model and other aspects of the High Impact Changes for improving hospital discharge.**
    - As a result of the focus in 2017/18 there has been a focus on all areas having trusted assessor models in place. This is often between the acute hospital and social care workers. There are areas are already using this model, where the community care provider undertakes the assessment for suitability for a home. This requires trust from the private sector that they won't send unsuitable patients.
- **Residential facilities**
    - Using field hospitals/hotels to create an inpatient setting or hub is unlikely to be feasible for community health care patients or adult social care service users as they would require staffing, some patients may be unsuitable to be moved and patients often require more than one type of care. There would also be significant resource costs to move someone from being cared for in their own home to a staffed facility.

- Possible benefits could include reduced travel time for staff, improved access to rural patients and possibility of earlier discharge from hospital. However, this would have to be matched with re-ablement and rehabilitation capacity to ensure that we are not consigning people to suboptimal care pathways that require them to require longer-term residential or hospital care rather than care at home.
- Explore national arrangements to advance purchase arrangements with larger social care to use their private care capacity to accommodate publically funded patients/service users.

Figure 1. Illustrative representation of activities during escalating periods of pandemic influenza surge

[DN: This is an initial draft and is not meant to be prescriptive. Input is still required from the DHSC winter pressures team and other partners.]

Consult with	Phase	
Ongoing discussions with DHSC (SofS, ministers), professional bodies, staff, legal, regulators etc.	Severe pandemic	• Withdraw all but life-critical services, if staffing allows • Increased palliative care • Maintain post-natal care, nutrition and toilet needs as much as possible throughout the whole pandemic • Adult social care and community health care staff to limit their tasks to those only they are qualified to do. • Limit admittance to residential services
	Moderate pandemic	• Identification of additional staffing requirements • Support and expand palliative care facilities • Prioritisation of elements of services, as per table 2. This will be dependent on local need and resources • Consolidate care from adult social care and community health care where possible. • Increased use of volunteers to collect medicines, food etc. • In the recovery phase, care needs assessments and services will re-commence in a phased approach as resources become available. • Reduction in the number of visits; increased use of phone and remote support. • CQC to ease regulations. • Limit admittance to residential services
	Mild pandemic	• Training to enable staff to undertake additional/ alternate roles • Increased collaboration between local authorities, community health care and adult social care, including identifying vulnerable individuals. • Reduced preventative services e.g. stop smoking, weight management. • Implement any agreed local escalation arrangements for faster hospital discharge or admission avoidance • Limit multiple visits where possible • Remove patient choice for residential home placements • Restore and re-commence services during recovery.

	Severe winter	• Reduce/delay non-essential services community health care and adult social services e.g. (*are there any current examples?)* • *INCLUDE CURRENT ESCALATION PLANS* • Implement business continuity arrangements
	Baseline	• Business as usual

7.0 OPTIONS AND RECOMMENDATIONS TO AUGMENT MULTI-AGENCY INTERACTION IN A SEVERE INFLUENZA PANDEMIC

7.1 Data sharing

- To ensure an effective multi-agency response, it will be necessary to share patient information between community health care and adult social care. For example, there may be a need for all providers and/or the local authorities to share lists of vulnerable patients, ensuring care can be prioritised effectively within a locality. In the case of vulnerable patients, there would be a common law duty of care to share their information with other providers or local authorities for the purposes of their care and in their best interests, or otherwise there would be a statutory duty to share their information under s.251B of the Health and Social Care Act 2012 for their direct care.
- More generally, in relation to sharing for indirect care, regulation 3 of the Control of Patient Information Regulations 2002 (SI 2002/1438) authorises the processing of confidential patient information for the purposes of communicable diseases and other risks to public health in the circumstances specified in the regulation. Otherwise confidential patient information may be shared in an emergency in cases where there is an overriding public interest, as outlined in the Cabinet Office guidance (REFERENCE).
- To prevent the restrictions on sharing patient data becoming a hindrance to the influenza response, it is vital that all information governance officers are aware of the above legal bases to share data in advance of any incident, in addition to emergency response leads being aware. This should be reinforced in the event of a pandemic.

7.2 Provider forums

- To ensure that local areas remain best placed to respond to severe pandemics through existing Local Resilience Forum mechanisms, good practice identifies meaningful and ongoing dialogue between council commissioners and social care provides as a key enabler. DHSC will ask the

Care Provider Alliance and ADASS to make recommendations on how best to ensure there is 100% provider forum coverage across England.

7.3 Removal of boundaries

- Enabling flexibility in zoning arrangements in home- care contracts, would allow providers to receive service users depending on bed/care availability, not locality.
- Existing provider boundaries may need to be disregarded, as patients go to where there is space, rather than in their home area.

8.0 DECISION MAKING AND REPORTING

There is likely to be a reduction in decision making staff across providers. This could be addressed by shared management staff/decisions across providers and co-location of leaderships. Reporting lines need to be as simple as possible, to remove pressure from the front line. Additionally, there is a need to consider who the best people to be the single point of contact are. The emergency planning liaison officers are not the best person for this role. When planning reporting, it is important to consider what needs to be known consistently at a national/regional level and what needs to be known differently at a local level. Further work is required to consider how this would be implemented.

9.0 ADDITIONAL SUPPORT

In addition to the above options for reconfiguring services, additional staffing and facilities, demand and reduction in capacity for both adult social care and community health care is likely to mean that additional support is required outside of the sector. Whilst much of this will need to be decided as the pandemic develops, the following tasks have been identified as suitable for the Public, voluntary and charity sectors (including possible MACA request) and possibly businesses to support:

- Portering
- shopping
- House cleaning
- Catering
- Collecting food/medicines
- Driving
- Helping people out of bed
- Phone calls to check on patients

However, the availability of volunteers and support from other sectors is also likely to be impacted by the pandemic. Due to the nature of the pandemic, support from the

Ministry of Defence or the Fire and Rescue service is likely be requested from multiple sectors, and community care may not be a priority. Additionally, previous pandemics have seen fear of infection in volunteers. Careful communication and infection control will be required to ensure that the number of possible volunteers is not limited through fear. Any planning should not reply on a significant amount of voluntary or additional support.

[DN: discussions are ongoing with DCMS, MOD and HO regarding additional support for community health care and adult social care in the event of an influenza pandemic. Also need to consider what our asks of the business sector may be.]

10.0 NEXT STEPS

The development of the clinical facing guidance and associated briefing to DHSC and central government will continue. A number of steps are planned towards delivery of guidance that is useful and meaningful for healthcare and adult social care professionals and for local authorities:

- Share for comment with CMO/CSA/CNO
- Incorporate community health care guidance into the NHS England service-facing guidance
- Consider the best public-facing document to incorporate the adult social care guidance
- Consider whether further ethical engagement is needed through CEAPI/ BMA Ethics committee
- Socialise further with Academy of Medical Royal Colleges and Presidents of the Royal Colleges and the Chief Social Worker
- Review with legislators/ regulators
- Review with professional bodies and lead professionals
- Engage with partner organisations including NHS Improvement, HEE, PHE and others
- Develop appropriate communications as required around this specific piece of guidance
- Engage with appropriate Devolved Administration representatives, possibly through 4N CMO and CNO groups

Name Redacted **)HSC**
– DHSC
Chloe Sellwood – NHS England

ANNEX A – Current position of adult social care and community health care

Adult Social Care

There are currently approximately 16,400 care homes (11,900 residential and 4,468 nursing), with 460,000 beds (239,000 residential and 221,000 nursing). Around 414,000 of these beds are in care homes serving older people and/or dementia sufferers. In addition to this there are approximately 8,700 home care agencies providing services to people with social care needs at home.

The provision of adult social care is a mixed economy between state and self-funded provision. Both residential and domiciliary social care is largely provided through an active and competitive market of independent sector providers (78% and 91% respectively), with the remainder a mixture of public and voluntary provision. Domiciliary care is largely state funded (80%) whilst most people in care homes are self-funders.

Workforce

There are approximately 1.11 million full-time equivalent jobs in adult social care in England (across 1.58 million job roles, including vacancies); 91% of the workforce works in the independent sector with the remaining 9% working for local authorities. Roles in social care include:

Roles	FTE
Senior management	15,700
Registered manager	22,300
Social worker	17,000
Occupational therapist	3,100
Registered nurse	42,700
Senior care worker	84,900
Care worker	817,100
Support and outreach	59,600

Key features of the workforce include:

- 51% of the total workforce work full-time, 37% work part-time, with the remainder having neither e.g. being on zero hour contracts. The subset of care workers have a low proportion of people working full-time at 46%.
- 82% of the total workforce is female.
- 11% of the total workforce is over 60.
- approximately 90,000 vacancies in the care sector; registered nurses and care workers have significantly high turnover rates

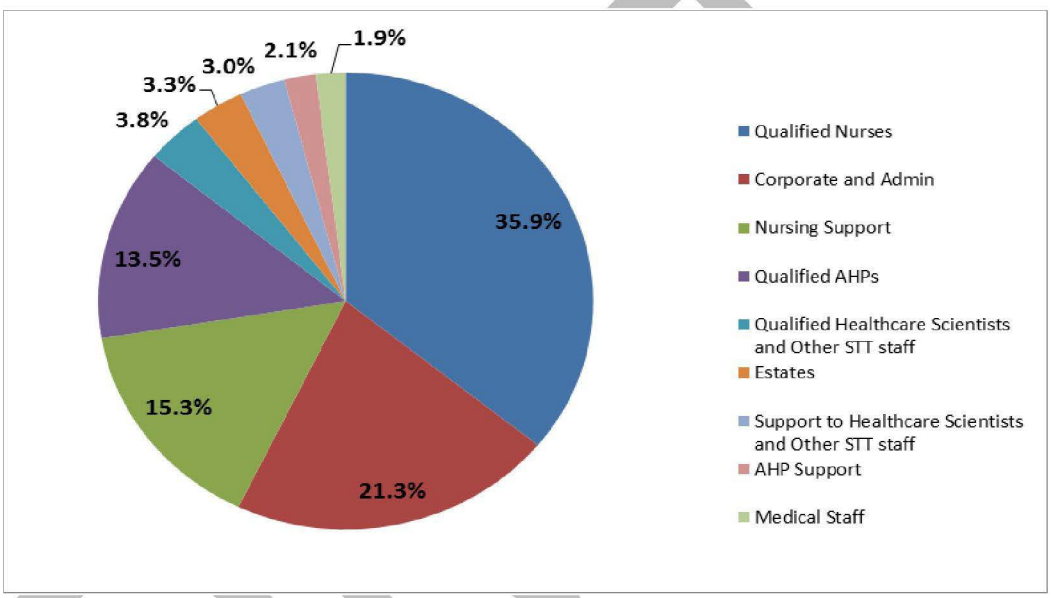
In addition to the formal care service, there are also more than six million informal carers in the UK (5.4 million carers in England) providing around 8 billion hours of support to family, friends and others with a range of needs arising from old age,

physical and learning disabilities, and illness. The carer population is fluid but it is estimated that 10% of the population can be considered as a carer, and that each year over 2.1 million adults become carers and almost as many people find that their caring responsibilities come to an end.

[DN: The Associations of Directors of Adult Services (ADASS) have recently completed a survey of 79 Directors of Adult Services, with responses from every region in England. The next version of this paper will include some of the findings.]

Community health care

NHS Improvement's review into operational productivity in community and mental health services found that the workforce (by full time equivalent) consists of:



Providers

- CCGs hold at least 50 separate contracts for community health services, and use **block contracting.**
- **69% NHS providers**:
  - 18 Standalone community NHS Trusts and Foundation Trusts (FT).
  - These Community Trusts ended 2015/16 in a small surplus.
  - Approximately 56 acute trusts and FTs; with almost 40% of all acute and mental health trust providing some community health services.
- **18% Private sector**
  - Around 1500 independent (private) providers
- **13% Third sector**
  - Charities and community interest companies, eg Alzheimers and Dementia Support Services

ANNEX B: North East London NHS Foundation Trust prioritisation of district nursing and first contact team.

Not all providers will offer the same elements of a service, therefore prioritisation will need to be localised.

A HIGH		B MODERATE	C LOW
DISTRICT NURSING:		Injections Renal Failure.	3/12 Cytamen Injection 3/12 Hosiery Change.
Injections: IV/IM/SC. Insulin. Post Chemotherapy. Antibiotics. Anti-Coagulants Analgesics Anti-Emetics Syringe Driver In Palliative Care Other (e.g. Apomorphine) Chemotherapy Pump Hickman Lines Palliative Care Referrals. Patients with pain/symptoms. (End of life stage/Personal Care) with Post Op Eye Surgery – Drops Dyresflexia).	Wounds. Necrotic. Cavity. Exudating. Infections. Diabetic Foot. Pressure Ulcers Grade 4+ Peg Feeding. Blocked Catheters. Tracheostomies. Breast - and any other Drains. Unplanned Care. Assessments – New Constipation-(Acute)*. (Requiring Enema, Patient Paralysis – Autonomic	Hormone Therapy. Flu/Pneumonia. Routine Re-catherisation Granulating Wound Dressing. Leg Ulcer Compression. O2 / Nebuliser Therapy. Diabetes Monitoring (Routine)*. Venepuncture. Assessment/Reassessment (Of continence) Health Promotion. Promoting self-care. Chronic Disease Management. Constipation*	Leg Care/Change stockings. Epithelising Wound Dressing. Blood Pressure Monitoring. Catheter Bag Renewal. Lubricant Eye Drops.