Paper 5b – PFRB Workstream 2

Pandemic Influenza briefing paper: Adult social care and community health care

1.0 PURPOSE

The purpose of this paper is to set out a framework on key considerations and options to maintain and augment community health care and adult social care sectors' response to an extreme influenza pandemic. This paper is to be presented to the Chief Medical Officer (CMO), the Chief Scientific Advisor (CSA) and the Chief Nursing Officer (CNO).

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.

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 March 2018. 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 service and local government facing guidance.

This paper can be read in parallel with the paper produced in 2017 by NHS England for CMO, CSA and CNO as part of the work around surge, escalation and triage in the acute and primary care setting.

An understanding of adult social care and community health care provision within the UK is assumed. Further detail can be found in Annex A.

This paper, and all data within it, refers to England only. The Devolved Administrations have committed to considering the issue, making use of these materials, and working on common approaches as much as possible. 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.

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 and support 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. This can be through short-term and long-term packages of care. 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 post-acute care **rehabilitation** and 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 a severe influenza pandemic, hospitals will only be able to treat the most seriously ill, increasing pressure on community care services.

Community health care providers and social care providers are aware of, and 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 a pandemic, e.g. single parents with young children, and adults living alone who may be remote from family.

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 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:

- greater numbers 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,
- 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.

3.1 Impact on Adult Social Care:

Initial analysis and modelling of the impact on adult social care, based on the National Risk Assessments reasonable worst-case scenario and existing data on patient flows, suggests that:

- 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 at the peak of the pandemic. Nearly 10% of care home providers and around 15% of domiciliary care providers have fewer than 10 staff and so should plan for an even higher level of staff absence as described above[1].
- Around 110,000 unpaid carers would be ill enough to require hospitalisation (and therefore unable to continue to provide care). Assuming a 1:1 ratio of carer absence to social care service need, this would potentially mean the equivalent of110,000 peoples' extra demand for social care services.
- It is expected that a large proportion of patients in hospital who are ready to be discharged according to population triage protocols but are waiting a care needs assessment may be discharged without a specific plan in place and at risk of dying in a community and social care setting .

Although not the purpose of this paper it is important to acknowledge that there will be longer-term impacts on the health and wellbeing of individuals and costs to the health and care system as a result of decisions taken during a reasonable worst-case scenario to ration health and care support.

The availability and capacity of adult social care beds and NHS services varies significantly across the country, therefore the flows between adult social care and the NHS in a pandemic situation is not quantifiable, however it is anticipated that any available business as usual surge capacity would be utilised by local organisations rapidly in a matter of weeks as pandemic pressures increase.

It is important to note that these figures are intended to be indicative of the scale of people needing extra support, rather than being hard estimates or predictions. Additionally, these estimates represent only a severe scenario; depending upon the particular characteristics of the pandemic strain, different age groups will be affected differently.

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[1] www.nmds-sc-online.org.uk

One of the current key challenges for both adult social care and community health care is limited national data on services provided and who is using them. This is discussed in more detail in following sections.

4.0 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 and effectiveness of community health care and adult social care response to an influenza pandemic. A number of actions are currently underway as set out below.

4.1 Local Resilience Forums

Ensure all LRFs have a pandemic influenza framework /plan which reflects the severity of the reasonable worse-case scenario and considers the breadth of organisations in their area including community health care and adult social care.

- DHSC is working with MHCLG to confirm all local resilience forums have a pandemic influenza plan that is of sufficient quality. Additionally, through LRF workshops and engagement with ADASS, work is underway to ensure that adult social care and community health care providers are linked in with these plans.

4.2 Vulnerable Individuals

Establish what 'vulnerable individuals' means in a pandemic situation: findings from the ADASS survey identified a discrepancy between what local authorities and central government consider 'vulnerable individuals' and the need for councils to have systems in place to identify those who might become vulnerable in a pan flu epidemic for example those in informal care or people living alone. Clarifying this ahead of any emergency would be beneficial.

- As part of the development of the Data Protection Bill, CCS has been working with other government departments to consider the definition of vulnerable individuals. In emergencies, such as an influenza pandemic, some individuals who would not usually be considered vulnerable, may be at increased risk. This could include socially isolated individuals and people cared for by family members who themselves are at greater risk of the effects of pandemic influenza (e.g. older people)

4.3 Regulation in Health and Social Care

Ensure that individuals, as well as organisations, know that they will not be sanctioned for a reduction in the level of care during a severe influenza pandemic.

- DHSC is building on ongoing discussions with CQC to formalise existing communication arrangements in situations of major social care provider failure or winter pressures. DHSC has also invited CQC to consider developing a framework document to provide reassurance to providers and commissioners

on what these easements will mean for them. Decisions to make such easements apply will be intelligence led and draw on either existing DHSC winter or LRF escalation systems

4.4 Local Providers

Ensure all areas have effective contact arrangements with providers for example a 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 are working together to establish a framework for this and to build on the partnerships in areas with established Provider Forums. Subject to funding DHSC should expect all areas to have effective contact arrangements in place [Estimate ~£100k in 2018/19 to implement]

4.5 Improve national oversight of data

Section 6 of this paper sets out the current challenges in quantifying the impact of many of the recommendations describe in this paper. Currently DHSC has limited data on community and social care activity at a local level. The lack of real-time data impedes rapid decision making at a local level and makes it challenging for ministers to access real-time advice on where pressures are emerging at a local level and how to offer appropriate support.

DHSC is taking action both in the community and social care front. In social care the key gaps include a granular real-time data on domiciliary care provision, including the number of hours being delivered. DHSC is addressing this. By September 2018 Beta data will be available through the Care Quality Commission Provider Information Collection project. Whilst this project will take time to scale up and offer a meaningful national and local planning resource it is a welcome step.

The lack of data available on community health services is a known challenge. 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 although it will take some time for the system to bed down and start to provide reliable baseline numbers.

4.6 Recommendations for future pre-pandemic actions

In addition to the above actions, there a number of actions which stakeholder engagement have identified as beneficial but are not currently being taken forward.

- **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 reablement 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, for example through

CQC addressing the ratio of carer to child in nurseries.

- **Voluntary and charity sector:** Identify the types of help the public could provide in an influenza pandemic, to help coordinate spontaneous volunteers rapidly.
- **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. This is linked to the data sharing issue in paragraph 5.1.
- **Access to private care capacity:** Explore national arrangements for health organisations and councils to advance purchase arrangements with larger social care providers to use their private care capacity to accommodate publically funded patients/service users.
- **Trusted needs assessment:** agreeing a shortened paper based or digitally enabled needs assessment process to enable timely transitions of care for people without a full needs assessment prior to allocation to care
- **Identify reporting lines:** work with providers and national government to develop agreed, simple reporting lines.

In the event of a severe pandemic, there is likely to be a reduction in the numbers of senior decision making staff across providers. This could be addressed by shared management staff/ decisions across providers and co-location of leaderships.

In the event of a pandemic local areas will need to establish an agreed protocol for decision making and reporting that fits within the national requirements. For social care, the DASS, in conjunction with the DPH and where relevant, appropriate Health Protection Lead, will provide overarching leadership and the framework for reporting both at national and local levels. For the NHS, this will be through (and with) CCGs and NHS England.

Reporting lines need to be as simple as possible, to remove pressure from the front line. Additionally, there is a need to consider the most appropriate single point of contact at local levels. It is unlikely that this is the emergency planning managers. 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.

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

In the event of a severe influenza pandemic, local authorities, adult social care providers and community health care providers will be required to work together to meet the needs of the community. This multi-agency response will ensure limited resources are prioritised to support those with the highest level of need. The following issues have been identified as key to resolve to ensure an effective

response. ADASS work has highlighted that national government should work to encourage educational and child care establishments to work with LRF partners to enable workers who can work to be available to work in a pandemic situation.

5.1 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[2].
- It is clear that the law already supports data sharing for these purposes but there is much nervousness at the frontline with regards to data sharing, as demonstrated during the Grenfell fire and Manchester attack. 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, most likely through Resilience Direct and NHS England.
- The Civil Contingencies Secretariat is developing an 'information sharing and management' resilience standard. It is suggested that this includes a recommendation that all LRFs develop an information sharing protocol in advance of any emergency and that a national template be provided to ensure consistency across the country. This should include adult social care and community health care to ensure that important opinion formers, e.g. UK Caldicott Guardian Council and the General Medical Councils are engaged.

5.2 Removal of boundaries

- Enabling flexibility in arrangements in home- care contracts, would allow providers to receive service users depending on bed/care availability, not

[2] Data protection and sharing guidance for emergency planners and responders. www.gov.uk/government/publications/data-protection-and-sharing-guidance-for-emergency-planners-and-responders (accessed 30.01.2018)

locality or geography.

- Existing provider boundaries may need to be disregarded, as patients go to where there is space, rather than in their home area. ADASS and CPA work highlights that there are good levels of engagement and flexibility in many places, although not exclusive.
- This already happens during periods of high pressure (e.g. during winter) on an ad hoc basis to enable patients to go to a bed (typically a specialist acute or mental health bed) anywhere in the country that is most appropriate to their needs. However, it will be important to watch for inflationary costs getting built in by inefficient spot purchasing of care, e.g. council A in the North East of England buying capacity from providers in the North West region and affecting locally agreed fee rates. One option suggested by ADASS is to consult on a national rate (with an allowance for regional variations e.g. London) for emergency placements and high dependency periods in residential homes. This could act as an advanced purchasing approach. This could destabilise fragile social care markets and would require considerable consultation and analysis. It is contra to government policy to intervene in local markets and this intervention could only really be considered as a long-term option.

5.3 Consolidating visits and delegating tasks

- As pressure on the system increases, there will be a need to reduce duplicative visits from domiciliary social care and community health services. This will require good communication between NHS services and domiciliary social care providers and is reliant on the issue of data sharing being resolved. Local health and care systems will need to work jointly to maximise resources and reduce duplication. This is likely to be less challenging in areas with mature integrated relationships.
- It would be beneficial to 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.
- 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.
- 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.

5.4 Staff training

- In a severe pandemic, it would be beneficial for all community based staff, as well as staff coming into support organisations to have a basic level of training. This would include basic training in mental health first aid and

palliative/ end of life care.

- It is also likely that 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.
- 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. This could be developed in advance as a training package that can be rolled out when needed, under the leadership of Health Education England (HEE) who could be requested to develop a list of suggested basic training to do.
- Community nurses would also need to take on tasks, e.g. personal care to release capacity in other areas for domiciliary care staff and minimise spread of infection (Buurtzorg model[3]).

5.5 Decision making and reporting

- In the event of a severe pandemic, there is likely to be a reduction in the numbers of senior decision making staff across providers. This could be addressed by shared management staff/ decisions across providers and co-location of leaderships.
- Local areas will need to establish an agreed protocol for decision making and reporting that fits within the national requirements. For social care, the DASS, in conjunction with the DPH and where relevant, appropriate Health Protection Lead, will provide overarching leadership and the framework for reporting both at national and local levels. For the NHS, this will be through (and with) CCGs and NHS England.
- Reporting lines need to be as simple as possible, to remove pressure from the front line. Additionally, there is a need to consider the most appropriate single point of contact at local levels. It is unlikely that this is the emergency planning managers. 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.

6.0 RECOMMENDATIONS FOR SERVICE RECONFIGURATION

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 and local authorities have business continuity, major incident and pandemic influenza planning and response arrangements (see **annex D Plymouth's Shackleton Plan**). *This plan is for internal DHSC use only and should not be shared.*

[3] www.eelga.gov.uk/innovation-programme/buurtzorg.aspx

However standard surge capacity will need to be reviewed in light of the extended duration of a severe influenza pandemic and the wider geographical impact and as such a flexible framework within which to operate is essential. Local decisions on priorities will need to be taken based on services provided and patient profile. 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 constrained 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 pandemic influenza 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 shared resources.

6.1 Options for prioritising care

Care prioritisation will be essential to maintain levels of service with limited resources. 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 to keep people out of hospital* - e.g. respiratory, rehabilitation care, diabetes care; re-ablement, telemedicine and telecare
- *Life critical* - e.g. PEG medication; social care outcomes a, c and d (in below list) However as the resources (e.g. PEG feed) run out, the switch to palliation and end of life support would need to be very carefully managed.

The table below suggests which community health care services could be considered critical and those that could be deferred. 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 C provides an example deep dive into one service, District Nursing.

Table 1. Possible prioritisation of community health care services

Services that could potentially be deferred	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 • 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 • Respiratory

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. Local authorities have Emergency Duty Teams who provide Out of Hours support.

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 table below),
- as a result of being unable to meet these outcomes, there's likely to be a significant impact on the adult's wellbeing
- carrying out any caring responsibilities, such as for a child

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

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 or illness would be prioritised. Alternatively, only those services supporting outcomes a, c, and d would be considered essential.

There would be merit in coordination of care with health / third sector to enable effective targeting of support to deliver services effectively and efficiently to a locality (for example a primary care network footprint serving 30-50,000 patients).

More patients could be supported by a greater focus on telecare / tele monitoring and moving away from immediate re-ablement / rehabilitation during the periods of pressure, which could be reintroduced when the pandemic is waning.

6.2 Key elements of service prioritisation

Following discussion with front-line services, the following four considerations will be important for both adult social care and community health care when assessing how to prioritise services within a locality. Examples of specific decisions are included here:

- Which services can be deferred?
    - Decisions will need to be made about how long it is possible to delay delivering a service, considering inconvenience versus life-threatening. For example, sexual health services, both planned and walk in, could be realigned to release nursing staff from routine contraceptive activities – 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 support were available.
    - Patients may have to remain in bed during the day, rather than supported to get up and back in bed, to help limit the number of visits and reduce the number of visits requiring more than one member of staff.

- Which services may need increasing?
    - 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.
    - There may be scope to do more interventions most commonly delivered in hospital (iv antibiotics, fluids) in community (or primary care) settings which could releases some hospital capacity.
    - There could be a greater focus on supporting acute care services by supporting transfer from hospital of those who don't fulfil admission criteria for palliative and/or end of life care, as well as working with paramedics to support those who cannot be transferred to hospital.

- What level of patient choice is possible?
    - Patients may no longer have a choice on the date or time of their visits or appointments. 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.
    - In the short term patients may have limited, if any, choice on the residential service they access. In the most extreme situations there could be removal of choice – to facilitate discharge from hospital.

- How can increased use of technology support the system?
    - Increase use of phone or video triage to identify (and then maintain through telecare) 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 to hospital.
    - Online consultations or near patient testing.

6.3 Options for staffing

A severe influenza pandemic is expected to cause significant staff absence rates. In addition to prioritising elements of services, both adult social care and community health care will need to consider staffing provisions. As noted previously, training and upskilling will be vital to enable the following options. The following principles could be considered with regards to covering the forced withdrawal of care resulting from *loss of care staff* with influenza:

1) The first tranche of diminished/ thinner care would be **SUBSTITUTION by other community staff**: the interventions in most part to maintain prior commitments and provide **'nursing' expertise only** for 2) and 3) below, i.e. maintain the current supported community bed-base.

2) The second string would be **REPLACEMENT of professional care staff by volunteers not related to the patients**. This has significant potential but difficult to estimate and model and may be affected in a pandemic by 'risk' of contracting and prioritisation of family (3). This may not generate any new capacity but could maintain home care provision.
3) New **RELATIVE RESPONSIBILITY** is the third string and relates to necessary commitment of family and close friends/ neighbours to immediately adopt the care needs of relatives/ friends who have a new onset requirement for personal care. This would also be applicable to 'forced discharges' from hospital. It may also overlap with volunteer replacement (2). Capacity could be estimated as 'everyone with a novel need for care who has able relatives'.

Practical interventions that could be deployed to release staffing are set out below:

- Re-deploying staff within the NHS
    - It may be possible to move staff from an aspect of community care provision to something else if a service is stopped/ reduced. It may also 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 other administrative NSH organisations 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 GP practices employ health care assistants; these could support community health care but it would need to be clear what role they could have.
- 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.

  - An understanding of the number of 'signed-up' volunteers regularly supporting the major charities (Age UK, RVS, etc.) could be used as an indication of the potential resources available from that sector, accepting some will have flu and there will be a concurrent increase in community volunteers.
- 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 ill family members but still be able to work in a different organisation 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.
  - Essential to avoid planning in silos and have a process whereby staff across health, social care and voluntary services are able to be aligned and coordinated to look after the most needy, provide individual support, and support informal / family carers.

This is a significant challenge, not just in a pandemic setting. It has been identified in a number of incidents, and has never been resolved. Regulators and other bodies need to be involved. A skills passport has been proposed that could travel with staff between sites or organisations; however staff would need orientation to the 'new' site's geography and other nuances, and would need to shadow a resident or be chaperoned for a period.

6.4 Options for facilities

Whist facilities are an important aspect of adult social care and community health care, the limiting factor is likely to be sufficient staffing with the correct skills or rapid training. However, the following options have been considered.

- Open additional beds
  - In response to the increased demand 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.
- Residential facilities
  - Whilst possible benefits could include reduced travel time for staff, improved access to rural patients and possibility of earlier discharge from hospital, 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. 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. There is also a risk of consigning people to suboptimal care pathways that require them to require longer-term residential or hospital care rather than care at home.
  - The space in existing residential / care homes could potentially be increased and maximised if capacity could be increased through

installing extra beds in each room or using communal areas for nursing support.

6.4 Resource benefits of service prioritisation and altering staffing provision

Options for quantified analyses of reconfigured social care
As with community health care there is a limited amount of available data about users and providers of social care. Nevertheless, as part of the exploration of the options and recommendations put forward in this report it is important to consider ways it may be possible to quantify their impact.

It is judged that the preparations proposed in section 4 and the options for multi-agency interaction in section 6 are necessary enablers, but not readily quantifiable as capacity gains themselves. Therefore this section focuses on the options for social care service reconfiguration put forward in section 6.

Summary of Quantifiable Gains

With the data available there is limited scope for quantified analysis of capacity gains. However it is possible to draw some generic conclusions:

- There is around 5% additional bed capacity nationally. This would likely come at additional spot purchasing price.
- There is potentially around 14% resource elasticity in domestic care resource. However, there are big caveats in terms of being able to use this capacity as a national resource as there is significant regional variation in the social care system. Instead this should be used as an indicative figure to inform local level planning.
- The combined effect of ASC reconfiguration options (reduce travel time/ration care, etc.) could provide additional marginal gains in resource flexibility/capacity and it is not clear that these would outweigh the effort required to implement them. This would need an Executive Committee commission to prioritise further analysis.
- Finally a key underpinning of local systems being able to leverage and deploy this capacity at a local level in emergencies will be the nature of local relationships and effective local response plans.

A more detailed summary of our analysis and assumptions is set out at Annex E.

Analyses of reconfigured community health care

Quantifying the capacity gained in community health care by the options for service reconfiguration in section 6 is incredibly challenging, due to the lack of national data sets and the huge variety is care provided.

Example - District nursing:

It is very difficult to put a number of visits on it as it would depend on the type of visit/treatment/acuity of patient and ultimately there are some visits where telemedicine just isn't feasible and a face to face is needed.

NHS England's IT agile team states that 'if a community nursing team is fully agile in its operations, this has shown to release in excess of 2 hours per day and reduce travel to/from an office base'.

One provider noted that their nurses should complete an average of 8 visits a day. However that average is made up of Band 5 nurses completing 12-14 simple nursing visits a day such as insulin and other meds administration, these visits are 20 minutes. Whereas more senior staff might only do 6 but these will be palliative and other more complex tasks.

This provider is already using telecare where possible, using a prompting approach to wean people off of having nurses come but for all other tasks the nurse needs to be physically present for such tasks as changing wound dressings, administering insulin. Additionally, they organise delivering care in small geographical areas which reduces travelling times to 10 minutes between patients.

This demonstrates that providers are already using some of the options available to them to reconfigure services and make the most of limited resources, meaning an influenza pandemic could have a significant impact more quickly, if there is no slck in the system. It has not been possible to provide quantifiable data on capacity released by the options in section 6.

7.0 ADDITIONAL SUPPORT

This paper has endeavoured to identify what can be done within the health and social care system, however discussions are ongoing with DCMS, MOD and HO regarding additional support in the event of an influenza pandemic. Requests of other sectors, such as the business sector, are also being considered.

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 potentially suitable for the public, voluntary and charity sectors (including possible MACA request) and possibly businesses to support:

- portering
- shopping
- house cleaning
- catering / feeding
- collecting food/medicines
- driving
- helping people in/out of bed
- phone calls to check on patients/ service users

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.

8.0 NATIONAL REQUIREMENTS OF THE LOCAL LEVEL

There is a need for up to date national frameworks and activation guidance that will enable health and social care organisations to operate in the ways described in this paper. These will enable local services to take their required actions.

- CCS are considering a pandemic influenza standard for LRFs – in the meantime DHSC could ask a cross-section of DASSs to refresh and test strategic and operational plans, engaging with LRFs.
- If we agree a national approach to prioritise care and support at home during the escalation phase of a flu pandemic, who should communicate this in the most appropriate and secure way?
- Communication routes to be planned and tested where possible
- Clear reporting system so national level has an up-to-date idea of capacity pressures using existing channels (LRF and Local Health Resilience Partnerships)
- All local areas to have effective contact points between local authority emergency planning teams and social care providers. Care Providers Alliance and ADASS to provide assurance of 100% national coverage [Date to be confirmed with dependency on implementation funding]

9.0 NEXT STEPS

The development of the service 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 this paper 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 with Academy of Medical Royal Colleges and Presidents of the Royal Colleges and the Chief Social Worker
- Review with legislators/ regulators, professional bodies and lead professionals
- Engage with partner organisations including NHS Improvement, HEE, PHE
- Develop appropriate communications around this specific piece of guidance
- Engage with appropriate Devolved Administration representatives, possibly through 4N CMO and CNO groups

NR – DHSC
Name Redacted – 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:

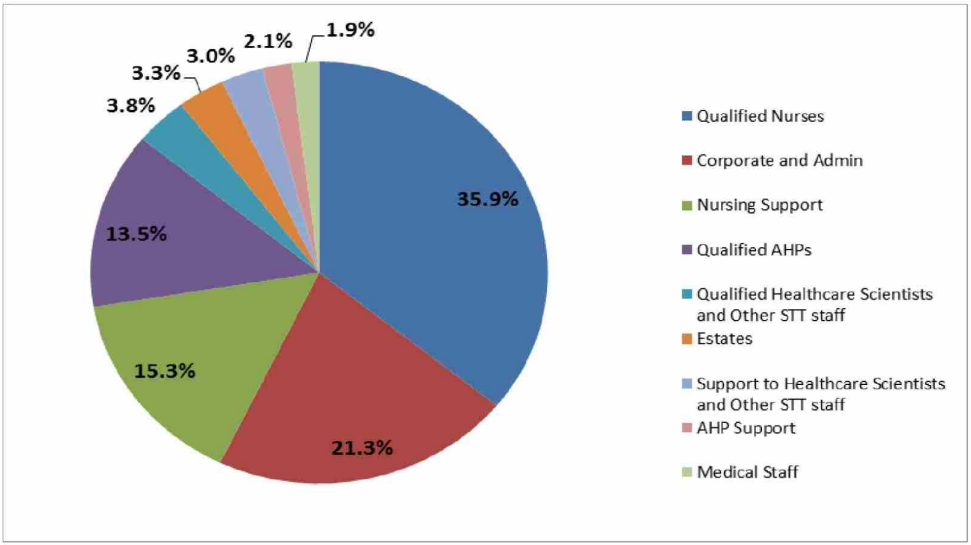
- 51% of the total workforce work full-time, 37% work part-time, with the remainder having neither e.g. being on zero hour contracts. The subset of care workers have a low proportion of people working full-time at 46%.
- 82% of the total workforce is female.
- 11% of the total workforce is over 60.
- 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.

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, e.g. Alzheimers and Dementia Support Services

CURRENT CHALLENGES

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.

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.

Annex B. Illustrative representation of activities during escalating periods of pandemic influenza surge – needs developing [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

ANNEX C: 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 Grade 4+ Syringe Driver In Palliative Care Other (e.g. Apomorphine) Chemotherapy Pump other Drains. Hickman Lines Palliative Care Referrals. Patients with pain/symptoms. (Acute)*. (End of life stage/Personal Care) Patient with Post Op Eye Surgery – Drops Autonomic Dyresflexia).	Wounds. Necrotic. Cavity. Exudating. Infections. Diabetic Foot. Pressure Ulcers Peg Feeding. Blocked Catheters. Tracheostomies. Breast - and any Unplanned Care. Assessments – New Constipation- (Requiring Enema, Paralysis –	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.