APPENDIX 1

Adults and Health Scrutiny Review Board Draft Topic Review Report

Topic Review: Protecting Care Home Residents and Staff

Contents

Working Group Membership

Adults and Health Scrutiny Board Members

- Councillor Alison Martin (Chair)
- Councillor Emily Lonsdale (Vice Chair)
- Councillor Rob Cooper
- Councillor Diane Froggatt
- Councillor Fareed Hussain
- Councillor Alan Grimadell
- Councillor Adrian Pegg

Foreword by Cllr Alison Martin, Chair

Care homes house the elderly and the vulnerable in our society. They are the homes that people turn to often when they are most in need, after a lifetime of working, caring and living in families, couples or as individuals. For many, the care home will be where they spend their twilight years, and probably their final years. Care home staff deal daily with the realities of later years life, something we all face later if not sooner. It is clear that when the Coronavirus pandemic in the UK was finally recognised by the government in March 2020, care homes were something of a twilight zone for the pandemic response and policy. In certain respects, care homes are anomalous in relation to the spectrum of the idea of 'home' held by much of the population: they are a form of collective living, yet people enter them *qua* individuals, often with high levels of dependency on institutionalised care by others, albeit in what is a *home*, not an institution. Blanket instructions to 'Stay Home' and 'Protect the NHS' thus rather inevitably missed the mark in terms of the specificities of care home living. Yet, given that the government were faced with a global pandemic already indicating elsewhere that it was posing a grave risk to the elderly and vulnerable, the scant attention paid to the particular situation of care homes in the early stages of the pandemic is a matter of national shame.

Many reports have documented the consequences of this neglect.[1] Releasing their latest findings, the Care Quality Commission stated in March 2021: "The impact of the pandemic on people who draw on and work in adult social care services has been devastating and despite the best efforts of staff, Covid-19 has contributed to a significant increase in the number of deaths in nursing and residential care settings."[2] On 27th April 2022, the High Court ruled that the government's policy of discharging patients into care homes in March and April was 'unlawful'. The Court was told that around 20,000 residents of care homes in England died of Covid-19 during the first wave of the pandemic, and that hospital discharge policies failed to take into account risks to the care home residents from non-symptomatic transmission of the virus, a policy described as 'irrational' by Lord Justice Bean: "The common law claim succeeds against the Secretary of State and Public Health England in respect of both the March Discharge Policy and April Admissions Guidance documents to this extent: the policy set out in each document was irrational in failing to advise that where an asymptomatic patient (other than one who had tested negative) was admitted to a care home, he or she should, so far as practicable, be kept apart from other residents for 14 days."[i3]

This Topic Review had the aim of looking into protections for care home staff and residents in the early stage of the pandemic with regard to the response of services and authorities in Derby. Much of that was dictated nationally, and our enquiries focused on the local response to the national guidance and the extent to which local decisions or actions were beneficial or could benefit from improvement in any future health emergency. For the most part, problems reported across the country during the early part of the pandemic (inadequate access to PPE in care homes) or which have become clearer subsequently (problems with hospital discharge policy, a lack of testing, the isolation of residents from their families),

[1] For example: https://committees.parliament.uk/publications/7497/documents/78688/default/

[2] Care Quality Commission publishes data showing death notifications involving COVID-19 received from individual care homes - Care Quality Commission (cqc.org.uk)

[3] https://www.cms-lawnow.com/ealerts/2022/04/government-failed-care-home-residents-with-unlawful-hospital-discharge-policy-so-whats-next

all existed in Derby, to a greater or lesser extent. Many of these issues were identified early on by the local agencies whose close collaboration ensured that some of the worst outcomes seem to have been avoided in our city, although Covid still led to an increase in care home deaths and left many staff unprotected whilst care home residents were isolated and separated from their families, who often had no contact with their relative.[4]

The focus on protecting the NHS was certainly a factor that side-lined care homes, leading to hurried discharge from hospital, a shortage of PPE for care home staff and some uncertain medical care, especially from GP services. Yet NHS services were not necessarily deployed to best effect. The Derby and Burton Hospital Trust responded to pandemic modelling in early March 2020, which predicted that their services would be rapidly severely overwhelmed. This led to a prioritising of Covid patients over all other forms of medical need, in spite of the fact that the modelling soon become inaccurate owing to the government's subsequent announcement of the first lockdown a few weeks later which prevented the level of transmission anticipated.

Opportunities for a localised response relevant to local conditions were limited and mechanisms for communication back up to Whitehall appear to have been equally limited. None of our enquiry respondents had felt empowered to anticipate dealing with a pandemic very far in advance of the governmental directions to do so in March 2020, despite international indications in late 2019 that a particularly virulent virus was spreading rapidly in other countries.

It was clear from all our enquiries, nevertheless, that all the medical and social care staff and managers were making the utmost effort to respond to what was, as became apparent in the spring of 2020, something previously unknown to them. The Local Resilience Forum did show resilience, and collaborative working between the NHS, public health, social care and the voluntary sector achieved much and gave evidence of a way to make things better in the future. It is a disappointment for the Board that we were unable to talk with care home residents and staff for the purposes of our Review, despite our best efforts to do so. Some important experiences of the pandemic thus remain under-represented here. However, all those we interviewed who work with care staff or who represent carers are very much of the view that care staff are underpaid and undervalued, and their status must improve if care home conditions are to be maintained and improved in the future. More work on the provision of care in a residential setting, and indeed in a domiciliary setting, would be desirable to maintain some focus on what is, in some respects, a problem for our time.[5]

I wish to thank all those who agreed to take part in this Topic Review to discuss their role, their actions and experience, and to offer suggestions for improvements for the future practice. I also thank my fellow Board Councillors for their input and assistance in the Review, and our Democratic Services Officer, Lindsay Stephens, for her work on the Review. On occasion, reflecting on and analysing what was, for most of the population, a very trying and sometimes tragic time, proved to be moving experience.

[4] See Appendix 2 for the statistical information that is available on the number of Covid cases and deaths in care homes.

[5] The inability to recruit sufficient numbers of care staff is creating serious backlogs in patient discharge from hospitals which have negative consequences not only for those left with unnecessarily prolonged hospital stays but also for other patients waiting to receive care, including accessing A&E.

We all pay tribute to the health and social care staff who were on the frontline during the pandemic and who did their best under challenging circumstances.

We remember all those who died of Covid-19, a pandemic which is not yet history.

Cllr Alison Martin

Chair of the Adults and Health Scrutiny Review Board

Recommendations

1. Establish a Care Forum in Derby to ensure ongoing and ready communication between all the relevant health and local authorities, care partners and the cared for and their advocates and relatives

2. Rethink emergency planning measures so that they more systematically incorporate anticipating the unknown to prevent hierarchical lines of authority and pre-established knowledge hindering the flexible response needed when the unknown arises.

3. Advocate for more two-way channels of communication between national and local government so that national guidance can be made more locally relevant and also be adapted to readily respond to actual needs in the community

4. Formalise the partnership working and informal local relationships that worked relatively well in Derby during the pandemic so that they are not dependent on ad hoc individuals but are structurally embedded in institutional resilience

5. Work towards ensuring that GP services are be more integrated into the NHS and LA emergency response teams and partnership working

6. Accelerate the Integrated Care Board's work on creating joint health and social care funds so that funding can be readily and rapidly directed to a given need without inter-institutional barriers

7. Where relevant to a future pandemic, ensure that regular testing is established as soon as feasible and ensure that stocks of PPE are adequate and available to care staff as well as NHS workers

8. Establish an annual civic awards event to recognise outstanding work by carers

9. Encourage all care homes to designate one member of staff to act as a 'communication bridge' between their residents and their families and friends

10. Further assist all care homes to promote cultural competency, and to address 'who' a care home resident is, alongside 'what' their care needs are

11. Promote information about the care system and how to access it via community groups and their community centres in the city

Scope of the Review

Following the declaration of the first lockdown on 23rd March 2020, it soon became apparent that protecting care home residents and staff from COVID 19 was a serious concern.

Whilst the government nationally was responsible for issuing guidance and regulations relating to Covid protection measures and to care homes, this topic review aims to reveal some detail regarding the protection of care home residents and staff in Derby in 2020, with a view to considering how the local authority, NHS and care homes can better work together in future to protect residents and staff.

Initial questions considered were:

1. How many care home residents were discharged from Derby NHS hospitals into care homes prior to the requirement for testing?
2. When did testing begin and what measures were put in place to deal with a patient with Covid-19, who was otherwise considered fit for discharge?
3. What role was the local authority playing at this time and were any local measures instigated to address this situation?
4. What measures did Derby care homes themselves use to manage patients discharged from hospital and residents with Covid-19?
5. Was PPE adequate? What local efforts were made to co-ordinate the supply and delivery of PPE, and when was that deemed necessary?
6. Do we know how many Derby care home residents and staff contracted Covid-19 and how many subsequently died from the virus?
7. Has the mental health impact of the pandemic in 2020 on care home residents and staff been assessed and have any measures been put in place to deal with that?
8. What lessons have been learned and what measures have been put in place already to co-ordinate better care and protection of care home staff and residents from now onwards?

Evidence Gathering

Members of the Adults Scrutiny Board undertook eight evidence gathering sessions from September 2021 to April 2022. They were able to question and receive further information on issues of concern. Notes of these discussions were taken.

Evidence was presented to Adults Scrutiny from the following organisations in the city:

- **Derby City Council**
  - Director of Adult Social Care
  - Director of Public Health
  - Cabinet Member for Adults, Health and Housing

- **NHS**
  - Director of Operations Derby and Burton Hospitals NHS Foundation Trust
  - Discharge and Integration Manager Derbyshire Community Health Services NHS Foundation Trust
  - Director of Quality Derby and Derbyshire Clinical Commissioning Group

- **Derby West Indian Community Association (DWICA)**
  - Elders Officer

- **Derbyshire Carers**
  - Operational Director

Care Home Managers in Derby, Associations, Alliances and Voluntary Organisations that represent the interests of the elderly and residents, carers in Derby as well as organisations that represent Care Home staff including nurses in Derby Care Homes were also contacted to seek their input. However, there was a poor response.

Summary of Evidence

Care Forums

A large part of the Care Sector is with private organisations, there was no knowledge of any organisation like a Carers Forum existing in Derby, this could be a gap in collaborative working as users of a service and their relatives are a useful resource to have.

How does the care home sector work within its own organisations and with other professionals? They are not seen as being of the same status as other professionals like consultants. The care home sector has been incredibly undervalued, should there be a body in place to represent the cared for and carers.

Organisations and bodies need to set up two-way channels of communications between themselves and care homes. Did anyone from services or bodies contact Derbyshire Carers during the pandemic? Derbyshire Carers met with senior hospital staff such as NHS Operations Directors, Service Directors regularly, they were all part of a Resilience Forum. They spoke with the CCG at weekly catch up meetings. There were regular emergency meetings to report emerging themes.

The issue of not being able to talk to loved ones in care homes has already been identified, but it had become clear that there were no real channels of communication between the Council, hospitals, and people in care homes. Senior managers were building resilience in their teams but were they getting response/feedback from residents or staff in care homes?

A lot had been learned, there was still a void around care homes particularly in the first 4-6 weeks of the pandemic. Was any thought given to speaking to groups who represented people in care homes. There were care homeowner groups, which were maintained during covid. The group looked at what information was shared with care homes, so that they were not inundated with information. Consideration to be given to establishing if resident representative groups were contacted

Overall, there had not been enough two-way conversations between bodies and organisations like Derbyshire Carers who had weekly meetings with the services.

Recommendation 1 - Establish a Care Forum in Derby to ensure ongoing and ready communication between all the relevant health and local authorities, care partners and the cared for and their advocates and relatives

Emergency Planning Measures

The Chair of the Liversage Trust used experiences at the Liversage Trust as a barometer in relation to the messaging that was being sent to care homes and if that messaging was clear enough for care homes to work with. Some policies and procedures which were requested to be adopted were not necessarily in the best interest of the care homes. The Liversage Trust provided isolation for residents until they were clear of infection. The guidance was not helpful nationally because discharges were being undertaken to free up beds that were urgently needed for covid in-patients at the hospital. These issues were raised nationally. The NHS was quite supportive in the case, but the instruction was to get people discharged as fast as possible

A councillor highlighted that there were discharges to care homes without testing for Covid, there was a shortage of beds and people were being forced out of hospital into care homes. People were sent to care homes, once they showed covid symptoms, they were not put into isolation but instead an ambulance was called, and they were taken back to hospital. It was explained that this was down to the particular care home's policy in relation to isolation and some did not provide isolation and people were sent back to hospital. To try and resolve this situation testing started to take place before people were discharged.

Plans need to be made for the unexpected. Organisations need to be quick and adaptable and should not try to model response on the known. When asked, none of the senior local professionals responsible for managing the health and care system in Derby had felt empowered to consider making plans for an impending pandemic prior much in advance of the government's own recognition of the pandemic in March 2020, despite all the evidence in the news that a pandemic was spreading globally.

New central government legislation was put in place for COVID-19. A lot of new working arrangements were set up quickly as the understanding of COVID-19 developed. A local web page was set up to provide information to care homes. Local care homes also joined together and shared information between themselves. Councils were required to publish an open letter to all care homes in their area giving information about the additional support available to care homes.

Recommendation 2 - Rethink emergency planning measures so that they more systematically incorporate anticipating the unknown to prevent hierarchical lines of authority and pre-established knowledge hindering the flexible response needed when the unknown arises.

Channels of Communication between national and local government

It was clear early on to the local authority that the exclusive focus on protecting the NHS by the government was side-lining social care and accentuating the relative isolation of care homes; the order to discharge all patients who had no reason to stay in hospital after 19th March 2020, despite the absence of Covid-19 testing, was rash and soon became unnecessary given that the lockdown prevented the numbers of Covid patients requiring hospitalisation and the Derby & Burton Hospital Trust (DBHT) had plenty of empty beds – local professionals should be able to react to such scenarios.

There were frustrations with Government instructions which had to be followed and were not always in the best interest of the collective group. The outbreak Engagement Board engaged with NHS England and NHS Improvement, National Public Health and Government. When issues were identified, they could have been addressed quicker and better. Some issues were challenged both locally and nationally. The Outbreak Engagement Board met weekly at the start of the pandemic. Information from the Board was supplied to councillors via the Members' Bulletin.

National Guidance for Care Home Staff

In the context of the national guidance and regulations issued relating to Covid protection measures and to care homes, what could the local council do in responding to national guidance? In the early part of the pandemic, DCC followed government guidance and supported all care homes to ensure they understood how to interpret the national guidance. Local authorities must follow national guidance, they cannot provide or make up different guidance locally as there was a possibility of getting it wrong. That was why DCC wrote to all care homes to remind them that they needed to follow national guidance.

A councillor was interested to know what local people could do to help in a crisis. They heard that many of the initiatives, such as the testing regime, were nationally led. Local teams were able to support by highlighting routes to testing, there was a lot a facilitation and joining up of roles.

Was there an NHS failure in providing support for care homes? Support was given under difficult circumstances, but care homes and staff needed hands-on, in-person help rather than email/letter guidance.

Both the NHS and Government work in an environment of central guidance on how to do things. The clinical environment is very much one of following prescribed guidance. In the early part of the pandemic DCC followed government guidance and supported care homes so that they understood how to interpret Central Government Guidance.

Recommendation 3 – Advocate for more two-way channels of communication between national and local government so that national guidance can be made more locally relevant and also be adapted to readily respond to actual needs in the community

Partnership Working and Informal local relationships in Derby during the Pandemic

Inter-institutional responses and whether people from different organisations could work together were examined.

Derby public health team worked closely with colleagues in other Council teams. During the pandemic, the Director of Public Health worked closely with the Service Director of Integration and Direct Services (Adults) who had responsibility for care homes and data analysis was undertaken by that team; there was a level of interaction between teams including the Commissioning Team and relationships between the teams were strengthened. The Derby Public Health Team worked closed with Derbyshire Public Health. The internal procurement and contract team worked with care homes and provided staff with information. The care homes themselves learnt at pace during the pandemic which meant they are now in a better position. DHU continue to undertake community outbreak swabbing.

There was also the Local Resilience Forum. Community Action Derby co-ordinated the local community and thousands of volunteers helped those who needed support at home rather than care homes. They were also instrumental in keeping the Arena running for the vaccination programme and providing pop-up vaccination centres.

Relationships with Health and Public Health had never been better with everyone pulling in the same direction. There were some hiccups along the way but most work was completed with total agreement and support from everyone.

It had been a difficult time especially in the early days of the pandemic because the medical profession did not know how to deal with the pandemic. The NHS was structured top-down and operated under guidelines and were acceptive of guidelines. Over time it became clear that the guidelines were not always as good as they could have been. Everyone was caught out with the pandemic and guidance was issued late.

There needed to be a realisation from the CCG and Integrated Care System that not everything was clinical. Often housing conditions for example could affect health. The ICS was due to come into being later in the year and there would be an all-member briefing. As a result of the pandemic, there were much better links between health, social care and local authorities.

The local authority had a bigger role to play in social care and the CCG had provided some funding to help with recruitment and retention of staff. They had realised that if people were not in care homes, then there would be more pressure on the NHS.

The Working Group were interested to understand what had been learnt locally and what should be put in place for the future. The following thoughts and ideas were suggested:

- The NHS dominated the government's agenda during COVID 19 Pandemic
- Adult social care is a small but critical player
- The NHS learnt that they need to take account of adult social care provision and services
- The NHS have had all the power and resources. However, Derby city was able to benefit from the fact that local relationships between the NHS and partner organisations were already in place.
- Local relationships are essential in times of crisis. If there are no local relationships in place, then there would probably have been a worse result for Derby in terms of the effects of the pandemic.

Recommendation 4 – Formalise the partnership working and informal local relationships that worked relatively well in Derby during the pandemic so that they are not dependent on ad hoc individuals but are structurally embedded in institutional resilience

Better Integration of GP services into NHS and LA emergency response teams and partnership working

There was a COVID Hub in place, but they only provided services like prescriptions, food banks and shopping. There was no help to make GPs more accessible, or to help with the social care side; simply assisting people to contact a GP would have been a big help.

It was difficult to get GPs to the table as they were all separate individual practices. It was explained that even before COVID, it was always difficult to find the best ways to engage with GPs as they were individual businesses, which proved a challenge. In relation to enhanced GP support in care homes,

each care home had a named GP. That GP would support care homes to make sure people were safe and would support the care home, although how available they were to assist care staff and residents in the care homes during the lockdown was contested.

Recommendation 5 – Work towards ensuring that GP services are be more integrated into the NHS and LA emergency response teams and partnership working

Joint Funding for Health and Social Care Funds

Was joint funding being considered as the way forward?

There had been a joint fund set up between health and social care and this had worked well. Rather than deciding which bits of care would be funded by health and which bits by social care it was funded from the joint fund. This sped up getting people home and was in place for the first 4 weeks of the person being discharged.

The Integrated Care Board was working towards the opportunities of a joint budget.

Recommendation 6 – Accelerate the Integrated Care Board's work on creating joint health and social care funds so that funding can be readily and rapidly directed to a given need without inter-institutional barriers

Testing arrangements

If there was another pandemic regular testing arrangements should be established as soon as possible.

Testing on a regular basis was key.

In the early days of the pandemic, public health was observing international developments, briefing generally about what was anticipated. The UK had experience previously of the flu pandemic in 1918, but had not been exposed to SARS, MERS, and Ebola. From the city perspective testing and data were a real issue. People infected with symptoms were being tested at Derby Hospitals and results were not reported to public health. Only people admitted to hospital were tested. Nationally there were approximately 4,000 tests per day undertaken using hospital laboratories. Community testing started in May 2020, and the situation improved gradually. However, any data was reported to Public Health England not to local public health teams. Local public health teams were incredibly challenged, they only had information about the number of cases in the city. They worked with Derby hospitals to understand the demographics of patients in hospital, and once local data was made available to them, they could see where the cases were in the city and begin to think about possible prevention measures.

An enhanced programme of testing for all residents and staff had been introduced into care homes in June/July 2020. The increased understanding of asymptomatic cases was significant, and the introduction of regular PCR tests began. Derby City Council's Public Health Team worked with the Derbyshire County Council Public Health Team and the Social Care Commissioning Team who contacted care homes. Derbyshire Healthcare United (DHU) undertook swabbing of residents and staff in all care

homes during the first period of the pandemic. Eventually, as care homes became more confident, they took over the role of swabbing their staff and residents. Polymerase chain reaction tests (PCR) and Lateral Flow Tests (LFT) were undertaken by care home staff.

In hospitals, there was no in-house testing at the start of the pandemic, so tests had to go to Birmingham, Leicester, Sheffield or Nottingham and results took between 24 and 72 hours. Normally there would be around 110 emergency medical patients per day so 2-300 patients were admitted before the results of the tests were received. It proved a challenge to ensure people were isolated. Covid presented a huge demand for infection control and isolation. Patients who were symptomatic isolated in grouped bays until the tests results were received. Positive cases were grouped together as were negative cases until they could be moved. At that point it was not in the guidance that people could be positive but asymptomatic. Testing capabilities improved over time and in mid to late April 2020, there was an instruction to test people being discharged to care homes and social care settings. In March there was no requirement to test patients.

Advice for Accessing Testing for Care Homes

On 11th May 2021, a National Portal was established; care homes, schools, etc, could request as many testing kits as they needed. All care homes in Derby were advised of the portal by letter from Derby City Council sent on that date. Prior to that, care homes had been advised on how to access the Public Health England testing regime.

Was the definition of when an outbreak should be classed as such known? The first few weeks of the pandemic were ones of incremental learning, Adult Social Care were not normally closely involved with Public Health England and would not know the PHE definition of an outbreak (as it varies depending on the disease). Public Health England have a well-established view of what an outbreak consists of (this is a national definition). As soon as it was apparent that there were more cases, Public Health England were the body that confirmed when there was an outbreak in care homes.

A letter attached from PHE in April described the early approach to testing: DHSC PHE Letter - Further information on COVID-19 testing in social care (local.gov.uk)

What was the position with Personal Protective Equipment (PPE)?

There was a significant shortage of PPE both locally and nationally. The NHS had no relationship with care homes regarding PPE, that was the role of local authorities and the Local Resilience Forum (LRF).

Local authorities asked for PPE to be supplied to care homes but there was a national shortage and so very little was supplied.

In relation to PPE at care homes, it was reported that some care homes had their own PPE despite the national shortage of PPE. A lot of contracts were not carried out in the way they would normally have been. There were regular supplies to care homes in Derby, but it was a two-tier system from the NHS and individual suppliers. There were some issues with supply in Derby.

The Board heard that Care Homes used PPE for everyday protection in their work prior to the pandemic.

In relation to the stocking of PPE there needed to be a way making sure there was not a panic situation.

Actions taken before lockdown by DCC included checking stock levels for Council-run care homes and advising privately-run care homes to check their stock levels. Private care homes knew how to order stock but the demand for PPE meant that normal supplies were disrupted.

There were informal offers of support from local suppliers who had spare PPE. The Local Resilience Forum received emergency supplies of PPE which were prioritised for care providers or people struggling. Since autumn 2020, central government has provided free supplies of PPE.

Carers who provided personal care for their loved ones' homes were not able to access PPE for their own protection. For carers of relatives, isolating was difficult as they had to go out to collect prescriptions or shopping.

Recommendation 7 – Where relevant to a future pandemic, ensure that regular testing is established as soon as feasible and ensure that stocks of PPE are adequate and available to care staff as well as NHS workers

Reward and Recognition for Carers

Recognition of carers and their work. The problem of attracting care home staff needs to be emphasised and the fact that it goes beyond recruitment and training: care home staff need to be valued and have a status in society, without that cared for people could be put at risk.

There is a problem of attracting staff for care homes; many people prefer to work in the supermarkets where there is better pay.

Staff turnover is high in care homes and the recruitment and retention of staff is a significant issue.

This was part of a national discussion about career progress, recognition and pay. Care workers' status should be viewed in a better way, and they should be more valued. The level and complexity of care needed by individuals was different now, carers are not just feeding and washing they deal with their medical needs, too.

There was a lot of praise for NHS staff, but unpaid carers felt devalued, they were left to take on all the roles of caring in their homes. There was no advice, or practical/advisory help given. They felt undervalued and unrecognized.

Care homes and nursing homes were under pressure and health care staff had been employed to help. It was difficult to recruit to care staff, the NHS positions were more attractive as they had better terms and conditions and more opportunities to progress.

Staff recruitment had been an issue early in the pandemic, particularly in relation to the requirement for all staff to be triple vaccinated. This was now the responsibility of the individual care homes to deal with. At the Liversage Trust all staff had been vaccinated. This was the responsibility of the manager of the care homes but not all of them followed the guidance. Some staff had left due to the vaccination position. There had been difficulties with recruitment for several years. Recruitment and retention incentives had been considered in recognition of some of the issues experienced.

Career progression needed to be offered. Good career paths could be very rewarding.

Recommendation 8 – Establish an annual civic awards event to recognise outstanding work by carers

Homes 'communication bridge' between residents, families and friends

There were a lot of hospitalisations from care homes, as well as difficulty in communications. No visiting was allowed, and carers became fearful and anxious for their loved ones. There were no ways available to talk to relatives who were residents in care homes and no arrangements were put in place for visiting.

During the first two weeks of the pandemic, staff from Derbyshire Carers spoke to all carers to establish what the issues were. One key area of concern for carers was the lack of communication from care homes; it was claimed that they did not keep families informed.

People felt cut off from their relatives due to care homes not allowing visitors. The Cabinet Member was aware of this, and a lot of work was done to help people visit outside, IT was used, WhatsApp and iPads were used to allow communication with relatives. Much of this was down to individual care homes willingness to do this. Guidance was given but could not be imposed. If it was a Council-run service, then the best possible position was undertaken, it was re-iterated that visitor guidance fell to the individual care homes and if it was possible to make visiting safe.

Some care homes had technology to allow residents to have contact with the outside world. At later stages of the pandemic, some provided tablets for visual linkups with patients and relatives. End-of-life care was given with sensitivity, but families felt more could have been done; it was very distressing indeed that loved ones were on their own when they died.

Most people in care homes would have had phones but not enough people had given thought as to how people in care homes and families could stay in touch and communicate. In some cases, people had been able to use their phones when they first went into care, but the phone could not be recharged, chargers were misplaced. People in care homes and hospitals were cut off.

This was a forgotten, neglected, and hidden community of the pandemic. There could be other communities that were bypassed in the same way. It was highlighted that it cannot always be down to relatives to communicate - phone calls could be scheduled better.

Some care homes had technology to allow residents to have contact with the outside world. It would be useful for care homes to have 'tech savvy' staff so that communications between residents and family and friends could be enabled. If there was space, could barriers be built that allowed people to see family and friends, even if they could not have contact with them and maybe activities could be organised as well.

There was concern about the mental health of residents.

Isolation in care homes was a challenge. There was a balance to be had on allowing visitors in and not allowing them in. Contacts were very restricted but were in line with national guidance

Recommendation 9 – Encourage all care homes to designate one member of staff to act as a 'communication bridge' between their residents and their families and friends

Care Homes to promote cultural competency: 'who' a care home resident is alongside 'what' their care needs are.

The longer people stayed in care homes the more issues developed. There was less structure in place to help residents, they were not engaging in activities, there was no routine in place, there was a significant deterioration in residents' abilities, a decline in their health and wellbeing, the usual exercise sessions did not take place for those who had Parkinson's Disease or Multiple Sclerosis, (MS) their mobility and cognition became worse, people with dementia got worse, it was a year of going backwards.

People were admitted but sometimes nothing known about the person behind the illness to enable care home staff to work better with that person.

It was suggested that when people were assessed for going into care the assessment should not just be based on practical needs, but also based on emotional and social needs. If people are unable to exercise what else could be done for them.

Conversations should be had with the professional carers to find out what activities their loved one enjoyed, they should have an overall picture of the person, carers at home would be more reassured that activities were taking place for their loved ones, and they were not just left alone and feeling deserted.

Residents in care homes did not undertake the usual activities, of games and jigsaws, there were no visits from hairdressers or chiropodists.

There should be a full assessment undertaken on the person going into care, it should be captured on a simple assessment form with triggers and de-escalation. This would make it easier for care home staff to provide better care.

A ClearView Research study from September 2020 was highlighted by DWICA. It found over 60% of black people in the UK do not believe their health was as equally protected by the NHS compared to white people. There are language differences; even if there was a shared language there were barriers in the way of communication. Another barrier was the cultural appropriateness and awareness of staff, issues that arise if cultural differences are not addressed including religious observance, food consumption differences and in some cases, the correct pronunciation of names.

DWICA looked at what solutions and actions need to happen to help resolve these barriers. They asked over 60 COVID Kitchen users (a hot meals on wheels service run by DWICA) for their opinions on social care and the barriers they found to access services. Cultural appropriateness was third highest. The Board heard about the weekly culturally appropriate food provided by COVID Kitchen one comment made was: "It's a healing thing for people, when you smell your people's food you become more alive".

Recommendation 10 – Further assist all care homes to promote cultural competency, and to address 'who' a care home resident is, alongside 'what' their care needs are

The Care System Information and Access

The importance of third parties or groups outside of mainstream services, like drop-in centres or community centres can assist the BAME community in combating barriers to accessing social services. Community organisations like DWICA can work with local authorities to act as information points and signpost the elderly community towards the services available to them. They can also act to raise the expectations of its community towards social care and advocate for those communities to help rebuild trust.

The COVID virus affected black Caribbean and black African ethnic groups disproportionately. The higher proportion of care home deaths came from the black Caribbean ethnic group. The research undertaken by DWICA examined what barriers black Caribbean elders faced when accessing social care. These included: a lack of knowledge of services available, a low expectation and poor perception of the services. The recommendations from their research were: wider information sharing with minority communities and in a way which doesn't disenfranchise at point of delivery; this could be done with support of community centres or churches. Culturally sensitive staff at all levels of the social care system. Culturally appropriate provisions like food have a positive mental and physical health impact and should be promoted. The social care system should rebuild trust with BAME communities following the Coronavirus pandemic and previous past negative experiences with healthcare.

DWICA were asked what they did as a signposting organisation to make sure it was effective especially for elderly people. It was difficult, especially with elderly people who are frustrated with ASC as a lot of information is online and older people need family or friends to help them research. If no-one was available, they are stuck. Leaflets would be good as they are constantly available.

Recommendation 11 – Promote information about the care system and how to access it via community groups and their community centres in the city

Background Information

Discharge arrangements from Hospitals to Care Homes

There seemed to be a picture of panic in preparedness, rapid action was taken but not fully informed of the need to discharge people to the community, discharge policy to care homes and community measures to protect people. Older people were more susceptible to disease and were disproportionately a more at-risk group.

There were concerns about discharges at the start of the pandemic. There seemed to be a rush to discharge at all costs and there was concern about the condition of life in care homes at that time. Care Homes are unique in that they are where people live collectively

Hospital discharges had been a big issue. Discharge to assess had been controversial. Discharge without testing for covid in the early days was a particular problem. This was raised seriously at all levels. It was realised that this had put care home residents in danger.

From 19 March 2020 all patients who were medically fit and didn't have a specific reason for needing to be in hospital were discharged in readiness for the wave of patients expected. Covid presented a huge demand for infection control and isolation. Discharges without testing occurred between March and mid-April 2020. If there was another pandemic regular testing arrangements should be established as soon as possible.

At the start of the Pandemic there was no advice in place for hospitals to discharge patients to Care Homes, it was a push to free up hospital beds, people were also discharged to their own homes. Testing was not widespread at that time and there was no testing in the community. Central Government had different phases in place in the lead up to lockdown, the hospitals were creating capacity to receive COVID 19 cases.

There was a central government push through the NHS to free up hospital beds to manage the anticipated needs for Covid patients, there was no widespread testing available for Care Homes until May. If anyone had symptoms, they could contact Public Health England. If there were more than two or three people in a place, be it a school, Care Homes or other settings, then a testing team would be sent in, this was the situation up until May 2020. Once cases were known Public Health England made a judgement call, testing is still controlled by the NHS.

Questions asked included what had happened locally with discharges to care homes particularly in the first wave of covid and to what could be learnt for the future. What was the response to the government instruction to rapidly discharge people to free up acute beds, how many people were discharged without testing and when testing started?

In the context of what was happening at the time, late February to early March 2020 instructions were taken from NHS England. Each Trust was its own legal entity and responsible for their actions, but instructions were taken from NHS England. National guidance and modelling stated that beds would be overwhelmed. The trust had 1,000 acute inpatient beds and the predication was that there would be 1,400 – 2,000 potential covid patients. This did not take account of anything other than COVID. In relation to intensive care the predication was 180 – 850 beds required and there were only 13 beds.

Command meetings were held 7 days per week to respond to the pandemic, the entire hospital was surveyed to see where people could be put in a bed with oxygen including outpatients, day care etc.

When there was the call for rapid discharge, how many people were discharged to care homes and the community? Testing couldn't be done in house initially but did become available in April 2020 around the time that testing was required for discharge to care homes. Discharges without testing occurred between March and mid-April 2020. Information was provided on the statistics see Appendix 2. Discharge to care homes was very small, most discharges were into the community or own homes. As soon as the guidance to test patients came in, patients were held until the test results were received. A lot of care homes were able to accept covid positive patients. Designated beds were set up for positive cases.

The system worked together to strategically look at the guidance, to see what could be done and mitigation etc. People were discharged to care homes and designated beds were set up for positive patients. The guidance was followed but there was also some system thinking on what was beneficial, which allowed people to be constructively challenged. The system worked better in Derbyshire than the rest of the country. It was noted that health and social care services were around the table but not so much GPs.

There had been a very good strategical and tactical relationship in relation to discharges. With care homes there was an operational relationship, which was responsible for infection prevention and control methods and support for outbreaks. There was concern about capacity to support discharges as winter approached. There was a workforce deficit, social care was struggling as well and there was a new variant Omicron.

Discharges were a health and social care joint decision. Referrals were considered jointly, and patients were constantly reviewed. Derbyshire was working together very well but this was not the case in other areas

A group had been set up to look at strategic discharge, as there was concern about getting people out of hospital safely. The system worked together to discharge vulnerable people and those with covid to the right places. There were difficult decisions to take, and people were discharged to care homes with COVID but needed to isolate for 14 days.

Were people only tested on arrival at hospital rather than leaving. Testing people leaving hospital came in around 4 to 6 weeks after that start of lockdown. COVID testing has moved on significantly since then, people were not routinely tested, only if they had symptoms. The guidance on testing came later. The first wave of people were discharged without testing but they would now go to designated beds in specialist care homes (6 beds).

The Strategic Discharge Group had had its work recognised as good practice. It has set principles of working in partnership, to support the system. There were examples of where nursing homes couldn't get staff, so the community trust offered up registered nurses, to help get back to normal levels and keep discharges happening.

Were there cases of people being discharged to social care homes which didn't have nurses and they were having to isolate in their rooms. People were discharged to designated beds. During the first 6 months, lots of people were discharged home rather than to care homes and so care homes had empty

beds, which became a financial issue. The care homes were supported to stay in business. Home first was always the best place for people, as long as they were safe and had the right care packages available.

The designated beds were in four care homes who went through a CQC registration to provide them. They needed to be in care homes that could be segregated and could provide therapy. There had been 12 beds at the height of the pandemic but there were currently 6. The CCG block contracted the beds to ensure they were always available.

The beds were not at the London Road hospital as that would not have met the CQC requirements and would have been difficult to staff. The CQC would not have wanted 12 beds in the same place. They also wanted people to be as near to home as possible. Care homes had a 33% decrease in numbers of residents during the first lockdown.

The discharge group has been involved in other work including, discussions with families and the person, if their first choice of placement could not be met. Care homes could not take people if they had an outbreak of COVID.

It had been a difficult time to meet the needs of vulnerable people. Did discharges play a part in spreading covid in care homes. When outbreaks were reviewed only 1 could be traced to have come from a hospital. The biggest issue was care home staff moving between homes. Directors of Public Health were very strict on what could and could not happen. Movement of staff between homes was no longer allowed. Cases had been mapped and some outbreaks in hospitals were due to staff not following the PPE rules. Care homes in Derbyshire were quick to act and the system worked with the care homes when issues occurred.

Care Home policy in relation to isolation differed, some did not provide isolation and people were sent back to hospital.

The Cabinet Member as Chair of the Liversage Trust had been able to use his experiences at the Liversage Trust as a barometer in relation to the messaging that was being sent to care homes and if that messaging was clear enough for care homes to work with. Some policies and procedures requested to be adopted were not necessarily in the best interest of the care homes. Liversage Trust provided isolation for residents until they were clear of infection. The guidance was not helpful nationally because discharges were being undertaken to free up beds that were urgently needed for covid in-patients at the hospital. These issues were raised nationally. The NHS was quite supportive in the case, but the instruction was to get people discharged as fast as possible

There were discharges to care homes without testing for covid, there was a shortage of beds and people were being forced out of hospital into care homes. People were sent to care homes, once they showed covid symptoms, they were not put into isolation but instead an ambulance was called, and they were taken back to hospital. It was explained that this was down to the particular care home's policy in relation to isolation and some did not provide isolation and people were sent back to hospital. To try and resolve this situation testing started to take place before people were discharged.

[i] https://www.cms-lawnow.com/ealerts/2022/04/government-failed-care-home-residents-with-unlawful-hospital-discharge-policy-so-whats-next