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

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1.0 PURPOSE AND INTRODUCTION

The purpose of this paper is to set out plan for the Chief Medical Officer, Chief Scientific Advisor, Chief Nursing Officer and Chief Social Worker on key options and considerations to maintain and augment the community health care and adult social care sectors' response to an extreme influenza pandemic. The plans and recommendations are set out to support up to a reasonable worse-case scenario of 50% infection rates, 4% of those requiring hospitalisation and staff absences of up to 50% of the workforce over the pandemic.

Exercise Cygnus identified a knowledge gap in community services preparedness, including both adult social care and community health care. These sectors will have two key roles in the event of a severe pandemic. Primarily, this will be to treat and support individuals in the community who were already receiving care, those with new care needs due to the pandemic or those who are unable to get into hospital due to pressure there. There is also a secondary role for both sectors working with the acute sector in helping to reduce pressure on hospital in-patient and out-patient services, by providing health and care services in the community to reduce avoidable hospital admissions and to support discharge from hospital. This work is part of a cross-government programme of pandemic influenza preparedness work, which includes:

1. **Hospital care**: to consider NHS surge escalation and triage in a reasonable worst case scenario pandemic (subject of previous briefing papers to CMO, CNO and CSA).
2. ***Community care****: to increase our understanding of and confidence in the ability of the community health care and adult social care sectors to respond to a reasonable worse-case scenario pandemic.*
3. **Excess deaths**: to ensure that there is sufficient capability in England (and Wales where relevant) to manage the volume of deaths set out in the National Resilience Planning Assumptions in an effective and coordinated, but respectful manner.
4. **Sector resilience**: to ensure that departments are confident that their key sectors have adequate resilience to anticipated levels of employee absence (both peak and duration) during a pandemic flu outbreak.
5. Cross-cutting themes:
    a. **Communications**: to update, improve and consolidate communications messages to ensure a coherent and considered response in an influenza pandemic
    b. **Legislation**: to produce a draft UK Pandemic Influenza Bill. The Bill will be held internally and provide a menu of options to be brought forward if required to support a four nation response to a severe pandemic close to the reasonable worst case scenario.
    c. **Moral and ethical**: to ensure that ministers understand that there will be moral and ethical considerations in a response to an influenza pandemic, and give them the opportunity to have access to moral and ethical advice on the subject in advance and/or at the time of a pandemic.

In addition to the above work programme, NHS England have been considering the

breadth of services delivered in primary care and how these interrelate to the above, and will shortly be focussing on mental health and end of life/palliative care in an influenza pandemic more specifically.

This paper is to be presented to the Chief Medical Officer (CMO), the Chief Scientific Advisor (CSA), the Chief Social Worker (CSW) and the Chief Nursing Officer (CNO) to inform and assure senior decision makers and is not intended to be a guidance document for clinicians or care providers.

The majority of the detail in this paper will not be replicated in any publically available documentation and this must be borne in mind when sharing this paper beyond its initial intended audience.

This paper is current as of June 2018. It is authored by the DHSC pandemic influenza team; DHSC Community and Transformation directorate with policy responsibility for adult social care and NHS England, with the latter two teams accountable respectively for adult social care and community health care (see PID at Annex B). Input has been gathered from key contributors in NHS England, DHSC and partner organisations and from service providers and care deliverers (see Annex A). Community care-facing guidance is already contained in NHS England's guidance to the NHS on current and future preparedness for an influenza pandemic. Consideration will be given to producing guidance for adult social care after February 2019.

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 ADULT SOCIAL CARE

Adult social care in England is a combination of **state-funded and self-funded** provision. It delivers **personal and practical support** to 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 or long-term packages of care and support.

Around **1.1 million people** receive long-term or short-term care and support during the year. Of these, in 2016/17, at any one time, around 655,000 were in receipt of long-term care. Working age adults (age 18-64) accounted for 39% of LA-funded or supported adult social care users at end-of-year 2016/17, although they accounted for 53% of local authority adult social care expenditure in that year.

Most people receiving formal care are **supported by the state**, but a significant proportion **pay for and arrange their own care.** Domiciliary care is largely state funded (80%) whilst most people in care homes are self-funders.

The majority of long-term care term users are in **community settings,** such as care homes, their own homes or day care/drop-in centres.

Adult social care is largely provided through a market of **independent providers**, including the vast majority of both residential and domiciliary care (78% and 91% respectively), with the remainder a mixture of public and voluntary provision. Providers of care services must register with the national regulator, the Care Quality Commission (CQC).

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 are set out in table 1.

Table 1: Staff roles in adult social care

Roles	FTE
Senior management	15,500
Registered manager	22,500
Social worker	17,000
Occupational therapist	3,100
Registered nurse	43,000
Senior care worker	85,000
Care worker	815,000
Support and outreach	60,000

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 has 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.
- there are 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 6 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.

2.1 Impact on demand and capacity of adult social care

In the event of a reasonable worse-case influenza pandemic, the number of people in the community requiring adult social care is expected to increase. Increases in demand may be as a result of a number of factors.

1. Existing service users having increased levels of need because they contract influenza.
2. Existing service users having increased levels of need because the family/carers who supplement their support fall ill with influenza.
3. People not receiving a service but who are usually supported by family networks/carers, who need new care packages because their carers are incapacitated by influenza.
4. People being discharged early from hospital with on-going care needs, due to overall increases in acuity and activity leading to shortages in bed capacity. (Whilst social services cannot be expected to deliver health care, these people may nevertheless have more extensive care and support needs).
5. Previously well individuals becoming ill with another condition but unable access the treatment and care they would normally receive due to shortages in hospital/primary/community capacity and so requiring adult social care.

<u>Workforce capacity</u>

Whilst demand will increase, capacity, which is already under pressure because of recruitment challenges, will also reduce because of staff absences. Absence should follow the pandemic profile. Additionally, the demographic profile of employees in adult social care means that a higher than average proportion of the workforce is likely to have personal caring responsibilities. This may further reduce capacity.

Absence rates for the social care workforce and NHS workforce are both estimated to be in the region of 17% - 20%. This consists of 15%-17% of people being absent directly due to illness and an extra 2%-3% to account for those who miss work to care for children (this does not include any impact from school closures). These are overall figures, in line with the workforce overall, and are likely to be higher for some workforces, especially if they are small.

<u>Provider capacity – care homes</u>

CQC’s provider information collection provides data on care home locations, numbers of beds, and the type of provision (residential care, nursing care or both).

As of June 2018, there are around 459,000 beds in care homes in England. The data does not show how many beds are occupied. However, DHSC estimates that, as a national average, homes operate at 87%-90% occupancy, although this will obviously vary over time and by area. So a reasonable assumption would be that 10% of the total bed holding, or around 46,000-59,500 **beds**, may be available at the onset of a pandemic, although not necessarily in the areas immediately affected and thus demand potentially the greatest.

Whilst some care homes would miss a pandemic altogether, those that do see cases would expect to see much higher attack rates in some of the very smallest facilities. Overall, we would expect **an attack rate of 55%.** Based on the overall death rates, this would equate to a total of **5,500-5,800 deaths** over the whole of the pandemic. This would be higher if the pandemic were to disproportionately affect older people, but even if they were twice as likely to die the number of newly available beds would be much lower than the number currently unoccupied. Therefore, for planning purposes we should not place over-reliance in additional social care bed capacity being freed up through additional deaths.

Provider capacity – domiciliary care

Nationally, we know that around 500,000 people receive personal care in the community, of which the vast majority is provided in their homes through domiciliary care. However, there is no national level data breaking down what this domiciliary care entails, and therefore any estimates calculating how our prioritisations plans would play-out will be misleading. The Care Quality Commission collection identifies the location of providers and age groups of service users but does not show providers' reach or the number of packages of care provided.

Through the Pandemic Flu Resilience Standard, Local Resilience Forums (LRFs) are expected to have a methodology to identify people who are likely to be vulnerable in an influenza pandemic, which should be agreed with partners, recorded and tested. This should include working with local authorities, who have good knowledge of their local social care market. Nonetheless, given the pressures on the sector in normal times, it seems reasonable to assume minimal to zero spare capacity.

Carers

There are currently 5.4 million informal carers in England. In the peak week we would expect 10-12% of the population to be incapacitated with influenza. Clinical advice states that we should expect that no one with influenza would be able to give care for the first 5 days and almost everyone who survives would be able to care again after 10 days. Assuming an average of 7 days, we would expect around **610,000 people no longer to be able to give informal care in the peak week**, with upper and lower estimates of 430,000-930,000. This number includes both the number who would become incapacitated and who would be incapacitated over the peak week.

Some carers care for more than one person, some people have more than one carer and others would have friends of family that could help care for them. The number of people who would require care as a result of the loss of informal care would

therefore be somewhere between these 2 figures, but closer to the latter.

Summary

Despite a significant amount of uncertainty and lack of national data, it is clear that the number of additional people requiring adult social care would be much higher than the number of unoccupied beds, even including those freed up by their occupants dying.

Capacity	
Care home beds (June 2018): Average occupancy: = Available beds:	459,000 87 – 90% 45,900 - 59,600
Deaths in care homes over duration of wave	5,500 – 5,800
Domiciliary care	*No National Data*
DEMAND	
Existing domiciliary care users getting ill from Flu (impact 1)	250,000
Average attack rate in care homes (impact 1)	55%
Peak reduction in informal carers (impact 2&3)	610,000
Discharged from hospital early with ongoing care needs in peak week (impact 4)	*Unknown*
Previously well individuals becoming ill with another condition, unable access the treatment and care they would normally receive due to shortages in hospital/primary/community capacity and so requiring adult social care. (impact 5)	*Unknown*

2.2 Service Reconfiguration

Surge capacity is already required on a regular basis when areas experience localised, short-term pressures (e.g. during winter, weather events, major incidents), and area partners can use their business continuity plans as starting points to identify their priority services for an extreme pandemic. Local authorities have business continuity, major incident and pandemic influenza planning and response arrangements and Local Resilience Forums (LRFs) are expected to consider adult social care provision and preparedness as part of pandemic influenza planning.

However, in the event of a reasonable worse-case scenario, standard surge capacity will need to be reviewed in light of the duration and wider geographical spread. Additionally, adult social care will have an increased role in supporting rapid discharge from hospital to help maximise hospital capacity.

The following 4 considerations (based on discussion with front line services) for adult social care should be used when assessing how to preconfigure services within a locality.

1. Which services can be deferred / reduced?
2. Which services may need to be increased?
3. What level of service user choice is possible?
4. How can increased use of technology support the system?

2.2.1 Prioritising care

Adult social care prioritisation will be essential in order to maintain services as pressure on resources mounts. A clear understanding of risks and consequences, and how to move into recovery, will be required. The recovery implications and consequence management are outlined in section 2.3.

CASE STUDY – Working Age Adult

An autistic 41 year old service user receives a package of care to promote independent living and support their social and physical activities.

This includes a personal assistant to attend to personal care (showering and dressing) and support cooking meals twice a day, as well as 3 meetings a week with a support worker to support social and physical activities.

In a severe pandemic influenza, this would be reduced to one visit by a personal assistant every three days, and a “meals on wheels” service would be provided.

Prioritising adult social care is incredibly challenging. Many service users will be receiving more than one type of care, such as personal care as well as a re-ablement package, or a support worker alongside a befriending scheme and welfare rights officer. The following categories should be followed when prioritising adult social care.

- *Low risk social support:* e.g. developing/maintaining family relationships, engaging with the local community, accessing work etc.
- *Low risk personal support*: e.g. maintaining personal hygiene, routine housework or laundry.
- *Preventative but necessary to keep people out of hospital/residential care*: e.g. re-ablement / occupational therapy.
- *Assessment*: central to keeping people out of hospital, and supporting rapid discharge when they have been hospitalised.
- *Life critical*: e.g. nutrition/hydration, medication, support with caring responsibilities.

In order to prepare for an influenza pandemic and target services effectively, local authorities will be expected to work with sector partners, including independent providers and the voluntary sector, to identify vulnerable people in order to stratify risk and provide a framework for prioritisation.

- Those who live alone with no support from family or friends.
- Those who do not live alone, but are dependent on carers for daily support and therefore would become vulnerable if that support were to fail.
- Those who have extensive support from a network of family, friends and

community groups and could be expected to manage without a normal service for a short period.

- People who are funding their own care.

Local authorities and providers should also put an emergency plan in place with each of its services users to identify what other support could be accessed during a pandemic, e.g. help from family or friends. This will be included in the Pandemic Influenza Resilience Standard for Local Resilience Forums.

In a severe pandemic, only those services that are life-critical will be maintained, along with the assessments needed to ease pressure on hospital services. Service users being cared for in their own homes will have to remain in bed during the day, with much reduced hygiene support. They will no longer have a choice about the date or time of their visits or appointments. Practical steps such as re-ordering visits so they are in geographical order, allowing care workers to go straight to a visit rather than via a place of work, and reducing double-handed visits where it is safe for both staff and client will help free staff time and so increase capacity.

In the short term, people will have limited, if any, choice about the care home they access, whether admitted from their own homes or hospital. In the most extreme situation, there could be removal of choice altogether. To facilitate discharge from hospital, patients receiving intermediate care or those for whom acute care is no longer required could potentially be discharged home, or to step-down beds, earlier than usual to enable others to be admitted.

More patients could be supported by a greater focus on telecare/tele-monitoring and by deferring re-ablement / rehabilitation during periods of pressure, which could be re-introduced when the pandemic is waning. Some assistive aids/technologies - e.g. grab rails, commodes, alarms - may also help people to manage more effectively in the short term in their own homes, particularly if these things were put in place at the start of a pandemic, before pressures mount significantly.

Local authorities and NHS community services will be expected to work with partners across the system, including the voluntary sector, so that services can be targeted and delivered effectively and efficiently in local areas (see section 4).

The table below provides an indication of the types of adult social care, and in the pandemic wave whether these could be reduced or deferred, and when it might be appropriate to do so. It is important to note that an individual may receive a number of elements of care, so by reducing some elements earlier than others, it may simply free up some time, rather than completely reduce the number of visits required.

Table 2: Prioritisation of Adult Social Care

	Detail	Training required?	Could the workforce be usefully redeployed?	When to stop?	Notes
Social Work	Professional advocacy for individuals & families	Yes	Yes. Providing basic services such as nutrition, personal hygiene etc.	Moderate	Services are specialist and in the main commissioned from independent practitioners (i.e. not LA-employed).
Day care centres		Yes	Yes. Providing basic services such as nutrition, personal hygiene etc.	Moderate	Linked to decision to close community facilities. Alternative arrangements may be needed e.g. for nutrition.
Counselling	Support overcoming bereavement, drug or alcohol addiction, living with a long-term condition etc.	Yes	Yes. Providing basic services such as nutrition, personal hygiene etc.	Moderate	Services are specialist and in the main commissioned from the independent practitioners (i.e. not LA-employed). Risk of deteriorating independence/ health.
Care needs assessment	Determine the help people need and how to access it. No time limit in legislation for completion.	Yes	Yes. Providing basic services such as nutrition, personal hygiene etc.	Moderate	Risk of deteriorating independence/ health.
Social Work	Safeguarding	Yes	Yes	MAINTAIN	Core duty and essential service for protecting 'at risk' individuals.
Nursing	Clinical tasks in a nursing home or in the community	Yes	Yes	MAINTAIN	Tasks should be prioritised
Personal Support:					
Getting up and down stairs		Yes	Yes. But only to provide other basic services.	Mild	Consider other networks e.g. family/friends. Reconfigure accommodation e.g. move beds downstairs.
Helping dress		No	No	Mild	Consider other networks e.g.

properly					family/friends.
Routine housework/ laundry		No	No	Mild	Consider other networks e.g. family/friends.
Washing face and hands		No	No	Mild	Consider other networks e.g. family/friends.
Shopping for food		No	Yes. But only to provide other basic services.	Moderate	But vital for indvs with no other support unless a substitute e.g. meals-on-wheels are provided.
Having a bath/shower		Yes	Yes. But only to provide other basic services.	Moderate	Consider other networks e.g. family/friends.
Getting in and out of bed		Yes	Yes. But only to provide other basic services.	Moderate	Consider other networks e.g. family/friends. Provision of equipment e.g. 'turning' beds may help maintain mobility/avoid health complications.
Paperwork of paying bills		No	No	Moderate	Risk of debt. Consider other networks e.g. family/friends.
Managing toilet needs		Yes	Yes. But only to provide other basic services.	Severe	Risk of deteriorating health. May be mitigated by the provision of aids e.g. commodes.
Eating, including cutting up food		Yes	Yes. But only to provide other basic services.	MAINTAIN	Vital for indvs with no other support.
Meals-on-wheels	Daily hot meals delivered	No	No	MAINTAIN	Private providers may be able to step up provision at cost. Provision of a 7-day service would support hospital discharge.
Taking medicine		No	Yes. But only to provide other	MAINTAIN	Care workers cannot administer medication but can

			basic services.		monitor/ oversee people taking their own medicines.
Social Support:					
Developing and maintaining family or other personal relationships		Yes	Yes. But only to provide other basic services.	Mild	
Accessing and engaging in work, training, education or volunteering		Yes	Yes. But only to provide other basic services.	Mild	
Getting out of the house		No	No	Moderate	
Carrying out any caring responsibilities the adult has for a child		No	No	MAINTAIN	
Advisory Roles					
Housing Support	Housing related support and advice to ensure people keep their tenancy & live independently.	Yes	Yes. But only to provide other basic services.	Moderate	Risk of homelessness, deteriorating lifestyle leading to safety concerns.
Welfare rights support	Advice for people around matters relating to legislation such as housing benefits, disability living allowances, employment benefits and rent support.	Yes	Yes. But only to provide other basic services.	Moderate	Other advice services.

2.2.2 Facilities

Whilst facilities are an important aspect of adult social care, the limiting factor is likely to be sufficient staffing with the correct skills or rapid training, at a time of high staff absences.

The option of opening short-term 'residential hubs', for example to improve access

for rural service users and to support earlier hospital discharge, has been much deliberated but the consensus is that such an approach is not feasible. Hubs would have significant staffing requirements, some service users may be unsuitable for transfer, and services users often require more than one type of care.

Furthermore, there would be significant cost involved in moving someone from being cared for in their own home to a staffed facility. There is also a risk of consigning people to sub-optimal care pathways that would ultimately lead to them needing longer-term residential, nursing or hospital care rather than care at home.

However, the following options should be utilised where staff and funding are available:

- In response to the increased demand in palliative and end of life care, empty, non-funded beds in hospices could be opened.
- 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.

2.2.3 Staffing

In addition to prioritising elements of services, both adult social care and community health care will need to consider staffing provisions, including options for increasing staff numbers and required training and upskilling. As shown in table 1, there is a wide range of staff working in adult social care, the vast majority of whom are care workers. They require core skills and are responsible for providing many of the services that will be life-critical during a pandemic such as nutrition. A key element of the response will be multi-agency working between community health care and adult social care, including consolidating visits. Details on this, and options for staff portability, are outlined in section 4.

Some of the practical interventions that could be deployed to release staffing are as follows.

- *Re-deploying staff within adult social care:* following the prioritisation principles outlined, staff should be re-deployed where possible to services that are of a higher priority.
- *Working at the top of the skills level:* staff should be providing the services for which they are best qualified, where the services meet agreed local priorities.
- *Increasing caring responsibilities:* family, friends and neighbours will be expected to meet individual's new requirements for personal care, including when they leave hospital.
- *Returning to work:* recently retired staff and people on parental leave, career breaks etc. should be incentivised to return to work.
- *Bringing in staff from other sectors:* people working in other related services e.g. dental nurses could transition to priority work.
- *Working with voluntary sector organisations not already providing 'core' adult social care:* the voluntary and third sector, including smaller, more local groups, may be able to support the response.

Staff training will be necessary to ensure that re-deployed or newly deployed staff are competent to act in different roles. In the event of a pandemic, local authorities will be expected to work with independent care sector providers and other partners to maximise the staffing pool by taking practical steps, including the following.

- *Housing staff on-site or nearby:* where feasible, this may help people work extended shifts.
- *Sharing staff:* e.g. pairing up nearby care homes or domiciliary care providers may help mitigate staff shortages.
- *Supporting return to work:* social workers who have been out-of-practice for between 0-2 years do not need to re-register with the Health and Care Professions Council, so could come back into the workforce immediately. Those who have been out of practice for between 1-5 years require 30 days of updating their skills and knowledge. Both groups could therefore be re-deployed reasonably quickly. Social workers who have been out-of-practice for 5 years or more require 60 days of updating their skills and knowledge but could with appropriate training could carry out less complex assessments, for example.
- *Extending employment opportunities to new care assistants:* training can be completed in 12 weeks in their employment role, so may be suitable for rapid expansion. Training is portable across care and health, and delivers some of the life-critical elements of social care, such as ensuring that people receive food and the basic necessities of life.

2.3 Recovery implications/consequence management

Prioritising care is likely to have knock-on effects.

- *Financial implications:* competition for packages of care could drive up costs in the short-term. These costs are unlikely to be sustainable post-pandemic, and could destabilise the market, as could spot purchasing unless local areas work closely with partners including the NHS.
- *Deterioration in service users' well-being and independence:* withdrawal or scaling back of services may mean that some users, particularly the most vulnerable such as those with mental health issues, deteriorate to the extent that they need more extensive/expensive packages of care and support long-term.
- *Deterioration in service users' health*: general lack of care may give rise to health issues e.g. bed sores, infection because of poor hygiene, that lead to longer-term pressure on health services as well as social care.
- *Delayed access to services:* may result in people needing more complex packages of care.
- *Impact on carers:* some carers may find that their ability to continue with their caring responsibilities or to continue them to the same extent compromised, resulting in more extensive packages of support being required.

One option suggested by ADASS is to consult on a national rate (with an allowance for regional variations e.g. for London) for emergency placements and high dependency periods in residential homes. This could act as an advanced purchasing approach, but would also run the risk of destabilising fragile social care markets and

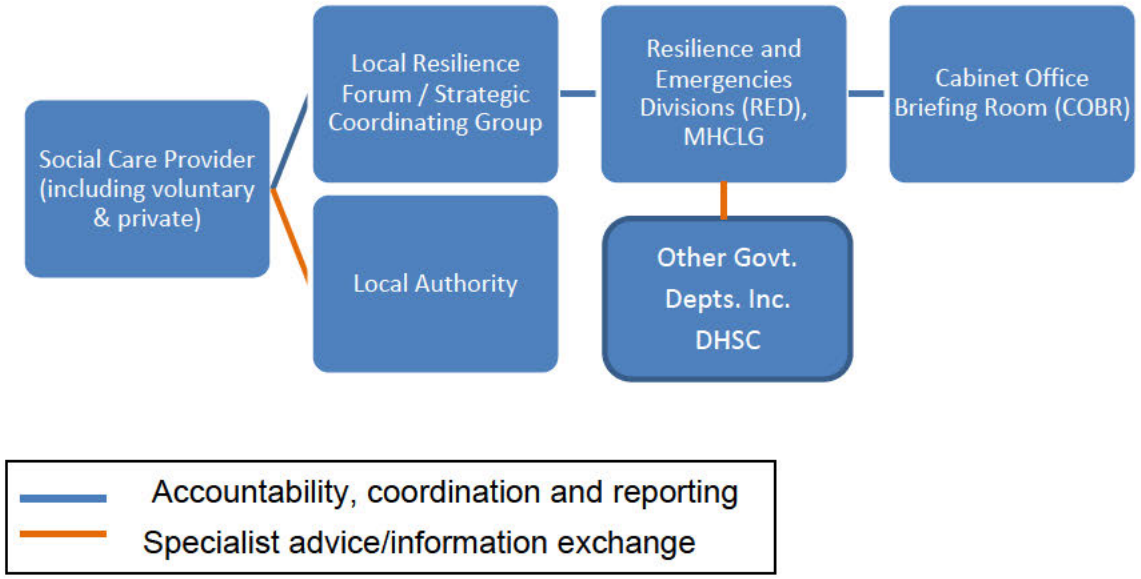
would require considerable consultation and analysis. It is contrary to government policy to intervene in local markets and this intervention could only really be considered as a long-term option. Officials will further explore the implications of this option in terms of market stability and the options for funding would have to be considered as part of the next Spending Review.

2.4 Reporting lines

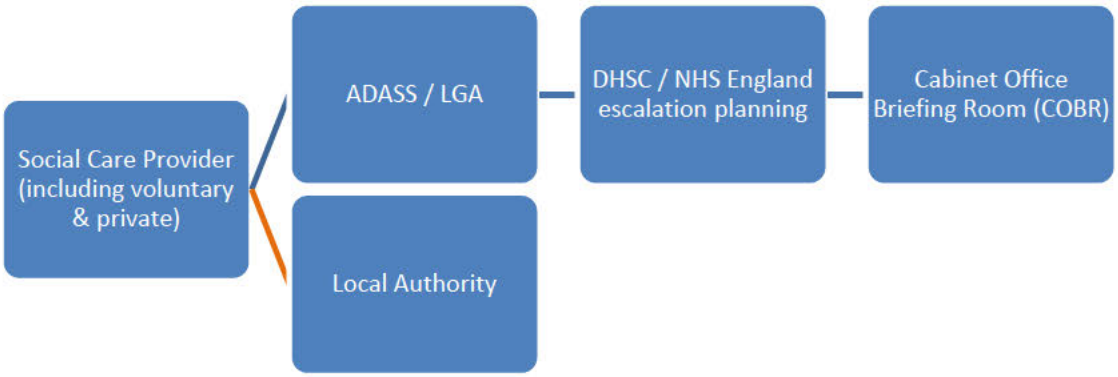
Primary responsibility for planning for and responding to major emergencies rests with local organisations, including local authorities, acting individually and collectively through LRFs and Strategic Coordinating Groups (SCGs). These groups will plan and work together to provide an effective, strategic tier to co-ordinate the response during a pandemic influenza epidemic. However, in even a mild pandemic there is likely to be national coordination of the response through COBR and so significantly greater national oversight of the sector.

Identifying potentially vulnerable people and monitoring care capacity in local areas will be a dynamic process, running over several weeks or months. It is at this level that early estimation of numbers, of types and locations of vulnerable people, and of services and staff, will enable planners, including local authorities to identify the resources and care capacity needed, and work with partners and independent and voluntary sectors, to prioritise access and co-ordinate mutual aid.

For reporting on pressures in adult social care, local authorities will report to Local Resilience Forums (LRFs). LRFs, through SCGs will report, potentially daily, up to government. This is outlined below.



However, in a time of increased pressure in both adult social services and community health care, such as winter or in the event of an influenza pandemic, the Association of Directors of Adult Social Care (ADASS) will also report into DHSC and NHS England's escalation planning at regional and national levels. ADASS and the Local Government Authority (LGA) should be engaged in operational planning and delivery at all levels. This is outlined below.



In the event of a severe influenza pandemic, it is agreed that existing reporting lines will be used, and new channels will not be created.

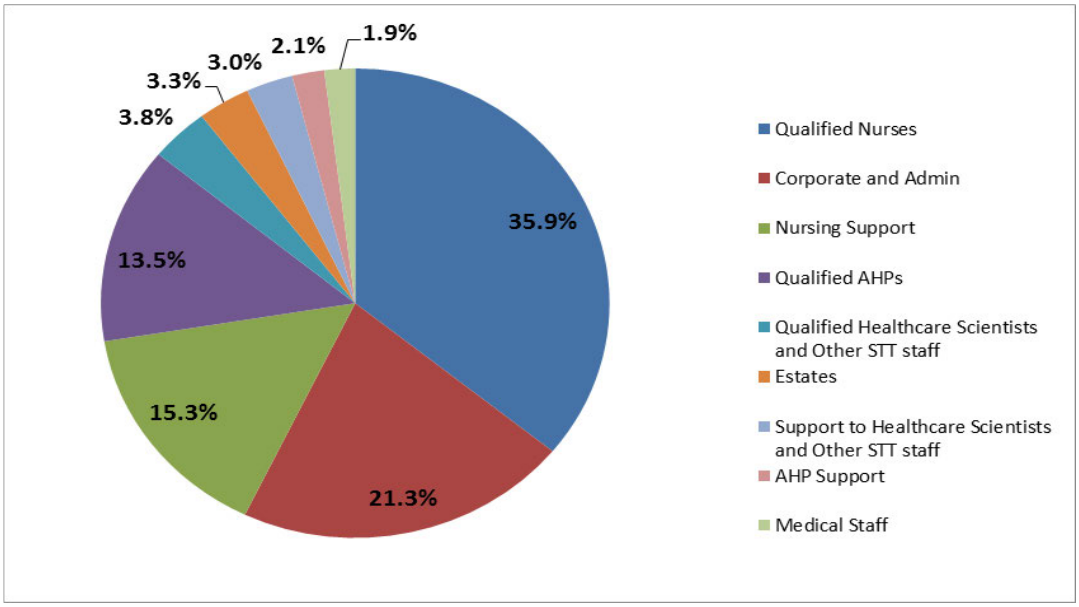
3.0 COMMUNITY HEALTHCARE SERVICES

The majority of **community health care** 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. 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, as well as ensuring patients can be discharged from hospital.

Services provided **vary dramatically** across England, with differences in both provision and patient need. Community health services are commissioned via block contract by Clinical Commissioning Groups (CCGs). Local Authorities also commission some community health services to fulfil their public health commitments; e.g. health visiting, sexual health services and others. Providers are approximately 69% NHS, 18% private sector and 13% third sector.

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



3.1 Impact on demand and capacity of community health care

As with adult social care, in the event of a reasonable worse-case influenza pandemic, the number of people in the community requiring some form of support is expected to increase significantly, many of whom will require community health care. Increases in demand may be as a result of:

- Individuals discharged early from hospital with ongoing health care needs, due to overall increases in acuity and activity leading to shortages in acute

capacity.

- Existing community health care patients having increased levels of need due to influenza infection.
- Previously well individuals needing community health care as a result of the pandemic.

It is difficult to estimate these numbers accurately, as the way a pandemic will impact is such an unknown variable, however some broad assumptions can be made. The NHS bed base (most recently collated for Jan-March 2018) indicates there are 130,000 total beds of which 103,000 are general and acute, with the remainder split between learning disabilities (1,000), maternity (8,000) and mental illness (18,000). Occupancy for the same period of time was 90% on average (range 58% maternity to 93% G&A). Extrapolating from the current population census for England (54 million) using the reasonable worst case planning assumptions in the UK Pandemic Influenza Strategy, between 270,000 and 1,080,000 people will need hospital care at some stage during a pandemic. Even if this was distributed evenly across a 15 week pandemic (which we know it won't be), this would range from 18,000 to 72,000 admissions being required per week (or 14 to 55% of the bed base). A further 26 million will need some form of care for their symptoms in the community, be that through primary care, over the counter medicines, or self-care due to influenza.

There will be further significant numbers of patients whose existing conditions exacerbate, and while they can normally be safely cared for in the community with minimal routine healthcare contact, additional primary or acute care contact maybe needed, for example patients with COPD, asthma, diabetes and other long term conditions (LTC) which are recognised in the Green Book as putting them at risk of seasonal influenza. In normal, non-pandemic influenza seasons, readmission rates are high for patients with respiratory conditions. The national COPD audit revealed that following an index admission for an acute exacerbation, readmission rates are 24% at 30 days and 43% at 90 days. Given we have 1,000 emergency admissions for respiratory HRGs per day, rising to 2,000 per day in winter, we could assume all these LTC patients would either need admission or enhanced care in the community in pandemic. The British Lung Foundation identifies ~2% of the population (over a million people) have a diagnosis of COPD. There is a suggestion that a further two million with COPD are undiagnosed.

Workforce

Whilst demand increases, capacity will reduce due to staff shortages. As with adult social care, the demographic profile of those employed within the community health care sector means that a higher than average proportion of the workforce has personal caring responsibilities.

Absence rates for the NHS workforce are both estimated to be in the region of 17-20%. This consists of 15%-17% of people being absent directly due to illness and an extra 2%-3% to account for those who miss work to care for children (this does not include any impact from school closures). These are overall figures and are likely to be higher for some workforces, especially if they are small.

Demand

The lack of data available on community health services is a known challenge. DHSC have worked with NHS England and NHS Digital to resolve this, by developing the Community Services Data Set (CSDS), which has been reporting since February 2018. However, it will take some time for the system to bed down and start to provide reliable baseline numbers.

Analysts have confirmed that **this data set is not suitable to model how a reasonable worse-case scenario pandemic will impact community health care demand**. In its aggregated form, it provides little insight into demand on community health care services. For instance it records the number of patients using the system in a one year period but this is not exclusively persistent use. It is not possible, at the aggregate level, to separate out counts for those who use the system briefly and those who are using it for all or most of the year. It is not possible to use the aggregate data to distinguish between those patients that require a great deal of care from those who require much less. Use of the CSDS at an aggregate level is not recommended for pandemic planning.

The only information currently available through the CDSC is on breast feeding, district nursing and end of life. Some narrative examples are given below. An ‘England total’ figure is not available due to low coucoverage, and thus any statistical analysis must be considered as ‘Experimental Statistics’; that being said, the following provides some indicative (which must be accepted to be low) estimates of demand for these services.

District nursing information is available from 63 providers:

- District nursing referrals (Oct to Dec 2017): 330,000 referrals from 233,000 unique patients.
- Care contacts (Oct 2017 to Jan 2018) following a referral to district nursing (Oct to Dec 2017): 1,800,000 contacts from 199,000 unique patients.
- The majority (86%) of the 199,000 unique patients are aged over 60 (over one third of the 199,000 are aged 85 and over).

Information on end of life referrals is available from 68 providers:

- End of life referrals (Oct to Dec 2017): 23,000 referrals for 16,000 unique patients (87% of whom are aged over 60).

Care contacts (Oct 2017 to Jan 2018) following an end of life support referral (Oct to Dec 2017):112,000 contacts for 11,000 unique patients.

3.2 Service Reconfiguration

Community health care providers regularly utilise surge capacity measures in delivering care in the current environment and, as with adult social care, organisations should use their business continuity plans to identify their priority services for an extreme pandemic. However, in order to respond to a reasonable

worse-case scenario, significant service reconfiguration will be required in addition to prioritisation.

As with adult social care, the key questions to consider when reconfiguring community health care are:

1. Which services can be deferred / reduced?
2. Which services may need to be increased?
3. What level of patient choice is possible?
4. How can increased use of technology support the system?

3.2.1 Prioritising Care

CASE STUDY

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

This provider is already using telecare where possible, using a prompting approach to reduce the need for a nursing visit but for all other tasks the nurse needs to be physically such 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 slack in the system.

Care prioritisation will be essential to maintain levels of service with limited resources. In order to prioritise and reconfigure community health care services, a clear understanding of the consequences is required. The recovery implications and consequence management is outlined is section 3.3. Prioritisation of the different elements of services should be based on the following categories:

- *Preventative: long-term prevention/minor* – e.g. Stop Smoking, Nutrition;
- *Preventative: quality of life* - e.g. Podiatry, Sleep problems;
- *Preventative: but necessary to keep people out of hospital* - e.g. Respiratory, Post-operative care,
- *Life critical* - e.g. PEG medication,

As the pandemic progresses, services will need to be reduced until only life critical services are maintained. 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. This will need an increase in the staffing numbers trained and able to deliver the service, as these are typically small teams in routine business. Options for increasing staffed

trained in these vital skills are to develop a of training packages now that could be rapidly rolled out when needed, or offering training now for interested staff. However, this latter option would require time to train staff now, and would need justification to remove them from their daily delivery of care to patients.

Additionally, many community health care services have a number of different elements, some of which will be more critical than others. Whilst individual providers will be expected to prioritise within their services, this paper outlines the suggested principles for prioritisation and suggested points of reducing and ceasing individual services which we would expect local NHS services to follow.

Community health care is typically not available on a 24/7 basis, 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. Options for alternative care models, including tele-care and 'hub and spoke' models, are outlined in section 5.0.

The table below outlines the prioritisation of services delivered by community health care providers and when they could be reduced, deferred or stopped. Changes to service delivery would release staff – either to fulfil other care roles or support critical administration functions required to support and maintain care delivery.

Case study: A trust providing services in the south of England advised that they did not cease delivery of any of the services listed below that they provide during the 2009/10 pandemic, and the way they are delivered would be modified first before ceasing a service (e.g. reduced frequency, or use of telephone consultations rather than face to face thus reducing travel etc.).

Table 3. Prioritisation of Community Health Care Services

Care service	Description	Home or clinic based	Staff group who deliver it	Training required?	When to stop?
Audiology	Hearing tests and hearing aids	Clinic	Audiologists AHPs, HCP/RCCP	Yes	Mild
Health Visitors	Professional public health service for individuals, families, groups and communities; enhancing health and reducing health inequalities	Both	RGN, RHV, RSN, CNN, midwives with training in community public health nursing	Yes	Mild
Nutrition & Dietetics	Assess, diagnose and treat diet and nutrition problems	Both	HPC Dietetics (Hons)	Yes	Mild

Sexual health	Counselling and advice, some prescribing	Clinic	Registered nurse, AHPs	Yes	Mild
Stop Smoking	Counselling and advice, some prescribing	Clinic	Trained stop smoking therapists	Yes	Mild
Podiatry	Home visiting and GP practice based plus hospital based	Both	HPC registered podiatrist & podiatric assistants	Yes	Mild/ Moderate
Bereavement visits	Post death support for relatives/ carers	Both	Nursing. be RGN or HCP with end of life knowledge	Yes	Moderate
Continence services	Advice & device service on urinary and bowel continence	Both	Advanced skill nurses; RGN & continence training	Yes	Moderate
District and community nurses e.g. PEG medication, occupational therapy, Physiotherapy	Provide advice & care in the home rather than in a clinical setting	Home	RGN	Yes	Moderate
Falls Prevention Service	Assessment service and treatment for recurrent fallers	Both	Medically overseen, usually nurse delivered; Physio/OT	Yes	Moderate
Heart nurses	Hospital and community based management, education post heart attack & heart failure	Both	Advanced practice nurses; Cardiac Specialist qualified RGN	Yes	Moderate
Phlebotomy	Taking blood samples	Both	HCP - venepuncture	Yes	Moderate
Routine immunisations	Largely childhood vaccinations	Clinic	Registered nurse	Yes	Moderate
Diabetes support teams	Hospital & community based case management, education for diabetes patients	Both	Advanced practice nurses; Diabetes specialist	Yes	Severe
Discharge teams	Arrange & receive hospital discharge patients at home	Both	Nurses ,OTs, physios, MSW	No	Severe
Respiratory Care e.g. asthma	Hospital and community based case	Both	Advanced practice nurses, RGN	Yes, oxygen & advanced	Severe

	management, education for COPD and asthma patients			respiratory assessment	
Speech therapy (Children and Adult)	Support to people with speech, language, thinking and swallowing problems; often following strokes	Clinic	Trained S&L Therapists	Yes	Severe
Stroke support service	Early Supported Discharge teams for discharged stroke patients	Both	Nursing, OT and PL plus SALT for some	Yes	Severe
Tissue Viability e.g. Leg Ulcer Service	Home visiting and treatment service	Home and GP practice based	Nurses: RGN, TVN	Yes	Severe
End of life care / Palliative care (Children and Adult)	Medical, psychological, social and spiritual support to help patients be as comfortable as possible, by managing pain and other distressing symptoms.	Clinic, GP practices	HCP	Yes	Maintain

3.2.2 Facilities

Community health care services are typically provided in domiciliary or community setting including GP surgeries, clinics and schools. There is little residential community health care. Therefore pressures on facilities is less of a challenge for community healthcare services than adult social care, and alternative care models, as outlined in section 5, will be more beneficial.

In a mild or moderate pandemic, it would be recommended that, where appropriate, community health care providers ask those that can travel to come to a central hub for services that they would normally receive at home, to reduce staff time spent travelling and release more staff time for direct patient care. This could include diabetes support, wound dressings and phlebotomy.

As noted in section 2.2., the option of 'field hospitals' has been much considered, but, for the reasons outlined above, this has not been considered feasible.

3.2.3 Staffing

Staff absence rates for community health care workers due to sickness is expected to broadly reflect that of the general population, but is recognised to be slightly

higher in the NHS than in the wider population for reasons set out earlier in this paper. As noted above, when prioritising care, it is important to consider when those staff can be usefully re-deployed. Additionally, training and upskilling will be vital to enable staff re-deployment and prioritisation of services.

The following principles would be considered with regards to covering the forced withdrawal of care resulting from *loss of staff* with influenza:

1. The first tranche of diminished/ thinner care would **be SUBSTITUTION by other community health care staff**: the interventions in most part to maintain prior commitments and provide registered '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 health care staff by volunteers not related to the patients**. This has significant potential but is difficult to estimate and model and may be affected in a pandemic by 'risk' of contracting influenza and prioritisation of family (3). This may not generate any new capacity but could maintain home care provision. There would also be concerns about safeguarding, indemnity and need for some form of background check/ registration.

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).

Some of the practical interventions that will be deployed to release staffing are:

- *Re-deploying staff within the NHS*: Following the prioritisation principles outlined above, staff should be redeployed, where possible, to services that are of a higher priority. It may also be possible to release clinically trained staff in CCGs or other administrative NHS 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. This is already underway in some areas where CCG-employed pharmacists support discharges in some acute trusts by supporting medicines provision to patients. Additionally, 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.
- *Work at the top of the skills level*: Staff should be providing services at the top of their skill level for which that are qualified. This would mean lesser skilled staff or unskilled volunteers may be required to undertake some care tasks that would routinely be provided by someone who could be described as 'overqualified'.
- *Bringing in staff from other sectors*: Other sources of staff could include registered nurses returning to practice, student nurses, midwives and medics, and allied health professionals. Registered dental nurses or even veterinary nurses could potentially support some aspects of community health care, however their training and skill sets are very different to healthcare nurses

and veterinary nursing skills in particular do not read across to many NMC registrants' skills. In a reasonable worse-case scenario, there will be a public request for registered nurses and midwives working in the corporate sector, or those who are no longer practicing to support aspects of community health care, through returning to nursing and/or working for community health care providers on a temporary basis. We are working to understand the potential sizes and uses of these staff groups, who would require a variety of registration checks, revalidation requirements, training and supervision depending on their skills, experience and length of time since practising. The issue of indemnity has been covered in the Draft Pandemic Flu Bill.

- *Increased relative responsibility:* There would be a necessary commitment of family and close friends/ neighbours to immediately adopt the care needs of relatives/ friends who have a new onset requirement for care. This would also be applicable to 'forced discharges' from hospital. This could include support taking medication, dressing changes and turning/ moving patients to prevent pressure sores.

Unlike adult social care, many of the community health care services are provided by trained individuals. Training should be rolled out sooner rather than later in a pandemic to ensure valuable patient care time can be maximised during a peak. Professional bodies could be asked to identify some of these skills and competencies (for example phlebotomy, end of life care, and mental health support have been suggested as key aspects by community health care providers) and, in partnership with Health Education England, develop a training package in advance that can be rolled out when needed. This requires a formal request from DHSC.

3.3 Recovery implications/consequence management

Changes to the frequency or delivery of community health care will undoubtedly have secondary consequences and there will be instances of harm which would ordinarily be avoided. Patients may have longer recovery times from both existing and new conditions, including influenza related illnesses, and this will mean an extended impact on community health care services through ongoing increased demand. As capacity in the acute setting starts to become available again, there may be opportunity to admit community patients and for them to receive secondary care which will help their recovery.

Case study

While perhaps not immediately directly comparable to an influenza pandemic, the community recovery to the Grenfell Fire has been significantly longer than recovery period within the acute sector, and indeed is still ongoing for patients, friends, families and staff.

Mental health and psychological care aspects will likely be significant and ongoing for a long time, for both patients and community health care workers. The pressures on mental health are already significant, and specific pathways may need to be developed to meet the needs of a reasonable worst case pandemic (for example in the same way as pathways were developed for people involved in and affected by the major incidents in 2016 and 2017).

Organisations themselves will also need to recover, and this will take time as staff

will be exhausted from providing increased services under pressurised situations for extended periods of time. It will likely be many months before normality is resumed, and could see a significant permanent change in the way community health care (and care in other settings) is delivered. As part of good emergency preparedness practices, organisations have recovery plans that would be enacted in a pandemic response. These consider aspects such as staff wellbeing, resumption of services, and restocking of equipment.

3.4 Reporting lines

There are well established mechanisms for reporting in healthcare that are utilised during periods of known and anticipated pressure (e.g. winter) as well as during major incidents. These involve the provider submitting data into a web portal, that is then accessed and collated by NHS England, and shared with others such as NHS Improvement, DHSC and CCGs as appropriate. Information is shared locally with multi-agency partners through tried and tested routes, however this is often different in each locality and does not necessarily always follow the same route or include exactly the dame data – instead it is tailored to what is required to be shared locally to meet local needs.

In a pandemic, health reporting would be via DHSC into central government, and not via the LRF route. This will ensure there is a considered understanding of health impacts and that LRFs do not conflate health impacts or pressures with other aspects. It will also reduce the risk of duplicate reporting, or out of sync reporting. Information will be shared with local LRF partners however as needed to understand the impact and manage the response.

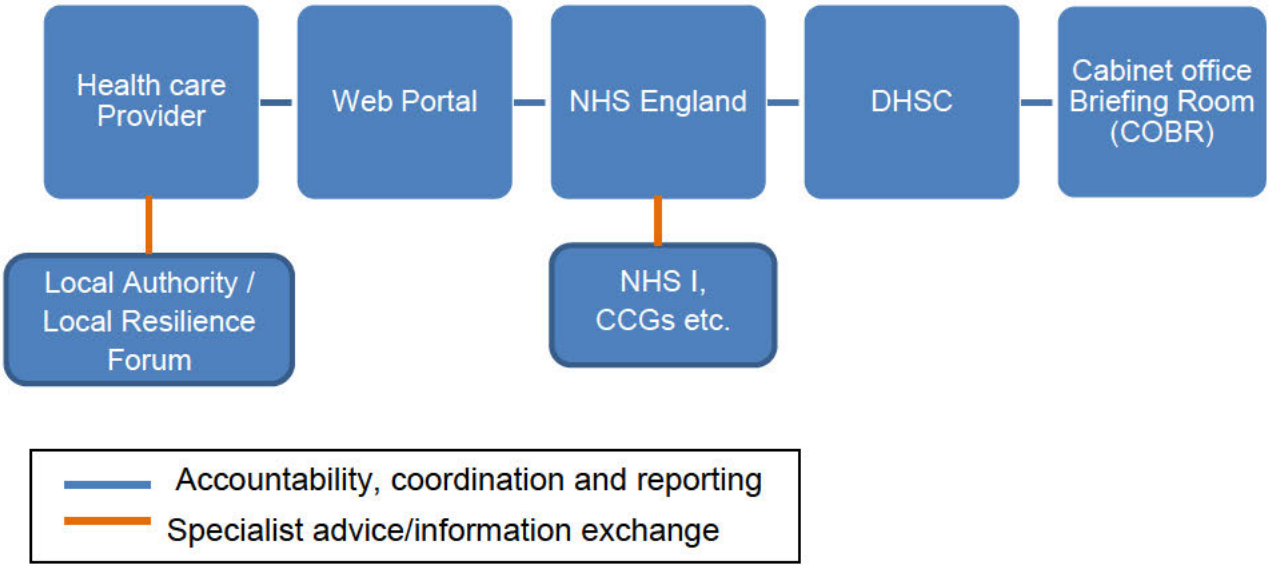


Table 4: Illustrative representation of prioritisation activities during the escalating periods of the pandemic influenza surge, for adult social care and community health care

Consult with	Phase	
Ongoing discussions with DHSC (SofS, ministers), professional bodies, staff, legal, regulators etc.	Severe pandemic	• Withdraw all but life-critical services, • Increased palliative care • Maintain post-natal care and nutrition 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 tables 2 and 3. 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. • Reduction in the number of visits; increased use of phone and remote support. • CQC to ease regulations. • Limit admittance to residential services • In the recovery phase, care needs assessments and services will re-commence in a phased approach as resources become available.
	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 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	• Instigate existing winter escalation plans • Implement business continuity arrangements
	Baseline	• Business as usual

4.0 MULTI-AGENCY WORKING

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 as part of the wider whole system response. This multi-agency response will ensure limited resources are prioritised to support those with the highest level of need.

A Pandemic Influenza Resilience Standard is currently being drafted, outlining what Local Resilience Forums will be expected to have in place in preparation for a reasonable worse-case scenario influenza pandemic. Additionally ADASS are drafting a 'top tips' guidance for Directors of Adult Social Services. The following issues have been identified as key to resolve to ensure an effective multi-agency response and will be included in both of these documents.

4.1 Provider contacts

- All local areas should have effective contact points between local authority emergency planning teams and social care providers, such as a provider forum.
- This is to ensure that LRFs/Local Authorities are aware of the total market provision, including private providers who only work with self-funded servicer users/patients. Building relationships with these providers will streamline communication in an emergency.
- 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].

4.2 Removal of boundaries

- During periods of high pressure (e.g. during winter) provider boundaries are flexed, 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 or where there is space.
- In the event of a pandemic, all providers should be prepared to receive patients/service users depending on availability, not locality or geography.
- 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.

4.3 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 (see section 5.1). 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.

Case Study

The Community Health Care provider in Camden uses an application to map their caseloads. Depending on data-sharing difficulties, this could be shared with other service providers in a locality to consolidate visits to those individuals.

- Local Authorities and Community Health Care providers will be expected to work together to identify health and social care clients who are in community settings, including the location of patients/service users, what services they receive, and their level of need, (see Section 5.1). This will support decision-making on whether tasks could be delegated from one to the other to make best use of resources and reduce infection risk. For individuals who receive multiple visits from adult social care and / or community health care, these would need to be prioritised to ensure the patient didn't deteriorate and require admission to acute care.

- There is already evidence that the current challenges with numbers of registered nurses within the community nursing workforce and access to primary care has resulted in the safe delegation of some appropriately 'low level' clinical tasks being undertaken by home care workers. In the event of a severe pandemic, district nurses delegating some basic nursing tasks to social care providers, if they have been given suitable training, will be a key way to manage demand.

4.4 Staff Training

- In order to facilitate consolidation of visits between adult social care workers and community health care workers, a certain level of training will be necessary. This will ensure re-deployed staff were confident and competent to undertake different roles.
- In a severe pandemic, it would be beneficial for all community based staff, as well as staff coming into support organisations to have an appropriate level of training. This would include basic training in areas such as mental health first aid and the relevant components of palliative/ end of life care. For example, even with changes to relevant legislation regarding opioids administration, the titration of the right pain or symptom management is a sophisticated skill and not a basic one.
- Local conversations at Local Resilience Forums or lower level could help facilitate the identification of skills locally that might be beneficial to share, and where resources and time permit – this cross-training could potentially take place now.

4.5 Identifying vulnerable individuals

- The methodologies to identify people who are likely to be vulnerable in an influenza pandemic should be agreed with partners and recorded and tested

as part of the Local Resilience Forum (LRF) planning.

- This should include recognition that in 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).
- Additionally, some people who become acutely ill with another condition may become highly vulnerable because the treatment and care they would normally receive is not available.
- LRFs will also be reminded that the cohort of vulnerable people will change during a pandemic – for example as a carer becomes sick a person maybe vulnerable, but then they cease to be vulnerable as soon as their carer recovers.

5.0 NATIONAL POLICY

Whilst the day to day operational aspects of the adult social care and community health care response to an influenza pandemic is likely to be led at a local level, there is much that the national level will do to support an effective response. The following issues have been identified as key roles for the national level to lead on, empowering the local level and unblocking major barriers.

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.
- It has been established that this is already permitted, depending on the scenario, under a common law duty of care, s.251B of the Health and Social Care Act 2012 or Regulation 3 of the Control of Patient Information Regulations 2002 (SI 2002/1438), which 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. Additionally, 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[i]. This will be reiterated to providers at the time to support their confidence in delivering the activity.
- To further ensure that the nervousness at the frontline with regards to data sharing, as demonstrated during the Grenfell fire and Manchester attack, does not become a hindrance, it is recommended that all Local Resilience Forums develop an Information Sharing Protocol and this will be in the Pandemic Influenza resilience standard.

5.2 Regulation in Health and Social Care

- CQC's primary statutory objective is "to protect and promote the health, safety and welfare of people who use health and social care". It will be necessary to ensure that individuals, as well as organisations, know that they will not be sanctioned for a reduction in the quality of care during a severe influenza pandemic where the effective running of the service has been impacted by e.g. a high level of staff absence. In these circumstances, CQC would expect providers to aim to meet as best they can the fundamental standards of care.

Case Study

Several years ago, the NMC did a piece of work on ensuring that registered nurses and midwives could be confident in knowing that they were 'allowed' to share data with social workers (e.g. in potential abuse queries). It was identified that the regulatory voice is important to assure registrants that they are not breaking their Code or risking their registration.

- As well as developing a Pandemic Flu Action Plan, the CQC have developed their messaging to provide reassurance to providers and information on what these easements will mean for them.
- This includes scaling back regulatory activity, fast-tracking provider registrations to ensure additional capacity and being pragmatic in their approach, taking into account pressures on services whilst being mindful of risks to people. CQC will respond appropriately and proportionately to risks to people using services.
- By taking a flexible and risk-based approach, and making a national statement on possible regulatory easements, the CQC would provide reassurance to providers and commissioners who feel constrained because of concerns that their quality rating may be negatively affected.
- The CQC recognises 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.
- NHS England and NHS Improvement have a tried and tested history of working well together in periods of pressure surge (e.g. winter) as well as during major incidents (for example in the aftermath of the Grenfell Tower fire) and when coordinating system responses (e.g. the Roche diagnostics issue). The two organisations are working increasingly closer together, and in an influenza pandemic will very much follow a 'pragmatic not bureaucratic' approach to managing the NHS response and supporting the system. Wider emergency preparedness arrangements are being aligned between the two organisations and pandemic influenza preparedness is an aspect of this.

5.3 Legislation

- There is a separate piece of work to produce a Draft Pandemic Flu Bill, which considers emergency registration of health professionals, discharge from hospital processes and flexibilities to the Mental Health Act 1983, alongside other measures across Government.
- The Draft Pandemic Flu Bill creates a new legal provision which enables the Secretary of State to provide indemnity cover in a pandemic for clinical staff who are not already covered by the Clinical Negligence Scheme for Trusts (CNST) or the proposed GP indemnity scheme (when activated).
- This means that individuals who are employed or otherwise engaged by NHS trusts to provide tasks for which they have adequate training, will have indemnity cover.
- This is particularly relevant for those individuals who are asked to take on additional responsibilities, work out of hours or in different locations, or individuals who are temporarily registered using the other provisions in the Bill. Therefore this will cover social care workers who are asked to also undertake some health care tasks on behalf of the NHS, where they are trained.
- Volunteers will be coordinated through formal organisations, such as the British Red Cross or Local Authorities. These organisations have insurance for their volunteers, such as Public Liability Insurance, providing indemnity for those individuals who support the response in a formal capacity.
- We are in discussion with MHCLG regarding the flexibility of all statutory duties. Any amendments required will be explored in the next review of the Draft Pandemic Flu Bill.
- Indemnity for Social Care workers in relation to the flexibilities introduced in this paper will be considered in the next review of the Draft Pandemic Flu Bill.

5.4 Voluntary Sector

- As the adult social care and community health care sectors come under increasing pressure, there will be a need to utilise volunteers to support the response.
- In the first instance, we would request that individuals support the care of their friends and family, especially in instances where informal carers are unavailable due to illness.
- We would then use formal routes to coordinate the voluntary response. This would include the British Red Cross Community Reserve Volunteer Program, and Community Volunteer Groups, as well as a number of other organisations that coordinate the volunteer capacity in a community. Many Local Resilience Forums also have a Voluntary Sector Panel composed of representatives of the national organisations as well as more localised organisations; this can help coordinate local activities.

- By coordinating the volunteer response through organisations rather than encouraging spontaneous volunteers, volunteers would have insurance/ indemnity, (see section 5.3) and the response would be more effective.
- Volunteers would not be requested to undertake caring roles, instead they may be asked to support:
    - Shopping
    - Collecting medicines
    - Cleaning houses
    - Administrative support for care providers
- 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 rely on a significant amount of voluntary or additional support.

5.5 Military and Police Support

- Following discussions with the MOD and Home Office, it has been established that there will be limited capacity for either sector to support the adult social care and community health care response. However, for where capacity is available, the following principles have been agreed:
    - No medical or personal care to be provided, other than by trained military paramedic.
    - We will not ask the MOD to cover private sector responsibilities e.g. rubbish collection. We expect the private sector to have robust contingency plans.* (*****This will also apply to private companies running adult social care, and we would want the MOD to support voluntary sector providers first.) However, if the Local Authority are asking for help for people they are responsible for, and in situations where the provider says "we can't cope without help", we will be requesting support for both private and state funded providers.)
    - For the majority of asks, there will be a precedent, hopefully easing deployment.

- This is all underpinned by an awareness that military or police personal may be out of the country or otherwise occupied.
- The sort of tasks we could request support for are:
    - Collecting and delivering medicines for patients/ housebound service users
    - Supporting community health care providers/ social care providers (e.g. through home visits or phone calls to do welfare checks)
    - Security support at NHS premises which do not have existing security arrangements (e.g. pharmacies, general practices)
    - Support from police medics (e.g. BTP medically trained staff) to ambulance/ acute trusts

- Portering
- Catering e.g. care homes / hospitals
- Logistics / management support

5.6 Stockpiling

- There are established national stockpiles of pharmaceutical and non-pharmaceutical countermeasures for health and social care providers in an influenza pandemic. These include personal protective equipment, medicines (antivirals/ antibiotics) and hygiene consumables. Some of these are stored on a just in case basis, while others have rapid call off contracts (just in time) for purchase when needed. There are storage and distribution mechanisms around these, and a substantial programme of work around maintaining these as well as a significant financial cost.
- It has been suggested that other items could also be stockpiled such as continence aids, commodes, fall sensors, and panic button necklaces. For example, if a customer self- funds their own continence products, they might appreciate additional supplies that have a greater capacity for retention, so would need changing less frequently. This is recommended to Local resilience Forums through the Pandemic Flu Resilience Standard and we will consider whether that is sufficient, or there needs to be a stronger national role, when this paper is next reviewed.

5.7 New technology options

Technology will be a key option to manage the pressure on services in a severe pandemic, ensuring staff time is used for most effectively, maintaining a very basic level of patient or service user care where possible. Many of these options are currently not widely used due to a variety of reasons such as cost, lack of empirical peer reviewed evidence or competing pressures. National support and funding of local initiatives, to embed such technologies now in routine business processes could aid service delivery in a pandemic response, however there would need to be clear and robust justification as to why funds were being used in this way rather than for more immediate care delivery.

5.7.1 Medication Management

- Some patients and service users who have specific diseases, e.g. Diabetes, Epilepsy, need their medication / food at very specific times to ensure their health and mobility are maximised. Enlisting the help of friends, family, neighbours can help with medication prompting.
- However, for individuals with limited support, providers will need to increase the use of technologies such as blood sugar monitors, medication prompting devices and self-administered anti-coagulants. There can also be an increase in the use of timed, electronic dossett boxes.

5.7.2 Near Patient Testing

- Rapid and near patient testing (also known as point of care testing) for influenza is increasingly being utilised in routine patient pathways in the acute settings. This helps rapidly confirm (often within 20 – 60min) whether a patient has influenza (or another respiratory infection) and can help guide appropriate admission locations, discharge and treatment. This in turn can help reduce nosocomial spread and bed blocking. Wider embedding and use of these technologies across the NHS in seasonal influenza, and for other pathogens, would be of benefit in a pandemic. Currently their cost is prohibitive to a community or primary care setting, however this could change in the future as the technology continues to develop and evolve.

5.8 New Care Models

In the event of a severe pandemic, there will need to be a drastic shift in the way adult social services and community health care services are provided. The most important of these will be a much closer integration between the two sectors, sharing tasks where possible and consolidating visits, as previously outlined. Below are some additional options to enable an efficient response in the event of a reasonable worse-case pandemic.

5.8.1 Staff portability

- 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.
- This could be resolved by a national agreement to allow staff to work wherever they are needed. One proposal is a ‘skills passport’ that could move with staff between sites and organisations.
- Key challenges of this include ensuring certain geographical areas do not become depleted of staff, staff orientation to the ‘new’ site’s geography and other nuances, and addressing safeguarding concerns (this could be met through shadowing a ‘resident’ staff member or being ‘chaperoned’ for a period.
- National consideration and leadership of this, working across relevant government departments, with arm’s length bodies and the professional organisations/ unions is needed to better understand the challenges and barriers, to be able to remove them in the face of a pandemic.

5.8.2 ‘Hub and Spoke’ Model

- The use of skype for Care/Rehab assistants whilst on site in a domiciliary setting to raise concerns with a remotely located, more senior clinician has been considered. This would be achieved by a hub and spoke model with

one senior nurse/therapist/GP being accessible on a rota and aligns with the model used in 111 – where a team of non-clinical call handlers are supported by a registered nurse or other clinician.

- There would be some risks to this including high demand on the clinician that prevents the care assistant accessing the advice in a prompt manner; however the risks are outweighed by the benefits.

5.8.3 Increased use of telecare

- For more able customers, telephone prompts/check-up calls (which could include video calling/skype) can support the less vulnerable, freeing capacity for those who cannot go without a visit. This could be linked to the above 'Hub and Spoke' model, with care assistants undertaking the calls and referring to a more senior clinician when concerned.

6.0 Conclusion

This paper sets out a plan on key options and considerations to maintain and augment community health care and adult social care sectors' response to an extreme influenza pandemic. In the event of a severe pandemic it can be updated and utilised by decision makers to inform system changes. It represents the conclusion of 'workstream 2' as commissioned by the Pandemic Flu Readiness Board on behalf of NSC(THRC). When this paper is next reviewed, that will include consideration of local implementation and whether there should be further national steps, such as national stockpiling or further legislative measures.

As noted in the introduction, this is one part of the cross-government preparedness work, and has been developed in alignment with those other pieces of work.

A resilience standard is being produced by DHSC, alongside the Civil Contingencies Secretariat and the Ministry of Housing, Communities and Local Government for Local Resilience Forums to outline what they should be including in their plans, and what leading practice exists. The 2011 National Pandemic Influenza Strategy will be refreshed in 2018/19 and will include more reference to the reasonable worse-case scenario, to ensure those involved in the response do not become complacent.

The community health care aspects will be included in guidance being developed by NHS England on system preparedness and response to pandemic influenza. The Adult Social Care service facing guidance will be developed following March 2019.

This paper outlines the prioritisation decisions that will need to be made by both community health care and adult social care. However, as has been demonstrated through this work, both community health care and adult social care will be under an extreme amount of pressure in a reasonable worse-case pandemic, and will be under pressure both to support the acute sector, as well as managing their existing and expanding caseloads.

Annex A: Stakeholders

The stakeholders listed below attended a workshop on 24th November 2017.

The purpose of the workshop was to understand best practice in local multi-agency interaction when are services under pressure, and to develop suggestions for managing an unprecedented demand and reduced workforce in community health and social care in a pandemic.

NHS England Community Service Commissioning Team Hospital to Home Team NHS England South East Emergency Preparedness, Resilience and Response
NHS Improvement Carter Team
NHS Providers Cambridgeshire Community Services NHS Trust Camden and Islington NHS Foundation Trust Central & North West London NHS Foundation Trust Hounslow & Richmond Community Healthcare NHS Trust NHS South East London Surge Hub North East London Foundation Trust West London Mental Health Trust
Local Government Association of Directors of Adult Social Services Local Government Association
Local Authorities Central Bedfordshire Council Waveney Borough Council
Public Health Southwark Council
Sector Organisations Care England National Care Association Registered Nursing Home Association UK Homecare Association
Voluntary Sector British Red Cross
Department of Health and Social Care Community Services Team

Annex B – Project Initiation Document

Project Initiation Document	
Project name	Work stream 2 – Community Care
SRO	[redacted]
Project manager	[redacted]
Date	01/05/2018
Last updated	01/05/2018

Aim

The aim of this work stream is to increase our understanding of and confidence in the ability of community and social care sectors to respond to a reasonable worse-case scenario pandemic.

In year one (2017/2018) an initial draft of policy options for social care and community health care surge has been developed. Additionally, ADASS undertook an analysis for adult social care information requirements, communications and support infrastructure and necessary easements in a severe pandemic.

Outcomes

By February 2019, we will:

- Understand the impact of a reasonable worse-case scenario on the caseload and on the workforce of community health care and adult social care.
- Agree which route for real time reporting on adult social care capacity.
- Have a vision for how adult social care and community health care will respond to expand its capability, including service reconfiguration and consequence management
- Develop national policy options to improve preparedness, response and consequence management in this sector
- Review and update / publish guidance for the sector

Note that progress on most of these was started in year one.

Governance

To enable these objectives, the Work stream 2 Steering group will continue to meet. The membership of the group includes DHSC, NHS England, CQC, CCS, MHCLG and the Devolved Administrations.

The governance is through the DHSC Pandemic Influenza Preparedness Programme (PIPP) Board, with regular updates to senior staff in DHSC Adult Social Care, DHSC Pandemic Influenza and NHS England EPRR.

Risks and issues will be escalated as necessary to the PFRB project team (DHSC, CCS and MHCLG) and to the PFRB if necessary.

Stakeholders and dependencies

- DHSC Pandemic Influenza Policy Team
- DHSC Adult Social Care Team
- NHS England EPRR Team
- Chief Medical Officer, Chief Scientific Advisor, Chief Nursing Officer, Chief Social Worker
- DHSC Pandemic Influenza Preparedness Programme (PIPP) Board
- Association of Directors of Adult Social Care
- Local Government Association
- Care Quality Commission

Resources:

Individual	Organisation	Time contribution
[redacted]	DH Adult Social Care	0.5 days a week
	DH Pandemic Influenza	2.5 days a week
	NHS England EPRR	1 day a week

General Risks:

Risk	Owner(s)	Mitigation
CMO/CSA/CNO/CSW do not agree with the content of the policy paper.	[redacted]	Regular engagement with private offices and clear communication of priorities.
Insufficient resources or resources later reallocated		Regular discussion regarding priorities.
Policy paper does not meet the scale of the challenge		Regular testing of policy options with the front-line and risk experts.
Data for community health care is unavailable to inform/ develop the models to the degree CMO/ CSA etc require		Narrative planning without detailed modelling

Outcome	Milestones	Responsible & Accountable	Risks	Mitigation	Status
Understand the impact of a reasonable worse-case scenario on the caseload and on the workforce of community health care and adult social care.	Year 1: Provide indicative modelling of the impact of a reasonable worse-case scenario on Adult Social Care workforce.	[redacted]	Lack of analytical capacity. Lack of accurate/ adequate data.	Conversation with analysts to establish timelines and resource capacity. Establish proxies for national data sets where possible.	Completed
	Year 2: Provide indicative modelling of the impact of a reasonable worse-case scenario on Adult Social Care caseload	[redacted]	Lack of analytical capacity. Lack of accurate/ adequate data.	As above	In progress
	Year 1: Provide indicative modelling of the impact of a reasonable worse-case scenario on Community Health Care workforce	[redacted]	Lack of analytical capacity. Lack of accurate/ adequate data.	As above	Completed
	Year 2: Provide indicative modelling of the impact of a reasonable worse-case scenario on Community Health care caseload	[redacted]	Lack of analytical capacity. Lack of accurate/ adequate data.	As above	In progress
Have an agreed system for real time reporting on adult social care capacity.	ADASS undertake an analysis for adult social care information requirements, communications and support infrastructure and necessary easements in a severe pandemic.	[redacted]	Timelines slip Resulting reports do not meet the ask of the work stream	Clear scoping of timelines and deliverables, with sound governance arrangements.	Completed
	Based on ADASS analysis, identify new capability requirements and agreed which reporting system will be used.	[redacted]	Operationalising the ADASS recommendations requires additional costs.	Develop reporting options, being clear where additional costs would support future work.	Not started

Have a vision for how adult social care and community health care will respond to expand its capability, including service reconfiguration and consequence management	Work with Directors of Adult Social Services, and local government to develop practical options for response to adult social care requirements	[redacted]	Stakeholders do not consider a severe enough level, providing options that inadequate to respond to a severe pandemic.	Regular engagement to share the assumptions of the reasonable worse-case scenario. Sense check by DHSC to ensure options are sufficient	In progress
	Work with community health care providers and discharge and surge teams to develop practical options for response to community health care requirements.	[redacted]	Stakeholders do not consider a severe enough level, providing options that inadequate to respond to a severe pandemic	Regular engagement to share the assumptions of the reasonable worse-case scenario. Sense check by DHSC and NHS England to ensure options are sufficient.	In progress
	Consider how multi-agency working will support both the adult social care and the community health care response to a severe influenza pandemic.	[redacted]	Guidance not well received/useable at the operational level.	Good use of operational expertise of LGA/ADASS/front line providers in developing the guidance.	In progress
Develop national policy options to improve preparedness, response and consequence management	Develop national policy options to support the local level responding to a reasonable worse-case scenario, including procurement, stockpiling, new technologies etc.	[redacted]	Lack of dedicated local government expertise/lack of engagement from LRFs to outline asks form the national level.	Workshops to be held in 4 locations across the country to increase attendance. Engagement with senior stakeholders including Directors of Public Health.	In progress
	Consider legislative easements		Timeline may not match with that of the legislative work	Provide initial thoughts, further requirements to be considered for later review	In progress
	Work with CCS and other government departments to understand additional sources of resources e.g. volunteers and Military.		Lack of clarity of the requests of OGDs and resources OGDs will be able to offer.	Develop key principles for roles of volunteers to use as a starting point. Develop indicative numbers based on previous exercises.	In progress

	Seek input from CQC on possible regulatory easements	[redacted]	Options are not severe enough. Changes in regulations not communicated to front line leading to risk averse behaviour	CQC to be a member of the steering group. Plans to include appropriate communication approaches.	In progress
Review and update / publish guidance for the sector	Identify the possible next steps for work on Adult Social Care pan flu preparedness	[redacted]	Guidance not well received/useable at the operational level.	Good use of operational expertise of LGA / ADASS and LRFs	Not started
	Develop extreme pandemic surge guidance for Community Health Care	[redacted]	Guidance not well received/useable at the operational level.	Good use of operational expertise of front-line providers and LRFs	In progress

[i] 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 09.05.2018)