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Helen Whately MP
Minister of State for Care
Department of Health & Social Care
39 Victoria Street
London
SW1H 0EU

29th May 2020

Dear Ms Whately

Support for care homes

Thank you for your letter dated 14 May 2020. I am pleased to confirm that the information contained in this response has been co-ordinated by the council in consultation with our partners, and represents a York system view.

Before setting out the detailed action plan, taking my lead from the structure of your letter and the associated guidance, I would like to begin by setting the scene here in York.
Our Joint Health and Wellbeing Strategy is for every single resident to enjoy the best possible health and wellbeing throughout the course of their life. This is translated into our commitment to reducing health inequalities, maximising people's independence during the whole life course, through strength based approaches and asset based community development.

In relation to health and care services, we are focused on reducing admissions to permanent care and have promoted a Home First model for discharge from hospital. In response to the pandemic, during our preparation for the expected surge in hospital admissions and the need to rapidly discharge non-Covid patients, we remained steadfast in our commitment to getting people home. We commissioned significant additional home care support including a rapid response service for Covid positive people, and developed new recruitment channels with our provider partners to achieve this. As a result, we contained the number of admissions to care homes to assist stability during this crucial period. Our care home market, with 37 homes, is unusually balanced with 65% of residents funding their own care, consistently high levels of occupancy and good quality standards.

We have well established relationships with our provider partners in the city, built over many years, with good channels of communication. This meant we were able to quickly augment our usual arrangements during the crisis.

Joint work to ensure care market resilience locally
Please find attached (for information) the operational York care market plan.

<u>Confirmation of daily arrangements in place to review the local data and information on the state of the market locally</u>:

Alongside the daily arrangements detailed below to provide a wide range of support across the care home sector and care sector in general, the Council has also provided support through a dedicated PPE helpline, dedicated 7 days a week e-mail and contact arrangements from Adults Commissioning Team and, alongside colleagues in the CCG, have provided additional support through Team Around The Home - a multi-agency and system wide approach to specific and immediate support for care homes.
The Council has followed a place based principle and approach in supporting care homes with:

- Our focus on asset based community development, prevention and social impact volunteering underpins our system response and capacity
- Home First remains our key strategic principle when planning care
- Positive alignment to the Covid-19 Discharge Service Requirements
- Capacity Planning based on Public Health modelling and monitoring actuals, and detailed intelligence about existing capacity and sustainability of the sector
- Close collaboration between Primary Care, Community Health Services, Social Care and the voluntary and community sector

Daily arrangements in place to review the local data and information of the state of the market locally:

By 10.30am	by 1.30/2pm	2.30pm meeting	By close of play	8am Gold meeting
•Capacity Tracker updated by homes and checked by CYC •Any homes requiring a call are contacted and calls logged. •Homes are usually contacted daily, even when Capacity Tracker has been updated	•Daily Dashboard is prepared by CYC - includes detailed information on all COVID cases, staffing, PPE, training, clinical support requested, IPC etc •Contents checked and validated (QA process	•Multi – agency meeting to review dashboard and agree the support to be requested for the following day •Adult Social Care Commissioning, Public Health and CCG Nursing and Quality in attendance	•Summary produced to accompany the dashboard, providing the narrative for the Gold meeting on the following day •CCG to send the dashboard summary to GPs •Summary shared with CYC rep for next day Gold meeting	•Priorities for support are discussed and agreed for the system •CYC DPH rep submits testing request via the portal •Other support measures agreed and allocated to named leads

York system's collective level of confidence that these actions are being implemented or plans are in place to urgently implement

The two-way communication flows of information gathering and sharing provides a good level of confidence that action is being taken, progress made and where issues arise they have been quickly identified and addressed.

At a strategic system level we established a Covid-19 Co-ordinating Group, chaired by the Accountable Officer of the CCG, bringing together the key multi-agency work streams, including clinical support to care homes, advance care planning and support for people at the end of life.

The level of information, and support that has been provided by the Council and its partners has been welcomed across the system. The Council has been complimented on its pro-active use of the Capacity Tracker and has been put forward as an exemplar site and a case study will be available shortly from NHSE. It has also received very positive feedback from NHS England and NHS improvement as to its approach and the level of information, detail and support that is available to the sector.

Providers have welcomed the support provided as can be evidenced through the following compliment from Catherine McClure, Owner, Support Solutions Care who commented: "*We just wanted to say thank you for the amount of information you have provided so far throughout this awful time. We have all read a lot of negative [comment] regarding a lack of support and we are letting all who ask know that this is not the case! Thank you to you all for what you're doing behind the scenes: it is very much appreciated.*"

<u>Infection Prevention and Control</u>

The Council has developed a robust plan to support the sector over recent weeks, aligned to the Care Home Support Package and the work of NHS partners. This approach, developed across our LRF footprint of York and North Yorkshire, ensures that a public health approach is taken to managing outbreaks in a care home as well as taking a longer term preventative view to protect Covid free homes. This approach involves colleagues in public health, adult social care, CCG, infection prevention and control, PHE, CQC and the independent care group. It is co-ordinated through a daily GOLD command call with these partners where the needs of homes are discussed and prioritised. This includes testing in the home, as well as IPC support, and training. Each care home has a dedicated member of the group who can provide this support to the home. We have developed this approach with the local CCG and health partners, branded the "team around the home", to provide an enhanced level of input, training and support into care homes including taking a pro-active approach to making sure homes remain Covid free. All care homes in York have received or are booked to receive the National IPC training by 29th May 2020.

<u>PPE</u>

The daily dashboard records any issues faced by care providers in relation to availability, stocks and supplies of PPE. As described above, the council has established a PPE helpline for providers, and has co-ordinated distribution of stock when required.

The CCG led IPC training also covers the correct use of PPE, observing donning and doffing techniques.

Reducing workforce movement between care homes and minimising risk for care workers
Through our daily contact with homes we have monitored their staff sickness and self-isolation, confirmed and suspected cases, dependence on agency staff and take up of the IPC training. Providers RAG rate their status daily on staffing and PPE, enabling the system to prioritise urgent support. We have also monitored the number of staff working in more than one setting, and encouraged homes to minimise this, which they have done.

Quarantining
Our dashboard captures each home's ability to isolate new hospital admissions, untested community admissions, and to cohort residents in the case of an outbreak. This has enabled us to work sensitively with local homes when planning admissions and discharges from hospital. Later in this letter I will go on to describe the alternative accommodation arrangements we have made for people who cannot return directly to their normal place of residence due to Covid positive status.

The hospital discharge service command centre ensures the discharge guidance is enacted to discharge people quickly from hospital, through swift multi-agency assessment, planning and provision before moving into a care home when that is the correct pathway.
A number of steps have been implemented to ensure the safe admission and discharge from care homes including the safe discharge post hospital admission.

- Each case has a plan in place to safely manage care and movement to avoid cross infection
- Step down facility managed by ASC, Peppermill court
- Self-Isolation periods post discharge where possible
- Individual testing prior to moving sites
- Restriction of inter home transfer where self-isolation period is not possible

Stepping up NHS Clinical Support
The CCG has mobilised the plans required as described in the letter from NHSE/I 1 May 2020 - Covid-19 response: Primary care and community health support care home. This includes identifying a clinical lead for each care home, weekly check-ins, process for personalised care planning and access to medicines management support including medication reviews. Weekly sit-reps have been submitted.

The CCG has also mobilised the requirements as set out in the document 5 May 2020 - Responding to Covid-19: Principles to Deliver an Enhanced Universal Support Offer to Care Homes in the North East and Yorkshire Region. In addition to the support from primary care this includes increased support from community services including daily registered nurse input, directory of specialist services, follow up post discharge and CCG led infection prevention and control training which includes train the trainer approach covering IPC principles, use of PPE and Covid-19 testing.

We have monitored the access to primary care support from the homes' local GP surgery. This has emerged as a positive picture during the pandemic.

Comprehensive testing

Our daily Gold prioritisation meeting has enabled a timely response to the emerging arrangements for access to whole home testing through all the relevant routes.

The approach that commissioners (LAs and CCGs) are taking to address short-term financial pressures experienced by care providers, taking into account local market context and pressures.

CYC and VoY CCG are working closely together to support local care providers during the Covid-19 pandemic. Measures taken include:

- Paying providers a 5% increase to fees
- Paying providers a month in advance on planned care
- The CCG has improved invoice payment terms from 28 days to 7 days
- Continuing to pay day support providers in full despite a drastically reduced service
- Passporting Funded Nursing Care increases direct to homes on 28th May 2020 with no invoices required
- Intention to distribute 75% of Infection Control Funding direct to care homes when received from the DHSC
- Having a S75 agreement enabling the delegation of duties resulting in providers being paid quickly without unnecessary delays around funding responsibility

We are in regular contact with our care home representative body, the Independent Care Group, as well as individual homes to respond swiftly to any issues around their financial viability. As yet, no providers have expressed concerns to the council around sustainability during and beyond the Covid-19 period.

The approach agreed locally to providing alternative accommodation where this is required, and care arrangements for people who need to be isolated or shielded, where their normal care home does not have capacity to provide this.

The Council commissioned Peppermill Court, a 24 bed facility, registered with CQC as a short-stay recuperation and recovery service as part of the City of York's response to the Covid-19 crisis. Although the service is led by City of York Council, the need for the service was recognised by NHS partners, and the admission criteria, staffing model / approach, and pathways in and out of the service have all been jointly developed in partnership with colleagues from the CCG, York Hospital FT, Public Health, and NHS Property Services. The service opened on the 4th May with a multi-agency project group steering its development that agreed to see this as a 'pilot' service which will need to be flexible and respond to developments, and our learning about what is needed and how patients are presenting, as time unfolds.

It has initially opened as a 12 bed unit but the staffing model is in place to be able to flex this up to 24 beds very quickly if/when demand dictates.

Purpose of Peppermill Court is to provide a short stay (ideally no longer than 14 days) recuperation and recovery service, in a residential care setting, for Covid-19 positive

patients who are discharged from York Hospital. The service is registered with CQC with the following conditions:

a) The registered provider must not provide nursing care under accommodation for persons who require nursing or personal care at Peppermill Court.
b) The registered provider must only accommodate a maximum of 24 service users at Peppermill Court.

Admission Principles

An appropriate patient for Peppermill Court will:

- Be Covid-19 positive
- Be a City of York resident aged 18+
- Have been assessed as medically optimised by York Hospital
- Be in need of a period of recuperation and recovery before they are ready to go home or onto another care setting
- Have been individually discussed and assessed in terms of level of risk before they come to Peppermill Court (e.g. severely immunosuppressed patients).

Peppermill Court was created to help free up capacity in York Hospital with a focus on supporting a period of recuperation and recovery so as to enable residents to be as independent as possible by the time they leave Peppermill Court. A resident's stay at Peppermill Court will typically be up to 14 days only. In order to maintain flow through the discharge pathway there is minimal flexibility around this, but it will be individual needs led, on a case by case basis.

After their stay a Peppermill Court resident will be discharged to one of the following options:

- Home – with no support
- Home with Support (Reablement / Home Care)
- Step down provision
- Return or admission to long term care home

To support these pathways and to support discharges from hospital for people not requiring Peppermill Court, the Council commissioned a Rapid Response Home care Service with capacity for approximately 250 hours per week, based on two hour discharge and Covid positive referrals, an additional 14 step down beds and 5 nursing care beds for use within this pathway. Alongside this the Council has worked with partners in developing successful social media recruitment campaign for care workers and used volunteers to support some care settings to enable care staff to focus on those who require support. The Council has also developed a plan to commission additional bed based capacity should the need arise in the future.

Local co-ordination for placing returning clinical staff or volunteers into care homes, where care homes request this support.

The CCG has worked with Health Education England and NHSE/I as part of the Bring Back Staff Campaign to identify clinical staff returning and the primary care weekly sitrep requires GP practices to report on numbers of returners they have employed and those volunteering to increase their clinical sessions. The CCG Director of Nursing & Quality and nursing team and the CCG Director of Primary Care and Population have offered their clinical expertise to care homes and to the group and committee structures responding to Covid-19.

The council has received 4,000 offers from people wishing to volunteer over the period of the crisis. A registration process was established to co-ordinate the most appropriate deployment of this fantastic resource. Below are two examples where their generosity has been supporting the health and care system directly.

Age UK York have a 'home from hospital' service, which is very important to support the discharge process of patients from York Hospital. They work closely with a number of teams within the trust and also are based there. As part of our Covid-19 response, the council has provided Age UK York with 25 additional volunteers from our pool of volunteers, who came forward recently to offer their support. These volunteers are supporting the hospital, Yorkshire Ambulance Service (YAS) and the council during the outbreak. They are primarily helping people get from the hospital to their homes (following discharge) and giving them a hand with any shopping they need when they get home, to help them get settled in. Volunteers will also be helping people to urgent appointments such as cancer treatments, to free up the YAS capacity which is crucial during the pandemic. This also contributes to the council's local social care support, as the Age UK York volunteers are reporting back to their office to identify any further support needs, which will then be shared with the council to ensure we don't miss anything during this busy time.

To support people with Covid symptoms at home, York CVS working with GPs have established a Covid-19 monitoring call hub. This is being serviced by volunteers complementing the Ways to Wellbeing social prescribing team and Link Workers. Welfare calls are made to residents to support them as they monitor their condition, whilst liaising with GPs. The pilot has been such a success that more volunteers have been requested from the council's pool of volunteers, to provide additional capacity. Feedback from patients and GPs has been excellent.

Directors of Adult Social Services (DASSs) core duties - basic safety, human rights and safeguarding - are still being delivered and that the support provided is underpinning this.
The ASC Safeguarding Team have allocated a link worker to every care home in York in order to ensure regular contact and support/advice over safeguarding issues. This was an initiative planned before the pandemic and will remain in place in the future.

There are weekly meetings between the Service Manager, Safeguarding, Safeguarding Lead Nurse at the Hospital, Safeguarding Lead Nurse in the CCG and Head of Service, Safeguarding Adults in CYC, where concerns are identified, discussed and where appropriate escalated.

Safeguarding practice and response to enquiries continues; the only change being that face to face visits have been restricted due to Covid-19, but undertaken where necessary. This is reviewed on a regular basis. The service has been able to maintain the statutory response required.

There is also a weekly meeting between the independent Chair of the Safeguarding Board and the Head of Service, Safeguarding to discuss emerging concerns.

The CCG Head of Legal and Governance has commenced, in partnership with Local Authorities, specifically to support care homes, a group linked to the Mental Capacity Act and how to support those who are lacking capacity to be tested for Covid-19 and to be managed in their placements if they need to have restricted movements as a result of Covid-19. This includes the production of a single set of documentation to support those who have perhaps not had to deal with these issues before as well as trying to source and circulate easy read guides etc. for a variety of matters related to Covid-19.

Whilst the focus of this group is on the link between the Mental Capacity Act and safety/safeguarding issues the same or similar issues will affect those with capacity and will also benefit from this group.

Local engagement
The majority of engagement around Covid-19 has been a public facing survey and stakeholder interviews, where we received over 600 responses. This was focusing on the impact of the Covid-19 restrictions on the public.

Public Health in the council together with the CCG have surveyed clinical staff to better understand the impact of Covid-19 now and in the medium and longer term which has resulted in a Rapid Joint Health Needs Assessment to plan for and respond to current and emerging health and care issues including care homes residents.

In relation to the preparation of this response on York's behalf, I have confirmed the support of the Health and Wellbeing Board, the Director of Adult Services, the Director of Public Health, the Accountable Officer and the Executive Director for Quality and Nursing from Vale of York CCG. This submission has also been presented to the multi-agency Covid-19 Discharge Steering Group to raise awareness across the health and care system.

Publication
The York local plan for support to care homes (covering letter and template) will be published on the local authority website in parallel with this submission, and will include information on the financial and other support put in place by the council to assist the whole sector through this challenging time.

Conclusion
I hope you will find this to be a comprehensive response to your request. Please do not hesitate to contact me if there is anything you wish to discuss linked to this letter.

Yours sincerely

Ian Floyd
Deputy Chief Executive & Director of Customer & Corporate Services