Annex 1 - Health, Housing and Adult Social Care

Response to COVID-19 and Recovery, July 2020

Place Based Principles and Approach

- Our focus on asset based community development, prevention and social impact volunteering underpins our system response and capacity – promoting 'what's strong, not what's wrong'
- 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 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

What these principle mean in practice

- Our response to the COVID-19 pandemic was informed and shaped by the commitment to supporting people to remain independent, with additional support to return to their own home from hospital or to their usual place of residence if that was a care home
- We avoided making new placements in care as far as that was possible
- We supported care homes to care for people and avoid admissions to hospital when appropriate
- We increased our partnership activities to join up resources, and focus on our strengths, such as the offer of volunteers to help their neighbours

Technology

- All staff working remotely from home or at the Discharge Command Centre
- We invested in additional telecare services to support the Discharge Pathways
- We have supplied equipment to care settings to enable remote consultations with health and care professionals

- People with care and support needs have been supplied with smartphone technology and supported to use this so that they can maintain their independence and wellbeing.
- The Grandcare system alerts people with care and support needs to the symptoms of Covid-19, and supports them to engage with family/friends through video calling .
- Virtual Talking Points are starting soon, using a tech solution called *Attend Anywhere*
- Utilisation of technology to allow the repairs and adaptations teams to support residents without entering the home

Keeping people safe

- Safeguarding team social workers appointed as link workers to all residential and nursing homes
- Commissioning compiled a list of all people with care and support needs who are not in supported living settings, who are either living with family or in single tenancies in the community
- Adult Social Care have made contact by phone with all individuals on the shielding list and all who have a Direct Payment, to support their welfare and help resolve issues that have arisen during this period.
- Housing made welfare calls to all vulnerable tenants, signposting to support services in their area
- Dementia Action Alliance the co-ordinator in regular contact with both Dementia Forward, and Alzheimer's Society - welfare calls for over 400 people with dementia identified by their GP
- Faster turnaround of empty homes to support hospital step down
- Additional temporary accommodation to further reduce the number of rough sleepers
- A link between Adult Social Care team and local community hubs supplying food parcels and delivering medication to those who need, to respond promptly to issues identified through the hub.
- For people with Learning Disabilities, activity kits have been commissioned from and delivered by Toolbox – kits for individuals living in the community as well as living in supported living settings.

Partnership – York and beyond

- York Discharge Command Centre was set up to support the national Covid-19 Hospital Discharge Service requirements and was operational by the 6th April. This was a joint endeavour between local authorities, health partners and the independent sector.
- Re-oriented preventative teams to support the work of community hubs
- To support people with Covid-19 to leave hospital, CYC collaborated with NHS and others to set up Peppermill Court short stay residential recuperation and recovery service. This avoided return to care homes for people with Covid-19.
- Working with partners through Local Resilience Forum to ensure Personal Protective Equipment and testing was accessed when needed in York, including daily Gold care home resilience meeting with colleagues in North Yorkshire County Council, North Yorkshire Clinical Commissioning Group, Vale of York Clinical Commissioning Group, Care Quality Commission, Public Health England.
- Developed primary care hub with system partners, maximising use of volunteers to maintain contact / wellbeing checks with people recovering from COVID-19 and at risk of deterioration – linking GPs and community health services to social prescribing volunteers

Working with providers

- Regular information bulletins and contact from the team for care providers
- Recruited additional workforce with home care using social media, increased provision by creating a Rapid Response home support service to support two-hourly discharges from hospital, live in care to support people with complex needs to return home and voluntary home from hospital capacity.
- Developed step down beds for COVID-positive people to support discharge from hospital
- Formed *The Team Around The Home* as part of our Care Home Support Plan, with NHS clinical leads / GPs, including access to Infection Prevention and Control training

- Daily arrangements are in place to review the local data and information of the state of the local care market and to support its resilience in responding to the pandemic.
- Adult Social Care has also provided support through a dedicated Personal Protective Equipment helpline, dedicated 7 days a week e-mail and contact arrangements from Adults Commissioning Team
- Successful bid for Testing Satellite Site in York, enabling daily distribution of tests kits for proactive / preventative approach

Impact on activity – June snapshot

- The number of contacts to Adult Social Care increased substantially; expect increased demand for services over the next few months
- The percentage of contacts resolved with Info, Advice and Guidance is higher than it has been previously
- Higher number of new users and number of visits to Live Well York
- The number of people receiving paid packages of care continues to increase; numbers in res/nursing care (and admissions) reduced, but offset by the rapid increase in numbers receiving home care (enabling hospital discharges and preventing admissions to hospital and care)
- Increase in reablement provision, in terms of number of clients (and slight increase in hours per client)

Impact on costs

- It will be some time before the final tally is known, partly due to the temporary support made available to the care providers – such as temporary increases in rates, payment on planned care for home care and day support etc
- The NHS is covering the cost of new and enhanced packages of care during the pandemic period, and customers are not being charged
- The government arrangements for funding the cost of COVID-19 via the NHS recharge are likely to end or be tapered in August / September. We have plans in place with the Clinical Commissioning Group to manage the care assessments and financial assessments as smoothly as possible
- The COVID-19 grant has not covered the full costs incurred

- Future costs may increase if more people require long term complex care or rehabilitation due to effects from the virus

Recovery planning

- Reflection with partners and citizens about what has worked well during the pandemic – build on the learning
- Continuing to promote use of technology and remote working
- Managing socially distant support and strength based approaches in communities – new ways of working with people
- Supporting volunteers to continue their contribution
- Maximise the advances in partnership working at a local level
- Re-setting social care services, alongside the restoration of NHS services
- Planning for a challenging winter