Safeguarding Adult Review (SAR) In-Rapid-Time - systems findings report

A SAR commissioned by a Local Safeguarding Adult Board

The SAB has conducted a SAR In-Rapid-Time to learn from the response of all partners to the outbreak of Covid-19 in Beech care home[1]. There is no suggestion of abuse or neglect within the home. The SAB is conducting the SAR under Section 44 (4) of the Care Act. This gives the SAB authority to arrange for a SAR in any situation where it believes that there will be value in doing so. In this case, the SAB is determined to capture and share learning that will enable more timely and effective responses to outbreaks of Covid within any care home context in the country in the future.

The SAB has collaborating with the Social Care Institute for Excellence to test a new process to enable learning to be turned around more quickly than usual through a SAR. This new process is referred to as a SAR In-Rapid-Time.

This document

This document forms the final output of the SAR In Rapid Time. It provides the systems findings that have been identified through the process of the SAR. These findings are future oriented. They focus on social and organisational factors that will make harder or easier to respond in a timely and effective manner to any future outbreak of Covid-19 in a care home setting. As such, they are potentially relevant to professional networks more widely. In order to facilitate the sharing of this wider learning the case specific analysis is not included in this systems findings report. Similarly, an overview of the methodology and process is available separately.

Each systems finding is first described. Then a short number of questions are posed to aid SABs and partners in deciding appropriate responses.

Contact

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[1] Names have been changed to preserve confidentiality

Systems findings

Introduction

We cannot overstate how different the world was six months ago in terms of the understanding and preparedness of professional networks for Covid-19. The medical knowledge, guidance, assessments of risks, processes and relationships that now exist were then not familiar or did not exist. The move from a situation where there was no guidance for the social care and community sectors, to a dizzying volume and rate of guidance produced, disseminated and updated for the sector.

The constraints of a SAR In Rapid Time mean that the learning captured in this report cannot be comprehensive. There are examples of innovations that are not covered. This would include the live flowchart developed by Public Health that is enabling the capture and coordination of Covid related data, allowing it to flow to the right places and be usable for oversight, management and operational support. We understand this has already been identified as a tool useful to share more widely. In the findings below, we have prioritised systems issues that dialogue during the SAR process suggested were not yet being addressed.

At the time of the outbreak of Covid in Beech, it is now widely acknowledged that across the country responses were focused on protecting the acute health sector, and social care including the care home sector were not in view. The SAR in Rapid Time focusing on Beech has highlighted a number of systems issues that reflect the on-going legacy of that bias, requiring attention to adequately address the needs of the care sector.

1. A PROACTIVE, STRATEGIC LOCAL RESILIENCE FORUM (LRF) THAT WORKS FOR THE CARE SECTOR

SYSTEMS FINDING:

A Local Resilience Forum (LRF) is a statutory body covering a police force area, designed to bring together category 1 and 2 responders for multi-agency co-operation and information sharing. Under the Civil Contingencies Act (2004) every part of the United Kingdom is required to establish a Local Resilience Forum.

The Resilience Forum (LRF) was formed in 2004. It brings together the emergency services, local authorities, National Health Service and other agencies which are all required to respond to any major emergency in the county.

Triggered by the outbreak in Beech, and the identification of the need to provide assurance about the residential sector, the LRF set up a Health and Social Care subgroup. This did not exist in the early stages of planning and prevention in the area and raises questions around the role, remit and timespan of its functioning.

Questions for SAB and partners:

- Is this LRF Health and Social Care cell now sufficiently set up to a) plan what multi-agency guidance and support is required as distinct from seeking assurances and b) assess the impact of individual Business Continuity Plans on the care sector as a whole?
- What are the plans for continuing the LRF? Will it reliably be in place as the coordinating forum as pandemic response moves to restore and recovery phases?

2. BUSINESS CONTINUITY PLANS

Systems finding:

Annual tests of a provider's Business Continuity plan and related systems, policies and procedures provide a vital check on preparedness for a range of emergencies and/or incidents. They provide an opportunity to test the knowledge and possible action to be taken by senior staff faced with such scenarios. The Beech experience highlighted that the scenario of a national pandemic was not a routine aspect of the BCP, and staffing and supplies, which became the most pressing issues within the Care Home, had not been adequately covered in the BCP.

Questions for the SAB and partners

- How effective is Business Continuity Planning for the multi-agency response?
- Is there now an understanding locally of what good care home continuity planning for staffing in a pandemic look like?
- Have the pandemic specific elements of a BCP been captured? Has a template been updated to accommodate them?
- Have the quality assurance processes involved with the development and review of BCPs been fine-tuned to incorporate the 'soft intelligence' now being gathered and shared by the CQC and others in order to test, for example, the adequacy and resourcing of the BCP.

3. MECHANISMS TO FLAG AND ADDRESS UNINTENDED CONSEQUENCES OF SYSTEM ADAPATIONS IN AN EMERGENCY

Systems finding:

By the nature of a pandemic, it requires flexible collaboration across the whole system that still leaves the constituent parts adequately resilient in the face of unprecedented challenges. By the nature of complex systems, decisions taken in one area will have knock-on effects in other parts of the system. It's imperative therefore that all parts of the system are able to flag up unintended consequences of decisions in other parts of the sector. It does not seem to be sufficiently clear whose role it is to identify such unintended consequences across agencies or how escalation processes would work to address them. Without such clarity, we risk repeats of examples such as identified in this SAR, when the requirement to redeploy CCG Care Home Quality Improvement Nurses and Infection Control Nurses to acute settings go ahead despite those involved recognising the evident risks for care providers.

Questions for the SAB and partners:

- Is it clear whose role this is to champion such issues and empower push-back when necessary?
- Should this be the part of the regulator, e.g. CQC and if not who?

4. PROVIDING TRAINING FOR CARE HOME STAFF TO ANTICIPATE RESTRICTIONS IN FACE-TO-FACE HEALTH CARE INPUT, IN ADVANCE OF WHEN IT IS NEEDED

Systems finding:

The Covid pandemic saw non– essential face-to-face visits from community nursing stopped, where possible, to reduce risk to resident's exposure to infection from visiting staff, and enable capacity to continue to deliver 'essential' services. Care home staff needing to take on a range of new tasks e.g. taking observations, wound care as well as requiring new expertise e.g. use of PPE and infection control. Supports were provided however specific training often came significantly after the fact, rather than reflecting any being part of a proactive plan to adequately equip care home staff for such eventualities. This was also reflected in other areas such as training in use of PPE and infection control.

Questions for SAB and partners:

- The NHS Improvement Framework for Enhanced Health in Care Homes supports the development of a comprehensive training and development plan for all health and social care providers, improving consistency and standards of training provided. Have training and development plans linked to NHS Improvement Framework for Enhanced Health in Care Homes, been reviewed to deliver training required for the Covid context in a proactive way, for example training on the use of PPE, infection control, taking observations, wound care?
- Locally is there adequate resourcing to provide the level of training required in order to avoid care providers receiving such training only after the fact?

5. INTEGRATION OF PROVIDERS IN MULTI-AGENCY PLANNING AND COMMISSIONING FORUMS.

Systems finding

Care providers do not seem sufficiently integrated into forums and processes for developing Covid-related support, including multi-agency planning and commissioning of approaches, tools, support. This inadvertently places providers in a passive recipient role, and leaves plans and interventions that are not sense checked for their relevance and viability on the ground.

Questions for SAB and partners:

- What are the perceived and actual barriers to enable better integration of providers?

6. VALUE ADDED OF "NHS IMPROVEMENT FRAMEWORK FOR ENHANCED HEALTH IN CARE HOMES" IN A PANDEMIC

Systems finding

The NHS Improvement Framework for Enhanced Health in Care Homes requires care homes to be aligned with the Primary Care Network (PCN), including GP Practices, and provide routine Multi-disciplinary Team (MDT) meetings for each care home. The framework supports advanced care planning and routine risk stratification of care home residents as part of this process. The benefits of this set up in normal times, proved

magnified in the Covid setting at Beech – though the arrangements were only put in place latterly. The routine MDTs, with the integration of the GP practice serving, Beech residents in the PCN, proved invaluable to care home staff in terms of reducing their time taken in contacting different teams for different residents, and enabling timely health care interventions for residents. In the event that death cannot be avoided, the set up will help minimise risks that those not familiar with the person, end up making time-pressured decisions without a clear and agreed written plan of their wishes, or that MDTs involved in palliative care are not brought in at the points appropriate.

Questions for SAB and partners:

- Is the added value of routine PCN MDT meetings for Care Homes in the Pandemic widely recognised?
- Are any further resources or supports needed to enable the Care Home MDT forums to be functioning effectively ahead of new waves of the Covid pandemic, or other new pandemics, when it is needed most?
- Is GP integration into PCNs consistent across all care homes in the area?
- Are there further ways that the benefits of the MDT mechanism to multi-agency responses in the Pandemic? For example, could the advanced care planning and routine risk stratification of care home residents, be proactively used to inform capacity planning across agencies?

7. RESOURCE-DEMAND MISMATCH IN INFECTION PREVENTION AND CONTROL EXPERTISE

Systems finding:

Infection Prevention and Control (IPC) expertise is a critical form of support in the context of a national pandemic. The current resource of a 1 FTE IPC role in the CCG does not seem to match the level of need across both GP practices and the 300+ care homes across the county. This risks making reactive interventions the norm, gaps in proactive and preventative work, and delays in arrangements for the delivery of training.

Questions for SAB and partners

- Has the LRF identified and discussed this gap?
- Are there options for joint-commissioning by CCG and ASC to bolster the resource?

8. MAINTAINING A HIGH INDEX OF SUSPICION

Systems finding:

Managing Covid over the longer term requires care homes and all partners to maintain a high index of suspicion to enable a timely identification of potential cases. However, we know that it is increasingly difficult to remain vigilant to signs and symptoms, the more time passes from an outbreak, and less frequently outbreaks occur more widely.

Questions for SAB and Partners:

- How can partners be enabled to maintain this vigilance and be provided with tools to help self-police any emerging complacency?