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Guidance

Coronavirus (COVID-19): provision of home care

Updated 2 September 2020

Contents

This publication is available at https://www.gov.uk/government/publications/coronavirus-covid-19-providing-home-care/coronavirus-covid-19-provision-of-home-care

Applies to: England (see publications for Wales (https://gov.wales/supporting-social-care-during-coronavirus-outbreak), Scotland (https://www.hps.scot.nhs.uk/web-resources-container/covid-19-guidance-for-domiciliary-care/) and Northern Ireland (https://www.health-ni.gov.uk/publications/covid-19-guidance-domiciliary-care-providers-northern-ireland))

Who this is for

This page aims to answer frequently asked questions from registered providers, social care staff, local authorities and commissioners who support and deliver care to people in their own homes, including supported living settings, in England.

In this pandemic, we appreciate that home care providers are first and foremost looking after the people in their care and frequently doing so under pressures of staff absence due to sickness or isolation requirements.

As part of the national effort, the care sector plays a vital role in looking after people as they are discharged from hospital – both because recuperation is better at home, and because hospitals need to have enough beds to treat acutely sick people.

Not all of this information is new, but aims to be a helpful resource that brings together all guidance related to coronavirus and home care in one place.

The guidance below has been informed by discussions with provider representative groups and many of the webinars that have been held to provide support to organisations working in health and social care during the coronavirus response. It will be reviewed and updated as further feedback is received and as the government and other agencies continue to refresh guidance.

There is separate guidance relating to personal assistants employed using direct payments (https://www.gov.uk/government/publications/coronavirus-covid-19-guidance-for-people-receiving-direct-payments/coronavirus-covid-19-qa-for-people-receiving-a-personal-budget-or-personal-health-budget).

What we mean by ‘home care’

By home care, we mean domiciliary care agencies that provide personal care (and sometimes other support) to people living in their own homes, whatever form this may take, which is regulated by the Care Quality Commission (CQC).

This is delivered by domiciliary care agencies, supported living and extra care housing services. These agencies vary significantly in size, scope, and the people that they care for. Most of these work with older adults, including adults with dementia. Others work with younger disabled adults, and some also work with children. Packages of care may be provided via the traditional route or as part of a third party or notional personal, personal health, or joint personal budget.

Many adults and older people require support in their own homes. This is essential to maintain an individual’s health, wellbeing and independence within their own community.

1. Personal protective equipment (PPE)

The most recent guidance from Public Health England on the use of PPE (https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-domiciliary-care) can be found on GOV.UK.

Getting the right PPE

PPE supply has been an issue globally, including for many in the care sector and we are working around the clock to ensure staff on the front line can do their job safely.

If adult social care providers are unable to obtain PPE through their usual wholesalers and there remains an urgent need for additional stock, they can approach their local resilience forum (LRF).

PPE stock levels should be reported in CQC's 'Update CQC on the impact of COVID' online form. Home care providers will have been contacted by CQC to advise on the process.

This short-term supply of critical PPE is intended to help respond to urgent local spikes in need across the adult social care system and other front-line services, in line with clinical guidance.

The government will continue to make drops of PPE for distribution by the local resilience forums to meet some priority need until the new parallel supply chain is widely operational.

National Supply Disruption Response

If local resilience forums are unable to supply, providers can also contact the National Supply Disruption Response (NSDR) system to make emergency PPE requests by calling 0800 915 9964.

The NSDR does not have access to the full lines of stock held at other large wholesalers or distributors but can mobilise small priority orders of critical PPE to fulfil an emergency need.

Before calling the NSDR hotline, please ensure you can provide the following details to the call handler:

- name, email and telephone number of the requestor
- name, email and telephone number of a contact for the next 24 hours (for example, out-of-hours cover if the original requestor will be unavailable)
- delivery address, including postcode; and named contact for receiving deliveries
- confirmation that your organisation is able to receive the delivery outside of normal business hours
- number of people with COVID-19 being treated (confirmed and suspected)
- number of beds in your organisation (if appropriate)
- how long your current PPE stock provides cover for (for example, less than 24 hours, 1 to 2 days, or more than 2 days)
- which products you are requesting and in what quantity

2. Clinically extremely vulnerable people and care groups

How home carers can support clinically extremely vulnerable people receiving home care during COVID-19

People who are 'clinically extremely vulnerable' will have received a letter from the NHS or their GP advising them of the recent changes to the government's shielding policy. From 1 August, the government is advising that clinically extremely vulnerable people do not need to shield because the transmission of coronavirus in the community has fallen.

Clinically extremely vulnerable people should follow the same guidance as the wider population on social distancing (https://www.gov.uk/government/publications/staying-alert-and-safe-social-distancing/staying-alert-and-safe-social-distancing). This group could be advised to shield again if the situation changes and there is an increase in the transmission of COVID-19 in the community.

Individuals' names will be kept securely on the shielded patient list by NHS Digital and they will be contacted quickly if the advice changes.

A wider group of people – including everyone aged 70 years or over and those with long-term health conditions of any age (anyone advised to get a flu jab as an adult) – are considered 'clinically vulnerable' and are also advised to carefully follow social distancing advice.

Dividing people who receive care into 'care groups'

While clinically extremely vulnerable people are no longer being advised to shield, many have been identified as having specific medical conditions that, based on what we know about the virus so far, place someone at greatest risk of severe illness from COVID-19.

One way of reducing the risk of exposure to COVID-19 to people who are clinically extremely vulnerable (https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19) is for providers to divide the people they are caring for into 'care groups' and allocate subgroups of their staff team to provide care to each.

The workforce and logistical challenges of doing this, especially within small and medium sized providers are acknowledged, and a decision about whether this is possible would need to be made locally. If providers are unable to divide their workforce into subgroups for each category, they may be able to divide the workforce into 2 groups:

- one to support the clinically extremely vulnerable
- the other to support 'clinically vulnerable' groups and everyone else

This is being proposed as a practical suggestion that may be viable for some providers, rather than a direction all providers are expected to follow. We acknowledge that different providers are experiencing different pressures. If providers are unable to work in this way, local authorities may be able to provide support through their plan to provide mutual aid. Should local authorities be unable to provide assistance, providers should contact their local resilience forum.

Commissioners, including local authorities and clinical commissioning groups (CCGs) should expect to support care providers with the costs of extra staffing and other costs incurred during the pandemic, for example donning and doffing PPE, time spent explaining to people with cognitive impairment why masks are being worn, and/or additional travel costs etc. Detail on the different types of care groups can be found in the annex.

Reducing contacts for clinically extremely vulnerable and clinically vulnerable people

Home care providers should be working with agencies involved in the health and wellbeing of the people they provide care and support to, in order to develop a multi-agency plan to reduce the number of people going into an individual's home. This should involve:

- working with commissioners, including local authorities and CCGs to identify which people they care for are within the clinically extremely vulnerable category, and identifying which other agencies are providing care and support
- working with the people identified as clinically extremely vulnerable and clinically vulnerable to understand which other professionals they have contact with and confirm whether they have received advice to shield or practise social distancing respectively

- identifying the priority needs and work with the person, their unpaid carer and partners in primary care, commissioning, and other care providers to review the plan for providing care and support across the wider community care team, it should have considered:
    - the priority health and care needs of the person receiving care and support
    - whether the needs currently met by different services can be met by a single, or reduced number of agencies
    - whether staff can perform the duties of other team members or partner agencies when visiting to avoid multiple visits
    - if visits from one or more agencies can be reduced
    - if the number of people seeing the person from within each agency can be reduced

Where it is not possible to allocate specific care groups to specific staff subgroups, it may be possible to schedule for clinically extremely vulnerable and clinically vulnerable individuals to be seen before people from other categories. Again, it is acknowledged that this may not be fully possible given that personal care tasks are often required at similar points in the day.

Reducing contact between staff

When reducing contact between staff:

- team meetings and handovers should be held remotely
- times of entry to a community base to collect equipment should be staggered – clutter should be kept to a minimum within community bases and hard surfaces should be regularly cleaned
- providers should ensure that there is a high level of support and a focus on staff health and wellbeing during this unprecedented time – access to the staff support initiatives offered through the Adult Social Care Action Plan should be promoted
- teams and individuals should have remote access to regular supervision
- remote, secure sharing of information relating to care between agencies should be supported through providers signing up to NHSmail, (https://www.digitalsocialcare.co.uk/covid-19-guidance/covid-19-quick-access-to-nhsmail/) or another secure email system.

How home carers can manage people they are caring for safely

Decisions about reallocating tasks or reducing visits will need to be made with:

- due consideration of the wishes and feelings of the person, and unpaid carer(s) in line with a personalised care approach
- agreement with partner agencies and/or commissioners that the reduction balances the risks of reducing care with that of potential transmission

If a person receiving care or their unpaid carer wishes to suspend their care, the organisation with responsibility for developing the care plan should be alerted to this. All involved parties should work together to agree whether this is an appropriate step and what can be done to ensure the person has access to essentials throughout this period, for example food, medicines etc. It is important to understand the reasons behind the request to cease care and provide reassurance around precautions taken to reduce the risk of transmission.

Providers will need to assess the risks posed by a reduction or suspension of visits. If you are concerned about the risks, or the capacity of the client to make this decision, you must seek advice from the commissioning authority. If the person receiving care is self-funding, contact the local authority for advice.

There is further guidance available on how the Mental Capacity Act applies to a person's ability to make decisions around receiving care (https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/). If you consider at any time that someone may be making this decision on behalf of an individual and not acting in their best interest, then contact your local safeguarding team.

If not all care tasks for people receiving care and support from the service can be delivered due to staffing capacity, interventions should be prioritised for those identified as highly vulnerable if they do not receive care. Where care is commissioned by the local authority then this must be the decision of the local authority in partnership with the person, and in accordance with Care Act Easements guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014) and the ethical framework (https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care) for social care. In this instance, mutual aid support should be urgently sought from the local authority, and escalated to the local resilience forum if required. This incident should be reported in CQC's 'Update CQC on the impact of COVID' online form.

3. Hospital discharge and testing

COVID-19 testing for home care workers and individuals receiving home care

Every social care worker who needs a test can access one, as confirmed in the government's adult social care action plan (https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan), and this includes those who work in the home care sector.

If you are a care worker and need a COVID-19 test because you have symptoms of COVID-19, you should be self-isolating and can access testing through the self-referral or employer referral portals (found on www.gov.uk/coronavirus (http://www.gov.uk/coronavirus)). This applies to home care staff, domiciliary carers and unpaid carers.

Anyone experiencing coronavirus symptoms can now be tested, which includes individuals receiving home care. This can be accessed through the digital portal (https://www.nhs.uk/conditions/coronavirus-covid-19/testing-for-coronavirus/ask-for-a-test-to-check-if-you-have-coronavirus/) or by calling 119 to book testing.

Testing for patients and discharge from hospital into the community

All people admitted to hospital to receive care will be tested for COVID-19, and hospitals should share care needs and COVID status with relevant community partners planning the subsequent community care.

Some people with non-urgent needs, who do not meet the clinical criteria to reside in hospital, will be discharged home for their recovery period. All individuals can be safely cared for at home by home care or supported living care providers, regardless of their COVID status, if the guidance on use of PPE (https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-domiciliary-care) is correctly followed.

Testing must not hold up a timely discharge as detailed in the hospital discharge service guidance (https://www.gov.uk/government/collections/hospital-discharge-service-guidance).

Where a test has been performed in hospital, but the result is still awaited, the patient will be discharged as planned and, while the result is pending, home care providers should assume that the person may be COVID positive for a 14-day period and follow guidance on the correct use of PPE.

Similarly, as set out in the COVID-19 adult social care action plan, (https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan) any individual being taken on by a home care or supported living care provider should be cared for as possibly COVID-positive until a 14-day period has passed, within their home. Providers should follow the relevant guidance for use of personal protective equipment (https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-domiciliary-care) for COVID-positive people during this 14-day period.

How home care providers can support the NHS Test and Trace service

NHS Test and Trace is a key part of the government's COVID-19 response. If we can rapidly detect people who have recently come into close contact with a COVID-19 case, we can take swift action to minimise transmission of the virus.

Full details on how NHS Test and Trace works (https://www.gov.uk/guidance/nhs-test-and-trace-how-it-works) and maintaining records of staff, customers and visitors (https://www.gov.uk/guidance/maintaining-records-of-staff-customers-and-visitors-to-support-nhs-test-and-trace) are on GOV.UK.

Staff from NHS Test and Trace or other public health professionals may contact home care providers if one of their staff or service users has tested positive for coronavirus in order to alert those who have been in close contact with them.

Home care providers can assist NHS Test and Trace by keeping a temporary record of their care staff and recipients of care. Many providers will already have the necessary record systems to store and provide this information on request. In these cases, providers do not need to duplicate records.

If you do not currently have a system to record this information, this should be done in a way that is manageable for your business, but sufficiently detailed to effectively support NHS Test and Trace.

It is recommended that providers ensure that their systems are set up in such a way that this information can be reported rapidly on request and identify the person(s) who can produce this information at short notice.

If a provider is contacted, the following information may be requested at short notice:

- the name and telephone number for a home care worker
- the dates and times that a home care worker is at work
- a log of the care worker's visits to individuals receiving care for the previous 21 days. This should include, where possible, arrival and departure times of their visit, as well as a record of the name and residence of any individual(s) they provided care to ('the client')
- the name and telephone number of the client and/or the client's representative
- the names and telephone numbers of other home care workers, when working in close proximity (for example, during a 'double up' visit)

NHS Test and Trace will ask for these records only where it is necessary.

General Data Protection Regulation

All collected data must comply with the General Data Protection Regulation (GDPR) and should not be kept for longer than is necessary.

Any records or reports produced specifically for NHS Test and Trace should be held for 21 days. After 21 days, this information should be securely disposed of or deleted. When deleting or disposing of data, you must do so in a way that does not risk unintended access (for example, shredding paper

documents and ensuring permanent deletion of electronic files).

Reports to NHS Test and Trace should not contain data that goes beyond what is requested.

GDPR allows you to request contact information from your staff and those receiving care and share it with NHS Test and Trace to help minimise the transmission of COVID-19 and support public health and safety. It is not necessary to seek consent from each person. If you already collect this information for ordinary business purposes, you should make staff and recipients of care aware that their contact information may now also be shared with NHS Test and Trace.

You do not have to inform every person individually. You might, for example, update the privacy notice on your website to add a section that sets out what data will be used for and the circumstances in which it might be accessed by NHS Test and Trace. You may need to offer some people additional support in accessing or understanding updates to your privacy policy.

Safely discharging into the community

The guidance on discharge to assess (https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model) is clear that the discharge to assess pathways must include NHS organisations working closely with adult social care colleagues, the care sector and the voluntary sector. No person should be discharged before it is clinically safe to do so.

Section 5.1 of the guidance advises the following:

To create a safety net and increase confidence in discharging, consider:

- person-initiated follow up – give people the direct number of the ward discharged from to call back for advice. Do not suggest going back to their GP or coming to A&E
- telephoning the following day after discharge to check and offer reassurance or advice
- calling them back with results of investigations and any changes or updates to a person's management plan
- bringing them back under the same team or speciality
- requesting community nursing follow up with a specific clinical need
- requesting GPs to follow up in some selected cases

All registered providers and managers will need to have confidence that legal requirements for assessments will be met, and that particular consideration will be given to safety and infection control-related needs during this heightened period. This will require hospital, community health, and social care providers to work together to make sure people have the right support in place.

Escalating inadequate discharge summaries

Where people are discharged from an acute or community hospital back to their own home, the requirements of the hospital discharge service guidance (https://www.gov.uk/government/collections/hospital-discharge-service-guidance) apply. The guidance requires that each locality appoints a local co-ordinator with accountability for all elements of the discharge process covered by the guidance, including the provision of discharge summaries.

Where home care agencies identify inadequacies in discharge summaries, these need to be escalated to the local co-ordinator. All areas are required to have a local co-ordinator during the COVID-19 response. Contact your local authority for clarity around who this person is if required.

How trusted assessors will work

A summary of guidance on trusted assessors and COVID-19 is available (https://www.cqc.org.uk/sites/default/files/20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf). Trusted assessors are a mandatory requirement as part of the High Impact Change Model.

Most hospitals already use trusted assessor schemes for discharges to care homes and care at home services in their areas. These should be kept up to date in local NHS Discharge to Assess (D2A) arrangements. This should be prioritised.

The hospital discharge service guidance (https://www.gov.uk/government/collections/hospital-discharge-service-guidance) sets out amendments to the existing CQC guidance (https://www.cqc.org.uk/sites/default/files/20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf) on operation of Trusted Assessment within Annex C. Key changes from the existing arrangements are:

- all hospitals will train additional discharge staff to operate as 'trusted assessors' – trusted assessors will continue to support care providers with discharge arrangements. The additional staff will supplement trusted assessors in existing schemes.
- most hospitals already use trusted assessor schemes for discharges to care homes and care at home services in their areas – these should be kept up to date in local NHS Discharge to Assess (D2A) arrangements. This should be prioritised.
- over this period CQC's priority is to continue to check that people are safe – where we have serious concerns, we will use inspection and other processes to do so.
- all registered providers and managers will need to have confidence that legal requirements for assessments will be met, and that particular consideration will be given to safety and infection control-related needs during this heightened period – this will require hospital, community health, and social care providers to work together to make sure people have the right support in place

4. Government support for social care

On 18 April, the government announced £1.6 billion of new funding for councils, in addition to the £1.6 billion provided in March. This takes the total funding provided to councils to over £3.2 billion, which councils can use to address pressures produced by COVID-19 including in adult social care. We have also brought forward £850 million in social care grants to councils to help with cashflow.

On 14 May, we announced an additional £600 million to support providers through a new infection control fund. The fund will support adult social care providers to reduce the rate of transmission in and between care homes and support wider workforce resilience. This will be allocated to local authorities and is in addition to the funding already provided to support adult social care sector during the COVID-19 pandemic.

Social care recruitment

The Department of Health and Social Care adult social care action plan (https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan) describes the ambition to attract 20,000 people to work in social care over the next 3 months.

The government is supporting providers' workforce needs through this £4 million social care recruitment campaign, encouraging job seekers to work in the care sector and giving access to free initial training.

The campaign highlights the vital role that the social care workforce is playing right now, during this pandemic, along with the longer-term opportunity of working in care.

It targets returners to the sector, as well as new starters who may have been made redundant from other sectors, and those able to take up short-term work (including those who have been furloughed). It directs people to the national campaign website which links to advertised social care jobs on https://findajob.dwp.gov.uk/ (https://findajob.dwp.gov.uk/).

We have launched a new website Join Social Care (https://www.joinsocialcare.co.uk/) to fast-track recruitment into the adult social care sector. The website allows candidates to access free training via Skills for Care (https://www.skillsforcare.org.uk/Home.aspx) and be considered for multiple job opportunities. This streamlines the recruitment process for candidates and employers, and sits alongside the many local initiatives that have been put in place to recruit staff.

Training to support those moving into the social care workforce

Key elements of the Care Certificate are available from Skills for Care, free of charge, to make it easier for employers to access rapid online induction training for new staff. Details of the training (https://www.skillsforcare.org.uk/About/News/COVID-19-Essential-training.aspx) and frequently asked questions (https://www.skillsforcare.org.uk/About/News/FAQs-for-rapid-induction-and-volunteer-training.aspx) can be found on the Skills for Care website.

Getting DBS checks for staff

NHS and many local authorities have set up local volunteer schemes and providers can deploy volunteers where it is safe to do so. The government has put in place arrangements for fast track DBS checks (https://www.gov.uk/government/publications/covid-19-free-of-charge-dbs-applications-and-fast-track-barred-list-check-service) that are free of charge for a list of roles, including emergency volunteers for health and social care services.

CQC also has guidance on interim DBS checks in this time (https://www.cqc.org.uk/guidance-providers/all-services/covid-19-interim-guidance-dbs-other-recruitment-checks).

Support from commissioners

Business continuity planning (https://www.local.gov.uk/coronavirus-information-councils/social-care-provider-resilience-during-covid-19-guidance-commissioners)

All local areas are required to have arrangements in place for responding to emergencies under Civil Contingencies legislation. These specify the roles of the different agencies involved and who takes responsibility for what.

In relation to adult social care, the lead role in responding to incidents is with the local authority. As more people will now be living at home with COVID-19 and those who have been hospitalised with the virus will be increasingly discharged from hospital, the strategic co-ordinating groups of the local resilience forum will be working with and responding to unresolved issues from local authorities, CCGs and safeguarding adults boards (SABs). These organisations are already working on:

- the relevant Category 1 and 2 responders (for example, CCGs) collaborating to support home care providers adequately, especially concerning their staffing levels; infection control practice and access to PPE

- the role of the local resilience forums to support the stabilisation and recovery of home care and care home providers is prioritised as specified in The role of local resilience forums: a reference document (https://www.gov.uk/government/publications/the-role-of-local-resilience-forums-a-reference-document).

Monitoring

To ensure the system can deal with unprecedented pressures, local authorities need to have the strongest possible intelligence about emerging risks to continuity of service, and at the centre we need to have robust information about risks to enable a national-level response where necessary.

CQC has developed a tool for home care providers to update daily about the impact of COVID-19 on their service. This will support local resilience forums and local authorities to direct mutual aid to providers where needed. Most local authorities have mutual aid protocols in place to get support from neighbouring and non-neighbouring councils.

Financial framework and payment mechanism support

Agreements are in place for commissioners to:

- protect providers' cashflow, including making payments on plan in advance
- monitor the ongoing costs of delivering care, such as higher workforce absence rates caused by self-isolation, sickness and family caring responsibilities
- adjust rates paid to providers to meet new costs.

The LGA has published guidance on mechanisms for commissioners to enhance the resilience of their providers during the COVID-19 response period. (https://www.local.gov.uk/coronavirus-information-councils/social-care-provider-resilience-during-covid-19-guidance-commissioners)

Steps for local authorities to support home care provision

Local authorities, working with their local resilience forums and drawing on local resilience and business continuity plans, should:

- ensure their list of individuals in receipt of local authority-commissioned home care is up to date and record levels of informal support available to individuals
- work with providers to identify people who fund their own care and help them to establish the levels of informal support available. It may be helpful for providers to share the number of hours of care they provide to help with planning, but they will want to satisfy themselves that it is lawful for them to share that information
- map all care and support plans commissioned by the local authority, to inform planning during an outbreak. Support providers similarly to map those packages that are self-funded
- contact all home care providers in the local authority area and facilitate plans for mutual aid across the area, taking account of business continuity plans and considering arrangements to support sharing the workforce between home care providers, local primary care and community service providers – it is vital that this includes all providers, including those who mainly or solely deliver services to people who fund their own care, and is not confined solely confined to local authority- or CCG-commissioned services. CQC publishes information about all regulated care services on its online directory (https://www.cqc.org.uk/about-us/transparency/using-cqc-data)

- consider the need to draw on local community services and primary care providers to support home care provision and draw up a plan for how and when this will be triggered
- consider how voluntary groups can support home care provision and link home care providers and voluntary sector
- take stock of how to maintain viable home care provision during the outbreak of COVID-19, including financial resilience – the Local Government Association, Association of Directors of Adult Social Services and the Care Provider Alliance has published best practice actions on financial resilience

NHS support for home care provision

CCGs, NHS providers and local community services and primary care, will be working with and supporting local authorities and home care providers in the provision of care.

Community service providers are already, or will be taking steps to:

- ensure their list of individuals in receipt of care at home support is up to date, establish levels of informal support available to individuals, and share lists with local authorities and home care providers to ensure join-up
- consider which teams need to extend 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
- explore options for alternative care models, including tele-care and ‘hub and spoke’ models to provide advice and guidance to patients and potentially their families
- take stock of how to maintain viable home care provision during the outbreak of COVID-19 – this includes developing joint plans with local authorities, home care and care home providers and primary care colleagues to agree how and when escalation processes can be triggered
- support local authorities in planning around resilience, including plans to share resources locally in an outbreak of COVID-19 – this should include workforce, including the deployment of volunteers where it is safe to do so, and where appropriate indemnity arrangements are in place.
- consider how voluntary groups that currently support NHS services could also support teams and specific individuals – make the links between those voluntary groups that currently support NHS services, home care providers and local authorities

5. Information collection and governance

How information and data will be collected during this time

To enable us to understand the impact of COVID-19 on the people providers care for, their workforce and their ability to deliver services, we need to collect data to ensure resources are targeted most effectively where they are needed. Read the latest guidance on information governance (https://www.nhsx.nhs.uk/covid-19-response/data-and-information-governance/information-governance/covid-19-information-governance-advice-social-care-sector/).

This will mean that:

- residential and nursing homes to complete only the NHS Capacity Tracker
- homecare providers to complete CQC's 'Update CQC on the impact of COVID' online form (from Monday 13 April) – this will be rolled out to Shared Lives services, Extra Care and Supporting Living services soon and we will be in contact with them directly when the service is available to them
- the small number of providers of both homecare and residential and/or nursing homes to complete both data collection sources

If this information is provided daily, through the appropriate route, local authorities, CCGs and other local bodies will receive that data. This means they will not need to make the same request and should not be contacting individual homes or services for this data.

This way of working is a requirement for our collective handling of the crisis but no doubt we will learn valuable lessons from taking this approach that might provide longer term benefits for all. We will want to identify and discuss those together.

6. Other areas

What to do if someone being cared for develops COVID-19 symptoms

If anyone being cared for by a home care provider reports developing COVID-19 symptoms they should be supported to contact NHS 111 (https://111.nhs.uk/service/covid-19) via telephone, or online.

Home care workers should report suspected cases of COVID-19 to their managers. Providers should work with community partners, commissioners and the person to review and impact on their care needs.

Suspected cases of COVID-19 should be reported in CQC's 'Update CQC on the impact of COVID' online form.

Mental health support for staff

Working closely with people, building trusting relationships, and delivering compassionate care are at the heart of home care provision. This is emotionally challenging work, and the difficulty of the circumstances people are working under at the current time are unprecedented. We want everybody working in social care to feel like they have somewhere to turn, or someone to talk to, when they are finding things difficult.

Social care staff can send a message with 'FRONTLINE' to 85258 to start a conversation. This service is offered by Shout and is free on all major mobile networks and is a direct support for those who may be struggling to cope and need help.

The Samaritans has extended its confidential emotional staff support line to all social care staff who might be feeling increasingly stressed, anxious or overwhelmed. This service offers care workers the opportunity to speak with a trained volunteer who can help with confidential listening and signposting to further support. To access this support, please call: 0300 131 7000

Hospice UK has extended its bereavement and trauma line to provide support to social care staff. This service offers a safe space for care workers to talk to a professional if they have experienced bereavement, trauma or anxiety as a result of the COVID-19 pandemic. To access this support, please call: 0300 3034434

We recognise that guidance is being updated frequently for the social care sector, and we need to make sure it is easy for frontline staff to access. We have introduced a new CARE branded website and app, CARE Workforce (https://workforce.adultsocialcare.uk/join), developed in partnership with NHSX and NHS BSA, for the social care workforce, aimed at providing timely information and signposting to support. It contains a range of resources to help individuals and their teams manage in this new situation, understand what they might need to be doing differently to support each other and pay attention to their mental and physical wellbeing. The site contains bitesize videos as well as guides to help staff access the information quickly.

Guidance to support and maintain the wellbeing of those working in adult social care (https://www.gov.uk/government/publications/coronavirus-covid-19-health-and-wellbeing-of-the-adult-social-care-workforce) has been published on GOV.UK. It provides advice and resources on maintaining mental wellbeing and how employers can take care of the wellbeing of their staff during and beyond the COVID-19 pandemic. This resource can also be accessed on the CARE Workforce app. (https://workforce.adultsocialcare.uk/join)

Safeguarding people where local authorities may not be subject to Care Act duties temporarily

Under the Care Act Easement guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014), local authorities will still be required to deliver their safeguarding responsibilities. Escalation of oversight over any decisions to withdraw aspects of services are described in the guidance. If there are any safeguarding concerns about an individual, local safeguarding teams should be contacted in the normal way.

The government has published an ethical framework (https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care) to guide local authorities in the event that they need to prioritise between competing needs. This states that decisions need to be made in a way that ensures people are treated with respect, minimises harm and is inclusive.

Any concerns that the guidance is not being followed should be raised with the relevant local authority. This could be done through usual contacts or any established complaint process where relevant. If it is felt Care Act easements have been operationalised without the correct process or authorisation taking place, then this can be raised with the Principal Social Worker (PSW) and ultimately the Director of Adult Social Services (DASS).

Additional resources

Further guidance is available on the Social Care Institute for Excellence (SCIE) website, including on supporting autistic people and people with learning disabilities (https://www.scie.org.uk/care-providers/coronavirus-covid-19/learning-disabilities-autism), and supporting those living with dementia (https://www.scie.org.uk/care-providers/coronavirus-covid-19/dementia/care-homes).

Annex: care group definitions

1. ‘Clinically extremely vulnerable’ people

Doctors in England have identified specific medical conditions that, based on what we know about the virus so far, place someone at greatest risk of severe illness from COVID-19. These individuals have been identified as ‘clinically extremely vulnerable’.

From 1 August, the government is advising that this group does not need to shield because the transmission of coronavirus in the community has fallen. Those who are clinically extremely vulnerable should follow the same guidance as the wider population. This group could be advised to

shield again if the situation changes and there is an increase in the transmission of COVID-19 in the community. Shielding, in this context means, remaining at home always and avoiding any face-to-face contact for at least 12 weeks. More guidance is available on GOV.UK (https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19).

Channels of communication should be developed locally to enable care providers to understand who has been placed within this category. This group includes:

- solid organ transplant recipients
- people with specific cancers:
    - people with cancer who are undergoing active chemotherapy
    - people with lung cancer who are undergoing radical radiotherapy
    - people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
    - people having immunotherapy or other continuing antibody treatments for cancer
    - people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
- people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
- people with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary (COPD)
- people with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as severe combined immunodeficiency (SCID), homozygous sickle cell)
- people on immunosuppression therapies sufficient to significantly increase risk of infection
- women who are pregnant with significant heart disease, congenital or acquired

2. People who are ‘clinically vulnerable’

This group have been advised to follow social distancing guidance (https://www.gov.uk/government/publications/staying-alert-and-safe-social-distancing/staying-alert-and-safe-social-distancing).

Review caseload lists to identify people aged 70 years or over and those with long-term health conditions of any age (anyone advised to get a flu jab as an adult each year on medical grounds).

This group includes:

- people aged 70 or older (regardless of medical conditions)
- people under 70 with an underlying health condition listed below (anyone instructed to get a flu jab each year on medical grounds):
    - chronic (long-term) mild to moderate respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis
    - chronic heart disease, such as heart failure
    - chronic kidney disease
    - chronic liver disease, such as hepatitis
    - chronic neurological conditions, such as Parkinson’s disease, motor neurone disease, multiple sclerosis (MS), or cerebral palsy

    - diabetes
    - a weakened immune system as the result of certain conditions or medicines they are taking (such as steroid tablets)
- people who are seriously overweight (a body mass index (BMI) of 40 or above)
- pregnant women

3. People with confirmed positive or suspected COVID-19

All confirmed and suspected cases of COVID-19 should be reported daily in CQC's 'Update CQC on the impact of COVID' online form.

4. All other people receiving care and support