

## Advice Note:

# Cohorting, Zoning and Isolation Practice - Commissioning for Resilient Care Home Provision

September 2020

**This advice note has been developed to support local decision making in relation to cohorting, zoning and isolation. This advice note is not statutory guidance to local authorities.**

### The brief

This advice note has been developed as a result of work with the Task Force to set out effective practice in cohorting, zoning and isolation practice in care home settings.

It is important to note that as knowledge about Covid-19 develops this document may be superseded. It is also important to note the funding requirements for this, which are set out later in the document and required from Government.

This document provides advice to support local decisions on the effective implementation of the Public Health England (PHE) national guidance and high standards of infection prevention and control. In particular, the work to identify:

- a) The appropriate requirements in facilities and the workforce and equipment implications that can care appropriately for people who are COVID-19 positive who are isolating. This is particularly in order to have the appropriate facilities in which to transfer people, where necessary, from hospital.
- b) Considerations for local authorities in commissioning particular facilities for this purpose. This may depend on the degree to which there are existing facilities that are suitable and in line with (a) above.
- c) Any additional resource implications, taking into account existing levels of commissioning in care homes and the expectation that this should be in place for the rest of the financial year. Are there any additional resource implications once costs have been offset by redirecting existing commissioning budgets where this is possible?

### About this document

Various examples and documents already exist which exemplify notable practice and provide national guidance. This document brings some information together in order to provide a checklist for commissioners to assess what they have already done / might do. It is split as follows;

- Context
- Some key principles to guide work in this area
- Describing good practice in cohorting – within existing provision, or in dedicated facilities

- What this means for commissioners and how they work with care providers recognising the critical relationships between them
- Resource considerations
- Practice examples and references

This document does not replace scientific and public health advice and should be read alongside other key documents which are not repeated here e.g. safe systems of working, including the use of Personal Protective Equipment (PPE), testing, visiting. Links to key documents are included in Section 8.

The focus of this advice note is on registered care homes, across all care groups, age groups and regardless of size of the home. It is also focussed on arrangements for care homes residents but some of the approaches might also be considered to support family and professional visits (in conjunction with national visiting guidance).

Issues around mental capacity and Deprivation of Liberty Safeguards (DoLS) are an important consideration, but not covered in this document. The current national guidance is included in Section 8.

This document has been prepared in a short timeframe. More detailed analysis and / or simple practice guidance may be helpful in the coming period.

ADASS has worked in partnership with Local Government Association (LGA) and key colleagues in developing this advice note; commissioners, providers, Care Quality Commission (CQC), Association of Directors of Public Health (ADPH), Public Health England (PHE), NHS and Department of Health and Social Care (DHSC) colleagues. We are grateful to all who contributed their time and expertise.

### **Context**

- It is now over 6 months since the start of the pandemic. There are good examples of providers, local authorities and wider system partners working together to cohort / isolate care home residents. Experience and increased knowledge, along with improved availability of PPE and testing means there is now greater confidence across the sector in managing arrangements; but also, some 'burn out' factor. We continue to learn.
- The initial spike may be over, but we know the coming months will bring further pressures; the risk of localised outbreaks, a second wave, combined with factors such as winter pressures and the impact of EU exit. There is a need to draw on best practice to support systems, to maximise their ability to respond at scale and pace.
- This work sits in a wider context – the long-recognised need for reform and a long-term funding settlement for adult social care. In some areas there was already significant market pressure and fragility, and significant financial pressure, now compounded by the pandemic. The LaingBuisson study commissioned by ADASS and LGA identified some of the pressures arising (see Section 8).

### **Key principles / assumptions**

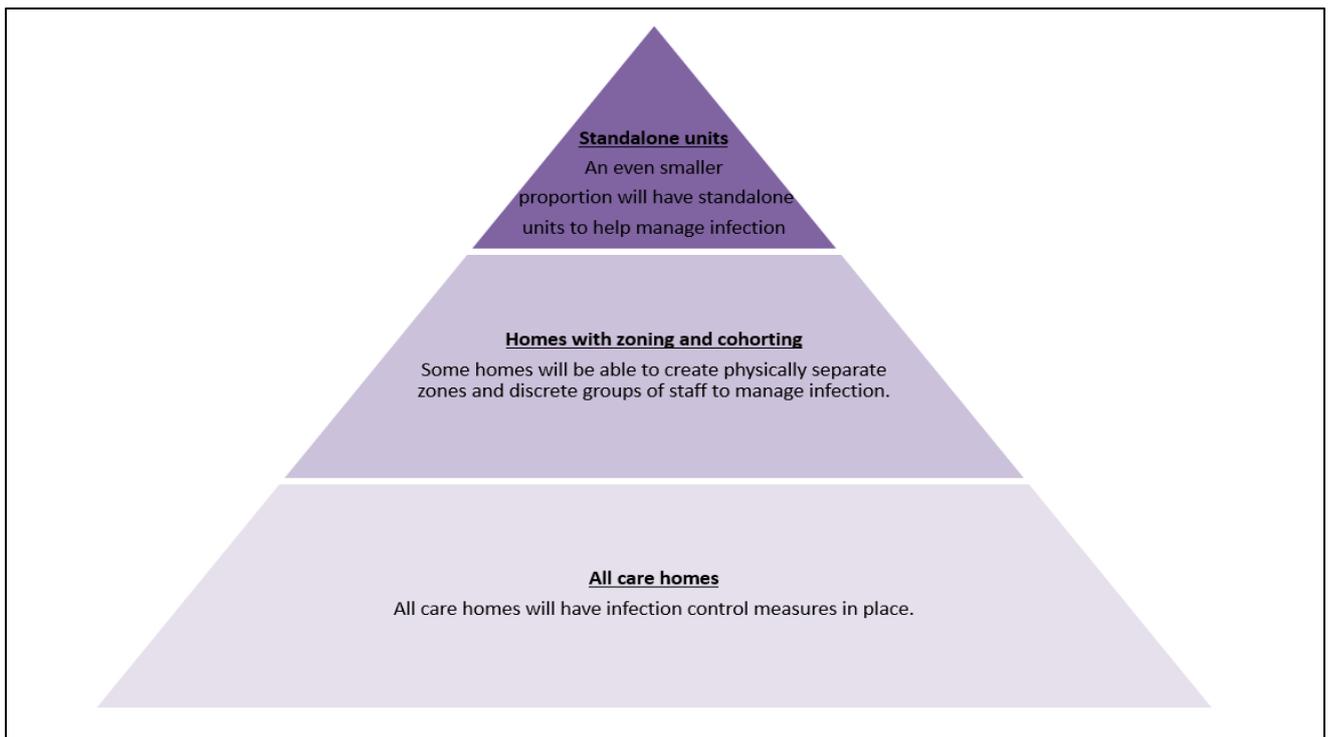
- The over-riding principle is that stopping infection spreading is part of putting the people we care for at the centre. The health and safety of people residing in care homes is a primary consideration. The care home where they live is their home and their views and wishes are paramount – we need to balance infection control with dignity.
- That we aim to keep to a minimum the number of ‘moves’ people experience, recognising the potentially negative impact of multiple moves for many of the people who live in care homes, but that step down or isolation facilities for infected people may be necessary to protect others.
- That we should prevent any further deconditioning (physical, cognitive, psychological or spiritual) for people especially when they have come out of hospital.
- That all work with people should take a dynamic approach to risk assessment - balancing the mental and physical wellbeing of residents.
- That the health and safety of people residing in care homes is paramount. Discharges from hospital must be on the premise that the COVID-19 status of the individual is known and accurately communicated to the receiving care facility with advice about ongoing management.
- Receiving care homes must be assured that they have the facilities and staff capability to safely cohort and manage COVID-19 positive transfers. A resident should only be admitted where there is a positive shared decision that this is the appropriate course of action. Care home staff should feel supported and not pressurised.
- When providers and commissioners are considering a placement in any care setting regulated by CQC due regard should be given to the principles of the Trusted Assessor guidance. This sets out the requirements of Regulations 9, 10, 11 and 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (and all other relevant legal requirements) and how they should be met. It is the providers responsibility to ensure they can meet people’s needs and consider the impact of new placements on people already living in the service. If they are unable to do so, they do not have to accept the placement. (see CQC guidance in Section 8).
- NHS organisations and clinicians have a duty to collaborate with these principles including timely testing and communication of test results to care home commissioners and providers
- The health, safety and wellbeing of staff is of equal importance.
- That all staff can access timely support and expertise including public health advice to enable them to manage any isolating/ cohorting situations that are providing challenge. This support would extend also to access to whistleblowing guidance, and fair employment and recognition.
- That all care homes have access to adequate equipment and support, and in the future have access to any new equipment support to comply with any changing practice guidelines. This ranges from access to equipment such as PPE, access to testing and access to appropriate support – including NHS support to care homes through, but not limited to, their named clinical lead.
- That care homes collaborate locally – with the council, Clinical Commissioning Groups (CCGs), Infection Prevention Control (IPC) and with other providers and are

transparent about successes and challenges with CQC, council staff, relatives and others.

### **Best Practice Provision**

The terms zoning and cohorting are understood in different ways and we have tried here to describe some broad approaches / models:

- All care homes applying safe practices – even where there are no known COVID-19 infections. This is a fundamental infection prevention control measure (universal precautions). This ‘category’ will include smaller homes or those in older buildings where it is not possible to create physical separation, so will require other considerations e.g. staffing levels. Practice arrangements will also be dictated by the client group being supported – for example with dementia or with a learning disability and / or autism.
- Various changes / adaptations, within existing facilities to cohort residents e.g. using one particular area of the home to support people with a confirmed COVID-19 diagnosis. Within this a smaller number of care homes have made physical changes to buildings to enable zoning of residents. This might also include taking some bedrooms or others spaces out of use to allow greater separation, so may impact on occupancy levels.
- A very small number of dedicated facilities have been opened to support people who have or possibly have COVID-19. Our work suggests that these have principally been for people being discharged from hospital, but some also consider for care homes residents to be placed while they have the virus, as a safer treatment setting than their current care home. This could be to serve a single local authority area, or across several ‘close’ authorities.



For all these models / approaches, the foundation is universal and effective infection prevention and control, and there are a number of essential pre-requisites:

- Applying safe working practices - this includes minimising staff movement between services (either between dedicated units or between homes), other steps to reduce physical contact between residents and staff and any essential visits, including signposting to direct one way movement if and following guidelines on use of PPE, ensuring regular testing, etc. These and other practices are covered separately in other national guidance / practice guides.
- Access to training for staff – including infection control practices, practical arrangements e.g. in use of PPE, and in identifying soft signs of deterioration.
- Testing – care home testing has helped to curb the spread of infection and target support to care homes that most need it, but testing of residents and staff needs to be available on a regular and repeat basis across all care homes to give confidence to care homes and to the rest of the system (DHSC Whole Care Home Testing)
- Personal Protective Equipment (PPE) – recent levels of PPE have stabilised, and care providers are reporting that they have what they need. However, future scarcity of supply would increase risks around infection prevention and control, particularly in situations where there are higher levels of clinical support.
- Primary and community health support – where this support is working well it is invaluable. Providers and health staff need a shared understanding and agreement about the clinical support available and have confidence in this to manage the needs of residents. This support will include clear clinical pathways including for escalation of care.
- Public health support and advice - on infection prevention and control, including if possible, a nominated IPC lead.
- Other more specialist support – for example in supporting people with dementia and / or who ‘walk with purpose’, and specialist end of life and palliative care input.
- Resources – That adequate resources are available to enable care homes to safely cohort / isolate residents. This is addressed further in Section 7.

In zoned arrangements (which could range from designated areas through to stand alone / dedicated units) in existing care homes, there are a number of considerations:

- Clarity about numbers of people to be accommodated in each zone or dedicated unit. Experience suggests that optimum numbers in any self-contained unit would be about 6-10, but this will be dictated by what is practically feasible.
- Clarity about target groups in each unit e.g. a dedicated unit for residents with confirmed COVID-19; for those with recent negative test – so assumed virus free; possibly a dedicated area for new residents etc.
- Each dedicated unit should be as self-contained as possible – access as separate as possible ( ranging from being on a different corridor right through to separate key pad entrance) - dedicated kitchen areas - sluice and bathrooms facilities – addressing laundry practice where it is not possible to create dedicated laundry facilities - stores including PPE, medication and linen storage - separate equipment, both domestic e.g. fridges, dishwashers, and more specialist e.g. hoists - IT and phone access

- PPE considerations include supplies at each entry point to each unit, and disposal at each exit point, and handwashing facilities – possibly temporary sinks.
- Staff – should be allocated to one unit – both care staff and all support staff e.g. catering and cleaning staff. Staff needs must be taken into account, particularly in allocating staff to an area for COVID-19 positive residents. This could also include consideration of separate social/staff rooms as we know this can increase risk of infection.
- External visitors- Some families and residents are desperate to be able to visit. Others are very keen that there should be no visits from people externally. Where possible, homes managers should consider how zoning and cohorting can satisfy these different needs and preferences.

It is recommended that all care homes consider the nature and level of support they are able to offer, drawing on IPC expertise if needed, and perhaps developing a position statement on this. This will be dictated by multiple factors and will change, often on a frequent basis, but could be useful in managing expectations around placements; particularly from hospital. This point is picked up again in the section on commissioning.

### **Best Practice Commissioning**

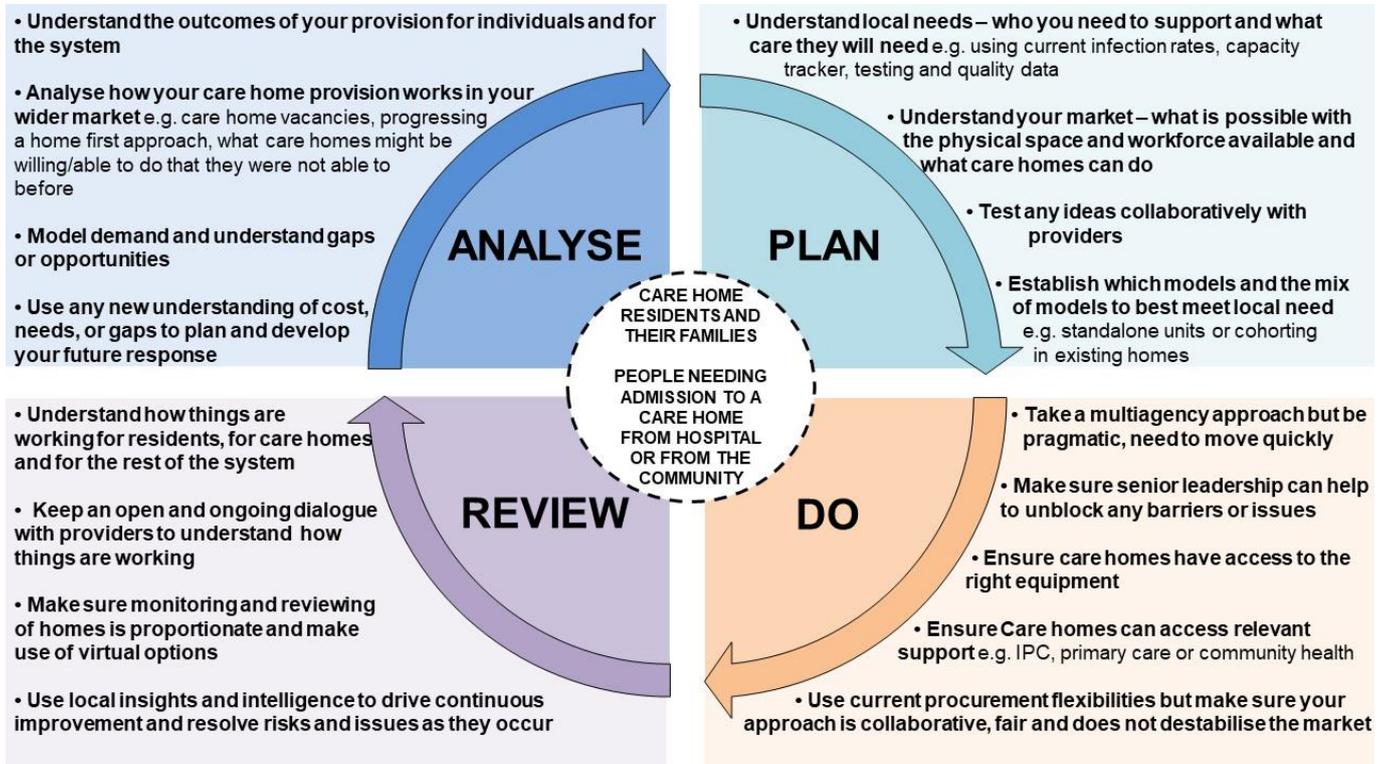
The following section lists key considerations for commissioners and then includes summary of key 'pointers' on a typical commissioning cycle diagram:

- Local needs assessment –
  - Using current infection rates, capacity tracker and quality data and whole care home testing results on immediate IPC/PH actions and prioritisation.
  - Using local, national and international evidence, including Joint Strategic Needs Assessment (JSNA), NHS England and NHS Improvement (NHSE/I) forecast demand, local market intelligence and Market Position Statement (MPS), capacity tracker, outbreaks, daily calls with providers, RAG ratings, quality and safeguarding data. What does this say about – populations / likely demand / local markets?
  - What is already in place and what else needs to be commissioned?
- Pragmatic, flexible and fast – balancing the ideal with what is realistic and achievable to put arrangements in place as quickly as possible and with maximum flexibility to step up and step down these arrangements given how volatile situations are going to be. Prepare now for a possible second wave combined with winter surge.
- With the longer-term in mind - opportunity to create capacity for future needs – not just the pandemic. Many commissioners have identified the need for more dementia and nursing provision and there may be some opportunity to create / design changes to contribute to this. This will include consideration of dementia friendly building design and other environmental concerns e.g. use of outside space, airflow etc
- Strong and equal partnerships – council Director of Adult Social Services (DASS) and Director of Public Health (DPH) with their CCG – working in partnership with clear agreement about resources – and in turn working with providers (including any providers who the council might not contract with) - health partners, wider voluntary /

community sector. The voice of care providers needs to be included in planning and commissioning to ensure that local systems can make the most of the assets, workforce and opportunities available. But also, so measures to maintain care home resilience work for all partners and give care providers confidence.

- Talk with providers about what they can do – engaging with providers on a home by home basis to consider what they are able to do to manage infection or take new admissions, and so there is shared agreement and understanding of any zoning or cohorting arrangements. Commissioners and providers might consider an ‘agreement’ to set out mutual expectations/opportunities on how they work together to get placements right. This would give both parties something to refer to if difficulties/challenges are encountered and could help build/cement positive working relationships. This dialogue with care homes must be ongoing, given the dynamic and rapidly changing environment. Resulting intelligence sharing can shape the support to all care homes regardless of COVID-19 status.
- Deciding what to commission – there is no prescription about the types of provision in each area; there is no right or wrong model. Commissioners will be assuring themselves that there is a ‘blend’ to meet local need, which maximises safety and infection prevention and control while representing value for investment. All services providing personal care need to meet CQC requirements for registration and should meet current best practice models. Learning disability services will not be registered if they do not meet the Registering the Right Support policy.
- Considering a dedicated / standalone service – the Norfolk and Leicester case studies in Section 8 provide further detail, but briefly commissioners will be considering a number of factors in making a judgment about this option; demand, availability of suitable building, mobilisation, staffing, potential disruption / risk of multiple moves for people, cost, ability to switch this capacity on / off.
- A strong network of community support – ensuring there is a strong network of support – as listed in Section 5.
- Procurement – COVID-19 procurement flexibilities make it possible to mobilise quickly, but local authorities and clinical commissioning groups need to work collaboratively with care homes to test what approaches would work best and to be transparent and fair in decisions.
- Reduced occupancy - Market capacity may be an opportunity, but also a cost pressure –councils should work with providers on the levels of occupancy that best enable homes to cope with the need to isolate and minimise staff movement, with the need for sufficient national and local funding to address the business implications. Commissioners (Council and CCG) will need to consider – with providers – the cost impact of e.g. taking bedrooms out of use, including impact of taking out bedroom that might be occupied by self-funders. In addition to considerations of reduced occupancy, commissioners will need to consider impact of lower referral rates for those – perhaps small homes – which are unable to offer cohorted environments.

## Commissioning cycle and summary of key considerations



## Resources

Many resources have already been committed to support zoning, cohorting and isolation practice through additional short-term government grants. Many care homes have committed their own resources, and commissioners have contributed from a number of sources; main council budgets, additional council funding to support the pandemic response, including the Infection Control Fund (ICF) and additional NHS resources to support hospital discharge.

This work has identified the following key areas which will need ongoing resourcing by Government as current funding runs out. These relate to specifically to zoning, cohorting and isolation practice, but sit alongside other costs such as PPE supply and testing which are essential prerequisites to support infection prevention and control. Commissioning new, alternative provision will also incur costs.

There will be continuing resource implications as care homes and council and CCG commissioners look at further improving practice and now need to plan for winter, and local outbreak management. This needs to be undertaken alongside the NHS. Providers will need help to pay for those costs either through increased payments from local authorities, the NHS and self-funders or through direct support from the government.

Commissioners have already re directed existing resources and have made full use of available additional resources e.g. ICF. It has not been possible in this piece of work to determine exact costs, but it is clear that additional resources will be required if the sector is to continue and further develop cohorting and zoning arrangements as part of a set of local measures to deliver effective infection prevention and control.

Cost heading	Pre cohorting	During cohorting	After cohorting
<b>Staff</b>	<p>Small – to prepare – managerial costs – staff training.</p> <p>Additional social work/care management if people need support moving.</p>	<p>Additional staff to provide cohort specific caring cleaning teams, catering, etc. Some cohorts – i.e. where COVID-19 positive – may have even greater staffing needs to support extra care requirements, additional cleaning etc.</p> <p>This includes enhanced support where people e.g. with learning disability who may not understand the need to isolate.</p>	<p>Possible costs of redundancy or retraining or redeployment of staff.</p>
<b>Building alterations</b>	<p>Could be for minor changes e.g. reconfiguring doors to enable separate exits or so people isolating can access the garden, creating small lounges so people are not confined to one room, creating small kitchenettes, additional laundry, catering, medication rooms through to more substantial building works to establish a standalone unit.</p>	<p>Limited capital costs.</p> <p>Possible rental costs.</p>	<p>Possible works to returning building to original state – enabling spaces to be brought back into style and feel of building.</p>
<b>Equipment costs</b>	<p>Purchase or hire of additional equipment for laundry, air conditioning for temperature-controlled medicine rooms, TVs for new shared spaces etc.</p>	<p>Ongoing hire costs.</p>	<p>Extrication from contracts if required to free space back up to original usage.</p>
<b>Opportunity cost</b>	<p>Limited – although depending on the building, meaningful cohorting may require lead in time to reduce usage of parts of the building – incurring voids.</p>	<p>Reduced occupancy across the building very likely.</p>	<p>Costs during period that home returns to usual occupancy.</p>

### **Case studies and References**

We have compiled 5 case studies below outlining how local systems have supported care homes and managed infections.

These case studies aim to showcase what different local systems have done and pull out what they identify as the main enablers, challenges and key lessons that they wanted to share.

## Norfolk and Waveney: the Outbreak Management Team and supporting care providers with cohorting

### Norfolk profile:

- 907,760 (2019, ONS)
- Fifth largest county in England (by geography).
- 348 total care homes
- 5 CCGs recently merged in to 1
- 3 Acute Hospitals, 1 Mental Health Trust and 1 Community Health Trust
- 14.5K (approx.) people with diagnosed or undiagnosed dementia

### Communication and engagement:

- Since early March weekly, now fortnightly catch up calls with all Registered Managers
- More frequent contact with any home experiencing an outbreak
- Provider Query Hub set up to answer questions and signpost to:
  - Dedicated [COVID-19 care provider website](#) – national and local perspective
  - Regular (initially weekly, now fortnightly) provider comms jointly Dir of Commissioning /Chief Nurse with key messaging and signposting.

### Key learning for other systems:

1. Effective join up with neighbouring SSD (Suffolk) in outbreak management - CCG footprint covers two Local Authorities.
2. Collaboration/co-production with care market in developing new COVID-19 ways of working (incl. virtual Quality Assurance)

### The Outbreak Management Team (OMT):

A multiagency wraparound team to support care providers with incidents or outbreaks of COVID-19.

#### Model:

- Hosted by Norfolk County Council
- 7 day a week service (08:00-20:00)
- From the Care Provider Incident Room (single point of contact) cases are referred to:
  - Outbreak Management Team for outbreak tracking, PPE, financial and workforce support, guidance, information, training and advice; or,
  - Local NHS for testing, infection prevention control and clinical advice.
- OMT comprised of: Integrated Quality Assurance function, Public Health Consultants, Infection Prevention and Control, CCG and Primary Care representatives.

### Supporting cohorting:

#### Conversations to support care providers covered:

- Consideration of restricted admissions where cohorting challenged
- Sharing expertise in supporting people who walk with purpose, activities and tips for management, engagement of specialist team where escalated
- Support to consider alternatives to DoLS (very few appropriate COVID-19 related DoLS applications submitted).

#### Actions taken included:

- Training ancillary staff in supporting residents to maintain social distancing
- Making 'prohibited' spaces 'resident friendly' (e.g. 1:1 helping staff)
- Novel activities (e.g. supporting the administrator, shredding, opening post)
- Innovative use/re-dedicating space (e.g. quiet lounge becomes isolation suite, garden shed a pop-up café)
- Retaining voids for re-allocation of rooms to support effective cohorting
- Sharing innovative practice with the care market via social media and provider communications

Contact for more information: [gaprovidersassd@norfolk.gov.uk](mailto:gaprovidersassd@norfolk.gov.uk)

## Newham: creating the Infection Prevention Control preparedness assessment tool

### Newham's profile:

- 363,552 residents
  - 25 care homes
    - 1 residential home
    - 6 dual registered residential and nursing homes
    - 18 care homes for individuals aged 18+ with Learning Disabilities, Mental Health needs and or challenging behaviour
  - Dominant role of large national providers in the 7 older people homes
  - 4 of the 7 older people homes have over 50 beds (CQC definition of a large home)
  - Other homes generally owned by small organisations, converted houses, communal washing/kitchen facilities
- Low levels of self-funders

### Enablers:

- WEL CCGs commissioned capacity for C-19 positive patients
- Capacity for “protective convalescence” commissioned where homes are not able to isolate effectively
- IPC staff with skills to understand the sector

### Challenges:

- Getting to a baseline quickly to support safe admissions
  - Building as they went along
  - Resources, especially IPC specialists
- Surveillance Testing system local strategic ambitions

Contact for more information:

[Samantha.Lewis@newham.gov.uk](mailto:Samantha.Lewis@newham.gov.uk)

### Purpose of the Preparedness Assessment Tool:

- To identify when it is safe for homes to receive residents discharged from hospital (including people returning home) or referrals from the community
- Each home is reviewed on a regular basis to ensure their preparedness status is up to date and to increase safety if necessary, through a jointly developed action plan

### What the tool covers:

- The size and layout of the home, shared facilities etc.
- The number of residents, those with a high level of need
- Access to testing for residents and staff
- IPC practices including ability to isolate and zone by cohort, PPE protocols, cleaning
- Staffing capacity, training, noncompliance and safeguarding risks

### Creating the preparedness tool:

- The tool was developed in partnership by colleagues from across Newham Social Care Teams, Public Health and Safeguarding Governance and Waltham Forest and East London CCGs

### What is next:

- Partners use the IPC status of each home to identify where additional support is required and inform placement choices
- Link into the Outbreak Plan - identify which homes are at risk and make alternative arrangements for C-19 + patients whilst they recover where the home is not able to manage
- Extend the approach across all our care sectors
- Publish the Preparedness Assessment Tool with guidance

### Key learning for other systems:

1. Ensuring that homes were not asked to take patients that they could not effectively manage made the greatest difference.
2. Commissioners need to fully understand the risks that their providers and therefore their patients are exposed to and work as a system to manage those risks, whether lack of training, equipment, specialist advice or infrastructure issues such as shared bathroom facilities.
3. Could not have achieved this outcome without bringing together colleagues from each part of the system and working in true partnership with our providers, in a supportive approach of shared risk rather than one of traditional “provider/supplier” relationship
4. Where placements into a home were suspended whilst corrective actions were taken, providers were financially supported. This demonstrated a “shared risk” approach and ensured they were not under pressure to accept admissions
5. Comms are vital, ensuring that providers and partners are aware of what you are doing and why (including all partners that place into the home) and the actions required to improve the status or IPC score

## Nottingham and Nottinghamshire: supporting homes to manage COVID-19 positive residents

### Nottingham and Nottinghamshire profile:

- Nottinghamshire
  - 328,101 residents
  - 289 homes
- Nottingham
  - 332,900 residents
  - 75 care homes

### Enablers:

- Joint working across Council, NHS and care providers
- Using daily reviews of care market and other intelligence to target support
- Merged dashboards for single version of the truth across health and social care
- Working individually with homes to understand what they can do and the support they need

### Challenges:

- The design and layout of care homes was a challenge. So provided alternative accommodation for COVID-19 positive residents in homes that passed an IPC checklist.
- Risk of overloading care homes with comms, data returns and requests for info. In future system working to align better.
- Balancing need for hospital discharge with what homes can safely do. Supporting care homes to say no when they are unable to accept a C-19 positive person.

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### Support for Care Homes:

- Working across the Local Resilience Forum footprint across Nottingham and Nottinghamshire. With joint working across Councils, CCGs, CQC and care providers
- Conversations with care homes and using an IPC checklist to understand whether homes can safely support someone who is COVID-19 positive.
- Using daily reviews of care market, the virtual care provider forums and sharing data to identify issues and prioritise where support is needed
- Process set up for supplying PPE to care homes who needed it free of charge
- Additional Infection Prevention Control support for homes who were able to cohort residents.
- Risk assessments were completed for each hospital discharge to a care home, focussed not only on the person being discharged but also other residents and staff in the home
- Health and social care staff were recruited or redeployed to help care homes maintain safe staffing levels if required
- Protecting and supporting the rights of people living in care homes, including through a briefing paper from the Principal Social Worker (for adults) to highlight some of the ethical issues that needed consideration, and guidance produced by Nottinghamshire Adult Safeguarding Board on issues concerning best interests, capacity and isolation.

### Key learning for other systems:

1. Joint working and supporting each other is essential
2. Opportunity for a more coordinated future approach across health and social care, working with care homes as full partners not “doing to” them
3. Regular comms and maintaining good relationships are important. Opportunity now to continue to build on this using some of the groups and governance that have been recently established and working with partners to reduce any duplication/confusion
4. Changes to policies and procedures can be disruptive so need to communicate these changes well. Consider how to ensure that everyone is following these new changes and how to support them if they are finding it hard.

## Leicester: developing a standalone unit

<p><b>Profile:</b></p> <ul style="list-style-type: none"> <li>• 329,839 residents</li> <li>• 103 total homes</li> <li>• Homes for 65+</li> <li>- 55 homes (38 residential, 17 nursing)</li> <li>- 2445 members of staff</li> <li>- 2056 beds</li> <li>• Specialist homes</li> <li>- 48 homes</li> <li>- 1089 staff</li> <li>- 655 beds</li> </ul>	<p><b>Why a standalone unit and why this model?</b></p> <ul style="list-style-type: none"> <li>• Only 3% of care homes were willing to accept a COVID-19 positive patient from hospital</li> <li>• Based on NHS England and Improvement modelling of worst-case scenario</li> <li>• Dedicated unit intended to make provision available to manage transmission, ease pressure on hospital and give confidence to the wider system</li> <li>• COVID-19 procurement flexibilities made direct award and rapid mobilisation possible</li> </ul>	
<p><b>Model:</b></p> <ul style="list-style-type: none"> <li>• 10- 15 bedded dedicated unit, with a dedicated staff for hospital discharge</li> <li>• Located in a residential and nursing home</li> <li>• Isolation of up to 14 days per patient, for up to 10 patients at any given time, on a block-funded 6-month contract (with break point at month 3)</li> <li>• Health and social care needs addressed by Primary Care input and further assessment</li> <li>• Service open to those aged 18+ in Leicester City, Leicestershire and Rutland (50% of beds held for Leicester City)</li> </ul>	<p><b>Enablers:</b></p> <ul style="list-style-type: none"> <li>• Strong relationships with providers through an existing provider forum</li> <li>• Procurement rules eased allowed greater flexibility for commissioners</li> <li>• Leicester, Leicestershire and Rutland had a joined up and coordinated approach around PPE, Testing, Information and the IPC Grant</li> <li>• Good knowledge of the market through the intel tracker</li> </ul>	<p><b>Challenges:</b></p> <ul style="list-style-type: none"> <li>• Market Availability – limited interest and willingness of providers to deliver such a unit</li> <li>• Market availability – limited availability of appropriate building to support the service</li> <li>• Cost negotiation</li> <li>• Hard to rapidly get system wide ownership and investment from all partners in the model</li> <li>• Timeframe and logistics of training all staff</li> <li>• Sourcing equipment for the unit</li> <li>• Personal Protective Equipment</li> </ul>
<p>Contact for more information:  <a href="mailto:caas.admin@leicester.gov.uk">caas.admin@leicester.gov.uk</a></p>	<p><b>Evaluation of the standalone unit:</b></p> <ul style="list-style-type: none"> <li>• Lower usage and referrals than anticipated</li> <li>• High cost due to block contract approach and time intensive to set up</li> <li>• Model rapidly/successfully implemented</li> <li>• Increased resilience and confidence in the rest of the market</li> <li>• Currently scoping future models, wider market response and community hospitals</li> </ul>	
<p><b>Key learning for other systems:</b></p> <ol style="list-style-type: none"> <li>1. When planning, think about the workforce as well as physical space to cohort and isolate</li> <li>2. Understand your market and work with care providers as full partners</li> <li>3. Consider your procurement approach, lead times and challenges so that capacity can be put in place and not come too late</li> </ol>		

## Norfolk and Waveney: developing a standalone unit

### Norfolk profile:

- 907,760 (2019, ONS)
- Fifth largest county in England (by geography).
- 348 total care homes
- 5 CCGs recently merged into 1
- 3 Acute Hospitals, 1 MH Trust and 1 CH Trust
- 14.5K (approx.) people with diagnosed or undiagnosed dementia

### Enablers:

- Strong systems relationships already in place pre COVID-19
- Joint commissioning and use of NHS funding
- Ongoing communication and engagement with providers through Norfolk Care Association
- Senior leadership commitment helped ensure system buy in and unblock issues

### Challenges:

- Staffing. Short timescale meant using a mixed model of staffing from in-house and home care providers
- Staff availability meant nursing or high needs dementia care was not possible
- Hard to identify a site, used multidisciplinary approach with clinical, therapy and commissioning staff to identify an appropriate one

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### Background: Why a standalone unit?

- Modelling predicted a worst-case scenario for c.250 additional beds.
- Short term beds for hospital discharge were not readily able to accept COVID-19 positive patients
- Concern that hospitals could be overwhelmed, and additional bedded capacity was needed
- Pathway agreed – test result prior to discharge, if positive would stay where they are, go to a step-down site or residential care setting (only if able to safely isolate)

### Model:

- For people who needed to leave hospital but cannot return to, or stay, in their home due to concerns about isolation requirements.
- 35 beds (opened 10 initially), 14-day length of stay
- Beds accessed through Integrated Community Response Teams
- Standard level of care (no nursing or high needs dementia)
- Local Authority as lead commissioner but whole system response
- Self-contained site with self-contained rooms
- Entire site operates as COVID-19 positive
- Equipped to meet a range of needs e.g. hospital beds, hoists, wheelchair accessible
- Primary care support wrapped around the unit in a virtual model (e.g. multiple practices supporting)
- £500k set up costs and since it has been stood down 'mothball' costs of £15 -£20k per month

### Evaluation:

- Low use of site as not needed by system due to scale of local peak
- Project plan and commissioning approach can be turned in to a 'step-by-step' guide to establish a step-down unit for cohorting
- Short (c.2 month) set-up time if effectively planned
- Expensive and highly intensive for staff to set up

### Key learning for other systems:

1. COVID-19 step-down space may be needed during a second peak over winter, to support the care market
2. Standalone units can be created in a short timescale but are resource and time intensive
3. Understand what the market can do, different staffing and physical set up will show what arrangements are possible.

### Other notable practice:

- [Portsmouth City Council](#): the learning and the practical steps they have taken to contain outbreaks in their care homes including – cohorting, building resilience, staffing and the importance of emotional support and wellbeing for residents, families and staff.

### References and guidance

**Department of Health and Social Care and Public Health England: [Coronavirus \(COVID-19\): adult social care guidance](#)**. This page brings together coronavirus (COVID-19) guidance published by the Department of Health and Social Care (DHSC) and Public Health England (PHE) for the adult social care sector and other relevant guidance. Includes links to guidance on:

- [PPE and how to work safely in care homes](#),
  - [visiting care homes](#),
  - [admission and care of people in care homes](#),
  - [testing](#)
  - [looking after people who lack mental capacity](#)
  - [hospital discharge requirements](#)
  - and other relevant guidance
- **North West ADASS: [care home infection control top tips](#)**. Compiled from desktop review of policy and best practice guidance and interviews with a selection of providers and commissioners from across the North West region. This guide seeks to stimulate ideas on how providers and commissioners can develop and enhance services in the context of COVID-19, whilst simultaneously building future resilience into existing infection control plans.
  - **CQC: [Trusted Assessor Guidance](#)**. Guidance on how Trusted Assessor Agreements can be made. And specific [COVID-19 Trusted Assessor Guidance](#) which was written to support NHS and social care providers and Trusted Assessor schemes during the COVID-19 pandemic.
  - **CQC: [Infection prevention and control in care homes guidance](#)**. Guidance for providers on the questions and prompts that CQC use to look at how well staff and people living in care homes are protected by infection prevention and control. Including what good looks like and further guidance.
  - **British Geriatric Society: [Managing the COVID-19 pandemic in care homes for older people](#)**. Guidance for care homes for older people, includes key recommendations and information on identifying residents who may have COVID-19, isolating residents, receiving admissions, advance care planning and escalation, escalation of care to hospital and supporting care home residents and staff.
  - **ADASS and LGA: [June briefing note about the financial pressures facing adult social care](#)**. Contains information and analysis about the cost of PPE, cleaning, staffing and lost income that providers have experienced.
  - **Registered Nursing Home Association: top tips for protecting residents and staff against COVID-19.**



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