THE COVID-19 PANDEMIC AND LONG-TERM CARE: WHAT CAN WE LEARN FROM THE FIRST WAVE ABOUT HOW TO PROTECT CARE HOMES?

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Summary: The COVID-19 pandemic has highlighted and exacerbated pre-existing problems in the long-term care sector. Based on examples collected from the COVID-19 Health System Response Monitor (HSRM) and the International Long-term care Policy Network (LTCcovid), this article aims to take stock of what countries have done to support care homes in response to COVID-19. By learning from the measures taken during the first wave, governments and the sector itself have an opportunity to put the sector on a stronger footing from which to strengthen long-term care systems.

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Introduction

Long before COVID-19, care homes across the World Health Organization (WHO) European Region were facing several challenges.[1] For staff, families and residents of care home these challenges and gaps in the system have been all too obvious. The long-term care (LTC) sector was already a myriad of financial, staffing and operational difficulties in most countries before the pandemic, and it has been hit badly, with as many as 47% of all COVID-19 related deaths happening among care home residents.[2] However, the impact has not been uniform within or between countries, which raises the question of whether some of these losses were avoidable. This article aims to take stock of what countries have done within care homes in response to COVID-19 in order to place the sector on a stronger footing from which to face future outbreaks. It also reflects on the importance of underlying structures and features in different countries and how the context into which a similar set of measures are introduced are likely to impact on how effective they are.

Key challenges predating COVID-19

Although every country's LTC system is different, there are a number of common challenges across the WHO

European Region that has meant the sector's response to COVID-19 was particularly complex.

A lack of coordination between health and LTC services

Organisation and governance of LTC services is often separate to that of health services [1] and countries frequently distribute responsibility for LTC across national, regional and local actors. In many countries, an absence of coordination between the two services, each with a diversity of actors, means that there are parallel but not always aligned systems for oversight, financing, staffing, and collection/management of data.[1] This underlying complexity (sometimes resulting in fragmentation) was brought to the fore during COVID-19 in many countries, where this lack of clear accountability for LTC services and underdeveloped information systems created complexities and delays in the COVID-19 response.[1]

Care systems have suffered significant underfunding

In many countries, LTC services have been poorly resourced, particularly when compared to health spending. This historic underfunding results in a high degree of rationing of publicly funded services and affects the quality of provision.[3] As the pandemic hit, the sector was in an already weakened position and not well-equipped to implement rigorous infection prevention and control measures nor absorb additional costs arising from personal protective equipment (PPE) needs, training needs and staff sickness.

Workforce shortages are widespread

Severe staffing shortages, fuelled by poor working conditions, low pay and a perception of low skill meant that the sector struggled during the pandemic. As a low-paid, predominantly female workforce,[4] many of whom work on flexible contracts with little or no sick pay, their exposure to the virus was high. It is not uncommon for care workers to work across multiple facilities, adding to the risk of spread of the virus.[5] As testing in many countries was slow to roll out, in the early phases of the pandemic care staff were faced with self-isolating for 14 days often without pay.[6] As absences increased, staff in care homes were more stretched than ever. In some European countries, migrant care workers make up a large proportion of the LTC workforce [7] and the closure of borders also had a impact on these workers.

Systems rely heavily on unpaid carers, even in care homes

Family carers provide an important share of LTC across countries, both through direct care, and by coordinating and complementing formal services.[8] Even when people with care needs move to a care home, many family members continue to be involved by providing emotional stimulation, activities, bedding and even food. This has become increasingly important in the context of staff shortages. As visits to care homes were restricted during COVID-19, this source of support for residents (and staff) disappeared.

What measures were taken to protect care homes during the first wave of the COVID-19 crisis?

Although data are still emerging, a scan of the region shows that countries largely implemented a similar set of measures which were focused on providing guidance, strengthening medical support, preventing the spread of the virus and minimising infection, and supporting the sector by boosting staffing and funding. The examples cited in the following section have been documented and can be read about in two key resources: the COVID-19 Health System Response Monitor (HSRM) and the International Long-term care policy network (LTCcovid). (**see Figure 1**).

Increasing oversight of LTC services

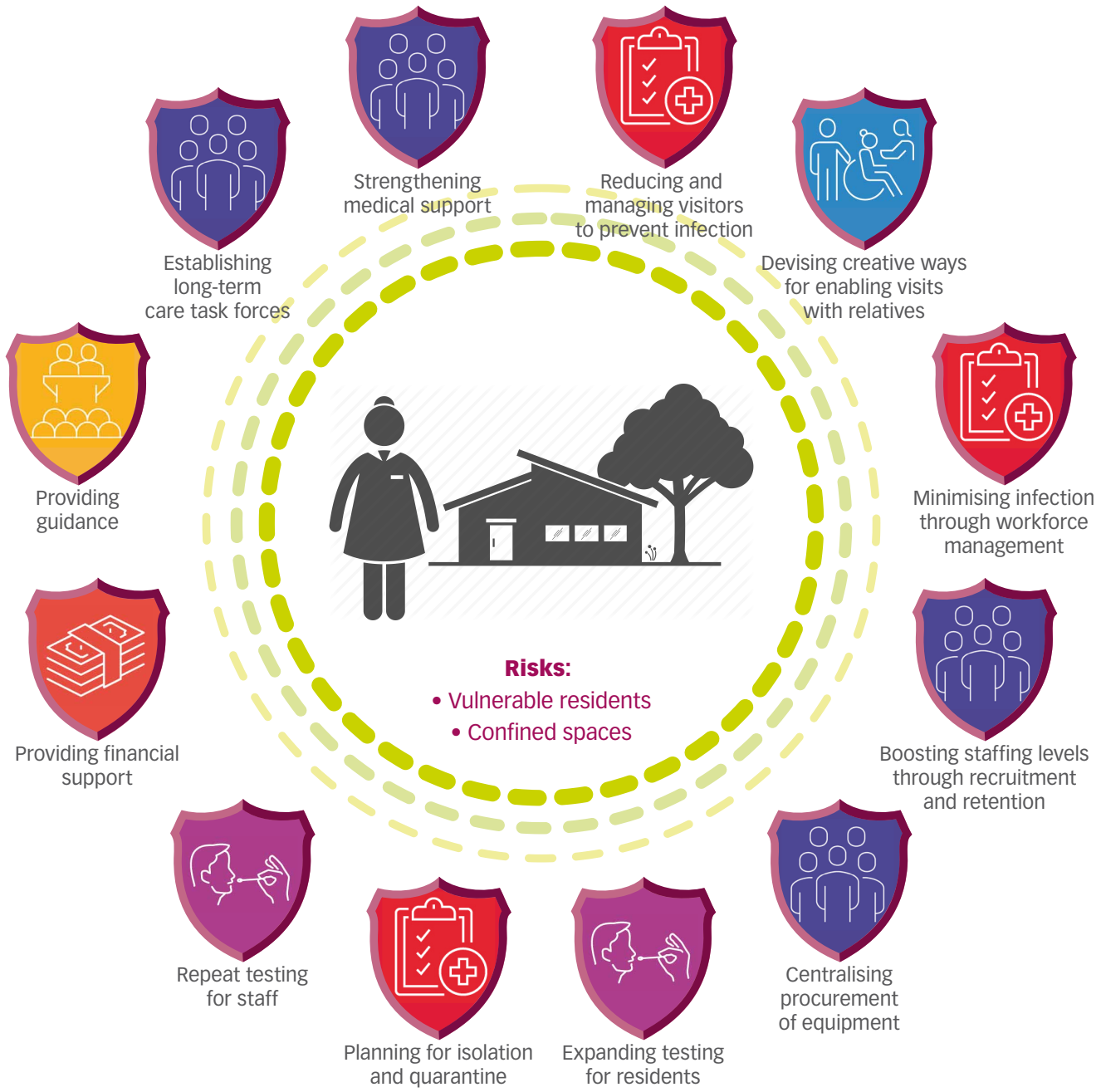
A number of countries sought to increase oversight of LTC services, strengthening central accountability and certain functions. This took a variety of forms. For instance, Austria, Greece, Hungary, Iceland, Israel and Germany established national LTC task forces. In Ireland, national and regional outbreak teams have been set up to oversee, prevent and tackle COVID-19 clusters in residential LTC settings. Care home providers started to report COVID-19 outbreaks to the Health Information and Quality Authority. Similarly, in Germany, teams from the Robert Koch Institute were deployed to support outbreak containment in these facilities.

The Czech Republic, Denmark, Estonia, Finland, Germany, Greece, Malta and the Netherlands centralised the management and/or procurement of PPE supplies for the care sector. In Spain, regional authorities have had to provide bi-weekly information on the number of infections, deaths, etc. in care homes to the national Ministry of Health. In a small number of countries examined (notably Hungary and Ireland), care homes have been required to appoint a COVID lead in order to define clear accountability in the event of an outbreak.

> countries largely implemented a similar set of measures

There has also been a trend towards centrally-produced guidance and regulation in an attempt to put in place support structures for the sector. In many countries, this has taken the form of guidance and training around the use and wearing of PPE and infection control but monitoring and enforcement has varied between countries. For instance, in Austria, responsibility for the development of guidance in LTC settings, their implementation and monitoring has been given to newly established national task forces. In Italy, the guidelines for nursing homes published by the Ministry of Health require providers to ensure the COVID-related training of care workers. In Ireland, a new Infection Prevention and Control Hub offers residential LTC settings guidance for outbreak preparation and management, information on infection prevention and control, and support with applying national advice. Some of this support is provided via tele-mentoring interventions and webinars for

Figure 1: Measures taken in countries to protect care homes during COVID-19



Source: [13]

nursing homes. In addition, the national membership organisation of home care providers has developed a COVID-19-specific National Action Plan.

Funding for care homes has increased in several countries

In recognition that care homes are facing increased costs (e.g. from extra PPE, staff sickness) and/or revenue losses (e.g. from reduction in occupancy), financial support has been provided in some countries. In Ireland, some of this was given directly to care homes which were able to receive immediate temporary assistance payment to respond to a COVID-19 outbreak. The regional Dutch LTC offices gave LTC providers extra funding if they faced additional costs due to COVID-19. Similarly, in Germany, institutions that incurred additional costs or loss of revenue due to COVID-19 were reimbursed by the LTC insurance. In contrast, in England and Sweden, additional money flowed to local authorities which had autonomy to allocate it according to their own priorities and this led to variation between local areas in how much was spent on LTC and, in England, some claims that additional funding was not reaching providers.

In some countries, the extra money was earmarked for specific purposes; e.g.

in Austria, some of the €100 million allocated to support the LTC sector was earmarked for expanding residential care bed capacity for people who could not be cared for sufficiently in their own home because of the complexities of delivering home care during the pandemic. In Denmark, Parliament provided DKK 100 million (about €13.4 million) to municipalities to support people in receipt of residential and community LTC with the intention of developing solutions to maintain social relations, quality of life and to prevent loneliness, including the use of digital technologies, reconfiguring spaces to enable limited visits and dedicated staff. In May, the English government allocated £600 million (about €660 million) for infection control in care homes.

> preventing infections entering care homes and managing outbreaks

A focus on recruitment and retention of staff

In the face of widespread staff shortages, many countries have made efforts to boost staffing levels in care homes through measures to increase recruitment and retention. England and Ireland launched recruitment campaigns to attract newcomers and former staff to the sector. In Finland, retired staff and students that did not fall into risk group have been recruited to maintain staffing levels. Similarly, in Spain care workers without the required training certificates could be legally employed and the Netherlands enabled nursing homes to recruit care workers more widely (e.g. medical students). Germany relaxed some staffing rules and operational frameworks to relieve pressure on the workforce. The impact of the relaxation of usual rules and requirements on standards and quality or the spread of infection is not yet known.

Efforts have also been made to retain the existing workforce. In the United Kingdom, Scotland and Wales have raised wages and offered special one-off payments to incentivise staff. Austria has awarded one-off payments of €500 to migrant care workers who have remained in the country to provide care. In Germany, there are plans to raise the minimum wage for care workers and all people employed in care homes will receive a one-off bonus payment of up to €1,000 (increased to €1,500 in four states).

Health care provision within care homes has been strengthened

The lack of health care provision within care homes [9] has created particular difficulties in places where transfer to hospital has been explicitly discouraged, because hospitals were both overstretched and a potential source of COVID transmission (e.g. England, France, Italy, the Netherlands, Norway,). Support has been deployed to LTC homes in some countries to avoid admission to hospital: Italy and Luxembourg have required care homes to have a 24/7 medical presence to follow up unwell residents and France, by May, was encouraging physician visits and offering greater remuneration after having told homes to minimise such visits in the early months of the pandemic. Austria requires its hospitals to offer support to care homes in the form of personnel, expertise and equipment. In Ireland, there has also been an agreement that enables the Health Services Executive (HSE) to redeploy HSE staff to private nursing homes on a voluntary basis. In Slovenia, medical teams are deployed to a residential care setting if the regular staff becomes exhausted or overwhelmed. In Israel, the Ministry of Health as made a special team available for period of 7 to 14 days to support residential care settings that are acutely short staffed and a 24h call centre has been established to support LTC facility managers with medical and management advice.

Efforts to prevent and manage outbreaks within care homes

A big challenge during COVID-19 has been preventing infections entering care homes and managing outbreaks. Bans on visits to care homes have been implemented in most countries. However, as the crisis has continued, it has become clear that physical distancing for people in LTC facilities can be detrimental to their wellbeing and therefore guidance and rules have since been amended to allow some contact with families and friends. In Germany and the Netherlands, care homes have created ways for residents to see and speak with relatives by using virus-proof containers, garden sheds, telephone boxes or other solutions.

Testing programmes in care homes expanded as the crisis unfolded but many countries have struggled with either logistical or capacity issues (or both) and so rolling out testing has been slow in many places. Several countries began with a relatively focused approach, only testing those with symptoms or, those with symptoms and underlying conditions, or those who had been in close contact with people who tested positive. Over time, efforts have been made to expand testing including for those in homes without symptoms. Denmark began testing all residents, regardless of symptoms. In the Czech Republic and, from mid-April in England, all new residents have been required to be tested before moving into homes. Prior to this, in England, people were being discharged from hospital into care homes after testing positive for COVID-19 or while awaiting a test, then from 3rd April care homes were advised to quarantine those individuals but many homes struggled to do so because of limited space or staffing. In most countries, guidance has been issued for the discharge of patients from hospitals to different care settings and since mid-April, most have required testing before discharge.

Like testing for residents, the policy on staff testing has evolved during the crisis period and varies between countries. The Czech Republic and Denmark have stressed the need for repeat testing with asymptomatic staff, or those with a negative test, being retested at regular

Box 1: The Impacts of Policies on Care Home Providers in England

In England, 26,500 excess deaths have been reported in LTC (until 7th August) and yet many of the policies recommended in WHO guidance[11] were theoretically in place, leading many to question what went wrong. Survey responses from LTC operators across England[12] at the end of May and early June show how implementation of some of the key policies was ineffective and delayed, with considerable variation between areas. We report some examples in the table below:

Policy area	Policy actions	Providers reported
Infection Control	*February–June:* Guidance published for LTC settings; government provision of PPE and infection control training	• Guidance changed frequently and contradicted itself, causing confusion and loss of confidence • Government provision only included emergency PPE, leaving providers to pay inflated prices for PPE without national quality control • Providers needed more funding and PPE rather than training
Surge workforce	*March:* NHS and social care advised to share workforces *April:* Government announced a recruitment campaign for social care and future plans to redeploy staff from the NHS to social care, which are still awaited	• Negligible perceived support to manage workforce shortages
Coordinated services	*March:* NHS and local authorities advised to provide mutual aid to LTC *May:* Improved clinical support promised to LTC	• Inflexible systems prevented effective collaboration between the NHS and social care, with only a few successful examples • Variable support from local authorities nationwide
Testing	*April:* Tests offered to asymptomatic staff, residents and patients discharged from hospital *July:* Repeated whole home testing announced	• Less than half of providers accessed tests by the end of May, when 90% of outbreaks had already happened • Hospital discharges were not universally tested on discharge, despite government guidance
Funding	*March–April:* £3.2 billion (about €3.5 billion) to support local government services *May:* £600 million (about €660 million) paid to LTC providers to support infection control	• Prior to the infection control grant, access to funding varied considerably between areas and was often conditional upon the number of publicly funded residents, with differences reported in what funds could be used for

Source: Authors' own

intervals (7 – 14 days). In Ireland, staff have been screened for symptoms twice a day since early April. The European Centre for Disease Prevention and Control suggest testing priorities should be linked to local levels of community transmission.[10]

Guidance on managing outbreaks within care homes largely focused on isolating or transferring residents. In Turkey, the health of residents was monitored and those with a suspected COVID-19 infection were immediately isolated and transferred to a pandemic hospital.

Similarly, where a positive case arises in care homes in Slovenia, people living in nursing homes have been moved to other facilities and Israel and Ireland have worked with hotels to accommodate people either with symptoms or awaiting transfer. Care homes in Israel have been required to establish COVID care units and in the Czech Republic, LTC facilities have been required to reserve 10% of their capacity to accommodate suspected or infected cases.

Conclusions

Our analysis has revealed that the countries for which information was available took a similar set of measures to protect care homes during the first wave of the pandemic. At the time of writing, it is not clear the extent to which single measures have been effective at protecting care homes and more research is needed to establish this. What is clear is that the impact of COVID-19 has not been uniform between (and sometimes within) countries.[2,9] Some differences in how countries implemented measures could account for some of the differing

impact. The speed of response differed between countries as did the extent to which approaches sought to clarify accountability. The level of centralisation of response has also varied between countries with some favouring a more locally-determined or state-level response. This largely reflects the individual country's governing structures and LTC organisation. It is likely that the effectiveness of measures will be affected by how they are implemented and the context within which they are enforced. **Box 1** on England demonstrates the same set of measures can impact LTC providers in different ways depending on how they are implemented. It is crucial, as countries face future waves, that consideration is taken not just about the effectiveness of measures but their appropriateness in a particular context and how they will be implemented and enforced.

> COVID-19 has disproportionately affected the most vulnerable in society

COVID-19 has disproportionately affected the most vulnerable in society across the world. Countries will be measured by how well they protected their most vulnerable during this pandemic. Following the first wave of infection, there is an urgent need to learn lessons from each other about what worked and what didn't work in order to ensure care homes are put on a stronger footing ahead of any future waves. But there is also an opportunity to make more fundamental changes to care systems, the weaknesses of which undoubtedly exacerbated and dampened the effect of some of the measures intended to protect it. These opportunities have been identified in the WHO European Region's Technical Guidance outlining 10 policy objectives for improving long-term care.[11] This crisis has laid bare the inadequacies of care systems and their inherent inequalities and weaknesses. If anything positive can come out of this period of history it will be a proactive effort to put in place financially and politically sustainable systems that enable the most vulnerable among us to live as independent and fulfilling lives as possible.

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