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Lessons learnt – How to avoid a second COVID disaster in social services

Every crisis and every mistake bring opportunities for change, lessons that will lead to greater preparedness if a similar situation occurs again. The COVID-19 pandemic has brought a devastating blow to the social services sector.

1) **Information & intelligence**
   a. Lack of correct and reliable information from public authorities
   b. Risk assessment and accounting of contaminations and deaths
   c. Difficulties to document and disseminate best-practices
   d. Inadequacy of communication with and between authorities
   e. Statements from politics vs academia/ researchers
   f. Differences in statements/ policies on national/ federal/ regional level
   g. Inconsistency of measures, frequent changes of measures and recommendations, ambiguity after the end of the emergency
   h. Lack of thought towards long-term consequences/impact on social services sector
   i. Little to no research done on impact of COVID-19 on social services, including at European level.

Lessons learnt:

- Strategies required to ensure smooth communication between authorities and service providers, and between service providers and residents and their relatives/ families in times of emergency/pandemic.
- Information provided by government, regulators and agencies should be transparent, uniform and trustworthy
- Rapid and relevant information, guidelines and share of good practices
- The importance of use of digital communication

2) **Media & dogmas/ prejudices**
   a. Invisibility of the social services sector and service users in public discourse
   b. Journalists' lack of knowledge about social services
   c. Stigmatisation of contaminated people, older persons, of residents and residential care
   d. "Stimmungmacherei"

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e. Dramatic media coverage, with negative effect on the public who who may be less willing to use formal care services, including residential, to fulfil their (or their loved ones) care & support needs

Lessons learnt:

- Restoring confidence in the provision of social services, in a safe and professional way.
- The concept of "Good health" must include physical, mental, spiritual and social aspects.
- Shift in how society values its older people and social care

3) <u>Procedures & standards</u>

a. Dilemma "quality of care" vs "quality of life"
b. Diversity and confusion of instructions given
c. Guidelines come from many different sources and are confusing and difficult to interpret
d. Guidelines and procedures are mostly focused on "safety", not on well-being and quality of life

Lessons learnt:

- Micro- and rigid management hamper human-centered care
- Flexibility in service delivery by all service providers
- Co-production and -consumption (carers for patients, carers as patients, patients as carers as a new working method
- Need for more co-ordination between "health and care spheres" (hospital, nursing home, community care)
- Rethink on the provision of LTC, move towards integrated care pathways?
- Better cooperation between health departments, hospitals and care facilities

4) <u>Protection and prevention</u>

a. Challenges in terms of training of staff on service provision during public health pandemic
b. Social services were not priority in supply of PPE & testing (at least in early stages)
c. How to provide face-to-face care services safely in times of public health pandemic
d. Shortage, procurement, storage, prices and reliability of PPE
e. Testing and availability of tests
f. Cautiousness and focus on "safety"

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Lessons learnt:

- Keep updated pandemic planning
- Keep a crisis management team on standby
- Keep stock of PPE in case of another wave
- Conduct regular trainings for care workers
- Create a schedule in the event of a crisis

5) <u>Over-medicalisation</u>

a. All attention to ICU, less attention for pre and post hospitalization
b. Insufficient attention to social aspects of the crisis, especially the provision of social services
c. Not differentiating differences between health/hospital and social care/services sector: different public, different staff, different providers/employers, etc
d. The use of non-traditional/ medical services as a key part of the care system (home delivery, volunteering)

Lessons learnt:

- There is a need for an intermediary structure or institution in-between the classical hospital and care facilities

6) <u>Finance & funding</u>

a. Management had to completely reorganise the day to day activities and the physical environment of the social services activities. This incurred additional, uncontrolled, unbudgeted expenses in the struggle to provide extra staff cover, the protective equipment required and additional expenses such as digital, infrastructure, etc.
b. Reduction in income (closure of certain services, reduction in charity/fundraising, closure of social entreprises, funding calls delayed, etc)
c. Daily financial management
    i. Permission to spend vs spending without permission
    ii. Maintaining liquidity (short-term)
    iii. Financial sustainability (long-term)
d. Lots of money available, but not accessible / not targeting social services
    i. State-aid mostly for businesses, traditional industries and vested enterprises
    ii. EU “funding jungle”: insignificant support from EU funds
e. Cost calculation and accountability (formal vs informal, declared vs undeclared)
f. Drop of new entries in residential care/ empty beds
g.

Lessons learnt:

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7) **<u>Staffing</u>**
   a. Understaffing
   b. Availability of "reservists" (ex care professionals)
   c. Cross-border access of carers
   d. Training and equipment of Informal carers/ volunteers
   e. Social distancing and hygiene protocols
   f. Dealing with highly anxious residents and families desperate to understand the situation
   g. Longer working hours and long term impact on professional and management
   h. Increases in need of mental health support
   i. Dealing with increase in sick leaves or non-attendance
   j. Staff leaving the sector as considered too dangerous for low pay
   k. Impact on attractiveness of the sector to professionals

Lessons learnt:

- Availability of "reservists"
- Improving attractiveness of the sector, especially through pay and working conditions.

8) **<u>Discrimination & human rights</u>**
   a. Discrimination
      i. "Covid only affects older persons", "youngsters are safe"
      ii. Treatment preference for younger and/or non-disabled people
      iii. Age limits for ICU
   b. Isolation/ quarantaine
   c. Impact of the pandemic on the choice and control of service users over their lives (for instance, older persons in residential care could have had certain freedoms limited/reduced)

Lessons learnt:

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9) **<u>Tech & ICT</u>**
   a. Implementation and under-use of existing solutions

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b. Privacy vs safety
c. Availability & acceptance
d. Training
e. Limited support by public funders

Lessons learnt:

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10) <u>Housing, logistics & service models</u>

a. Isolation vs loneliness
b. Centralised catering services
c. Routing vs freedom of movement
d. Increase in demand for homecare and community-based services
e. Temporary closing of day activity centers, not only for residents, but also for external visitors

Lessons learnt:

- The more community-based services were better able to deal with the consequences of the COVID19 pandemic, than more institutional settings (for instance: residences built on the “hospital” concept (common rooms on ground level and sleeping rooms on higher levels) had to lock up residents In their rooms earlier than community-based designed residences (common rooms grouped around small number of sleeping rooms)
- Separated COVID-units have had negative effects on orientation and home-feeling of contaminated residents
- Access to green spaces and fresh air is essential during lock downs
- Appetite of residents has grown as they were allowed to eat in their own living space/ room
- Increase in demand for non-residential services (homecare, etc)