Stockton-on-Tees
BOROUGH COUNCIL

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Adult Social Care and Health Select Committee

Scrutiny Review of Hospital Discharge (Phase 1)

(Discharge to care homes during the COVID-19 pandemic)

(DRAFT) Final Report

November 2020

Adult Social Care and Health Select Committee
Stockton-on-Tees Borough Council
Municipal Buildings
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Acknowledgements

The Committee would like to thank the following people for contributing to its work:

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Foreword

TBC

Cllr Evaline Cunningham
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Cllr Clare Gamble
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Select Committee

Original Brief

Which of our strategic corporate objectives does this topic address?

The review will contribute to the following Council Plan 2019-2022 key objectives:

- Protect the vulnerable
  - protecting people who are subject to or at risk of harm
  - assisting people whose circumstances make them vulnerable
- Help people to be healthier
  - providing mainstream services that are available when needed
  - providing preventive services that are available when needed

What are the main issues and overall aim of this review?

In an extension to the originally intended Hospital Discharge review (focusing on discharge from hospital to an individual's own home), this first phase will briefly examine the impact of the 2020 COVID-19 pandemic on hospital discharge to care homes, an issue which has gained national attention following the UK Government's response to a surge of hospital admissions in March 2020. This initial element of the review will focus on the national guidance, the process around hospital discharge to care homes, and any potential learning ahead of an anticipated second COVID-19 surge.

The Committee will undertake the following key lines of enquiry:

Phase 1

- National guidance for discharge to care homes during the escalating COVID-19 outbreak in the UK; how and when this was disseminated to local hospital Trusts.
- What was the process around hospital discharge, and how was this communicated between key partners (i.e. local Trusts, care homes, Local Authority)?
- What factors were put in place to keep people safe; how did key partners work together to address concerns?
- What can be learned ahead of an anticipated second COVID-19 surge?

Provide an initial view as to how this review could lead to efficiencies, improvements and/or transformation:

This overall review provides an opportunity to assess whether local hospital discharge arrangements, and any initiatives put in place to improve these, are effective and safe.

From a COVID-19 perspective, this review may also identify some local learning that can be put into practice if a second surge of the virus emerges.

1.0 Executive Summary

1.1 This report outlines the findings and recommendations following the Adult Social Care and Health Select Committee's scrutiny review of Hospital Discharge (Phase 1).

1.2 On the 30th January 2020, the Director-General of the World Health Organisation (WHO) declared the novel coronavirus (which would become known as 'COVID-19') outbreak a public health emergency of international concern (PHEIC), WHOs highest level of alarm. According to WHO, at that time, there were 98 cases and no deaths in 18 countries outside China. Four countries had evidence (eight cases) of human-to-human transmission outside China (Germany, Japan, USA and Vietnam).

1.3 In the UK, the month of March 2020 saw a considerable upturn in the numbers of people being confirmed as COVID-19 positive (culminating in the decision to announce significant restrictions in social contact via a national lockdown on the 23rd March 2020). Of particular concern was the sharply increasing demands on the National Health Service (NHS), with large numbers of infected individuals requiring emergency treatment in hospital. This was comparable with several other European countries, specifically Italy, who were experiencing extreme pressures on their health systems during this time.

1.4 On the 19th March 2020, the UK Government and NHS published a *COVID-19 Hospital Discharge Service Requirements* document (note: this has since been withdrawn as it is out of date) which stated that unless required to be in hospitals, patients must not remain in an NHS bed. Acute and community hospitals were told to discharge all patients as soon as they were clinically safe to do so, and that transfer from the ward should happen within one hour of that decision being made to a designated discharge area, with discharge from hospital happening as soon after that as possible, normally within two hours.

1.5 After the initial COVID-19 surge had seemingly peaked around mid-April 2020, many media commentators turned their attention to the impact of the pandemic on the care sector. With 38% of care homes experiencing an outbreak and the number of COVID-19 deaths in care homes only gradually reducing (ONS data, 12th May 2020), NHS Trusts were accused of causing excess mortality in care homes by 'systematically' discharging known or suspected COVID-19 patients into the care sector, a suggestion which Trust leaders strongly refuted. A key concern around the discharge of patients from hospital to care homes was the decision not to require a test to be conducted prior to discharge until new guidance was issued on the 15th April 2020. Responding in July 2020 to the Health and Social Care Committee, Sir Simon Stevens, Chief Executive of NHS England, stated there was a necessity to ensure hospitals could deal with the sharp increase of incoming COVID-19 cases.

1.6 The first phase of this review aimed to briefly examine the impact of the 2020 COVID-19 pandemic on hospital discharge to care homes, an issue which has gained national attention following the UK Government's response to a surge of hospital admissions in March 2020. This element of the review would focus on the national guidance, the process around hospital discharge

to care homes, and any potential learning ahead of an anticipated second COVID-19 surge.

1.7 During the Committee's evidence-gathering, some local providers expressed their unease at being pressured into accepting patients without knowing if they were infected, as well as the at-times unclear nature of discharge arrangements.

1.8 The Committee was reassured that strong partnership-working between local health and social care providers was evident throughout the information received during the first phase of this review. These already established relationships, further enhanced via the onset of regular multi-agency meetings from March 2020, have never been more critical, and will continue to be relied upon for the remainder of 2020 and beyond.

1.9 Support provided to care homes by North Tees and Hartlepool NHS Foundation Trust (NTHFT) was commended, in particular the work of the Infection Prevention and Control team (whose guidance and training was frequently heralded by care homes as part of this review) and the Community Matrons. As seen within the care homes survey responses, some concerns were raised around communication during the initial pandemic stage, and the Committee invite NTHFT to reflect on the issues raised so that future discharge-related information is exchanged in a timely and accurate manner.

1.10 Whilst the Committee was pleased to hear of the help given to the wider health and care system by South Tees Hospitals NHS Foundation Trust (STHFT), in particular the work of their Community Matrons, the importance of the internal measures (testing all patients upon admission from early-April 2020, PPE provision / safe use guidance for staff, estate configuration, etc.) put in place to keep hospital patients and staff as safe as possible was also recognised. Minimising the transmission of infection within hospitals is crucial and reduces the risk of patients having to be discharged with COVID-19.

1.11 An invaluable asset in managing safe discharge from hospital, Stockton-on-Tees Borough Council's Rosedale Centre proved to be a crucial alternative option when patients could not be accommodated within other care homes. Ensuring that robust plans are in place to step-up the service again should the need arise will be vital in the local management of hospitalised COVID-19 cases, particularly since it is incumbent upon the Local Authority to make alternative arrangements if a care home cannot take a discharged hospital patient.

1.12 The Committee was grateful for the input of local care homes to this review and were very keen to hear their experiences since the emergence of COVID-19. The notion previously expressed within the sector that care homes were an afterthought in the early phase of the pandemic was echoed by some respondents, along with a number of communication challenges between themselves and the hospital service. More encouragingly, examples of positive (and improving) engagement with the wider health and care sector were provided, and it was reassuring that no local PPE issues were reported, an area which has often been highlighted in the national media.

1.13 The subject of testing was raised by all contributors to this review, and the Committee fully support the aspiration and commitment of both local NHS Trusts to enhance their testing capacity. The UK Government has expressed

a desire to further ramp-up the country's testing capabilities, and the potential of local Trusts to expand their offer needs to be heard and acted upon (with the required resources provided) for the benefit of hospital patients, care home residents and their respective staff. Ensuring test results are made available to relevant parties as quickly as possible is also a critical element in fostering safe working environments, reducing the risk of infection to others and getting staff back to work.

1.14 The challenges faced by both hospitals and care homes in March and April 2020 have been extreme, and it can be difficult for organisations to be mindful of the pressure on others when they themselves are under great strain – continuing regular and effective engagement by all key partners as part of a system-wide approach should therefore be a high priority moving forward. Reassuringly, local services in both the health and social care sectors have indicated that they feel better-prepared ahead of a second COVID-19 surge following experiences from the first phase, though controlling numbers requiring hospital admission and, in turn, discharge to care homes remains critical. The Committee are mindful though that the actions of national Government, and the compliance of the general population to any local restrictions put in place, are outside the control of local health and social care providers, who are ultimately left to manage what remains an unpredictable and fast-changing public health emergency.

Recommendations

The Committee recommend that:

1) **There is continued regular engagement between local NHS Trusts, SBC and care providers regarding escalation-planning and how this will be managed, with arrangements to be agreed by all stakeholders.**

2) **North Tees and Hartlepool NHS Foundation Trust provide a prompt response to the communication issues raised by care homes through the survey undertaken as part of this review.**

3) **The recently issued 'designated settings' guidance (for discharge of positive COVID-19 cases from hospital to CQC-approved care home accommodation) be fully implemented.**

4) **Planning for the use of the Council's Rosedale Centre (a recently CQC-approved 'designated setting') for a second surge takes into account the possibility of higher demand than what was required from March 2020.**

5) **Local leaders support the desired expansion and funding of local Trust testing capabilities, and that any increase in capacity be prioritised for both Trust and care home staff and patients / residents.**

6) **Regular testing of care home staff and residents is supported, with a continued push for a quicker turnaround in the notification of test results.**

7) **The latest guidance from the UK Government, in conjunction with recognised best practice, is fully understood and acted upon by key partners, and is considered during the regular dialogue that takes place between health and social care services.**

2.0 Introduction

2.1 This report outlines the findings and recommendations following the Adult Social Care and Health Select Committee's scrutiny review of Hospital Discharge (Phase 1).

2.2 The first phase of this review aimed to briefly examine the impact of the 2020 COVID-19 pandemic on hospital discharge to care homes, an issue which has gained national attention following the UK Government's response to a surge of hospital admissions in March 2020. This element of the review would focus on the national guidance, the process around hospital discharge to care homes, and any potential learning ahead of an anticipated second COVID-19 surge.

2.3 The Committee focused on the following key lines of enquiry:

- National guidance for discharge to care homes during the escalating COVID-19 outbreak in the UK; how and when this was disseminated to local hospital Trusts.
- What was the process around hospital discharge, and how was this communicated between key partners (i.e. local Trusts, care homes, Local Authority)?
- What factors were put in place to keep people safe; how did key partners work together to address concerns?
- What can be learned ahead of an anticipated second COVID-19 surge?

2.4 The Committee took evidence from both the local NHS Trusts (North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust), Stockton-on-Tees Borough Council and NHS Tees Valley Clinical Commissioning Group. To understand the experiences of local care homes during this period, a survey was issued to all providers across the Borough.

2.5 Recognising the increasing pressure on the Council's finances, it is imperative that in-depth scrutiny reviews promote the Council's policy priorities and, where possible, seek to identify efficiencies and reduce demand for services.

3.0 Background

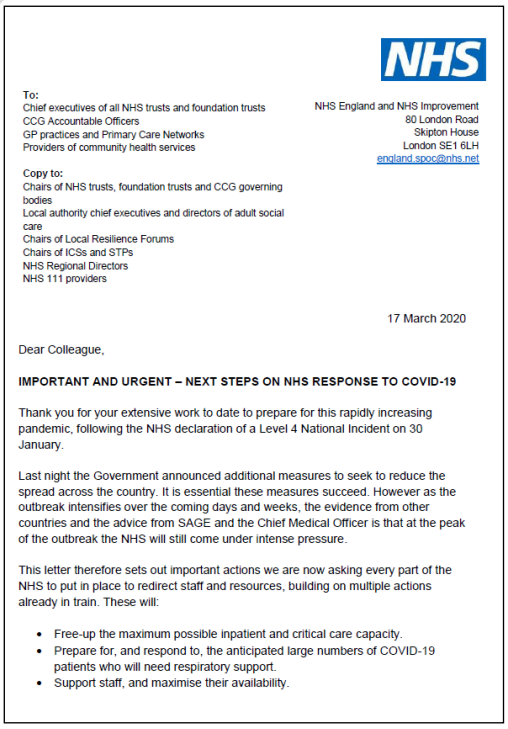
3.1 On the 30th January 2020, the Director-General of the World Health Organisation (WHO) declared the novel coronavirus (which would become known as 'COVID-19') outbreak a public health emergency of international concern (PHEIC), WHOs highest level of alarm. According to WHO, at that time, there were 98 cases and no deaths in 18 countries outside China. Four countries had evidence (eight cases) of human-to-human transmission outside China (Germany, Japan, USA and Vietnam).

3.2 Deeply concerned both by the alarming levels of spread and severity, and by the alarming levels of inaction, WHO made the assessment on the 11th March 2020 that COVID-19 could be characterised as a pandemic. Recognising that COVID-19 was not just a public health crisis but one that would touch every sector, the Director-General restated WHOs call for countries to take a whole-of-government, whole-of-society approach, built around a comprehensive strategy to prevent infections, save lives and minimise impact:

> *'We cannot say this loudly enough, or clearly enough, or often enough'… 'all countries can still change the course of this pandemic [if they] detect, test, treat, isolate, trace, and mobilise their people in the response.'*

3.3 In the UK, the month of March 2020 saw a considerable upturn in the numbers of people being confirmed as COVID-19 positive (culminating in the decision to announce significant restrictions in social contact via a national lockdown on the 23rd March 2020). Of particular concern was the sharply increasing demands on the National Health Service (NHS), with large numbers of infected individuals requiring emergency treatment in hospital. This was comparable with several other European countries, specifically Italy, who were experiencing extreme pressures on their health systems during this time.

3.4 Ahead of the anticipated peak of the outbreak, and to address the rising stresses on hospital capacity, a letter was sent to the Chief Executives of all NHS and Foundation Trusts on the 17th March 2020 from the Chief Executive and Chief Operating Officer of NHS England and NHS Improvement. This letter set out several important actions, the first of which was to free-up the maximum possible inpatient and critical care capacity by postponing all non-urgent elective surgery, urgently discharging all hospital inpatients who were medically fit to leave, and block-buying capacity in independent hospitals.



NHS

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
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Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums
Chairs of ICSs and STPs
NHS Regional Directors
NHS 111 providers

17 March 2020

Dear Colleague,

IMPORTANT AND URGENT – NEXT STEPS ON NHS RESPONSE TO COVID-19

Thank you for your extensive work to date to prepare for this rapidly increasing pandemic, following the NHS declaration of a Level 4 National Incident on 30 January.

Last night the Government announced additional measures to seek to reduce the spread across the country. It is essential these measures succeed. However as the outbreak intensifies over the coming days and weeks, the evidence from other countries and the advice from SAGE and the Chief Medical Officer is that at the peak of the outbreak the NHS will still come under intense pressure.

This letter therefore sets out important actions we are now asking every part of the NHS to put in place to redirect staff and resources, building on multiple actions already in train. These will:

- Free-up the maximum possible inpatient and critical care capacity.
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support.
- Support staff, and maximise their availability.

3.5 On the 19th March 2020, the UK Government and NHS published a *COVID-19 Hospital Discharge Service Requirements* document (note: this has since been withdrawn as it is out of date) which stated that unless required to be in hospitals, patients must not remain in an NHS bed. Acute and community hospitals were told to discharge all patients as soon as they were clinically safe to do so, and that transfer from the ward should happen within one hour of that decision being made to a designated discharge area, with discharge from hospital happening as soon after that as possible, normally within two hours.

3.6 The *COVID-19 Hospital Discharge Service Requirements* document stated that discharge requires teamwork across many people and organisations, and the funding and eligibility blockages that currently exist cannot remain in place during the COVID-19 emergency period. Therefore, a 'discharge to assess' model (diagram below), based on using four clear pathways for discharging patients, would be introduced across England. Acute hospitals would be responsible for leading on the discharge of all patients on pathway 0; community health services providers on pathways 1-3. It was acknowledged that pathways 1-3 would only be successful if NHS organisations work hand-in-glove with Adult Social Care colleagues, the care sector and the voluntary sector.

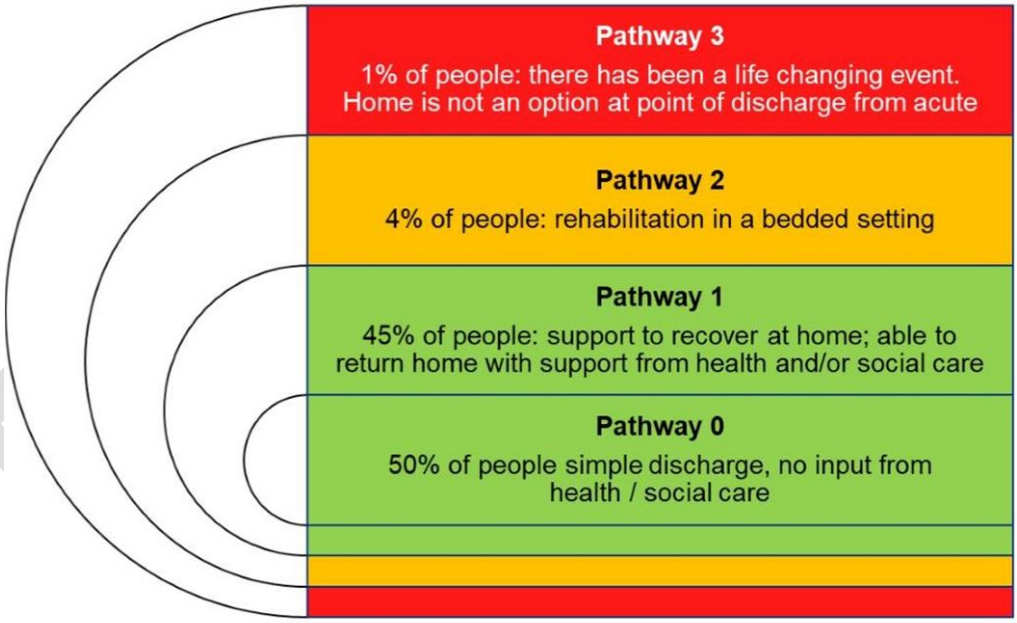


Figure 1: Discharge to Assess model

3.7 As stated at paragraph 1.12 of the *COVID-19 Hospital Discharge Service Requirements* document, whilst most people would be discharged to their homes, a very small proportion would need and benefit from short or long-term residential or nursing home care. The existing North of England Commissioning Support (NECS) care home tracker would be extended to cover all care home places, all NHS community hospital beds and hospice beds, and all providers had to sign up and start using the tracker by Monday 23rd March 2020 (note: local care homes have been signed up to the capacity tracker for some time now – well before March 2020. However, the intelligence gathered by the Council through the Quality Assurance and

Compliance team is used in preference to the capacity tracker as it is more accurate and up-to-date). The requirements also noted that during the COVID-19 pandemic, patients would not be able to wait in hospital until their first choice of care home has a vacancy. This would mean a short spell in an alternative care home, and the care co-ordinators would follow-up to ensure patients were able to move as soon as possible to their long-term care home.

3.8 After the initial COVID-19 surge had seemingly peaked around mid-April 2020, many media commentators turned their attention to the impact of the pandemic on the care sector. With 38% of care homes experiencing an outbreak and the number of COVID-19 deaths in care homes only gradually reducing (ONS data, 12th May 2020), NHS Trusts were accused of causing excess mortality in care homes by 'systematically' discharging known or suspected COVID-19 patients into the care sector, a suggestion which Trust leaders strongly refuted. A key concern around the discharge of patients from hospital to care homes was the decision not to require a test to be conducted prior to discharge until new guidance was issued on the 15th April 2020. Responding in July 2020 to the Health and Social Care Committee, Sir Simon Stevens, Chief Executive of NHS England, stated there was a necessity to ensure hospitals could deal with the sharp increase of incoming COVID-19 cases.

3.9 Such is the scale of impact of COVID-19 that the UK Government's response in the early stages of the pandemic will undoubtably be scrutinised through a national inquiry at some point in the future. However, until that time, this localised examination of the national guidance, how it was applied, and what key partners did to keep people safe, has been undertaken to identify any potential learning points ahead of a widely-anticipated second COVID-19 surge.

4.0 Findings

National Guidance

4.1 As outlined by NHS Providers (the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS) in their Coronavirus briefing '*Spotlight on… Recent NHS Discharges into Care Homes*' (19th May 2020), and corroborated by local NHS Foundation Trusts, national COVID-19 guidance was directed to NHS Trusts and care homes as follows:

4.2 13th March 2020: initial guidance from Public Health England (PHE) encouraged residential care homes to review their visiting policy, asking people not to visit if they were unwell and emphasising hygiene measures. However, the guidance also suggested that care home managers balance the potential risk of restricting visiting against the social and mental distress a ban on visiting may cause residents (commentators suggest it was not until the 2nd April 2020 that guidance for care homes made clear the need to restrict visiting).

4.3 17th March 2020: NHS England and Improvement instructed Trusts to urgently discharge all medically fit patients from hospital as soon as it was clinically safe to do so. This rapid implementation of the 'discharge to assess' model aimed to free up 15,000 acute beds by the 27th March 2020 and maintain this model thereafter, so that hospitals would have capacity to care for the anticipated influx of patients who were seriously ill with COVID-19. NHS England and Improvement made this decision having just witnessed the health and care system in Northern Italy being overwhelmed by COVID-19 demand. The letter from NHS England and Improvement (provided to the Committee) directed Trusts and Clinical Commissioning Groups (CCGs) to work with Local Authorities to deliver this policy.

4.4 19th March 2020: These new rapid discharge arrangements were set out in detail two days later, when the Department of Health and Social Care (DHSC) and NHS England and Improvement published the *COVID-19 Hospital Discharge Service Requirements*. This document and accompanying letter described how teams across the NHS, Local Authorities and Social Care would work together to maintain rapid discharge from hospital for the foreseeable future. The guidance effectively gave the health and care sector a broad framework to adapt discharge arrangements to local circumstances. Where a patient had been tested for COVID-19, the guidance specified that results – whether negative or positive – should be included in a patient's discharge documents.

4.5 2nd April 2020: DHSC published guidance on the admission and care of people in care homes which stated that some new admissions to care homes may have COVID-19 – whether symptomatic or asymptomatic – but all of these patients could be safely cared for in a care home setting if the appropriate guidance around infection prevention and control (IPC), isolation requirements and personal protective equipment (PPE) was followed. The guidance stated that negative tests were 'not required prior to transfers / admissions into the care home', as at this time the national policy was for

testing capacity to be limited to symptomatic patients. If a care home was happy to admit patients who tested positive for COVID-19, then the hospital discharge service would include their test results, date of onset of symptoms and a care plan for discharge from isolation in the discharge documents.

4.6 15th April 2020: the Government published its Adult Social Care Action Plan which announced that Trusts would need to test every single patient prior to discharge back to their care home or new admission to a care home (insofar as this was not already happening) – whether they had symptoms or not on discharge from hospital. The guidance stated that the patients waiting for test results should be discharged and isolated as suspected COVID-19 patients. If the test result was negative, the guidance still recommended isolation for 14 days. If care homes were unable to meet isolation requirements, alternative arrangements would need to be made by the Local Authority, assisted by NHS primary and community care. The guidance recognised that while some care homes were confident to accept COVID-19 confirmed or suspected patients, others were not, and Local Authorities needed to lead the local system to create other arrangements if care homes were unable to accept COVID-19 or suspected COVID-19 patients.

4.7 15th May 2020: the new operating framework for urgent and planned care in hospitals stated that all patients being discharged to a care home should be tested up to 48 hours prior to discharge. That same day, the Government published a document outlining support for care homes, which emphasised the risks of asymptomatic transmission of COVID-19 in care homes via both residents and staff.

Implementation of Guidance / Discharge Process

4.8 NHS Providers note that the instruction and guidance deliberately, and rightly, left it to local health and care partners to agree how to implement the guidance in each system, but was explicit that arrangements need to be agreed by all relevant partners including NHS Trusts and the care sector.

4.9 Following communication with Trust leaders, NHS Providers stated that the following principles guided the local discharge arrangements they agreed with their local health and care partners in response to the 17th March 2020 instruction and the 19th March 2020 guidance:

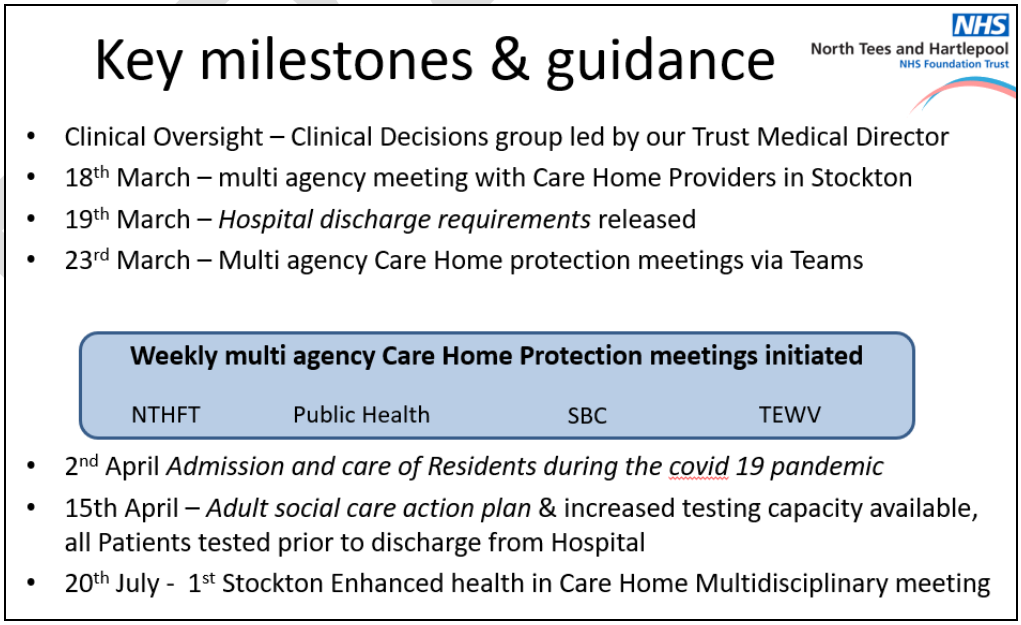
- The 'discharge to assess' model was based on existing best evidence / practice for hospital discharge that was already being used in some acute Trusts in England.
- There was a clear national focus on creating sufficient NHS hospital capacity to treat patients who were seriously ill with COVID-19, and this was recognised and accepted by both the NHS and the care sector.
- Discharge approaches were agreed on the basis, as they always have been, of a measurement of the overall balance of risk to individual patients, which considers the fact that acute hospitals are not safe environments once they have recovered.
- Discharge approaches were also made based on evidence that supports as few moves as possible for older people, as too many moves push up mortality rates.

- Given that Trusts collaborate daily with the care sector, they recognised the fragility of some care providers and the vulnerabilities of people receiving care and were keen to protect them from the outset.
- Trusts worked closely with Council's and local care providers to identify discharge pathways for suspected and known COVID-19 patients, finding individual solutions that varied depending on local circumstances.

4.10 NHS England and Improvement also took steps to support care homes, including bringing forward essential elements of the Enhanced Health in Care Home model on the 1st May 2020 and developing a 'train the trainer' programme in early May for CCG infection control nurses to train care homes on IPC measures. In a letter to the NHS on the 29th April 2020 about the next phase of the NHS' response in managing COVID-19, NHS England and Improvement set out actions for the NHS to continue supporting social care colleagues and residents.

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

4.11 Facilitated through a strategic approach with oversight from senior management, the Trust had provided a very localised response to the COVID-19 pandemic since its escalation in March 2020. As such, there was a strong desire to build on the already established relationships to best support care homes across the Borough during this exceptionally challenging time. To this end, a multi-agency forum was established with care home providers on the 18th March 2020 to ensure appropriate support was availed to care homes in addition to answering any questions or concerns that were raised.



4.12 The key role of the Clinical Decisions group (led by the Trust Medical Director), which dealt with all information (including Government guidance) coming into NTHFT and then disseminated this both internally and to wider partners where required, was highlighted, and the Committee was also informed that the NTHFT was already operating the guidance issued on the 19th March 2020 (*COVID-19 Hospital Discharge Service Requirements*) prior

to the pandemic through its work with partners and care homes to facilitate safe discharge. In addition, attention was drawn to the start of the weekly multi-agency care home protection meetings on the 23rd March 2020, which allowed key partners to come together, address concerns and put measures in place.

4.13 Whilst the national guidance regarding testing changed on the 15th April 2020 (requiring the testing of all patients prior to discharge from hospital), the Trust had robust measures in place before this date in relation to discharge and infection control / isolating in accordance with the guidance at the time. The Trust's Infection Prevention and Control (IPC) team provided training and specific support to care home providers to ensure guidance was shared and understood in care homes, along with practical guidance relating to isolating and cohorting of residents. It was also noted that, in terms of more general discharge requirements, it is not good for people to stay in hospital if they no longer need acute-based care.

4.14 The Committee expressed concern regarding the back-up care homes were receiving from organisations, specifically the dependence on virtual meetings in place of face-to-face involvement, and the scheduling of the first multi-agency care home protection meeting which did not take place until several days after a number of care homes had already closed. The Trust confirmed that face-to-face contact continued throughout the pandemic (and that this had never stopped), and clarified that the virtual / digital component was in addition to what was already provided. In terms of support, the Trust were able to clarify to the Committee, that the care homes were supported with training, IPC advice and guidance, provision of PPE, testing of workers where indicated, fit testing with FFP3 masks, and regular communication and support from senior colleagues from the Trust in addition to support with care for residents within the care homes.

4.15 Clarity was sought around the testing process that had been in place, particularly what was meant by 'rapid response' testing. The Trust provided assurance that testing had been in line with national guidance throughout, with the requirements evolving over time. Since the 15th April 2020, the Trust had been testing patients upon admission, after seven days (if still within the hospital), and prior to discharge to a care home, with results obtained before people are moved. It was also highlighted that testing was only one element in protecting care home residents, but was a vital indicator in establishing whether a person needed to be isolated within the care home – as such, the testing of care home residents had been prioritised when considering laboratory capacity. Regarding 'rapid' testing, it was noted that swabs can be taken in the community, with results ascertained very quickly.

4.16 Reflecting on testing capacity, Members queried if there were any local concerns similar to those that had been reported in other areas of the UK. The Trust commended the work of their very responsive Laboratory Team and were actively working to increase capacity (as was the case elsewhere).

4.17 The issue of discharging without testing during the initial stages of the pandemic was raised, and the Committee was keen to know whether this was ever questioned by hospital staff. In response, the Trust advised that all clinical guidance was considered initially by the Clinical Decisions group, and this was then disseminated via robust systems. Clarity was sought when needed and challenge to ensure appropriate implementation of guidance

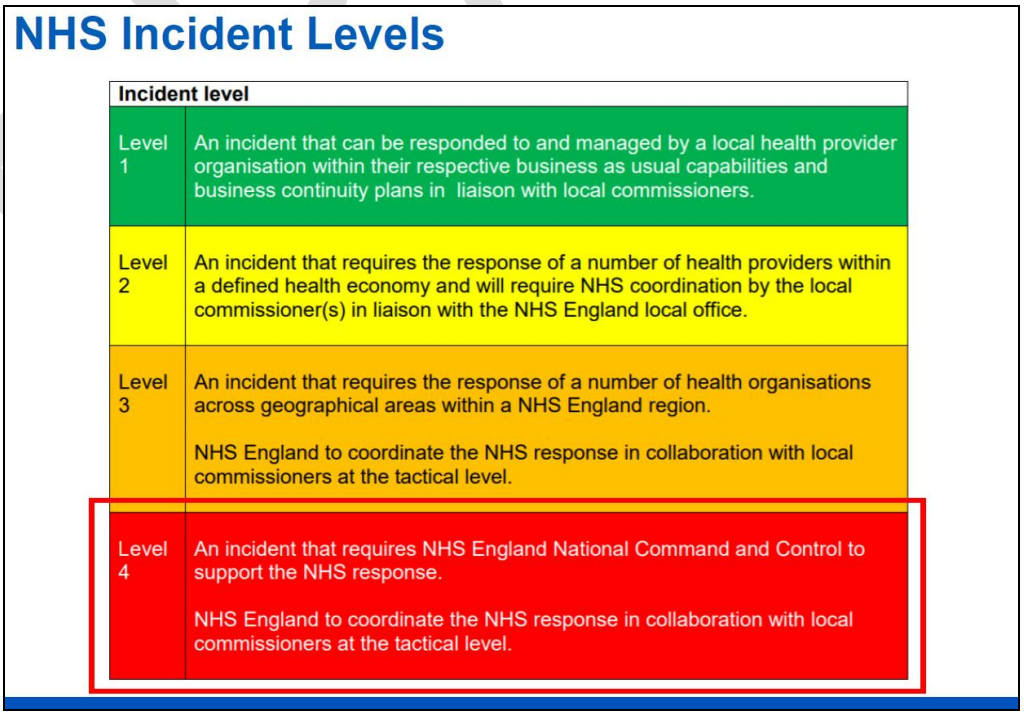
would occur. Some queries did arise from individual care homes who were supported on an individual basis, and the Trust had been involved in webinars with other Trusts where approach was debated and lessons learned were shared.

4.18 The strong partnership-working evidenced in the presentation was commended, and the Trust confirmed that other care home residents who are on different (non-COVID-19) pathways should benefit from the relationships that have been built between partners during the pandemic.

4.19 Challenges for all partner organisations in relation to interpreting the national guidance was discussed, particularly since it was often issued at short notice, and could be viewed as incomplete and / or contradictory. What was clear in the initial stages of the pandemic escalation was that the Government did not state that testing prior to discharge to care homes was required (with the focus at the time on creating space on hospital wards for an anticipated influx of COVID-19 patients), and that this would likely form part of a future national inquiry.

South Tees Hospitals NHS Foundation Trust (STHFT)

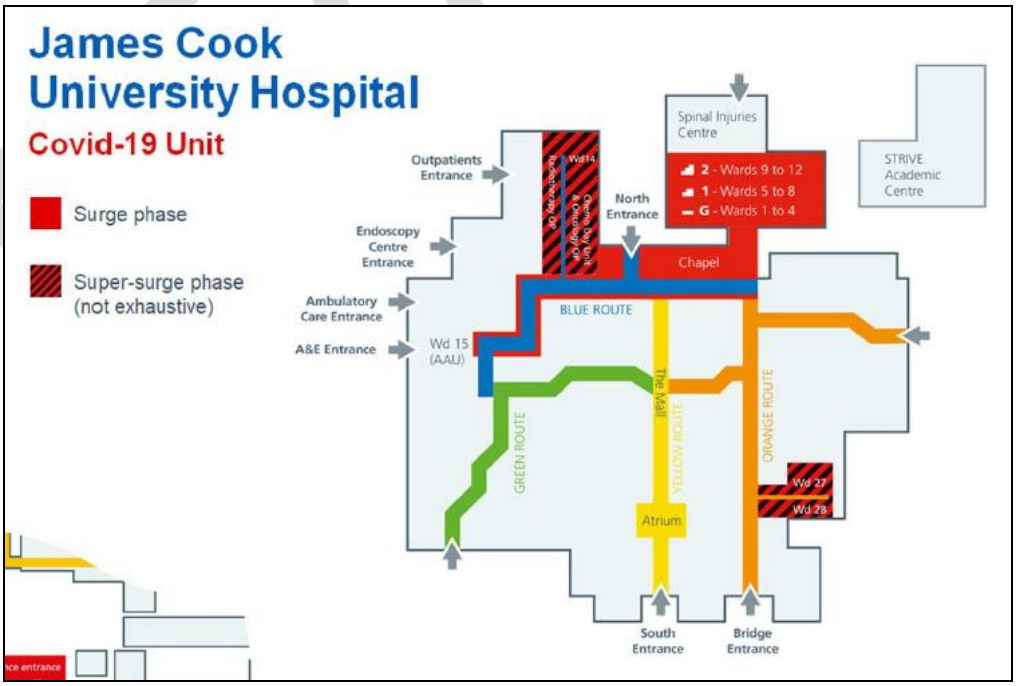
4.20 STHFT initiated a clinically-led response to the declaration of a NHS Level 4 incident on the 30th January 2020, and set-up internal working groups that mirrored the existing organisational structure. The number one priority was the protection of staff, the protection of patients, and the delivery of as much safe care as was possible. It was noted that a recent Care Quality Commission (CQC) inspection of STHFT had resulted in positive comments and feedback on its approach to the pandemic when compared to peers.



4.21 The implications of moving into a Level 4 emergency incident were relayed to the Committee, specifically the change in all Trusts having to respond to, and implement, guidance together (via NHS Command and Control) as opposed to operating with individual autonomy. National guidance often being issued on a Friday afternoon brought challenges, and STHFT quickly moved to anticipating, rather than just reacting to, changes in policy and procedures (e.g. PPE requirements).

4.22 In terms of liaising with partners, interactions with Social Care were highlighted as well as communication with the North Tees and Hartlepool NHS Foundation Trust (NTHFT) Command Centre. Throughout the pandemic, safeguarding had been prioritised and maintained, one element of which involved each patient being given 20 masks when they were discharged to a care home.

4.23 Members were taken through the timeline of key developments since the Level 4 incident was declared at the end of January 2020, a crucial part of which was the Trust's introduction of COVID-19 testing on the 12th March 2020 for all admitted patients who met the national case definition (list of symptoms), and for all inpatients upon their arrival at hospital (irrespective of the case definition) from the 6th April 2020 – this was prior to the requirement to test patients being discharged from NHS hospitals to a care home. The Trust had quickly built-up its capacity to test on-site (though needed to purchase equipment), and was therefore well prepared for the guidance issued on the 15th April 2020 as it was already testing all inpatients. Currently, 1,500 tests can be conducted on-site daily (24-hours a day), and the Trust has also offered mutual aid to both NTHFT and County Durham and Darlington NHS Foundation Trust in relation to testing.



4.24 The impact of the initial COVID-19 surge on the Trust estate was outlined, with sites split in readiness for an anticipated huge influx of infected patients (see example above). Separating COVID and non-COVID areas in order to

keep people as safe as possible involved a significant amount of work, but led to very little spread / contraction of the virus within the hospital itself. It was also emphasised to Members that the Trust's focus was not solely on delivering care to COVID-19 patients during this time, and that the ability to treat non-COVID-19 patients was only possible due to this separation of wards.

4.25 The Committee was informed that at no time did the Trust run out of PPE on-site, and that PPE was issued to staff in both hospital and community settings before the guidance around this was published. In addition, robust testing of staff was initiated, and employees who displayed COVID-19 symptoms were not allowed to come back to work until they returned a negative swab (they could not just isolate for 10 days and then return).

4.26 As previously noted, staff wellbeing and safety was a critical priority, and STHFT was the first Trust in the region to produce a COVID-19-specific staff policy. Employees on the frontline and beyond also benefitted from support provided by the psychological service, and this was key in limiting staff sickness (which was lower compared to other Trusts). Furthermore, the military experience of some of the Trust's staff greatly helped in supporting several aspects of COVID-19 planning, including the safe use of PPE.

4.27 From a recovery perspective, the Committee was notified that all Trust services had now either fully or partially resumed, and measures had been implemented to prevent the potential transmission of the virus in social areas of the estate (e.g. distancing, use of face masks). It was imperative to keep staff COVID-free so they could treat people – if not, the Trust would have let down patients.

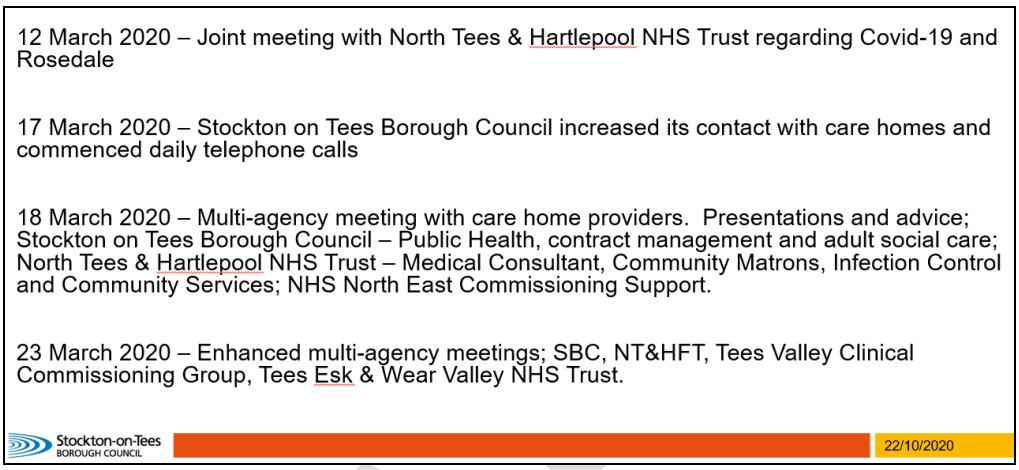
4.28 The Committee probed further around the low number of patients contracting the virus on-site and asked why this had been achieved. In response, the Trust felt it had quickly developed a 'gold standard' by effectively splitting the hospitals in two, equipping staff with PPE, and ensuring they could use the PPE safely (a crucial requirement). As equipment was purchased and the Trust's capability grew, more robust testing became available. The Trust was compliant with the required discharge testing and had to be confident it was not sending people to care homes unknowingly infected.

4.29 Members were reassured by the systems put in place by STHFT regarding COVID-19, and commended the Trust for implementing certain measures in advance of national guidance. Moving forward, it was queried if testing capability could be further enhanced, something which the Trust confirmed it was keen on achieving, expressing a desire to get up to 2,500-3,000 tests a day if extra equipment was available – however, uncertainty around the future sourcing (equipment is in high demand nationally) and funding (support had previously been through COVID capital schemes) of equipment may inhibit this potential. Limitations on the availability of rapid tests were noted – a greater supply of these would help for urgent pathways, particularly in getting certain staff back to work.

4.30 The value of the decision to test all inpatients early on was re-iterated, and the Trust felt that if such a capability is available, it should be used (rather than wait to be told to). If this was not in place, there would have been a greater risk of placing COVID-infected patients on non-COVID wards, a situation which could have brought significant consequences.

Stockton-on-Tees Borough Council (SBC)

4.31 In addition to the timeline of key events involving the Council that took place from mid-March 2020 (see below), of vital consideration was how best to use the Rosedale Centre (a short-term residential rehabilitation and assessment centre, owned and managed by SBC) in order to support other care homes and the wider health system.



4.32 The financial support provided to local care homes was outlined, which included the passing-on of a Government infection control grant worth £2.5m. In terms of contract management / provider support, the implementation of a RAG-rating system to flag-up any issues around COVID-status, staffing, PPE stocks, capacity and critical risk areas was highlighted, information which was also shared with other key partners. Emotional support was critical during April / May 2020 and was well received by care homes, who appreciated having someone to talk to during this incredibly difficult time.

4.33 The Committee was informed of the commissioning (on behalf of the Tees Valley Clinical Commissioning Group) of two care homes for block-booked beds following hospital discharge in early-April 2020 – these care homes were chosen as they had the capacity and staffing resources, as well as offering segregation via a separate wing within the premises.

4.34 In relation to the £2.5m infection control Government grant distributed to care homes, Members queried if organisations providing care in the community had been equally supported. Officers noted that 75% of the Government grant was disseminated directly to care homes, with the remaining 25% a discretionary amount – as such, a grant application process was open to both care homes and care at home providers.

4.35 Members asked about the decision to select two care homes for block-booked beds following discharge from hospital, and whether this had been an effective choice (particularly since a number of high performing care homes across the Borough do not have separate wings). Officers stated that a mixture of providers had expressed interest in offering block-booked beds, and that a decision was taken to stop allowing people into one of the selected care homes, with a replacement quickly identified.

4.36 Members queried if any updates were available in relation to the CQCs *Provider Collaboration Review*, work which the Council had been selected to be part of (as referenced at the Committee meeting in July 2020). This rapid review, which began in the week commencing the 27th July 2020, investigated the experience of those aged over 65 who went into care homes during the pandemic, and the CQC were now in the process of preparing feedback that would be shared with the Council, the Health and Wellbeing Board, and the Adults Health and Wellbeing Partnership. Officers were aware that the support provided to care homes had been very positively recognised by the CQC, and it was noted that the regional care home group continues to operate.

Keeping People Safe

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

4.37 The importance of the Integrated Single Point of Access (ISPA) during the pandemic was emphasised to Members, a key element of which involves support to care homes – this was developed in partnership with the Local Authority to enhance care home support as part of a multi-disciplinary team.

4.38 The role of the Community Matrons, who were pivotal in providing responsive daily care and continued to recognise underlying non-COVID-19 issues with residents during this time, was also highlighted, features of which included:

- Completing COVID-19 swabbing as per changing guidance, and support care homes with blanket swabbing and training to individual care home staff as required.
- Commencement of remote prescribing for low level conditions to reduce unnecessary visits and ensure timely intervention.
- Support for care staff and advice on how to contact and access mental health support as needed.
- Review existing Emergency Health Care Plans (EHCP) and DNAR adapting to the current pandemic as appropriate.
- Enhanced support to care homes where clusters of residents with potential or positive COVID-19 cases.
- Commencement of a resilience unit for all residents swabbed to ensure comprehensive understanding of the COVID-19 status across care homes.

A short video showing examples of the infection control work provided by the NTHFT both internally and to care homes was subsequently shown to the Committee.

4.39 Members learned about the increased use of the Whzan system (providing live data for clinical interpretation regarding basic health checks), a tool which had been vital in identifying resident deterioration and prompting care homes to seek support. The Enhanced Health in Care Homes (EHCH) model, involving virtual meetings (first one held on the 20th July 2020), had strengthened communications with care homes and primary care colleagues,

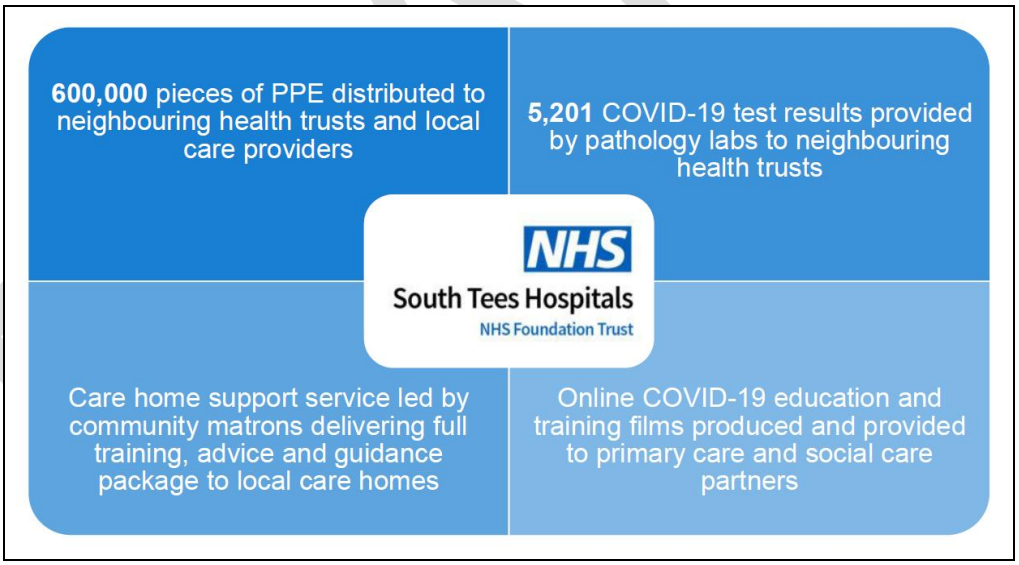
with all discharges to homes discussed with GPs and Community Matrons – it had also enabled any required actions to be given to the most appropriate teams in a more timely manner. Whilst the EHCH concept had always been intended, the pandemic had accelerated the implementation of the model. The Committee was informed that these digital advancements complemented face-to-face contacts within care homes to ensure timely and appropriate care was provided at all times.

4.40 Noting the benefits of the Whzan system, Members were pleased to see an increase in the number of care homes using this tool. The Trust advised that it would continue to promote its value and monitor its use on a weekly basis. Whzan will be utilised in conjunction with the 'Is my resident unwell' communication tool, a further resource which assists care home staff in recognising signs and recording a set of observations of residents.

4.41 Concerns were expressed in relation to the current state of care home residents' mental health, particularly around the impact of visiting restrictions upon both families / carers and professionals. The Trust noted that the Whzan system was only an aid to clinical work, not a substitute.

South Tees Hospitals NHS Foundation Trust (STHFT)

4.42 Support provided to the wider health and care system was highlighted:



4.43 The Committee sought further detail on the work of the Trust's Community Matrons in supporting care homes. Immediate concerns regarding the level of footfall (visitors, professionals) through care homes led to remote functions being implemented, and in early-May 2020, contact was made with 130 care homes to offer training and development sessions. Over 500 care home staff received training in PPE use, hand hygiene, swabbing patients and isolating / segregating residents. An outbreak-response (alongside Public Health colleagues) was offered, and the Community Matrons also assisted with the swabbing of residents who were displaying COVID-19 symptoms – for those

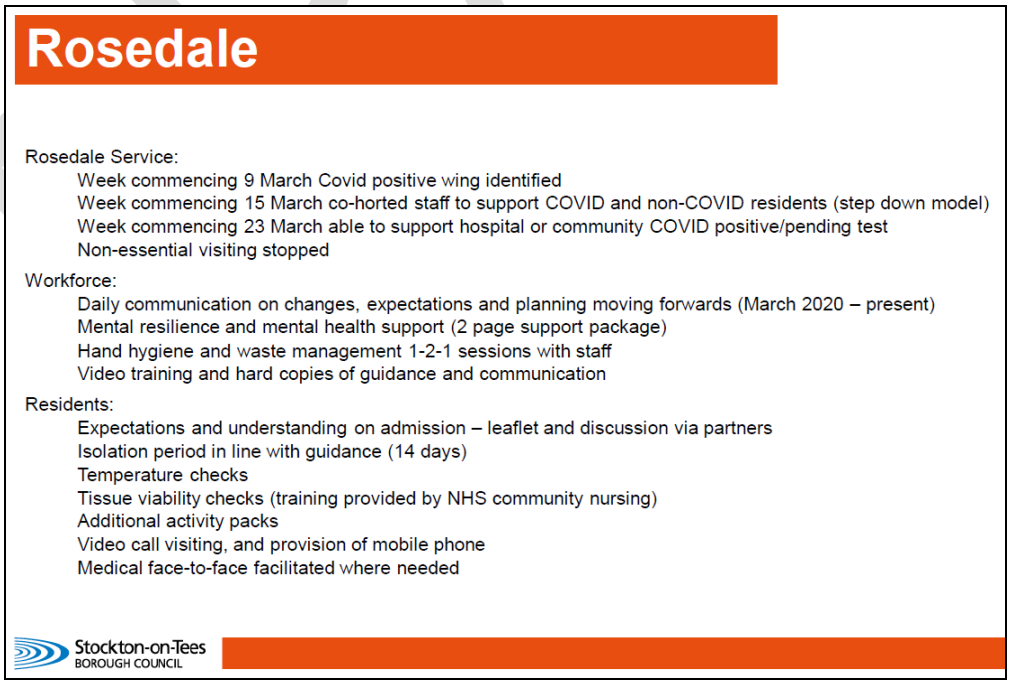
who returned positive tests, support was provided to care home staff around managing the resident appropriately.

4.44 Responding to a question on the most effective innovations that had helped during the emergence and escalation of the pandemic, the Trust pointed to the provision of training and development to care homes, as well as the initiation of a named contact with care homes (which is now standard). Relationships with Local Authorities had also been reinforced (via the Trust's Command Centre and daily (including weekend) communication) as partners worked collectively to deliver the best outcomes. Nothing is more important than staff and patient safety – the latter being the first thing that is considered in any pathway (not just COVID-related).

Stockton-on-Tees Borough Council (SBC)

4.45 Enhanced contractual support around PPE was outlined – stock levels, future orders and supply chain problems were discussed with care home managers every day as part of the enhanced intelligence gathering and risk assessment process that was implemented in March 2020. Throughout April and May 2020, 7,650 pieces of PPE were delivered by 16 emergency PPE drops to care homes.

4.46 A detailed insight into the service provided at Rosedale since early-March 2020 was presented to Members (see below), who were reminded that there are no permanent residents there, and that 95% of residents come direct from hospital. The changing of the staffing model to ensure staff remained in their designated areas and did not mix was an important element in limiting risk to both the residents and those caring for them.



4.47 The rapid development of the Integrated Single Point of Access (service based at Tithebarn) was noted – this allowed key stakeholders to be aware of

patients being discharged from hospital, and, crucially, their needs. If they could not be accommodated within other care homes, Rosedale was able to step in.

4.48 From a Public Health perspective, there was close partnership-working with Public Health England colleagues (who are regionally based) in addition to collective efforts with local NHS and Social Care services and staff. Local advice and support was provided based on guidance from the regional care home group. A regional COVID care home protection / infection control checklist had been completed by all care homes in Stockton and was evaluated to understand and address emerging themes and local concerns. A programme of COVID-assurance visits to local care homes was initiated in July 2020, with updates provided to the local multi-agency operational care home group. The care home group monitors current cases / outbreaks, visits, infection prevention and control training, and compliance with NEWS (early warning system which indicates any deterioration in residents).

4.49 The Committee expressed its gratitude to the Rosedale service, and, when considering the current COVID-19 situation, were thankful that this remained a Council asset.

4.50 Officers were asked if staff numbers had to be increased at Rosedale to manage the impact of COVID-19 – it was confirmed that staff ratios were not raised, though plans were in place if this was required. Safety measures were constantly considered and, where needed, implemented in the build-up to lockdown on the 23rd March 2020, and there was no-one within Rosedale who was knowingly infected before this date. Members were also informed that a new Registered Manager for the service started today.

4.51 Current levels of PPE stock were queried – there is now an alternative source available for care homes in the form of a national PPE Portal (online system). Members were also interested in the overall cost of PPE that had been distributed to care homes and domiciliary providers, something which Officers would endeavour to gather more information on following this meeting.

4.52 Thinking ahead, the Committee was keen on understanding which of the measures involving the Council had been most effective, particularly in light of the recent rise in COVID-19 cases. The ability to utilise Rosedale was of great benefit as part of a system-wide approach, and Officers confirmed that the service would be stepped-up again to take COVID-positive individuals should the need arise (Members were reminded that it is the responsibility of a Local Authority to make alternative arrangements if a care home cannot take a discharged hospital patient). In addition, the strictest infection control measures (distancing, PPE, how staff travel to work, restricting visitors) must be maintained, and a routine testing programme is crucial.

NHS Tees Valley Clinical Commissioning Group (TVCCG)

4.53 The CCG worked collaboratively with NTHFT, Local Authorities, TEWV and Primary Care Networks (PCNs) to ensure safe and effective discharges to care homes during the pandemic. Complementing the collaborative working evidence already provided by the NTHFT and SBC, specific CCG responsibilities included:

- Enhanced Health in Care Homes Framework: Implementation of the Enhanced Health in Care Homes Framework, including aligning PCNs and practices to individual care homes to support improved relationships, communication, regular 'home rounds', multi-disciplinary resident discussions, and personalised care planning for existing, new and returning residents following discharge.

- Commissioning of block-booked beds: Commissioning specific and isolated short-term care home beds in line with COVID-19 infection prevention control discharge guidance.

- Discharge Groups: Leading and chairing various collaborative / partnership discharge groups during the pandemic.

- Engagement with Care Homes: Various engagement events and regular communication with care homes to support the PCN / practice re-alignment, progress pandemic digital solutions such as the use of Microsoft Teams to support e-consultations and communication, implementation / access to NHS Mail to support secure transfer of personal information, and development of 'proxy' medication ordering for the homes.

- Adapting / enhancing existing commissioned services: including working with Trust and TEWV colleagues to adapt the health offer / support to care homes. Enhancing the medicines management support to homes to address medication issues following discharge from hospital. Enhancing the clinical and digital support to homes to regularly collect National Early Warning Scores (NEWS) via the Whzan system to support early identification of COVID-19 symptoms.

Impact on Care Homes

4.54 For some time now, a range of views around the national guidance on hospital discharge to care homes during COVID-19 (and how this was subsequently implemented) have been publicly expressed by those involved within the health and social care sectors:

4.55 NHS Providers: Trust leaders tell us that they consistently followed the guidance of informing care homes if discharged patients had COVID-19. They only discharged known or suspected COVID-19 patients if the relevant care home agreed they had the capacity to treat and isolate them. This is in line with the national discharge guidance and has been publicly acknowledged by the Association of Directors of Adult Social Services as appropriate.

4.56 NHS Providers: Trust leaders tell us that they recognise that, in the first few days after 17 March, small numbers of asymptomatic COVID-19 patients may have been discharged into care homes. Trust leaders tell us that they quickly became aware of the risk and 'within one or two days' had developed new agreed discharge arrangements that were based on testing all discharges and isolating those awaiting test results using the options available for isolating COVID-19 or suspected COVID-19 patients.

4.57 NHS Providers: According to data referred to by NHS England and Improvement and the DHSC, there was a 40% drop in the number of NHS patients discharged into care homes in February to mid-April 2020 compared to January 2020. During this time, care homes were a minority destination: only 1 in 20 patients discharged from hospital went to a care home for the first time (the figure was 3 in 20 including patients who returned to care home settings). The vast majority of acute hospital discharges during the period between the publication of the discharge guidance on 19 March and the change in testing strategy on 15 April were therefore not discharged into care homes but to other 'step down' NHS community settings, as advised in national guidance.

4.58 House of Commons – Health and Social Care Committee (23rd July 2020): Professor Sir Paul Nurse (Chief Executive and Director, Francis Crick Institute) – 'My colleagues at the Crick contacted Downing Street in March and wrote to Minister Hancock in April, emphasising two main things. The first was the importance of regular, systematic testing of all healthcare workers, including not only frontline doctors and nurses but support staff, ambulance drivers, and other healthcare providers such as care homes, GP surgeries, community nurses and the like. They all needed to be tested. At the height of the pandemic, our own research, which only backs up what has been done elsewhere, is that up to 45% of healthcare workers were infected. They were infecting their colleagues and patients, yet they were not being tested systematically. The second point… it was quite clear that those without symptoms were likely to be transmitting the disease. Again, our own research has shown that nearly 40% of healthcare workers at that time were infected but had no symptoms. That was a major failure. In the healthcare environment, we were not providing proper protection.'

4.59 House of Commons – Health and Social Care Committee (23rd July 2020): Professor Devi Sridhar (Chair of Global Public Health, Edinburgh University) – 'It is not just in the UK. It is also true in Sweden, the Netherlands and other places that care homes have borne the brunt of the crisis… when the modelling was done on the care home sector, I do not think there was an understanding of how people who work in care homes operate and that they might actually be working in different care homes. With the discharging of patients back to care homes without being tested, it became like a fire once you were in a care home; when one person had it, it spread.'

4.60 As referenced on the Care Home Professional website (3rd April 2020), the guidance issued on the 2nd April 2020 included PPE provision, an area where care home providers had complained of inadequate supplies and of preference being given to the NHS. Cllr David Fothergill, health and social care spokesperson for the County Councils Network, warned county authorities were facing 'real challenges' in securing supplies.

4.61 In May and June of 2020, a survey of the Queen's Nursing Institute (QNI) Care Home Nurses Network was carried out by the QNI International Community Nursing Observatory (ICNO) to understand more about the impact of COVID-19 on the Care Home Nurse workforce within the UK. Having to accept patients from hospitals with unknown Covid-19 status, being told about plans not to resuscitate residents without consulting families, residents or care home staff, lack of guidance on issues like personal protection and issues of poor access to pay if they became ill were some of

the major issues the care home workforce faced during March and April 2020. Of 163 participants:

- 66% (107, 66%) of respondents reported always having appropriate PPE while 2 (2, 1%) of respondents reported never having access to the appropriate type and quantity of PPE during the first three months of the pandemic (March-May 2020). 75% (123, 75%) reported that their employer had provided all their PPE.

- During March and April 2020, 34 (21%) reported receiving residents from the hospital sector who had tested positive for Covid-19 in hospital. 70 respondents (43%) reported receiving residents from the hospital with an unknown Covid-19 status during March and April 2020.

- 16 respondents reported negative changes which they found challenging such as "blanket DNACPR" decisions, or decisions taken about resuscitation status by others (GPs, hospital staff or clinical commissioning groups) without discussion with residents, families or care home staff or that they disagreed with some of the decisions on legal, professional or ethical grounds.

Care Home Survey (Sep / Oct 20)

4.62 To understand the experiences of care homes across the Borough following the UK Government's response to a surge of hospital admissions in March 2020, a survey was issued to all local providers with the following questions:

- From March 2020 to now, can you describe what has worked well in relation to discharges from hospital into your care home? *In your response, can you please consider key processes, relationships and communications with key partner organisations.*

- From March 2020 to now, can you describe what could have been improved in relation to discharges from hospital into your care home? *In your response, can you please consider key processes, relationships and communications with key partner organisations.*

- Do you feel you have had sufficient infection prevention and control advice and guidance from community staff from the acute NHS Trust, the Health Protection Team at Public Health England and the Public Health team in Stockton-on-Tees Borough Council? *If you have answered 'no', can you please advise what additional advice and support you feel would be beneficial to receive?*

- Do you feel there are any learning points ahead of a potential second surge of the virus?

4.63 A total of 12 care homes responded – overarching themes that emerged in response to each of the above questions are included in the below table:

What worked well?	What could have been improved?
➢ Good communication between health organisations and care homes (which has improved since the initial stages of the pandemic) ➢ Good support from Social Workers	➢ Communication in the early stages of the pandemic (between hospitals and care homes) ➢ Pressure to accept patients into a care home without confirmation of their COVID status / lack of testing prior to discharge ➢ Timeliness and accuracy of assessments / discharge information
Sufficient infection prevention and control guidance?	**Learning points ahead of potential second surge?**
➢ Excellent support from North Tees Trust Infection Control Nurses (advice, guidance, training) ➢ Good support from Health Protection Teams at Public Health England and Public Health at Stockton (though difficult to distinguish)	➢ Better communication between hospital departments / staff so multiple calls (about the same issue) to care homes are not required ➢ Quicker return of staff / resident test results ➢ Importance of knowing a patient's COVID status prior to discharge ➢ Prompt and accurate communication vital to ensure safe discharge

Full feedback can be found at **Appendix 1**.

4.64 Reflecting on the survey feedback, the Committee was encouraged to note the comments regarding improvements in the communication between hospitals and care home since the initial pandemic phase, though expressed concern in relation to a lack of clarity around discharge information, as well as the inappropriate timing of some discharges that were highlighted.

Second Surge Preparation

4.65 On the 21st August 2020, the UK Government published a *Hospital Discharge Service: Policy and Operating Model* document (updated on the 16th September 2020) – this replaced the *COVID-19 Hospital Discharge Service Requirements* document published on the 19th March 2020. Key features of this new model include:

- The Government has provided funding, via the NHS, to help cover the cost of post-discharge recovery and support services, rehabilitation and reablement care for up to six weeks following discharge from hospital.
- The discharge to assess model will be fully implemented across England.

- From the 1st September 2020, the Government has decided that social care needs assessments and NHS Continuing Healthcare (CHC) assessments of eligibility will recommence.

4.66 To support full implementation of discharge, a set of discharge guidance action cards (https://www.gov.uk/government/publications/hospital-discharge-service-action-cards) have been developed to summarise responsibilities for key roles within the hospital discharge process. Key messages are as follows:

- Once someone no longer meets the clinical criteria to require inpatient care in an acute hospital, they will be discharged as soon as possible today, and any further assessment required will be done in a community setting. Discharge to assess will be the default for all people who require assessment of their care needs.
- Transfer from the ward to a designated discharge area should happen promptly. Discharge home should be the default pathway. If people are not able to go home immediately, they will be transferred to a safe place to await discharge, which should happen as soon as possible.
- Due to COVID-19, everyone being discharged to a care home must be tested for Coronavirus and, irrespective of test result, will need to be isolated in that setting. If their destination cannot do so, the Local Authority is responsible for providing suitable alternative accommodation.
- No one will be discharged to a care home without Local Authority involvement.

4.67 NHS Providers note that one of the features of coronavirus is that patients can be infectious without displaying symptoms. The only way to definitively identify asymptomatic COVID-19 patients is to test them. As set out above, the requirement on NHS trusts to systematically test asymptomatic patients was only introduced on 15 April. Testing capacity was very constrained in the period from March to mid-April, and there is still a lot to do to ensure the health and care sector has access to the volume of tests, and the swift turnaround of results required.

4.68 More recently (13th October 2020), a letter from the Department of Health and Social Care (DHSC) was sent to directors of adult services in relation to the delivery of a designation scheme with the Care Quality Commission (CQC) of premises for people leaving hospital who have tested positive for COVID-19 and are transferring to a care home (a commitment included within the *Adult Social Care Winter Plan* published on the 18th September 2020). These new requirements were listed as follows:

- Anyone with a Covid-19 positive test result being discharged into or back into a registered care home setting must be discharged into appropriate designated setting (i.e. that has the policies, procedures, equipment and training in place to maintain infection control and support the care needs of residents) and cared for there for the remainder of the required isolation period.

- These designated accommodations will need to be inspected by CQC to meet the latest CQC infection prevention control standards.

- No one will be discharged into or back into a registered care home setting with a COVID-19 test result outstanding. or without having been tested within the 48 hours preceding their discharge.

- Everyone being discharged into a care home must have a reported COVID test result and this must be communicated to the care home prior to the person being discharged from hospital. The care home's registered manager should continue to assure themselves that all its admissions or readmissions are consistent with this requirement.

A full list of the actions required by Local Authorities, CCGs and local NHS providers was included within the letter (see **Appendix 2**).

Local Views

4.69 In terms of learning from the initial outbreak, the NTHFT felt confident that the strong collaborative approach amongst local partners, enhanced through some of the measures outlined previously, would enable it and others to manage an escalation of the current COVID-19 situation. In addition, there is a desire to evolve the multidisciplinary EHCH meetings regarding what they do and can potentially achieve.

4.70 Planning for a second surge of the virus had already been undertaken by the STHFT, and would again involve the re-classification of identified wards as COVID-19 areas (one ward is still operating as such). However, a further spike in cases is not anticipated to lead to the reduction of non-COVID services (as happened initially), and continuing to provide treatment to non-COVID patients, albeit in a COVID environment, would be a Trust priority. Maintaining support to the wider health and care system would also be a key focus.

4.71 As outlined in paragraph 4.63, local care homes identified the following key areas in relation to lessons learnt from the initial stages of the pandemic:

- Better communication between hospital departments / staff so multiple calls (about the same issue) to care homes are not required.
- Quicker return of staff / resident test results.
- Importance of knowing a patient's COVID status prior to discharge.
- Prompt and accurate communication vital to ensure safe discharge.

5.0 Conclusion & Recommendations

5.1 The question of national preparedness for a global pandemic will be long-debated in the future, and it is this readiness (or otherwise) which can dictate the effectiveness of subsequent responses. One of the most controversial aspects of the initial COVID-19 escalation period during late-March / early-April 2020 was the lack of a requirement to test hospital patients for COVID-19 prior to discharge to care homes. This approach has already attracted widespread attention and criticism, and will continue to be scrutinised by politicians and the public as the country reflects on the response to the COVID-19 outbreak.

5.2 It is well-established that the overriding aim in the early stages of the pandemic was to ensure maximum hospital capacity for the anticipated surge in admissions. The experiences of other European countries, who were thought to be some weeks ahead of the UK, understandably shaped such a need, but the ramifications of this aim for care homes were profound. Some local providers expressed their unease at being pressured into accepting patients without knowing if they were infected, as well as the at-times unclear nature of discharge arrangements.

5.3 The Committee was reassured that strong partnership-working between local health and social care providers was evident throughout the information received during the first phase of this review. These already established relationships, further enhanced via the onset of regular multi-agency meetings from March 2020, have never been more critical, and will continue to be relied upon for the remainder of 2020 and beyond.

5.4 Support provided to care homes by North Tees and Hartlepool NHS Foundation Trust (NTHFT) was commended, in particular the work of the Infection Prevention and Control team (whose guidance and training was frequently heralded by care homes as part of this review) and the Community Matrons. As seen within the care homes survey responses, some concerns were raised around communication during the initial pandemic stage, and the Committee invite NTHFT to reflect on the issues raised so that future discharge-related information is exchanged in a timely and accurate manner.

5.5 Whilst the Committee was pleased to hear of the help given to the wider health and care system by South Tees Hospitals NHS Foundation Trust (STHFT), in particular the work of their Community Matrons, the importance of the internal measures (testing all patients upon admission from early-April 2020, PPE provision / safe use guidance for staff, estate configuration, etc.) put in place to keep hospital patients and staff as safe as possible was also recognised. Minimising the transmission of infection within hospitals is crucial and reduces the risk of patients having to be discharged with COVID-19.

5.6 An invaluable asset in managing safe discharge from hospital, Stockton-on-Tees Borough Council's Rosedale Centre proved to be a crucial alternative option when patients could not be accommodated within other care homes. Ensuring that robust plans are in place to step-up the service again should the need arise will be vital in the local management of hospitalised COVID-19 cases, particularly since it is incumbent upon the Local Authority to make alternative arrangements if a care home cannot take a discharged hospital patient.

5.7 The Committee was grateful for the input of local care homes to this review and were very keen to hear their experiences since the emergence of COVID-19. The notion previously expressed within the sector that care homes were an afterthought in the early phase of the pandemic was echoed by some respondents, along with a number of communication challenges between themselves and the hospital service. More encouragingly, examples of positive (and improving) engagement with the wider health and care sector were provided, and it was reassuring that no local PPE issues were reported, an area which has often been highlighted in the national media.

5.8 The subject of testing was raised by all contributors to this review, and the Committee fully support the aspiration and commitment of both local NHS Trusts to enhance their testing capacity. The UK Government has expressed a desire to further ramp-up the country's testing capabilities, and the potential of local Trusts to expand their offer needs to be heard and acted upon (with the required resources provided) for the benefit of hospital patients, care home residents and their respective staff. Ensuring test results are made available to relevant parties as quickly as possible is also a critical element in fostering safe working environments, reducing the risk of infection to others and getting staff back to work.

5.9 The challenges faced by both hospitals and care homes in March and April 2020 have been extreme, and it can be difficult for organisations to be mindful of the pressure on others when they themselves are under great strain – continuing regular and effective engagement by all key partners as part of a system-wide approach should therefore be a high priority moving forward. Reassuringly, local services in both the health and social care sectors have indicated that they feel better-prepared ahead of a second COVID-19 surge following experiences from the first phase, though controlling numbers requiring hospital admission and, in turn, discharge to care homes remains critical. The Committee are mindful though that the actions of national Government, and the compliance of the general population to any local restrictions put in place, are outside the control of local health and social care providers, who are ultimately left to manage what remains an unpredictable and fast-changing public health emergency.

Recommendations

The Committee recommend that:

1) **There is continued regular engagement between local NHS Trusts, SBC and care providers regarding escalation-planning and how this will be managed, with arrangements to be agreed by all stakeholders.**

2) **North Tees and Hartlepool NHS Foundation Trust provide a prompt response to the communication issues raised by care homes through the survey undertaken as part of this review.**

3) **The recently issued 'designated settings' guidance (for discharge of positive COVID-19 cases from hospital to CQC-approved care home accommodation) be fully implemented.**

Recommendations (continued)

The Committee recommend that:

4) **Planning for the use of the Council's Rosedale Centre (a recently CQC-approved 'designated setting') for a second surge takes into account the possibility of higher demand than what was required from March 2020.**

5) **Local leaders support the desired expansion and funding of local Trust testing capabilities, and that any increase in capacity be prioritised for both Trust and care home staff and patients / residents.**

6) **Regular testing of care home staff and residents is supported, with a continued push for a quicker turnaround in the notification of test results.**

7) **The latest guidance from the UK Government, in conjunction with recognised best practice, is fully understood and acted upon by key partners, and is considered during the regular dialogue that takes place between health and social care services.**

APPENDIX 1: Care Home Survey (Sep / Oct 20) – Collated Responses

	1. From March 2020 to now, can you describe <u>what has worked well</u> in relation to discharges from hospital into your care home? *In your response, can you please consider key processes, relationships and communications with key partner organisations.*
1	Potential residents having a negative covid swab before admission. Communication with Social Workers is good. Access to current social work assessment. Communication with mental health hospitals is good – provide one week's leave medication plus a month's supply.
2	Since the beginning of March 2020 to now, we have only had 1 discharge from hospital into our care home. We had no issues with this discharge, and ourselves and the staff were more at ease with the discharge under the circumstances as it was required for the resident to have a COVID-19 test prior to admission into our Home. Having a test prior to admission helped to stop not only some of the staff anxiety regarding the discharge and the possibilities of COVID entering the Home, but also the anxieties of the resident's family. At the time of the discharge, the results for the test came very quickly and we were informed of the results as soon as they had been received by the hospital, which made for a quicker admission into the Home as we weren't waiting a long time for the results.
3	In consideration with regards to hospital discharges, we have not experienced any difficulties since COVID-19 pandemic began. Ward staff, Nurses and Discharge Co-ordinators and Consultants have endeavoured to give us as much information about a potential resident to ensure safe discharge, we have worked in Partnership throughout the pandemic. All residents have been COVID tested with confirmed results prior to discharge to us.
4	At times there has been effective relationships between us and the hospital. Some staff at the hospital have been very helpful and others haven't. Communication has also been effective at times. Overall, it hasn't been a consistent service throughout.
5	We have had no problems at all with hospital discharges during this time. COVID tests have been completed and results given to the home prior to discharge. We have been able to speak to key staff to complete pre-admission assessments over the phone and communication between the hospital and the home has been good.
6	Not admitting potential residents who were positive.
7	Only had one discharge and it was a poor discharge.
8	The first part of March and April we did not have any discharges from hospital. When did start taking discharge from hospital (May) we did feel that we had to continue to ask if COVID test had been <u>completed.</u> Lady went in tested negative, before discharge tested positive. Due to not having COVID in the home, she went to a nursing home that had COVID – we were made to feel that this was the wrong thing to do, but we were supported by Social Worker and family. This (testing?) did not seem a priority before discharge. As the months went on, this did improve greatly and communication

	between ourselves and the hospital. As a home, we as a team feel everything is a learning curve – we have never had to deal with anything like this, as the hospitals I'm sure feel the same. But as the months have moved on, feel communication is much improved on both sides.
9	The home had an embargo in place, therefore we did not accept patients from Hospital.
10	Back in March 2020, it was a very confusing time – residents where not being tested and 1 resident we were told had been tested when in fact he had not. We also had a resident come home from hospital that we were told was negative, then received a call from the hospital at 4am to say he was in fact positive (all residents were isolated on return from hospital). Some of my senior staff when asking the question "have they been swabbed" were often informed "this is not needed" – it appeared that the pressure to discharge from the hospital was more important, but I question what was their guidance at that time? Since June, I feel we as a service are better prepared and we will now push back to the hospital if needed (for example, very little information at that time was coming from the hospital paperwork and it was very limited as we could not go in and to speak to the ward or to assess the person for ourselves – we also found it very difficult to speak to nurse looking after the person via telephone and were often informed "she will call you back" and never did). Hospital discharges have improved since, but I feel in March/April/May time everybody was working in a very confusing period with no clear direction. We were also following SBC letter (dated 3 April): 'Provider must confirm that they will accept referrals particularly from hospital discharge – this may include suspected and/or confirmed COVID-19' – which was of course an additional concern to us. Relationships and communication have improved vastly over the last few months with the hospital wards who do call back to give us a handover, and we also heavily rely on Social Workers who have been very supportive. NHS infection control team – Gill Roberts & Claire have also been supportive for guidance and support when we have needed it, and who I was able to contact regarding new residents being tested while in hospital when I couldn't speak to the ward.
11	We have had very few admissions via hospital since March 2020. The main stipulation that we had was that we received confirmation and evidence of negative test results for COVID. We have had no issues in getting this information.
12	Relationships with SW and discharge teams have been good during the Covid times. The phone assessments have both good and bad points (see below). Not having to travel and get parked at the hospitals is good and there have been some good quality information shared that has resulted in safe admissions. Equipment needed for admission has arrived promptly and before the resident (I am not sure what this was like before COVID but it has been efficient since March). Social Workers have been helpful and willing to discuss concerns and put them right. I imagine that it was always this way but I have noticed. The COVID funding helped with securing admissions.

Themes:

- Good communication between health organisations and care homes (which has improved since the initial stages of the pandemic)
- Good support from Social Workers

APPENDIX 1: Care Home Survey (Sep / Oct 20) – Collated Responses

	2. From March 2020 to now, can you describe <u>what could have been improved</u> in relation to discharges from hospital into your care home? *In your response, can you please consider key processes, relationships and communications with key partner organisations.*
1	Difficult for relatives as they cannot currently come and visit the home and meet the team. Communication around resident funding is not always known by staff on the ward. Lack of communication between multiple disciplines in the general hospital (for example, a physio ringing asking for information and then later the same day an OT ringing and asking all the same information) – this is often multiple disciplines that do communicate with each other or utilise patient notes. Red bag scheme is often not followed – resident bag goes missing with personal information in – information will all be in the red bag, however staff will contact the home and ask multiple questions that could be answered using the information handed over. Medication received is not consistent – you receive different amounts of all medications meaning they all run out at different times and care home staff have to contact GP etc to rectify and manage a shortfall. Discharge documentation has very limited information and is not always consistent (for example, staff may discuss a resident having pneumonia, however this often not found on the discharge summary) – someone may be in hospital a long time and the discharge summary has limited information such as UTI. Residents were not tested consistently (only if displayed symptoms), however this issue is now rectified.
2	Since the beginning of March 2020, we have only had 1 discharge from hospital into our Home, and as stated above, we had no issues at all.
3	None.
4	Understanding! At the beginning of the pandemic, the hospital were very quick to discharge residents to care home without a COVID test. We are aware this was mainly due to the government's poor decision-making. However, we were classed in my opinion as an afterthought. We were pressured a lot throughout to take admission who were COVID positive. When I declined it created a 'rift' between myself and the hospital. Also, cut off times – residents were discharged from hospital late at night or very early hours in the morning which was not right, especially those living with dementia.
5	Nothing.
6	Testing of potential residents prior to discharge. If a potential resident tested positive, to isolate for 14 days somewhere else prior to admission to the care home. A unit where potential residents could safely isolate, without taking up a hospital bed. Communication between hospital and care home required improvement. Hospital expectation that care homes will take any person in to relieve the bed management, hospitals reporting care homes to Local Authority if they refused to take a positive potential resident.
7	Wards are asked to give us prior notice of when the residents will be discharged, this does not always happen. If the residents needs have changed in regards to mobility, we request that a Mobility assessment is sent prior to the discharge so that we as a home can make sure that we have everything in place ready for the resident returning back home to us – this does not always happen and we have had residents returning home with the mobility assessments sent home with them. We have had residents return home without discharge notes and have had to chase these with wards, we have had

APPENDIX 1: Care Home Survey (Sep / Oct 20) – Collated Responses

	residents return home without DNAR forms in which they were sent in with and they have had to send their hospital staff out or send our staff out of the home to go and get this collected/dropped off as this is a very important document that needs to be with the resident at all times. We contacted ward 41 at NTGH the other day when one of our residents was discharged to be told by one of the nurses who answered the phone "well I've been on annual leave so I don't know who that is (about the resident we named) and I don't think you have had her from here because we haven't had any discharges this morning" – when I asked to speak to someone else, another more helpful nurse clarified the resident had been on their ward and was in fact discharged from their ward that morning!
8	Communication to be made sooner, not right when the client needs to be discharged. At times felt everything was a rush – we keep in contact with the wards when our residents are in hospital, but we have found it difficult at times to get up-to-date information or to get the ward to pick up phone.
9	-
10	Clearer information from the beginning (March/April/May) which should have been given first to the hospitals to give them clear guidance, then filtered through to the care homes so we were all working together from the beginning. Hospital wards were under pressure to clear the wards for expected COVID patients to be admitted – this in turn put pressure on the Social Services to find beds, which in turn put pressure on care homes. I received a call in March to ask if we have beds available because Social Workers had a limited time to place people in to care homes – if testing had been standard at that time, this would not have put undue pressure on the care homes.
11	Only changes to key processes has been us being reliant on trusted assessments, which have not always been as accurate as we would have wished, and I believe that since March we (all those involved in discharge process) could have come up with a standardised way to ensure that we received accurate and consistent information, which would ensure that we could meet the needs of the individuals. Some discharges have felt rushed, with those being sent out more unwell than expected and on a couple of occasions, dying within the first 24/48 hours of arrival (when they were not sent to us as end of life) – this all ties back into an accurate discharge assessment process.
12	The phone assessments have been problematic – it can be tricky to get through to wards and there appears to be some phone problems with N Tees in particular. Sometimes the information provided has born no relation to the resident who has arrived and they have come without drugs or equipment. Transport times has been variable – the admissions that have gone wrong have usually been those that arrived late (so we have not stopped taking out-of-hours admissions as it has not been safe). The reliance on Microsoft Teams is causing some issues – we have limited IT capability amongst the care staff and this can get in the way (not really a discharge issue but worth mentioning). The referral of young people to a care home for older adults is concerning – if I was 55 I would not want to come here either. I am happy to offer the bed but it seems wrong. Having a negative COVID test is a plus. We have had COVID here and I do not want to reintroduce it.

APPENDIX 1: Care Home Survey (Sep / Oct 20) – Collated Responses

Themes:

- Communication in the early stages of the pandemic (between hospitals and care homes)
- Pressure to accept patients into a care home without confirmation of their COVID status / lack of testing prior to discharge
- Timeliness and accuracy of assessments / discharge information

	3. Do you feel you have had sufficient infection prevention and control advice and guidance from community staff from the acute NHS Trust, the Health Protection Team at Public Health England and the Public Health team in Stockton-on-Tees Borough Council? *If you have answered 'no', can you please advise what additional advice and support you feel would be beneficial to receive?*
1	Communication from Infection Control Nurse at North Tees has been very good – face-to-face training provided and always available for advice. Health Protection Team and Public Health England helpful at times, however very limited tests available initially. Health Protection Team very helpful.
2	Yes.
3	We have received excellent Infection Control Prevention and Control advice and support from everyone involved. All Partners have excelled in communication support and guidance.
4	Yes, Gill Roberts has been fantastic! I really cannot find any faults with anything Gill Roberts has said or assisted us with. Public Health have been helpful also.
5	Yes, we have had lots of communications at the home and are due to receive training week commencing 21/09/20.
6	I have received sufficient infection control prevention and control advice and guidance from PHE, Gill Roberts. Always available to answer any queries. Gill Roberts has provided training, donning and doffing, always goes over and above any expectations.
7	Yes, advice helpful with good guidance.
8	We have been supported daily from infection control NHS trust and training provided to support staff knowledge. Public Health supported well when we had two confirmed cases and continued to phone while we were going through the testing of the whole home.
9	-

10	I do now, at the beginning the advice was very changeable and confusing – this has much improved. We as a service have good relations with Infection Control Nurses Jill & Claire, and can and do contact often for advice, guidance and reassurance that I am doing the right thing. Over the last couple of weeks, we have been supported well by PHE Rebecca who made daily calls to ensure we were ok and offer support.
11	Yes.
12	Gill Roberts has been fabulous! The HP teams have been helpful and quick to respond to outbreak information and give advice where requested. Not had too much to do with the PH team in Stockton.

Themes:

- Excellent support from North Tees Trust Infection Control Nurses (advice, guidance, training)
- Good support from Health Protection Teams at Public Health England and Public Health at Stockton (though difficult to distinguish)

4. Do you feel there are any learning points ahead of a potential second surge of the virus?	
1	Don't force care homes to take new admissions of COVID-positive residents when the home is currently COVID-free. Lack of support and simply told to contact a number provided. Community support should be encouraged and accepted, not scrutinised during such a difficult time when PPE is so sparse. Contacting for advice, however the issue is simply passed back to you to resolve. When external non-essential visits are stopped, the care home receives mass amounts of phone calls from the same team about the same person or multiple people rather than communicating with each other. Phone calls are not booked in and some external professional expect us to have time to take phone calls when these can be 30 minutes+. Appointments should be made by external professionals and emailed over (for a positive time-saving example, during lockdown the Memory Clinic admin contacted the home and asked if they have multiple queries can they email those over and someone will get back to them – I requested ICLS to do the same thing, however this was not listened to and we continued to receive multiple phone calls throughout the day. This took up a lot of the Nurses time which could have been better spent supervising staff and concerned families).
2	The only issues we are currently having (and needs improving on) is the time in which it takes for the results of a COVID test to be returned. Since starting the regular testing of staff and residents, none of the results have been returned within the 72 hours as indicated in the guidance. In some cases, depending on the day a test is taken, results aren't being returned until 7-8 days later. At times, staff have taken another test before the results of the first test have even come through.

APPENDIX 1: Care Home Survey (Sep / Oct 20) – Collated Responses

3	With the ongoing advice, training and support, all agencies have put us in a position of further knowledge, skills, and education for a potential second surge of the virus. One thing that needs to be addressed is the length of time swab results are coming back for residents and staff this will prevent potential cross contamination of the virus to ensure the pandemic is not spread throughout the home.
4	Yes, that care homes are not an afterthought and do deserve the same recognition as the hospital does. Hospital to be more understanding and work with care home and not against. Have clear direction and communication at all times.
5	The only problem, currently, is the length of time it is taking for test results to come back. Staff are worried that they are taking too long and if a positive result was to come back it could potentially have a massive impact on the home.
6	Not to expect care homes to take anyone in without a COVID test, and if positive to have isolation elsewhere prior to admission.
7	-
8	We will always have learning points as we are all unsure what impact the second surge will have on our resources, but feel easier communication between hospital and ourselves sooner will help to create easy and more safer discharges.
9	-
10	-
11	See point 2 above.
12	-

Themes:

- Better communication between hospital departments / staff so multiple calls (about the same issue) to care homes are not required
- Quicker return of staff / resident test results
- Importance of knowing a patient's COVID status prior to discharge
- Prompt and accurate communication vital to ensure safe discharge

APPENDIX 2: DHSC letter to directors of adult services regarding designated settings (13th Oct 20)

Department of Health & Social Care

CARE

To
Directors of Adult Services

Copied to
Local Authority Chief Executives
CCG CEOs
Acute Trust CEOs
Directors of Public Health

39 Victoria Street
London
SW1H 0EU
02072104850

13 October 2020

Dear Directors and Chief Executives,

Winter Discharges - Designated Settings

COVID-19 presents an unprecedented challenge for social care. There is an extraordinary amount of work underway up and down the country, with local authorities and care providers at the forefront of this vital response, working in partnership with the NHS. Thank you for all that you and your teams are doing to provide care and support for the many people who need it, and for helping to keep people safe during the pandemic.

The Adult Social Care Winter Plan was published on 18th September, setting out our plan for the next phase of the COVID-19 response and how we will achieve this, working alongside Local Authorities, social care providers and the NHS. In doing all we can to protect the vulnerable from Covid-19, the plan includes a commitment to deliver a designation scheme with the Care Quality Commission (CQC) of premises for people leaving hospital who have tested positive for COVID-19 and are transferring to a care home.

This joint letter sets out:

1. an overview of the requirement for designated care settings for people discharged from hospital who have a COVID-19 positive status; and

2. an instruction for Local Authorities to commence identifying and notifying CQC of sufficient local designated accommodation and to work with CQC to assure their compliance with the Infection Prevention Control (IPC) protocol.

We have worked closely with ADASS in the development of this letter, alongside colleagues from LGA, NHSE, CQC and PHE.

APPENDIX 2: DHSC letter to directors of adult services regarding designated settings (13th Oct 20)

What is the new requirement?

The new requirements are the following:

- Anyone with a Covid-19 positive test result being discharged into or back into a registered care home setting[1] must be discharged into appropriate designated setting[2] (i.e., that has the policies, procedures, equipment and training in place to maintain infection control and support the care needs of residents) and cared for there for the remainder of the required isolation period.

- These designated accommodations will need to be inspected by CQC to meet the latest CQC infection prevention control standards.

- No one will be discharged into or back into a registered care home setting with a COVID-19 test result outstanding. or without having been tested within the 48 hours preceding their discharge.

- Everyone being discharged into a care home must have a reported COVID test result and this must be communicated to the care home prior to the person being discharged from hospital. The care home's registered manager should continue to assure themselves that all its admissions or readmissions are consistent with this requirement.

The commitment builds on existing guidance on admission to care homes published on 2nd April 2020 (updated 16th September) that already includes a requirement, in line with the Hospital discharge service guidance, that if appropriate isolation or cohorted care is not available with a local care provider, the individual's local authority will be required to secure alternative appropriate accommodation and care for the remainder of the required isolation period. Sufficient accommodation must be available to meet expected needs now and over the winter period. **The costs of the designated facilities are expected to be met through the £588 million discharge funding.**

Residents who contract COVID-19 within the care home setting should be treated and managed in line with the Admission of Residents in a Care Home during COVID-19 policy. This guidance still requires all patients discharged from hospital, even with a negative test, to be isolated safely for 14 days to ensure any developing infections are managed appropriately.

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[1] Some registered residential settings might also be designated CQC assured alernative settings, where people may be discharged to designated accommodation within a registered residential setting. For example, a care home with a designated safe zone for COVID-19 positive people.
[2] Some people will be able to go back to their residential care home, where they are usually resident, if that care home is assured as designated accommodation.

APPENDIX 2: DHSC letter to directors of adult services regarding designated settings (13th Oct 20)

Which people will this affect?

The designation scheme is intended for people who have tested positive for COVID-19 and who are being admitted to a care home. This applies to care homes who provide accommodation for people who need personal or nursing care. This includes registered residential care and nursing homes for older people, people with dementia, and people with learning disabilities, mental health and/or other disabilities and older people.

Anyone with a COVID-19 positive test result being discharged into or back into a registered care home setting must be discharged into an appropriate designated setting[3] and cared for there for the remainder of the required isolation period.

The designation scheme does not apply to the following cohorts:

- People who have contracted COVID-19 within the care home setting – there is no requirement to transfer COVID-19 positive residents from a care home into designated accommodation, as long as safe isolation and care is being maintained.
- People using emergency departments who have not been admitted to hospital do not need to be transferred into designated accommodation.
- People living in their own home, including sheltered and extra care housing or living in Supported Living do not need to be transferred from hospital into designated accommodation.

How the CQC assurance process will work?

The CQC process would operate by providing assurance that each 'designated accommodation' has the policies, procedures, equipment and training in place to maintain infection control and support the care needs of residents. Once this assurance is received, premises would be able to receive COVID-19 positive people discharged from hospital, prior to their admission to a care home[4].

Emphasis should be on commissioning stand-alone units or settings with separate zoned accommodation and staffing. Given the diversity of existing provision and arrangements, it is acknowledged that there needs to be flexibility to meet local circumstances. The accommodation must meet CQC registration requirements, and additionally adhere to the CQC inspection guidance in the IPC protocol.

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[3] Some people will be able to go back to their residential care home, where they are usually resident, if that care home is assured as designated accommodation.
[4] This approach applies to hospital discharges only, and does not apply to admissions from people's own homes to residential care homes.

APPENDIX 2: DHSC letter to directors of adult services regarding designated settings (13th Oct 20)

What action is required?

In time for winter, CQC has the necessary capacity and is ready to deploy to deliver 500 assurances by the end of November.

Local authorities should identify sufficient designated accommodation to meet current and future demand over winter in their local area and notify CQC of the details of these facilities **as soon as possible and ideally by Friday 16th.** Details of this process are below. Following notification of the facilities to CQC, local authorities will be asked to work with CQC to assure their compliance with CQC's revised Infection Prevention Control (IPC) protocol.

In order to meet this potential demand across England as quickly as possible, we aim for every local authority to have access to at least one CQC designated accommodation by the end of October. Local authorities will also be able to identify more than one facility to be CQC assured, if needed to respond to geographical spread and size, and to take into account the specific needs of particular cohorts, and increasing demands. We anticipate, for obvious reasons, that CQC will prioritise inspections in Local Authorities in Tier 2 or Tier 3. Please notify CQC as soon as a facility is available for assurance and return to CQC as and when further facilities come online. Local authorities should continue to use the existing regional structures and support systems that are in place which may be necessary to provide resilience across local boundaries.

In the longer term, CQC's IPC protocol will be rolled into their planned programme of non-IPC focused inspections, which should increase the volume of 'designated' capacity even further over the coming months.

In implementing these requirements, we provide a full list of actions below:

- **Local Authorities:**
    - Following consultation with care providers, identify a sufficient number of facilities[5] within their local area to meet likely demand over the winter months.
    - Working with **local system leaders,** should ensure that the designated accommodation identified adheres to the standards set out in the CQC IPC protocol and wider requirements for registration. They should also ensure that there is repeat testing, PPE, arrangements for staff isolation or non-movement, protection from viral overload, sickness pay and clinical treatment and oversight.

APPENDIX 2: DHSC letter to directors of adult services regarding designated settings (13th Oct 20)

- Notify **CQC** – **as soon as possible and ideally by Friday 16th** - by completing a proforma which includes all information required for CQC to progress to inspection, sent to ASCGovernance@cqc.org.uk. (Local Authorities might choose, for expediency, to identify an initial premises, and follow up subsequently with details of further premises). Once notified of premises selected by local authorities the CQC will inspect against the IPC protocol, report their findings and publish them on their website as part of a provider page that summarises the outcomes of inspection. Once assurance is received, premises would be able to receive COVID-19 positive people discharged from hospital, prior to their admission to a care home. CQC regulatory mechanisms, to prevent non-designated care homes from accepting COVID-19 positive people from hospital, will not apply.

- Communicate to **CCGs and providers** when the new designation scheme is in place to commence its operation.

- **CCGs and Local NHS Providers** should:

  - Support **local authorities** to ensure that patients who receive a COVID-19 positive test result and are to be discharged to a care home, are discharged to assured accommodation[6].

  - Ensure that all COVID-19 test results are provided prior to discharge to enable the smooth operation of discharge, zoning, staffing and isolation, and for subsequent transfer of care. They should also ensure that patients being discharged follow the Discharge to Assess. pathways outlined in the hospital discharge service guidance.

CQC will monitor and share data regarding where these services are being commissioned across the country. **DHSC, ADASS and PHE** will then work together to identify any particular localities in England that require additional designated accommodation, and a prioritised roll out for CQC inspection based on local prevalence rates or population size.

What will happen next

Once local facilities have been designated and assured by CQC, Director of Adult Social Services communicate to providers and Clinical Commissioning Groups (CCGs) that the new designation scheme is in place. Current discharge guidance using the 'Discharge to Assess' (D2A), HomeFirst model, should continue to be prioritised. Current discharge arrangements, including notification of the person's COVID-19 status to care providers and 14 day isolation of all residents discharged into

[6] Some care homes may also be designated CQC assured alernative settings.

APPENDIX 2: DHSC letter to directors of adult services regarding designated settings (13th Oct 20)

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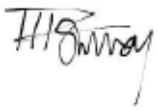
care homes, should continue to apply until CCGs are notified that designated premises are available.

We are currently working with system leaders to co-design further detailed guidance, and resolve what we recognise are practical concerns. We aim to provide more detailed information to local systems shortly.

This will include further information on:

- Clinical pathways for patients being discharged from hospitals to care homes.
- Further details on working with providers, and the operation of funding.
- Further details on data management.
- Caring for people with particular care needs, in line with line with the COVID-19 ethical principles the relevant requirements of the Care Act 2014 and hospital discharge service guidance.
- Further support available to implement these new arrangements.

Yours Sincerely,



Tom Surrey – Director for Adult Social Care Quality, DHSC