June 2020

OVERVIEW OF THE REGIONAL RESPONSE TO COVID FOCUSED ON CARE HOMES

Introduction

The purpose of this report is to provide a comprehensive overview of the regional response to COVID, highlighting key issues and providing a balanced view in relation to both strengths and challenges.

The report is, by nature, a summary of key issues. Inevitably decisions have been made on a daily basis as the crisis has unfolded, as new information has become available, and as national guidance has changed. Extensive and detailed documentation is available to evidence activity at all levels of the governance arrangements, but is beyond the scope of this report, for example;

- Minutes and action notes at Gold and Silver level.
- The Care Home Matrix maintained to record all interactions with the sector.

At the outset of the crisis, a strong set of governance arrangements was established, with a particular focus on ensuring effective partnership working.

These arrangements directly addressed the challenge of partnership working by establishing the interface group as a point of escalation and issue resolution. This group reports and escalates issues to the Chair/Leaders informally, or sitting as the RPB, as necessary.

There has been a strong commitment, even in the face of adversity, to regional working and establishing a regional response on all key issues.

Working together in this way has been very effective, as will be demonstrated when reviewing the key issues later in this report. However, it is not without its challenges. Not all issues fit neatly into the fold of joint ownership and joint accountability. An obvious example is ‘testing’. This is clearly a responsibility of the health service, and ultimately decisions and accountability sit there. Nevertheless, the partnership has strived to work together to both influence policy and deliver local solutions, for the benefit of the community. There are, of course, other examples.

In providing a frank assessment in relation to the key issues, great care has to be taken. When identifying what went well and not so well, an element of hindsight inevitably comes into play, and must be guarded against. The partnership has focused on complying with existing guidance at all points, whilst often challenging and questioning where appropriate. Decisions and actions should primarily be judged against the prevailing circumstances and guidance at the time they were made.

This report will now present an overview of the key issues arising in our joint efforts to support the Care Home Sector.

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General Support to Care Homes

Throughout the period of the crisis, there has been extensive work with care homes on an almost daily basis. An Externally Commissioned Care Homes Group was established as a sub-group of the multi-agency Community Silver group to manage the region's plans and interactions with care homes.

- Local commissioning teams have been in regular contact with all care homes, not just reacting to outbreaks, but ensuring early communication of any or all emerging issues.
- Local public health and EHOs have advised on infection control generally and have responded to specific outbreaks.
- The Matrix details a range of other support; when and how it has been provided, including;

    - Pastoral – bereavement and trauma
    - Financial
    - Providing staff to cover shortfalls
    - End of life care guidance
    - Guidance in relation to BAME

Irrespective of the extent of support, key issues need to be addressed in more detail. Firstly, the management of infection in care homes and, secondly, prevention of infection in care homes.

Managing Infection in Care Homes

First, the positives;

1. There has been a proactive approach to securing additional PPE rather than relying on a national supply chain that took a number of weeks to reach adequacy.
2. Set up regional procurement and store management infrastructure to ensure supply to care homes was sufficient and timely.
3. Moved to 'table 4' of guidance requiring full use of PPE (issued regional guidance to that effect) in advance of national advice that 'community transmission' was sustained, which was officially the trigger for doing so.
4. Established and published proactive regional guidance on 'lockdown' in care homes, ie moved to full barrier care of all residents if either residents or staff presented as symptomatic or tested positive. This regional guidance has become the mechanism through which all national guidance is brought together and communicated to care homes within the region.
5. Agreed proactive regional protocol and operational guidance that facilitated early local testing of symptomatic care staff, rather than relying upon the nationally agreed testing infrastructure that was not working.

Then, the challenges;

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1. National guidance led to a reliance on the presumption that if all of the above measures were implemented and that if any new admission to a care home was isolated for 14 days (as per the national guidance), then infection would be controlled.
2. The reliance on the presumption that the efficacy of testing was such that there was only value in testing symptomatic residents and staff between day 1 and day 5 of those symptoms.
3. There have been a small number of examples which appeared to indicate a possible breakdown of communication between Health Board, Public Health Wales, Local Authorities, and individual care homes. Concerns raised indicated that known information that an individual resident was infected was not passed to the responsible care home in a timely manner. However, any individual concerns of this nature were immediately referred for investigation via the usual complaints or safeguarding processes.

Preventing infection getting into care homes

First, the positives;

1. In advance of national guidance, a regional position was agreed that we would not 'knowingly transfer infection into a closed setting' (subsequently extended to cover all circumstances in which commissioned personal care is being provided).
2. All regional guidance and operational protocols refreshed and published to reflect the above organisational principle.
3. Set a threshold for the presumption of 'infection free' at 14 days post a positive test or symptoms in advance of national guidance to that effect. Eventually, that threshold has become the requirement of a negative test (as per national guidance).
4. A multi-agency infrastructure was established to oversee the practical implementation of an expanded testing regime, and to agree prioritisation in circumstances in which demand would likely outstrip capacity. Care home testing was agreed as the overriding priority.
5. A programme of testing for all care home staff and residents was initiated, and that programme was completed slightly ahead of schedule for older peoples' care homes.
6. Care staff have been prioritised for local testing, utilising the same local arrangements that the HB operate for their own staff in contradiction of the national arrangements, which were not effective.

Then, the challenges;

1. National guidance led to an over-reliance on the presumption that infection could be safely managed within a care home setting; meaning that infection is likely to have been transferred into some care homes as part of the national strategy (implemented nationally, regionally, and locally) to ensure capacity within the acute hospital setting in order to manager 'surge'.

2. Hospitals are closed settings. Once there was COVID spread in the community, then any person admitted to hospital was potentially infected, which also inevitably results in a risk of spread of infection within hospitals. Keeping some of the most frail and vulnerable members of our society in acute hospital beds, when they did not need the level of care provided in acute hospitals, and would have been at risk of acquiring the infection, would not have been the right course of action.
3. It took longer than ideal to agree the 'don't knowingly transfer infection …' principle.
4. Operational implementation of that principle was not as effective as it should have been, and therefore, some clinicians continued to operate on the basis that once an individual was MFFD, they could be transferred to a care home setting, even if still COVID positive.
5. In a small number of cases, there were examples of miscommunication between PHW, HB, LAs, and individual care homes; meaning that individuals were discharged on the presumption that they were not COVID positive when in fact, they should have been known to be so.
6. The national guidance on hospital discharge/care home admissions and step up/step down beds was not issued until the end of April. Whilst in theory, the principle of 'not knowingly transfer infection …' predated this guidance, operational implementation may well have been more easily facilitated if the guidance had then been referenced. Full implementation of that guidance in relation to step up/step down beds is agreed in principle, with the details of implementation still being worked through.
7. The over-reliance on symptomology and then testing within the first 5 days of those symptoms (as per PHW advice) meant that asymptomatic staff and residents are likely to have been introducing infection into care home settings.
8. National guidance on mass testing of care home staff and residents took too long to develop. Politically and ADSS were petitioning for such testing to be rolled out. For ADSS, the knowledge that asymptomatic transmission was known to be a factor in high rates of care home deaths in other countries prior to the surge in this country, makes it particularly difficult to square the national and public health guidance. Once the guidance was issued, it was implemented quickly at a regional level, and capacity was prioritised to support testing of care home staff and residents.
9. Subsequent mass testing has identified that asymptomatic staff have continued to work and, therefore, have been a <u>possible</u> source of infection transmission for longer than necessary.

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General issues relating to testing

The partnership has throughout strived to comply with national guidance. The frequency with which new guidance has been issued has presented a major challenge. On several occasions, ministerial announcements have been made altering the guidance without prior consultation or warning. The practical implications and impacts on local resources have meant that there have been short periods between national announcements and local implementation. This has created frustration at both a managerial and political level.

It appears that guidance has not always been aligned with PHW advice nationally and public health advice locally. It has often been difficult to reconcile the 'laymen's' view of the usefulness of testing with professional advice on efficacy/reliability etc.

Local politicians and managers have lobbied extensively on testing issues, as the mismatch between public expectations of 'test, test, test' and the reality of guidance have come into sharp focus. On occasion, this lobbying has preceded further change in national guidance.

The issue of testing and the uncertainty created nationally has put strain on local partnership arrangements. However, despite this, local solutions have been found to deliver care home testing and key worker testing when national systems proved unworkable.

Ethics

There has been much debate nationally on a number of ethical issues that arise across the spectrum of response to the COVID crisis. These range from the access of the elderly to acute services based on need; the ethical issues arising from the hospital discharge process; issues arising at end of life; and much more.

It will be for UK and WG politicians to account for ethical choices they have made in setting policy and guidance at that level (if indeed, ethics was an overt consideration).

Whilst there remains work to be done locally, it is to the partnership's credit that ethical discussions have taken place regularly at the Interface Gold Board, and elsewhere. Local policies and practice have been influenced by these ethical discussions; for example, the adoption of a guiding principle, 'do not knowingly transfer harm/infection'.

Work is underway to formalise these ethical discussions, in order that assurances can be given or otherwise with regard to, for example;

- The extent to which we can evidence compliance with existing and revised ethical guidance.
- The extent to which the elderly's right to access services has been protected.
- The extent to which the guiding principle of transferring no harm/infection has been operationalised.
- The appropriateness of the various guidance on:

  - Return to work 7 days
  - Isolation 14 days
  - Care home 'closure' 28 days

- The ethical issues arising from our emerging discharge policy.

This crisis has sharply focused attention on the ethical framework that has underpinned Health and Social Care for years but is rarely directly debated. The likely impact of this is that ethical matters will need to be overtly considered in the post-COVID rebuild of services and beyond.

There clearly will be a need to differentiate between national decisions that constituted instructions and local decisions that have clear local accountability.

Creating capacity in the NHS

An urgent response at the very start of the COVID crisis was a move by UK and WG to create capacity in terms of NHS beds in anticipation of the NHS otherwise facing being overwhelmed.

This initiative had many and dramatic implications. Non-urgent clinical activity was put on hold; additional general medical (~ 1,200) and intensive care (112) capacity was created locally; and a major initiative to empty hospital beds was initiated. The dire forecasts on which this activity was based were emphasised by the rapid provision of additional mortuary capacity and emergency body storage. Large numbers of temporary staff were also recruited to work in the additional field hospital capacity, and to provide cover for workforce shortages which were anticipated as being as high as 20% throughout the pandemic.

The key documents from Welsh Government which set out these requirements are:

Document	Date
Letter from CEO of NHS Wales to prepare for COVID-19 including: Engage with social services partners to help ensure social care is ready and able to locally manage their residents that may be impacted and that they have infection prevention control measures in place, and their staff are aware of how to maintain these measures	5th March 2020
Statement from the Minister for Health and Social Services on actions to protect our communities, including: Expedite discharge of vulnerable patients from acute and community hospitals	13th March 2020
Letter from CEO of NHS Wales confirming the above	14th March 2020
Welsh Government issued: COVID-19 preparedness and response: framework for the health and social care system in Wales, which included requirement to:	18th March 2020

- Discharge vulnerable patients from acute and community hospitals to suitable alternative placements in the community. - Plan now to manage the extra challenges relating to bed capacity shortages and high levels of long-stay patients, delayed transfers in care and poor social care infrastructure.	
Letter from CEO of NHS Wales advising on requirement to create additional capacity in the NHS (1,242 acute medical and 112 critical care beds in Swansea Bay)	3rd April 2020
Letter from CEO of NHS Wales advising on need to review additional capacity in light of demand	16th April 2020

The local partnership was instructed to vigorously pursue a policy of emptying hospitals of those 'medically fit for discharge' (MFFD). The beds emptied by these initiatives were not sufficient to meet the bed capacity targets set by WG; hence the commissioning of field hospitals.

As the April peak passed and lockdown was continued, it would be easy to think that the actions were an unnecessary overreaction. However, as lockdown is eased, Test, Trace, Protect is implemented, and we move through the Autumn to Winter, there remains a number of scenarios where this capacity could yet be required. Time will tell.

These capacity-creating targets were driven hard by WG, and the local partnership was, unsurprisingly, equally focused on meeting the requirement.

At the point that the MFFD programme was at its peak, guidance was at a minimum, though the policy intent was crystal clear. The reality is that little was known about COVID and its impact at a national or local level.

There is no evidence that the capacity-creating exercise was driven by anything other than avoiding the NHS system being overwhelmed, or that the ethical issues arising were understood or considered.

Locally, Multi-Agency Community Silver was tasked with delivery of the targets and compliance with the guidance, and it was from this work that local ethics discussions were generated.

No assurance can be given that this discharge process avoided the transfer of infection, however, we do know that there was infection in the community which may have been transferred into hospitals. The then guidance presumed that infection could be managed in closed settings; no testing regime existed.

Creating capacity in Social Care

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Both LAs took steps to create additional capacity, both physical and manpower, in anticipation of not only demand, but the potential impact of COVID on the available social care workforce. However, the most important, and bold, step was taken collectively by the emergency RPB. Despite national pressure to not be so transparent, the RPB publicly launched revised social care 'eligibility' criteria. This work emphasised the need to prioritise and manage safe care. The strategy sought to avoid care home admissions and unnecessary personal care where a safe alternative family or community option was available. The RPB remains the only one in Wales to take this necessary strategic move in a transparent and open form.

Escalation

The strength of the local partnership, irrespective of tensions that inevitably arise, has allowed the region to have a strong voice on the national stage. The weekly meetings held between the Chair/Leaders/Chief Executives and lead officers from the LAs and Health Board have enabled this.

Key issues relating to testing, PPE, the shielding programme, and much more, have been regularly raised via political and managerial routes. These include;

- LA Leaders' meetings with WG
- LA Chief Executives' meetings
- WLGA
- ADSS
- HB re TTP liaison
- HB Chief Executives' meetings
- HB Chair meeting

It is evident that strong partnership working locally has facilitated advocacy on behalf of the local community interests, rather than the parochial needs of individual organisations.

Learning and Future Preparedness

It remains the case that future surges in COVID 19 are possible whereby infection rates increase, along with hospitalisations and, ultimately, deaths. The easing of lockdown and the potential for annual flu and COVID to occur at the same time are real risks.

The Health and Social Care system is undoubtedly better placed to cope with future surges as a result of recent experiences and developments. There is, of course, no room for complacency.

The areas that have benefitted from learning and development include;

1. **Capacity**

   NHS capacity has been both released by stopping non-essential services and reducing the numbers of Delayed Transfers of Care/Medically fit for Discharge, and increased by

the provision of field hospitals. The former will reduce as services are re-opened, but the latter is a significant addition in the medium term at least. The NHS has devised clear trigger points to respond to increased activity levels at 'surge' and 'supersurge' levels.

Social care has created additional capacity by adding beds. Additional flexibility has also been created by adopting (albeit time limited) new eligibility criteria focused on safety. Both organisations have demonstrated an ability to flex staff and increase numbers to deal with peak demand.

2. Infection Control

Working practices are now well established. The use of full PPE and isolation are now the norm in the event of an outbreak. The support systems provided by Public Health and EHOs are now well established and clear.

3. Prevention of spread of infection

A new discharge protocol has been agreed regionally, founded on the principle of 'not knowingly transferring infection'. The process of embedding this principle systems-wide is underway.

Testing protocols are now established, and capacity is in place locally to respond promptly to outbreaks. A regular programme of routine testing is also established.

The introduction of TTP will identify clusters and allow for intervention, including specialist advice and assistance, at the earliest possible time.

4. Ethics

The immediate ethical issues have been addressed, particularly by adopting the 'not knowingly transferring infection' protocol. This should stand us in good stead in most scenarios. If any surge were so large as to completely overwhelm the enhanced NHS capacity, the ethical implications would need to be overtly considered as indicated earlier.

Undoubtedly the local risks sit within a national policy framework, set at UK and WG levels. The timing of further lockdowns, local or national, and the continued effective use of TTP are key determinants, largely outside the control of local arrangements.

Conclusion

This report gives an overview of the partnership approach to care homes and more.

The partnership can give a good level of assurance in terms of complying with extant guidance, and challenging it, when appropriate.

There are, however, a number of areas, notably national NHS capacity-creation, where assurance cannot be given in relation to the transfer of infection or harm. This does,

however, need to be viewed in the context of the then paucity of facts in relation to the nature of COVID, and the national imperative.

The partnership cannot be accountable for that.

The period March to June has seen rapid development in terms of the national and local response to managing COVID 19. The region is undoubtedly better prepared to deal with surges in activity going forward. However, the risks remain high and whilst the possibility of the NHS being overwhelmed has diminished, it is that scenario that is the most difficult to prepare for.