# RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL

## MUNICIPAL YEAR 2020/21

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| **HEALTH AND WELLBEING SCRUTINY COMMITTEE** | |
| **8TH DECEMBER 2020**<br><br>**REPORT OF THE GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES** | **Adult Services: Covid-19 response and winter planning** |

**Author: Neil Elliott, Director of Adult Services.**

## 1. PURPOSE OF REPORT

1.1 The purpose of this report to provide the Health and Wellbeing Scrutiny Committee with an update on Adult Services response to the Covid-19 pandemic in Rhondda Cynon Taf. This report also provides an overview of the plans in place across health and social care that addresses the challenges associated with both the Covid-19 pandemic and the usual winter pressures across the Cwm Taf Morgannwg region.

## 2. RECOMMENDATIONS

It is recommended that the Health and Wellbeing Scrutiny Committee:

2.1 Acknowledges the information contained within the report; and

2.2 Scrutinises and comments on the information provided.

## 3. REASON FOR RECOMMENDATIONS

3.1 To provide the Health and Wellbeing Scrutiny Committee with an opportunity to examine Adult Services Covid-19 on-going response and the plans in place to support the increased pressures placed on health and social care during the winter period.

## 4. BACKGROUND

4.1 The Social Services and Wellbeing (Wales) Act 2014 ("the Act) sets out how people's care and support needs should be met, ensuring local authorities place

people's wellbeing at the centre of all it does. The Covid-19 pandemic placed considerable pressures on adult social care making it necessary for the Welsh Government to introduce modifications to the Act, which provides a relaxation of some local authority duties around the provision of care and support needs, alongside an ethical framework specific for adult social care.

4.2 Adult Services in Rhondda Cynon Taf continues to work within its statutory duties, although there continues to be some temporary disruption while we prioritise services and modify care and support offers, based on assessed need and risk.

4.3 As the pandemic continues, Adult Services are experiencing growing pressures as more people need care and support, and whilst currently all decisions are being made are in line with our Act duties and other Covid-19 guidance, we may need to revisit these decisions in the future if we face any significant staffing and demand pressures as a result of changes in the infection rate relating to Covid-19.

4.4 The Covid-19 pandemic has meant that Adult Services has needed to implement new ways of working and extensive national guidance, in partnership with health and social care providers and partners, to ensure the continued delivery of quality care and support through the pandemic period. The guidance has been very frequently revised and updated and a key role for Adult Services has been to ensure that partners and all providers are fully aware of and supported to implement new guidance. New and significant guidance continues to be issued.

4.5 The Covid-19 pandemic has brought changes to the lives of everyone in society and most particularly to those who use adult social care services and their carers. The majority of people who use adult social care services have complex health needs and/or disabilities and many have been "Shielded" during the pandemic period. There have been very significant demands on all staff working in Adult Services and across the adult social care provider sector.

## 5. COVID-19 CURRENT RESPONSE

5.1 At its meeting on 14th September 2020, the Health and Wellbeing Scrutiny Committee were provided with a verbal report in relation to Adult Services response to the Covid-19 pandemic and the developing recovery actions at that time.

5.2 The table below provides an update on Adult Services recovery actions, which are included in the Council's 2020/21 Corporate Plan.

| Actions | Update |
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| 5.2.1 Continue to assess and prioritise cases, in accordance with the flexibilities afforded by the Social Services and Wellbeing (Wales) 2014 Act, based on need and risk in a way that safeguards people and involves them and their families in decision making. | Assessments continue to take a person-centred approach as far as practicable and visits by social work staff are undertaken safely, where necessary.<br><br>The focus has been on ensuring that people with an assessed need and carers continue to be able to access information, advice, assessments and services and to minimise harm and adverse impacts in terms of the Covid-19 virus and of lockdown restrictions.<br><br>Changes to the way we work, and the services offered have impacted some older people and those with a physical disability, learning disability or mental illness. These impacts are mitigated through the use of interim support services for people and carers with the greatest needs. All arrangements will be reviewed at the declared end of the pandemic.<br><br>Workloads across adult services remain high and caseloads are becoming increasingly more complex as the Covid-19 pandemic continues and there remains a waiting list of cases awaiting allocation, across Care and Support and in the ACE Team.<br><br>The Council has continued to respond to safeguarding concerns reported. The referral rate into the safeguarding team is consistent with pre-Covid-19 levels and there is no particular pattern of concerns.<br><br>Additional external support continues to be commissioned to reduce assessment and review backlogs across Care and Support.<br><br>Accessing service provision is becoming more difficult due to capacity issues in some areas and increasing staff absence. This continues to be subject to ongoing review with the aim of ensuring people receive the care and support based on their assessed need. |
| 5.2.2 Continue to work with NHS Partners to ensure people are discharged safely and timely from hospital and supported in the community with | Hospital discharges have continued to be a priority for Adult Services and its providers – this work has increased through the pandemic and returned to pre-Covid-19 levels.<br><br>Capacity to take on new work has become more limited and delays arranging care packages and care homes placements (dementia and nursing dementia) are increasing and some discharges are taking longer to complete. |

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| appropriate health and social care support. | Covid-19 hospital outbreaks during the Autumn significantly impacted on patient discharges and new enhanced protocols have been developed to ensure that people with care and support needs are safely and expediently discharged.<br><br>Where people ready to be discharged to their own home or care home, this should only take place where they have been tested and have not tested positive for Covid-19. Where patients do test positive for Covid-19, the current agreed pathway is for a patient to remain in hospital care for the period when they continue to be infectious.<br><br>During November 2020, Adult Services supported circa. 130 discharges from hospital back home or to a care home setting. |
| 5.2.3 Continue to work in partnership with Linc Cymru to deliver the extra care housing schemes at Pontypridd (Cwrt yr Orsaf) and Porth and enable more people to live independently in their own home | Construction of the new state-of-the-art 60 apartment Cwrt yr Orsaf facility began during summer 2019. It will include dining areas, a communal kitchen, lounge areas, a hair salon and SPA, communal landscaped gardens, together with an integrated day care unit.<br><br>We are working close with Linc Cymru and their contractor Jehu – adhering to UK Government and Construction Leadership Council guidance to ensure social distancing. Construction at Cwrt yr Orsaf has remained ongoing during the whole of the Covid-19 pandemic and whilst experiencing some impacts and delays, the works have progressed well, for example:<br><br>• Concrete and lightweight steel frame superstructure works are complete and external brickwork on the lower ground floors is ongoing;<br>• Pitched roof trusses have been erected to all roof areas and roof tiling, fascias, soffits and rainwater goods is ongoing to pitched roof areas, including flat roof areas;<br>• Internally, room boarding and partitioning along with mechanical and electrical and carpentry first fix works have started from the lower floors upwards.<br><br>Artist drawings and photos of Cwrt yr Orsaf can be found at Appendix 1a & 1b of this report.<br><br>The majority of the work to be completed is now internal which is where the biggest impact of the |

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<tr><td></td><td>current Covid-19 measures will be experienced and it is with some caution we are reporting an anticipated completion date of August 2021 at this stage. This will be re-evaluated regularly during the remaining period.<br><br>Cwrt yr Orsaf will be the third extra care facility in Rhondda Cynon Taf after Ty Heulog in Talbot Green and the recently opened (May 2020) Maesyffynnon extra care facility in Aberaman. There are currently 22 residents living there and new residents are moving in based on need and risk. A video of Maesyffynnon can found at Appendix 2 of this report.<br><br>Extra Care proposals for Porth are being reported to Cabinet on 3rd December 2020.</td></tr>
<tr><td>5.2.4 Continue to work in partnership with housing providers to deliver modern additional supported housing accommodation for vulnerable people, including Crown Avenue, Treorchy and Oxford Street, Mountain Ash.</td><td>Crown Avenue refurbishment completed in early October 2020. Assessments of new tenants have started, and the first tenants are planned to move in during December 2020.<br><br>Construction of the Oxford Street, Mountain Ash has made good progress through the pandemic and is due to be completed in spring 2021.<br><br>Development of a new housing with care and support strategy for vulnerable adults is underway to confirm the Council's approach to ensure that it can adapt and respond to future service demands and requirements.</td></tr>
<tr><td>5.2.5 Continue to ensure that care homes and other care providers receive appropriate ongoing operational and financial support as the situation continues to evolve in line with Welsh Government guidance.</td><td>A range of measures remain in place to ensure, where possible, the resilience of our commissioned care providers in ensuring safety, capacity and sustainability of provision. Feedback from our care providers continues to be positive in that they have found this supportive - reinforcing our long-established relationships.<br><br>The Council continues to facilitate hardship funding allocated by Welsh Government to help meet the additional costs adult social care providers are incurring as a result of Covid-19. Payments made to external care providers between April and October are set out below:<br><br>
<table>
<tr><td>Domiciliary Care</td><td>£ 509,616.93</td></tr>
<tr><td>Direct Payment</td><td>£ 104,561.35</td></tr>
<tr><td>Residential Care</td><td>£3,726,159.84</td></tr>
<tr><td>Supported Living</td><td>£ 628,963.88</td></tr>
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| 5.2.6 Work with care homes to implement procedures with them to safely accommodate visits from friends and family in line with Welsh Government guidance. | Virtual visits remain an option for all care homes. In terms of physical visits, in accordance with current guidance, all care homes must be Covid-19 free prior to any visits being facilitated. If a positive result is reported within the care home, then all visits must be suspended for a period of 28 days, in line with Public Health Wales Guidance. Care home Covid-19 status can frequently change, but in the best interest of residents and their families we actively encourage visits when we are in a position to do so.<br><br>All Council care homes have developed robust risk assessments outlining the procedures visitors must comply with prior to and during visits. These include strict restrictions on who can visit, PPE and sanitizing guidelines when attending the care home. All care homes have identified safe visiting areas within the home and have introduced systematic measures to safely coordinate and record all visits.<br><br>We have also contacted all independent sector care homes sharing relevant guidance and advising that as long as they are Covid-19 free and have the required risk assessment in place which is in line with Welsh Government guidance that they can commence visits and thereby ensure a consistent approach can be maintained across the market sector. |
| 5.2.7 Continue to review options for phased opening of day and respite services in line with demand and social distancing guidelines. | Our current day service and respite offer is as follows:<br><br>All older people day centres are temporarily closed i.e. Tonyrefail; Trecynon; Riverside and Bronllwyn.<br><br>All older people with dementia day centres are open at reduced occupancy levels, in line with social distancing guidance i.e. Cwmni Dda (Trecynon); Lewis Merthyr Day Unit (Treorchy) and Tonteg Day Unit Pontypridd).<br><br>The following learning disability and autism day centres are open at reduced occupancy levels, in line with social distancing guidance:<br><br>• Llwynypia Leaning Curve<br>• Gadlys Learning Curve (Aberdare)<br>• Talbot Green Day Learning Curve<br>• Abercynon Learning Curve<br>• Danymynydd Learning Curve (Porth)<br>• Autism Life Centre (Trealaw) |

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| | All other learning curve centres and work-based projects remain closed, but we will continue to review the need to open the remaining centres based on demand and Covid-19 guidance.<br><br>The following learning disability respite accommodation are open, based on need and risk, in line with social distancing guidance - Beech Cottage (Aberaman); Belle Vue (Treforest); Ystradfechan Bungalow (Treorchy) and Brynsadler (Pontyclun).<br><br>In addition to the above, we are ensuring, where necessary, based on assessed need and risk, that there is alternative care and support at home through outreach services and direct payments for people and their families affected by these temporary changes. |
| 5.2.8 Work with regional partners to continue the phased reopening of regional equipment services to full capacity and restarting of windows manufacturing at Vision Products. | The Community Equipment Service at Vision Products continues to provide a full range of services, based on prioritised need and increases in demand, to health and social care partners across the Cwm Taf Morgannwg region.<br><br>Vision Products have been commissioned to provide regional management of Welsh Government issued PPE from 1st December 2020, following agreement by Bridgend, Merthyr Tydfil and Rhondda Cynon Taf Councils.<br><br>Manufacture and installations of UPVC windows on a phased basis commenced from October 2020 at Vision Products. |

5.3 The period since September 2020 has continued to be demanding operationally as we ensure that people with an assessed need who require information, advice, guidance, assessment, care and safeguarding are supported. Covid-19 has impacted so many people and as the pandemic continues, we have experienced an increase in requests for more intensive care and support.

5.4 Some people and their carers have elected, since March 2020, to decline services because of concerns about Covid-19. As a result, some people have relied disproportionately on carers and family during the pandemic and there is now evidence that this is leading to a raised demand for adult social care. It is clear that support for carers is becoming an increasing issue.

5.5 The separation from family and friends has been a difficult issue for many and particularly for people living in care homes and supported living environments who in normal circumstances would have contact with relatives and friends. The Council's Supported Living Service and commissioned providers have made

use of new technologies to ensure communication between family members and friends and as the pandemic continues providers are developing ways to enable contact, which is in line with recently issued Welsh Government guidance.

5.6 As the impact of the pandemic continues, we have noted a steady increase in staff across the adult social care sector unable to work due to self-isolation and Covid-19 symptoms as well as those diagnosed with Covid-19. There has also been a steady increase in staff isolating as a result of Test, Track and Protect and related issues such as childcare when children have been sent home from school needing to isolate. This steady increase is compounded by non-Covid-19 related sickness and the need to ensure all staff are taking their required annual leave. There are also understandable concerns about the very significant pressures on the resilience and wellbeing of some staff across the adult social care sector due to the impact of Covid-19 related anxieties and pressures of home-work life balance during this extremely challenging time.

5.7 Within Adult Services, we have continued to provide support and monitoring for our staff and we have worked with Human Resources via counselling, wellbeing and Occupational Health Services to ensure our workforce is appropriately supported. Some examples to date include:

- Human Resources staff allocated to specific employees to keep in touch with via telephone on a weekly basis (where identified as in need of specific support);

- Care homes given direct access to a senior counsellor for specialised support where staff experienced sudden or traumatic events;

- A new dedicated wellbeing helpline was set up on 27 March 2020 and was available to all staff to access via telephone or email. The wellbeing line offers support for both employee physical and mental wellbeing covering a range of topics such as mental and physical wellbeing, nutrition, sleep and weight management.

- Occupational Health have continued to provide a clinical service for counselling, nurse, doctor, physiotherapy and health surveillance via telephone (and more recently a restricted face to face appointments)

- A dedicated area was created on RCT Source with a range of support information for staff e.g. information of Covid-19 guidance, wellbeing area, nutrition, sleep and working from home.

- A dedicated 7-day Covid testing booking line for key workers and their families was introduced to increase the availability of testing capacity.

- Occupational Health have introduced the flu campaign, in support of the national drive to encourage people to take up the flu vaccine.

## 6. CARE HOMES

6.1 The Covid-19 pandemic has been challenging for care homes across Wales and Rhondda Cynon Taf due to the nature of the virus and impact on the older generations within our communities.

6.2 The impact of Covid-19 on our care homes, staff and residents has been significant. In Rhondda Cynon Taf, there are currently 37 care homes with a total of 1,449 registered beds for older people - in February 2020, care homes were reporting 165 empty beds and in September 2020 they are reporting 363 empty beds, but, importantly, we have not yet lost a provider due to the pandemic.

6.3 All care homes staff and residents are currently tested 2 weekly. This process has identified asymptomatic residents and staff and infection control measures are immediately followed in response. The current situation in Rhonda Cynon Taf care homes as at the 26th November 2020 is summarised below:

- 20 care homes have a reported outbreak and have to followed Public Health Wales 28 day Covid-19 free restrictions
- 51 staff with suspected or confirmed Covid-19
- 40 residents with suspected or confirmed Covid-19

6.4 Sadly, despite following IPC guidance and caring for people in isolation where this was required, Rhondda Cynon Taf has experienced deaths of people symptomatic or confirmed as Covid-19 positive in its care home population, including Council care homes. The fact that this was not unexpected in a pandemic from an easily spread airborne disease does not take away from the impact that every death had on family and the care home and adult social care. In light of this impact, we have continued to work with Human Resources, as mentioned above, to ensure our workforce is appropriately supported and the opportunity, where relevant, has been extended to independent sector care providers.

6.5 Welsh Government have developed a national action plan to support care homes across Wales following a rapid review by Professor John Bolton during the Summer. A copy of the rapid review for care homes in relation to Covid-19 is at attached at Appendix 3 for Members information. A summary of progress against these actions has been published at: https://gov.wales/care-homes-action-plan.

6.6 The Cwm Taf Morgannwg Regional Partnership Board have developed a regional action plan to focus on key areas identified through Professor John Bolton's rapid review and to help prevent the spread of the virus and to support

residents and care home staff. A copy of the regional action plan can be found at Appendix 4.

## 7. WINTER PRESSURES

7.1 As we move into the busy winter months, health and social care staff will be working together, building on our experience in previous winters, to deliver responsive and joined-up services throughout this winter season. Covid-19, means that this year looks very different so it's even more important that health and social care have a joint approach and plan in order that we are able to work collaboratively and provide the safest care for people in Rhondda Cynon Taf.

7.2 Winter is a high-pressure season for health and social care services, leading to increased demands on hospitals, GPs and social services. To keep people safe and well over the winter period, it is important that we work together to provide the right support at the right time - making sure that people are cared for outside of hospital, too. This is a key priority for the Council and in particular Adult Services.

7.3 As in previous years, Cwm Taf Morgannwg University Health Board has been required this year to prepare an annual Winter Protection Plan in response to the Welsh Government Winter Protection Plan. The Plan has been developed in partnership with regional statutory and voluntary sector partners and builds to demonstrate an integrated regional plan and an approach that is deliverable and addresses the challenges associated with both the Covid-19 pandemic and usual winter pressures across the region.

7.4 The Plan builds on existing plans that focus on preventing four harms by:

- Remaining ready to provide the full range of services needed to prevent, diagnose, isolate and treat Covid-19 patients and

- Ensuring that we can continue to provide services that are essential at all times. This includes services that are urgent and life threatening or life impacting as well as services that without timely intervention could result in harm over the longer term such as maintaining vaccination programmes;

- Reinstating routine services where it is operationally possible and safe to do so, with strict adherence to infection prevention and hygiene procedures and maximising the use of virtual consultations;

- Health and social care professionals working tirelessly to ensure people have been prioritised according to need and what matters to them.

7.5 The Plan also looks to support and retain new ways of working adopted in the first Covid-19 wave which supported integrated working between health, social care and third sector. This means:

- A whole system approach where seamless support, care or treatment is provided as close to home as possible;

- Services designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcome;

- People only going to a general hospital when it is essential, with hospital services designed to reduce the time spent in hospital;

- A shift in resources to the community that enable hospital-based care, when needed to be accessed more quickly; using technology to support high quality services.

7.6 A copy of the Plan, attached at Appendix 5 for Members information, was submitted to Welsh Government on 30th October 2020, following endorsement, as required by Welsh Government, by Regional Partnership Board.

7.7 Welsh Government as in previous years has allocated additional funding to support delivery of health and social care services during this winter and this has been further supplemented by additional Cwm Taf Morgannwg Health Board funding. For the Cwm Taf Morgannwg region, the Health Board and partners will look to deploy a circa **£10m** additional funding towards winter protection, subject to approval by Welsh Government, including:

Health Board Allocation - Primary Care: £1.2m
Health Board Allocation - Hospital and Community Health: £6.0m
Third Sector Allocation - Community Resources & Third Sector: £0.5m
Council Allocation - Discharge to Assess Pathways & Care Home Support: £2.0m

7.8 The announcement of the additional funding for delivery of Discharge to Recover and Assess Pathways & Care Home Support by Welsh Government on 5th October 2020 was very welcomed and will provide important additional capacity for care and support services that will prevent unnecessary admission to hospital and enable people to leave hospital when they are ready in order to provide care closer to home and limit time in hospital unless essential, in line with key commitments by Welsh Government and by this Council in our Corporate Plan.

7.9 Proposals include additional capacity to support:

- @home services (i.e. Stay Well @Home) and other domiciliary care provision
- Carers, including crisis support
- Community equipment services

- Social work and community occupational therapist assessments
- Care homes placements, including in particular 121 support for dementia

7.10 The discharge to Assess Pathways and Care Home Support funding has been allocated specifically to the Local Authorities in region. The breakdown of funding across the local authority areas is based on the social services funding formula and is approximately:

- Rhondda Cynon Taf - £1.2m
- Bridgend - £0.61m
- Merthyr Tydfil - £0.28m

7.11 A range of performance measures will be used to measure the impact of the Winter Protection Plan, including:

- Preventing hospital admission for specific conditions / complaints.
- Timeliness, quality and frequency of assessment in Emergency Departments.
- Improving flow of patients through hospital to reduce risk of harm and delays in onward care.
- Focusing on timely transfer home to reduce risk of harm and improve outcomes.
- Discharge data.
- Delayed transfers of care.
- Flu rates.

7.12 The National Programme for unscheduled and the NHS delivery Unit will support evaluation and measurement in relation to Discharge to Recover and Assess elements of the Plan and there will be regular progress updates through the Regional Partnership Board governance structure and within sovereign bodies as required.

## 8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 This is an information report - there are no equality and diversity implications associated with this report.

## 9. CONSULTATION

9.1 This is an information report - there is no consultation required for this report.

## 10. FINANCIAL IMPLICATIONS

10.1 This is an information report - there is no financial implications aligned to this report.

## 11. LEGAL IMPLICATIONS OR LEGISLATION CONSIDERED

11.1 This report identifies the work of Adult Services in Rhondda Cynon Taf that allows the Council to meet the requirements of the Social Services and Wellbeing (Wales) Act 2014.

## 12. LINKS TO THE CORPORATE AND NATIONAL PRIORITIES AND THE WELLBEING OF FUTURE GENERATIONS ACT

12.1 This report supports the Council's People corporate priority - promoting independence and positive lives for everyone.

12.2 The work of Adult Services outlined in this report contributes to the following wellbeing goals, namely: a Wales of cohesive communities, a healthier Wales and more equal Wales and due regard has been made to the five ways of working, as contained within the Wellbeing of Future Generations (Wales) Act 2015.

## 13. CONCLUSION

13.1 Whilst it is not possible to cover all of the work undertaken across Adult Services in response to the Covid-19 pandemic, this report highlights key issues and acknowledges the work and dedication of all care staff in Rhondda Cynon Taf. It also outlines the work undertaken in order to support all social care providers as they have worked with skill and commitment to provide quality care to people and carers through the unique and highly complex circumstances of the pandemic.

13.2 The response to the Covid-19 pandemic and the plans that are in place to support the increased pressures placed on health and social care during the winter period would not have been as strong without the partnership approach that we have established across health and social care partners and providers.


Main Entrance View


West Garden View


Cross Section thru Station & Union Street

Quattro designarchitects



www.quattrodesign.co.uk

**REVISIONS**
REV: DATE - DRAWN - CHECKED: NOTES
-: 14.05.18 - MJM: Drawing Created.

**PROJECTS**
Pontypridd Extra Care

**SCALE** NTS

**DATE** May 2018

**DRAWING TITLE**
Pre-Application Consultation Report, Board 3

**DRAWING NO.** **REV**
**5808-P-4102**

Matthews Warehouse, High Orchard Street
Gloucester Quays, GL2 5QY T: (01452) 424234

## Appendix 1b – Cwrt yr Orsaf (Construction Photos)

Maesyffynnon Extra Care
Aberdare

# Rapid Review for Care Homes in Relation to Covid-19 in Wales

## July - September 2020

**By Professor John Bolton**

## Commissioned by Welsh Government

# Rapid Review for Care Homes in Relation to Covid-19 in Wales

## Executive Summary and Key Recommendations

After a bumpy and in some places fragmented start the health and care sectors have worked very hard with care homes to reduce the spread of the virus in Wales. Overall, care home providers have appreciated the help and assistance offered to them. In particular there was consistent praise for support offered by Care Inspectorate Wales (CIW) in providing regulatory flexibility to help care homes ensure the well-being of all residents.

Prior to the final publication of this paper seminars have been run across the country to reflect on the best practice lessons that have been learned for both Local Authorities and Health Boards in order to assist them in preparing for any future wave of the virus and to assist in planning for the coming winter. The recommendations of the report have been fully explored and discussed and now have been converted into action plans by these regional partnerships. These action plans have been scrutinised and all of them were found to be complete and had considered the recommendations for Health and Care Partnerships that are made in this report.

This report has a strong emphasis on the need for co-production between the public sector and the independent and public-run care homes. The report tries to highlight where best practice has worked for both providers of care and public sector organisations, in the hope that partners across the public and independent sectors will be encouraged to continue to share learning and best practice in the future.

The following key messages came from this study:

- **Health and Care need to work in partnership with care home managers in order to ensure that:**
- **Every care home has an effective Infection Control Plan that is put into place;**
- **Every care home has an effective plan for business continuity that includes ensuring that there are staff available to meet residents' needs;**
- **Every care home should be supported to ensure there are meaningful and helpful day to day activities for residents and that the wellbeing of both staff and residents are taken into account in all the decisions that are**

**made. This must include help offered to ensure that residents can remain in touch with relatives and friends;**

- **Every care home has the right protective equipment;**
- **Every care home has access to tests for residents and staff to know who may have the virus;**
- **Every care home has good access to primary health services including GPs.**

The report includes sections summarizing the methodology used to produce this report, the context for care homes, the initial impact of the virus and the response, the best practices that were found in helping care homes to address the pandemic and the final section draws together a set of considerations that health and social care partners could use to assist them in completing their action plans for the winter. There are some appendices referred to in the document.

# 1 Introduction

This "rapid" review was commissioned by the Welsh Government in order to ensure that the lessons from best practice are learned and shared by Local Authorities and Health Boards who were involved in working with care homes during the initial period of the Covid-19 pandemic in the spring and summer of 2020. The work for the review has included reading some research studies, reading many submitted reports by Health and Social Care leaders from Wales and a series of interviews with stakeholders including a number of Care Home managers and owners.

Contacts were made with all 22 Local Authorities, 9 Health Boards (of which all the relevant eight Boards responded), Care Inspectorate Wales, The Older People's Commissioner for Wales, The Children's Commissioner for Wales, The Equality and Human Rights Commissioner for Wales, Care Forum Wales, Social Care Wales and Public Health Wales (all of whom responded). There were also additional interviews with 15 care home owners, General Practitioners and Environmental Health Officers. Interviews were conducted using Microsoft Teams (the majority), Skype or Google Meet. On average there were four people who joined each interview. For example, a Local Authority might involve any combination of the Director, an Assistant Director, a Senior Commissioning Officer, Contracting Officers an Environmental Health officer, a Public Protection Officer, a Health and Safety Manager or a Senior Social Worker. In total over forty interviews were conducted.

After an initial report was drawn up and shared a series of seminars were held in order to ensure that the messages from best practice were discussed and understood by Local Authority and Health Board partners in each region. This final report has been

produced following those seminars and scrutiny of the resulting action plans from each of the regions.

For a number of reasons it was not possible to arrange any meetings with people who had used care home services during this period. There was good information from people with experience of services and carers shared from the Older People's Commissioner and from Care Inspectorate for Wales. The interviews took place in July 2020 and the seminars in August 2020.

The review has mostly focused on the issues that have impacted on older people during the pandemic. There are a few references to younger adults living in care homes though they broadly seem to have been protected from the virus. The Children's Commissioner was contacted to hear her views and to capture key messages from her.

From the outset, the virus presented a real challenge to the owners, managers and staff working in care homes. Some staff were unable to work as they were required to stay shielded (either to protect themselves or people with whom they lived), or they had to keep socially isolated for an initial period. Those who went into work faced unknown conditions, a potentially deadly virus and often limited (or even none) personal protective equipment (PPE). They were, not surprisingly, highly anxious, very concerned both on behalf of the people for whom they cared and for themselves and their families. Despite this they rose to this challenge and gave a massive service to support a range of highly vulnerable people who lived in care homes. This report starts by recognising the selfless service and the highly professional commitment that these staff, managers and owners provided in the most challenging of circumstances. In addition, many staff in the public sector worked incredibly hard for long hours to offer the support and guidance to assist care homes in best managing the virus.

Through this report I offer my personal condolences to those who lost loved ones in care homes from Covid-19. It had been a difficult time not only for staff but also for relatives and friends of those who died in care homes sometimes without any opportunity for people to say their "good-byes" or for people to have a full funeral in the way in which they would have been able to do prior to the virus hitting the care home sector. I can at least assure those relatives that during this study I found care home owners, managers and health and care staff who were working diligently and professionally to try and reduce the impact of the virus into care homes. There were some problems of coordination and of understanding the nature of the virus in the early stages but once these were ironed out the sector has worked hard to reduce the risks.

Throughout this paper reference is made to "care homes". This includes all residential homes and nursing homes that offer care on a permanent or temporary basis to adults of any age.

Even after six months of the virus spreading across the United Kingdom it is clear that scientists are still learning more about the virus, its nature and behaviour and the way in which it spreads. Much that was not known in the early days has only been discovered as the work to protect people continues. This has of course had an impact on the frustration and sometimes confusion in the care sector about what has to be done. Much of what people shared in this review has been developed over time. A lot of what we now know to be good practice was much less known at the start. The material shared in this report has mostly come from the participants themselves. This demonstrates the strong commitment and resolve of all partners to look to protect care homes particularly if a second wave of the virus hits communities which is what many experts predict will happen.

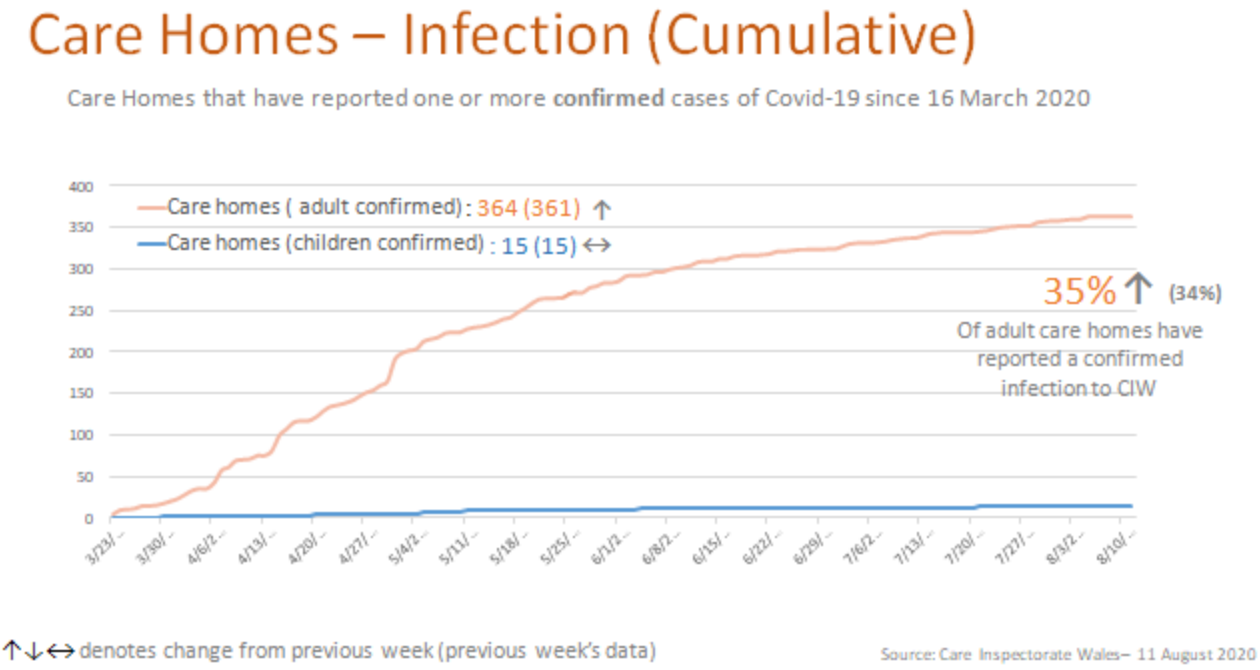
## 2 Background: Care Homes in Wales

There are 1294 Care Homes in Wales caring for 26,681 people of all ages. These are made up of 217 Children's Homes (with capacity for 927 children), 814 homes for adults and older people (13357 people) and 263 Nursing Homes (12397 people). The majority of places for older people in care homes in Wales are funded by Local Government or the NHS. There is variation in this by local authority area. In Monmouthshire, Denbighshire and Wrexham for example the majority of beds are occupied by self-funders. In Neath Port Talbot, Gwynedd, Rhondda Cynon Taf and Ceredigion the vast majority are funded by the Local Authority/ NHS[1].

The majority (75%) of care homes for older people in Wales are owned by a single owner or an owner who has less than five homes. A much smaller percentage of homes are owned by larger group providers (8%) or by local authorities (17%)[2]. 29% of care homes in Wales for older people are run by organisations based in England. Care homes can expect to function with occupancy of between 85%-90%. There are parts of Wales where care homes did not reach these levels before the pandemic. This was already presenting a problem for the sustainability of the sector which of course is further challenged by the lower occupancies now being seen as a result of Covid-19.

[1] Study undertaken by Institute of Public Care in 2015 – The Care Home market in Wales: Mapping the sector IPC (2015).

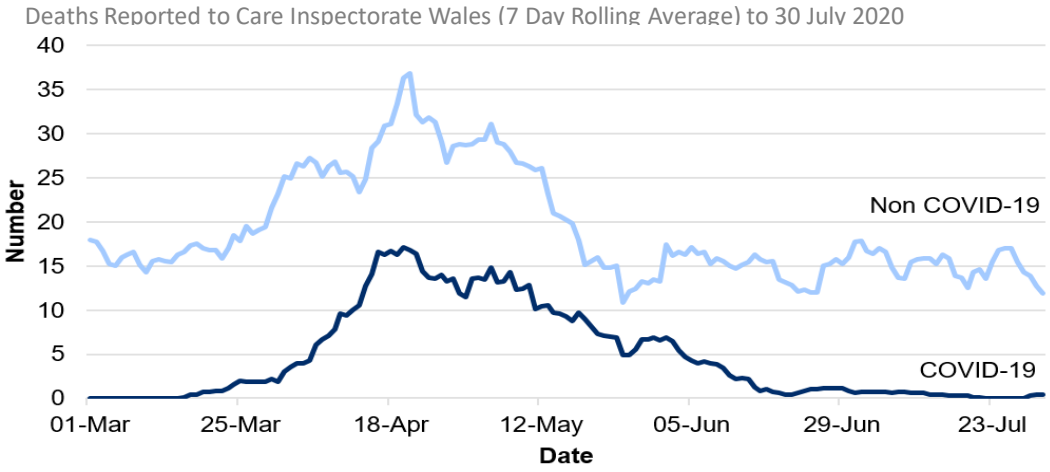
[2] Information from CIW Annual Report (2018-19) and Study undertaken by Institute of Public Care in 2015 – The Care Home market in Wales: Mapping the sector IPC (2015).




As reported by Welsh Government on August 12th 2020 there had been 364 care homes for adults reporting a minimum of one case of the virus and 15 care homes for children with a report of the virus being present. This means that 35% of adult care homes reported a confirmed infection. This reached a peak at the end of May and though there has been a steady increase since (thanks to the increased testing) it has not been at the rate that was experienced in April and May. Care homes are now able to appropriately help those who have caught the virus (through social isolation etc).

Care homes were required to report all known Covid-related deaths to Care Inspectorate Wales. The diagram below shows that the Covid-related death rate (7 day rolling average) peaked in mid-April and has been declining since then. From the middle of June the newly reported deaths in care homes from Covid-19 has been very low. The period from the end of March to the beginning of June was particularly challenging for care homes and those helping them.

# Care Homes – Mortality (CIW)




*CIW are notified of deaths of all residents, regardless of location. Notifications are not based on clinical assessment as to cause of death.
** This data is now updated fortnightly

Source: CIW 4 August 2020

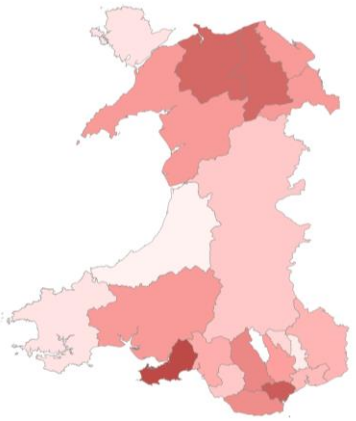
The Office for National Statistics[3] report that "…*in Wales mortality rates were statistically significantly higher for male Care Home residents than for female residents".* They also report that in Wales deaths involving Covid-19 were higher in the care home population than in the non-care home population. Finally, they report that residents of care homes were much more likely to die within their care home setting than in a hospital.

The infection rates in care homes for adults and older people have varied between regions with the higher numbers of care homes with reported infections in the Swansea and Cardiff areas followed by Conwy and Denbighshire and the lowest numbers in Merthyr Tydfil and Ceredigion. The reported cases in care homes for children included 4 for Powys and 2 for Bridgend and Vale of Glamorgan.

[3] Deaths involving Covid-19 in the care sector, England and Wales.

# Care Homes – Infection by Location

Adult Care Homes that have reported one or more **confirmed** cases of Covid-19 since 16 March 2020



| Local Authority | Adult Care Home - Confirmed Cases |
|---|---|
| Swansea | 32 |
| Cardiff | 29 |
| Conwy | 27 |
| Denbighshire | 27 |
| Rhondda Cynon Taf | 22 |
| Vale of Glamorgan | 21 |
| Carmarthenshire | 19 |
| Flintshire | 19 |
| Gwynedd | 19 |
| Wrexham | 19 |
| Caerphilly | 18 |
| Neath Port Talbot | 16 |
| Monmouthshire | 15 |
| Newport | 14 |
| Bridgend | 12 |
| Powys | 12 |
| Blaenau Gwent | 10 |
| Isle of Anglesey | 8 |
| Pembrokeshire | 8 |
| Torfaen | 7 |
| Ceredigion | 6 |
| Merthyr Tydfil | 4 |

**364**

Adult Care Home - Confirmed Cases

Source: Care Inspectorate Wales– 11 August 2020

## 3. Background: The Covid-19 Lockdown Phase

The Covid-19 pandemic hit Wales in February/March 2020. This led to action from the Government to ensure that there was enough capacity in the acute hospitals to meet the health needs of any citizens who required hospital care as a result of contracting the virus. During March 2020 some patients in acute hospitals who were medically fit were discharged from hospital and placed with care and support either in the community (mostly in their own homes) or in residential care homes. At this time there was much uncertainty in the United Kingdom about the nature of the virus, how it was transmitted and the associated risks. There were however studies from the United States[4], Italy and Spain that all indicated that older people's care homes were places that were likely to be at significant risk.

It is worth noting that the evidence about the impact of Covid-19 that was available was not widely known in care homes at the outset of the Welsh experience of the pandemic in March 2020– though a few owners (and other professionals) had read some of the research (cited in summary in Appendix Two). As a result of medical advice and local initiative many care homes in Wales locked down "early" in March 2020 (usually about two weeks before the formal lockdown from Government), but this did not prevent the virus from getting into some care homes quite quickly before the local systems were in place.

[4] McMichael TM, Currie DW, Clark S, Pogosjans S, Kay M, Schwartz NG, et al. Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington. N Engl J Med. 2020.

It is also worth noting that in March 2020 little seems to have been known about how the virus might be spread. There was a belief that it was spread through droplets (coughs and sneezes) but this was not fully understood. This meant that there was little clear understanding of the purpose of personal protective equipment (PPE) and how it should be used. As “experts” became more aware of the need for PPE so the alarm bells rang out in care homes. They had at best a limited supply and many had no supply at all.

The response to the challenge of the virus in the very early stages was described by many stakeholders as being “fragmented” with many different professionals all working very hard to do their best to understand what was happening and looking to reduce the impact of the virus on care homes. It probably took between two and four weeks from the first signs of Covid-19 in care homes in most places for an orderly and better managed response to emerge. The challenges in the early days included:

- A perceived view by many in the care sector that the NHS acute services were getting priority support as opposed to people who had care needs;
- A lack of knowledge of where and how the virus was spreading;
- A lack of knowledge in some places of the best forms of infection control against the virus;
- A lack of protective equipment (PPE) – specifically the right type of equipment to help protect staff;
- A lack of testing for residents and staff in the care homes;
- Staff off sick not being paid when they are required to shield or socially isolate (some coming into work);
- Regular or agency staff being brought in who also worked in other settings;
- A difficulty for some people in obtaining supplies for care homes including food and pharmaceutical goods;
- A large number of public bodies all looking to play their role in the system but sometimes “tripping over” each other to collect data and to understand what was happening in specific care homes without obvious benefits to the care homes themselves;
- Some professionals who were involved in assisting care homes had no previous experience of working in this sector and did not fully understand that a care home is a place where someone lives and that the quality of their life is one of the most important aspects of the care delivered;
- The use of inappropriate interventions to “assist” Care Homes in addressing the virus especially the use of “Safeguarding Procedures”;
- A lot of advice and guidance (including formal guidance) issued in the first few weeks. Sometimes this was issued at short notice (e.g. on a Friday before a bank holiday weekend) and it was not always clear to people busy running care homes

how the latest guidance had been changed from the guidance issued the previous week;
- Some confusion between what was being said by politicians and press in Westminster and the official policy in Wales;

Fortunately this phase only lasted for a brief period in most places and quite quickly a good working relationship was established between those providing care and those advising them.

From the evidence collected in this quick review it is absolutely clear that care home owners and managers have overwhelmingly only had one primary concern - to protect older people and younger adults from the pandemic whilst trying to maximise their residents' enjoyment of life. Best practice suggests that care homes must be treated as equal partners - experts in providing day to day care - who are committed to their residents' welfare. There were areas where care homes required help and support. Some of this they received from other care homes (including Council-run homes) and other areas where Public Health Wales, Care Inspectorate Wales, Environmental Health officers, Infection Control Nurses, Social Care Commissioners, Health workers, GPs, Geriatricians, Public Protection, ambulance paramedics and other care professionals where co-ordinated advice and support proved invaluable. Where this support was disjointed, uncoordinated or disparate it was experienced by care homes as a bureaucratic nightmare.

It is important that the public sector works as a single agent in full partnership, recognising each other's roles and responsibilities in order to maximise the benefits of their advice and support for care homes. There are some excellent examples across Wales of local partnerships working together in a multi-disciplinary way to assist care homes, though in most places this took at least two weeks for it to all come together.

There are two major areas where concern has been expressed by stakeholders about the way in which the care home sector has been protected during the pandemic. These are the availability of personal protective equipment for staff (PPE) and the availability of testing for the virus for both residents and staff. These issues have been well documented and covered in local and national media. At the time of writing this report it appears that both of these matters have been resolved after a very worrying period (for staff and residents in care homes) through a combination of partners working well together led by Welsh Government. The availability of free personal protective equipment co-ordinated and purchased through Welsh Government and distributed locally is very much a welcomed action by local authorities and care homes alike.

Some care home owners reported that despite enormous efforts from the local authorities and multiple directions and guidance issued to them that they felt very much

on their own (there were places where local authorities were reported to be more supportive than others). These providers believed that they have got through the virus through mutual support, shared advice and by developing their own evidence of what has worked. In addition they stated that some of the guidance appeared to be written by people who had little understanding of the lives of residents in care homes and they would have benefitted of checking their advice with providers before issuing things that were impractical and unworkable.

# 4 The role of Health Boards and Local Authorities

## 4.1 Strategic arrangements

**Each partnership might consider the nature of their relationship with their care home providers and ensure that future work is carried out in a spirit of true partnership with those providing care to some of the most vulnerable adults in the health and care system.**

**At a local level there needs to be an operational group that is clear on their roles and responsibilities that can coordinate the support that is needed by different care homes.**

An important feature in tackling challenges such as the pandemic and its impact on residents and staff in care homes is to recognise that the concerted actions of professionals has to be undertaken as a partnership. The partnerships operate at a strategic level for senior managers as well as at an operational level. In addition, in many places people commented on the importance of local political leadership in both empowering their officers to do the “right thing” including allocating additional resources and as a conduit between local agencies and national government.

There was a need to bring together the very different cultures from health and social care as well as the different values that people brought to the effort. There was often a tension created between those who had a ‘can-do’ attitude and just got on with trying to ‘do the right thing’, and those who were concerned that the governance wasn’t in place for certain actions to be taken. These are natural tensions and they require good leadership to resolve them. In many places (but not all) it was reported that as time has gone on some of these cultural differences have been ironed out and much better working relationships and mutual respect are now in place.

In most Health Board regions a “cell” was established to support and co-ordinate the operational actions in relation to Covid-19. In parallel with this Local Authorities established their own working group to co-ordinate their efforts to reduce the risks of the pandemic. These initiatives have now led to a joint Strategic Board between the Local Authority and the Health Board and a joint operational (multi-disciplinary) group. It is

advised that the Strategic Board (but not operational multi-disciplinary meetings) should have representatives from independent care homes on that Board.

At local operational level this means ensuring that the skills and knowledge of all of the following are pooled: Health Care Staff (Health Board Commissioners/Planners/ Contract Staff/ Complex Care Leads/ Pharmacists, GPs, Palliative Care leads/ community/district nurses, Infection Control Nurses, mental health services); Local Authorities (commissioners, contract monitoring, social workers, environmental health and their corporate centre); Care Homes (including managers, staff, residents and relatives); Care Inspectorate Wales and community and advocacy-based organisations.

No one party can manage the range of issues that need to be addressed. Good communication, respect for and an understanding of each other's roles and a willingness to work as partners was found to be critical in supporting care homes to best manage the pandemic when it did occur and avoid it where it had not occurred. It is worth noting that there are some attitudinal differences in relation to how the public sector views care homes run by independent providers. In the some places the care home owners, managers and staff are seen as partners playing a really important part in the health and care system looking after older people in their later years and caring for younger people who require intensive support. In other places they can be seen as "commissioned services" which require monitoring and support to ensure they were doing the right thing. The view of the care home sector that was taken locally by the professionals working in the health and care sector made a difference to how care homes experienced the help they received.

There are some excellent examples of operating procedures that spell out the specific roles of organisations and individuals in the health and care system which then helped clarify the different parts different professionals had to play. One important role for the strategic leaders was to ensure that the different skills available were brought to bear in the most effective ways.

Managers who are running care homes reported that they responded best to the advice offered where this was done in a spirit of partnership and collaboration. Where providers were seen only as 'providers' who needed to be directed by the local authority or health board, their response was more mooted. One provider reported, *"There was too much command and control from the authorities and not enough practical help*". Another said, *"I always felt they were making a judgement on me rather than trying to help".*

In many councils local authorities run their own residential care homes. This gave them some direct insight into the problems that managers, staff and residents were facing. There are many examples of local authorities creating partnerships with the local independent care sector in order to share best practice and together face the

challenges that the virus brought. In the best examples the local authority brought together Social Care, Environmental Health, local health practitioners and Health Board officers, as well as care home managers to have regular calls to offer mutual support and to identify where there were risks in the care home sector. Local Authorities had to recognise their dual role as a provider of care but also their responsibility to advise and assist the independent care homes to protect their residents from the pandemic.

Local Authorities and Health Boards found that one of their roles was to advise care home owners and managers on new guidance when it was issued to ensure that it was understood and implemented appropriately. As has already been stated often guidance was issued at awkward times - late in the week, sometimes before a bank holiday weekend and it was sometimes seen as being unclear on its difference from previous guidance. Sometimes there was confusion for care home staff as to the media coverage of the guidance in England and announcements from the UK Government and the nuanced differences that the Welsh Government had chosen to make. This was sometimes compounded by the guidance being used by those providers who had care homes in both England and Wales. The role of health boards and local authorities to help interpret and communicate the guidance to care home managers who were busy keeping their operations running became an important feature of local work.

There are some excellent examples of joint strategic partnership boards working together to make executive decisions to ensure that the front line of care homes were being supported during the pandemic.

## 4.2 Operational support

### 4.2.1 Continuity planning and general support

**The Health and Care partnership should support each Care Home to have a business continuity plan**

There is an expectation that local authorities and health boards have continuity plans in place to address any “unforeseen events” that are likely to cause challenges to their emergency planning processes. It has emerged during Covid-19 that there should be continuity plans both for individual care homes and for the local health and social care partnership in relation to the actions that may be required from them to ensure the sustained running of the care home sector during a pandemic.

Care homes should have their own plans, but the public authorities will have a duty to care for and protect any residents who are at risk because of a shortage of goods/ supplies or staffing for a care home. Some local authorities had to ensure that food was delivered to care homes in the early stages when it was difficult to get food supplies from shops and also to link with local pharmacies at this same stage to ensure that the

right drugs were available and being delivered to care homes. Pharmacy advice was also required in some care homes in relation to managing the “Just in Case” boxes which are used for palliative care.

Many local authorities had daily calls with care homes to collect data and check how things were progressing. A couple of local authorities worked in partnership with health boards and CIW to ensure that there was one single form that their local providers had to complete before submitting it electronically to a place where the data could be safely stored and then used appropriately by different agencies.

Care home managers also found weekly webinars or Skype phone calls into which all providers could dial very useful (where they were made available). This not only ensured a consistent message to care homes but also offered a place to develop strong mutual support. Care homes developed good relationships with each other in places and this added to the support networks that helped managers get through the challenging times.

In the early stages of the pandemic some councils helped their local care homes to access provisions including food, cleaning materials and pharmacy goods as these were in short supply. Often the council could negotiate special arrangements with supermarkets and others when care homes’ regular suppliers were not able to get the provisions that were needed.

Appendix 1 includes a list of actions that care home managers, owners and some Health Board and Local Authority officers have advised might be the best ways to reduce the risks of such a virus in the future. This is worth consideration by anyone working in the sector. This of course relates closely to the recommendations laid out in this report.

### 4.2.2 Preventive measures to manage infection control

**Each partnership might assist in ensuring that there is an “infection control” action plan in place for every care home in their area.**

All care homes irrespective of their position need to be clear how they are meeting the required standards for infection control to ensure they are able to minimise risks. It is the professional responsibility of public health, infection control nurses and environmental health officers (part of Public Protection Teams in Councils) to ensure and support this. For some council in-house services there was also additional support from their Health and Safety Teams. These are really important but scarce resources at the time of a pandemic so need to be used well without duplicating effort. There needs to be a clear protocol in place to ensure that each of these professionals is clear of their responsibilities within the care home settings. Probably the best equipped professional

groups to carry out infection control audits in care homes are infection control nurses who already provide this service to all hospital wards. They are familiar with the associated risks, are skilled in self-managing their own risks of infection and can offer good quick practical advice and training to front line staff. In addition Environmental Health Officers can play an important advisory and supportive role here. However, they were in short supply given the scale of the problem. Locally, partners need to allocate the resources available according to need but with a strong emphasis on preventive actions to reduce the risks.

Telephone advice can play a part, but the best evidence that informed this work was that undertaking a full in-person audit of any premises and offering practical advice as a result of that audit was the best way of ensuring that managers and staff understood what was required of them to reduce the risks of passing on the virus. This action is particularly important given the numbers of either staff or residents who have been found to be asymptomatic during recent testing. Every care home should be supported to ensure that a clear evidence-based plan for infection control is in place. Many care homes “locked down” at least two weeks prior to the formal government announcement. However the pandemic had already reached some Homes before then. It was found by those professionals in touch with care homes that they only had a basic understanding of the detail of infection control. In some places audits took place in care homes (irrespective of whether they had the virus or not) in order to offer advice and to properly train the staff;

Infection control is by far the most important knowledge that a care home needs to understand in order to reduce the risks of any pandemic. It is best managed through action in the following areas:

- Ensuring that a process of decontamination is consistently taking place;
- Ensuring the staff understand the proper use of personal protective equipment (PPE) and understand how to don and doff that equipment;
- Ensuring that staff are aware for the need to wash their hands properly and regularly as well as using hand gel as a contributor to cleansing;
- Ensuring that staff at all times follow social distancing practices including not car sharing, maintaining distances during shift changes and on breaks;
- Ensuring that the right chemicals are being used to clean the care home (chlorine based)
- Ensuring that meal times are properly managed achieving the aims above;
- Ensuring that any professional visitors are kept to a minimum and where they are required to visit (e.g. to offer medical support to a resident or to visit a dying relative) that they follow the above rules, including the current visiting guidance.

It has to be noted that after the initial uncertainties local authorities have done well to manage equipment stores with a good supply of PPE for all care homes. There may still be some advice required on the right form of protection for more specialist care but the distribution and availability of a stock was not reported to be an issue in recent weeks.

Care homes need to consider their layout and design in relation to the safest way to socially isolate individuals or groups of individuals who have tested positive for the virus whist maintaining a reasonable quality of life. This space needs to be linked to an identified sterile area where staff who are caring for these residents can put-on and take-off their protective clothing. It has been easier to find appropriate spaces in some settings than in others. Once Covid-19 is known to be present within a care home, advice should be offered as to whether it is feasible and practical to divide the care home into zones where those with a diagnosis of Covid-19 or who are required to isolate themselves can be cared for in a separate environment from those who have tested negative. There needs to be a local decision made with each home as to the safest way they can identify how the home can be managed with either individuals or groups of residents socially isolating. If this is not possible then there needs to be consideration of a short term move for such residents to an intermediate care setting where they can be helped and supported in their recovery from the virus. (See section on Intermediate Care).

It has been found[5] that the larger the care home the greater the likelihood that Covid-19 will be found in the home. There are of course a number of reasons for this ranging from the difficulty in ensuring all parts of the property are fully decontaminated to the coming and going of many people including staff, professional visitors, goods and services etc.

Some authorities made online training available for managers and staff around infection control. This is of course helpful although the busy schedule of people working in care homes during the pandemic has made access to these quite difficult. The broad view of infection control nurses who contributed to this review was that where possible it is best to offer direct training to staff on site. It is recognised that as this is scarce resource the on-line training does at least offer a sensible alternative.

Dealing with infection control and hearing the messages that need to be given can create anxiety and additional concerns amongst the staff team working in a care home. It is important that though this is probably the most important area that requires attention and detail that the messages are given with sensitivity and recognising the emotional support that staff need when the pandemic is either in or feels close to the

[5] https://www.gov.uk/government/publications/vivaldi-1-coronavirus-covid-19-care-homes-study-report/vivaldi-1-covid-19-care-homes-study-report

care setting. As one respondent put it, “it is our job to help the staff feel they have become experts in managing the pandemic”.

### 4.2.3 – Staffing for Care Homes

**Each partnership might ensure there is a staffing contingency plan in place for their area. Health Boards may wish to seek guidance from Welsh Government on how this can be achieved within the current legal framework.**

**Each partnership might consider how they advise care homes on the best way to deploy staff during an outbreak eliminating those staff who work in more than one setting.**

**Each partnership might consider how they continue to support the well-being of all staff who have worked through the pandemic.**

The other key area on which care homes may require support is to ensure a good supply of “Covid-19 free” staff (including nurses and managers).

There is clear evidence emerging[6] that staff are the most likely carriers of the virus both from outside the care home and within the care home. In the section above, the importance of staff understanding infection control is laid out. There are other important considerations for staff.

When staff have been diagnosed as having the virus (Covid-19) they should not be at work. The evidence suggests that where staff are paid (sick pay) for socially isolating themselves there is a much higher rate of compliance.

It is also clear that staff who work in more than one setting (including agency staff) are much more likely to catch and spread the virus. Some Health Boards and Local Authorities asked the agencies they knew were used by their local care homes to limit staff to working in only one setting and a number happily complied. Other risks that have been identified include staff travelling to work together (car sharing) and staff socialising without observing social distancing during breaks in the day including in designated smoking areas.

With the need for a number of staff to be off whilst they socially isolated, the reduction in the numbers of staff who could be used from the agencies, and the shortage of staff working in the sector prior to Covid-19, there was a serious risk to the ability of some care providers to run their homes. This included the shortage of nurses who are formally required to be present in nursing homes. Some local authorities developed a bank of

[6] https://www.gov.uk/government/publications/vivaldi-1-coronavirus-covid-19-care-homes-study-report/vivaldi-1-covid-19-care-homes-study-report

their own redeployed staff to act as cover for any emergency situation. Often these staff had already been redeployed into the existing in-house care homes to act as additional staff often running activities for residents (as these were often staff whose substantive posts were in day centres). These staff became a pool of people who might be asked to volunteer to work in any care home setting across their authority area (including in independently run homes), though most local authorities only made these staff available for their in-house services. In most of these places staff were offered a course in basic care including manual handling, medication management, infection control and food hygiene before they were asked to start working. In one small council over 130 people were trained to be available if required. There were not only shortages of care staff but at times this could include catering and cleaning staff who were significant to the running of the home. One council redeployed their own staff into a privately run care home to meet an emergency when these critical staff were off.

All authorities might consider this being part of their contingency planning to support a care home under pressure – whether Council or independently run. It should be noted that these staff all volunteered to cover or add additional posts to care homes. Many care homes in both the independent sector and those run by councils paid an additional premium rate to care staff who have worked during the pandemic. One council increased its rate to time-and-a-half. These payments appear to have reduced the need for extra agency staff.

It was less clear whether Health Boards might adopt a similar approach to using nurses to support nursing care homes. There is a clear responsibility on Health Boards to ensure that there is good quality nursing available to support nursing homes as well as their duty of care for all residents. In a paper prepared for one Health Board (which noted the lack of precedent for action in ‘failing homes’) it was proposed that the Director of Nursing would provide staff to a nursing home in an emergency, if all other avenues had failed (e.g. there were no available agency staff), that the action would be short–term (no more than five days) and that the welfare of the residents would be seriously at risk if no action was taken. The Health Board determined to recruit a team of nurses that would work part time on other duties but who would be available to support a nursing home in the circumstances described above. The recruitment had not taken place before Covid-19 so a team of nurses were on stand-by but not required during the recent pandemic. This appears to be the best approach in an emergency. In more than one place the Health Boards have provided volunteer nurses to help out in an emergency on the basis that at the time it was “the right thing to do”. This of course has only happened in an exceptional case where the alternative would be moving a whole group of residents – probably to a hospital ward.

A couple of Health Boards made their own bank staff available to the wider sector, but this was not used (to my knowledge). It was reported that at least two Health Boards

propped up a Nursing Home over a challenging weekend bringing in their own health and care staff. The thought in most Health Boards was that if a nursing home was unable to function that the Health Board would have to consider moving all of the residents to an intermediate health care or hospital setting (at a high cost and with great inconvenience to residents). Health Boards might usefully consider the contingency plans they should put in place to support the nursing homes during a pandemic.

Many care homes (including those run in-house) used additional staffing to assist them during the pandemic. This was necessary to maintain the social isolation of some residents in order to limit staff to working in smaller groups (to reduce the risks of cross infection) and to support residents in social activities including making contact with relatives. In many cases the additional staffing hours were made available requiring additional resources with staff prepared to work longer hours (overtime) to meet local needs. One pattern of shifts for staff was to work for 3 days on a 12-hour shift and then have a 3- day break. Initially these costs were met by care home owners. The hardship fund (see later section) was subsequently available for residential care homes.

There were a couple of occasions where the local multi-disciplinary team considered that advice from a senior nurse would assist in the running of a residential care home. This would not be for the nurse to run the home or to have any management responsibilities but to ensure that the best health care of residents was being considered in the home.

There is no doubt that there was pressure on staff and their managers whilst working in the context of Covid-19. Staff were required to shield themselves or to have periods of social isolation when they were absent from work. Those who remained at work were remarkably loyal and worked additional hours (some even sleeping in the care home to reduce the risks of infection). For everyone it has been stressful and emotionally draining. Local Authorities and Health Boards may wish to consider which of the facilities that they run for their own staff may be of benefit to staff in care homes during a pandemic (e.g. Occupational Health) and make these resources available to the independent sector.

There was a specific problem highlighted from one area where a number of staff who worked in a home for adults with learning difficulties had to be off work at the same time (included some shielding and some self-isolating). This left only two of the permanent staff on duty and this presented a challenge for the residents who felt much more comfortable having people they knew to care for them. It was hard to find a solution for this problem except to get the regular staff back as safely as was possible.

The well-being of staff was an important consideration. It is reported that staff can face very similar experiences to those who have Post Traumatic Stress Disorder (PTSD)

from working on the front line in the forces or in acute care. Various arrangements were put in place to offer counselling and support. These included using local psychological services, arrangements with local voluntary organisations such as MIND, access to human resources and occupational health services from within public bodies and counselling support offered on-line for staff to use including “mindfulness sessions”. One council ran a weekly webinar for staff to support their “well-being” which had originally been designed for their in-house services but the offer to join was extended to the independent sector. In one area an arrangement was made by the health board with the local hospice for counselling support and advice to be made available for care home staff.

Of course it is important that staff have time and space to wind down and support each other whilst they are at work. This may well be in a staff room or similar setting. It is important that staff understand the importance of maintaining social distancing during their breaks and other times when they might be together.

The Social Care Wales and the Social Care Institute for Excellence (SCIE) websites have some useful materials available to download which provide up to date advice and guidance for mangers and for staff on how to manage in the pandemic.

There is an important issue in relation to the disproportionate Black, Asian and minority ethnic (BAME) staff who were in positions where they were vulnerable to the virus in both health and social care settings. One Health and Care partnership reported that they paid particular attention to this and included these risks in their risk assessment tool (All Wales Covid-19 Workforce Risk Assessment Tool). This also warrants further investigation in the near future.

### 4.2.4 Care for residents

**Each partnership might consider how to assist all care homes in having meaningful activities in place for residents during any pandemic with a focus on activities that are appropriate for those who are socially isolating and for those with dementia.**

**Each partnership might consider how emotional and well-being support continues to be offered to all residents (including younger adults) even though the current pandemic appears to be easing in care homes.**

A lot of concern has been expressed about the emotional impact of lockdown on residents; this may range from missing loved ones, to frustration and boredom from remaining in the same environment, and the result of rapid and unpredicted changes to

living arrangements in care homes. There has been a clear recognition of the impact on the psychological well-being of both residents and staff. It is important that someone is listening to both residents and staff about their experiences and that future action is undertaken in response to the comments made.

People living in care homes have all been able to maintain contact with family members mostly through the use of Ipads. The Welsh Government provided funding to Digital Communities Wales: Digital Confidence, Health and Well-being Programme to distribute around 1,000 digital devices to care homes, hospices and wards to support residents to connect with their loved ones. Other Ipads were donated to the care homes by Local Authorities and some through local community fund raising and some assisted with Wi-Fi connections. One provider said that a larger screen would actually have made this contact easier for some residents. He suggested a 52" screen would be ideal for his residents. It is important to note that probably the most important communication that is required during a pandemic is that between the residents in a care home and their close relations. Many care homes set up regular newsletters for relatives and made arrangements for times when they would receive calls from relatives or developed Facebook pages to ease communication. For some relatives it is distressing when they can see (on video calls) the deterioration of a loved relation but are unable to reach out to them. One idea that was popular with residents was to ask relatives to send in photographs of themselves, grandchildren, favourite places etc in order to keep a memory going of the "outside world".

Many care homes have either taken on additional staff (almost all in-house council run care homes redeployed their day care staff to work in their care homes) or in the independent sector they asked staff to work additional hours in order to sustain the quality of experience for residents. This has proved a necessity in order to both meet the requirements of infection control and ensure a good quality of life for the residents. Councils have offered some direct support to care homes with a range of actions including:

- Reminiscing programme that are available on-line;
- Specialist "games" to assist people with dementia (See Alzheimer Society Website);
- Sensory boxes for adults with dementia (a programme that was started prior to the pandemic but proved to be very helpful during it);
- Special activities such as VE Day celebrations, gardening competitions, dance and parties;
- Concerts in the car park;
- Introducing "corridor bingo";

- Linking the home through Skype to local community organisations and friendship groups;
- Providing traditional games and games downloaded from the internet;

A study of what happened to residents during the SARS epidemic in Hong Kong[7] emphasises the participation of the residents in reducing the risk of the spread. It is important that, where reasonable, residents should be fully engaged in the actions the home is taking to protect them from the spread of Covid-19. The engagement of residents, and the sense of agency this encourages, is known to have a positive impact on their well-being and of sustaining their quality of life.

The hardest part of delivering the care was when a resident was required to socially isolate because they either had a diagnosis of Covid-19 or had been close to someone who had a positive test. This was usually for a fourteen day period. This required additional staffing to be with the person to meet their needs. This could be a particular problem for those with dementia who may be prone to wandering around the home (sometimes referred to as "walking with purpose") in normal times. Care homes were sometimes divided into red and green zones distinguishing between those who had a positive test for the virus and those who had not. One authority introduced a monthly questionnaire for residents to examine their Covid-19 care plan. This assessment used the "signs of safety" assessment for adults that focuses on: What are you worried about? What is working well for you? What would you like to happen? This is an approach which originated in Australia for child protection but has now been developed in working with adults[8].

Sometimes the design of a care home allowed for people to operate in small "protective bubbles" or teams where they could be protected and remain safe, but for other care homes their design and layout meant this was not possible. It was reported that some care homes used a "buddying" system where two staff worked together on the same shift most of the time in order to reduce the risk of any virus spreading.

One of the big issues during the main peak of the pandemic was the fact that residents could not safely "entertain" guest in their homes. This was overcome by the use of I-Pads and video conferencing which was very important. Recent guidance has now enabled more visits to take place in safe settings. However, some care homes did (very carefully and ensuring full infection control processes were in place) allow relatives to

[7] Tse MM, Pun SP, Benzie IF. Experiencing SARS: perspectives of the elderly residents and health care professionals in a Hong Kong nursing home. Geriatric Nursing. 2003;24(5):266-9.

[8] See work of Dr Tony Stanley Principal Social Worker London Borough of Tower Hamlets – An introduction to signs of safety and well-being.

visit and meet with relatives who were known to be dying. Though this would be done in full PPE it was very consoling for relatives and very appropriate for residents to have a final farewell meeting. The visits of friends and relatives to residents of care homes are known to be very important for the person's overall health and well-being. It is important that this is safely sustained wherever possible. Blanket decisions to stop close relatives and friends visiting people in care homes should not be taken lightly. Each care home can be assessed according to its known risks and the ability to manage infection control in the home. Visitors who are brought into an infection free place can be protected with PPE, with sanitisation, with keeping safe distances and thorough cleaning of the appropriate areas. If this is properly managed the risks can be negligible and are well balanced against the known benefits to the overall well-being of residents.

In addition, mental health services were commissioned to provide ongoing support for both staff and residents. These included people who had experienced the trauma of living in close proximity to the virus, the death of fellow residents and people for whom they may have been caring for a number of years and for those who are recovering from the virus. The support available had been commissioned so that people who were identified as experiencing difficult traumas, bereavement, depression and social isolation could discuss their feelings with a professional person (usually online) in a confidential setting. Where this support has been made available it has not been heavily used but is much valued by the recipients.

There was an incident where an adult with a learning disability required a non-Covid-19 related hospital admission. A member of staff accompanied her to the hospital to ensure she had someone she knew and understood her needs whilst she needed acute care. They stayed together until the person was ready to return to the care home.

### 4.2.5 Primary health care during the pandemic

**Each partnership might consider how they can assist local GPs in establishing clear enhanced arrangements for every care home in their area. Where this is not possible the practitioners who have patients in particular care homes need to be clear on their responsibilities and how they will carry them out.**

All areas and many care home managers reported on the continued engagement of District Nurses in carrying out their invaluable work for the care of elderly patients in care homes during the pandemic.

In some areas there was a lack of clarity on the roles that GPs might play to support care homes during the virus. There was some excellent practice (cited below) but in other areas care homes were unclear what they might expect.

On July 1st the new role of the enhanced GP was due to come into effect for care homes in Wales (known as The Care Homes Directed Enhanced Service – DES). This was however suspended by a directive issued on June 2nd 2020 (COVID-19 Care Homes Scheme Directed Enhanced Service Specification). Enhanced services are, in essence, elements of essential or additional services delivered to a higher specification, or medical services outside the normal scope of primary medical services, which are designed around the needs of the local population. The new directive laid out the following roles for GPs:

- Optimise access to primary medical care for care home residents.
- Enable urgent access to primary health care advice for staff in residential Care Home.
- Continue provision of pre-emptive proactive and anticipatory care.
- Promote a high quality consistent approach across health boards whilst at the same time being flexible enough to be adopted by clusters or individual practices.

In addition, the guidance stated that the roles of the GPs were to:

- Regularly and effectively engage with care home staff in the comprehensive management of care home residents on a weekly basis, termed for the purposes of this DES a “weekly ward round”, followed up where necessary with structured clinical consultations to Care Home residents.
- Allow General Medical Practitioners to support a multi-disciplinary team to provide comprehensive management of care home residents and ensure appropriate assessments are completed.
- Work with the cluster lead practice, local general medical practices and care home managers, to reduce the numbers of clinicians and community staff that need to visit care homes during the Covid-19 pandemic, e.g. by streamlining patient registration policies where it will benefit care to residents whilst preserving and respecting residents’ choice

In addition, there were responsibilities for new residents to care homes to have an initial assessment: *‘Each care home resident must have a comprehensive review of their mental and physical health completed within 28 days of moving in / being admitted to the care home. (A pro-forma template outlining the areas for review is at Annex B in the guidance). The Care Home will hold a copy of the completed initial patient review. The assessment can be conducted via remote audio-visual means when the home and resident are more comfortable from an infection control point of view. This review will include discharge medicines review to:*

- *Reconcile medicines prescribed.*

- *Address issues of polypharmacy.*
- *Address any antipsychotic prescribing and other high risk medicines,*
- *Update the record of prescribed medicines, maintained by the GMS contractor.'*

In some places the GPs that were already piloting the new enhanced role for care homes continued to provide weekly telephone assessments available to all residents. This meant that the GPs knew the residents individually, understood their longer term conditions and could recognise when people were ill and how best to treat them. In particular circumstances these GPs would actually visit the homes to personally examine their patients but generally this was not required.

Most areas reported that District Nurses continued to visit their patients in care homes during the pandemic and they of course complied with the requirements for infection control within the care home during their visits. In one area they encouraged homes to have (where it was feasible) a medical room which visiting health staff could use. The room would be decontaminated after each visit and there would be space for the staff to don and doff their PPE.

It was seen to be very helpful when staff in care homes became competent in taking daily measurements from their residents e.g. tympanic temperature checks, checking pulse rates, blood pressures and using Oximeters to check blood oxygen levels and to report these to medical advisers. This assisted in prioritising the right medical help for residents. This is particularly important when older people are known to not always show the symptoms of their conditions (atypical symptoms) including Covid-19.

In the early stages of the pandemic it was important to ensure that the correct proscribed drugs were available for residents in care homes. This required ensuring that pharmacists were supporting care homes and working in partnership with medical practitioners and care home managers to ensure both the correct supply and the right drugs were able to be correctly administered.

There was some confusion with regard to "advanced care plans" which would normally be in place for any patients who had capacity and in receipt of palliative care. In some places there were reports that GPs were not able to visit to work with their patients on these plans. Care home managers often felt that they did not have the knowledge or the skills to draft the plans and required professional support from health care staff. It was unreasonable to expect any staff to draw up these plans. The plans should be drawn up by involving the person (who must have the capacity to do this), their family members and appropriate medical advisers. It was important to distinguish between the necessity for these plans to be in place for those residents whose medical conditions indicate that

they are likely to die soon and those who may or may not be at risk of Covid-19. One of the important issues is to be clear that each advanced care plan needs to be written on an individual basis for each resident who meets the criteria. These plans should include much more than the medical assessment where it is noted that a person should not receive further treatment at a particular point in their condition. It is in essence a plan to assist a person to die with dignity in a way of their choosing.

### 4.2.6 Personal Protective Equipment (PPE)

**Each partnership might consider how they can assist care homes in ensuring they have equal priority for the available supply of PPE if there was a further pandemic.**

The supply of free PPE for care homes worked well once it was centrally distributed to local authorities and their depots have then distributed the equipment to care homes as requested. Most of the distribution centres have been externally audited by military stores experts and they have all met the required standards.

It was reported that the availability of PPE caused the most worry at the onset of the pandemic with a mixture of uncertain supply, mixed messages from the guidance and lack of a co-ordinated strategy. However, for the past few months after the Government took control over the supply and its distribution to care homes via Local Authorities it has worked very well. There needs to be some consideration as to how these arrangements might work in the future. Who is responsible for creating an adequate supply?

One additional issue was ensuring that staff are properly trained in the use of PPE. There were some earlier experiences where health staff visiting care homes noted that staff had not been fully trained. This was of course immediately remedied.

In the early days of the pandemic as soon as it became apparent that PPE was not easily available for care homes in some places there was a fantastic response from the local community sewing and making protective equipment and then donating it to their local care homes.

At the time of writing this report it appears that the Government will maintain its commitment to ensuring a supply of free PPE “until the end of this pandemic”. This is a notable commitment from the Welsh Government.

### 4.2.7 Tests for residents and staff

**Each partnership might consider how they can ensure that they have the processes in place to back up the test and trace arrangements for care homes.**

All partners interviewed said that they wanted an efficient and effective testing regime that enabled them to respond quickly to any risk this might include regular testing of both staff and residents in care homes, and an ability to track and trace where outbreaks are occurring and to take specific action to protect care homes and their staff.

Recent guidance that enables both staff and residents to be tested regularly has been well received in both care homes and with the public services. There were reported challenges in some places in getting back test results in a timely fashion.

Now that it is fully recognised that there are many people carrying the virus who show no signs of the symptoms (asymptomatic) it is even more important that staff can take tests regularly (for example, once a week) so that it is clear who may be carrying the virus and who may not. This makes a significant difference to the day-to-day running of any care setting.

The biggest concern expressed by many respondents was the policy for either returning residents from hospital or for new placements that were being proposed from an acute hospital. The current guidance enables care homes to not receive people back from hospital where they cannot make them safe (see sections above). This requires planning for intermediate care services (see below).

### 4.2.8 Risk Assessments for Care Homes

**Each partnership might consider how their local risk assessments are undertaken and how these are shared with care homes enabling them to take action to reduce their risks.**

Local multi-disciplinary teams from the public sector have tended to apply their own risk assessment approaches to care homes during the pandemic. At one level this can be quite simple – those care homes where the virus is present (or has been recently present) = Red Homes, and those where the virus is not known to be present = Green Homes. There is a desire in some places to look further at the running and management of the care home, at the known history of the care home in relation to regulation compliance, changes in senior staffing, assessment of compliance with safety standards etc. These together can make a more complex risk assessment. Other places have used a traffic light system to make a daily assessment of the “state of their care homes”.

It is essential that care homes have their own risk management action plans and that they are given confidence to believe in them – this is the best way for them to both take

ownership of the issues and to reduce the risks. If a risk assessment is going to be made on a care home and its ability to manage the pandemic, the evidence for the assessment must be shared with the owner/manager of the home and they should be assisted with an action plan to mitigate against the predicted risks.

### 4.2.9 Discharges from hospital

**Each partnership might consider how they arrange for short term beds (intermediate care) to be available to help the recovery of patients who have been in hospital and are required to isolate to ensure they are not spreading the virus.**

**Each partnership should ensure that acute hospitals understand and can use the local arrangements that are put in place to support the discharge of patients.**

There is no doubt that the virus spread into care homes in several different ways. One of the ways was when residents who had been in hospital returned to their homes having contracted the virus in hospital or new residents entering a Care Home for the first time after they had contracted the virus.

Guidance has been issued on the care pathways to support discharge from hospital during Covid-19[9]. It is expected that most people would return home and, in some places, 'Home-First Bureaus' were established to ensure that people could be supported in their own homes (in line with the guidance). It was recognised that a minority of patients may still require a bedded facility to support their recovery post-hospital and an even smaller number may be assessed as requiring permanent care at the point of discharge (though this is not considered to be good practice). One authority established a "find a place" website where providers could log when they had vacancies and when they were closed to new people. This is being developed across the country – "The Care and Support Capacity Tool" which currently has almost 900 Care Homes using it to post vacancies. (There is a separate system – Findaplace used in West Wales). The NHS Delivery Unit reported that they found most Regional Partnership Boards invested their additional monies (allocated to assist with speedy hospital discharges) in teams to support discharging people into their own homes (discharge to recover and then assess in their own homes), though recruiting staff quickly for these roles presented a challenge.

Guidance[10] currently states that no older person should return from hospital or move from an acute hospital to a care home without a negative test for Covid-19. It is not

[9] https://gov.wales/hospital-discharge-service-requirements-covid-19

[10] https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-healthcare-workers-in-wales/prevention-and-management-of-infection-and-outbreaks-of-covid-19-in-residential-settings-in-wales-version-4/

appropriate for those older people who are unable to return to a care home to stay additional days in an acute hospital as they need to start their rehabilitation and recovery period post-acute care.

It is important that Local Authorities and Health Boards work together to ensure that there are sufficient intermediate care settings where older people who are either self-isolating or recovering from the virus can live safely with the best possible care both during a pandemic but also when there is no pandemic in order to help with their recovery and recuperation. Some care homes were able to take residents back to their home if they could assure themselves that they could isolate the older people within the home. However this gave challenges for staff as well as the overall infection control within the home.

In most parts of the United Kingdom for many years care providers have not been "commissioned" in the true sense of the word. Providers have mostly made decisions as to where they think they might provide a service and then hoped that the local authorities and health commissioners will procure services from them. This means that the care home market has in many places grown in a less controlled way than some areas may require. For example there are more standard residential care homes than are probably needed but fewer homes for older people with dementia, particularly when this includes challenging behaviours. At this moment in time there are sadly some care homes with high vacancy levels. This does however give an opportunity to explore where it might be best possible for Local Authorities and Health Boards to commission "**short term recovery to assess beds".** (It is best that Intermediate Care beds are a separate group of beds designated for that purpose as part of a care home or as a separate unit). This could have a positive impact on both the need for recovery beds for patients who have experienced Covid-19 as well as helping to contribute to the overall plan for the winter[11]. The National Primary Care Programme has established a work stream to look at the function of step-up / step-down beds including designing a minimum specification for this key function. This will include community hospitals. It will build on the "right-sizing" work undertaken last year.

In my work (Commissioning Out of Hospital Care Services to reduce delays) [12] it is suggested that these beds should be:

- Short term, with a view to helping support the recovery of the resident with the prime aim to help them get back home (evidence suggests that a minimum of 75% of older people who are placed in these beds post acute care should be able to return home).

[11] https://ipc.brookes.ac.uk/publications/Out_of_hospital_care_to_reduce_delays.html
[12] https://ipc.brookes.ac.uk/publications/Out_of_hospital_care_to_reduce_delays.html

- Recovery-based so that they are over seen by therapists who can look with care staff at the best way of helping people to regain their strengths and confidence to assist them to return home;
- And that an assessment for the longer term needs of these residents is not made until after a period of working to support recovery has taken place (often at three weeks and again at six weeks after admission).

It is often good practice for commissioners to procure these beds on the basis of the outcomes they will achieve. In other words an expected standard can be set as a minimum on the numbers of older people placed in these beds who end up returning back to their own homes.

Health Boards and Local Authorities should look to ensure that they have in place sufficient intermediate care services (both bedded and in the community) to meet likely demand to support older people being discharged from hospital. The amount can be calculated from the work on "right-sizing community services"[13]. These facilities can then be specifically used to support patients/residents who are affected by any future pandemic as an alternative to moving to a care home. There are good examples of services being commissioned during the pandemic for this purpose and them delivering good outcomes for older people/ homeless people and those recovering from mental ill-health. Those who already live in a residential care home can return safely after their period of recovery and isolation. There were a range of different approaches to this to create intermediate care facilities at short notice. These included the purposeful use of a community hospital, the short-term use of former residential care homes, the use of proposed short-term beds in care homes and the use of a motel site. All of these services offered a short term place where people were safe and could receive rehabilitative support.

It is suggested that for those residents who are normally resident in a care home and who are offered care in an intermediate care facility, the fee for the care home should be used to cover part of the costs of the intermediate care bed. This will require some discussions with care home providers.

It is worth noting that there is an important recovery period post Covid-19 which can take quite a while. People who have had the virus and are recovering can feel lethargic and it can appear they are reluctant to take part in "normal activities". It is important that this is recognised and appropriate therapeutic help is made available to assist with recovery that may take some time.

[13]Right Sizing Community Services to Support Discharge from Hospital - IPC Oxford Brookes University and NHS Delivery Unit (Wales). May 2020.

### 4.2.10 Communication

**Each partnership might consider how they ensure that communication with care homes is managed in a spirit of sharing information to ensure that homes get the best possible support whilst limiting the burden on the care homes.**

**Each partnership might consider how they determine the best way to simplify and coordinate the dissemination of national and local guidance and to share it with their care home providers.**

In most local authorities there was already regular communication between the council and the care homes and therefore it was a natural progression for them to work together to address Covid-19. The challenge was how to include other stakeholders in those conversations without either breaking the existing relationships or overburdening the care homes.

Every place reported regular contact between Local Authorities, Health Boards and care homes. For some places there was also communication with Care Inspectorate Wales, Public Health and other national organisations. It was important that this communication was rationalised and made as simple as possible to be supportive but to reduce the burden on the managers of care staff. Some managers reported so many contacts in a day they didn't know with whom they had spoken.

In most places a rational approach was taken in order that a single contact developed for each care home with public bodies and communication was channelled through a single agency and then shared through the multi-disciplinary teams. Comment has already been made that this worked particularly well when the data required was not covered through a phone call but was submitted electronically by care homes (at their own convenience) and then collated digitally with access to the appropriate data made available to each of the appropriate public organisations. Some places used the Microsoft "share-point" system to achieve this.

Many places developed special mailboxes and Covid-19 hotlines for care homes to communicate with public bodies during the pandemic.

Care home owners and managers made their own videos (and some put them on Youtube) to highlight how they were coping with the virus and this was shared widely with their colleagues. The Providers Forums also created WhatsApp groups where information and problems could be shared and mutual help offered.

It has already been noted that some care home managers reported positively that they really appreciated it when there were weekly webinar/Skype calls into which they could dial in where other care home managers were also on the call. This enabled them to

extend their support networks as well as receive advice from health and care professionals.

In some places special websites were established to share information between councils and care homes as well as with each other. In other places Facebook pages (and networks) were established with a particular focus on communicating between care homes and families.

Support to care homes worked on a seven-day week (including bank holidays) from the public sector. This was necessary and appreciated.

### 4.2.11 The Hardship Fund and Finances

**Each partnership might consider how they will support their care sector financially now and in the future.**

It is important to note that many care home owners took action that increased their costs at their own risk as soon as the pandemic looked like it would hit them. They purchased their own PPE sometimes at exorbitant costs; they had to increase their staffing costs for care staff (including activity co-ordinators) and cleaning staff as well as dealing with a loss of income due to lower occupancy.

Many local authorities made an immediate/temporary increase in funds to care homes once the pandemic started (it hit some care homes prior to the formal lockdown). The increases varied from 5% -10% fee increases. These decisions were made prior to any national announcements. In addition some local authorities increased the pay to the staff they employed who were working on the front-line during the pandemic. There was no equivalent uplift in the Continuing Health Care (CHC) or the Funded Nursing Care (FNC) rates.

All parties commented favourably on the existence of the provision made by Welsh Government for social care during the Coronavirus outbreak of £40 million. This is known as the “hardship fund” and the way in which local authorities were applying it both fairly and appropriately. The use of the fund to support additional costs such as higher costs for PPE before it was provided centrally, the additional staffing required (including auxiliary staff) in order to support homes during the height of the pandemic and the use of the fund to help where there were low occupancy rates were all welcomed. There are slightly different practices on funding voids in the care market – the most sensible one being a payment when occupancy went below 90% paying 90% of the costs of the voids.

There were many comments made on the concern that there was no similar fund established to assist nursing homes and this seemed to present a challenge to partners

trying to sustain (in the medium term) the current supply of care in their areas. **There is a new financial risk for many care homes as owners reported that they are either having difficulty in getting insurance to cover their work or the premiums have escalated to a very high level.**

The existence of this fund and its local administration should go somewhere to ensuring that the care sector is protected and there is less chance of unforeseen provider failures in the short/medium term.

### 4.2.12 Mental Capacity Act (2005)

**Each partnership might consider how and when they are looking to undertake "best interest assessments" under the Mental Health Capacity Act.**

There were some concerns expressed during this review on the use of the Mental Capacity Act. The Welsh Government issued guidance on how the Mental Capacity Act 2005 (MCA) should be applied during the pandemic[14]. This guidance is only valid during the COVID-19 pandemic and applies to those caring for adults who lack the relevant mental capacity to consent to their care and treatment.

The guidance advises that *"decision-makers in hospitals and care homes, and those acting for supervisory bodies will need to take a proportionate approach to all applications, including those made before and during the pandemic. Any decisions must be taken specifically for each person and not for groups of people.*

*Where life-saving treatment is being provided, including for the treatment of COVID-19, then the person will not be deprived of liberty as long as the treatment is the same as would normally be given to any person without a mental disorder. The Deprivation of Liberty Safeguards (DoLS) will therefore not apply.*

*It may be necessary, for a number of reasons, to change the usual care and treatment arrangements of somebody who lacks the relevant mental capacity to consent to such changes. In most cases, changes to a person's care or treatment in these scenarios will not constitute a new deprivation of liberty, and a DoLS authorisation will not be required. Care and treatment should continue to be provided in the person's best interests. In many scenarios created or affected by the pandemic, decision-makers in hospitals and Care Homes will need to decide:*

*(a) if new arrangements constitute a 'deprivation of liberty' (most will not)*

[14] https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-covid-19-pandemic

*(b) if the new measures do amount to a deprivation of liberty, whether a new DoLS authorisation may be required (in many cases it will not be)"*

There were issues expressed during this review on whether there was sufficient clarity on when "best interest assessments" need to be undertaken to ensure that people who live in residential care who have capacity can make their own judgements about how they manage their safety.

The guidance seems clear that the existence of Covid-19 should not make a difference as to whether an assessment should take place or not. However, when making decisions during the pandemic, about the care and treatment of people who lack the relevant mental capacity, staff should seek consent on all aspects of care and treatment to which the person can consent. This particularly implies that there must be the involvement of residents in the decisions made about their care arrangements even where these are to protect them during the pandemic. **I am advised by local authorities that their current experience is that the courts are requiring new assessments to be made if an older person who is already subject to a DOLS assessment is further restricted because of the need to manage the virus in a care home.**

Decision-makers should always consider less restrictive options for a person. They should avoid depriving someone of their liberty unless it is absolutely necessary and proportionate to prevent serious harm to the person. In most cases, a best interest decision will be appropriate, and the person will not need to be deprived of their liberty. Those undertaking DoLS assessments are discouraged from going to care homes to carry out their assessments which mean they must use the current information they have, discussions with the care home and with close relatives if they are going to make an assessment.

This issue came up most in care homes or supported living accommodation for younger adults either with a learning disability or for those recovering from mental ill health. The challenge was how to ensure that these residents/tenants remained protected, adhered to the strict rules of social distancing whilst going about their daily lives and trying to retain as much independence as was feasible.

### 4.2.14 – Issues from Children's Homes during the pandemic

In the interviews with health and care partners the focus was rightly on the impact of the virus on older people living in care homes. However, an interview did take place with the Children's Commissioner in order to ensure that no serious issues had arisen for younger people in care during the period of lockdown. The one issue that was raised for the review was the challenge faced by those running children's homes on how to

manage contact with parents where many children had a legal right to access that had been set up by the courts. Often this access takes place in special centres which were closed during the lockdown periods. It is not usual for the access to take place in the children's home (and this would be counter to guidance on visiting) but there were often no suitable places available for the access to take place particularly where the court order required this to be under some form of supervision. The care home managers were often caught between the legal right of the child in their care to have the access and their responsibility to protect them from the virus. This was further compounded by the rule that no one could travel more than five miles as many children are placed in homes away from where they lived prior to coming into care.

There was also a difficult challenge when new children were brought into care as to how to introduce them into a new care home placement and keep them socially isolated at the same time. It would be hard enough for the young person to be brought into care with a lot of emotional turmoil let alone then having to keep them isolated to serve their period of quarantine.

There is no doubt that those working with children in these homes had the best interests of the young people at heart. They had both a duty to protect their children from the virus and ensure their rights were protected. Both of these issues – parental access as agreed by courts and placing new admissions into children's homes may require some further consideration in preparing for any further pandemics.

### 4.2.15 – Learning from the actions taken during the pandemic

**Each partnership might consider how they capture the lessons learned from their actions during the current pandemic where they have had to take emergency action.**

It was impressive to hear of two examples of health and social care partnerships commissioning internal reviews of actions that they had taken during the pandemic to ensure that lessons were learned. One partnership actually undertook a review of the last 100 deaths that had occurred in care homes during the pandemic to ensure that the processes that should be in place had worked in every case.

The learning from the review proved invaluable and was shared across all agencies involved. In another partnership there was a review of a specific incident when a care home with some nursing beds was under pressure. Actions taken in an emergency over a weekend period were subsequently reviewed with an assessment made of the decisions taken and recommendations developed to assist if similar situations recurred and some pointers as to how the incident might have been avoided.

## 5.0 Summary of key considerations for health and care partnerships

1 **Each partnership might consider the nature of their relationship with their care home providers and ensure that future work is carried out in a spirit of true partnership with those providing care to some of the most vulnerable adults in the health and care system.**

2 **Each partnership might consider that they might assist in ensuring that there is an "infection control" action plan in place for every care home in their area.**

3. **The Health and Care partnership should support each care home to have their own business continuity plan**

4 **Each partnership might consider that they might assist in ensuring that there is a staffing contingency plan in place for their area. Health Boards may wish to seek guidance from Welsh Government on how this can be achieved within the current legal framework.**

5 **Each partnership might consider how they advise care homes on the best way to deploy staff during an outbreak eliminating those staff who work in more than one setting.**

6 **Each partnership might consider how they continue to support the well-being of staff who have worked through the pandemic.**

7 **Each partnership might consider that they might assist all care homes in having meaningful activities in place for residents during any pandemic with a particular focus on activities that are appropriate for those who are socially isolating and for those with dementia.**

8 **Each partnership might consider how the emotional and well-being support continues to be offered to all residents (including younger adults in care homes) even though the current pandemic appears to be easing in care homes.**

9 **Each partnership might consider how they might assist local GPs in establishing clear enhanced arrangements for every care home in their area. Where this is not possible the practitioners who have patients in particular care homes need to be clear on their responsibilities and how they will carry them out.**

**10 Each partnership might consider how they can assist care homes in ensuring they have equal priority for the available supply of PPE if there was a further pandemic.**

**11 Each partnership might consider how they can ensure that they have the processes in place to back up the test and trace arrangements for care homes**

**12 Each partnership might consider how their local risk assessments are undertaken and how these are shared with care homes enabling them to take action to reduce their risks.**

**13 Each partnership might consider how they arrange for short term (intermediate care) beds to be available to help the recovery of patients who have been in hospital and are required to isolate to ensure they are not spreading the virus.**

**14 Each partnership should ensure that acute hospitals understand and can use the local arrangements that are put in place to support the discharge of patients**

**15 Each partnership might consider how they ensure that communication with care homes is managed in a spirit of sharing information to ensure that homes get the best possible support whilst limiting the burden on the care homes.**

**16 Each partnership might consider how they determine the best way to simplify and coordinate the dissemination of national and local guidance and to share it with their care home providers.**

**17 Each partnership might consider how they will support their care sector financially now and in the future.**

**18 Each partnership might consider how and when they are looking to undertake "best interest assessments" under the Mental Health Capacity Act.**

**20 Each partnership might consider how they capture the lessons learned from their actions during the current pandemic where they have had to take emergency action.**

## 6. Learning from the seminars

The process for this rapid review concluded with an on-line seminar/ workshop for each regional grouping involving key people from social care and from the NHS. An extract from this review was drafted and shared with all those who participated in the seminars. The extract focused on the best practice recommendations that are listed above in 5.0. Those attending the seminars generally welcomed the findings from the review and agreed that the report would assist them in establishing action plans.

The seminars did raise some questions that may require more local exploration.

1. The report urges Health and Care professionals to take a positive and helpful role in working in partnership with care home owners and managers. Where this had been the attitude of the public bodies the care homes found this much more helpful and constructive in these challenging times. However it was noted that this was not always possible where for example there were real concerns about the quality of care on offer at a specific care home or where the manager was reluctant to take good advice from individual professionals. It was concluded that the spirit in which public bodies should enter discussions with care homes to tackle the virus should always be in the spirit of “helpful partnership”. There may be a few rare examples where this was not possible but those examples should not change the way in which the overall system worked. In addition the report suggested that representatives from care homes should sit on strategic boards established locally to set the direction for work between the public bodies and the care sector. This has been successfully happening in North Wales for a period of time. Again it was recognised that representatives of care homes could not be involved in discussions about individual homes (which might compromise confidentiality and commercial interests) but should be involved in wider strategic discussions particularly about the future of the care markets in each region.

2. The section on intermediate care also raised some questions. There was a clear view from care home owners that no older person should be moved from hospital to a care home (either as a new patient or as a person returning to the place where they lived) without a negative test for the virus. (Some care homes wanted two negative tests). The report suggests that there should be some Intermediate Care beds commissioned specifically to both assist older people who are recovering from the virus and where their rehabilitation can take place. These beds should not be scattered around existing care homes but commissioned either in separate buildings or in separated wings of existing homes. Some places had arranged for this to happen during the pandemic. One participant in the seminar rightly raised the issue of people having too many moves when they

are not well and another suggested that it was important that any intermediate care service followed all the correct protocols for infection control. In addition it was commented that there is always a challenge when the arrangements to protect someone requires that they are socially isolated. The final point made was, can care homes be assured in taking back older people who may be testing positive for the virus but are not spreading (shedding) the virus as the test shows they are no longer infectious?

3. There was a question raised about the nature of the help that can be offered directly to care homes when they are struggling and the difference between the circumstances where a home is struggling in normal times and when a home is struggling for staffing during the Covid-19 pandemic. It was acknowledged that the normal advice from CIW is that the public bodies should not involve themselves in the running of care homes when they are in a crisis as this could compound the difficulties being faced. However, is this different during a pandemic e.g. in relation to helping to find staff or redeploying their own staff to ensure a care home can continue functioning? The alternative to non-intervention is usually having to move all the residents to another location which is seen as both unpopular and risky (there is evidence that unplanned moves of older people place them more at risk of dying). It was accepted that these are very different circumstances and direct help should be offered whenever this is feasible.

4. Some managers were concerned about who has responsibility in the longer term to ensure there is always an adequate supply of PPE for care homes? How might this be best managed given the success of the national distribution for this pandemic? Fortunately the Welsh Government announced that it was going to continue the supply of free PPE for care homes for the duration of this pandemic. Some contributors thought that in the future there should be a local stock available in case a new pandemic hit the country.

5. There was a plea from one senior manager that we should recognise the commitment to the work and the skills demonstrated by many staff during the pandemic. This could be an opportunity to review the pay structures that exist for front line care workers. It was noted that however important that this point is - this was not within the remit of this review.

6. There was a plea from several regions that the plans that arise from this “rapid review” should be clearly linked to other plans e.g. winter planning arrangements which were well underway at the time of the seminars.

Overall, the clear recommendations of the report were welcomed and specifically the proposal that every care home should be assisted to have a business continuity plan and an infection control plan was well received. This is reflected in the action plans that were submitted.

A few amendments were made to this final draft as a result of discussions that took place in the seminars. These did not change the recommendations.

There was a discussion that took place with the Equality and Human Rights Commissioner for Wales towards the end of the process. She rightly made the point that the interests of each individual older person must be respected whatever the risks of the pandemic. She wanted to be assured that there would be no blanket policies for care homes that impacted on the rights of residents. For example visits of close friends and relatives to a care home should not face a full stoppage in a region but each home should be assessed on its own level of risks and each resident assessed as to the balance between their overall well-being and any associated risks. Other policies such as issuing blanket Do Not Resuscitate (DNR) orders to care homes should definitely not be happening as it is again important that these orders are considered seriously only for those receiving palliative care that have capacity to make such a personal decision on an individual basis.

**All the regions have now submitted an action plan which demonstrates that they have understood the draft report, taken account of most (in many cases all) of the recommendations and have clear plans to implement any changes required in the coming weeks as they face the second wave of the pandemic.**

## 7. Conclusion

This has been a very rapid review of what has been a very challenging time for care homes.  The review has operated in three phases: collecting information (one month); sharing best practice (a further month) and finally signing off individual action plans for each region (a further two weeks). It is now expected that the lessons that were learned in a hard way from the early days of the virus first hitting care homes are now clearly embedded in best practice for all those working from health and social care. Those responsible for helping the care homes manage the pandemic are now preparing for a potential second wave. It is accepted that if this hits our communities for a second time that the health and social care partnerships are much better prepared to offer good advice and support to care home owners and managers.

## Professor John Bolton

Professor John Bolton has over forty years' experience of working in social care. John qualified as a social worker in 1974 and has worked in both Local Authorities and National Roles in England becoming the Director of Social Services for Coventry in 2001. In 2007 John joined the Department of Health in Westminster as the Strategic Finance Director. Since 2010 John has worked as a freelance consultant in adult social care with a strong focus on making the best use of the resources available. In 2010 John was appointed as a Visiting Professor at Oxford Brookes University and he has worked and published many papers for the Institute of Public Care. In the last ten years John has worked across the United Kingdom and has been involved in several major projects in Wales including recent work on the cost of care in Care Homes (Lets Agree to Agree) and work with the NHS Delivery Unit on Out of Hospital Care. John is also an Associate at Newton (Europe) and has been the Efficiency Adviser for the Local Government Association. He sits on the advisory board for the Economics of Social Care and Health Research Units (ESCHRU).

## Appendix One: How Care Homes can protect themselves from the pandemic

During interviews with care home providers, local authorities and health colleagues the following picture emerged as to the common features of care homes that had avoided the virus:

- Many care homes locked down earlier than the formal government announcement – many up to two weeks earlier in early March.
- Care homes operated really strict infection control measures that included:
    - Strict control on people and goods entering the care home including special areas where staff could change from outside clothes into work clothes and don and doff PPE. Some home owners erected special constructions on the front of their care homes in order to have an infection control area through which any “visitor” had to pass and sanitise before entering the home.
    - In the early stage no visitors other than staff or professionals allowed into the home.
    - Strict use of PPE for all staff.
    - Strict cleaning regimes in place all of the time with regular sanitising of surfaces that people touched e.g. door handles, tables etc.
- Same staff working in smaller teams with set groups of residents (in a bubble).
- No use of agency or bank staff – asking existing staff to increase their shifts (which they responded to very well).
- No use of staff who work in more than one setting.
- Working 12 hour shifts and 3 day working week.
- Not receiving residents back from hospital with a negative test in previous 48 hours.
- Not receiving any new residents unless they had a negative test in previous 48 hours.
- Increasing staffing levels to ensure support was available to individual customers but only from within the existing staff group e.g. by asking them to do overtime.
- Ensuring those residents who were required to self-isolate were kept in a part of the home where they could be well supported (especially those with dementia).
- Ensuring there was good communication with other care providers to support each other in emerging best practice (in some places this was well facilitated by the local authority – was found to be additionally helpful when the local authority was also running its own residential care services or there was a strong long term relationship already achieved between the council and local providers who were used to working in partnership).

- Having split shifts for meals so residents could be operate safe distancing during their communal times.
- Reducing times that some residents spent in lounges together (as above) to maintain social distancing.
- Having a clear contingency plan in place from the outset so that everyone was clear on their roles and responsibilities in the event of an outbreak.
- Staff were asked to commit themselves to only working in one setting or one Care Home (for those who worked part time in a number of settings).
- If any staff had any signs of the virus – they were sent home and told to self-isolate for a week. In some case homes made full pay for this (in others the finances did not allow this and they were sent home on statutory sick pay).

## Appendix Two: Studies on how to manage a Pandemic

An important study (English study of Four Seasons Care Homes) was published in early July 2020 called the Vivaldi Study into Covid-19 in Care Homes[15] . This study came to the following conclusions:

- Regular use of 'bank' staff (healthcare professionals who do temporary work in different settings as needed) is an important risk factor for infection in residents and staff.
- Infections in staff are a risk factor for infection in residents and infections in residents are a risk factor for infection in staff. However, the magnitude of this effect suggests staff are more likely to transmit infections to residents than vice versa.
- Emerging data suggests that the number of new admissions and return of residents to the care home from hospital, may be important risk factors for infection in residents and staff. This has only been tested in unadjusted analysis due to a high proportion of missing data across these variables.
- Region is an important risk factor for infection in staff and residents, but its effect is different in staff and residents. This may be due to temporal differences in the timing of testing between staff and residents.
- Important transmission risk is now likely to focus on staff, who will now be tested weekly via the new whole home testing rollout.

[15] https://www.gov.uk/government/publications/vivaldi-1-coronavirus-covid-19-care-homes-study-report/vivaldi-1-covid-19-care-homes-study-report

There was some evidence around about the likely ways in which any pandemic spreads in care homes. There was a particularly important piece of work bringing together existing research undertaken by academics from the Centre for Evidence Based Medicine at Oxford University that was published in April 2020. They drew from studies that were already published in English[16]. This is a summary of their findings:

Effectiveness of infection control measures is dependent on a number of factors and a combination of strategies with the most significant being:

- Hand hygiene: access to hand hygiene facilities at the workspace, in addition to use of four or more of the WHO multi-modal strategy generally improve adherence to hand hygiene measures;
- Environmental decontamination: daily cleaning of most touches surfaces and weekly deep clean;
- Staff rotation: allocating staff to one facility consistently may reduce spread across several locations;
- Visitors: restricting visitation to only emergency / critical cases;
- Testing: creates rapid response in placing added measures to contain and prevent further spread

**Hand Hygiene**

The effectiveness of hand hygiene for preventing the spread of infection is well documented and a number of papers evaluated interventions to improve hand hygiene among staff in care homes. These were of mixed quality, often using a before and after study design without a control group. Infection control interventions focusing on education generally showed mixed or negative results. Cohort studies that evaluated care home characteristics similarly did not find a relationship between infection control training programmes and outbreaks

*Key point: While education interventions to improve hand hygiene in Care Homes achieve limited results, adequate provision of hand sanitiser and gloves, along with line management support, have been shown to reduce infection rates.*

[16] How can pandemic spreads be contained in Care Homes? – study by Mona Koshkouei, Lucy Abel, Caitlin Pilbeam from Oxford University Centre for Evidence –Based Medicine.

**Environmental decontamination**

The spread and transmission of COVID-19 is now well documented in literature with an estimated life expectancy on a variety of surfaces. A before-and-after study in an American nursing home using Ultraviolet light in assisting disinfection processes found that weekly use of a pulsed-xenon disinfection device, in additional to daily manual disinfecting, reduced respiratory system infection rates and hospitalization by pneumonia.

*Key point: Regular disinfection of high-traffic surfaces reduces infection spread. Disinfection devices may support this.*

**Staffing**

Cohort studies and simulations that modeled care home characteristics found that larger care homes were at greater risk of pandemic outbreaks than smaller ones. These studies also found that staff were a key source of outbreaks and transmission; in particular, staff entry and re-entry, including community nurses working across a number of locations.

A number of surveys have been conducted on pandemic preparedness, one specifically for the UK context[17]. This study reported that UK care homes expected to be reliant on temporary "bank" staff as their own staff took sick leave. This may leave care homes particularly vulnerable.

*Key point: The evidence supports limiting movement of staff between Care Homes. Care Homes relying on temporary staff should be aware that these staff are a key potential source of infection.*

**Visitors**

We did not find any evidence specifically on the effectiveness of preventing or limiting visitors to the care home. However, as staff movement is a risk factor for outbreaks, so similarly may visitors be a potential source of infection during a pandemic with widespread community transmission.

*Key point: No evidence on restricting visitors was identified, but if visitors have similar impact as staff re-entry, then restriction is supported.*

[17] Fell G. Preparedness of Residential and Nursing Homes for Pandemic Flu. Journal of Public Health. 2008;30(1):99-102

**Testing**

Evidence exists that prompt identification of an outbreak, typically less than three days, is required for providers to coordinate an effective response, in addition to routine/standard infection control precautions. Such measures include introduction of contact and droplet precautions such as PPE, isolating cases, and cancelling group activities and meals.

We did not identify any evidence on testing strategies for staff, although staff testing may be effective in limiting outbreaks given the evidence on staffing discussed above.

*Key point: Rapid identification of cases among both staff and residents through testing may facilitate a coordinated response that minimises within-Care Home spread, although further evidence is needed.*

**Resident wellbeing**

Holistic wellbeing in care homes is also an important consideration. Whilst there is some acknowledgement of the potential impact of different public health measures and emergencies on care home residents and their families, this area is under-researched.

Particular concerns expressed in literature include that physical isolation practices, suspension of visiting hours and care home activities, and restrictions on movement within the facility may increase loneliness and depressive feelings. For dementing patients, for example, regular interaction with familiar staff brings comfort, but staff wearing face-masks may be scary or confusing. There is also potential worry about and fear of health threats in care home residents, who may feel and be particularly vulnerable, or may not know very much about the public health emergency.

One study reviewed the perspective of care home residents in Hong Kong during the SARS epidemic. This study emphasised the participation of residents in reducing the risk of spread and recommended an education programme for residents, both to encourage buy-in to mitigation practices, and to address fears and safeguard residents' quality of life.

*Key point: Quality of life is an important consideration when planning responses to public health emergencies in care homes. Education of residents can aid compliance with mitigation strategies, and address considerations of quality of life and anxiety. Further research on maintaining quality of life in care homes during outbreaks is urgently needed.*

**Implementation challenges**
Challenges in implementing infection control guidance during outbreaks was variable and included: maintaining adequate staffing; maintaining supplies necessary for implementation of infection control precautions; the potential negative impacts of restricting residents to their rooms; and difficulties controlling the movement of residents with dementia.

**Isolation**
Recommendations from Public Health England have included advice to isolate symptomatic patients. We did not identify any evidence on the effectiveness of this for viral infections in care homes.

**Coronavirus case study**

The only study yet published on COVID-19 in care homes is a report of the spread of an outbreak through an American care home, finding that the virus spread quickly among the majority of residents, staff, and visitors, with 81 cases among the approximately 130 residents.

The authors identified the following factors that contributed to the outbreak:
• staff continuing to work while symptomatic;
• staff members working in more than one facility;
• inadequate adherence to standard droplet and contact precautions, and eye protection recommendations;
• poor infection control practices due, in part, to inadequate supplies of personal protective equipment and hand sanitiser;
• delayed recognition of cases, limited testing availability, and difficulty identifying COVID-19 cases based on signs and symptoms alone.

These factors, although from a single site, closely match the findings of the available literature.

There is a list of the studies from which they drew their evidence that is available at:

https://www.cebm.net/covid-19/how-can-pandemic-spreads-be-contained-in-care-homes/

Cwm Taf Morgannwg
Bwrdd Partneriaeth Rhanbarthol | Regional Partnership Board

# Rapid Review of Care Homes Cwm Taf Morgannwg

## Care Home Action Plan

**Introduction**

The COVID-19 pandemic represents an unprecedented challenge for health and care in Cwm Taf Morgannwg.

Mitigating the impact of COVID-19 is the number one priority for the health and care system, and has the daily, detailed attention of Senior Leaders, both Elected Members and Officers. It challenges every service across health and social care, and, in particular, our care homes.

A number of reports, reviews and guidance have been developed with a view to support the Care Homes in keeping residents and staff safe throughout the COVID-19 pandemic. These include the following;

- **Rapid review of care Homes**

  This "rapid" review was commissioned by the Welsh Government in order to ensure that the lessons from best practice are learned and shared by Local Authorities and Health Boards who were involved in working with care homes during the initial period of the Covid-19 pandemic in the spring and summer of 2020. The report sets out 19 recommendations for consideration by each Region.

- **Welsh Governments National Action Plan**

  The Deputy Minister for Health and Social Services set out six themes in July that would be considered over the summer to support care homes. The themes encompass work being undertaken with our partners including Regional Partnership Boards who have identified specific support they will deliver to care homes in their areas.

  The Care Homes Action Plan sets out WG high-level actions under these themes to ensure the care home sector is well supported ahead of winter pressures, learning lessons from the Covid-19 pandemic. This plan is a component of our overarching Welsh Government winter protection plan.

- **All Wales Care Home Framework – Role of Health Board Primary and Community Health Care Services**

  As stated above the Care Home Sector has, along with health and social care services, been at the forefront of the approach to managing the COVID-19 pandemic in Wales. The challenges experienced by all partners during this period has highlighted the need to ensure that primary and community health care services are accessible and provide wraparound support for care home residents.

  The National Strategic Programme for Primary care recognises this and commissioned the development of a Framework in preparation for winter 2020-21 and beyond. The framework sets out a consistent framework to support the planning and provision of primary and community health care services and the implications for the care home sector. It reflects the expectation that care home residents have equal access to primary and community health care services as anyone living in any other type of residence in the community.

  The framework sets out Strategic Health Board Actions, a set of 9 self-assessment statements and Operational Health Board actions, include 3 practical applications that can inform the Health Board planning and provision of services to care homes.

- **Older Persons Commissioners Report – Leave no one behind**

  During the pandemic the Older Persons Commissioner has been talking and listening to older people, carers, community organisations, volunteers, care home workers and many more about their experiences. This report sets out what the Older Persons Commissioner believe needs to happen next. There are short term actions that need to be taken now and over the next three months, and longer-term actions which need to start as soon as is practicable but will take some time to be fully realised.

- **Care Inspectorate wales – Prevention and promotion of independence for older adults**

  CIW looked at the experiences of people aged 65 and over while they had support from social care and health services, following peoples journeys as they went into a care home or until they no longer needed help and support. The report sets out 23 key findings, judgements and areas for improvement, focusing on 4 key areas;

  - People – voice and control
  - Partnerships, integration and co-production,
  - Prevention
  - Well-being

**In order to address regional issues and to meet the recommendations within these reports especially the Rapid Review of Care Homes report (IPC report), WG National Action Plan and the Framework for Primary and Community Health Care Services the Operational Group has set out the following actions.**

## 1 Care Home Support Governance

This links to CTM Action Plan – action 1 and action 2

| CTM Action Plan | IPC Rec | WG Action Plan | Action Plan | Detailed Actions | Update following Strategic Group meeting 27-11-20 | Timescale | By |
|---|---|---|---|---|---|---|---|
| **1.1** | 1 | Structure | Review the Complex Care Group aims and objectives. | Complex Care Group to be stood down.<br><br>The Care Home Support Structure has been agreed.<br><br>**The CTM Care Home Review Group**<br>To discuss and monitor individual care homes in a lockdown situation. This group will escalate issues to the Operational Group for advice and guidance. Meets weekly.<br><br>**Operational Group**<br>To address the actions set out in the regional Care Home Action Plan<br>To undertake tasks as directed by the Strategic Board.<br>To receive and respond to issues and feedback received from the CTM Care Home Review Group. Meets fortnightly.<br><br>**Strategic Board**<br>To consider/agree the recommendations made by the | Complex care Group has been reviewed and is now the Strategic Group<br><br>This meeting is managed by OHW/EHO<br><br>Fortnightly meetings have been scheduled.<br><br>Initially agreed that would meet monthly however pressures have meant that this has been changed to meet fortnightly. | Complete<br><br>Complete<br><br>Complete<br><br>Complete | All |

| CTM Action Plan | IPC Rec | WG Action Plan | Action Plan | Detailed Actions | Update following Strategic Group meeting 27-11-20 | Timescale | By |
|---|---|---|---|---|---|---|---|
| | | | | Operational Group. Meets monthly | | | |
| **1.2** | 1 | Structure | Review the representation of the group to ensure that there are representatives from Social Care Sector and Health, including Care Home representation. | Care Home representative to attend Strategic and Operational Group meetings | **Strategic Group representation**<br>Care Forum Wales to be invited to attend Strategic Group meetings.<br><br>**Operational Group**<br>In order to engage fully with the Care Home Sector the Operational Group recommends monthly Care Home Forum as a Stakeholder Reference Group are held where revised guidance, policy and procedures can be shared so all Home are able to have an input into the process. | Complete | Op Group<br><br>Op Group |
| **1.3, (2.2)** | 1 | Structure | Develop and Agree Values and Behaviours that govern the relationships and effective working of the Group. | Terms of reference to be drafted and agreed. | This will be included within the ToR for each of the Strategic and Operational Groups. | Early Dec | Op. Group |
| **1.4, (2.3)** | 1 | Structure | Ensure that all members are considered equal and that future work is carried out in a spirit of true partnership. | Terms of reference to be drafted and agreed | This will be included within the ToR for each of the Strategic and Operational Groups. | Early Dec | Op. Group |
| **1.5 (2.1)** | 12 | Structure | Agree Risk Assessment Criteria for escalation | Highlight report to be drafted to provide update at each Strategic Group. | Operational group to agree the format of the report. | Complete | Op. Group |
| **1.6 (2.5)** | 15, 16 | 1 | Operational Group to ensure that communication with Care Homes is managed in a spirit of sharing | Review current communication mechanism.<br>Discuss at Care Home Forum | To be agenda item at Care Home Forum.<br>Is this working?<br>If not what could be done better? | Early Dec | Op Group |

| CTM Action Plan | IPC Rec | WG Action Plan | Action Plan | Detailed Actions | Update following Strategic Group meeting 27-11-20 | Timescale | By |
|---|---|---|---|---|---|---|---|
| | | | information to ensure that homes get the best possible support. | | | | |
| **1.7 (2.6)** | 19 | Process | Agree a mechanism to capture the lessons learned where emergency action has to be taken. | Operational Group to include 'lessons learned' as a standing item on the agenda. | The weekly **CTM Care Home Review Group** have started to identify themes from the issues that are being discussed. It was agreed that this will be a set agenda item to be discussed and appropriate actions agreed at the Operational Group.<br><br>This agenda item will also include feedback from concerns raised at a local area level. E.g. RCT Nurse Managers Forum, MAOG etc.<br><br>This is also an opportunity to share good practice across the region. The Comms support team within UHB has offered to support the group with mechanism and best ways to present and share this across the region. | Ongoing | Care Home Review Group<br><br>Local area reps. |

## 2 General and clinical support for care homes

| Ref | IPC Rec | WG Action Plan | Action | Agreed Action | Update from Strategic Group meeting 27-11-20 | Timescale | By |
|---|---|---|---|---|---|---|---|
| 2.1 (4.3) | R9 | 3.1, 3.2 | Ensuring that the Direct Enhanced Service for Primary Care, is in place across the region. | Confirm where the DES in place across the region? | This will be considered at the next meeting. | TBA | TBA |

| Ref | IPC Rec | WG Action Plan | Action | Agreed Action | Update from Strategic Group meeting 27-11-20 | Timescale | By |
|---|---|---|---|---|---|---|---|
| 2.2 (4.4) | R13 | | Process for arranging availability of short term (intermediate care) beds to help the recovery of patients who have been in hospital and are required to isolate to ensure they are not spreading the virus. | CTM have formed a Silver Cell group focussed on discharge. Silver Cell meets twice a week to look at discharge from hospitals and the barriers to discharge. Several discharge pathways are being developed that will assist swift and safe discharge.<br><br>The Operational Group will look at drafting guidance to address these barriers.<br><br>This will be a standing agenda item. | - <u>Discharge Pathways</u><br>The issues with discharge are complex and causing additional pressure in the hospital environments. Barriers to discharge have been highlighted and the Operational group are working to address these barriers. These include;<br>- Revisit discharge pathways<br>- 28 day restriction on placements PHW Lockdown<br>- Requirement for 2 negative tests prior to re-admission to care Home or new admission<br><br>**Update 27-11-2020**<br>A proposal for discharge from hospital for different patient pathways based on a Covid risk assessment has been drafted and it needs to be considered by Public Health Wales and Welsh Government as their guidance would need to be changed to facilitate it. This request has gone into Welsh Government from the CTM Incident Management Team(IMT) and is being considered and Heather Lewis has put the request into Public Health Wales IMT also.<br>We are awaiting a response and actively chasing.<br><br>- <u>Guidance for re-admission to Care Home in a PHW 28 day lockdown.</u><br>Operational group working on regional guidance as an appendix to the Revised COVID Hospital discharge guidance (v3)<br>Comments to be returned to Pete Tyson for review at meeting on 09-11-20. | Ongoing<br><br>Op group 09-12-20 | Silver Cell<br><br>Angela Jones, PHW<br><br>Op. Group |
| 2.3 (4.5) | R14 | 3.1, 3.2 | Agree local arrangements to support the discharge of patients and ensure that the acute hospitals understand and can use these local arrangements. | | | | |

| Ref | IPC Rec | WG Action Plan | Action | Agreed Action | Update from Strategic Group meeting 27-11-20 | Timescale | By |
|---|---|---|---|---|---|---|---|
| 2.4 (3.3) | R2 | 6.4 | **Consider how we might assist in ensuring that there is an "infection control" action plan in place for every Care Home in their area.** | This was discussed and there were a number of concerns in relation to the action.<br><br>This also links to WG Action plan (see WG action 6.4 below)<br>WG action plan states that there will be a National Infection Prevention and Control Clinical contingency template.<br><br>This will enable care homes to consider their own resident group, staff group, environmental layout and service delivery. This will be shared with care home providers along with details of assistance that will be available to aid completion.<br><br>It is anticipated that individual care homes will be supported to complete the template by Local Authority Environmental Health Officers and community Infection Prevention & Control teams | There is no tool or template Infection control action plan available to Care Homes.<br><br>Each care Home have their own infection control plan but how robust these are is unknown.<br><br>Contact each Care Home to see if they have these in place? Who would be able to review these to see if these cover each area as required? Seek assurance that IP&C Prominent in Business continuity plans or is there something separate. Seek assurance that these are in place and these are reviewed when circumstances change.<br><br>**Update 27-11-20**<br>Issues raised by EHO in relation to WG Action and implications for the region.<br>- Resource implications<br>- Conflict of interest<br>- Accountability<br><br>Agreed<br>Strategic group agreed that this would need to be considered by Environmental Health as this would be seen as within their remit. | Ongoing<br><br>LA Contract Team | Op. Group |
| 2.5 | | 1.2 | Vaccination Programme | Ensure that all GDPR requirements are met and that there is an Information Sharing protocol in place to assist the vaccination programme for all residents and staff. | At the Operational group meeting on 11th Nov the vaccination team were present, it was agreed that the LA would assist the team in obtaining staff names and contact details.<br><br>Each Care Home has been sent a letter asking for them to populate the template, this letter covers the issue of GDPR. | End Nov (asap)<br><br>Ongoing | LA<br><br>LA, Vaccination team |

| Ref | IPC Rec | WG Action Plan | Action | Agreed Action | Update from Strategic Group meeting 27-11-20 | Timescale | By |
|---|---|---|---|---|---|---|---|
| | | | | | Queries raised regarding those staff who do not want to receive the vaccination. It is not as simple as sending the details of all staff. | | |
| | | | Recommendations from the All Wales care Home Framework - Role of Health Board Primary and Community Health Care Services | The group has just received the Framework for Primary and Community care. This needs to be considered against the areas within the action plan.<br>. | An action from the Op. Group meeting is to establish whether there Is an action plan being developed outside this group. | 09-12-20 | St. Group<br><br>UHB - Primary Care Services |
| **The following actions are within the WG National Action Plan. These may have implications for the region.** | | | | | | | |
| N/A | N/A | 2.3 | Digital Recording system for request of PPE items | **WG are considering whether a digital recording system will aid the request and receipt of specific PPE items**<br><br>WG will monitor the implementation of the 'Stockwatch' PPE inventory management system which will be deployed by NWSSP across all Joint Equipment Stores.<br>Data input will initially be undertaken by NWSSP with a plan including training and support to migrate data input responsibilities to<br>JES personnel | Agreed that progress on these actions would be updated from the WG action plan when this is made available. | | WG |
| N/A | N/A | 1.3 | COVID-related training | WG has established an IP&C training task and finish group that is developing consistent Covid-related training materials across health and social care, reporting to the Nosocomial Transmission Group. | Agreed that progress on these actions would be updated from the WG action plan when this is made available. | | WG |

| Ref | IPC Rec | WG Action Plan | Action | Agreed Action | Update from Strategic Group meeting 27-11-20 | Timescale | By |
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| | | | | WG will continue to work with the Nosocomial Transmission Group to raise awareness and provide training, guidance and support to care homes | | | |
| N/A | N/A | 1.5 | Arrangement for testing care home residents and staff in line with scientific evidence | WG will monitor prevalence rates in care homes and communities closely and the testing programme will be amended accordingly.<br>WG will continue to update care homes on the arrangements for testing residents and staff in line with emerging scientific evidence | Agreed that progress on these actions would be updated from the WG action plan when this is made available. | | WG |
| N/A | N/A | 6.4 | Develop a National Infection Prevention and Control Clinical Contingency template | WG action plan states that there will be a National Infection Prevention and Control Clinical contingency template<br><br>This will enable care homes to consider their own resident group, staff group, environmental layout and service delivery.<br>This will be shared with care home providers along with details of assistance that will be available to aid completion.<br><br>**It is anticipated that individual care homes will be supported to complete the template by Local Authority Environmental Health Officers and community Infection Prevention & Control teams.** | Agreed that progress on these actions would be updated from the WG action plan when this is made available. | | WG |

## 3 Residents and social care Workers well-being

| Ref | IPC Rec | WG Action Plan | Action | Action | Update from Operational Group meeting 25-11-20 | Timescale | |
|---|---|---|---|---|---|---|---|
| 3.1 (4.1) | R7, R8, R9 | 4.1, 4.2, 4.3, 4.4 | Support Care Homes to ensure that appropriate levels of care including emotional and well-being of residents is maintained. | Operational Group to consider options to be able to support Care Homes.<br><br>We will ensure care home residents are supported to maintain contact with their friends and family<br>- **Care Home Visits**<br>This was seen as a priority action. | **Care Home Visit Guidance**<br>The Op Group has drafted care Home Visit Risk assessment. The overarching template has been agreed with minor tweaks for each LA.<br><br>Letters have been sent to Care Homes from Bridgend and RCT LA informing them of the outcome of the Risk Assessment. As long as there are RA in place that comply with the guidance and they aren't within the 28 day restriction they are able to accept family visiting.<br><br>Merthyr RA is in the process of agreeing their Risk Assessment.<br><br>**For information –**<br>- Visitor PODS.<br>WG have asked Care Homes to submit an expression of interest re PODS. LA's are being asked to sense check these submissions.<br>- Family testing pilot<br>A Care Home in Bridgend has been identified for family testing pilot. | Complete<br><br>Early Dec | RCT/Bridgend<br><br>MT |
| 3.2 (4.2) | R7<br>R8 | 4.1, 4.2, 4.3, 4.4 | Support Care Homes to ensure that meaningful activities for residents are available | Operational Group to consider ways to support care homes | It was agreed that the weekly CTM Care Home Review Group would highlight any issues or concerns that care homes are facing in relation to activities. | Ongoing | Op Group |

| Ref | IPC Rec | WG Action Plan | Action | Action | Update from Operational Group meeting 25-11-20 | Timescale | |
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| | | | | | This would be fed back as a standing agenda item (see action 1.7 above) | | |
| 3.3 (3.2) | R6 | 5.1 | Support Care Homes to ensure that there is appropriate levels of support the well-being of staff | Operational Group to consider ways to support care homes | It was agreed that the weekly CTM Care Home Review Group would highlight any issues or concerns that care homes are facing in relation to activities.<br><br>This would be fed back as a standing agenda item (see action 1.7 above) | Ongoing | Op Group |
| **The following actions are within the WG National Action Plan. These may have implications for the region.** | | | | | | | |
| N/A | N/A | 5.1 | Access for staff to receive online and face to face support. | WG are continuing to develop a broad range of provision from online and virtual face to face support to suit the variety of ways that staff may prefer to seek support at this sensitive time.<br><br>Details of the emotional wellbeing support available to social care workers was collated and a road map to signpost social care workers to specific resources was published on Social Care Wales' website . An Employee Assistance Programme for social care workers who do not already have access to such a scheme will be established and managed by Social Care Wales. | | | |
| N/A | N/A | 4.1, 4.2, 4.3, 4.4 | WG will ensure care home residents receive the care and support from | WG will continue to encourage projects funded via our Third Sector Sustainable Services Grant | | | |

| Ref | IPC Rec | WG Action Plan | Action | Action | Update from Operational Group meeting 25-11-20 | Timescale | |
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| | | | professionals in the most appropriate way, either via technology or in person | to extend their support to older people living in care homes and their carers | | | |
| N/A | N/A | 5.2 | WG Has developed an All Wales Covid-19 Workforce Risk Assessment Tool which helps workers consider their personal risk factors for Covid-19 and suggests how to stay safe. Support for the social care sector to use the tool has included good practice webinars, a social care champion's network, FAQ and animation. | WG will evaluate the use and effectiveness of the tool via the First Minister's COVID-19 Social Care Implementation Group. The tool is available https://gov.wales/covid-19-workforce-risk-assessment-tool | | | |
| | | 4.1 | Ensure that residents have the opportunity to share their experience of living in care homes during COVID-19 pandemic. | WG will ensure care home residents have the opportunity to share their experiences of living in care homes during the COVID-19 pandemic | | | |

## 4 Financial Stability

| Ref | IPC Rec | WG Action Plan | Action | Action | Update from Strategic Group meeting 27-11-20 | Timescale | By |
|---|---|---|---|---|---|---|---|
| 4.1 | R2, R3 and R17 | 1.1 6.4, | Operational Group will ensure that Care Homes have robust Business Contingency plans (BCP) | This was discussed at the Strategic group meeting on 16-11-20. It was agreed that Sian Lewis team would look at the Business | This was discussed but further clarity of expectation of the Operational Group need to be set out. | ASAP | LA / Sian Lewis |

| Ref | IPC Rec | WG Action Plan | Action | Action | Update from Strategic Group meeting 27-11-20 | Timescale | By |
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| | | | in line with CIW regulations. | Contingency plans and that Pete, Gwyneth and Angela to get copies of the Homes Business Contingency Plans and send to Sian Lewis for consideration.<br><br>The plans need to refer to the following;<br>- Staffing Contingency Plans to include management of staff deployment during an outbreak<br>- to support the well-being of staff<br>- opportunities for support within the local community<br>- continuity of supplies | Sian Lewis is leading on a task and finish group to take forward this action. Strategic Group to nominate appropriate people to form the Task And finish group | T&F Group to meet Early Dec | Sian Lewis |
| 4.2 | R4<br>R5<br>R6 | 1.4,<br>5.1,<br>5.2,<br>5.3<br>6.4 | The group will ensure that the Care Home BCP include:<br>- Staffing Contingency Plans to include management of staff deployment during an outbreak<br>- opportunities for support within the local community<br>continuity of supplies | | | | |
| 4.3 | | | Each partnership might consider how they will support their care sector financially now and in the future | | Considered at a future Operational Group. | | |
| **The following actions are within the WG National Action Plan. These may have implications for the region.** | | | | | | | |
| N/A | N/A | 6.2 | Review the range of support and funding made available to care home businesses through a variety of mechanisms across Welsh Government departments and the impact they have had on improving sustainability | WG will ensure there are performance reporting arrangements in place to demonstrate the impact and use of the additional funding | | | |

| Ref | IPC Rec | WG Action Plan | Action | Action | Update from Strategic Group meeting 27-11-20 | Timescale | By |
|---|---|---|---|---|---|---|---|
| | | | during the COVID-19 pandemic. | | | | |

Cwm Taf Morgannwg
Bwrdd Partneriaeth Rhanbarthol | Regional Partnership Board

# WINTER PROTECTION PLAN 2020/21

## Final Version

# Contents

## 1.0 INTRODUCTION

The Cwm Taf Morgannwg Regional Winter Protection Plan sets out the regions response to the Welsh Government Winter Protection Plan. The plan has been developed with input from all of the regional statutory and voluntary sector partners and builds to demonstrate an integrated regional plan and an approach that is deliverable and addresses the challenges associated with both the COVID pandemic and usual winter pressures across the region.

The plan builds on existing plans that focus on preventing four harms by;

- Remaining ready to provide the full range of services needed to prevent, diagnose, isolate and treat COVID-19 patients and
- Ensuring that we can continue to provide services that are essential at all times. This includes services that are urgent and life threatening or life impacting as well as services that without timely intervention could result in harm over the longer term such as maintaining vaccination programmes
- Reinstating routine services where it is operationally possible and safe to do so, with strict adherence to infection prevention and hygiene procedures and maximising the use of virtual consultations
- Health and Social care professionals working tirelessly to ensure people have been prioritised according to need and what matters to them.

The plan provides also looks to support and retain new ways of working adopted in the first COVID wave which supported integrated working between health, social care and third sector.

This means:

- A whole system approach where seamless support, care or treatment is provided as close to home as possible
- Services designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes
- People only going to a general hospital when it is essential, with hospital services designed to reduce the time spent in hospital
- A shift in resources to the community that enable hospital-based care, when needed to be accessed more quickly; using technology to support high quality services.

## 2.0 AIMS OF THE 2020 WINTER PROTECTION PLAN

The aim of the plan is to;

- Respond to the Welsh Government's 6 goals of urgent and emergency care
- Prevent unnecessary hospital admission
- Optimise digital technology
- Enhanced support for the frail and elderly at home , in care and within healthcare settings
- Minimise impact of COVID 19 resurgence and seasonal influenza
- Ensure that Care Homes are supported to deliver ongoing quality care for their residents
- Enhance the working arrangements and support from third sector partner agencies
- Maximise and enhance access and support via community therapy services
- Review patient and staff experience focusing on 'what matters'
- Ensure ongoing consideration and timely support to prioritise staff well-being

**A range of performance measures will be used to measure the impact of the Winter plan including;**

- Preventing hospital admission for specific conditions / complaints.
- Timeliness, quality and frequency of assessment in ED.

- Improving flow of patients through hospital to reduce risk of harm and delays in onward care.
- Focusing on timely transfer home to reduce risk of harm and improve outcomes.
- Discharge data.
- Delayed transfers of care.
- Flu rates.

The National Programme for unscheduled and the NHS delivery Unit will support evaluation and measurement in relation to Discharge to Recover and assess elements of the plan and there will be regular progress updates through the RPB governance structure and within sovereign bodies as required.

## 3.0 DEVELOPMENT OF THE PLAN

Our winter plan has been developed on a partnership basis with the Local Authorities, Third Sector and Health Board. The plan is in line with A Healthier Wales commitments and looks to ensure that the programme of work undertaken as part of the Transformation Programme in the Region is maximised. It follows those clear design principles of:

- A whole system approach where seamless support, care or treatment is provided as close to home as possible;
- Services designed around the individual, based on their unique needs and what matters to them;
- People will only go to a general hospital when it is essential, with hospital services designed to reduce the time spent in hospital;
- A shift in resources to the community that enable hospital-based care (when needed) to be accessed more quickly; and
- Using technology to support high quality services.
- Develop more meaningful measures and use feedback from patients and staff to measure what matters most to people.

It is anticipated that we will see an increase in pressure on health and social care services as the population contends with both the global pandemic of COVID 19 as well as the usual seasonal activity. The impact upon health

services in our DGH and Community Hospitals has for the first time been modelled by month and by Hospital and accounts for the bed capacity need to accommodate also our elective programme and the potential impact of the opening of the Grange Hospital with the consequent changes in flow from this.

In preparing for Winter 2020/21, the Health Board has considered numerous scenarios for the spread and impact of Covid-19 on health and care services. The scenario which has been used as the premise for our whole system planning during quarters 3 and 4 of 2020-21, from surveillance and the TTP programme to delivery of core elective services, is based on current community infections levels and accounting for the current 14 day national lock down.

In addition, the health board have also modelled the requirements to enable them to put in place the capacity to enable Wales to respond to the most serious of circumstances, as described in the letter from Welsh Government in June 2020. This requires the UHB to have an increased number of both acute and critical care available for Covid-19 patients, whilst also being able to continue to provide the anticipated levels of capacity to deliver non–elective and maternity services safely and have assumed that critical care demand over the winter is in addition to any typical winter demand. Further detail can be found in the Health Board Q3/Q4 Plan.

The 2020/21 winter plan is underpinned by reference to the 6 goals of urgent and emergency care recently published through Welsh Government and with a very clear emphasis on;

- Contact Ahead and introduction of 111
- Creation of a 24/7 urgent primary care model in at least one Cluster and the ongoing enhancement of our Out of hours urgent primary care across CTM
- Enhancing the capacity and capability of the AEC/SDEC offer in each of our ILGs

- Ensuring the delivery of the four discharge to recover then assess pathways

Over and above this the Health Board in conjunction with our Local Authority Partners has been delivering the Test Track and Protect service which is fundamental to managing the COVID pandemic in the community. Plans are also well advanced in regard to Mass Vaccination for COVID 19 as vaccine becomes available and finally there is both a comprehensive staff immunization programme for influenza as well as a robust primary care delivery set up to deal with the previous cohorts of patients as well as an increase in the spectrum to those over 50 as and when vaccine supply become available for such. Further details below.

The Health Board has required the newly formed ILGs to create multiagency plans at locality level, covering all aspects from community care, enhanced primary care, additionality in mental health services and enhanced capacity both in the Emergency Departments, Ambulatory Care settings and the wider community admissions avoidance and rapid discharge services.

These three integrated plans will along with TTP and Vaccination programmes incorporate the discharge to recovery pathways as well as a strong emphasis on supporting care homes. They have a very clear focus on work that we intend to fund from the Third sector on isolation, volunteering and building digital confidence. The proposals and schemes that fall within the ILG plans can be found at Annex 1 to 3 covering the whole of the region.

**Annex 1 Rhondda and Taf Ely Winter Preparedness**

**Annex 2 Merthyr & Cynon Winter Preparedness**

**Annex 3 Bridgend Winter Preparedness**

In overall terms the Health Board and partners will look to deploy circa **£10.9m** towards winter protection excluding TTP and Mass Vaccination.

This will look to cover the following;

| | |
|---|---|
| Enhanced Capacity and Capability on Ambulatory Care / Same Day Emergency Care | 3.700m |
| Capacity and Capability in each ILG | 3.050m |
| Discharge to Assess Pathways & Care Home support | 2.000m |
| Community Resources and Third Sector Support | 0.500m |
| Contact Ahead & NHS 111 | 0.750m |
| Primary Care Capacity | 0.750m |
| 24/7 Urgent Primary Care | 0.150m |

A submission outlining the AEC/SDEC proposals has been submitted to WG colleagues as required as has the Contact Ahead and Urgent Primary Care proposals. A summary of the proposal is contained for each of these three elements in Annex 1 to 3. The proposals in regard to D2RA and Community resources are contained in the ILG schemes by LA and are referred to in the section below. Also note the read across to the Health Board Q3/Q4 plan.

The Capacity and Capability at ILG level relates to a host of schemes that cover enhanced staffing in community hospitals and across our community services especially targeted at palliative care as well as District General Hospitals within wards and the Emergency Department.

They cover Mental Health service deployment around faster access to mental health assessment. In addition a range of schemes designed around the community respiratory hub, therapy services including the hub that operated in COVID first wave and in reached to care homes.

## 4.0 Initial Surge Response and Discharge to Recover and Assess

On the 24th April 2020 the Welsh Government announced £10m of financial support for Covid surge response. The purpose of the funding was to enable safe and accelerated discharge of patients from acute and community hospitals to community settings in line with the COVID-19 Hospital Discharge Requirements published by Welsh Government on 7th April 2020.

Note a further update on discharge requirements was made on the 29th April 2020 which aligned the COVID-19 Discharge Guidance with the new approach to testing on discharge for people normally resident in care homes or potentially being discharged to a care home on Discharge to Recover then Assess Pathway 3 or 4.

The Discharge to Recover then Assess model is predicated on optimising recovery and reablement/rehabilitation. The Welsh Government is encouraging a new model where going home is the default pathway given most patients benefit from assessment in their normal place of residence with the ability to cope in familiar surroundings. The 'home first: discharge to recover and assess' pathway means patients are discharged home once they are medically fit and no longer need a hospital bed. Patients' immediate support needs will have been assessed prior to discharge and the necessary arrangements put in place. Ongoing assessment of patients' support needs can be safely continued at home by members of the appropriate community health and social care team. The approach means patients are not kept in a hospital bed longer than is necessary.

Intensive effort has been put into increasing Critical Care capacity in the three acute hospitals in Cwm Taf Morgannwg, including skilling up staff in other areas to provider a higher level of care than is typical is acute medical and surgical settings. As part of this process and utilising £1.3m surge funding, Gold Covid-19 members approved a proposal to operationalise a number of former Nursing Homes.

The community intermediate step down facilities operationalised were Abergarw Nursing Home (Bridgend) and Marsh House (Formerly Glan Yr Afon) in Merthyr Tydfil. These facilities formed a key part of the regions COVID-19 Hospital Discharge Pathway and an important intermediate step whilst onward discharge planning is progressed.

An initial transfer of patients took place with Abergarw Manor going live on the 14th April 2020 and Marsh House on the 22nd April 2020.

The Health Board are providing the staffing for the facilities, including Registered Nursing, therapies and Health Care Support Workers whilst contracting some support services through the Local Authorities such as Catering and Cleaning. The Health Board is responsible for all patients in the homes and has fitted out each of the homes to ensure the environment is as safe and appropriate as possible in the context of COVID and the timescales.

In addition to Local Authority partners and Health board, Age Connects have been a key Partner repurposing their existing contracts to provide direct support to patients which includes access to technology to engage with friends and family thus reducing the chances of depression and decline in mental health during isolation, daily activities to support mental and physical wellbeing and supporting discharge planning as required.

The welcome announcement of the funding for delivery of Discharge to Recover and Assess (D2RA) pathways received on the 5th of October has enabled further discussion and enhancement of models of care that prevent unnecessary admission to hospital and enable people to leave hospital when they are ready is essential in order to provide care closer to home and limit time in hospital unless essential, in line with key commitments of *a Healthier Wales*.

Planning for this element of the Winter Plan has been led by Local Authority Colleagues and complements the Locality Plans.

The plan whilst responding to emerging modelling also looks to ensure we adopt a cautious and flexible approach, building on new ways of working, more robust whole systems engagement and joint working, which was clearly evidenced during the first wave of the COVID 19 pandemic.

Full list of proposals can be found within the ILG Annex 1-3.

Proposals include;

- Additional capacity for support @home services (short term intervention) over winter period to facilitate hospital discharge or prevent admission.
- Additional capacity to support carers including crisis support to facilitate hospital discharge or prevent admission.
- Increased capacity for community equipment services, including delivery drivers and equipment provision.
- Increased support to ED and frailty teams and improved partnership working, Improved patient safety and experience.
- The provision of additional capacity across community services will support people to return home through the provision of packages of care and further assessment to be undertaken.

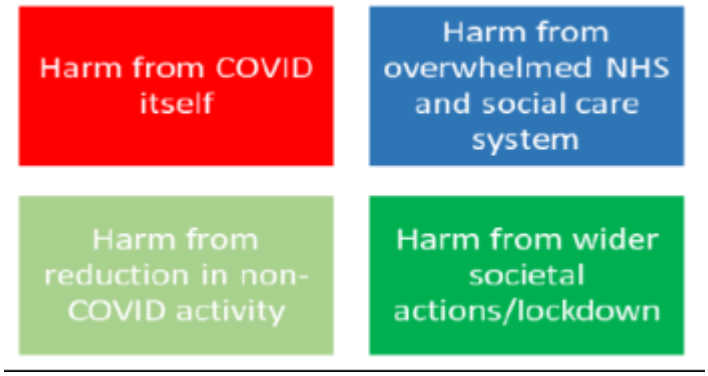
The breakdown of funding across the local authority areas is based on Social Services funding formula and is approximately;

- Rhondda Cynon Taf £1.2m
- Bridgend £0.61m
- Merthyr Tydfil £0.28m

These proposals will be submitted to Welsh Government approval alongside the winter plan.

## 5.0 PREPARATIONS FOR A SECOND COVID SURGE

For 2020/21 the Winter Plan needed not just to address the typical pressures of Winter but to deliver health and social care and support services through a second COVID surge. Throughout the year planning has been focused on preventing the following 4 harms:




The health board has worked to maintain essential services, reintroduce urgent and routine services and adapt to new ways of working, such as video and telephone consultations with patients via a number of virtual platforms. The HB will continue to work with partners in social care, care homes and via the Third sector to join up and deliver the services needed for our population ensuring more collaborative and joint whole system approaches.

Maintenance of essential services must be and will be the priority during the midst of the second COVID surge, initial discussion and a further military led planning exercise and strengthened our understanding that we will have to set in place specific phasing and trigger points for escalation and senior decision making for the potential to stand elements of service down. Whilst we will aim to attempt to review our ability to maintain more

routine services on an ongoing basis based on clinical risks associated and emerging guidance received.

## 6.0 RAPID REVIEW OF POPULATION NEEDS

In light of the unprecedented scale and impact on population and services brought by the pandemic, RPBs and their partners are required to undertake a rapid review of their population needs assessments to understand the effect of the pandemic. This review focused on some of the most affected groups and how services may need to change in order to meet needs in the new landscape for the priority groups under the RPB;

- Children and young people with complex needs (ref new part 9 definition)
- Unpaid carers
- Older people, with specific reference to supporting people living with dementia
- People with physical disabilities
- People with learning disability/autism
- People with poor mental health
- Sensory impairment

The rapid review provided a summary of Population Needs assessment as compiled for original assessment (including additional information relating to Bridgend that was outside of the original scope), national survey information regarding the impact on specific priority groups and local intelligence including feedback from Strategic Sub Groups of the RPB where this was available.

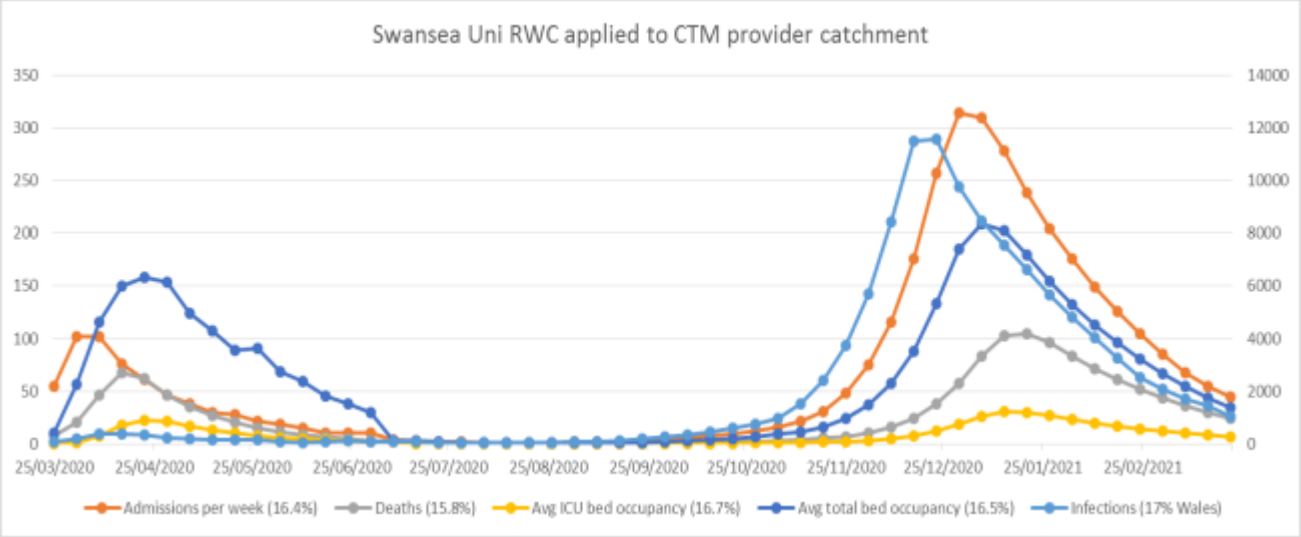
Local intelligence priorities were captured through the Citizen Engagement through Lockdown report. These priorities have been established following basic analysis of data collected by the Our Voice Matters project (ICF funded Project) in collaboration with citizens and partner organisations prior to the COVID-19 pandemic and subsequent lockdown measures through the

projects phase 1 activities, and the #CTMLockdownVoices campaign that has been running throughout the lockdown period.

The information will be used to inform Regional Partnership Boards planning and priorities and further support engagement and co-production with local communities.

## 7.0 COVID IMPACT ASSESSMENT

As a region we have reviewed the potential worst case scenarios for winter and bed modelling forecasts undertaken to inform further our winter planning discussions and COVID surge readiness. Modelling presumes that the reasonable worst case scenario in terms of COVID infections and admissions will be more severe than the first COVID wave experienced earlier in the year.




Therefore, taking all these assumptions and modelling into account, the health board are refocusing their winter plan and the proposals to needing to respond to a second COVID surge. With the added pressures that a usual winter pressures season bring with it, we have to react early to the clear facts presented to us, we are still in the midst of a pandemic, if we

are not prepared and ready to respond to the apparent next phase of the surge it could overwhelm everything we are aiming to do for our local communities.

## 8.0 SHIELDING

Based on the experience of the last 5 months and the impact this has had on residents that the areas that require resources to ensure that people previously shielding continue to get the support they need over the medium to longer term are:

- **Befriending services** which have been vital in helping to address loneliness and social isolation for many during Lockdown;
- Accessible information on the range and level of support available for people of all ages who need **mental health support**;
- Reduction in waiting times for **bereavement counselling** services so that people can access the support they need more swiftly;
- Expansion of **digital skills programmes and loaning of digital equipment** to enable more people to get online and maintain contact with relatives and friends as well as undertake a host of other activities that are reliant on being digitally included;
- Support for **volunteer training** to ensure that volunteers have the confidence and skills to provide appropriate support as the need arises;
- On-going **funding for local organisations and community groups** (on less than £1000 during lockdown, local organisations and community groups were able to deliver vital services within their area. They were quick to respond and individuals in the local area were appreciative of the comfort, entertainment and support they felt as a result of the intervention. Moving forward, this avenue needs to remain open to local groups responding to Covid 19.)

The above will be built into ongoing support to local communities.

## 9.0 WORKFORCE MODELLING

Our workforce challenges are likely to be significant this winter applicable to all Partner agencies.

In addition to regular seasonal illness, we are expected to experience additional staff absence due to:

- COVID illness
- Winter pressures and normal recruitment risks
- Childcare
- Bereavement
- Self-isolation
- Shielding, if reintroduced
- Stress and anxiety
- Careful management of low level symptoms where staff would usually continue to work through (e.g. Coughs, colds etc) which will result in staff being off work due to being symptomatic

The health board is urgently reviewing workforce models and rotas from medical and nursing teams to include 7 day COVID rotas to inform our staffing modelling for the COVID / winter period. These workforce models and assumptions have been used in the Q3/Q4 submission made by the HB to WG on 23 October 2020

For Social Care staff the Regional CTM Social Care Workforce Strategic Governance Board oversees the strategic planning for social care.

# 10.0 PREVENTION AND RESPONSE

## 10.1 TEST, TRACE, PROTECT STRATEGY

Welsh Government released their "Test, Trace, Protect" strategy on 13th May 2020. This was based on Public Health Wales advice. It worked by:

- Identifying those who have COVID-19 symptoms, enabling them to be tested while self-isolating.
- Tracing people who have been in close contact with the symptomatic person, requiring them to self-isolate for 14 days.
- Providing advice and guidance, particularly where the symptomatic individual or their contacts are vulnerable or at greater risk.
- Ensuring that individuals and their contacts can get back to their normal routines as soon as possible.

The CTM response plan, referred to as the CTM TTP Programme, is being managed on a regional (CTM) footprint under the leadership of the Director of Public Health. A multi-agency Regional Oversight Group (RSOG) comprising of members of the Health Board, Local Public Health Team, Public Health Wales (PHW), the three Local Authorities and Regional Partnership Board Chair has been set up to operationalise the response plan within the CTM area.

The CTM plan is based on the three pillars of the PHW plan (sampling and testing, contact tracing and case management and population surveillance) underpinned by a risk communication and community engagement plan.

A further area, comprising of the 'protect' element of work was agreed by the UHB and LA Chief Executives, the role of the RPB is as outlined below.

Chaired by the Chair or the Regional Partnership Board, Rachel Rowlands and the work is overseen and driven through the RPB.

## 10.2 PROTECT

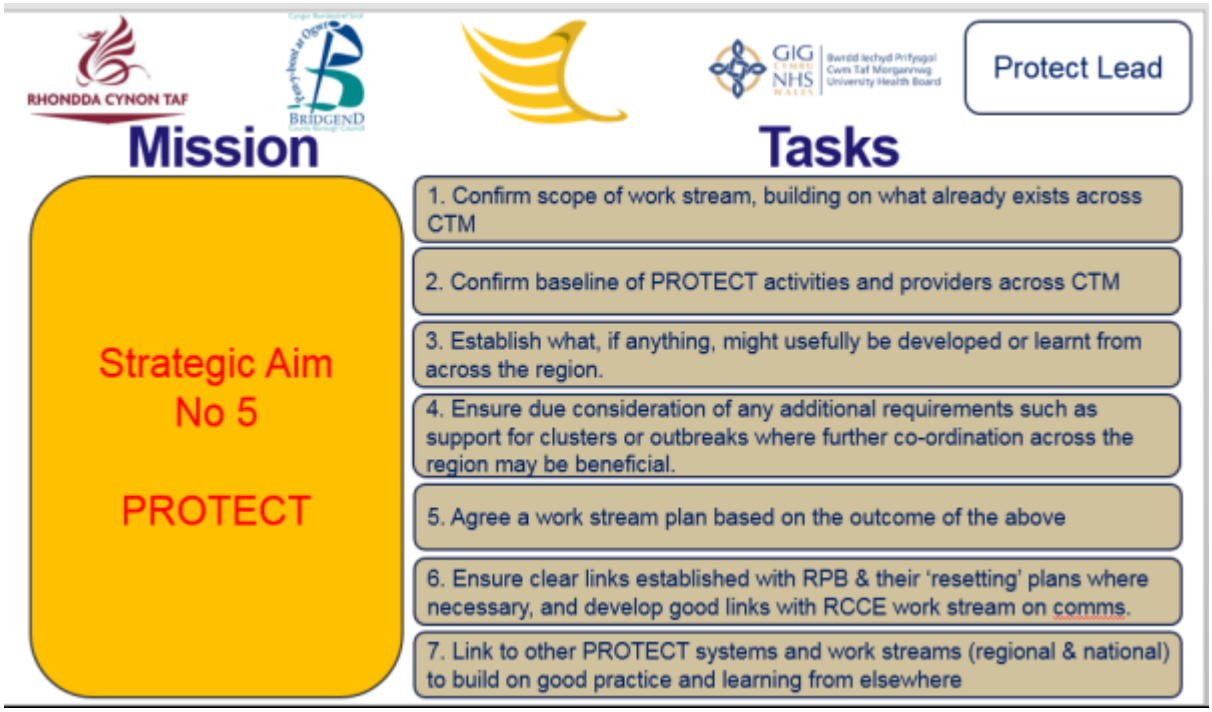
The strategic aim of the Protect work stream is to identify the support which may be required by some people to enable them to successfully self-isolate and ensure this support is provided openly and equitably across CTM.

Ensuring high levels of adherence to the need to self-isolate in response to symptoms, a positive test for COVID-19 or having been contact traced is fundamental to the success of the overall Test Trace Protect programme. It is recognised that people will face different challenges in successfully self-isolating, potentially on more than one occasion.

A range of support has been provided to individuals who have faced challenges during lockdown. Local Authorities, in partnership with the Third Sector and Volunteers, have helped people with shopping, collecting medicine, loneliness and isolation, emergency food and support and a very wide range of other support needs.

This current 'offer' provides a guide to the kind of support likely to continue to be relevant to support self-isolation as part of the CTM Test Trace Protect Programme, as well as the identification of additional developments, depending on how events with Covid-19 unfold.

The following sets out the agreed initial scope of the Protect work stream and was endorsed at the RSOG meeting held on 30 July:




In response to COVID-19 a range of support structures were established across the region to meet the needs of the shielding community. The work led by Wendy Edwards of the RCT Core Steering Group been held up as an exemplar by WLGA, WG and the third sector and similar support networks have been established across Bridgend and Merthyr Tydfil.

It is important that as we move into COVID recovery planning that work plans and activities are routed within existing governance arrangements and structures. It will also provide opportunity to re-align pre-COVID multiagency work streams such as social prescribing and asset based community development and rehabilitation programme into a post COVID re-setting agenda.

A weekly 'Protect' task group, Chaired by Rachel Rowlands is set up. The group provide local intelligence and dissemination of key local messages and coordinate any gaps in service.

The RPB is firmly placed to provide the lead in the development and oversight delivery of the health and social care elements incorporating and recognizing the role of third sector service providers and community groups in providing the front line practical and emotional support needed to help protect those at risk.

## 10.3 Vaccination (Flu and COVID-19)

A sixth work stream under the CTM TTP programme has been added in order to help us to respond to the requirements in the recent Chief Medical Officer's letter – that of the COVID-19 mass vaccination work stream. This is closely linked in with our current arrangements for delivering the flu vaccination also this year.

The aim of this work stream is to deliver an end-to-end pathway for the delivery of a Covid-19 Mass Vaccination Programme within CTM ready for when required.

The objectives for the work stream are as follows:

| | **Objectives** | **SMART Measures (further work required to make them measurable where possible)** |
|---|---|---|
| 1. | Agree mass vaccination plan and test via a multi-agency table-top exercise, building in lessons learnt from elsewhere, including from mass testing arrangements. | Mass Vaccination Plan developed and tested via exercise and scenario planning, with local learning built in together with learning from elsewhere. |
| 2 | Ensure a blended delivery approach with flu vaccination programme | Blended delivery programme developed and tested as part of the above exercise testing. |
| 3 | Identify and put in place the necessary resources, including workforce, training, PPE, | All necessary resources in place including with contingency plans where required. |

| | | |
|---|---|---|
| | vaccination supply and storage etc. | |
| 4. | Provide vaccinations for designated priority groups across CTM, including health and care workers, shielding and vulnerable groups | Vaccinations delivered to priority groups with agreed target measures. |
| 5. | Building on the above, provide vaccinations to remaining groups across CTM as required. | Vaccinations delivered to remaining groups with agreed target measures. |
| 6. | Work with Surveillance work stream & others to establish agreed metrics and reporting, including vaccine uptake & links with disease surveillance. | Agreed metrics and reporting arrangements established. |
| 7. | Work with the RCCE work stream & others to deliver an underpinning communication and engagement plan for staff and residents of CTM. | Clear, underpinning communication and engagement plan. |

Seasonal flu immunisation has commenced. there is both a comprehensive staff immunisation programme for influenza as well as a robust primary care delivery set up to deal with the previous cohorts of patients and essential workers.

## 11.0 HEALTH INEQUALITIES

People from Black, Asian and Minority Ethnic (BAME) backgrounds, vulnerable groups and poorer communities are disproportionately affected by coronavirus. We are committed to reducing health inequalities across the region and remain focussed on equity and equity of access to the services individuals and communities need.

The all Wales COVID-19 Workforce Risk Assessment Tool addresses individual risk factors and has the potential to be used in a wider range of workplace settings for staff to assess their personal risks and support discussion with employers about appropriate protection.

## 12.0 THIRD SECTOR PROVISION

Third Sector organisations across CTM operate at all levels of in our communities and are best placed and often far more responsive to the daily and ongoing needs within and across our local communities.

They are able to make a significant – and rapidly increasing – contribution to the health and well-being of local communities across CTM and indeed Wales. It has been made every clear that charities and Third sector voluntary organisations would be expected to perform an increasing amount of the social and cultural functions which previously the public sector struggled to provide. Our attempt's and efforts to fully and truly engage with our Third sector colleagues has enabled us to refocus more of our health and social care services to the more clinical aspects across our communities releasing much resource within the Third sector across our communities, therefore maximising the excellent work undertaken and looking at how they influence and build on this work further.

The Third sector are currently playing a vital role in developing high-quality services the public rightly expects and helping direct existing and future pathways as they are developed and reviewed. They have particular strengths, such as reaching the most disaffected people, finding innovative solutions and offering a personal touch as well as really understanding the needs at a local level.

We are as a region benefitting from effective Third sector engagement and this plan looks to continue our approaches by further increasing the community resources and support mechanisms within a consistent community wide system of care and support.

Voluntary Sector proposals can be found in Annex 5 and focus on supporting discharge, hospital to home services, loneliness and isolation and supporting carers.

## 13.0 Primary Care and Community

Primary Care provides the essential and high value services including TTP, immunization, vaccination, screening, prevention services. The focus will be equally on prevention as it is on treatment and rehabilitation.

As in recent year within the region there will be increased investment in community and primary care services to meet demand and continue the care closer to home focus. This will include providing support to care homes to support vulnerable residents and specific areas of focus include an enhanced COVID and winter respiratory and palliative care hub and multidisciplinary response to prevent acute admission and support discharge. In addition to this central to the plans is increased support to the care home sector in line with the requirements of the revised Direct Enhanced Service and enhancing capacity on primary care out of hours to ensure this is 24/7. Flu is covered earlier but critical to the wider plan is the increased delivery in primary care this year and this is well underway through GP's and Community Pharmacies.

## 14.0 SOCIAL CARE

Key areas of focus remain;

- Protecting the rights of people who need care and support and carers who need support, including through developing a National Plan for Carers
- Supporting the workforce

- Stabilisation and reconstruction of the sector
- Continued focus on integration of health and social care, with regional partnership boards supporting the integrated delivery of winter plans.

Through the winter, there will be a continued focus on maintaining the resilience of the social care sector to support people's wellbeing in keeping with the principles of integration, prevention, collaboration and co-production.

## 15.0 CARE HOMES

In order to inform the Welsh Government Rapid Review of Care Homes Cwm Taf Morgannwg RPB were asked to;

- Provide a summary letter setting out the key actions led by the authority or health board and the issues undertaken in partnership with one another identifying successful achievements and actions that they wish to fulfil in the forward look towards the autumn.
- Participate in an individual discussion with Professor Bolton about the summary letter.
- Join a regional workshop to reflect on the partnership actions required, and
- Produce a regional action plan for care homes by early September 2020.

Building on a solid foundation of working in partnership across the health and social care system in Cwm Taf Morgannwg we were able to collaborate and shape a regional response from the outset of the COVID19 pandemic.

This platform has shaped our response, ensured we are consistent with government guidance and best practice across the region and to target and

deliver an enormous amount of support to these vital assets in our community.

This extends beyond the focus of residential and nursing care home market as we are providing daily communications on all relevant policy and practice to care providers.

**Working in partnership across the health and social care system**

Our work, across partner agencies, to ensure care market resilience locally and regionally includes;

- General and bespoke advice on all areas, including infection control, PPE, testing and a range of support in response to individual care homes requests.
- Supplies of Personal Protective Equipment (PPE).
- Surveillance and response to cases and outbreaks.
- Additional health and care support, as required.
- Dedicated regional Public Health Wales support and advice providing a valuable "golden thread" across health and social system.
- Testing of new admissions and symptomatic cases – and the rollout of testing to asymptomatic cases.
- Hospital discharge planning and in particular early regional response to step up/down accommodation and negative discharge testing.
- Set up of regional respiratory hub to support care homes.
- Responding to assurance from government on future funding, we acted swiftly to support financial pressures experienced by care providers.

Key actions of the Regional Care Home Action Plan are;

- Review the CTM Complex Care Group objectives and representation.
- Develop a Regional Support Structure / Escalation Process to assess Risk and provide appropriate support care homes who are experiencing difficulties.
- Operational Group to present options to the Complex Care Group how the region can support Care Homes to provide appropriate level of care, emotional and well-being support to all residents
- Operational Group to work with Care Homes across the region to develop robust Contingency Plans and Infection Prevention Plans.

A workshop will be held on 15th October 2020, with the current Cwm Taf Morgannwg Complex Care Group to consider appropriate timescales and implementation leads.

## 16.0 OLDER PEOPLES COMMISSIONER REPORT, LEAVE NO-ONE BEHIND - ACTION FOR AN AGE-FRIENDLY RECOVERY

**The Commissioner's recommendations for immediate action are:**

Public bodies should take action to ensure that public health messaging is communicated more effectively to older people.

• Public bodies should undertake community-level audits of vulnerable older people who have been digitally excluded during the pandemic and provide user-friendly devices with access to the internet.

**The Commissioner's recommendations for longer-term action are:**

• Establish a right to digital connectivity – viewing digital infrastructure as an essential service that the whole population needs affordable access to

• Introduce a social tariff for internet access and work towards the provision of free universal access to the internet.

• Place a duty on public bodies in Wales to demonstrate how they will engage with and serve citizens that are not online.

• Health boards and local authorities should establish outreach programmes to build digital confidence for older people to access digital public services, building upon the work being delivered by Digital Communities Wales.

The Commissioners report will be addressed via the strategic planning group under the RPB. Communication and engagement is being addressed under a sub group of the Test, Trace and Protect work streams and digital inclusion for older people to engage in online platforms of support has been picked up within planning for ongoing support.

## 17.0 TRANSFORMATION PROGRAMME

Within the Cwm Taf Morgannwg Region the Transformation programme comprises 8 Work-streams supported by a Welsh Government grant under the national Transformation Programme to support the implementation of the A Healthier Wales plan.

The Work-streams are focused upon building up community-based services in order to both improve patient/service user/carer outcomes and to create greater efficiency within the health and social care system as a whole, reducing the reliance and pressure on in-patient services.

In Cwm Taf there are 5 Work-streams building on and scaling up existing services to improve support for people at risk in communities and to reduce pressures on acute services by:

- Scaling up the **Population Segmentation & Risk Stratification** pilot to tailor interventions to specific populations and to support targeted and anticipatory care.
- Building on the **Assistive Technology** service to include a mobile responder service that will operate 24 hours a day, 365 days a year responding to triggered alarms and establishing/deploying the most appropriate response.
- Scaling up cluster focused **MDTs with a 'virtual ward' approach** to reduce demand on general practice both in and **out of hours** and on A&E.
- Extending the **SW@H** hospital model to give community professionals an alternative to hospital care and support, providing access to social care, community equipment and @home nursing services 7 days a week, 8.30a.m. to 8.00p.m.
- Developing a service to deliver urgent primary care out-of-hours, with new roles and an MDT approach.

In Bridgend 3 Work-streams are concerned with accelerating the pace of change for its integrated services by:

- **Ambition 1**: Providing 7-day access to community health and social care services – "*Every Day Is Tuesday*", delivering extended alternative service options to hospital and long-term care
- **Ambition 2**: Having a primary & community care MDT approach, delivering a one team approach around people, coordinating primary care and community services cluster responses.
- **Ambition 3**: Developing and delivering resilient coordinated communities; with key organisations, their partners and the communities they serve developing benefits, by working collaboratively to apply preventative approaches that enhance the wellbeing of the population of Bridgend.

All of the service-based projects were due to 'go live' between January and April 2020. Whilst there was disruption to implementation, with resources required to be diverted to meet urgent demands over the short term, the capacity and drive for delivering these services remains across the region and will provide additional support within local communities over the winter period.

## 18.0 REHABILITATION

The health board has allocated funding to ensure the capacity to deliver rehabilitation has been enhanced to respond to winter pressures and the additional Covid surge. Evidence suggests that timely assessment and a clear rehabilitation focus improves patient outcomes.

- Therapy staff have been deployed to Ysbyty Seren to sustain patient flow from acute services, to provide rehabilitation to those recovering from Covid-19 and to ensure timely discharge back to the patient's own home or locality.
- A Therapy hub has been developed which will provide a single point of access for both secondary and primary care to meet the rehabilitation needs of people recovering from or affected by Covid-19. This will be staffed by a multidisciplinary team of therapists who will facilitate immediate needs assessment, triage and signposting to appropriate community rehabilitation services or self-management resources.
- Therapy support to the three DGH's has been enhanced to ensure timely assessment, intervention and discharge planning to support patient flow.

## 19.0 CHILDREN AND YOUNG PEOPLE

The CYP specific winter plan recognises the current pandemic crisis in addition to expected winter pressures. The plan makes proposals for additional pediatric staff to respond to the increase in activity arising from the combination of COVID 19 and bronchiolitis / influenza (usually November until March) the department are already seeing these expected pressures early during in September.

The impact of COVID on children and young people's mental health is well documented. The British Psychological Society (2020) explain children who have experienced care may be more vulnerable to the pandemic, having faced insecurity and stressful situations before or they may have had to be alert to danger, which can cause stress responses during lockdown, affecting their behaviour and emotions.

National Youth Advocacy Service (2020) found 50% of children in care and 4 in 5 care leavers felt lonely and anxious during lockdown. Voices from Care Cymru (2020) also found children felt more isolated and anxiety had increased, they claim isolation may impact mental health of children who have already experienced trauma, and those receiving mental health support may have found this disrupted.

The Regional Partnership Board is committed to engaging and responding to children and young people's mental health and wellbeing and there are a number of developments being driven by the PRB including development of therapeutic services for children looked after and finding innovative ways of engaging children and young people through the development of mobile phone application to improve communication between social work teams and young people.

## 20.0 MENTAL HEALTH

In a press release from the Royal College of Psychiatrists (2020), psychiatrists have reported a 43% increase in emergency appointments and a 45% reduction in routine appointments, they warn of a surge in mental health cases could be ahead. The report from NHS Confederation (2020) reflects this prediction, highlighting increased referral rates, higher than pre-lockdown. They are expecting further rises with; those with existing mental health issues, those relapsing and new patients. Statistics from the Office for National Statistics (2020) show depressive symptoms doubled during lockdown with 1 in 5 adults experiencing some form of depression and we know that the shorter daylight hours in winter will only make this worse. Mind (2020) reported 1 in 5 people in Wales were unable to access mental health support at the start of lockdown, they claim this can lead to people reaching crisis point and needing emergency care. Mind, also report increased access to their online services. With this in mind our focus for supporting people's mental health will focus on a number of areas. The first includes increased capacity led by the voluntary sector for Tier 0/1 interventions using the recently allocated Mental Health Covid Response Grant and the 6 priorities identified included people who are finding themselves socially isolated, particularly digitally excluded, people experiencing economic hardship, those with Co-occurring Mental Health and Substance Misuse needs and carers who are providing support. In addition to this crisis services are being strengthened to ensure both timely responses to ensure no delays in hospitals but also to test the demand for a crisis community drop in facility.

A study from Mental Health Wales (2020) showed 1/3 of children experienced mental health issues during lockdown. Alfven (2020) also reported an increase in anxiety and depression amongst children and raised concerns about how; missing education, poverty, malnutrition and inequalities may exacerbate these problems. See Children and young people's section above.

## 21.0 CONCLUSION

Across Cwm Taf Morgannwg we will continue to work in partnership ensuring continuous learning and development through our plans as they are implemented, enabling reflection and collaborative approaches to service modelling into and throughout the winter period.

We will aim to ensure successful delivery of the six goals approach, transformational interventions and their underpinning operational plans will change the ways that individuals access services across our local communities and into our acute or nursing home / community resources, as set out in *A Healthier Wales* commitments and design principles.

This should result in both an improved experience and outcome for patients and reduced risk of nosocomial transmission. We will strive to ensure a more supportive and clear service model for our staff in order to maintain and enhance their well-being. Throughout this plan we will look to deliver greater efficiency and clinical effectiveness through treating individual's at the most appropriate care setting for them.

We will utilize any resources to support effective operational implementation of our winter plans and service remodeling across our community services and acute site, thus removing any barriers to services and ensuring patients are not caught between rigid inflexible service pathways.