

Spotlight on...

RECENT NHS DISCHARGES INTO CARE HOMES

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

This is the fourth in a new series of *Spotlight on...* briefings, aimed specifically at sharing key information on the impact of the coronavirus pandemic on NHS trusts.

Trusts are committed to supporting their partners in the care sector, who look after the most vulnerable members of society, and this commitment has never been stronger than during the COVID-19 pandemic. This briefing sets out how national guidance around NHS discharges into care homes developed in March and April 2020, how trusts sought to support care homes during this period and why trusts refute the suggestion that they 'systematically' and 'knowingly' transferred known COVID-19 patients into care homes.

Background

In recent weeks the care system has become the media and political epicentre of the COVID-19 pandemic, with 38% of care homes experiencing an outbreak and the number of COVID-19 deaths in care homes only now gradually reducing.¹ Care providers, including care homes, are working around the clock to keep their staff, and the vulnerable people in their care, safe. In the past week, trusts have come under scrutiny for following national policy directives to discharge patients from hospital in preparation for the peak of the pandemic.

This briefing sets out trust leaders' perspective on this topic. The information is drawn from our conversations with trust leaders, who strongly refute the suggestion² that their actions have caused excess mortality in care homes by 'systematically' discharging known or suspected COVID-19 patients into the care sector. It sets out trust leaders' views within the context of the relevant national guidance that trusts and care homes were following at the time.

What did national COVID-19 guidance direct trusts and care homes to do?

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

On **17 March**, NHS England and Improvement **instructed** trusts to urgently discharge all medically fit patients from hospital as soon as it was clinically safe to do so.³ This rapid implementation of the 'discharge to assess' model aimed to free up 15,000 acute beds by 27 March and maintain this model thereafter, so that hospitals would have capacity to care for the anticipated influx of patients who were seriously ill with COVID-19. NHS England and Improvement made this decision having just witnessed the health and care system in Northern Italy being overwhelmed by COVID-19 demand. The letter from NHS England and Improvement directed trusts and clinical commissioning groups (CCGs) to work with local authorities to deliver this policy.

1 ONS data, 12 May 2020. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/weekending1may2020> [Accessed at 15 May]

2 See for example, <https://www.dailymail.co.uk/news/article-8302039/Hospitals-probed-sending-elderly-care-homes-despite-KNOWING-coronavirus.html>

3 The emergency COVID-19 Bill, which was introduced on 19 March and became law on 25 March, removed the need for eligibility assessments, and the government committed to fund all 'out-of-hospital' support packages during this emergency period. These two actions removed the legislative and funding barriers that often blocked quick, safe discharges prior to COVID-19.

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

On **2 April**, DHSC published [guidance on the admission and care of people in care homes](#) which stated that some new admissions to care homes may have COVID-19 – whether symptomatic or asymptomatic – but all of these patients could be safely cared for in a care home setting if the appropriate guidance around infection prevention and control (IPC), isolation requirements and personal protective equipment (PPE) was followed. The guidance stated that negative tests were “not required prior to transfers/admissions into the care home”, as at this time the national policy was for testing capacity to be limited to symptomatic patients. If a care home was happy to admit patients who tested positive for COVID-19, then the hospital discharge service would include their test results, date of onset of symptoms and a care plan for discharge from isolation in the discharge documents.

On **15 April**, the government published its *Adult social care action plan* which announced that trusts would need to test every single patient prior to discharge back to their care home or new admission to a care home (insofar as this wasn't already happening) – whether they had symptoms or not on discharge from hospital. Trusts were already testing patients and care home residents with symptoms wherever testing capacity allowed, but this capacity was not reliably and consistently available across the country before mid-April. The guidance stated that the patients waiting for test results should be discharged and isolated as suspected COVID-19 patients. If the test result was negative, the guidance still recommended isolation for 14 days. If care homes were unable to meet isolation requirements, alternative arrangements would need to be made by the local authority, assisted by NHS primary and community care. The guidance recognised that while some care homes were confident to accept COVID-19 confirmed or suspected patients, others were not, and local authorities needed to lead the local system to create other arrangements if care homes were unable to accept COVID-19 or suspected COVID-19 patients.

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

How did trusts implement this national guidance?

We have spoken to a range of NHS hospital and community trust leaders to understand how they implemented the instruction of 17 March and the guidance of 19 March to discharge medically fit patients to create hospital capacity to treat COVID-19 patients. The instruction and guidance deliberately, and rightly, left it to local health and care partners to agree how to implement the guidance in each system but was explicit that arrangements need to be agreed by all relevant partners including NHS trusts and the care sector.

There has been a suggestion by some commentators that trusts knowingly and systematically discharged known and suspected COVID-19 patients to care homes without informing them and this discharge approach has been a primary driver of the high mortality rate in care homes.

Trust leaders tell us that the following principles guided the local discharge arrangements they agreed with their local health and care partners in response to the 17 March instruction and 19 March guidance:

- The discharge to assess model was based on existing best evidence/practice for hospital discharge, that was already being used in some acute trusts in England.
- There was a clear national focus on creating sufficient NHS hospital capacity to treat patients who were seriously ill with COVID-19, and this was recognised and accepted by both the NHS and the care sector.
- Discharge approaches were agreed on the basis, as they always have been, of a measurement of the overall balance of risk to individual patients, which takes into account the fact that acute hospitals are not safe environments once they have recovered. These included managing the risk that, if a patient is medically fit for discharge, it is better for them to be discharged as rapidly as possible from hospital as this group of patients do not fare well with long hospital stays given the risk of, for example, de-conditioning, contracting a hospital acquired infection, and the onset or worsening of dementia.
- Discharge approaches were also made on the basis of evidence that supports as few moves as possible for older people, as too many moves pushes up mortality rates. Moreover, many care home operators were also clear that residents should return to their home – the care home – to be looked after.
- Trusts were acutely aware of the need to protect patients they were discharging to community services and care homes. Given that trusts collaborate on a daily basis with the care sector, they recognised the fragility of some care providers and the vulnerabilities of people receiving care and were keen to protect them from the outset. In some areas, trusts redeployed staff from planned care in community services to support care homes with therapeutic, nursing and mental health teams, who worked closely with the primary care team assigned to each home.

- Trusts worked closely with local authorities and local care providers to identify discharge pathways for suspected and known COVID-19 patients, finding individual solutions that varied depending on local circumstances. Options for consideration included:
 - keeping the patient in hospital for the 14-day isolation period where absolutely essential and where there was no alternative
 - moving the patient to an intermediate rehabilitation or step-down community bed for the 14-day isolation period
 - supporting the patient to return home, with a care package if necessary, and advising them to isolate for 14 days
 - providing alternative accommodation arranged by the local authority, but funded by the COVID-19 NHS budget, pending test results (e.g. hotels were used as isolation facilities in Cornwall)
 - discharging the patient to a care home, if that care home agreed they had the capacity, capability and equipment to admit COVID-19 positive or suspected residents.

The precise mix of options used in each locality varied according to the capacity available and the arrangements agreed in each local system.

Trust leaders tell us that they consistently followed the guidance of informing care homes if discharged patients had COVID-19. They only discharged known or suspected COVID-19 patients if the relevant care home agreed they had the capacity to treat and isolate them.

- One of the features of coronavirus is that patients can be infectious without displaying symptoms. The only way to definitively identify asymptomatic COVID-19 patients is to test them. As set out above, the requirement on NHS trusts to systematically test asymptomatic patients was only introduced on 15 April. Testing capacity was very constrained in the period from March to mid-April, and there is still a lot to do to ensure the health and care sector has access to the volume of tests, and the swift turnaround of results required.
- Trust leaders tell us that they recognise that, in the first few days after 17 March, small numbers of asymptomatic COVID-19 patients may have been discharged into care homes. Trust leaders tell us that they quickly became aware of the risk and “within one or two days” had developed new agreed discharge arrangements that were based on testing all discharges and isolating those awaiting test results using the options available for isolating COVID-19 or suspected COVID-19 patients.

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

Evaluation

Did trusts systematically discharge patients from hospital in the wrong way?

It will be for any future public inquiry to determine the causes of the mortality rate in care homes during the coronavirus outbreak. There is no doubt that the mortality data available, coupled with evidence from families and care workers at the frontline, of course requires that level of investigation.

NHS Providers cannot verify every single discharge in all 217 trusts and we are aware that there may be some variation across the country. We also know that there are reports of care homes being forced or pressured to accept discharges which will of course warrant local investigation. But our conversations with NHS leaders lead us to conclude the following:

- The trust sector did not 'systematically' and 'knowingly' discharge patients they knew or suspected had COVID-19 into care homes, as recent media reports have suggested. They have followed national guidance throughout the pandemic.
- There were, and still are, some places where trusts have been discharging confirmed and suspected COVID-19 patients into care homes, but this is on a planned and agreed basis and our understanding is that the numbers of these discharges are small. This is in line with the national discharge guidance and has been publicly acknowledged by the Association of Directors of Adult Social Services as appropriate.
- While there may have been a small number of asymptomatic patients discharged in the immediate period 17-19 March, this was quickly identified as an issue and appropriate arrangements were put in place. It is impossible to tell at this point how much of an impact this has had, but trust leaders are clear that any such discharges were unwitting and in line with the national guidance at the time.

On this basis, we believe it is right to say that trusts have not systematically and regularly discharged confirmed or suspected COVID-19 patients into care homes. If there were some asymptomatic patients transferred early on, trusts believe these were not in large numbers.

How has the NHS worked with the social care sector throughout the pandemic?

The trust leaders we spoke to strongly resented the suggestion that they had systematically and knowingly discharged known COVID-19 patients to the home care sector, at increased risk to those individuals and care home staff. They feel they have been investing considerable time and effort to support their local care sector given their knowledge of the pressures the care sector is under. This builds on the mutually supportive relationships between the NHS, local authorities and care homes which pre-date the outbreak of COVID-19, which are relied upon in a variety of contexts such as 'flu outbreaks, norovirus or problems with the care home estate.

Examples from our conversations included trusts:

- supporting care homes and other providers with PPE, including setting up mutual aid schemes
- opening up their lab testing capacity to care homes as soon as possible
- sending multidisciplinary teams to review care homes' processes around IPC including hand hygiene and laundry, PPE and segregating COVID and non-COVID residents – these teams delivered training on appropriate use of PPE and IPC protocols, and supported care homes to develop processes that meant agency staff did not undertake shifts in multiple care homes
- delivering advice and training via digital technology, in addition to enhanced clinical support for staff and residents
- redeploying staff into care homes to maintain capacity when they had staff shortages to prevent closures.

NHS England and Improvement also took steps to support care homes, including [bringing forward essential elements of the enhanced health in care home model](#) on 1 May and developing a 'train the trainer' programme in early May for CCG infection control nurses to train care homes on IPC measures. In a [letter](#) to the NHS on 29 April about the next phase of the NHS' response in managing COVID-19, NHS England and Improvement set out actions for the NHS to continue supporting social care colleagues and residents. This work will continue to be vital in the coming weeks.

Conclusion

Why has there been a COVID-19 crisis in care homes?

Trust leaders are working closely with their social care partners to support our most vulnerable. In their view it is unhelpful to frame the debate about the current crisis in care homes in terms of whether ‘we have prioritised the NHS at the expense of the care sector’? The NHS has done everything it could to respond to the unprecedented challenge presented by coronavirus. The suggestion that the NHS should have done less, or been given less support, to enable more support to be given to care homes, seems inappropriate.

It is also worth emphasising that the NHS prepared for and entered the crisis in a weakened position, with high and growing demand, high vacancy rates and widespread capital and other financial constraints. It was also grappling with its own challenges in the early days of the pandemic.

So, the more appropriate question which warrants serious consideration, is whether the government has given sufficient priority in its considerations to the care sector and provided the right support at the right time during this crisis. These are questions for a public inquiry, but we would make the following observations:

- Long before COVID-19, there was widespread agreement that the care sector had suffered from years of underinvestment leading to an unsustainable funding model and a fragile provider market.⁴ This has exacerbated workforce challenges with carers inevitably facing low pay despite offering high value services, 122,000 vacancies and high turnover rates.
- Successive governments have made empty promises to resolve the long-standing social care crisis, and their failure to do so has had devastating consequences during the pandemic. Any solution needs to both decide how to fund these services and how to fully integrate them into local health and care systems. Health and social care are two sides of the same coin, and we need to ensure the care workforce receives better pay, training and clinical governance.
- During the pandemic, the widespread failures of PPE and testing have hit the care sector particularly hard. It is still not clear who is responsible for testing care home residents and staff;⁵ nor how the government will meet its own commitment to test all care home residents and staff by early June. Care providers are still waiting for their online PPE distribution portal (only 2,300 providers currently have access) and remain reliant upon private suppliers and emergency deliveries from Local Resilience Forums.

4 The challenges facing the social care sector are set out in various reports, including the Care Quality Commission's (CQC's) latest report on [The State of Health Care and Adult Social Care in England 2018/19](#), published on 15 October 2019.

5 In the [adult social care action plan](#), the government named CQC as responsible for leading the coordination of testing of care workers. However, on 7 May, ministers instructed directors of public health in local authorities to take charge of testing in care homes.

We also note the care sector's **view** that:

- The government did not focus on the care sector sufficiently or soon enough. For example, visitors were only restricted from visiting care homes on 2 April.
- Additional government emergency funding has been welcome if slow to arrive and insufficient in some areas. Given the care home sector is made up of a diverse range of different sized providers across the country, co-ordination including via local authorities has been necessarily more complex than within the NHS hierarchy.

These are all questions that will need to be examined in a public inquiry at the appropriate time. Any such inquiry will need to consider the timeliness and effectiveness of decisions taken by the government including learning from the international community with regard to care homes, the role that the delay in developing testing capacity and sufficient supplies of PPE has played in the high number of care home deaths from COVID-19, as well as why the UK was prepared for a flu-type pandemic, in terms of the PPE stockpile and testing infrastructure, rather than a SARS-type pandemic.⁶

Our understanding of how community transmission reached the care sector and spread within care homes is developing at pace and will also inform the inquiry. But trust leaders are clear that at no point did they 'knowingly' and 'systematically' discharge COVID-19 positive patients into care homes.

⁶ Jeremy Hunt interview on Radio 4 Today programme, 14 May 2020. Also reported in The Times on 23 April <https://www.thetimes.co.uk/article/jeremy-hunt-whitehall-pandemic-strategy-focused-too-much-on-flu-threat-t60sxw2r7>

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