



ADSS Cymru

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 Leading Social Services in Wales

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Dr Dai Lloyd MS
 Chair of the Health, Social Care and Sport
 Committee
 Welsh Parliament
 Cardiff Bay
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<http://www.adss.cymru>

Dear Dr Lloyd

Thank you for affording us the opportunity to provide supplementary evidence in order to clarify some of the points that Members raised during the evidence session on 9 December 2020. We have addressed the questions under the themes below.

Hospital Discharge Guidance

All regions have developed robust standard operating procedures agreed between Health Boards and Local Authorities, which enables statutory agencies to follow the COVID-19 discharge guidance issued by Government. In the main, those procedures are being adhered to. However, there are still incidences in various parts of Wales where those procedures are not being adhered to, which leads to poor (and in some cases very poor) discharge practice. For example, some individuals are being discharged without having a negative test or ambulances turn up at care homes on a Sunday evening or overnight with a resident in the back and the care home manager feels pressurised into having to accept them rather than them returning to hospital.

In trying to understand why procedures are not followed, it is our perception that the interpretation of the guidance is dependent on the pressure to discharge from hospital. Care homes have been very clear about the guidance and will insist on a negative test result before considering the admission, however, that does not mean that attempts are made to discharge without the test result or asking for the discharge to happen before the result is known. There are also incidences of Health Boards trying to use 'technicalities' to bend the rules. For example, a care home resident may have spent time (often for a lengthy period of time/overnight) in a hospital assessment unit, as opposed to being admitted to a ward. The hospitals then insists that as they have not 'technically' been admitted they should be able to return to the care home from which they originated without isolation or without making use of a step-down facility.

This in our view poses very real risks. In these instances, there is a reliance on care home providers to have the confidence to challenge such discharges and refused to admit patients into care homes when the process has not been followed. However, this is not easy and is not helped when, in one region, care homes have to deal with two District General Hospitals who apply different time scales in hospital (A&E) before a negative test is required.

When a sub-optimal (unsafe) discharge has occurred that incident will be recorded by the care home or Local Authority and will be escalated with the Health Board so that the incident can be reviewed, and any learning implemented. At times, such incidents have constituted a safeguarding concern, so have been investigated in line with statutory safeguarding processes. However, there have been occasions when an incident has been escalated with health colleagues but there has been no resolution or feedback provided

back to us in local government to understand whether any appropriate action has been taken. So, there is a variability that needs to be addressed but, more importantly, health colleagues must be respectful, understanding and supportive of providers when they are reluctant to take citizens who are still COVID+ or their test status is unknown.

Weekly staff testing

Again, there is some variability in terms of testing across the regions. For example, in Powys, Public Health Wales (PHW) had recently stopped weekly testing but has now reinstated it. In Carmarthenshire, routine Weekly testing of care home staff is no longer in place, however, it will be reintroduced shortly, following the introduction of the Lateral Flow Tests for asymptomatic staff. In other areas, weekly testing is undertaken if determined necessary by PHW because there has been a COVID outbreak, otherwise it is done fortnightly. We know from providers that this is a time-consuming process and concerns have been raised around using the test portal and lighthouse labs and particularly the paperwork, time and effort this has creates for care homes. However, the timeliness of test turn around is still the most significant challenge and cause of frustration for providers. Anecdotal evidence shows that in some cases, it can take up to 4 days for test results to be received, which is not acceptable. Local Authorities, providers and care staff must have confidence in the system, otherwise we will see increase staff opt-out of the process.

Collection and availability of data

The current information being collected is very generic and not specific. As one colleague stated:

“This is supposed to be a whole system approach but all we get is figures thrown from one side of the system i.e. there are 150 people awaiting a discharge in hospital. We are not able to respond by saying we have discharged patients in the last 7 days; or are providing domiciliary care packages to so many residents on a weekly basis. In addition, we focus on those who require support from Social Services, we are never told how many patients who do not need any Social Services input are awaiting to be discharged, which is a far greater number.”

Capturing this full range of data would be allow a whole picture to be painted and not just focussing on one part of the system but the whole system and what it is providing to the whole community, not the small numbers who are in hospital at any one time.

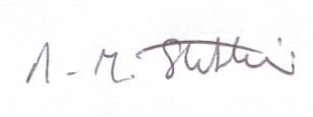
There are good practice examples of data collection and mining. The Gwent Community Care Sub-Group (CCSG), for example, has developed regional data situation reports (SitReps). In particular they have developed a sitrep for care homes which monitor the number of care home vacancies, especially in clean care homes, where there are no COVID outbreaks. They have also developed a domiciliary care sitrep to monitor care packages and staff absence. In addition, a Closed Setting group established by Aneurin Bevan University Health Board (ABUHB), regularly monitor care home incidents and infection rates as well as how many staff and residents are COVID positive. From a commissioning perspective regular data is obtained on vacancy rates, financial risk, numbers of staff isolating, incidents and out of incident data (care homes and domiciliary care). All this is reported to CCSG on a weekly basis and all commissioners. This has led a number of Gwent-wide regional initiatives to increase capacity in the health and social care work force:

- Feasibility of developing a staffing bank for emergency deployment
- Partnership with Coleg Gwent to access the student body to add capacity
- 18 students recruited to ABUHB’s Resource Bank during first wave of pandemic.
- Feasibility of utilising ABUHB’s resource bank workers to provide emergency cover in care homes.

- DWP's Kickstart Scheme regionally promoted as a way to increase staff capacity.
- Technical Co-ordinating COVID-19 Group – Mutual Aid Agreement for Local Authorities and partnership agencies to support ABUHB staff capacity and vaccination rollout.

I hope the Committee finds this additional information helpful. If you require any further information, please do not hesitate to contact our Policy and Research Lead, Paul Pavia, within the ADSS Cymru Business Unit [REDACTED]

Yours sincerely,

A handwritten signature in black ink, appearing to read 'N. Stubbins', written over a light grey rectangular background.

Nicola Stubbins
ADSCC President