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- NHS England (https://www.gov.uk/government/organisations/nhs-commissioning-board)
- Public Health England (https://www.gov.uk/government/organisations/public-health-england)

Guidance

Discharge into care homes: designated settings

Updated 17 May 2021

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Some of the rules on what you can and cannot do changed on 17 May. However, many restrictions remain in place. Find out what you can and cannot do (https://www.gov.uk/guidance/covid-19-coronavirus-restrictions-what-you-can-and-cannot-do).

A new COVID-19 variant is spreading in some parts of England. There may be additional advice for your area. Find out what you need to do (https://www.gov.uk/guidance/covid-19-coronavirus-restrictions-what-you-can-and-cannot-do).

1. Summary

1.1 As set out in the adult social care winter plan (https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021), we have committed to deliver a designation scheme with the Care Quality Commission (CQC) of settings for people leaving hospital who have tested positive for COVID-19 and are transferring to a care home (this includes working age adults who reside in a care home). This document provides guidance in the delivery of this scheme, for local authorities, clinical commissioning groups (CCGs), care providers and people who use these services. In line with the hospital discharge service guidance (https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model), discharges from hospital should follow the principle of ‘Home First’ and only a small proportion of people who are in hospital will be discharged to care homes.

1.2 This guidance builds on the letters that were sent to Directors of Adult Social Services (https://www.gov.uk/government/publications/designated-premises-scheme-letter-to-directors-of-adult-social-services) on 13 October 2020, and 10 November 2020, which instructed local authorities to begin identifying and notifying CQC of local designated accommodation and to work with CQC to assure their compliance.

1.3 This guidance has been co-produced with NHS England (NHSE), Public Health England (PHE) and CQC, in consultation with the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), care provider associations and user groups.

2. Introduction

2.1 Our priority is ensuring that everyone receives the right care, in the right place, at the right time, and the prevention of infection in care homes (and elsewhere). We also seek to ensure that the wellbeing of residents and their relationships with friends and family is considered and supported.

2.2 To further support safe and timely discharge and protect care home residents and staff from COVID-19 throughout winter, we have worked with the CQC to develop a designation scheme. This scheme ensures that anyone who has tested positive and is still likely to be infectious with COVID-19 is discharged to a designated care setting to complete a period of isolation before moving to a care home. These settings will meet a set of agreed standards to provide safe care for COVID-19 positive residents.

2.3 This is one element of wider government efforts to minimise the risks of spread and transmission of COVID-19. Additional guidance includes measures to enable safe visiting in care homes (https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus), information on testing (https://www.gov.uk/guidance/overview-of-adult-social-care-guidance-on-coronavirus-covid-19#get-people-tested) for

social care workers and people in care homes; and managing risks around transmission through the workforce and visiting health professionals that are set out in the adult social care winter plan (https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021).

2.4 The commitment builds on existing guidance on admission to care homes (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes) published on 2 April 2020 (updated 16 September) that already includes a requirement, in line with the hospital discharge service guidance (https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model), that if appropriate isolation or cohorted care is not available with a local care provider, the individual's local authority will be required to secure alternative appropriate accommodation and care for the remainder of the required isolation period. Local authorities must ensure that sufficient settings are available to meet expected needs now and over the winter period. The costs of the designated facilities will be met through the £588 million discharge funding.

2.5 In relation to confirmed COVID-19 positive cases, no care home will be forced to admit an existing or new resident to the care home if they are unable to cope with the impact of the person's COVID-19 illness. All residents should be discharged to a designated setting in the first instance. Only under the exceptional circumstances where a designated setting is not appropriate, the local authority should make alternative arrangements (see section 4 for more information).

2.6 Some local authorities may agree with local NHS partners to make use of NHS settings to fulfil the role of a designated premises. In this instance, it will not be necessary for the NHS setting to be inspected by CQC against the infection prevention and control (IPC) protocol (https://www.cqc.org.uk/guidance-providers/residential-adult-social-care/infection-prevention-control-care-homes) specifically for the purpose of this arrangement. This is because NHSE will conduct their own assurance/checking of these facilities.

The new requirement

2.7 The new requirements are the following:

- Every patient must receive a COVID-19 PCR test result within 48 hours prior to discharge (see section 4.3 and the clarification note (https://www.gov.uk/government/publications/designated-settings-for-people-discharged-to-a-care-home/discharge-into-care-homes-for-people-who-have-tested-positive-for-covid-19) for more information around exceptions to this). No one will be discharged into, or back into, a registered care home setting without being tested, and having received their test result. Separate policy applies for individuals who have tested COVID-19 positive within 90 days of illness onset (please see section 4.3 for more detail).
- Anyone who is likely to be infectious with COVID-19 being discharged into or back into a registered care home setting should first be discharged into a designated setting (see section 4 for more information). Infectiousness is determined either by a positive COVID-19 test 48 hours prior to discharge or, in some instances, a clinical assessment prior to discharge – see section 4.3 and the clarification note (https://www.gov.uk/government/publications/designated-settings-for-people-discharged-to-a-care-home/discharge-into-care-homes-for-people-who-have-tested-positive-for-covid-19) for more information. Designated settings should have the additional policies, procedures, equipment, staffing and training in place to maintain infection control and have the capability to support the care needs of residents as set out in CQC's IPC protocol (https://www.cqc.org.uk/guidance-providers/residential-adult-social-care/infection-prevention-control-care-homes). This is an important precaution to protect care home residents and minimise, where possible, the risk of infection.

- People should undergo a 14-day period of isolation before moving into a care home from a designated setting, whether that be hospital or local authority commissioned - the total 14-day period of isolation can be shared across 2 designated settings if IPC practices are not breached. Subject to the care home provider's decision and a clinical assessment to determine if the individual is likely to be infectious, residents will not have to undergo a further period of isolation (see section 4 for further details.
- These designated premises will need to have undergone an inspection by CQC to assure that they meet the latest CQC infection prevention control standards, as set out in CQC's IPC protocol (https://www.cqc.org.uk/guidance-providers/residential-adult-social-care/infection-prevention-control-care-homes). The results of these inspections will be posted on the CQC website as per usual practice.
- Everyone being discharged into a care home must have a time-stamped reported COVID-19 test result, and this must be communicated to the person themselves and the care home prior to the person being discharged from hospital (see section 4 for more information). The care home's registered manager should continue to assure themselves that all its admissions or readmissions are consistent with this requirement. Local authorities should ensure they are involved in the discharge process for anyone being admitted to a care home for the first time.
- Local authorities must ensure that they have sufficient designated settings available (see section 3 for more information). This is vital to minimise transmission of COVID-19 and protect the lives of those living and working in care homes. If a local authority does not have any 'switched on' designated settings available, either due to lack of CQC assurance, local authority nominated beds, or assured beds not being 'switched on', the local authority must take rapid steps to ensure designated settings are nominated and assured.
- In exceptional circumstances where designated setting arrangements are not yet 'switched on' in the local area, current discharge arrangements for COVID-19 positive individuals, as set out in the existing discharge guidance (https://www.gov.uk/government/collections/hospital-discharge-service-guidance) and admissions to care home guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes), should continue to apply (see below on actions for local authorities). This includes the requirement to provide a test result prior to discharge, and notify the person's COVID-19 status to the person themselves, unpaid carers, and care providers. Nobody should be discharged to a care home without a test result (see section 4 for more information).

Who this will affect

2.8 The designation scheme is intended for those:

- who are leaving hospital and require care within a CQC-registered care home for the first time, or are returning to an existing placement (see section 4 for details on exemptions), and
- who are likely to be infectious with COVID-19 and/or those who are within an appropriate formal isolation period having tested positive for disease. For those entering care homes this would be 14 days in line with the care homes admission guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes). Infectiousness is determined either by a positive COVID-19 test 48 hours prior to discharge or, in some instances, a clinical assessment prior to discharge – see section 4.3 and the clarification note (https://www.gov.uk/government/publications/designated-settings-for-people-discharged-to-a-care-home/discharge-into-care-homes-for-people-who-have-tested-positive-for-covid-19) for more information

2.9 This applies to CQC-registered care homes who provide accommodation for people who need personal or nursing care. This includes registered residential care and nursing homes for older people, people with dementia, people with learning disabilities, and/or other disabilities, and people with mental health issues. The principle behind the policy applies to discharge from any NHS inpatient setting, including mental health and learning disability wards.

2.10 There may be exemptions for particular individuals on clinical or care grounds; more detail is set out in section 4.

2.11 The designation scheme does not apply to the following people:

- people who have contracted COVID-19 within the care home setting. There is no requirement to transfer COVID-19 positive residents from a care home into designated settings, as long as safe isolation and care is being maintained, as set out in the care homes admission guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes)
- people using hospital services, including emergency departments, outpatients, emergency assessment areas and day case facilities, who are not admitted to a bed for an overnight stay, providing that appropriate infection prevention and control measures are followed whilst in the healthcare facility
- the vast majority of people who, on leaving hospital are not going directly to a care home. This will include:
  - people returning to their own home
  - people returning to sheltered and extra care housing or those living in Supported Living. Please refer to the current guidance on supported living (https://www.gov.uk/government/publications/supported-living-services-during-coronavirus-covid-19) for more information

3. Locating and designating settings

3.1 It is important that sufficient settings are located and designated as quickly as possible to meet potential demand across England over winter. We therefore intend for every local authority to have access to at least one designated setting or suitable alternative premises (for example, NHS community hospital beds). Local authorities will also be able to identify more than one facility to be CQC-assured if needed, to respond to geographical spread and size, and to take into account the specific needs of particular people and increasing demands (see section 4 for more information on specific needs).

3.2 We anticipate that some local authorities will arrange to share one or more designated facilities with neighbouring local authorities. This is acceptable provided local authorities are confident that they have access to the capacity and range of services they may need for their geographical and likely user needs.

3.3 The CQC process will operate by providing assurance that each ‘designated setting’ has the policies, procedures, equipment, staffing levels, appropriate skill mix, and training in place to maintain infection control and support the care needs of residents. Designated settings are also expected to have appropriate physical separation of COVID-19 positive people, and a designated staff team. Once this assurance is received, settings would be able to receive people who are infectious with COVID-19 discharged from hospital, prior to their admission to a care home [footnote 1].

Type of facility required

3.4 Given the diversity of existing provisions and arrangements, it is acknowledged that there needs to be flexibility to meet local circumstances. Emphasis should be on commissioning stand-alone units or settings with separate zoned accommodation and staffing. These designated facilities will be best identified locally and can include care homes, NHS community hospitals or other bedded or residential facilities. All types of designated facilities must be specifically assessed and authorised by the CQC to receive people who are infectious with COVID-19 unless they are NHS facilities.

3.5 The setting:

- must meet CQC registration requirements and not be in breach of legislative requirements
- must meet the CQC IPC protocol (https://www.cqc.org.uk/guidance-providers/residential-adult-social-care/infection-prevention-control-care-homes) as set out on their website
- should provide a service that is rated 'good' or 'outstanding'. If the service is rated as 'requires improvement' with no breach of regulation, CQC will assess this on a case-by-case basis [footnote 2]

3.6 Care home providers must also ensure they have sufficient insurance cover to provide the services. Providers who find they are unable to get sufficient cover, should notify their local authority and/or CQC contacts. This intelligence will be passed onto colleagues in the Department of Health and Social Care (DHSC), to ensure the scale and impact of any issues are more fully understood and can be addressed where needed.

3.7 CQC regulations (https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-financial-position#full-regulation) set out what is required of providers with regards to their financial viability. Insurance arrangements will necessarily feature in any assessment of this. If an individual provider is concerned their insurance arrangements may put their financial viability at risk and breach the CQC regulations, then they should inform the CQC.

3.8 In addition, the following expectations should be met regarding infection prevention control and clinical support:

- There should be adequate separation of the designated setting.
- The setting must accommodate each individual in their own room.
- It is strongly advised that individuals should isolate in their room. It is recognised this is a particular challenge for people living with depression, anxiety, and dementia, as well as people with learning disabilities or autism. Please refer to SCIE guidance (https://www.scie.org.uk/care-providers/coronavirus-covid-19/dementia/care-homes?utm_campaign=11544303_SCIELine%2014%20May&utm_medium=email&utm_source=SOCIAL%20CARE%20INSTITUTE%20FOR%20EXCELLENCE%20&utm_sfid=003G000000w1tbsIAA&utm_role=Regulator%20or%20Inspector&dm_i=4O5,6VFN3,5HYUWV,RL3DJ,1) and the admissions to care homes guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes) for further support on supporting people with dementia in care homes. Please also refer to guidance on supporting people with mental health issues, learning disabilities or autism (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0454-mhlda-spec-comm-legal-guidance-v2-19-may.pdf). People with mental health issues or autism living in care homes are often very mobile and used to leaving and returning to the home on a regular basis; supporting people to understand why this is no longer possible will be a factor. Decision makers, including care home managers and social workers, should consider the ethical framework for adult social care (https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care), alongside issues of consent to determine a course of action that is in the best interests of the person.

- Where possible, providers should also ensure that each person has access to their own bathroom. If this is not possible, the provider should ensure that bathrooms in the facility should be designated for a particular set of individuals in the setting.
- The setting must be supported by sufficient clinical treatment and oversight. CCGs will be asked to ensure the necessary clinical support is in place, drawing on support through the Enhanced Health in Care Homes (EHCH) programme plus any additional monitoring required given the cohort of people being cared for. This will require agreement between local acute trusts, community health providers, GPs and the providers of the designated settings. (see section 5 below on clinical support for more information). EHCH will be provided to CQC registered care homes in England only.
- A separate staff team will be required, and arrangements should be in place to ensure all staff movement is limited unless absolutely necessary (see Annex E of the admission and care of people in care homes guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#annex-e) for more information). The government will be publishing more information on a proposal for staff movement regulation following consultation shortly, including how this relates to designated settings.
- Sufficient arrangements should also be guaranteed for staff to have repeat testing, PPE and sickness pay[footnote 3], including if they need to isolate, and support for their wellbeing (see the annex for more information on IPC requirements for designated settings, and section 8 for more information on funding).
- If the designated setting is also functioning as a discharge to assess and/or reablement/rehabilitation centre for people who are infectious with COVID-19, then it should also have access to professional staff to fulfil those functions.

Actions for local authorities

3.9 Local authorities must ensure that sufficient settings are available to meet expected needs now and over the winter period.

3.10 Local authorities, working with local system leaders, should ensure the designated premises they put forward to CQC for inspection meet the criteria in paragraphs 3.4 to 3.8 above.

3.11 Local authorities should work with NHS providers and CCGs to ensure that the designated settings can support the diverse care needs and cultural backgrounds of the community.

3.12 Local authorities, in partnership with the care provider, should notify CQC by completing a proforma which includes all required information on proposed designated settings for CQC to progress to inspection, sent to ascgovernance@cqc.org.uk. Once notified of premises selected by local authorities the CQC will inspect against the IPC protocol (https://www.cqc.org.uk/guidance-providers/residential-adult-social-care/infection-prevention-control-care-homes), report their findings and publish them on their website as part of a provider page that summarises the outcomes of inspection (http://www.cqc.org.uk/).

3.13 Local authorities should communicate to CCGs and providers when settings are 'switched on'; as each further designated setting becomes available [footnote 4] to receive patients who are infectious with COVID-19 leaving hospital local authorities should ensure that CCGs and providers are aware of this availability. The designation scheme will be operational in the local authority area once NHS partners are notified of the first available premises, and local authorities must ensure that designated beds are operational as soon as possible after CQC assurance.

3.14 Local authorities, in partnership with the care provider, can at any time put forward additional settings to the CQC to inspect or propose the removal of the designation.

Managing designated setting capacity

3.15 Local authorities must ensure that they have sufficient designated settings available within their local area to meet likely demand over the winter months. This is vital to minimise transmission of COVID-19 and protect the lives of those living and working in care homes. As set out in section 7, national bodies (including DHSC, CQC, ADASS and LGA) will support local authorities in collecting and assessing data to identify where additional capacity is required across the country. The default discharge arrangement for an individual who is infectious with COVID-19 should always be to a designated setting (exemptions for particular individuals on grounds of clinical or care needs are set out in section 4).

3.16 In the eventuality that designated setting capacity becomes temporarily full in a local area, local authorities should seek to expand capacity as soon as possible. This could be through designating additional settings (including NHS step down or community settings), or using existing regional structures and support systems to share capacity across local boundaries. While finding additional capacity, local authorities should consider options that balance the need to minimise COVID-19 transmission, and meet individual care needs.

3.17 Where local authorities are facing temporarily full capacity in their designated settings, they should notify DHSC via winterplan@dhsc.gov.uk so that capacity issues across England can be monitored. As part of this, they should communicate what their temporary alternative discharge arrangements are.

3.18 Local authorities should ensure that any temporary arrangements are communicated clearly to local providers and CCGs.

3.19 As stated in 2.6, if a local authority does not have any ‘switched on’ designated settings available, either due to lack of CQC assurance, local authority nominated beds, or assured beds not being ‘switched on’, the local authority must take rapid steps to ensure designated settings are nominated and assured.

4. Discharge arrangements

4.1 The policy on discharge from hospital is set out in the document issued on 21 August 2020: Hospital discharge service: policy and operating model (https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model). The discharge policy enshrines the principles of Home First, whereby at least 95% of discharges from hospital should be back to the person’s own home. Health and social care systems should continue to implement and embed Discharge to Assess (D2A) arrangements to support timely discharge. This should include early discharge planning and proactive COVID-19 tests to prevent discharge delays.

4.2 While most people will be discharged to their own private homes, a very small proportion will need and benefit from short or long term residential, nursing home or hospice care, or reablement functions as part of discharge pathways 2 and 3 (see existing discharge guidance (https://www.gov.uk/government/collections/hospital-discharge-service-guidance) for more information on discharge pathways).

COVID-19 testing prior to discharge to a care home

4.3 To prevent the risk of infections entering care homes, anyone who is infectious with COVID-19 should be discharged to a designated setting in the first instance to see out their isolation period. NHS provider organisations must ensure all people being discharged into care homes have received a COVID-19 test within the preceding 48 hours of the discharge date (unless the situation in the fourth bullet point below applies):

- For most people being discharged, a positive COVID-19 test result within the 48 hours prior to discharge will determine whether a person is infectious and therefore whether they need to be discharged to a designated setting first.
- Those individuals who test positive for COVID-19 in a hospital setting within 48 hours of being discharged into a care home should undergo a 14-day isolation period before moving into the care home. The total 14-day isolation period can be shared across the hospital and a designated setting if IPC practices are not breached.
- Anyone with a COVID-19 positive test report from the past 90 days who has completed their 14-day isolation period, has no symptoms and is considered by clinicians not to pose an infection risk can be discharged into a care home without going to a designated care setting (see clarification note (https://www.gov.uk/government/publications/designated-settings-for-people-discharged-to-a-care-home/discharge-into-care-homes-for-people-who-have-tested-positive-for-covid-19) on discharge into care homes for people who have tested positive for COVID-19).
- Individuals in hospital who have received a positive PCR test for COVID-19, are within a period of 90 days from their initial illness onset or positive test date, and have already completed their 14-day isolation period, should be exempt from testing prior to hospital discharge (if asymptomatic), unless they develop new COVID-19 symptoms. This is because it is possible for tests to detect residual virus for some time after COVID-19 infection. A clinical assessment will be made to determine subsequent onward movement.
- Individuals must be clinically ready for discharge and have no underlying severe immunosuppression. The hospital clinical team, in conjunction with an infection specialist if required, should undertake a clinical assessment. This must take into account whether the individual has completed their 14-day isolation period, as isolation can only be stopped when clinical improvement criteria (https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients#stopping-covid-19-isolation-and-ipc-measures-if-the-patient-is-staying-in-hospital) are met. The clinical assessment must also take into account whether the individual has developed any new COVID-19 symptoms, and had any new COVID-19 exposure (for more information see clarification note (https://www.gov.uk/government/publications/designated-settings-for-people-discharged-to-a-care-home/discharge-into-care-homes-for-people-who-have-tested-positive-for-covid-19) on discharge into care homes for people who have tested positive for COVID-19).

4.4 To achieve this, a regular programme of testing for patients should be in place in line with testing guidance (https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients). This should form part of early discharge planning (see details on the High Impact Change Model (https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high)) to ensure all care, support and communication is in place as part of organised activities that support timely discharge from hospital.

4.5 For persons whose hospital stay has been less than 48 hours, the COVID-19 PCR test undertaken at the point of admission will still be valid to enable discharge to a care home.

4.6 NHS provider organisations must ensure that COVID-19 test results for all people being discharged into a care home are received and shared with the individual themselves, their key relatives or advocates, and the relevant care home provider prior to discharge taking place. As set out in the hospital discharge service: action cards (https://www.gov.uk/government/publications/hospital-discharge-service-action-cards), NHS medical staff and ward managers are responsible for ensuring that COVID-19 test results are available before discharge, and are shared with individuals and receiving care homes. This is regardless of whether a designated setting is operational in the locality.

Discharge of people who are infectious with COVID-19

4.7 Designated settings are being established within each health and social care system to support the safe ongoing care and isolation of people who are likely to be infectious with COVID-19 and are not returning home on discharge. These settings will be used for those who would otherwise be returning to the care home from where they were admitted, or for the small proportion of individuals who are unable to go home and therefore being discharged to a care home for the first time. They may also be used to provide Discharge to Assess (D2A), rehabilitation or reablement functions for people who are infectious with COVID-19 but in need of residential care whilst this happens.

4.8 If a local authority does not have any ‘switched on’ designated settings available, either due to lack of CQC assurance, local authority nominated beds, or assured beds not being ‘switched on’, the local authority must take rapid steps to ensure designated settings are nominated and assured. In exceptional circumstances where designated setting arrangements are not yet ‘switched on’ in the local area, individuals should be discharged according to current discharge arrangements for COVID-19 positive individuals, as set out in the existing discharge guidance (https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model) and admissions to care home guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes). This includes discharging the individual to a non-designated care home which has sufficient IPC arrangements, and is willing and able to receive the individual and support their care needs.

4.9 When the local designated settings do not have an available bed, the local authority will have communicated to the CCG what temporary discharge arrangements are in place (see section 3.18) for people who are likely to be infectious with COVID-19.

4.10 It is essential that staff working within discharge hubs are fully aware of the designated settings available in their area, and have accurate information about available capacity within these settings to facilitate effective and timely discharge planning. Hospital discharge teams should work with local care home providers to develop trusted assessment arrangements to facilitate the prompt return of residents after a hospital stay.

4.11 For discharge managers, this means that:

- when planning for discharge, discharge managers should be mindful of potential risks to individuals of multiple transfers. Individual care needs and preferences should be considered (see sections below for detailed information)
- discharge managers should advise the local council of any potential new admissions to residential care (on a Discharge to Assess, rehabilitation or potentially permanent arrangement) so that all the options to support people at home (or temporarily with family, shared lives etc. in line with Home First principles) have been explored

- NHS provider organisations must ensure that people (or their advocates, or any deputy or attorney if relevant, if they lack capacity) and their original place of residence where that is a care home, have full information and advice about the temporary arrangements and ensure they fully comply with Deprivation of Liberty Safeguards (DoLS) (https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/) requirements
- once the scheme has been ‘switched on’, discharge managers can start discharging patients to the designated settings
- the care home’s registered manager is legally responsible to ensure that the service can meet the needs of people admitted. The decision to accept or decline an admission lies with a registered manager of the care service. Care home managers should be given sufficient time to take decisions
- discharge managers should ensure that the individual’s specific care needs and any relevant care information is transferred to the receiving designated setting
- where individuals are entering a care home for the first time, a preferred destination for the person should be agreed with them and their relatives before being discharged from the acute setting, to ensure that a care home placement is secured and kept available for them after they have completed their period of isolation in the designated setting

Exemptions on clinical or care grounds

4.12 The default discharge arrangement for all people who have tested positive for COVID-19 and are likely still to be infectious with COVID-19 moving from hospital to a care home should be into a designated setting (once the scheme has been ‘switched on’). There may be a minority of people for whom being discharged into a designated setting may not be appropriate based on their individual needs.

4.13 Only in exceptional circumstances there may be instances where the discharge of a person who is likely to be infectious with COVID-19 to a designated setting will not be appropriate on clinical grounds, as the setting may lack the ability to provide the specialist care to meet that person’s needs, while managing the risk of transmission to other residents, staff and visitors. This may particularly apply to supporting people with mental health issues, learning disabilities or autism, people with dementia whose needs require a specialist care home services or approach that cannot be met in the designated service, people at the end of their lives[footnote 6], or those in drug and alcohol settings.

4.14 Individual assessments of need, preferences and risk need to be undertaken by appropriate health and social care practitioners to ensure that the individual has a personalised care and support plan (and where appropriate, an Advance Care Plan) to aid their discharge from hospital and ongoing care. The individual, their family and any relevant advocates should be involved to ensure the most appropriate care and support plan is agreed. Consideration should be given to social and relational needs, in addition to care and support needs. The individual’s needs and preferences should be considered alongside potential risks to other care home residents. In the minority of cases where the assessment concludes it is not appropriate for the individual to be discharged to a designated setting, the individual should be discharged in line with existing discharge and admissions to care home guidance. As part of this, the local authority should seek alternative accommodation for the individual and the individual should not be expected to remain in hospital for their isolation period.

4.15 For more guidance on meeting specific needs of people with dementia, people with learning disabilities or autism, and people with mental health issues within designated facilities, please see section 5.

Support planning with people

4.16 People should expect to receive high quality care from acute and community hospitals. This includes regular and open sharing of information on the next steps for their care and treatment, as well as clarity on plans and joint decision-making processes for discharge into designated settings.

4.17 The designated settings pathway should be clearly explained to the individual (and where appropriate, family or advocates) prior to discharge, and the individual must be involved in the decision-making process, by actively seeking their views. It may be helpful to reference information on personalised care and support, in particular staying in control: when things need to change (https://www.thinklocalactpersonal.org.uk/makingitreal/about/six-themes-of-making-it-real/when-things-need-to-change/). The conversation should cover the following points:

- the reasons that the step-down pathway has been developed. The step-down pathway has been developed to provide the safest and most appropriate care and support for people leaving hospital to care homes (and for the other residents of respective homes), who are likely to be infectious with COVID-19
- information regarding location, set up and facilities of the designated setting, including how it will meet the specific needs of the individual being discharged, and additional information on the setting's current visiting policy and recent history of outbreaks
- the process for assessment, reablement and support planning for care (if required) following an individual's stay in a designated setting, including information on how any onward transfer to their usual or permanent place of residence might be handled
- the prognosis from the positive test and how this may impact on the individual and others, so that they are aware of risks and benefits
- for anyone with a learning disability or autism (or both) of any age, for whom discharge to a designated setting is being considered, a person-centred multi-agency meeting should be convened (virtually if necessary). This should ensure that the potential challenge of multiple moves for the individual has been considered, and conversely the impact and potential increased restrictions of remaining in hospital. This will ensure that appropriate consideration is given to the need for reasonable adjustments, to enable the best outcome for the individual

4.18 It is the responsibility of CCGs and local authorities to ensure individuals are discharged into an appropriate setting that meets their care needs. Current government guidance on isolation states that individuals tested as COVID-19 positive are required to complete the recommended 14-day isolation period [footnote 7], prior to moving to any longer term care arrangements. This guidance is based on balancing the individual's care needs with the need to protect care homes from COVID-19 transmission.

4.19 If, following these conversations, an individual does not wish to be discharged to a designated setting, then alternative care arrangements should be discussed. Options considered must balance the need to minimise COVID-19 transmission in care homes, and the need to meet individual care needs and preferences. Only as a last resort, options could include an individual being discharged to a non-designated care home with sufficient IPC arrangements, that is willing to receive the individual and support their care needs.

4.20 The decision makers should consider the ethical framework for adult social care (https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care), alongside issues of consent to determine a course of action that is in the best interests of the person.

4.21 Reasonable adjustments should be considered and actioned to ensure that disabled adults are able to be supported safely and appropriately within designated settings. It is important to engage with both the disabled person themselves and with their families and/or personal assistants, who will be clear about their needs if a move to a designated setting is under discussion. This may require the support and

advice of community social care and community health professional teams. CCGs and local authorities should ensure this is available. Please refer to the NHS guidance on supporting patients with a learning disability or autism (https://www.nice.org.uk/Media/Default/About/COVID-19/Specialty-guides/learning-disability-autism-during-pandemic.pdf). The rights of all affected people should be considered under the Human Rights Act.

Support for people without relevant mental capacity

4.22 Duties and powers under the Mental Capacity Act 2005 still apply during this period. If there is a reason to believe a person may lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before a decision about their discharge is made.

4.23 Where the person is assessed as lacking the relevant mental capacity and a decision about moving the person to a designated setting needs to be made, there should be a 'best interest' decision made for their ongoing care in line with the usual processes. The decision maker must consider all the relevant circumstances, including the person's wishes, beliefs and values, the views of their family and what the person would have wanted if they had the capacity to make the decision themselves. They should make a record of their decision.

4.24 The person may also have a donee appointed under a lasting power of attorney or a court appointed deputy with a specific authority in relation to the decision. In such cases, the deputy or attorney with relevant authority must make relevant decisions on the person's behalf.

4.25 If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards (DoLS) in care homes and orders from the Court of Protection for community arrangements still apply. Further information can be found in DHSC's guidance on looking after people who lack mental capacity (https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity).

Onward transfer back to usual place of residence

4.26 People who have been discharged to a designated facility will remain in this setting for 14 days, or the remainder of their isolation period, after discharge. Given that test results could continue to be positive for a number of days or weeks after people are no longer infectious, a clinical assessment must take place prior to discharge from a designated setting to a care home to determine whether a person is still infectious. This assessment should be taken in line with the clinical improvement criteria set out in the stepdown infection control guidance (https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients#stopping-covid-19-isolation-and-ipc-measures-if-the-patient-is-staying-in-hospital).

4.27 If an individual meets the clinical improvement criteria, the individual can be discharged to their usual or new place of residence in another care setting without the need for further isolation. The period of isolation in the designated setting would mean it is not necessary to isolate individuals for a further 14 days on admission to a care home, though this is ultimately a care home provider's decision. Repeated periods of isolation could adversely impact on an individual's health and wellbeing.

4.28 The manager of the designated setting should clearly communicate information regarding the person's COVID-19 status and clinical condition, as well as their hospital discharge summary to the manager of the new care home receiving the resident.

4.29 CCGs are responsible to ensure the necessary clinical support is in place for clinical assessments in designated settings. In case of any query about this clinical support, designated settings providers should contact their clinical lead within their CCG.

5. Clinical and social support and meeting care needs

Clinical support

5.1 Where a designated setting is a care home, it will be able to access the primary and community health services support offer available to care homes (see section 2E of the care homes admission guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#section-2) for further details).

5.2 Where a designated setting is an NHS facility, it should have the necessary clinical support by default.

5.3 Requirements for the delivery of Enhanced Health in Care Homes (EHCH) by Primary Care Networks (PCNs) are included in the Network Contract Directed Enhanced Service (DES) for 2020/21. Complementary EHCH requirements for relevant providers of community physical and mental health services have been included in the NHS Standard Contract. This supports the NHS Long Term Plan goal of 'dissolving the historic divide' between primary care and community healthcare services, and sets a minimum standard for NHS support to people living in care homes. From 1st October 2020, the following should all be in place:

- every care home has a named clinical lead
- every care home is aligned to a named PCN
- every care home has a weekly care home round, with input from the multi-disciplinary team (MDT). The MDT will usually be comprised of primary care, community services, and social care staff and can include support from the Community Mental Health Team (CMHT), and the voluntary, community and social enterprise (VCSE) sector
- for every resident, the PCN must aim to carry out an assessment of need within 7 working days, unless there is a good reason for a different timescale. This will include assessment of the physical, psychological, functional, social and environmental needs of the person, including end of life care needs where appropriate;
- the PCN must aim to develop a personalised care and support plan for new residents based on the assessment of need, within 7 working days unless there is good reason for a different time scale
- the rollout of Structured Medication Reviews to those in care homes identified as a clinical priority

5.4 A summary of the primary and community support offer to people in care homes can be found in section 2E of the care homes admission guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#section-2). The information in this section should be read alongside this guidance and alongside the enhanced health in care homes framework (https://www.england.nhs.uk/wp-content/uploads/2020/03/the-framework-for-enhanced-health-in-care-homes-v2-0.pdf).

5.5 Designated settings for supporting COVID-19 positive people will vary between health and social care systems. For those areas using care homes for this purpose, there should be a review of the NHS clinical support and equipment being provided into these homes. This should consider whether any

specific additional services are required to meet the needs of COVID-19 positive residents, many of whom are likely to have greater healthcare needs than an average care home resident, and may be at higher risk of deterioration.

Provision of specific care needs

5.6 Local authorities should work with NHS providers and CCGs to ensure that the designated settings can support the diverse care needs and cultural backgrounds of the community. In some cases, this may involve ensuring reasonable adjustments are in place within a setting, and providing appropriate specialised staffing (for example, learning disability or mental health nurses). This is particularly relevant when supporting the needs of:

- people with dementia (please refer to Social Care Institute for Excellence (SCIE) guidance (https://www.scie.org.uk/care-providers/coronavirus-covid-19/dementia/care-homes) for more information and support)
- people with learning disabilities and / or autism (please refer to National Institute for Health and Care Excellence (NICE) clinical guide (https://www.nice.org.uk/Media/Default/About/COVID-19/Specialty-guides/learning-disability-autism-during-pandemic.pdf) for more information)
- people with physical disabilities or complex health issues
- people with severe mental illness. Please refer to NICE guidance NG53 on discharge to care home settings (https://www.nice.org.uk/guidance/ng53)and the NHSE/DHSC guidance on mental health discharge (currently in production)
- people from black, Asian and minority ethnic (BAME) backgrounds, where the cultural diversity of BAME residents should be considered when planning support

5.7 As per section 4, if it is assessed that a designated setting is unable to meet an individual's care needs, then they can be exempt from being discharged to a designated setting. Decisions on where to discharge the individual should take into account individual needs and preferences, and ensure that the place of admission has high IPC standards, and is willing and able to receive the individual and support their care needs.

6. Support for care providers and providers of designated settings

6.1 Care providers must give their full agreement to the local authority in becoming a designated setting.

Actions for providers of designated settings

6.2 Providers should take steps to ensure that all workforce movement is limited unless absolutely necessary, to minimise workforce transmission. (For more information, please see Annex E of the admission and care of people in care homes guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#annex-e).) Following consultation, the government will shortly be publishing more information on a proposal for staff movement regulation, including how this relates to designated settings.

6.3 Providers should ensure that there are appropriate arrangements in place for staff isolation. More detailed guidance on this can be found in the annex of this guidance on IPC requirements for designated settings, section 5 of the admission and care of people in care homes guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#section-5-advice-for-staff) and support

for employers on working safely during coronavirus (https://www.gov.uk/government/publications/guidance-to-employers-and-businesses-about-covid-19/guidance-for-employers-and-businesses-on-coronavirus-covid-19). Providers should ensure that staff are paid normal wages if they need to self-isolate (in line with the adult social care winter plan (https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021)).

6.4 Providers should ensure that there are appropriate arrangements in place to support staff. Section 5 of the admission and care of people in care homes guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#section-5-advice-for-staff) provides advice for staff and care home managers. More detailed guidance on managing health and wellbeing for those working in adult social care can also be found in guidance on the health and wellbeing of the adult social care workforce (https://www.gov.uk/government/publications/coronavirus-covid-19-health-and-wellbeing-of-the-adult-social-care-workforce).

6.5 Providers should review the risk reduction framework for adult social care (https://www.gov.uk/government/publications/coronavirus-covid-19-reducing-risk-in-adult-social-care/covid-19-adult-social-care-risk-reduction-framework) as a guide for employers on how to have individual conversations about COVID-19, to discuss sensitively and manage specific risks to their staff. Providers should review section 3 above to ensure that they meet the requirements to be designated.

6.6 Providers should review the CQC IPC protocol (https://www.cqc.org.uk/guidance-providers/residential-adult-social-care/infection-prevention-control-care-homes) to ensure that they meet the required standards.

6.7 Providers should ensure that they provide safe and appropriate care and support to meet people's individual needs. Section 2 of the admission and care of people in care homes guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#caring-for-residents-depending-on-their-covid-19-status-and-particular-needs) provides advice on supporting residents in care homes. Further guidance is available for supporting people with a learning disability and people with autism (https://www.gov.uk/government/publications/covid-19-supporting-adults-with-learning-disabilities-and-autistic-adults), people with dementia (https://www.scie.org.uk/care-providers/coronavirus-covid-19/dementia/care-homes?utm_campaign=11544303_SCIELine%2014%20May&utm_medium=email&utm_source=SOCIAL%20CARE%20INSTITUTE%20FOR%20EXCELLENCE%20&utm_sfid=003G000000w1tbsIAA&utm_role=Regulator%20or%20Inspector&dm_i=4O5,6VFN3,5HYUWV,RL3DJ,1), and where relevant, people tackling drug and alcohol dependence (https://www.scie.org.uk/care-providers/coronavirus-covid-19/drugs-alcohol-rehab-detox).

6.8 Care home providers should also ensure they have sufficient insurance cover to provide the services. Providers who find they are unable to obtain sufficient cover should notify their local authority and/or CQC contacts. This intelligence will be passed onto DHSC.

6.9 Providers should work with the discharging facility to ensure that individuals and their loved ones, advocates, and any deputy or attorney (if relevant) have a good understanding of the designated settings pathway. Providers should ensure clear communication on what the individual and their families should expect on admission to the designated setting (for example, transport arrangements, transfer of personal belongings and visiting arrangements). Individuals and their families/advocates must be involved in the decision-making process, and their views actively sought. It may be helpful to reference information on personalised care and support, in particular Staying in control when things need to change (https://www.thinklocalactpersonal.org.uk/makingitreal/about/six-themes-of-making-it-real/when-things-need-to-change/). See section 4, discharge of people who have tested positive for COVID-19, for further information.

6.10 As per section 7.4, designated settings providers should input data into the capacity tracker on a daily basis. This will comprise information on the number of beds in the designated setting that are currently occupied, and the number that are currently available for admissions.

7. Information collection and governance

7.1 Local authorities should notify CQC of all settings that they nominate to be designated to receive COVID-19 positive individuals. This includes notifying CQC of NHS facilities that will not require CQC assurance; where they intend to share settings with another local authority; or where they are making alternative arrangements, such as supporting individuals to temporarily return to friends, family, or shared lives with home care support.

7.2 DHSC, ADASS, LGA and PHE (and NHSE, if there were to be any shortfalls in primary or community services cover) will then work together to identify any localities in England that require additional designated settings, and what input or support might be needed. CQC will prioritise inspections based on local prevalence rates or population size.

7.3 CQC will provide management information to DHSC and other system partners, to track numbers of designated settings, and total numbers of places, including by local area. This will support assuring system partners that we are meeting local needs.

7.4 Providers of designated settings are asked to input data into the Capacity Tracker on a daily basis in line with the admission to care homes guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#annex-i). This will comprise information on the number of beds in the designated setting that are currently occupied, and the number that are currently available for admissions. This will support partners to understand how well we are able to meet potential demand.

8. Funding

8.1 Local partners will already be working together to ensure sufficient accommodation is available to meet expected needs now, and over the winter period. Local authorities are responsible for commissioning sufficient accommodation, and will be working with CCGs to agree sufficient capacity. For arrangements organised from the date of this guidance, the CCG should also seek approval for the affordability of this from the NHS regional lead identified as the lead for the hospital discharge programme.

8.2 The costs of the designated settings will be met through the £588 million discharge funding until the end of March 2021. CCGs should not reduce commitments for Discharge to Assess (D2A), which remains the overall policy governing hospital discharge, with the ambition that 95 per cent of people are discharged home, with support where necessary.

8.3 In line with the Care Act 2014 statutory guidance, local authorities and CCGs should assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with the agreed quality of care.

8.4 This agreed rate should reflect the actual cost of care, including increased overhead costs for providers incurred by running these designated settings. These might reflect, for example, extra costs because of enhanced infection prevention control or additional insurance costs. CCGs should work through what the costs are with the provider and be assured of the appropriateness of these.

8.5 The time spent by an individual within a designated setting contributes towards the 'up-to-6 weeks' funded care provided on discharge from hospital for new or additional care needs.

8.6 Existing local authority or CCG care contracts for individuals placed in designated settings will be maintained, and we would expect ordinary funding sources to pay for these. Where the policy causes a material impact to care providers because of a shortfall between this contractual entitlement and the ordinary level of funding received for this patient, it is for local areas to agree any recompense, as appropriate.

8.7 The current discharge guidance (https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model) provides further detail on financial support.

9. Annex

Visiting designated settings

9.1 Visiting a COVID-19 positive resident in a designated setting may present a risk to the visitor and a risk of outward transmission to the community. Therefore, visits to residents who are likely to be infectious with COVID-19 in designated settings should only be made in exceptional circumstances (for example, severe distress or end of life), and visitors should follow the principles outlined in the hospital visiting guidance (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0751-visiting-healthcare-inpatient-settings-principles-131020_.pdf).

IPC requirements for designated settings

9.2 For full infection prevention and control measures in designated settings, see CQC's IPC protocol (https://www.cqc.org.uk/guidance-providers/residential-adult-social-care/infection-prevention-control-care-homes).

9.3 For infection prevention and control measures for care homes that contain both designated and non-designated areas, see below:

- CQC IPC requirements for designated settings should be applied to the designated area, and regular CQC requirements and IPC measures as set out in the admissions to care homes (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes) guidance should be applied to the non-designated section.
- Establish physical separation of staff flow to minimise contact between designated and non-designated areas. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access (physical separation or separate allocated time slots) to communal areas (changing rooms, rest areas, canteens).
- Ensure designated and non-designated areas are clearly signposted, using physical barriers as appropriate.
- Ensure local standard operating procedures detail the measures to segregate equipment and staff including planning for emergency scenarios.

9.4 Designated settings are expected to have a separate staff team to care for residents who are likely to be infectious with COVID-19, and arrangements should be in place to ensure staff movement is limited between designated and non-designated areas unless absolutely necessary to minimise workforce

transmission (see Annex E on cohorting staff in the admissions to care homes guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#annex-e). However:

- where it is essential that communal areas need to be shared, designated and non-designated staff teams should have separate allocated time slots, to ensure appropriate cleaning is conducted between the use of such areas (further information can be found in Annex G in the admissions to care homes guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#annex-g)).
- in an exceptional circumstance where a member of staff is required to move between designated and non-designated areas due to the unique function of their role, all IPC measures including physical distancing must be maintained.

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1. This approach applies to hospital discharges only, and does not apply to admissions from people's own homes to residential care homes.
2. New services will be considered on a case-by-case basis, including consideration of any regulatory history where available, or consideration for a fast track registration assessment.
3. Providers should continue to support staff who are self-isolating/absent due to COVID-19 related sickness by paying their normal wages, in line with government guidance. The Infection Control Fund is available to meet the costs of this measure
4. A designated setting is classified as 'available' where it has been CQC-assured, has sufficient staffing arrangements, and has appropriate insurance cover in place.
5. See NHS guidance on end of life care for more information on supporting people at the end of their lives (https://www.nhs.uk/conditions/end-of-life-care/what-it-involves-and-when-it-starts/).
6. The total 14-day period of isolation can be shared across hospital and designated settings if IPC practices are not breached.

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