Health & Social Care Board
12-22 Linenhall Street
BELFAST
BT2 8BS

Tel : 03005550115
Web Site: www.hscboard.hscni.net

Mr Colm Gildernew MLA
Chairperson
Committee for Health
Room 410 Parliament Buildings
Belfast
BT4 3XX

20 October 2020

Dear Mr Gildernew,

COVID AND CARE HOMES

Thank you for the opportunity to contribute to your Committee inquiry into the impact of COVID-19 on care homes.

Care homes are a vital part of the health and social care system, providing care and support to the most vulnerable citizens. The Health and Social Care Board has worked consistently to support care homes, both in advance of COVID and throughout the pandemic. We will continue to do so in the future as part of our core areas of work.

The attached paper sets out an overview of the support we have provided to care homes, paying particular attention to the subject areas identified in your correspondence of 23 September 2020.

I look forward to receiving the final report from your Committee.

Yours sincerely,

SHARON GALLAGHER
Chief Executive

Cc. Laverne Montgomery
Lynne Curran
Wendy Patterson

Health and Social Care Board

Covid-19 Care Homes and HSCB Engagement

1. Discharge to Care Homes

Describe the need for change:

Care homes are an integral part of the system that supports people through admission and treatment in an acute setting such as a hospital. Patients should not remain in a hospital setting longer than is clinically indicated as this can have a detrimental effect on their long term wellbeing. Effecting discharge as soon as possible also helps to reduce the risk of hospital acquired infection.

Places within care homes, even of a temporary or step-down nature, are registered and regulated by RQIA. Patients can only be discharged to a care home placement where that placement has been assessed as being able to meet their needs e.g. someone living with dementia can only be placed in a home that has been assessed by RQIA as able to meet the needs of this group of people.

When the pandemic struck in March it was imperative that consideration was given to the availability of hospital beds and flow through the system. This was particularly so, given the experienced of the Italian and Spanish Healthcare systems where it was widely reported that their hospital system had been overwhelmed. The need to expedite delayed transfers of care was recognised as a key part of ensuring that Northern Ireland did not repeat the experience in Italy and Spain.

Evidence what the HSCB did to minimise infections in care homes and care for those infected while prioritising the care and wellbeing of all residents:

Delays relating to the placement of dementia and delirium patients had been raised as an issue regionally prior to the COVID pandemic. The HSCB recognised early on the need to provide an immediate solution that would

prevent delays occurring in the discharge of this patient cohort during the course of the outbreak.

Provide details of the changes introduced:

After consultation with colleagues in PHA, RQIA and DoH, it was agreed that for the duration of the COVID outbreak only, people living with dementia or experiencing complex delirium, could be discharged to a general nursing home bed rather than a specialist dementia registered bed, as long as there was clear evidence that the placement could safely meet their assessed needs and that the relevant protocols re testing prior to hospital discharge were observed.

The COVID outbreak meant that many of the activities in respect of hospital discharge arrangements had to be temporarily modified eg Care homes would also normally be expected to meet certain standards in agreeing to a placement from hospital. These include close liaison with the placing hospital, patient and their family or carers. Due to infection control imperatives, care homes were not able to meet this standard at the height of the outbreak.

Similarly, in normal circumstances patients and their families would have a choice as to which home they transferred to from the hospital. Under COVID conditions, this level of choice was severely constrained and patients were asked to transfer to the first available suitable bed, with recognition that there could be a move to the home of choice when it was available and safe to do so.

What was the result?

These temporary arrangements have helped reduce the amount of time vulnerable patients remain in an acute setting when it is no longer appropriate.
Data codes are currently being developed to capture COVID related delays from the acute setting. These delays will include discharge to care homes.

What were the costs?

There were no additional costs incurred.

Who was involved?

The following organisations were involved in this decision:

- The 5 Health and Social Care Trusts
- HSC Board
- PHA
- RQIA
- DoH

What worked well and why?

Close liaison with operational leads in HSC Trusts facilitated timely communication and identified emerging challenges early on. It also facilitated a standardised response across the region.

Collaborative working with colleagues in PHA and RQIA ensured that solutions developed to the challenges outlined above were compatible with the strategic direction, regulation and standards and IPC requirements, whilst maintaining a focus on the wellbeing of individual patients and residents.

What have we learned?

Unfortunately, the speed of response required meant that normal consultation processes and engagement with users and providers prior to decisions being made were not possible. Professional staff had to draw on their history of engagement and knowledge obtained through pre-COVID practice.

Who should know about this initiative?

- General public
- People admitted to hospital
- Staff working on the interface between acute and community care
- Care Home providers

2. Access to PPE

Describe the Need for Change

Care homes in the statutory and independent sector already had an existing supply of PPE to care for those who required direct hands on care. What quickly became apparent during the pandemic was that additional PPE was required to meet requirements and to keep care home residents and staff safe. Global shortages meant that the care home sector had to be actively supported and closely monitored with regards to their availability of PPE.

Evidence what the HSCB did to Minimise Infections in Care Homes and Care for those Infected while Prioritising the Care and Wellbeing of all Residents:

The Social Care and Children's Directorate (SCCD) of the HSCB recognised the importance of PPE and sought to develop in consultation with PHA colleagues Regional Surge Plans for the care home sector. Two Surge Plans have been produced to date, the PHA/HSCB COVID-19 Regional Surge Plan for the NI Care Home Sector available in May 2020 and the Northern Ireland COVID-19 Regional Action Plan for the Care Home Sector available from September 2020**.**

Within the Surge Plans there was a distinct section on PPE and its availability. Knowledge as which indicators to use and the level of PPE stocks required, was informed through communication networks established because of the pandemic to include Trust colleagues, RQIA, care home representatives and the DoH.

In seeking to develop the Northern Ireland COVID-19 Regional Action Plan for the Care Home Sector available from September 2020, consideration has been given to the recommendations from the Rapid Learning Initiative, to include the need to establish a sustainable mechanism for supporting the supply of PPE to Care Homes in a pandemic.

What was the result?

The result of the above strategy was to provide regional guidance and direction to the care home sector and the HSC Trusts who provided support. Objectives,

principles and actions considering the areas of prevention, mitigation and resilience were clearly outlined.

Regional Surge Plans were supported by agreed metrics. Monitoring Templates ask for feedback from care homes and Trusts as to existing supplies and delivery and sought a self-reported RAG rating. Initially a weekly return of the metric was requested to allow a clear overview of concerns and issues arising. This has been kept under review and timelines changed to reflect changing need.

What were the costs?

Covered in the section on Funding and Increased costs for care homes.

Who was Involved?

The following organisations were involved in this decision making process:

- HSC Board
- PHA
- RQIA
- HSC Trusts
- Care Sector
- DoH
- NISCC

What worked well and why?

Surge Plans and the resulting metric were developed in close consultation with the relevant stakeholders. Timely and frequent communication identified emerging challenges which were incorporated into the regional documentation. The actions developed were of a sufficient breadth to consider the needs of care homes that provided a service to elderly service users within the different categories of care. A standardised response to the pandemic and the support needs of care homes was developed to include PPE requirements. The

recommendation from the Rapid Learning Initiative into the Transmission of COVID-19 into and within Care Homes in

NI was also incorporated into the September 2020 version of the Surge Plan and corresponding matric.

The Surge Plans and metric were reviewed and actioned by the key stakeholders with an active process developed for receiving the information, considering areas of concern or which required clarification such as RAG ratings and actioning any issues arising. Multi-agency meetings were developed for this purpose co-chaired by HSCB and the PHA and work schedules prioritised in recognition of the need to support care homes in all areas including PPE.

What have we learned?

Going forward into the second surge, it would be helpful for care homes to provide a baseline of the actions they have taken to secure their own independent supplies of PPE to include engagement with local companies who may not have capacity to meet large scale regional orders from the BSO but could satisfy lower level requests.

Who should know about this initiative?

- General public
- People admitted to hospital
- Staff working on the interface between acute and community care

3. Testing in Care Homes

Describe the need for change:

During the Covid pandemic it became apparent that clear guidelines were required for residents and staff within care homes in respect to testing.

Evidence what the HSCB did to minimise infections in care homes and care for those infected while prioritising the care and wellbeing of all residents

HSCB worked with the DOH, Trusts, PHA and RQIA to provide a mechanism for clear communication channels between the key stakeholders. Bronze, Silver and Gold commands were established to ensure information flowed between PHA, Trusts and Department of Health.

In addition HSCB established an Assistant Director Forum that meet 3 times per week and a Director Forum which meet weekly. The Director Forum included representation from HSCB, PHA, RQIA, HSC Trusts and DOH. The Assistant Director Forum had representation from HSCB, Trusts, PHA and RQIA. In mid-April 2020 invitation was extended to NIAS as they were supporting the role out of testing into the care home sector.

These forums enabled the statutory services to consider, clarify and determine the key issues associated with testing in care homes. Discussions focused on the process of testing and also the morale implications associated with them. HSCB ensured conversations considered all key aspects of the testing process including the care and welfare of the residents. The human rights, dignity and respect of the resident were crucial to ensure their voice was heard in the midst of the pandemic. HSCB among others advocated that residents within care home have the same human rights as other people and debated the ethical dilemmas that were placed upon staff to determine the right of individual's freedom of choice –v- the right to safety in group settings.

Provide details of the changes introduced:

Since 24th April 2020, testing has been offered to all residents and staff when an outbreak of Covid-19 is declared within a care home.

The week commencing 11th May 2020 retrospective testing of all staff and residents in care homes began with the support of NIAS staff.

Regional guidance was agreed and issued in respect of care home providers and continues to be kept under regular review.

What was the result?

A systematic universal approach was implemented for all staff and residents to be tested in care homes. Retrospective testing was concluded in June 2020.

New arrangements are now in place so that residents and staff continue to access and receive regular testing regardless if they are symptomatic. These arrangements seek to ensure that the interests of residents are protected and that the public health measures introduced do not disproportionately impact on their rights and liberties.

HSCB continues to utilise their established forums to enable all key stakeholders communicate and clarify concerns thereby enabling and promoting a consistent approach to testing within the care home setting.

What were the costs?

HSCB incurred no costs to this initiative.

Who was involved?

- PHA
- The 5 Health and Social Care Trusts
- Care homes
- HSCB
- NIAS
- RQIA

What worked well and why?

There was good communication between the statutory agencies. PHA led on this initiative and communicated the needs and requirements with Trusts using various forums including those established by HSCB. Separate communication channels were in place to engage directly with the care homes. These forums

enabled key personnel to debate the ethical and human rights perspective of testing residents in care homes.

What have we learned?

The staff within care homes were required to consume and understand frequent changing messages in relation to testing. This often led to frustration and anxiety both for them, their residents and families. Going forward clear guidance and channels to communicate these would improve confidence and engagement with the care home sector.

In addition, there is a need for clarity and specific guidance in relation to testing of those staff that is required to visit care homes to ensure that they do not inadvertently spread the virus.

Who should know about this initiative?

Guidance on testing has been issued nationally and internationally to protect residents and staff of care homes. Therefore anyone involved in developing and reviewing testing should know about this initiative to promote learning and understanding not only from a public health perspective but to ensure the rights of residents are heard and upheld.

4. Funding & Increased Costs to Care Homes

HSCB in conjunction with DoH, PHA and Trusts have sought to ensure that independent care home providers have been supported financially during the COVID-19 disruption period by providing some measure of financial stability and to assist in managing operational pressures which care homes face as a result of COVID-19.

Independent Sector care homes are a critical resource in the effective operation of the entire health and social care system in Northern Ireland. Current regional annual expenditure on independent sector care homes is estimated at c£430m (18/19 Trust Financial Returns (TFRs)).

For the Independent Residential and Nursing care home sector, there have been 3 broad elements of financial support:

I. In order to ensure that Care Homes were supported to maintain financial resilience during COVID-19 disruption as well as provide some degree of financial stability, care homes were advised that, where, as a result of the COVID-19 outbreak a nursing or residential care home's income reduces by greater than 20% below the past 3 months' average then Trusts should block purchase 80% of the vacated beds at the regional tariff (in effect, in such circumstances, block purchasing 80% of vacated beds would equate to 96% of activity being secured for care homes) . The Trust would then fill these beds as required over the next three months. If beds are still vacant at the end of that period a further review would be undertaken by the Trust working with the Health and Social Care Board. This should be managed within Trust budgets as there is no financial implication above current expenditure levels as only 80%of the vacated beds will be purchased.

II. The care home sector continued to note that they had additional financial pressures dealing with the COVID 19 outbreak. HSCB secured temporary support to provide additional funding in the form of a one off sum to the sector taking account of care home size, with total funding of £6.5m made available to address cost pressures specifically related to COVID-19. Following validation of RQIA care home data by Trusts £5.4m of grants were processed by Trusts to 370 independent sector care home providers in May 2020. From a governance perspective care home providers are expected to maintain a clear record of how the funds have been applied and complete a template confirming the application of the grant on Covid 19 related costs. A sample is subject to audit review/verification.

III. Following ongoing discussion across the HSC and with care home providers a number of key areas were identified that secured a further funding envelope of up to £11.7m; this is substantially to be accessed by care homes on a claims basis. This is to cover:

a. Up to £3.05m to assist care homes to pay their employees at 80% of their pre-COVID-19 average salary if they had to shield, isolate or were ill as a result of COVID-19 for the period of claim June to August 2020.
b. Supporting care homes to increase their level of environmental cleaning hours with up to £6.4m being available.
c. Up to £2.2m to allow Care Homes to purchase additional essential equipment (to include pulse oximeters, thermometers, portable tablet devices to support video communications) and with Trusts procuring defibrillators and syringe drivers for providers.

Regionally, to date, however the information from HSC Trusts, that are managing the claims process, indicate that the level of claims from care homes are in the region of £1.3m. Together with Trust equipment procurement the overall spend is currently c £2.1m.

It is noted that a number of Care Homes had not made any claim as at the end of August and also in some instances no supporting evidence presented in respect of claims made.

5. Staff Issues and Levels

Describe the need for change

At the beginning of the pandemic, the Chief Social Services Officer directed HSC Trusts to work with providers to develop Mutual Aid Plans (contingency arrangements) to respond to the pandemic. This included the provision of staff and other supports to the sector.

HSCB staff developed a 4 Stage Model to assist providers identify when and in what circumstances they should contact the Trusts for help.

Prior to the outbreak of Covid-19, many care home providers had already reported challenges in recruiting and retaining staff to meet legislative requirements.

In addition to the development of a Mutual Aid approach, the challenges for Trusts and providers were examined and responses developed through the regular regional Trust Assistant Director's meetings (facilitated by HSCB and including PHA and RQIA) and the weekly Director's meetings with Social Care Director HSCB

Evidence what the HSCB did to minimise infections in care homes and care for those infected while prioritising the care and wellbeing of all residents

Guidance / equipment was issued via Department and PHA however, local interpretation and exchange of learning took place at regional HSCB led meetings (with Assistant Directors and Directors of Trusts)

What was the result?

Regional meetings facilitated an exchange of ideas and learning and helped provide some level of consistency across all Trusts, clarified issues and improved communication

Where Care Homes did not have adequate and safe staffing resources they were able to link with the HSC Trusts, who were able to support, mainly be re-deploying Trust staff. No Trust reported not being able to respond to this need.

However there are concerns that should significant demand present during a second surge, the availability of Trust staff may not be sufficient, as services resume and staff return to their substantive positions. Provide support and clarity on guidance and advice and respond to queries.

What were the costs?

Please refer to the section of Finance and Funding to the care home sector

Who was involved?

- DoH

- HSCB
- PHA,
- Trusts
- Care Home providers

What worked well and why?

There was good communication between HSCB, Trusts and RQIA through the regional meetings along action plans which were regularly reviewed, RAG rated and updated

What have we learned?

Improved access to real-time data in respect of staffing levels within each care home and any risks arising from high levels of staff absence would have assisted decision-making.

Attention to the need to ensure adequate cover by ancillary staff eg cleaners, cooks etc would also have assisted appropriate, timely problem solving and risk management.

Who should know about this initiative?

- General public
- DoH

6. Staff Pay and Conditions

Describe the need for change:

The challenges of acquiring staff, maintaining satisfactory staffing levels, reducing footfall in homes, protecting residents and providing assurances about health, safety, well-being and environmental standards were on every agenda of the regional HSCB led response groups.

Early in the outbreak it became apparent that variations in the Terms and Conditions of employment across the care home sector were having a negative

impact both on recruitment/retention and on staff willingness or ability to adhere to specific guidance eg staff were reluctant to move to self-isolate as this meant a significant reduction in earnings. Similarly, staff who became unwell were disincentivised from going on sick leave as they were only entitled to the minimum Statutory Sick Pay (SSP).

Staff working on the frontline were also reporting challenges in accessing the correct Personal Protective Equipment (PPE) and keeping up to date with the Infection Prevention and Control advice.

Evidence what the HSCB did to minimise infections in care homes and care for those infected while prioritising the care and wellbeing of all residents:

Working with colleagues in Finance and the DoH additional funding was made available to the Independent Sector to ensure that staff on sick leave or self-isolating were paid above the standard SSP rate.

Funding was also made available to pay staff working overtime or additional hours to cover for colleagues who were ill or self-isolating.

Staff were able to access additional training and support through on-line or e-learning platforms such as Project ECHO, organised through the PHA.

What was the result?

The dedication of this group of staff was evident from the beginning of the outbreak, with anecdotal evidence suggesting that individuals were prepared at times to risk their own health and wellbeing in order to support the most vulnerable people in care homes. While most staff were prepared to continue to work without additional support or remuneration, the symbolic importance of additional resource being directed to front line staff cannot be overestimated.

What were the costs? If relevant.

See section on Finance and Funding

Who was involved? Organisations, disciplines

- HSC Trusts
- HSCB (Social Care Finance and Commissioning)
- PHA
- Independent Sector Providers

What worked well and why?

As above

What have we learned?

Provide additional funding to support the sector earlier on ie proactively rather than re-actively

The process for accessing or disbursing funding could be more streamlined eg one HSC Trust responsible for co-ordaining the process across Trust boundaries

Who should know about this initiative?

- Independent Sector Providers
- Staff side representatives
- Training and regulatory bodies
- DoH
- General public

7. Visitors

Describe the need for change

Throughout the pandemic, the HSC system has attempted to balance the need to reduce the incidence of COVID 19 in care homes with the need to maintain and promote the emotional health and wellbeing of residents living within homes and their relatives/carers.

Whilst family members have generally understood the need to shield residents by halting visits or restrict access to their loved ones, there can be no doubt that these decisions have taken a heavy toll on residents and family members.

Restricting footfall within care homes in order to reduce the potential for infection to enter the facility has also meant that many routine review processes have had to be delayed or suspended.

Evidence what the HSCB did to minimise infections in care homes and care for those infected while prioritising the care and wellbeing of all residents

Regional Guidance on visiting within care homes was developed and issued by the DoH.

Interpretation of the guidance and its application was overseen at regional HSCB led meetings. Where necessary, feedback was provided to the DoH which influenced later versions of this guidance.

At all times, priority was given to ensuring that people nearing or at the end of life were supported by visits from their families wherever possible. Most homes were able to support families to visit albeit in a restricted way at this very sensitive time.

As part of the package of financial support made available to care home providers, allowances were made for the purchase of electronic tablets to facilitate virtual meetings with families wherever possible.

Individual providers introduced local initiatives (dedicated visiting areas, visiting times, use of technology and regular telephone contact with families) which, while never substituting for direct contact with loved ones, went some way to re-assuring families about the wellbeing of their loved one living in the care home.

Particular difficulties were identified in relation to caring for people with dementia / cognitive impairment, who struggled to understand the rationale behind the reduction of ban on visiting.

The Regional Dementia Lead (HSCB) distributed guidance on support to people with a dementia during Covid-19.

What was the result? Provide any metrics available in terms of outputs (put supporting documents / links in the folder).

Contact with families was maintained within strict limitations.

Visits by professional staff went ahead on the basis of assessed risk (governance and safeguarding etc) and using alternative methods eg virtual meetings, telephone contact with family members and so on.

What were the costs?

Please refer to the section of Finance

Who was involved? Organisations, disciplines

- DoH
- HSCB
- PHA
- Trusts
- Independent Sector providers

What worked well and why?

Use of technology and localised initiatives within homes appeared to work well but the long term impact has yet to be seen

What have we learned?

There is a need for regional discussion on use of technology (reminiscence / communication / e-health / reduced isolation / assessment and review). This will

require investment in equipment and major training programme for staff and the general public - need for improvements in digital literacy

Who should know about this initiative?

- DoH
- Independent Sector Providers
- HSCB
- PHA
- General Public

8. Regulation: RQIA Engagement

Describe the need for change:

The Chief Medical Officer wrote to RQIA requesting they provide practical support to nursing and residential care homes during the period of the coronavirus pandemic emergency. It was requested that some inspectors be deployed to support homes who were experiencing staff shortages due to illness, shielding or in need of support for enhanced IPC measures. An essential part of this process was to develop key principles, one of which was how RQIA would ensure there was no conflict of interest between its support and its regulatory role and how it would determine which facilities to offer support to. Therefore HSCB were asked to ensure that the system for engaging with the care homes sector was open and transparent.

Evidence what the HSCB did to minimise infections in care homes and care for those infected while prioritising the care and wellbeing of all residents:

HSCB and RQIA developed an operational plan which outlined how RQIA would implement the on-site support team and how it would communicate and engage with key stakeholders. RQIA and HSCB representatives held regular meetings to consider services identified as requiring support and to review when support should be withdrawn.

HSCB would give the final approval for RQIA to proceed and depending on the nature of support required; more than one home could be supported at a time. The period of support was flexible so that it could meet the needs of the care home and all decisions made at these meetings were to be clearly documented.
At this point, HSCB had established 3 weekly Covid-19 meetings with Trust Assistant Directors, PHA and RQIA personnel. The RQIA lead for the on-site support team was extended an invitation to enable effective communication between the statutory agencies.

Provide details of the changes introduced:
The On-site support team was established from existing inspectors and focused its support on residential care homes that did not have an active COVID-19 infection. The rationale for this decision was to strengthen infection prevention and control practices within residential care homes as they were not nurse led. The decision to support only those care homes without Covid-19 was to ensure that RQIA would have enough staff that could be deployed whilst maintaining their core duties.

What was the result?
The team operated from late May to early July in which 13 care homes were offered support, 2 of which contained both residential and nursing units.

The team withdraw support from one home before the commencement date due to a Covid19 outbreak.

4 care homes declined support.

The initial request from the Chief Medical Officer was to support the private sector, however a statutory home was offered assistance as it was considered appropriate and in agreement with the host Trust.

Support for the care homes tended to be one member of the team deployed for a one-off site visit. Due to the workforce available to RQIA, they considered the

short deployments more effective for the care homes and better use of the staff resource available. Deploying the team in this way enabled more care homes to be supported.

What were the costs?

HSCB incurred no costs to this initiative.

Who was involved? Organisations, disciplines:

- RQIA
- The 5 Health and Social Care Trusts
- HSC Board
- PHA
- Care homes

What worked well and why?

There was good communication between RQIA and HSCB to establish the principles and operational guidelines for engagement between the two organisations. Identification of homes for this support occurred in partnership with other key HSC organisations. The engagement enabled care homes to strengthen their infection prevention and control practices which minimised as far as possible COVID-19 outbreaks.

What have we learned?

All deployments were one-off site visits by one team member, despite there being the option to deploy a number of group members for up to 7 days. Whilst the care homes that engaged in the process indicated the visits were useful, there was no opportunity to follow up if the advice provided had been adhered to.

Confusion of the role and function of the team was evident. There were no direct requests from care homes for support and RQIA needed additional time to reinforce that their attendance was in a supportive capacity and not a regulatory one. This was a regular feature both within the independent sector and statutory

homes. On reflection longer deployments may have provided care homes an opportunity to differentiate between the roles as the longer deployments would have looked very different from the normal inspection site visits.

Who should know about this initiative?

RQIA's evaluation will determine who should know about this initiative and if it is appropriate to offer this resource again in knowledge of their workforce commitments and organisational priorities.

9. Medical care within care homes and advance care planning

Describe the Need for Change

People living in care homes are amongst the most vulnerable groups in our society. Many are living with complex health conditions which require significant levels of clinical as well as social and emotional support.

This group of people require not only the highest standard of clinical care, but also to be as fully informed and involved as possible in any decisions about their on-going treatment and care.

The provision of medical care in care homes and advanced care planning involves careful consideration of complex ethical as well as clinical concerns.

Evidence what the HSCB did to Minimise Infections in Care Homes and Care for those Infected while Prioritising the Care and Wellbeing of all Residents in relation to medical care and advance care planning,

The Social Care and Children's Directorate (SCCD) recognised the importance of medical care and advanced care planning in the development, in consultation with PHA colleagues, of Regional Surge Plans for the care home sector.

Within these Plans an objective was to provide; "Robust, integrated Medical, Nursing, AHP and social care response commensurate with resident health care needs including acute clinical management of CoVID-19 in patients." Mitigation measures included creating mechanisms for virtual wards and working alongside

GP's and COVID Centres with the concept of enhanced clinical resources. It is of note that the May Surge Plan advised of the need for medical care to be available virtually and on the ground to provide clinical assessment and management in the care home. The Surge Plan advised of the need for particular attention to the support of residential care homes. Advanced care planning was also addressed and the concept of 'ceilings' of care.

What was the result?

The result of the above strategy was to provide regional guidance and direction to the care home sector and the HSC Trusts who provided support. Objectives, principles and actions considering the areas of prevention, mitigation and resilience were clearly outlined.

Regional Surge Plans were supported by agreed metrics. The May 2020 Monitoring Template asked for assurances to be provided by HSC Trusts to the HSCB and the PHA on the enhanced medical resources which had been provided. Areas considered included: actions when COVID is suspected; assessment and management in the care home; care delivery models to include on-site care and acute care responses to include, respiratory physicians, geriatricians and acute care at home.

What were the costs?

No direct costs to HSCB.

Who was Involved?

The following organisations were involved in this decision making process:

- HSC Board
- PHA
- RQIA
- HSC Trusts
- Care Sector
- DoH

- NISCC

What worked well and why?

Surge Plans and the resulting metric were developed in close consultation with the relevant stakeholders. Timely and frequent communication identified emerging challenges which were incorporated into the regional documentation. The actions developed were of a sufficient breadth to consider the needs of both nursing and residential care homes that provided a service to elderly service users within the different categories of care. A standardised response to the pandemic and the support needs of care homes was developed to include medical care and advanced care planning. The recommendation from the Rapid Learning Initiative into the Transmission of COVID-19 into and within Care Homes in NI was also incorporated into the September 2020 version of the Surge Plan and corresponding matric.

The Surge Plans and metrics were reviewed and actioned by the key stakeholders with an active process developed for receiving the information, considering areas of concern or which required clarification. Multi-agency meetings were developed for this purpose co-chaired by HSCB and the PHA and work schedules prioritised in recognition of the need to support care homes in all areas including medical care.

What have we learned?

Going forward into the second surge it might be helpful to develop specific metrics in relation to the support provided by Acute/Enhanced Care at Home services. This service developed from a directive by the CMO.

Who should know about this initiative?

- General public
- People admitted to hospital
- Staff working on the interface between acute and community care
- Care homes

10. Preparedness within Care Homes

Describe the need for change - What problem were you seeking to address:

Care home providers are expected to deliver care and support to residents in line with the Standards set by the Department of Health. These include Standards in respect of Infection Prevention and Control.

Initial advice to the care home sector was to apply the arrangements every home is expected to put in place in order to meet the Standards expected of them in respect of Infection Prevention and Control while specific COVID-related guidance was being drafted. However, these Standards, while helpful, were not sufficient to prepare Care Homes to deal with the COVID pandemic.

Evidence what the HSCB did to minimise infections in care homes and care for those infected while prioritising the care and wellbeing of all residents

The HSCB co-ordinated and standardised HSC Trust activity to support individual care homes, using existing professional networks. This included ensuring a standardised response to queries from care home providers in respect of the provision and use of Personal Protective Equipment.

As part of the response to the pandemic, HSCB worked with PHA and the NISCC to ensure that staff working in care homes continued to have access to relevant on-line and virtual training, with sessions focusing on how to deliver quality care during the outbreak.

Provide details of the changes introduced:

Working in partnership with the Public Health Agency, the HSCB developed a COVID-19 Regional Surge Plan for the NI Care Home Sector which identified key actions required across the HSC system to respond to the COVID outbreak within care homes

HSCB established and chaired the Social Care Surge Cell under the Emergency Response structures, which acted as a central point for all queries, issues and concerns in respect of social care provision, including care homes.

What was the result?

Trust Acute Care at Home and Care Home Support Teams were mobilised to offer hands-on support to care homes as required or requested;

- Daily telephone contact between the Trusts and each care home assisted in identifying emerging challenges and to address them at an early stage;
- Specialist IPC advice to care homes provided through colleagues in PHA;
- HSCB agreed that the calendar of annual reviews of care home residents should be temporarily suspended so as to reduce footfall into the homes and help prevent the spread of infection;
- HSCB co-ordinated implementation of the Care Home Surge Plan mobilising existing networks to oversee the progression of the identified actions.;
- HSCB facilitated joint problem-solving and collaborative working to address emerging issues;
- HSCB facilitated communication between HSC Trusts, providers and Silver and Gold Command Structures, speeding up responses to queries;
- Decisions on interface issues eg management of care home residents attending emergency departments or other day procedures, were expedited.

What were the costs?

Covered in the section on Funding and Increased Costs to Care Homes.

Who was involved? Organisations, disciplines:

- The 5 Health and Social Care Trusts
- HSC Board
- PHA
- Care homes
- RQIA
- NISCC

- CEC

What worked well and why?

Where Care Homes did not have adequate and safe staffing resources they were able to link with the HSC Trusts, who were able to support, mainly be re-deploying Trust staff.

Ensuring the workforce is adequately and appropriately trained has been addressed by providing some of the training on-line and free of charge from both NISCC and the Clinical Education Centre. This has also been supplemented by ECHO sessions with subject experts being able to provide support and clarity on guidance and advice and respond to queries.

Re-purposing existing established professional and organisational networks to focus on COVID related challenges allowed for speedy, timely and effective communication, as well as effective problem-solving.

What you consider doing differently?

There are currently 229 providers with a total of 482 Care Home facilities registered with RQIA. The registered bed capacity across all care homes is 16,082 – 10,804 Nursing home beds and 5,278 Residential beds, and covers a range of categories of care. The sheer size and variability within this service area makes communication with front line staff very challenging. Moving forward, there is a need to develop alternative clear lines of communication that enable front line staff to contribute more effectively to strategic planning and decision-making.

Who should know about this initiative?

- Care Home providers
- Care home residents and their families
- HSC Trusts
- General public

- Primary Care practitioners
- DoH

Committee for Health

Ms Valerie Watts
Chief Executive
Health and Social Care Board

By email: valerie.watts@hscni.net

Our Ref: C221/20

23 September 2020

Dear Ms Watts

COVID-19 and Care Homes

The Committee for Health is conducting an inquiry into the impact of COVID-19 on Care Homes and is seeking the views of your organisation with a view to developing recommendations aimed at mitigating and managing a second surge in infections.

The Committee has gathered evidence from a wide range of stakeholders on this matter since March, which has informed the enclosed terms of reference and identified the following areas for particular consideration:

- Discharge from hospitals to care homes;
- Access to PPE;
- Testing in care homes;
- Funding and increased costs for care homes;
- Staffing issues & levels;
- Staff pay and conditions;
- Visitors;
- Regulation: RQIA role, inspections & risk factors including public versus private ownership;
- Medical care within care homes and advance care planning; and
- Preparedness within the HSC and in care homes.

The Committee feels it has a good sense of the problems experienced but is keen to develop constructive recommendations that will inform decision-making in coming months.

I would therefore be grateful if your evidence could focus on the steps required to minimise infections in care homes and care for those infected, while prioritising the care and wellbeing of all residents in the broadest sense as well as the wellbeing of staff. It would be very helpful if you could use the above headings to structure your response, subject to any additional suggestions you wish to make.

The above headings are supplemented overleaf by a list of sub-topics designed to illustrate, in a non-exhaustive way, the type of information that would be useful. Appendix 2 sets out the Committee's terms of reference.

I would grateful for your reply by 19 October in order to maximise the usefulness and timeliness of the Committee's report.

Yours sincerely,

Colm Gildernew MLA
Chairperson
Committee for Health

Enc.

CC: laverne.montgomery@health-ni.gov.uk
Lynne.Curran@health-ni.gov.uk
Wendy.Patterson@health-ni.gov.uk

Appendix 1

Further information on topics of interest

- **Discharge from hospitals to care homes**
  - Testing prior to & post discharge
  - Isolation within care homes
  - Step-down facilities

- **Access to PPE**
  - Costs
  - Security of supply
  - Procurement: central v individual

- **Testing in care homes**
  - Effective frequency and management
  - Symptom monitoring
  - Personnel
  - Consent issues

- **Funding and increased costs for care homes**
  - Cleaning
  - Other infection control measures
  - Technology

- **Staffing issues & levels**
  - Additional staffing requirements;
  - Recruitment, regulation
  - Staff movement, shifts, roles
  - Training & guidance

- **Staff pay and conditions**
  - Sick pay
  - Environment including staff changing facilities
  - Other support

- **Visitors**
  - Virtual visiting
  - Socially distanced visiting
  - Wellbeing

- **Regulation**
  - RQIA role including inspections & advice
  - risk factors
  - HSC-run versus privately-run homes: impact/outcomes comparison

- **Medical care within care homes**
  - In-reach teams / support from Trusts & GPs
  - advance care planning

- **Preparedness within the HSC and in care homes: pre-COVID baselines and future requirements**
  - DoH consideration of care homes within pandemic plans
  - Coordination & communication between DoH, Trusts & care homes
  - Care homes:
    - standards in place for infection control
    - staff training including infection control, dealing with infectious disease outbreak
    - PPE stocks typically in place and usual levels of need /cost

Appendix 2

Aim of Inquiry

The aim of the Committee's inquiry is to produce recommendations to mitigate and manage the impact of a potential second surge of coronavirus on care homes.

Terms of Reference

The Committee will:

- Identify the key issues impacting care homes as a result of the COVID-19 pandemic;
- Identify domestic and international examples of best practice in arrangements to protect and care for residents of care homes during the pandemic; and
- Report to the Assembly on its findings and recommendations by **13 November 2020.**

Committee for Health
Room 410, Parliament Buildings, Stormont, Belfast BT4 3XX
Telephone: (028) 9052 1634 E-mail: committee.Health@niassembly.gov.uk
follow us on Twitter: @NIAHealth