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By email -19 October 2020

Mr Colm Gildernew MLA
Committee for Health
Parliament Buildings
Stormont

Dear Mr Gildernew

Re: Request for written evidence – Covid-19 and Care Homes

I am writing in response to your letter dated 23 September seeking ihcp input to the Health Committee's inquiry into the impact of Covid-19 on Care Homes. As requested, I have used the headings provided in your template as the areas of particular concern and where possible focussed on the steps necessary to minimise infections in care homes and care for those infected including the wellbeing of residents and staff. I have included references to Homecare (Domiciliary Care) Services, where relevant, as I see these services as an integral part of the connected plans going forward.

Initially I thought it might be useful to outline some brief background information about the Independent Health and Care Providers (ihcp). Ihcp is the representative body in NI for independent providers of care services for older and vulnerable people. This includes charity, church-affiliated, private and not-for-profit organisations. The services our members provide include both care at home (Homecare/ domiciliary care), residential accommodation (including nursing care beds) and Day Care.

1. Discharges from hospitals to care homes.
   Testing is required 48hours prior to discharge from hospital to a care home. The results of these tests are not always available on discharge and care homes isolate all new residents for a period of 14 days. In Spring there was evidence that there was pressure on care homes to continue to support discharge pathways for older people out of hospital and this is a concern again. Not all Trusts have discharge pathways to accommodate those who have tested positive for covid and either continue to test positive, or are medically fit for discharge, but remain in the infective period. Some care homes are providing step-down facilities completely separate from the main care home residents so that there is an

opportunity for patients who have tested positive to be discharged into a unique safe environment. There is no universal approach and no safety net of retesting residents discharged after 4-7 days to ensure that they have not contracted the virus in hospital. Homecare Services (domiciliary care) - Hospital discharges to homecare services are not tested and we believe testing should be carried out.

2. Access to PPE.
   PPE continues to be supplied where necessary by Health Trusts and there have been no recent concerns about availability. We have been advised that the support to supply will continue but an assurance on the continuity of supply and how long this will last would be of benefit. The costs of procuring PPE on an individual basis is significant with prices soaring across all PPE products. We need to be mindful that any change to the PPE guidance needs to be communicated early to Care Homes and Homecare providers. A consistency of approach to these guidelines across all Trusts needs to be assured.

3. Testing in care homes.
   Staff are tested every 14 days and residents every 28 days. These routine tests are carried out by care home staff using the National testing system and there have been considerable problems with delays in results, the IT system and the courier service. In the past week there has been an improvement in the results turnaround but as there is more testing being carried out there remains a concern about capacity of the system to deliver. An outbreak is two symptomatic cases at present so Homes can get into outbreak before positive tests are confirmed. Repeat positive tests are also putting Homes into outbreak. This stops admissions and curtails visiting. PHA/Trusts take over the testing in the case of an outbreak with tests being carried out locally. However recent feedback indicates that Trusts are starting to struggle with their capacity to complete the repeat testing at day 4-7 in care homes due to resourcing issues. This is resulting in a delay in completing this repeat testing process and subsequently a delay in identifying positive cases. The Trust PCR test appears to be a more sensitive and reliable test.
   There are symptom monitoring systems in place but as you are aware many of the positive tests are now from asymptomatic people. The symptom monitoring guidance from PHA needs to be revised. We are aware of ongoing engagement around the 'wellness checklist' which is referenced in the Care Home guidance – this need progressed.
   There are staffing problems arising from the additional resource required to undertake these tests and I have covered this issue in more detail in a later heading.
   Consent issues – not all residents agree to testing and ihcp has asked PHA what monitoring system is in place to quantify the number of untested people. There has been no response to this question.
   Footfall into care homes has increased with AHP's and inspectors now accessing for visits. We have asked that any footfall into a care home should fall within the routine testing protocol – It is the sectors view that testing should be carried out weekly for staff and every two weeks for residents. All those professionals who interface with Care Homes including RQIA/Trust teams and agency workers should be required to undertake the same mandatory testing as care home staff.
   As mentioned previously discharges from hospital to homecare services or the homecare staff are not included in the routine testing protocol.

4. Funding and increased costs for care homes.
   Increased resource demands have been created by the routine testing process, visiting monitoring and supervision. This is compounded by reduced staffing levels due to isolating and no childcare due to school class closures.

Grant funding has been made available for enhanced cleaning, staff sick pay and technology but has been significantly under-claimed/utilised due to the eligibility criteria and qualification time limits. In addition there has been support for care homes that have been under- occupied as a result of Covid, however not all of these payments have been processed and there is a delay in sorting out the blockage for payment.
There have been on-going meetings with the Department of Health since July regarding funding pressures with continued commitment for submissions to be provided to the Health Minister.

5. Staffing issues and levels
   Additional tasks have been added to current staffing levels including those mentioned earlier – routine testing and visiting. Other resource pressures have arisen as a result of additional monitoring, assurance, surveys and audits etc. Staff shortages are a challenge to cover and agency staff are being used at additional costs. Concerns have been raised with ihcp about agency staff and Student Nurses moving from care home to care home and to Trusts. We are very concerned that all the expectations of controlling footfall into care homes is left with the care provider, and other stakeholders are not being set requirements to follow or supporting solutions to cover staff gaps.
   Problems attracting new recruits are also occurring with a number of our members stating that there has been a very poor response to recent recruitment campaigns. There has been a meeting within the last week with the DoH to try to resolve some barriers in the recruitment processes.
   Training and guidance- We appreciate the access to online learning which has been opened up to care homes and homecare providers via Trusts and CEC. Attendance at these sessions is important in embedding the key knowledge and learning regarding covid but requires releasing staff from hands-on care which there has been no recognition for. Trusts have also been completing IPC monitoring/audit visits which again requires resource to support. It seems there is an expectation that all of these very important and valued interventions can be delivered at a time when care homes have less resource.

6. Staff pay and conditions
   Staff terms and conditions vary from employer to employer. Support to top up Statutory Sick Pay has been made available to staff in the homecare services but was limited to a time specific period for care home staff. We have sought to address the inequality between these two workforces and also the inequality of compensating those in care homes that were off in the latter part of the pandemic but not those at the peak. There is considerable pressure and cost to address issues such as those off isolating or needing to remain at home because their children are isolating.
   Staff have been managing through particularly difficult and challenging times and many are very tired. This is further impacted by reduced resource. Many of the staff who continue to work through the experience of losing multiple residents due to Covid are afraid of going back to that position. And those care homes that have not had that experience are afraid of being impacted with the second wave. Care home providers and staff are doing all they can to reduce the risk of Covid entering their homes.
   Staff changing facilities -Care homes have worked hard to assure the IPC measures around uniforms and PPE wearing are adhered to. This has required a review of areas in care homes where staff can safely have space to achieve good compliance. In some care homes bedrooms have been taken out of use to accommodate donning and doffing.
   Other support has included the psychological support services from Trusts being available to the independent sector. I am unsure of the uptake levels for this service. I am aware that

Trust Psychological support teams provided additional support to the care homes that faced multiple covid related bereavements.

7. <u>Visitors</u>
   There have been a range of innovative ideas to assist with family visiting which include video, zoom calls, garden visiting and visiting pods. However the restrictions are putting serious pressure on residents and families and moving into colder weather impacts on the outdoor visiting solutions. The recent visiting guidance has caused concern particularly against a backdrop of the worrying increase in community transmission. The Care Partner idea was included in the guidance but was not discussed with the sector and there are many problems which were not foreseen within the policy not least insurance and regulatory requirements. We have flagged the issues that need to be addressed in order to mitigate the risk of the increased footfall which could be as high as 2 care partners for each resident with unlimited access. These include routine testing increasing in frequency and results delivered on time, staffing issues addressed, appropriate funding support and recognition for staff. Until these are addressed it is unlikely to be assessed as appropriate to increase the footfall into care home while the community transmission rate increases.
   The wider impact of this pandemic on residents has been significant going much further than visiting restrictions. Normal life in a care home has been greatly impacted by such things as isolation, the additional IPC requirements, and reduced services such as podiatry – all of these have an adverse impact on people and even for those not directly impacted by covid itself.

8. <u>Regulation</u>
   RQIA have commenced a mixed approach to inspections and have indicated that they are doing this on a pilot basis. There are concerns that the virtual visits are actually more resource intensive than 'on the ground' visits. There remains a number of avenues for care homes to raise concerns via PHA and RQIA however reports are that access to advice out of hours is challenging.
   HSC-run versus privately-run homes – ihcp has been asking for the past many years for an independent economic review to be completed to identify the true cost of care. In addition we have suggested that this could be supported by a financial regulator. On the basis of a financial and economic analysis the full comparison between public and private provision of services could be appropriately assessed.

9. <u>Medical care within care homes</u>
   In-reach teams/ support from GP's/advance care plans – While each Trust had a covid response plan in the first surge that differed in composition, the interface with the residents own GP's who best know them, was almost non-existent. These covid response teams seem to have been stepped down in some areas and the commitment to completing advance care planning for all residents has not been fully achieved. Again some Trusts have advanced their plans through virtual reviews (NHSCT).

10. <u>Preparedness within the HSC and care homes – future requirements</u>
    There has been a myriad of workstreams on planning and reviewing including Surge Planning, Rapid learning, Keeping Covid out of Care Homes and Psychological support for staff. If the Care Home Surge Plan is to be the overarching document which connects all stakeholders in the safe and effective management and delivery of care then there needs to be an urgent commitment from DoH to address the queries we have raised with the surge plan including the requirements levied on care providers to confirm they are meeting the

actions listed. We are concerned that the resourcing and funding to deliver on the surge plan is not in place across all stakeholders.
Ihcp has continued to emphasise the need to integrate the homecare services into the reviews and forward planning. A homecare surge plan is not yet in place and there is a need to utilise the potential capacity of the homecare workforce. We are seeing shifts in landscape from the first wave to the second and these two areas of care overlap. Referral mechanisms to Homecare services remain at a virtual standstill and we are aware that there are people in need in their own homes.

In conclusion Ihcp members have advised that they are concerned about the capacity to continue to deliver care together with the expectations placed on them, facing the continuing increase in covid transmission in NI.

Yours sincerely

Pauline Shepherd
Ihcp CEO