

FROM THE MINISTER OF HEALTH

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Health

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Date: 22nd April 2021

Dear *Colm,*

Health Committee Inquiry Report on the Impact of COVID-19 in Care Homes

Thank you for the Committee's Inquiry Report on the impact of COVID-19 in Care Homes, of which we took receipt on the 2nd February.

Please find enclosed my Department's response to the recommendations contained within the Report.

I hope you find this response helpful.

Yours sincerely

Robin Swann MLA
Minister of Health



VISITING

Recommendation 1. The Committee recommends that safe and meaningful visiting be facilitated and resourced through the identification, development and implementation of innovative measures.

Recommendation 2. The Committee recommends that residents and families be involved directly in decision-making around visiting, to ensure that the particular needs and circumstances of each resident is considered, including their, and their family's, attitude to risk.

Recommendation 3. The Committee recommends further work in the area of messaging and communication around visiting, COVID-19 outbreaks in homes, including direct communication with families in respect of their loved ones and wider developments affecting the home in which their family member resides.

Recommendation 4: The Committee calls for the implementation of the care partner initiative to be expedited, supported by urgent work with unions and providers to resolve issues raised, including safeguarding, insurance, role specification and testing.

Recommendation 5: PPE must be provided as required to facilitate safe visiting.

Recommendation 6: The Committee recommends that the implementation of visiting guidance be monitored across care homes to ensure consistency and compliance with best practice.

RESPONSE:

All six recommendations are accepted.

It remains our position that care home visiting and the utilisation of care partners' support can be safely facilitated through compliance with the regional principles for visiting in care settings as set out in the existing guidance.

Support and funding has been made available to help homes implement the approach set out in regional guidance and it is encouraging to see substantial take up of funding and examples of good practice visiting and care partners' initiatives across the Sector. Trusts will continue to seek assurance that visiting is being accommodated for residents using a dynamic risk assessment approach, in accordance with guidance. In addition, Trusts will continue to provide support and advice where there are difficult to navigate situations relevant to a particular Trust client.

The PHA will continue to provide advice to homes in the event of outbreaks and both the Trusts, RQIA, HSCB and PHA will continue to provide advice and support through existing forums and directly to care homes as and when needed. A number of homes have already

undertaken training and support made available to help them complete their dynamic risk assessments.

Additional testing for Care Partners remains in place and again we stress through this additional assurance measure visiting can and should be accommodated safely in line with published guidance including strict adherence to all Infection and Prevention Control standards.

To help ensure the right balance is being struck by individual care homes, in line with regional guidance, RQIA will continue to assess the approach to care home visiting including when undertaking inspections of residential and nursing homes, in line with existing standards. Visiting policy and practice will continue to be a material consideration in the inspection and regulation of each care home.

In addition, Trusts are asked to ensure that where regional guidance is not being followed and there are concerns about, for instance, human rights or safeguarding, that all the existing mechanisms within the regional contract are used to the full to ensure compliance. Trusts should also continue to take account of any concerns about these issues when making decisions about which care homes to place clients in.

Training and guidance materials have been made available to all care homes to support the development of local visiting policies and these include reference to the importance of engaging with families and carers.

Clarification on the role of the care partner has been supported by development of specific information leaflet. PCC have established a Care Home Family Reference Group who have been involved in the development of the leaflet for visitors. This group has provided a forum to enable concerns to be raised and these have been addressed by PHA, RQIA and HSCB collectively. Leaflets for relatives / carers co-produced by PCC Stakeholder Reference Group /PHA/ HSCB/ RQIA and was distributed to named next of kin in January 2021. It has also been distributed by RQIA to all care homes and will be is accessible on the PHA website. A social media information campaign will highlight the availability of these leaflets. An animated video will also be part of this awareness campaign.

PHA/HSCB Care Home Action Plan identifies an action for Care Homes to co-produce a communication strategy with residents and relatives. The PHA PPI team are working to develop a system which provides a continuous feedback loop between residents, relatives, staff and decision makers and will help identify good practice / areas for development.

All HSC organisations are working together to address and remove any substantial barriers that have been identified – with the vast majority of care homes operating in compliance with guidance and implementing the care partners initiative. A monitoring process has been put in place to track progress against implementation of visiting and care partner polices, as part of daily monitoring returns from care homes.

PPE continues to be made available free of charge to all care homes, where needed, including to facilitate safe visiting.

Whilst recognising the risk of transmission will be increased with any rise in footfall in care homes, we have sought to put in place a risk based, sustainable approach to

supporting residents and loved ones to have meaningful connections, in particular where isolation is detrimental to resident's physical and mental health.

Under the auspices of the PHA, we have established a Moving Towards Normalised Care Home Visiting in Northern Ireland Task and Finish Group. The purpose of the Group is to develop an approach, for endorsement by the Minister, which supports a safe and proportionate return to normalised care home visiting as restrictions in Northern Ireland are eased from April 2021.

The Grouping is made up of representatives from the:-

- HSCB, PHA, RQIA, Trusts, COPNI and PCC;
- Departmental policy Directorates;
- Representatives from various relatives groupings; and
- The Independent Healthcare Providers

This will be an area on which we will continue to focus, continuing to give careful consideration to the recommendations of the committee.

Testing

Recommendation 7: The Committee recommends that, subject to rapid testing becoming available, care home workers should be tested daily; those moving between homes be tested before entry to any home; and residents should continue to be tested as frequently as necessary and at least fortnightly.

RESPONSE

Partially Accepted

A regular programme of COVID-19 testing is one of a range of measures which have been successfully implemented across all care homes in Northern Ireland during the pandemic response, to effectively protect some of the most vulnerable citizens in our society.

At this stage, the frequency and type of COVID-19 testing in place for asymptomatic care home residents and staff is considered proportionate and appropriate. There are no plans in the short term to introduce daily rapid testing (for example, using lateral flow devices (LFDs)) for care home residents and staff. The care home COVID-19 testing programme is kept under active review by the Department and is refreshed in line with new and emerging scientific and medical evidence.

The primary factors underpinning the Department's position include: the well-established and comprehensive Polymerase Chain Reaction (PCR) care home testing arrangements; current transmission rates of the virus in Northern Ireland; and current mitigation measures which are supplemented by the successful deployment of the COVID-19 vaccination programme across all care homes.

At this point in the pandemic, we are seeing a reduction in community transmission rates of the SARS-CoV-2 virus; this has contributed to an observed reduction in COVID-19 related hospital admissions and in COVID-19 related deaths in care homes. There are also fewer care homes experiencing a COVID-19 outbreak. As of 13 April 2021, 5 care homes had a confirmed COVID-19 outbreak, in comparison to 115 care homes which had a confirmed COVID-19 outbreak on 7 December 2020, prior to the commencement of the COVID-19 care home vaccination programme and during a period of high community transmission of the SARS-CoV-2 virus.

Protecting residents and staff in care homes will continue to be a key priority for the Department throughout our continuing COVID-19 pandemic response. PCR testing is still considered to be the 'gold standard' for detecting SARS-CoV-2 as it is characterised by both high sensitivity and specificity in detecting viral ribonucleic acid (RNA). PCR testing in care homes has been facilitated from the earliest opportunity and is delivered through a collaborative and robust multi-agency partnership between the Department, the Public Health Agency, Health and Social Care Trusts and care home providers.

In recognition that care homes are distinct from other care settings - they are enclosed environments and have a specific and particular risk profile - the Department extended

its testing programme to include an initial round of PCR testing to all care home residents and staff across Northern Ireland in May 2020.

Since August 2020, a comprehensive programme of regular PCR testing has been implemented in all care homes across in Northern Ireland. This programme is ongoing and includes regular testing undertaken through the National Testing Programme (Pillar 2) in care homes which do not have a COVID-19 outbreak. Through this regular programme of testing, all asymptomatic care home staff are tested on a weekly basis (increased from fortnightly testing at the start of November 2020) and all asymptomatic residents are tested every 28 days.

In addition to the regular asymptomatic testing programme, there is an enhanced testing protocol in place for care homes with a suspected or confirmed COVID-19 outbreak. In such situations, testing is undertaken through local HSC Laboratories (Pillar 1), with Health and Social Care Trusts supporting care homes to complete this testing, and with appropriate input and advice from the Public Health Agency Health Protection Duty Room in relation to management of the outbreak.

The regular programme of asymptomatic testing in care homes across Northern Ireland has undoubtedly reduced the impact of COVID-19 during this pandemic and protected some of the most vulnerable citizens in our society. The early identification of single cases and potential clusters and outbreaks has enabled immediate steps to be taken at the right time to prevent the spread of infection and to prevent further transmission in care home settings.

New testing technologies designed to help detect and fight COVID-19, such as rapid Lateral Flow Devices (LFDs), are continuing to develop at pace. These types of rapid tests can help to identify individuals who have the virus but who are not symptomatic and may therefore be spreading the virus unknowingly. These emerging testing technologies require careful planning and are subject to ongoing review regarding extended use in Northern Ireland, including in care home settings.

As part of the continued expansion of routine asymptomatic testing utilising LFDs, the Department's Expert Advisory Group on Testing (EAG) is progressing the implementation of an offer of voluntary testing for staff groups within primary care and secondary care settings. The EAG will consider expanding the scope of this asymptomatic staff testing programme to consider those individuals i.e. visiting professionals who may attend and/or move between care homes.

The COVID-19 vaccination programme commenced in Northern Ireland care homes in early December 2020 and by the end of February 2021, all care homes had been offered first and second doses of the COVID-19 vaccine. The Public Health Agency is currently progressing an important epidemiology study to examine the impact of vaccination on care homes. The Department will share the key findings from this study with the Health Committee in due course.

As explained at the outset of this response, the care home COVID-19 testing programme is kept under active review by the Department and is refreshed in line with new and emerging scientific and medical and evidence.

Recommendation 8: Testing should be extended to all those entering care homes including visitors, care partners, residents returning from an external appointment, and all professionals entering homes; and should take place as often as necessary to take advantage of improvements in testing capabilities.

RESPONSE:

Partially Accepted

A comprehensive programme of regular PCR testing is in place across all care homes in Northern Ireland. This includes regular testing undertaken through the National Testing Programme (Pillar 2) in care homes which do not have a COVID-19 outbreak. Through this regular programme of testing, all asymptomatic care home staff are tested on a weekly basis (increased from fortnightly testing at the start of November 2020) and all asymptomatic residents are tested every 28 days.

In addition to the regular asymptomatic testing programme, there is an enhanced testing protocol in place for care homes with a suspected or confirmed COVID-19 outbreak. In such situations, testing is undertaken through local HSC Laboratories (Pillar 1), with Health and Social Care Trusts supporting care homes to complete this testing, and with appropriate input and advice from the Public Health Agency Health Protection Duty Room in relation to management of the outbreak.

In Northern Ireland, we have also been actively progressing work on a number of New Testing Interventions (NTIs) utilising the latest testing technologies.

As an additional mitigation to assist and support visiting in care homes, an NTI using lateral flow devices (LFDs) commenced in early 2021 and this testing continues to expand. This care home NTI will play an important role in adding to the growing evidence base on the benefits of deploying these new testing technologies across a number of different settings.

The Department also continues to support the Care Partners' Scheme by making regular testing available to nominated care partners.

At this time, the testing of residents returning from external appointments to hospital or other health and care facilities is not recommended, but is kept under review. Visits by care home residents to a hospital or other health care facility, are appropriately risk assessed and risk managed, with provision made for the required Infection Prevention and Control (IPC) measures to be in place.

As part of the continued expansion of routine asymptomatic testing utilising LFDs, the Department's Expert Advisory Group on Testing (EAG) is progressing the implementation of an offer of voluntary testing for staff groups within primary care and secondary care settings. The EAG will consider expanding the scope of this asymptomatic staff testing programme to include visiting professionals who attend and/or move between care homes.

While a test for COVID-19 can reduce the risk associated with care home visiting, it does not completely remove the risk of infection. When used alongside Personal Protective Equipment (PPE), social distancing, good hand hygiene, and other robust IPC measures, it can support care homes to safely maintain a balance between infection control and the vital benefits of visiting to the health and wellbeing of care home residents.

Recommendation 9: The Committee recommends that local capacity to undertake testing and process results should be increased to improve timeliness of results.

RESPONSE:

Not Accepted

There is currently sufficient PCR testing capacity within the National Testing Programme (Pillar 2 of the Northern Ireland testing arrangements) to accommodate the regular asymptomatic testing programme deployed across all care homes on a timely basis.

Since the beginning of February 2021, through Pillar 2, the weekly turnaround times for test results reported within 48 hours of testing being undertaken, has ranged from 95% to 98%.

Recommendation 10: Pooled testing should be explored as a means of enhancing testing capacity.

RESPONSE:

Partially Accepted

The Department will explore the potential benefits of pooled testing.

The Department acknowledges that there are reported potential benefits of pooled testing, for example where COVID-19 testing capacity is constrained and there is a consequential impact on the deployment of COVID-19 testing in line with the preferred frequency. There are also reported limitations in relation to pooled testing, including: a lower sensitivity; pooled testing is not recommended for individuals who have previously tested positive for COVID-19; and the need to retest each individual within the pool when a pooled test result is positive in order to identify infected individual(s) which further delays test results.

As stated in the response to Recommendation 9, there is currently sufficient testing capacity for the regular asymptomatic care home testing programme through Pillar 2, in line with the required frequency of testing for both staff and residents. There is also

adequate testing capacity to support care homes which have a suspected or confirmed COVID-19 outbreak through Pillar 1 testing arrangements.

In view of the available capacity across both Pillars of our testing arrangements in Northern Ireland, there is no requirement to introduce pooled testing in care homes at this stage in the pandemic response. However, the Department's Expert Advisory Group on Testing (EAG) will explore the potential benefits of pooled testing with a particular focus on determining its suitability for the care home sector, should it be required in the future.

Recommendation 11: Access to, and training in the use of, appropriate clinical equipment should be provided as a priority, to facilitate effective twice-daily symptom-monitoring; and compliance with guidance on symptom-monitoring should be included in regular checks.

RESPONSE:

Accepted

Clinical equipment relevant to individual care homes has been provided as required by those individual homes.

Training is currently made available free of charge to all care homes and can be accessed via the Clinical Education Centre and via HSC e-learning.

In addition, RQIA will continue to issue information on any relevant training which is made available to the independent sector and will also, as part of their inspections, assess whether guidance issued to Care Homes has been implemented and adhered to.

There are, of course, differences in competence and skill level required in relation to clinical observation practices between Nursing Home and Residential Care Home staff and this will be taken into consideration by the RQIA when undertaking inspections.

Recommendation 12: Further research should be undertaken to establish the means by which the virus is getting into homes, whether via staff or deliveries etc.

RESPONSE:

Accepted

The Department has published a bank of evidence papers that have helped shape its response to Covid-19. The documents include reports from SAGE (Scientific Advisory Group for Emergencies), weekly papers on the R number in Northern Ireland, and links to other expert assessments. Also published are the slides made public by the

Department each week, detailing the path being taken by the virus. This evidence bank brings documents on key Covid-related issues together in the one place. The scientific evidence documents and the R number papers can be found on the Department's website.

An Evidence Paper entitled 'SARS-COV-2: Transmission Routes and Environments' – was published on 22 October 2020. Among its findings were that large, long-term care facilities such as nursing homes and homeless shelters have seen increased rates of infection, in part because of patterns of contact among staff and residents. In an investigation of 17 nursing homes that implemented voluntary staff confinement with residents, including 794 staff members and 1250 residents in France, staff confining themselves to a single facility for a weeklong period (stayed in the facility) was associated with decreased outbreaks in these facilities.

As part of our ongoing research programme we will consider further opportunities for research into the virus and how it is getting into care homes etc. Ongoing research is being conducted nationally and internationally to inform the evidence base for this virus and the results of this will be considered as we continue to move through the response to the pandemic.

Recommendation 13: The Committee recommends that further consideration be given to the capture and analysis of testing data, such as asymptomatic positive tests, to inform the pandemic response.

RESPONSE:

Accepted – recommendation has already been implemented

Detailed analysis of data in relation to the care home testing programme has already been implemented. To help inform the current position and to inform future approaches to care home testing arrangements, the Department, in conjunction with HSC colleagues, continues to closely monitor all care home testing results from both the regular asymptomatic testing programme, and testing undertaken in the context of all COVID-19 outbreaks occurring in care homes.

Robust data capture and reporting arrangements includes monthly reporting on the uptake and results of staff and resident testing through the regular asymptomatic testing programme, and testing results in suspected or confirmed COVID-19 care home outbreaks.

Since 2 December 2020, information on asymptomatic outbreaks identified in care home settings, at the time of the testing, is published on the DoH COVID-19 Dashboard, available at the following link: <https://www.health-ni.gov.uk/articles/covid-19-daily-dashboard-updates>

Recommendation 14: Guidance should be reviewed to ensure consideration of human rights issues around testing.

RESPONSE:

Accepted

The primary human rights issue with regards to COVID-19 testing is that consent must be obtained from the person to be tested, prior to the test being conducted.

The COVID-19 Testing Guidance for care homes which references the consent principle is already in place and has been published. This guidance document is available on the Public Health Agency's website at the following link:

<https://www.publichealth.hscni.net/sites/default/files/2021-01/Care%20Home%20Testing%20Guidance%20Northern%20Ireland%20v21-01.pdf>

Care home providers have an existing responsibility to obtain residents' consent before commencing any examination, starting treatment or physical investigation or providing personal care; the consent principle extends to obtaining permission for COVID-19 testing to be undertaken

It is therefore for care home providers to arrange to obtain the consent of residents to be tested for COVID-19; this should be done in line with the care home's written policies and procedures on obtaining valid and informed consent. If a resident with capacity to consent makes a voluntary and appropriately informed decision to refuse to be tested for COVID-19, this decision must be respected. In situations where a resident does not have capacity to consent, a care home must follow the process for "a best interest" decision.

The Department will ensure that its COVID-19 Guidance for Nursing and Residential Care Homes in Northern Ireland is updated to include the matter of consent.

Discharge Policy

Recommendation 15: The Committee recommends that no-one be discharged from hospital to a care home in which they are a resident, without having tested negative for COVID-19, unless the care home confirms that it has the staffing and facilities to ensure isolation for the required period; and that this is subject to monitoring and review.

RESPONSE:

Partially Accepted

Discharge is an area of policy that the Department continues to keep under active consideration. The Department seeks to ensure that care homes are protected from any risk of infection and importantly that residents do not remain in hospital for a period longer than they need to.

It is not necessary to require a negative COVID-19 test in all circumstances involving the discharge of a resident to a care home setting. It is necessary to consider and fully understand the individual circumstances of the patient; this will include for example the timing of the patient's test result, and the period in which the patient remains infectious.

We are currently revising existing Departmental policy which required that individuals discharged from a hospital to a care home should be tested for COVID-19, ideally 48 hours before discharge, and subject to 14 days isolation on arrival into the care home. The revision to the policy is in the context of recent advice issued by the PHA (30 March 2021) in relation to isolation periods. The advice from the PHA Guidance Cell confirms that the Departmental guidance for care homes/ supported living in NI should be reviewed to reflect the updated PHE guidance on the discharge of positive patients/residents from hospital which is available at the following link:

<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>

The updated PHE guidance explains that:

'The total 14-day isolation period can be shared across the hospital and designated setting if infection prevention and control practices are not breached. If the individual has had a new COVID-19 exposure prior to discharge, then the 14-day isolation period should start from the day of the last exposure.'

The PHE guidance also explains that the care home retains the discretion to isolate a resident if they wish.

The PHA IPC Cell has agreed that 'from an IPC perspective isolation can be shared across facilities provided all IPC practices and Covid secure behaviours remain in place.'

It is key in the discharge decision to understand the period during which a person remains infectious to others if they have tested positive for COVID-19. This should be considered as part of the risk assessment process undertaken to inform the care and treatment of the patient, for example any period of isolation that may be required.

It is important to note that testing an individual for COVID-19 within 90 days of a positive PCR test is not recommended unless that person has developed new symptoms potentially consistent with COVID-19 infection. This is because a repeat test may result in a positive result due to the presence of residual (dead) virus within the individual's system. This does not represent active infection with the virus.

The Health Committee may wish to note that plans are also underway to deploy Lumira DX, a rapid nasal swab test which delivers results in 12 minutes, to individuals on the day of discharge from a hospital to a care home setting. The Lumira DX test has been deployed successfully in Emergency Departments across Northern Ireland since January 2021. Lumira DX is a 'rule out' test and enables very quick identification of patients who do not have COVID-19. As the Lumira DX test will be undertaken on the day of discharge, this should provide additional reassurance to a care home provider that an individual is not infectious.

Recommendation 16: New residents should not be admitted to a care home unless they have tested negative.

RESPONSE:

Not Accepted

Please see the Department's response to Recommendation 15 which is also relevant to this Recommendation.

We are currently revising existing Departmental policy which required that individuals discharged from a hospital to a care home should be tested for COVID-19, ideally 48 hours before discharge, and subject to 14 days isolation on arrival into the care home. The revision to the policy is in the context of recent advice issued by the PHA (30 March 2021) in relation to isolation periods. The advice from the PHA Guidance Cell confirms that the Departmental guidance for care homes/ supported living in NI should be reviewed to reflect the updated PHE guidance on the discharge of positive patients/residents from hospital which is available at the following link:

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The updated PHE guidance explains that:

'The total 14-day isolation period can be shared across the hospital and designated setting if infection prevention and control practices are not breached. If the individual has had a new COVID-19 exposure prior to discharge, then the 14-day isolation period should start from the day of the last exposure.'

The Department is in agreement that new residents should not be admitted to a care home where a positive COVID-19 test has been obtained and the care home has confirmed that it does not have appropriate facilities or resources to allow for appropriate implementation of the required period of self-isolation. However, the Department does not agree that a care home should refuse to accept a new resident who is COVID-19 positive where the care home has the ability to safely facilitate the required period of isolation.

The Committee is referred to the Department's response to Recommendation 15.

It is key in the discharge decision to understand the period during which a person remains infectious to others if they have tested positive for COVID-19. This should be considered as part of the risk assessment process undertaken to inform the care and treatment of the patient, for example any period of isolation that may be required.

It is important to note that testing an individual for COVID-19 within 90 days of a positive PCR test is not recommended unless that person has developed new symptoms – potentially consistent with COVID-19 infection. This is because a repeat test may result in a positive result due to the presence of residual (dead) virus within the individual's system. This does not represent active infection with the virus.

The Health Committee may wish to note that plans are also underway to deploy Lumira DX, a rapid nasal swab test which delivers results in 12 minutes, to individuals on the day of discharge from a hospital to a care home setting. The Lumira DX test has been deployed successfully in Emergency Departments across Northern Ireland since January 2021. Lumira DX is a 'rule out' test and enables very quick identification of patients who do not have COVID-19. As the Lumira DX test will be undertaken on the day of discharge, this should provide additional reassurance to a care home provider that an individual is not infectious.

Recommendation 17: The Committee recommends that the potential benefits of step-down isolation facilities be explored.

RESPONSE:

Accepted

HSC Trusts have utilised a number of dedicated facilities to provide cohorted and isolated care for individuals including those from care homes who have tested positive for Covid 19 on discharge from acute settings. These facilities will continue to be used where a care home has indicated it is unable to meet the care needs of services users during their infectious stage.

We continue to keep all discharge pathways under regular review and adapt accordingly to changing needs. We will undertake a review of learning from Covid surges 1, 2, 3 to inform how the principle of a step-down isolation facility could be implemented as an alternative for people waiting in hospital or at home (should direct access to a care home not be available).

Access to PPE

Recommendation 18: The Committee recommends that during a pandemic, there should be centralised procurement and supply of PPE to care homes, without charge.

RESPONSE:

Accepted

The Department took an early decision in March 2020 that Trusts should make available PPE to care homes, without charge. Procurement of PPE was centralised through BSO and supplied to care homes. Other nations have followed this approach and we continue to provide millions of items of PPE, without charge, to care homes.

Cumulatively, over 100m items have been provided to Independent Sector Care Homes with an estimated value of approximately £31m.

We fully recognise the additional costs associated with the use of PPE during this pandemic and funding has also been made available to support care homes where they have continued to purchase their own PPE.

Trusts are currently continuing to work with nursing and residential homes on the provision of appropriate PPE without charge, where they are unable to source their own supplies. However this situation will be kept under constant review.

Recommendation 19: Further charges for PPE should not be imposed care homes without a review of the tariff.

RESPONSE:

Accepted

The Department has not made any charges for PPE and there are currently no plans to do so.

Recommendation 20: Training remains critical and all staff should be able to access regular and prompt updates as new knowledge or innovations emerge.

RESPONSE:

Accepted

The Department has made available videos and training, through both the Clinical Education Centre and NISCC for instance, which focus on IPC and PPE. In addition there are programmes from the CEC aimed at those staff who do not regularly look after respiratory patients and/or have limited ward/community based experience - alongside a number of clinical skills type programmes to support staff dealing with respiratory patients. CEC programmes related specifically to Covid-19 are open free of charge to all sectors across

NISCC have provided free training both, face to face, online and via their interactive learning zone for the period of the pandemic. NISCC have provided the Department with the total numbers from March 2020 for their virtual interactive on line training resources - in particular around 'Hopes, Hints and How to – helping you respond to living and dying issues during Covid 19,' (almost 10,581 people accessed and completed the learning module) , 'Supporting Good Infection Control' (22,471 people accessed and completed the module) and 'Shielding, Social Isolation and Staying connected during Covid 19' (6,341 people completed the module).

Recommendation 21: Consistency in the use of PPE should continue to be monitored.

RESPONSE:

Accepted

There is a role for each individual Care Home Manager to monitor consistency in the use of PPE within their own care home. HSC Trust visiting professionals also have a role in observing consistency and raising issues with the home manager where necessary.

HSC Trusts monitor the volumes of PPE provided to care homes and it is expected that they would follow up on any discrepancies identified with the volume of PPE used by any care home.

In addition, RQIA review the application of Infection Prevention and Control Guidance during all inspections in line with departmental guidance. This includes the availability and appropriate use of PPE by residents, staff and other visitors to a care home. Where the RQIA have concerns about the use of PPE this would be raised in their inspection report and subject to appropriate follow-up.

In addition, in May 2020 the Department wrote to all Trusts asking for them to ensure they conducted an urgent audit of all care homes in their area to:

1. identify care homes where AGPs are being conducted—including patients in receipt of respiratory support equipment such as Continuous Positive Airway Pressure (CPAP);
2. ensure that the correct PPE (in line with guidance available at the time) was available and being used by staff conducting AGPs in those care homes; and
3. ensure that all staff conducting AGPs had been properly fit-tested for FFP3 masks.

Trusts were subsequently required to provide a written assurance to the Department that these actions had been completed and that any issues or concerns identified had been addressed with the provider as appropriate.

We will consider what further measures are available to ensure consistency in the use of PPE and how readily these can be implemented.

Funding

Recommendation 22: The Committee recommends that streamlined processes be developed for administering funding, subject to audit and verification, but flexibly enough to allow care homes to meet their particular needs.

RESPONSE:

Accepted

Funding support for care homes was an area where we took early action. We guaranteed a level of income for care homes, at an early point in March, to minimise the impact of vacant beds and provide certainty. In addition, funding has been made available to address the additional costs faced by homes – an initial up to £6.5m was announced in April, just a few weeks into the pandemic. Neither of these initial funding streams required an application form to be submitted by the care home – the £6.5m was paid out on a grant basis based on the size of the care home while the income guarantee is paid out based on an average of pre-Covid occupancy rates.

Officials and HSC staff have continued to work closely with care home sector representatives on the processes for claiming additional funding provided by the Department. As the committee recognises in their recommendation, we do need to balance administrative overheads with the requirements for appropriate audit and verification. A number of discussions with provider representatives have taken place since the latest allocation of funding was confirmed on 29th October, in order to inform the process and communications used with care homes.

Trusts have been provided with funds to administer applications to this fund in a regionally coordinated and consistent way. There is ongoing work with the sector to ensure there is clear guidance on what can be claimed and a streamlined and efficient process for administering applications.

Recommendation 23: Funding for adult social care should be considered as a whole, including care packages and day-centre capacity which impact on care home pressures and bed-flow across the system.

RESPONSE:

Accepted

The commissioning and planning process will continue to take a whole system approach to determining the focus of any new investment. The current work on the HSC Future Planning model supports an Integrated Care System approach whereby existing services, system and community assets can come together to meet the needs of the local population which will underpin the whole system approach to funding/investment decisions.

In relation to funding for adult social care during the pandemic the Minister announced a funding package of up to £5m for Domiciliary Care which could be used to address costs such as the purchase of PPE, enhanced sick pay and additional staffing costs, such as further recruitment and training.

With regards to day centre capacity, the HSCB and Trusts continue to lead on the rebuilding of services in line with the regional plan and adherence to guidance and Infection Prevention Control measures and Trusts are currently reporting service levels at between 30 – 50% of pre-Covid levels, dependent locally on the availability of physical space, staff and transport. In the interim, services are continuously monitored and assessed so that service uptake and unfilled spaces are reallocated where possible to do so. Aligned to this process, Trusts have been working with families and community colleagues to scope additional/ alternative supports, including Direct Payments, and domiciliary and respite options.

Progress on the restoration of key services, including day services, are being regularly monitored by the Rebuilding Management Board and engagement is ongoing with the HSCB/Trusts to help identify alternative options and approaches to maintain or grow service provision.

Recommendation 24: The Committee recommends that work be prioritised to establish the 'true cost of care' as part of wider reform.

RESPONSE:

Accepted.

The Expert Advisory Panel in the Power To People Report proposed that commissioners and care providers work collaboratively and openly together to develop and introduce a framework based on an agreed true cost of care which includes agreement of a 'sustainable return' for providers. Work on this will be taken forward as part of work on the Reform of Adult Social Care.

Staff Terms and Conditions

Recommendation 25: The Committee welcomes the Minister's commitment to progress reform urgently and calls for low pay and poor terms and conditions to be addressed as quickly as possible.

RESPONSE:

Accepted.

The Minister is fully committed to improving pay and terms and conditions for the social care workforce. Departmental officials are developing a business case with options for improving low pay for social care workers employed by independent sector providers. This, along with the improvement of training and career pathways, is in line with key objectives for this reform as proposed in the Expert Panel's report 'Power to People – Proposals to reboot adult care and support in Northern Ireland' which was published by my Department in 2017. It is clear that this will require a significant recurrent financial commitment and Minister will be seeking the support of colleagues across the Executive and the approval of funding from the Department of Finance.

Recommendation 26: The Committee recommends that the Department set minimum standards for sick-pay in care home workers' contracts and that arrangements be put in place to ensure standards are adhered to.

RESPONSE:

Accepted.

The Expert Advisory Panel in the Power to the People report proposed that the care and support sector should be, at least, a Living Wage sector as a first step to recognising it as a professional workforce. In the longer term the vision should be to equalise pay and conditions across the social care workforce. We will pursue the recommendation in relation to minimum standards for sick pay in care home workers' contracts as part of the work on the Reform of Adult Social Care.

Recommendation 27: In the interim, the Committee recommends that any additional funding provided to care homes should include conditions regarding fair pay and treatment.

RESPONSE:

Accept in Principle

In relation to the provision of additional funding the Department will undertake further work to consider this going forward. For example, we are currently considering whether the provision of any future income guarantee can be linked to ensuring appropriate terms and conditions are in place for staff in the care home sector.

Recommendation 28: The Committee recommends consideration of additional measures to make social care a more attractive career, including developing career pathways.

RESPONSE:

Accepted.

As well as the ongoing measures regarding pay and conditions for social care staff, the Minister has also asked officials to develop proposals relating to the development of improved career opportunities for the social care workforce.

The reform work being undertaken by the Department has created a new opportunity for social care workers to gain a social work degree and this has been successfully implemented in conjunction with the Open University. 15 places will be allocated each year among the Independent, Voluntary and Statutory sectors. The Department has also worked with Ulster University's My Home Life programme to commission additional places for care home managers for the leadership programme during 2020/21. Take-up for the programme has been very positive.

The Reform Project Team in partnership with NISCC is also developing a workforce strategy for social care, including developing the training, CPD and career pathways for the workforce. In addition, a media awareness campaign to promote the value of social care and to support recruitment has been commissioned and will be delivered by the Northern Ireland Social Care Council.

Staff Levels and Issues

Recommendation 29: The Committee recommends that appropriate staff ratios for care homes be agreed in discussion with stakeholders.

RESPONSE:

Accepted

A phase of work focused on nurse staffing in Independent Sector Nursing Homes is underway as part of the Delivering Care Nurse Staffing Policy. This work phase should provide recommended staffing ranges when completed.

Recommendation 30: Strenuous efforts must continue to be made to minimise staff movement between homes and, where possible, agency staff should work at one home only.

RESPONSE:

Accepted.

Funding has been made available to care homes to facilitate the block booking of agency staff to minimise staff movement between homes. In addition, the Public Health Agency has provided clear guidance for bank and agency staff on this issue. A letter was issued to all care homes and nursing agencies in January 2021 providing key advice and guidance on reducing workforce movement. In addition, a poster entitled "Key Principles for Bank and Agency Staff" is available on the PHA website. One of the key messages stressed is that where a staffing shortfall is clearly defined, agency staff should limit the number of places where they work in order to minimise movement between settings. It is also recommended that care providers should as far as possible promote contracts that enable block booking of staff for periods of weeks rather than individual days; agencies should assign the least number of individuals to adequately cover any rota or shift and agency staff must travel to and from work in their own clothes and change into a clean uniform on arrival.

Recommendation 31: The Committee recommends that care home providers be required and supported to put in place robust measures to ensure the safety of BAME staff and other staff at increased risk from the virus.

RESPONSE:

Accepted.

A number of measures have been put in place to ensure the safety of BAME staff and other staff at increased risk from the virus. The Department announced on 2 June 2020 an investment, totalling £11.7m of financial support for the care home sector. Part of this package included up to £3.05m available to pay care home staff up to 80% of their salary (or average salary, based on the 3 months December '19 to February '20), when they are on sick leave because they are self-isolating, shielding or ill due to COVID-19. This scheme was due to end on 31 August but was extended to cover sick leave up to 31 March 2021.

In addition to financial support, the Department took an early decision in March 2020 that Trusts should make available PPE to care homes, without charge. We continue to provide millions of items of PPE, without charge, to care homes to ensure the continued safety of all staff including those at increased risk from the virus. We continue to work closely with PHA in relation to the provision of expert advice in regards to ensuring staff safety and review guidance provided to care homes to ensure that it is up to date and in line with best practice measures as required by the PHA. The PHA website includes a document providing information on employer responsibilities, precautionary measures and a risk assessment.

A UK level inquiry has been launched to understand why people from BAME backgrounds appear to be disproportionately affected by coronavirus. There is as yet no UK or local guidance on whether BAME staff are vulnerable to more severe COVID-19. At present we are presuming there is vulnerability because of data observed. This is a precautionary step.

We will continue to consider what additional measures can be put in place to ensure the safety of BAME staff and other staff at increased risk from the virus.

Access to Health and Social Care

Recommendation 32: The Committee recommends that the Enhanced Clinical Care Framework should embed the principles of the acute care at home programme within care homes and should confirm GP participation.

RESPONSE:

Accepted.

The Enhanced Clinical Care Framework will embed the standards being developed for a regionalised model of Acute Care at Home service. GP participation is inherent throughout the development of the model and with delivery of its aim.

Recommendation 33: There is a need for consistent implementation of the policy on in-person access to care homes, as deemed necessary by the HSC professionals concerned, and subject to testing and PPE requirements.

RESPONSE:

Accepted

A priority piece of work involving a range of relevant stakeholders is underway which includes provision of guidance for safe management of in-person access to care homes. Inclusion of representatives of families with relatives in care homes, care home provider representatives, as well as RQIA and HSCT representation in the development of the guidance, will assist in consistent implementation.

Advance Care Planning

Recommendation 34: Advance Care Planning should be discussed with each care home resident, on an individual basis, ideally ahead of any crisis; it should be led by the clinician who knows the individual best, with the input of other relevant professionals; and reviewed as necessary.

RESPONSE:

Accepted

Advance Care Planning is a voluntary process and should be led by individuals, it should be available to each care home resident, who has mental capacity. This conversation is best facilitated by the health or social care professional who has a relationship with the person and knows the individual best. If the resident wishes, the conversation should include family members or those important to the person.

The Minister has approved the development of an Advance Care Planning Policy which will include those in care homes. The policy will support people of any age to think about their present and plan for their future, to make known what their wishes, feelings, beliefs and values are and to make choices that reflect these. This is important for everyone, at whatever stage of life.

A key aim of the policy will be to promote clear and consistent messages and practice amongst HSC professions across health and social care and increase public awareness and understanding of what advance care planning is, encouraging people to consider and plan ahead for future care. The policy will be supported by guidance and information for professionals and the public. Training and education to support the policy will ensure staff have the knowledge and self-efficacy to have advance care planning conversations and document appropriately. This includes staff within the HSC and the independent sector.

An initial draft policy has been developed which has been the basis of early stakeholder engagement. This has included engagement with health and social care staff including care home staff, carers, regulators, community and voluntary sector organisations and a wide range of Section 75 groups. This will be reviewed and revised to reflect the commentary from the early stakeholder engagement, with further stakeholder engagement and revision to follow and with the view for public consultation later this year.

Recommendation 35: The Department of Health should clearly outline and communicate the rights of older people and families regarding end-of-life planning

and this should reference the approach to treatment and care planning recommended under NICE guideline NG163.

RESPONSE:

Accepted

NICE guideline NG163 provides recommendations for managing Covid 19 symptoms for patients in the community, including at the end of life. It contains recommendations on treatment and care planning for patients with Covid-19. In addition, NICE guideline NG142 - End of Life Care for Adults: Service Delivery (published 16 October 2019) - provides guidance and recommendations on organising and delivering services that provide care and support for adults approaching the end of their life with any conditions and diseases. Within this wider context, NICE Guideline NG142 makes recommendations on the planning and preparation for this, including recommendations for advance care planning, with the aim of ensuring that people have access to the care that they want and need in all care settings irrespective of their condition. It should be also noted that family and those important to the person should be included in relevant communications.

As noted above (Recommendation 34) the Department is progressing on the development of an Advance Care Planning Policy for adults, which will include older people and those in care homes. The policy will reflect the good practice in relation to advance care planning set out in NICE Guideline 142.

The policy will support people of any age to think about their present and plan for their future, to make known what their wishes, feelings, beliefs and values are and to make choices that reflect these. This is important for everyone, at whatever stage of life.

A key aim will be to promote clear and consistent messages and practice amongst HSC professions across health and social care and increase public awareness and understanding of what advance care planning is, encouraging people to consider and plan ahead in discussion with health and social care professionals and those who are important to them.

The policy will be supported by guidance and information for professionals and the public that will help increase awareness and understanding of advance care planning. In addition, training and education to support the policy will ensure staff across all care sectors have the knowledge and self-efficacy to have advance care planning conversations and document appropriately. This includes staff within the HSC and the independent sector.

Recommendation 36: Steps should be taken to ensure that relevant professionals have access to appropriate training in advance care planning.

RESPONSE:

Accepted

As noted above (Recommendations 34 and 35), work is progressing on the development of an Advance Care Planning Policy for adults. The implementation of the policy will be supported by training and education to ensure staff have the knowledge and self-efficacy to have advance care planning conversations, including where appropriate discussions in relation to resuscitation, and to document appropriately. This includes staff within the HSC and the independent sector.

Regulation

Recommendation 37: The Committee recommends that additional resource be provided to ensure that routine inspections continue, subject to appropriate PPE and testing, in tandem with a high level of dedicated advice and support for care homes, during a pandemic.

RESPONSE:

Accepted in Principle

The pandemic has enabled RQIA to develop a more targeted and risk-based approach to inspection overall. RQIA wish to continue to provide support and guidance to the care home sector in addition to regulation and monitoring.

Funding for, and work pressures on, the RQIA are subject to ongoing assessment and discussion. There are, of course, often challenges in recruiting suitably experienced and qualified staff, even where resources are available.

Recommendation 38: Additional monitoring is required to ensure the consistent implementation of guidance and policy.

RESPONSE:

Accepted in Principle

Additional monitoring in care homes could require significant additional resourcing.

RQIA's current inspection programme requires 2 inspections per year, which are point in time evaluations of a service and so opportunities for continual monitoring are limited. We believe that ongoing monitoring should be supported by better use of information and

intelligence and partnerships with Trusts, rather than increasing the number of inspections.

Increased monitoring will be dependent on continued partnership working between the regulator and HSC Trusts, who also undertake extensive monitoring of homes.

During the pandemic care homes have been required to submit a daily return via an online portal to the RQIA providing data on a number of key issues. This includes information on: whether there is a current outbreak, the overall status of the home, the PPE and equipment status of the home, the workforce status of the home, details on the type of visiting being offered and data on care partner arrangements. The return also indicates whether the home considers that an RQIA call back is required to deal with any particular issue the home may be facing that day.

Although the data return is facilitated by RQIA the data return is disseminated and sent to Trusts, PHA etc. for action as required. RQIA will only look at this in terms of monitoring if they receive any intelligence.

We consider that there is a link between increased monitoring and particular circumstances – such as a pandemic. Whilst there will be a clear need to increase monitoring in particularly difficult times such as a pandemic it is important that an appropriate balance is struck in terms of delivering this additional monitoring in the most appropriate way and the potential impact on hard pressed care homes of supplying more information.

Recommendation 39: The Committee believes there must be consequences for failures of care and recommends consideration of models by which quality and delivery of care, and adherence to guidance and best practice, could be linked to funding and considered in future contracting arrangements, including the capacity to recoup public funds where poor service has been evidenced.

RESPONSE:

Accepted

The Department is currently reviewing the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and this includes a review of the enforcement powers and sanctions open to RQIA. As work is still ongoing, we will consider how this recommendation can be incorporated into the review.

The existing Regional Care Home Contract requires providers to comply with all Departmental guidance and circulars. We have undertaken a recent review of this contract and are satisfied that there are a range of provisions within it that can be invoked in the event of a failure of care. This includes financial penalties and refusing to allow further admissions to care homes. The HSCB will be writing shortly to Trusts to advise them of the specific provisions within the contract and to request that they make full use of these existing mechanisms as part of their monitoring of the delivery of service by care home providers.

Recommendation 40: The Committee recommends that further work be undertaken to improve communication of guidance across the different tiers of the system, including with unions.

RESPONSE:

Accepted

There has been a substantial amount of communication across the different tiers of the system during the pandemic and we are keen to continue that high level of cooperation and communication.

An Adult Social Care Governance - Surge Planning Covid-19 Working Group (the Working Group) was established in August 2020 to replace previous groups and to consider and coordinate the various strands of ongoing work connected to Covid-19 across adult social care – including care homes, domiciliary care (home care), supported living and all learning disability services. The Working Group's membership comprised representatives from:

- Mental Health, Disability and Older People Directorate;
- The Chief Nursing Officer's group;
- The Chief Medical Officer's group;
- The Office of Social Services;
- The Health and Social Care Board; and
- The Public Health Agency.

The Working Group's responsibilities included overseeing the development of a suitable communications plan, including the use of social media, to ensure key messages are relayed in a coordinated fashion to the sector.

Engagement with sector representatives such as the IHCP and ARC has been frequent, to ensure there is discussion across a wide range of important issues. We have also made use of forums, such as those created by NISCC for leaders in social care, and created new networks such as those through nursing leads. Key communications have been shared with both sector representatives and with key unions, such as the RCN. Looking ahead, we are keen to work with bodies such as NISCC to strengthen routine engagement with key leaders in social care.

In relation to engagement with families, the Department has had regular contact with families and family representatives during regular engagement meetings facilitated by the PCC. In addition, the PHA/HSCB Care Home Action Plan identifies an action for Care Homes to co-produce a communication strategy with residents and relatives; while the PHA PPI team are working to develop a system which provides a continuous feedback loop between residents, relatives, staff and decision makers and will help identify good practice / areas for development.

Pandemic Preparedness and Systemic Issues

Recommendation 41: The Committee recommends that the requirements of care homes are central to detailed pandemic planning for the future, including PPE, infection control and visiting facilities.

RESPONSE:

Accepted.

Future pandemic planning will reference care homes including PPE, infection control and visiting facilities.

Recommendation 42: The Committee recommends that consideration be given to having ring-fenced funding available that could be accessed quickly by care homes in any future pandemic.

RESPONSE:

Accept in principle

Funding support for care homes was an area where we took early action. We guaranteed a level of income for care homes, at an early point, to minimise the impact of vacant beds and provide certainty. In addition, funding has been made available to address the additional costs faced by homes – Minister announced an initial £6.5m in April, followed by further packages including an additional £27.3m in October.

Whilst we accept the principle there may be a need for funding to be available that can be accessed quickly by care homes in any future pandemic we do not consider that holding and ring fencing a particular amount of funding is the best way of achieving this. This effectively prevents the funding from being used elsewhere if it is not needed by the care home sector. We would point to the fact that when we needed to move quickly we made available both the income guarantee and the £6.5m announced in April. We will therefore consider the learning from this early phase of the pandemic giving due consideration as to how to best give effect to this particular recommendation.

Recommendation 43: The Department should consider how to maintain streamlined systems such that, in any future pandemic, funds could more quickly and easily be released, ideally by a single nominated body, on the basis of fair and transparent criteria, and appropriately back-dated to the start of the pandemic.

RESPONSE:

Accept in principle

We consider that funds were quickly and easily released, particularly in the first wave of the pandemic with the provision of an income guarantee for care homes and the announcement of up to £6.5m, which was paid through grants based on the size of the home and did not require an application form to be completed. In addition, it is worth noting that a number of more specific funding streams made available have been backdated, where this is appropriate.

However we would have concerns about allocating full responsibility for the payment of funds to all care homes to a single nominated body as that would add administrative complexity. It would require setting up new payment systems and mechanisms which already currently exist in Trusts. This could therefore delay and slow the processing of any payments. During the pandemic Trusts have worked together to take a regional approach – with, for instance, one Trust taking responsibility for all the payments to the region's largest care home provider. We will, of course, consider the learning from all

surges of the pandemic, including the administration and allocation of funding and identify where any future improvements can be made.

Recommendation 44: The Committee recommends that future pandemic planning should factor in the central procurement and supply of PPE to care homes.

RESPONSE:

Accepted

Future pandemic planning will factor this in.

PHA has developed PPE modelling that includes Independent Sector services; this modelling will support DoH pandemic planning. Current arrangements are delivered in partnership with regional procurement in respect of regional demand and with HSC Trusts to manage supply.

Recommendation 45: Pandemic planning should include consideration of the particular needs of those with cognitive decline and this should inform dedicated guidance, on testing, ability to isolate, application of deprivation of liberty safeguards, meaningful contact with family and access to health and social care services not based in the care home.

RESPONSE:

Accepted

The existing Covid-19 Guidance for Nursing and Residential Care Homes in Northern Ireland contains specific references to residents with a dementia and we will continue to build on this going forward.

Emerging research on the impact of the pandemic on people with cognitive decline will provide an evidence base to inform future pandemic planning. This work will be informed by strategy and policy in respect of cognitive decline for example the Dementia Strategy and mental capacity legislation.

Recommendation 46: Dedicated efforts should be made to gather and learn from the breadth of international experience of pandemic planning and management.

RESPONSE:

Accepted

Throughout the pandemic to date the Northern Ireland Executive has received expert advice and recommendations from the Chief Medical Officer and the Chief Scientific Adviser in respect of the most appropriate public health response. This advice has been based on the emerging evidence from the rest of the UK and the rest of the world. For example, the Chief Scientific Adviser attends the Scientific Advisory Group for Emergencies (SAGE) and reviews the evidence from the Scientific Pandemic Influenza Group on Modelling (SPI-M) which examines the data on the trajectory of the virus both nationally and internationally. In addition, evidence from UK government analysis and published scientific papers is regularly reviewed with regard to international experience.

As part of the Departmental Covid-19 dashboard, data is published each day on the number of cases, doubling times and deaths for a number of countries. These include the United States, China, Japan, Germany and Spain as well as the Republic of Ireland and the UK as a whole. This ongoing monitoring provides an indication of which countries are performing best and where Northern Ireland might best learn from.

There is ongoing engagement and co-operation with colleagues in the Republic of Ireland to ensure the best delivery of health & social care. This has continued throughout the pandemic to date, although there are different administrative, legislative and regulatory arrangements.

In future pandemics we will consider what further action we can take to ensure appropriate learning from existing international experience.

Recommendation 47: The Committee notes the finding of the RLI that there is no recognised regional training on environmental cleanliness and endorses its recommendation that care home staff be provided with a 'freely accessible regional IPC training e-learning module'.

RESPONSE:

Accepted.

The HSC Clinical Education Centre provided free access to care home staff from April 2020 by offering all of their programmes free of charge, including Covid related and IPC training. CEC have agreed to extend that support to 30 June 2021 by continuing to offer free access to all of their programmes. The position will be reviewed thereafter.

Recommendation 48: Each home should be required to appoint a designated and appropriately trained staff lead (other than the manager) for IPC, including disseminating guidance and training, with support from PHA.

RESPONSE:

Accepted in Principle.

Whilst we agree with the premise of the recommendation the appointment of a specific designated IPC lead will be subject to the necessary funding being made available. In the

interim we will consider with PHA / RQIA colleagues how this can be taken forward through future reviews of the existing Regional Contract.

Recommendation 49: A database should be established of designated IPC lead staff in care homes and this should be integrated into the regulatory and monitoring framework.

RESPONSE:

Accepted in Principle

This would require significant investment in infrastructure and personnel whichever agency is responsible. Further consideration will be given as to how to implement this recommendation.

Recommendation 50: Effective engagement is required with all relevant stakeholders, including providers, unions and families, with policies developed on a co-design and co-production basis.

RESPONSE:

Accepted.

There has been a substantial amount of co-design and co-production that has happened during the pandemic and it is our intention to continue that. Engagement with provider representatives such as IHCP has been extensive and ongoing on issues including funding, visiting, care partners etc.

In relation to engagement with families, the Department has had regular contact with families and family representatives during regular engagement meetings facilitated by the PCC.

Under the auspices of the PHA, we have established a Moving Towards Normalised Care Home Visiting in Northern Ireland Task and Finish Group. The purpose of the Group is to develop an approach, for endorsement by the Minister, which support a safe and proportionate return to normalised care home visiting as restrictions in Northern Ireland are eased from April 2021.

The Grouping is made up of representatives from the:-

HSCB, PHA, RQIA, Trusts, COPNI and PCC;
Departmental policy Directorates;
Representatives from various relatives Groupings; and
The Independent Healthcare Providers.

We fully recognise that there is a need to build stronger points of leadership in the independent sector though and will work with NISCC and others to find ways to do that.

Recommendation 51: Robust communication plans must be put in place and monitored, to ensure families are promptly informed of key developments regarding the home in which their loved one resides, including staff shortages, infection outbreaks, inspection findings and changes to relevant guidance.

RESPONSE:

Accept in Principle

Both the Trusts and RQIA will consider communication and engagement with families when appropriate to do so as part of their normal role. There is however an expectation that homes will also engage with resident families on a more regular basis as they are the initial link to families.

We will consider what further measures are available to ensure there are robust communication plans in place so that families are promptly informed of key developments and how readily these can be implemented. We will ensure that all relevant guidance is strengthened so there is a clear expectation of robust communication with families which should be appropriately monitored.

Recommendation 52: Pandemic plans should include ensuring rapid access for care homes to a single point of contact for advice and support, accessible twenty-four hours per day, seven days per week.

RESPONSE:

Accepted

PHA Health Protection Duty Room provide an acute response service which is available 24 hours per day, 7 days per week, including Public Holidays. This service provides specialist Health Protection advice and support relating to incident / outbreak management to the independent sector nursing and residential facilities.

Recommendation 53: Guidance should be developed on consideration of human rights during a pandemic, including the right of residents to visits and communication with loved ones; and best practice on managing testing and self-isolation.

RESPONSE:

Accepted

Consideration of human rights during a pandemic has and will inform all of our guidance both during a pandemic and in more normal times.

The Moving Towards Normalised Care Home Visiting in Northern Ireland Task and Finish Group, has been established to develop an approach, for endorsement by the Minister, which supports a safe and proportionate return to normalised care home visiting as restrictions in Northern Ireland are eased from April 2021. A specific focus of this Group is the area of human rights to ensure that this forms the basis of any guidance going forward which will consider issues such as the right of residents to visits and best practice on managing self isolation etc.

Recommendation 54: Bereavement and mental health support for staff, residents and families will be required beyond the short-term and should be resourced and promoted as required.

RESPONSE:

Accepted

HSC is already taking a number of measures to protect mental health and build mental resilience which will help people stay in – or return quickly to – work. These include a number of initiatives to help staff deal with stress and build resilience.

A Workforce Wellbeing Framework was published on 16 April, in order to guide and support the wellbeing of health and social care staff and volunteers across all sectors throughout the current Covid 19 crisis. This Framework was developed with input from senior clinicians in clinical psychology alongside other partners including Trade Unions, occupational health services, the Public Health Agency and the Health and Social Care Board. The Framework is available online at <https://www.publichealth.hscni.net/covid-19-coronavirus/guidance-hsc-staff-healthcare-workers-and-care-providers/staff-health-and>

The Framework includes a range of measures to enhance the psychological wellbeing of staff. These include access to Psychological Support Helplines manned by psychologists (care home and GP staff also have access to these helplines in each Trust area), a broad range of online resources and drop-in services in critical facilities.

A Staff Wellbeing Working Group has been established to oversee service delivery and review implementation of the Framework across NI, and my officials receive reports from this group on a regular basis.

In addition Palliative Care in Partnership is a regional body incorporated within PHA and established to progress a single structure and regional work plan for palliative care in Northern Ireland.

Specific resources focussing on bereavement during pandemic were developed and disseminated to all care homes.

Set out below are the resources/support available:-

(a) <https://regional.sharepoint.hscni.net/sites/shw/SitePages/Home.aspx> ;

(b) <https://www.mindingyourhead.info/> ; and

(c) The new Mental Health Strategy is currently out for consultation
<https://consultations.nidirect.gov.uk/doh-1/mentalhealthstrategy/>.

