From: **Robin Swann MLA**
Health Minister

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To: **Executive**

COVID-19: UPDATE ON SUPPORT TO CARE HOMES

Introduction

1. This paper provides Executive Colleagues with an update on measures to support and protect care homes as Covid-19 continues to spread in the community and as infection levels in homes continue to rise.

Funding and support

2. Executive colleagues will be aware that on the 22nd October I announced a further package of funding of £27m to support care homes during the pandemic. This built upon the £6.5m announced in April (with payments issued on a graduated basis depending on the size of the home) and the £11.7m announced in June (which was to support enhanced cleaning, improved sick pay and to fund key equipment). The total consolidated funding package provided to care homes since the start of the pandemic is therefore £45.22m. Underspends from the first two allocations have been rolled forward and will help address current financial pressures facing homes.

3. In addition, we moved quickly in the early stages of the pandemic to guarantee incomes for care homes. Some care homes have seen a significant reduction in the number of residents in their homes during the pandemic for a number of reasons. Consideration is being given to how long this guarantee extends for. This guarantee is in addition to the £45.22m.

4. There is continuing evidence of the pressures care homes face, particularly as they implement a rolling programme of testing, seek to follow guidance on safe visiting, facilitate and enable the introduction of the Care Partners initiative and manage the consequences of the rising number of care home workers who are required to self-isolate. The £27m funding package will help address these and a number of other pressures.

5. My officials have continued to work on the detail of the £27m I announced on the 22nd October. That funding was able to be confirmed after the DoF announcement on 29th October.

6. As I announced at the time, £9m of this £27m announced will be paid to homes based on the number of residents they have. While homes will have to confirm they are implementing the regular testing programme to receive the funds associated with it, and implementing the visiting and care partner guidance to receive the funds linked to it, they will not have to complete an application form or provide evidence of spend. Once this confirmation is received HSC Trusts will work to pay funds to care homes as swiftly as possible. A communication to care homes seeking that confirmation is being issued by Trusts today and tomorrow.

7. The rest of the funds are available to cover issues including additional PPE costs, enhanced sick pay, additional staffing costs, IT costs, insurance and other professional costs, additional cleaning equipment and cleaning costs, physical infrastructure improvements to deliver enhanced COVID-19 secure environments and equipment/ furniture to support safe visiting.

8. The communication from Trusts this week provides the opportunity to apply for cleaning equipment, physical infrastructure and equipment/furniture costs through a one page form and provision of appropriate proof of expenditure (e.g. receipts or invoice). A second letter will provide the opportunity to claim for other types of expenditure with appropriate proof. The process of claiming enhanced sick pay was already extended in October, with details on how to claim provided at that point. All the letters are accompanied by appropriate Q&A and HSC Trusts have been, and will continue to, spend significant time support care homes through the process.

9. Trusts have been allocated funds to administer and process Care Home applications to this fund in a regional and consistent way across Northern Ireland, taking account of lessons learned from early rounds of funding.

10. The letters being issued this week reflect ongoing discussion with provider representatives and Departmental officials and HSC Trusts are continuing to engage with them to ensure a streamlined and efficient but robust process.

11. In addition to the funding that we have made available, care homes have been provided with 42 million items of PPE, at a cost of over £14m. We also continue

to connect smaller local providers with homes, so that they can purchase their own PPE.

Workforce

12. In addition, Trusts have stepped in to provide over 26,000 hours of staff time in care homes in the first surge. While continued provision of support from Trusts to care homes forms part of our surge plans, the staffing situation in Trusts is significantly more challenging than during the first wave of the pandemic. This is partly a consequence of illness and requirement to self-isolate but also reflects our commitment to keep key services running, now that we have plans in place to allow many of these services to operate safely.

13. Figures from NISCC highlight that between September 2019 and September 2020 an additional 3,400 care workers were added to their register – with nearly 50,000 staff registered in total. However, we know significant workforce pressures remain – particularly when it comes to accessing nursing staff. We continue to review and consider what additional measures can be taken to address likely staffing pressures – and have been discussing these with sector representatives.

14. My officials have recently relaunched our workforce appeal and we remain clear that Trusts should consider how individuals identified through this mechanism can be placed in the independent sector – subject to all the appropriate risk assessments being in place. We are considering if there are further steps we can take to create a reserve of job ready staff for the sector.

15. In discussion with the sector the issue of staff being financially penalised by the benefit and tax system once they work more than 16 hours a week has been raised. Colleagues will have seen my correspondence to the Finance Minister on this issue.

Visiting arrangements

16. I must be clear at the outset that the visiting arrangements for health and social care settings during the ongoing Covid-19 pandemic are not what anyone would wish for those using services and their families. We must balance our need to keep them, those providing their care, and our health and social care systems safe from the devastating impact of Covid-19 as we continue to live through it with the understandable distress that results from these protective measures.

17. However, even though there are challenges to be overcome, I am encouraged by ongoing developments around testing and vaccination and give a reassurance that we will continue to be guided by evidence. That evidence will be reflected in the visiting guidance, including where it may be possible to relax or remove some of the restrictions in some health and care settings in time to come.

18. Since March 2020 a series of guidance documents have been issued for nursing and residential care homes based on knowledge of the virus and the extant Alert Level.

19. "Covid-19: Regional Principles for Visiting Care Settings in Northern Ireland" published on 30 June 2020 introduced a move towards a risk assessed approach to the safe management of visiting arrangements, acknowledging that virtual visiting remained the preferred option in the prevailing circumstances, but other options such as outdoor arrangements, and indoor arrangements in exceptional circumstances, should be considered and accommodated.

20. Dynamic risk assessment training for care homes was facilitated by the Public Health Agency and made available to the sector free of charge in July 2020. Subsequently the supporting suite of training related resources, such as a risk assessment template, were distributed to every registered care home. This training continues to be available to the care home sector free of charge through the Clinical Education Centre, as is a range of other educational and skills building training programmes.

21. As community transmission rates of Covd-19 increased in September 2020 and the Executive introduced further restrictions, visiting guidance for all health and social care facilities, which of course included care homes, had to be revised quickly to reflect the escalating situation. The need to respond rapidly to the rise in transmission rates impacted on the ability to engage with the range of stakeholders affected by visiting guidance.

22. The visiting guidance outlines that the specific restrictions for each care setting are aligned to the pandemic Alert levels/R value, which represents the risk of the virus spreading from one infected person to another, on average. The guidance is based on the best scientific advice available, with restrictions applying in line with the current Regional Alert Level Position. We are currently at Level 4, defined as ***"a high or rising level of transmission - enforced social distancing".***

23. As described in the visiting guidance, care homes should be providing a range of methods for visiting, such as indoor visiting rooms/areas, visiting pods, outdoor visiting and virtual visits, that can take place in line with the care home's visiting policy. The visiting guidance acknowledges that the number of visits may have to be limited to a maximum number per week to allow every resident to avail of opportunities for visiting. The guidance does not currently stipulate a number as a maximum, other than those who can only receive visitors in their own rooms, in acknowledgement that each home and its risk assessment and policy will be unique to that home. With regards to visiting in a resident's room, this should only be accommodated in exceptional circumstances and where this has been indicated in individualised visiting plans as the method appropriate to that particular resident's needs.

24. The visiting guidance also makes reference to facilitating visits for those residents who are considered to be actively dying.

25. This guidance, published on 23 September continues to advise that visiting arrangements should be based on dynamic risk assessment and individualised visiting plans that determine how visiting can be safely managed to allow residents of care homes meaningful contact with families/friends, suggesting a range of methods to accommodate a range of situations. Individual care home risk assessments will take account of the challenges for that care home in safely managing visiting arrangements, such as the internal and external environments, staffing levels, technological infrastructure and the potential complexities of individual residents.

26. The currently available evidence[1] related to care homes indicates that it is difficult to analyse specific cause of infection transmission as environments change quickly. Current guidance represents the best available evidence at this time, and details are subject to update as new evidence emerges. Whilst studies do not rule out any route for entry of infection to a care home (staff, visitors, visiting professionals, new or returning resident admissions and so on), the evidence notes that is important not to generalise or to place emphasis on one route of infection over other routes without clear evidence; studies undertaken so far indicate multiple introduction routes are possible. However, while some modelling studies are demonstrating that allowing visiting to a care home has only a marginal impact on increased risk of infection, further research in various areas, such as the

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1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925141/S0780_Social_Care_Working_Group_update_paper.pdf

influence of physical layout of the home, ways of staff working and cohorting of residents, is required to further develop preventative and management strategies.

27. Until the outcome of that research is available and we learn more about this infection it remains prudent to continue to protect vulnerable residents and take precautions to minimise the risk and impact of unintended spread of infection in care homes therefore reducing footfall will remain a key protective strategy. Precautions will also involve robust internal infection prevention and control measures and advised public health protective measures (Personal Protective Equipment (PPE); limiting person to person close contact; good hand hygiene; good respiratory hygiene; frequent environmental cleaning).

28. Implementing these measures directly affects the day to day management of the care home and staff working to deliver care safely to residents and will, unfortunately, have an associated impact on visiting arrangements, with advised limitations for visiting based on the particular Alert level at any one time.

29. We continue to work with the sector on the implementation of this guidance. We know that many homes understandably wish to be cautious based on their experiences to date of managing the transmission and impact of Covid-19 but as a society, we need to strike the right balance between protecting life and protecting the quality of life.

Care Partners

30. In response to the number of correspondences received from and on behalf of distressed relatives and friends of care home residents throughout the pandemic, the increasing number of these correspondences, the growing evidence of the detrimental physical and psychological impact of restricted visiting for care homes residents and their families, and the acknowledgement that Covid-19 would be a situation that the entire world would have to learn to live with for the foreseeable future, the care partner concept and principles were included within the revised guidance published on 23 September 2020,following the Executive's decision to raise the Alert level.

31. This recommendation was informed by learning in the other jurisdictions and internationally. For example Wales introduced "a designated visitor" role in care home visiting guidance, effective from 28 August 2020 and Scotland introduced an "essential visits" approach from 3 September 2020 intended help to ease significant stress or other exceptional circumstances. England's Covid-19 Winter

Plan provides reference to plans to allow up to two nominated visitors to have physical contact with a care home resident, including providing personal care, hugging and holding hands. Nationally, high profile organisations, such as Alzheimer's Society, John's Campaign and Dementia UK have joined forces in recognition of the detrimental impact of restricted visiting on care home residents and in full support of a "care partner" type arrangement.

32. The concept was also informed by the outcomes of the Rapid Learning Initiative work, concluded by my Department in July 2020, which considered and analysed the shared experiences of residents, families and staff working in the care homes sector.

33. Care homes were asked to consider the care partner approach and move to implementation by 5 November 2020. Supplementary information to support implementation was developed in conjunction with a range of stakeholders including residents/relatives and their representative organisations, care home providers and representative organisations and HSC organisations.

34. This supplementary information was published on 13 November 2020, however, as previously stated, the care partner concept and principles were included in guidance published in September and at no point was it expected that care homes would wait for supplementary information before considering how they could facilitate this approach.

35. Care partner contact is in addition to visits to a resident which are organised according to the care home's visiting policy and the DoH Covid-19 regional principles for visiting.

36. The role of care partner is voluntary which is complementary to care home staff. It does not replace, nor is there any expectation that it should replace the existing roles and responsibilities of care home staff or professionals involved which they must continue to fulfil for that resident. The care home manager should make the boundaries between staff and care partner roles very clear and agreed with the care partner. The care partner is not an employee or a formal role, therefore legal and regulatory requirements, such as AccessNI or employment indemnity do not apply.

37. A care partner is the person in the life of a care home resident who did more than "visit". A care partner will have previously played a role in supporting and

attending to their relative's physical and mental health, to ensure that other health and social care needs are met due to a pre-existing condition. Without this input a resident is likely to experience distress and that is why this role is critical for the health and wellbeing of some of our most vulnerable residents. For example, as the supplementary information on care partners describes, it is the son with intellectual disability whose personal hygiene has deteriorated because he will only shower when assisted by his father; It is the mother who had previously been assisted at lunchtime every day to eat her specially prescribed and prepared meal by her daughter, and who now won't eat.

38. The underlying concept for the role of a care partner is to find a balance between mitigating the impact on the health and wellbeing of residents through the transmission of Covid-19 by restricting access to care homes, and mitigating the impact on the health, wellbeing and the human rights of residents by restricting access to those who had been providing an essential element of support to the resident's physical and psychological well-being.

39. Families and friends need to see their loved one to be reassured about their well-being. Equally families and friends need to understand the strains and pressures on those who are caring for their loved one, as a consequence of the continuing pandemic situation. Achieving the balance in protecting residents from infection and protecting the other factors that affect well-being and welfare is difficult to achieve. We do not underestimate both the practical and the emotional challenges for residents, families and care home staff in seeking to achieve that balance.

40. Work continues through the Public Health Agency to collaboratively develop additional supportive resources for the care home sector to further assist the implementation of the care partner approach. PHA is also working on a plan to develop and implement a programme of testing for care partners.

41. As the care partner approach forms part of a person-centred and individualised care plan it is difficult to quantify how many care partner arrangements might be required across our care homes, particularly as individual needs can change, sometimes very quickly.

42. A small number of care homes were able to move to implement care partner arrangements as soon as visiting guidance was published on 23 September 2020. However, other care homes have not yet moved to accommodate the variety of visiting arrangements that may be required to meet the individual needs of residents or to consider and implement the care partner approach. The Patient

and Client Council is working with families affected by lack of visiting and poor uptake of care partners to find a way forward so that visiting can be established

43. The care partner is a concept that will be applied differently for individual residents who live in the many different environments that make up the care home sector. Each care home is responsible for agreeing how the concept will be applied in all of those individual circumstances.

44. Health and Social Care Trusts have been asked to work with care homes to provide the support they might require to move forward with dynamic risk assessments that facilitate safely managed and meaningful visiting arrangements and implementation of the care partner concept. They have also been asked to provide assurance to my Department, through the Chief Social Work Officer and Chief Nursing Officer, that care homes are implementing the visiting guidance appropriately.

Conclusion

45. I hope that these initiatives will help to show how much I and my officials continue to value both the Care Homes Sector and our social care workforce as we continue to move though this phase of the pandemic.

Robin Swann MLA.