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Committee for Health, meeting on Tuesday, 13 October 2020

Members present for all or part of the proceedings:

Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Mr Gerry Carroll
Mr Alan Chambers
Mr Alex Easton
Mr Colin McGrath
Mr Pat Sheehan

Witnesses:

Ms Linda Robinson, Age NI
Ms Emer Boyle, Commissioner for Older People for Northern Ireland
Mr Eddie Lynch, Commissioner for Older People for Northern Ireland

COVID-19 and its Impact on Care Homes: Commissioner for Older People for Northern Ireland; Age NI

The Chairperson (Mr Gildernew): I welcome Ms Linda Robinson, chief executive of Age NI; Mr Eddie Lynch, the Commissioner for Older People (COPNI); and Ms Emer Boyle, head of legal and policy advice at COPNI.

I invite the commissioner and the chief executive of Age NI to brief the Committee. You are very welcome, commissioner. It is you to start, and then we will go to Linda.

Mr Eddie Lynch (Commissioner for Older People for Northern Ireland): Thank you, Chair and Committee members, for the invitation to provide evidence to this important and welcome mini-inquiry. I thank the Committee for the important role that it has played during the pandemic in scrutinising the various authorities on a range of issues. As you said, I am joined today by my head of legal and policy advice, Emer Boyle.

I acknowledge that the invitation from the Committee outlines that the Committee feels that it has a good sense of the problems experienced to date in the pandemic and is keen to come up with constructive recommendations to inform decision-making. I will focus my evidence on the headings that the Committee provided, with a key focus on the issues that I feel most relate to my role as commissioner and are more in line with my work and that of my office.

When we talk about care homes, we are talking about the lives of 14,000 older people, and those homes are their homes. They are not just one group of people; they are individuals who have a wide range of needs, hopes, views and wishes. We have a duty to protect their human rights, and I have a duty, as commissioner, to ensure that their rights are protected during this very difficult time, including their right to see family members and their right to be cared for and treated with respect and dignity. I confirm that I will provide a full written submission to the Committee by 19 October, as requested.

Initially, I have few points that are, I believe, important to make to the Committee today. On the issue of discharge from hospital settings to care homes, at the start of the pandemic, my office was contacted by families saying that that had happened to them, and, as a result, their relatives became unwell. We have worked closely with families and the authorities on this and highlighted the danger. Going forward, it should be clear that nobody should be discharged and placed in a home before having tested negative for COVID. The risk is simply too high for the other people in the home.

At the start of the pandemic, the levels of access to PPE were not adequate for many of the independent providers. I had many calls with them and officials in the early stages. For many weeks, care home providers could not get access to sufficient PPE, and that continued to be an issue until late April/early May. That has to be addressed. It is, I believe, being addressed now, but we need to keep a focus on that and make sure that there is security of supply. Care home providers should be provided with PPE free of charge for the foreseeable future and until we have a review of their tariff. I do not believe that there are any excuses as we enter the autumn and winter for us not to ensure that, as we face a second wave, homes do not experience shortages of PPE. Another point on PPE is the need to ensure that staff in the homes are properly trained in donning and doffing PPE so that it is done correctly.

The other big issue is testing in care homes. As we know, in the early months of the pandemic, there was no testing at all of residents or staff. In fact, it was only by the end of July that every home was being tested. The current testing regime is every 14 days for staff members and every 28 days for residents. However, the Department and the Minister have stated in the past that, if community transmission increases, they will relook at the regularity. Now that we are faced with significant increases in community transmission, it is time to look at the regularity of testing again. I am calling for testing of care home staff, in particular, to be increased to once a week. That action is needed now. They are the people who are going in and out of the homes regularly, and, as community transmission increases, it is important that we increase the rate of testing. I have also heard of issues around delays in testing for care home staff. Some care homes reported that tests did not come back for four to eight days. That needs to be addressed. We also need to look at testing for visitors and potential care partners in care homes.

It is clear that the pandemic is increasing costs for care home providers. I recognise that there has been an £11·9 million support package to help with certain areas, but I am advised by some providers that this has not always been straightforward. We need additional funding put in place to facilitate safe visiting for the next six months and beyond. For many years, the sector has been advising me and others that it was not sustainable at the current care tariff. A review of the cost of care was long overdue before the pandemic, and the current situation highlights, yet again, the need for that to take place.

Care homes need additional financial and staffing resources to enable them to organise and manage care homes, particularly for visiting. The Department's most recent guidance on visiting has presented

homes with many challenges. I understand that there are restrictions on staff working across multiple homes, which will possibly put further pressure on some providers as well. It is vital that staff receive training in the operations of a home and any additional COVID measures in place. We are facing into a potentially difficult second wave, so time is of the essence on this issue. We need to get these measures working as well as possible, very quickly.

The Committee also raised the issue of staff pay and conditions. My 'Home Truths' report on Dunmurry Manor care home issued a number of recommendations on care home staff and how we treat them. The availability of nurses has been a particular pressure for care homes in many areas. Many homes have reported problems with retaining staff, and large numbers of agency staff have been required. The broader issue is that caring for older people in care homes is a very difficult job — one that is still not properly valued — and the people doing the job are not paid at the level that they should be. We all have the duty to ask ourselves, as a society, "Is this how we value the role and jobs of those who care for our older relatives? Is that OK?" The reality of the pandemic here is that 17-, 18- and 19-year-olds were required to go into care homes, without proper protection on many occasions, to look after the most vulnerable. We all have a duty to make sure that, going forward, we look at that issue and better value the staff who play that key role.

Maintaining contact with relatives in care home settings is essential for many families in Northern Ireland. The restrictions have caused huge issues. The revised guidance has, in some ways, given families hope — sometimes, false hope — that they will see their relatives and loved ones more often. It is the biggest concern brought to my office at present. Many families are deeply concerned about not being able to visit their loved ones. Many are more concerned about that than they are about COVID. Many families have seen the negative and detrimental impact on their loved ones: they have seen them deteriorate over a period of months and believe strongly that the lack of social contact has played a part in that. It is not easy, but we need to facilitate some form of safe visiting that allows the older people in care homes the chance to see their family members, and vice versa. We need to do everything in our power to make sure that that happens.

Turning to support from the trusts and advance care planning, I understand from officials that the health and social care trusts have been providing assistance to care homes — virtual ward rounds and the like have been happening. Whether that is sustainable in the longer term remains to be seen. It is very important that conversations about advance care planning are handled sensitively between the clinician and the family/next of kin. It is not appropriate that a family member is asked that question for the first time when their loved one has become unwell and needs hospital treatment. That should be thought of in advance.

Clearly, COVID has had a devastating impact on our care home population, but it is also important to point out that many older people have survived it. Many who contracted COVID have come out the other side, and we also have to remember that. Many in care home settings have survived COVID, and that is a message that we do not hear quite as often.

In conclusion, my team and I have, in recent weeks, been involved in many meetings with the different authorities on all these matters. It is clear that much planning and preparation has gone on in the health and social care system. The only point to make at this stage is that it is not always clear to me how some of the plans and guidance will be implemented on the ground. The challenge is to make sure that the guidance produced by all the authorities, particularly the care home providers, is realistic and that it can be implemented and make a real difference for residents in care homes and

for their families.

I am very happy to take any questions that the Committee may have.

The Chairperson (Mr Gildernew): Thank you very much, commissioner, for that very detailed response. There is some very interesting information there. We will ask Linda to give her presentation, and then we will have questions for each or either of you.

Ms Linda Robinson (Age NI): Thank you for the opportunity to speak to the Health Committee today on what is a very important issue. Our contribution, like that of the commissioner's, will follow some of the sets of issues that were in the letter that the Committee distributed. We fall in behind what the commissioner has said about many of those areas, so I will not necessarily cover them again in detail — Eddie has done that in a way that we fully support and recognise.

Our insights are very much based on the experiences of older people. Committee members will have received a document from us that outlines some older people's lived experiences. If members have not received that document, we can email it to them. It was very much an opportunity for us to hear the voices of older people over the last six months on their experiences of COVID and, in particular, as we are talking about today, the residential and nursing sector. In addition, we will have some feedback in the form of a written submission, which will be with the Committee by 19 October. That will give members more detail on some of the points that I will share with you this afternoon.

We were delighted to have the opportunity to gather evidence through hearing people's comments on their lived experience. Today is very much about gathering the evidence of what went very well in supporting people but also about where the challenges and the learning can come from. We have been able to gather that, and, hopefully, that will support the Committee as it goes forward.

One of the big areas has been visiting in care homes, which is challenging for residents, staff, relatives and families. It is about the balance between the individual and the collective in a home, which is the person's home. We are very supportive of looking at a way that will bring compassion and judgement to how we facilitate visiting in future.

At the moment, the guidance is a struggle for some people. The one hour per week visits by the same person allow the homes to manage the situation, but some of the feedback that we have received from families is that they feel that a bit more judgement could be exercised. What I mean by compassion and judgement is that, particularly for older people with dementia, it might be better to support a visit a couple of times a week, which would mean splitting the hour into two half hours and managing visiting across families who are caring for people with dementia. What I am saying is that one size does not fit all. I know that the guidance has an element of collective responsibility but, going forward, I would like to see some compassion and enabling.

The term "care partner" has been talked about, and there is a possibility of exploring the role of family and relative committees in supporting visiting routines. At the moment, our care staff, who do a tremendous job of providing direct care on the ground, have to come away from the floor to manage and supervise the visiting process and ensure that people are properly protected with PPE and following the guidance. We wonder whether there could be a more enhanced role for families. That would mean that they were involved in the process and provided with the appropriate PPE. A small group of relatives' committees could manage the process of supporting visiting across the home sector. I recognise that that would mean a bit more work, but there is a possibility of enabling people

to feel assured and reassured about how they visit their families, while adding a bit of compassion.

We also want to promote the point that we all recognise that we are partners in care. That includes the nursing staff in care homes, the trusts' involvement, the commissioner's involvement, our involvement as a charity organisation and the more general view of relatives' involvement and their support of each other. We want to pose that question and look at the possibility of whether that could be brought in while looking at whether that compassion could be added.

We recognise that a large piece of work needs to be done on bereavement, not just with family members who have been bereaved through COVID but with residents of homes and staff members, whom we saw daily on television and heard from daily on radios at the height of the pandemic. We observed that from a distance, and I wonder whether we could capture that in a way that supports those groups of people who have been directly bereaved. There is an impact on a home from losing a number of residents over a very short period, and it creates a very empty nest for residents and families. I wonder what our feeling is about having a bereavement service that tackles that adequately and takes on board the bespoke nature of how we dealt with bereavement linked to a pandemic, taking into account the restrictions that we had at the time. We should not forget the experience of the care staff who had to face that, day in and day out, or the relatives who had to view it from the outside. That is a very important area.

Eddie mentioned the social care workforce. For some time, we have wanted to push that agenda. We have highlighted that the social care framework is broken. We are fully supportive of transformation, but part of that transformation has to be recognition of the value of the social care workforce. That workforce has predominantly supported and catered for the needs of those who need social care. While the Committee is focusing on the nursing and care home agenda, many of those care staff work in a framework, which means that they work not only across homes but across community settings. We also have to remember that the social care workforce in the community supports a significant proportion of our older population and, indeed, those with other conditions at any age. All aspects of that section of the workforce — the training, the value, the terms and conditions — are important. They are part of what will make us successful in social care. It is about being valued and being partners in care.

The lived experience also requires us to ensure that, throughout this, we are protecting the rights of older people: the human rights of those who may not have a voice for themselves; and, equally, making sure that the voices of those who have the capability and capacity are heard. You will find a little bit about the lived experience through reading our submission.

Wrap-around health and social care is the other important piece of the jigsaw. What I mean by that is that a number of health and well-being professionals are going in and out of the care sector, particularly the nursing home sector, and we want to make sure that the GP and healthcare service is tightly wrapped around it and working as one team. Some of the concerns that came to our door included the view that, if GPs were not able to visit, home staff had to take a photograph and send it to the surgery. We feel that there has to be a better way to do that. Given that people have to go in and out of care homes — nursing staff from the trusts, PPE staff and infection-control staff — can we get the role of the GP back and get GPs engaged? It is a vital service for the general emotional and physical well-being of all patients and in supporting nursing managers.

The final bit, for us, is regulation. There has been discussion of the role of the Regulation and Quality

Improvement Authority (RQIA). That is very much a quality assurance role that gives confidence to us all. Perhaps the focus could be more on the observations of the quality of life, the practice of care and PPE. Perhaps, during a time of heightened crisis, there could be a move away from paper trails and records of inspection in order to focus on what we see in front of us. Might that not be a better way to use the expertise and skills that the inspectorate can bring to these matters?

From our point of view, care is very much about the communication of all that. We work closely as teams, as do Eddie and Emer, the trusts and the Department, to make sure that, during the surge that is upon us, the service works better for older people, others who need support and their families. It is all about the communication and about our all being viewed as partners in care. By that, I mean all sectors; we should ensure that the independent, statutory, private and voluntary sectors are all seen as partners. At the heart of that will be the older people and their carers, most of whom are family members. What we decide must work for them in terms of their human rights and quality of life, because that has to go on. We have to make sure that those are protected, particularly as we go into another phase over the next six months.

That is about taking on board the trusts' rapid learning initiatives and feeding those through quickly into practice. We all support and work together on that. A lot of work has been done in that field. I am sure that Eddie and Emer will agree that, over this last couple of months, much more has been coming together. That is good for health and social care. It is also good for visibility: what residents and families see as a trusted force. The core of that would be really good, tight communications that we all understand and can support.

The Chairperson (Mr Gildernew): Thank you both very much. Both presentations were very interesting. I will ask a couple of questions and then go to members.

Eddie, you spoke about the whole testing issue. The Committee had been extremely focused on that in the early stages, and we very much welcomed the rolling out of the testing programme. Recently, in the Assembly Chamber, the Minister indicated that, as a result of the testing programme in care home settings, a large number of asymptomatic cases had been picked up, which I found interesting. Positive cases were picked up before people were showing symptoms, and that is to be welcomed. It may flag up approaches that could be taken in the wider health and social care workforce. However, in this session, we will continue to focus on care homes.

What is your impression, commissioner, of the roll-out and effectiveness of the testing regime at the moment? This question is for either or both of you: what is the potential impact of the testing on residents? Maybe that is for you, Linda. Eddie, what is your experience of the roll-out, and where is it at present?

Mr Lynch: Chair, what you are saying is correct. Obviously, in the early days of this, we did not have any testing, and me, the Committee and others were calling for it. It was very welcome when it was introduced. At the time, I had some concerns about the regularity of testing being only every couple of weeks for staff, but, at the time, the Department and the Minister were very clear that that would be kept under review. You will remember that, when this was brought in, it was at a time when we were starting to see fewer cases in the community, so there was a clear understanding and commitment that, if we saw an increase in transmission of the virus in the community, it would be reviewed. When we see the figures that have been coming out in the past number of days and weeks, we see that it is clear that, unfortunately, the spread in the community has increased to much higher levels. In that situation, we need to now look at the care workers and the nurses who live in the community and

come in and out every day, and that is why we need to up the testing to at least weekly.

I have had a number of calls with experts and virologists on this issue. It is clear that the testing has been working quite well. The authorities are saying that it has caught a number of cases — as you say, those include asymptomatic cases — but we need to ramp it up some more, because some of the experts have clearly said that 14 days is too big a gap and that there is definitely more scope for you not catching the virus in between those tests when people become infected. It is about trying to recognise that there is no perfect answer, but moving from twice-weekly tests to weekly tests for care workers would be an appropriate response to the current level of risk.

The Chairperson (Mr Gildernew): Thank you. Linda, from Age NI's perspective, what is your experience of the impact of testing on residents?

Ms Robinson: In all this, we cannot lose sight of consent, and we also have to recognise that the staff on the ground and the families know residents best and can, as Eddie said, support the achievement of delivering that model of testing. We are following the advice of our experts on science and medicine, and, if that is the approach, we have to make it happen, but we have to make sure that we support the home, which will probably be the hub for delivering that in a timely way. It is about how the whole workforce plan can enable that to happen, and that might involve an increased number of staff on duty to make sure that it is done effectively, if we are reducing the time. In small homes of 20 people, that might be fine, but we must remember that a lot of our homes are 70-bed or 100-bed homes.

We have to consider the time that it takes to deliver the testing, because it is not straightforward if you are dealing with people who have advanced levels of dementia. We have to make sure that we get consent right and that our staff are comfortable delivering the tests. If we can capture that in a way that is efficient and effective, I think that we will see the benefits of a testing programme, as Eddie said, in nursing homes and care homes.

The Chairperson (Mr Gildernew): OK. I will move on to visiting. The Committee heard evidence that, in Hong Kong, the number of deaths in care homes was kept to around 30 to 40 in a total population of 7·5 million but that that was achieved by restricting all visits in person. We also heard evidence over the course of the pandemic about the huge impact on mental health. Could either or both of you elaborate further on how we should seek to balance the impact on residents of restricted visiting with trying to prevent further infections in homes?

Ms Robinson: Eddie, do you want me to go first?

Mr Lynch: Go ahead, Linda.

Ms Robinson: That is a very difficult question. Countries around the world are trying to get the correct answer to that. We are trying to balance compassion with the fact that many homes did not have COVID. Many people will say that that was because of the cancellation of visiting, but lots of other things can make that the case. We do not want to lose the value of families supporting relatives and staff, which is the other important aspect of this, at a very difficult time. If it were purely about staff in the home constantly having that 24-hour guard, wearing PPE and making sure that the residents' well-being in general is looked after, we would have to support them in doing that. It is about the balance between the individual, the collective response and the responsibility that we all feel to protect people.

We have found in the last six months that there were a lot of detrimental impacts on families and

residents. We have all seen those. I think that we can find a way to make it work. I think that people, generally, and, particularly, carers and family carers — I know that you will hear from people on that over the next week — will tell you that we have to find a better way of looking after the health and well-being of residents. In social care, social contact and being connected with those whom we care for is so important. It would be remiss of us not to at least try different things. I put forward the potential of exploring the role of a family carer in supporting a caring rota. We might find that, when that is explored, it is not ideal. The Northern Ireland experience and the design of nursing in care homes here are very different from those in other parts of the world, including Singapore. Countries have to find a measure that meets the needs of their communities. That is what we are striving for here. I think that there is great benefit in making sure that people are still connected and that we have the appropriate measures and PPE in place. We have to make sure that families are supplied with that whenever they enter the home. We have to make sure that it is the same type of PPE for us all and that it is of the best quality and grade so that we have as much protection as possible.

We have also looked at innovation. Some homes have divided rooms and put barriers into them so that, although people are physically present, the no-touching rule is still observed. We should all explore those measures, but we understand that they have to be resourced. We have looked at virtual visiting. To a point, that has been very positive and good, but nothing beats eye-to-eye contact and that feeling you get whenever you are in the room with someone who is cared for very deeply by a family member. We have to find ways of making that happen.

The Chairperson (Mr Gildernew): Are you suggesting that PPE be provided to allow socially distanced visits?

Ms Robinson: Absolutely. We have to enable people to visit, and we have to have the compassion to support homes. I know that a lot of homes will be doing that already. From what I hear, and, certainly, from the evidence that has been submitted to us, that seems to be working. We need to make sure that someone who is trained regulates the PPE that is delivered to homes. Our view is that that does not have to be a care worker, who would have to come off the floor, where they are providing much-needed support to the rest of the residents; a very well-trained member of the families committee could do that job very well with enough support from the infection-control teams that are going in and out of homes at the minute where needed. They could make sure that that is being delivered correctly within the framework in which we are asking people to provide track-and-trace details at the minute when they go in and out of a lot of public spaces.

People are delivering at a very high standard. We can deliver a model, with a little bit of exploration that means that, with the right PPE, people can get in and out while recognising social distancing and all the rules that go with that. We could explore the possibility of two half-hour visits a week to support people with dementia on their journey. A full week with no family support is tough, and it is tough for family carers as well.

The Chairperson (Mr Gildernew): OK. Thank you. I will go to members for questions, and first is Gerry Carroll.

Mr Carroll: Thanks, Chair. Thanks, everybody, for your points. It is important, as you said, that we have this discussion, and thanks for your input. Most of my comments are directed at Eddie, the commissioner, and are about Runwood Homes and, in particular, Dunmurry Manor. I was there in, I think, June 2018 when you released your report. I am quite concerned that there have been repeated issues with Runwood Homes and, at different levels, with Dunmurry Manor and Clifton Nursing Home. Can you comment on whether you think that that provider is fit for purpose and should continue to get

contracts? For me, given the concerns, it should be seriously reviewed. That is the first point.

It has been brought to my attention that staff at Dunmurry Manor are still trying to whistle-blow, but they are frightened and concerned, possibly about their livelihood and their job. I think that there is still a massive question about that provider. Some people seem to think that, if it were not affecting only elderly people, that type of action may not be happening. The issue was brought into focus yesterday given the news that Four Seasons is putting its care homes up for sale. I have been banging on for months, or even longer, about the fact that the for-profit model of care homes is not, in my view, fit for purpose. A response to some of those points would be helpful, commissioner. Thank you.

The Chairperson (Mr Gildernew): Before you go to that, commissioner, I want to point out that this session is specifically designed to look at the general situation in care homes because of COVID, and I am aware that that is our focus. You can take that into consideration when you are thinking about how you answer those questions.

Mr Lynch: OK. Thanks, Chair, and thanks, Gerry, for the questions. You certainly raise important issues, and they are ones that my team and I have been continuing to work on since the Dunmurry Manor investigation and the 'Home Truths' report. Those issues, unfortunately, continue to come to my office on a regular basis. You are quite right to point out that, in recent times, there have been issues with Dunmurry Manor, which is now Oak Tree Manor, and with Clifton Nursing Home and Glenabbey. My office has been involved in working with family members and the workers in those homes on those issues. In our normal work, we continue to liaise with the authorities on those matters, as we do with any care home.

Obviously, it is disappointing to again see similar care homes experiencing problems a number of years on from the investigations. The issues that the 'Home Truths' report highlighted still need to be followed up. Generally, there is a need for a lot of the recommendations to be progressed if we are to tackle the issues. Many of the issues that we have here and now are, unfortunately, the same ones that we had before COVID. That is my response on that. I certainly have raised it with the authorities. I believe that the authorities need to look at any provider that has clearly had shortcomings or failures of care in multiple homes and to consider that more in the round as opposed to on a single-home basis.

I have a couple of points to make on visiting, following on from what Linda said. A balance has to be struck, and it is a very difficult balance. On visiting is that there is more evidence now than there was at the start of the pandemic about the impact of a lack of visiting. Also, we are in a different position. In March, we had homes without PPE and we had no testing system in place. At that stage, it was seen that the best option was to lock down those homes to anyone who did not have to be in them. Now, we are seeing that that has a detrimental impact on those people's physical, mental and emotional well-being.

We are balancing the right to protect life with the right to have a family life. It is really important that we work together to create a condition where we can have some sort of safe visiting going forward. I believe that it would be inhumane to just have a blanket ban on visiting for the next six or nine months. We are dealing with many people for whom these are the last months of their life, and it would be a cruel system that imposed that.

As I said, many families have come to my office seeking support on this issue. On paper, the latest guidance is good in many ways, as it allows for more flexibility in visiting, but I cannot stress enough

the need for more work to be done between the authorities, the providers and the families to work on the system. I think that it can be done. Providers are coming forward with ideas and recommendations, such as outdoor plastic pods that can be put in place that can enable safe visiting and easy cleaning. Those are the sorts of innovations that we need to look at, because this will not be gone in a month or two. We are looking at this situation potentially lasting for another year or longer. We need to put those longer-term plans in place in order to enable older people not just to have their life protected but to continue to have some quality of life, and part of that is to see their family.

The Chairperson (Mr Gildernew): We talked about the balance between visiting and protecting residents from COVID-19, but do we have the balance right between the autonomy of private care home providers and the provision of article 8 rights and the guidance? Has that balance been appropriately managed?

Mr Lynch: These are testing times for the whole industry. We have never experienced anything like this before. We hear the term "co-production" used a lot, and I think that there has never been a time, never more so than now, that the authorities, the providers and the families all have to work together in a spirit of cooperation to see what can be done.

As Linda pointed out, we need to have compassion. We need to recognise the risks. We need to have that clinical analysis, the protection, the PPE and the testing, but we also have to remember that care homes are people's home. Those are people who deserve as a good quality of life as possible, and we all have the challenge to try to get through this. There is no perfect solution. There is no risk-free solution, but we cannot simply just say that we should shut these people away and just forget about them. In my view, that is not a sustainable option.

The vast majority of families are very clear about this and are really desperate to have some sort of system in place that allows that contact to continue. That is where the focus should be now. Without taking our eyes off the PPE and the testing regime, which is all vital and remains vital, we have to complement those with some sort of compassion and visiting regime.

Mr Sheehan: Thanks to all the panel for your contributions. I am just wondering whether any analysis has been carried out on why some care homes perhaps performed better than others. Maybe that is not the best way to put it, but I am sure that you get the gist of what I mean. Some care homes may have had more PPE, or they may have been using fewer agency staff. There is a suggestion that homes that used more agency staff are more likely to have transmissions, particularly those with agency staff who worked in multiple care homes. You had visiting and the admissions criteria that care homes used to admit residents from the community. I presume that not all care homes took the same approach to all those different issues. Has any analysis been carried out, or are there any plans for some analysis to be carried out in the future?

Mr Lynch: That is probably a question for the Department and some of the authorities who have the data on those issues. Certainly, we will be asking for information on the number of homes that have outbreaks, and we understand that the authorities will be doing an analysis of the outbreaks that are happening, the extent to which they are happening and where they are happening. I think that that is an issue as well that is linked to local transmission rates. Just because a home gets an outbreak, that does necessarily mean that that home has been at fault. It has been proven that this is a very difficult virus to control. It is very difficult to keep it out of care homes when you have so many people coming in and out, particularly staff, and that is why the testing has been so important.

At the minute, I am not aware of any significant analysis. There has been talk about inquiries looking

back at this taking place down the line, but I suppose my focus in the last few months has been on the learning from the start of the pandemic, where there have been failings and how we can learn very quickly. We all know that we are now at this second surge, and it is a deeply worrying time for us all, particularly the most vulnerable. Obviously, the figures bear out that almost half the victims of this virus the first time around were people who were living in care homes.

I have to say that this is a very big challenge for the homeowners. A lot of extra work and activity have been required at the providers' level in order to put these situations in place. As we saw with Dunmurry Manor and other homes in the past, it does not help if you have a high turnover of staff, because you have to train people up and make them aware of how the home runs. I think that providers also need support. They need support with resources and capacity to manage what will be a very difficult winter, and I think they need extra support if they are going to be able to facilitate the safe visiting guidelines that families so desperately want.

The Chairperson (Mr Gildernew): Linda, is there anything from you on that, or will I go on ahead to the Committee?

Ms Robinson: Those points are important. We are dealing with a population of homes that are of different sizes, in different locations and have different staffing rotas. When we look back for learning from the impact of the virus in March and April, we will see that there are a lot of variables that explain the source of the outbreaks. I think that the commissioner is right in what he said. As with hospitals, lots of things have been put in place, and the virus has gone through some very good solid systems. We are learning all the time, and I think that that is important. That learning reduces the number of areas with potential for the virus to move into. At the end of the day, we have to make sure that these are people's home and that we protect them in their home.

Mrs Cameron: Thank you, Linda and Eddie, for your presentations to the Committee. A lot of the questions have been asked and answered. You may not be the right people to ask about staff turnover in homes, but I will ask you anyway. Are you concerned about staff shortages heading into this second wave, especially now that we have the StopCOVID NI app and the risk of getting a "ping", as we call it, which knocks you off the grid for 14 days? Are you aware that staff are being advised to turn off their Bluetooth when they go to work if they know that there are COVID cases in those homes? I do not know whether you know the answers to any of those questions, but I am interested in hearing whether you do.

The Chairperson (Mr Gildernew): Before you answer, can I ask everyone online to mute their phones if they are speaking? We are getting some background noise.

Ms Robinson: Thank you very much. Yes, there is great fear in the social care workforce. Obviously, that has been heightened over the past six months when we were asking people to go in and out of situations that were putting them, and their families, at risk. That has a knock-on effect with recruitment. Before this, as I mentioned earlier, the whole social care workforce needs urgently reviewed. I know that some work has been done, but we are still today using a model that was developed probably 30 years ago when we moved into mixed economies of care and social care. That model is not fit for today. We need a service that is a bit like what we have in our nursing progression. We need a social care workforce career progression that will encourage people in the workforce. Our social care workforce tends to have an older age profile.

We need to encourage people coming out of university into the social care field to feel that they are in a valued, valuable and caring profession, and we do that by structuring the workforce and career

paths to show the value. That is so important and is part of the resourcing. In the past six months, we have been looking at what happens over the next 10 to 20 years. The majority of the social care workforce is in the community dealing with domiciliary care. That is equally gapped at the minute around nursing in residential care. The pressures on nursing and residential care staff when a staff member does not come into work, apart from the regulated staffing that the Care Inspectorate report said we must have, are so much greater.

The workforce has felt fearful, and we were short in numbers. However, that can be eased by getting a very rapid review of workforce planning for social care. Move from where it is at the minute into practice and get it happening. These are highly skilled members of the staff teams. When social care was first brought in, it came from the old home-help service where it was much more social care. Our care staff today do not just do social care; they do practices that traditionally would have been done in hospitals. It is a very different role — a very skilled role — that requires a lot of training, and that is not recognised. By doing that, we can start to look at how we fill those gaps because we need to do that. It will not happen overnight. We have to have a career path in mind that will move people into the sector so that they want to work with older people and so that there is a quality of life for everyone by enhancing that connection.

Mrs Cameron: Thank you, Linda. Do you consider that there is a role for volunteering in the midst of the pandemic? We have heard stories about relatives who volunteered in care settings in order to be useful but also to enable them to see their relatives.

Ms Robinson: Many families will continue with that visiting role, particularly at mealtimes. With the best will in the world, sometimes the family carer just knows how to support someone if they have problems with swallowing or eating because they have a longer experience of caring for them. Families do have a role; they have a role in this care partnership. We just have to explain what we mean by a care partner. It has its place, particularly in visiting where people can spend time together. The direct care and the support that is needed on medications, moving and handling, and the delivery of care in the home site is where we need our trained staff to deliver. We take those staff away if we need them to sit in on visiting and observe. There is an excellent role — a good-quality, compassionate role — for family carers to take charge of that piece of the partnership. It has to be done right and it needs to be explored, revised and tightened, but it is an ideal role that families would take on willingly because it connects them with the home and with the residents and in their role in supporting care. It would also challenge the view that some people may have that once you go into a nursing home you are shut off. We want people to be engaged: it is a community and a home. Volunteer family members have a very strong role in that side of it.

Mrs Cameron: Should a care partnership involve more than one family member?

Ms Robinson: That is a judgement call. We set our regulations so that we all follow them. I fully understand that, but sometimes there needs to be a bit of judgement. I know that whenever we use a judgement, homes will, perhaps, interpret it in different ways. However, we have to get a model that works for the individual. If we are being true to person-centred, individual care, we ought to have a bit of judgement on practice that is safe, compassionate and well led. By doing that, we can bring family members in. I am not suggesting that it should be 20 family members, but I know that there are, maybe, one or two people who, for the last five years, have been regularly visiting a sister, a brother or a family member, and they now have to choose. Both of them, probably, kitted out well and followed the rules and examples and did very well in supporting the home and the resident. We owe it to everyone at least to try it.

Mr Chambers: The Chairperson mentioned the presentation from the professor in Hong Kong a few weeks ago. He gave us some interesting statistics that showed that care homes did a very good job in controlling the number of deaths in those settings. The average residency in those homes is around 100, so they are all quite big. One of the interesting facts that he gave us was that no health workers had contracted the virus in the healthcare sector. The other very surprising thing was that they were not doing any testing at all at that point in care homes or of care-home staff. I was quite surprised by that. However, what they had, which we do not, was a bespoke isolation unit. As soon as there was any sort of outbreak in a nursing home, everybody was lifted lock, stock and barrel and taken to that isolation hospital or unit — whatever you want to call it — for two or three weeks before returning to the home, which, obviously, would have been deep-cleaned.

My question is for the commissioner: prior to the pandemic, would care homes have carried a residual stock of infection-control PPE to cope with the likes of gastric infections and so on? How long would that stock normally have lasted? Would it have been a month's stock or a couple of weeks' stock? Prior to the outbreak of the pandemic, would staff have been routinely fully trained in infection control, and would that training have been regularly kept up to date?

Ms Robinson: My understanding is that most homes that follow the RQIA regulations will follow the procedures and requirements for staff to be trained regularly in infection control. That forms a part of the inspection of training records. In addition, when it comes to the stockpiling of PPE, nursing and care homes and, indeed, the domiciliary sector — and all of us — were probably in exactly the same position as the hospitals. Organisations keep a stock, but we can see, from the gaps in our hospital services, that there was not enough per se at the beginning to support everyone. At that time, in our commentary, we felt that everyone's eye was on making sure that hospitals were fully supported, fully kitted out, and everything was directed to that. At that point, there is a recognition that care models, whether that be care in people's homes — people at home do not stockpile PPE either — or in nursing and residential homes, the amount of PPE stock was not at the levels that it should have been, just as it was not at the levels that were needed in hospitals.

My understanding now is that the supply chain is working very well, and the trusts are delivering PPE to every home weekly. Is that enough? I think that we all have to be ready for the fact that we may need to increase numbers again and stockpile more. However, from my understanding of the feedback, at the moment the trust delivery system that is in place is working. We need to be agile of foot if that needs to increase, but that is hospitals, people being cared for in their own homes, and people in the residential facilities.

Mr Chambers: Prior to the pandemic, did the inspection regime require a nursing home to demonstrate that it did have an immediate supply of PPE available to cope with any local infections?

Ms Robinson: My understanding is that the measures for infection control in the case of normal illnesses, such as bugs and sicknesses, meant that staff had appropriate masks, aprons and gloves prior to COVID-19. The intensity of COVID-19 meant that the actual numbers and type of PPE increased. For many homes, the PPE had to go to the highest level of protection, which was not the required standard prior to the pandemic. The higher standards of PPE required for COVID-19 outbreaks is the stock that we need to ensure is in place now.

Mr Chambers: Thank you.

Mr Lynch: The supply of PPE is very important. Homes will have had a limited supply of PPE at the beginning of this, but nobody was fully ready for the pandemic. It is clear that many homes felt left

behind at the start and did not have the support and supplies that they needed, and it took many weeks before they did. Fortunately, the situation seems to have improved in the last number of months. However, it is important to point out that support and supplies were a major problem at the beginning, and it was one that we cannot take our eye off. In future, we need to make sure that there is security of supply so that we do not run low on PPE and that we can up the testing regime. It is clear from the evidence that older people living in care homes are the most at-risk group and that, therefore, they should be prioritised.

I will make another point about the testing regime. care workers in care homes are in the pillar 2 testing regime, so they are not in the same testing regime as other health workers in hospital settings. Those people are key workers in front-line roles, and they need to be seen as a testing priority.

The Chairperson (Mr Gildernew): Thank you, Commissioner. Other issues have arisen with the pillar 2 testing about access to testing or the late return of testing. That is interesting. Finally, I will go to Alex.

Mr Easton: Thank you for your presentation. You mentioned staff getting tested every 14 days. Does that apply to agency staff? The second question is a bit more difficult, as it is something that I have not got my head round yet. Residents have contracted COVID-19 in nursing homes, and of those who unfortunately passed away, a significant number passed away in nursing homes. What I cannot get my head round is that if those residents are so ill, why are they not being taken to hospital, or is the hospital coming to them? How does that work? Why are they not going straight to hospital and being put into intensive care? How does that work, to the best of your knowledge?

Mr Lynch: Thanks, Alex. The testing is for all staff. Obviously, people will come and go, and if somebody is in a home for one day and does not return to it, that person will not be tested. However, the testing regime is for all staff who are regularly in a home.

As for transition to hospital, Linda pointed out that the level of care that people can get now in care homes is very high, and even before the pandemic, homes were dealing with very serious infections and conditions. They try to treat people as much as they possibly can. We have received guarantees that if a clinician deems that a person was unwell enough and needed to be treated in a hospital, they would be moved.

We saw at the beginning of the pandemic that being moved to hospital is not a nice position to be in either, because one of the terrible things about coronavirus is that you are isolated once you go to hospital. You do not have family or people you know around you. It is not taken lightly. If a person can be treated in a home, that will be the first option, but if it is deemed that they should be transferred to hospital, they will be. Unfortunately, we saw that in the figures as well. Many people who died in the first phase were care-home residents who had passed away in hospitals.

Mr Easton: OK. Thank you.

Ms Robinson: Just to follow on from what the commissioner said, there are very good end-of-life care pathways for residents now. In the past, there would have been a push to get people into hospitals. A lot of work has been done through PHA and the trusts to make sure that those pathways meant that the quality of end-of-life care was such that you could die peacefully at home, in the nursing or residential home, and that was the preferred option.

I certainly do not have any knowledge of anyone being prevented from going to hospital if they

needed to be there for a particular reason. GPs, or other clinicians, along with the homes and families, have always worked very well to make sure that end-of-life care has quality and human rights around it. In our experience, most people at that period prefer to stay at home. There is support from trust nursing staff, and I understand that that does happen.

__The Chairperson (Mr Gildernew):__ OK. Thank you. I have a couple of quick clarification questions for each of you and then a final one.

Linda, to clarify, when you spoke about the family carers and the family carers' committee in relation to PPE and visiting and donning and doffing, were you suggesting that family carers could play a role in organising and providing that type of support and training to take pressure off homes when donning and doffing and visiting?

Ms Robinson: They would play the role, once they are trained, in making sure that they have the necessary and adequate training skills in knowing how to don and doff. We can learn that very quickly; it can be done with the help of the infection-control nurses who are going in and out of the homes to train care staff. The nurse manager could train a couple of family members who really want to be involved in supporting the home, in making sure that they understand the importance of PPE and the importance of using it and donning and doffing correctly. They could then monitor the families coming in and out. The families are coming in and out to the visiting room, not into the full home where all the residents are. Most homes have a designated room that is checked before and after a visit. The feedback that I have had is that family support plays a very positive role that many families welcome. However, training, in the first instance, comes from the trained specialists.

__The Chairperson (Mr Gildernew):__ Commissioner, you said that no one should be discharged with a positive result or if awaiting the result of a test. Have you had any discussions with the Department on that, or have you received any assurances that that will be the case? We are moving into a worrying second surge. Moreover, care-home infections have risen from 25 to 35 and now to 45; they have almost doubled in a few weeks. Has either of you had any communication about that policy?

Mr Lynch: Chair, there was communication about that fairly early in the pandemic, and we sought assurances. My understanding then was that the policy was introduced so that nobody would be placed in a care home until they had received a negative COVID-19 test. I understand that that is still the case.

__The Chairperson (Mr Gildernew):__ To wrap up, both of you indicated that there were some useful elements in the guidance published a couple of weeks ago. However, both of you said that there were some issues. Would you like to advise the Committee on what the issues were in the guidance from your perspective? I will take you each in turn. I will first go to Linda and then finish with yourself, commissioner.

Ms Robinson: Thank you, Chair. The one point that I want to come back to is the type of visiting. We absolutely need guidance, and we support the work that has been done to get the guidance out because we are in a very challenging environment. However, from the feedback that we have got, I think that there is an opportunity for a judgement and compassion piece around perhaps more than one designated family member. One hour could perhaps be allocated as two half hours. For very frail older people, particularly those with dementia, a couple of visits a week would make such a difference. However, we recognise that that has to be appropriately managed and monitored, and that is where we think the support of a really confident relatives' committee could come in.

The Chairperson (Mr Gildernew): Thank you. Commissioner, what are your key issues with the guidance?

Mr Lynch: I agree with Linda. I think that the guidance is good on paper in the sense that it allows flexibility and individual risk assessments. However, the difficulty is with the implementation and practicalities of it and the extra help that care homes need to introduce it. I agree with Linda that families have a key role in working with the homes.

My concern is that now, in the mouth of a second wave, we do not have the time to do lots of planning. We need to come up with practical solutions that put in place a safe environment while working with families, providers and the authorities to come up with conditions that allow for some safe form of visiting. The care partner idea is good, but, again, that went on a lot before COVID-19 whereby families played a key role in supporting homes. It becomes very difficult to introduce that to any high degree because of the scale and threat of the pandemic and the amount of work that has to go in.

People have to work together, the homes need to be supported, and the families have to be listened to. I think that the Committee will find the testimonies of the families powerful as part of this. I welcome the fact that the Committee has announced this inquiry. I also welcome the quick turnaround because we need decisions quickly. We are doing our best to work with authorities to highlight the issues that come up, but we really are all in this together, and we need to work through it if we are to protect older people in care homes while also giving them some quality of life.

The Chairperson (Mr Gildernew): Thank you very much. Thank you both for your presentations, your answers and your input into the Committee's inquiry. It is very welcome. We look forward to the fuller submissions that you both mentioned. We appreciate your time and effort and look forward to hearing from you again in more detail. For now, on behalf of the Committee, I wish you and your organisations all the best in the work that you are doing with this crucial sector. Go raibh maith agaibh agus ádh mór.

Mr Lynch: Thank you.

Ms Robinson: Thank you.