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Health Minister

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To: **Executive**

COVID-19: UPDATE ON MEASURES TO SUPPORT AND PROTECT CARE HOMES

Introduction

1. This paper provides the Executive 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 start to rise.

Rapid Learning Initiative and other evidence

2. On the 2nd September I published the Rapid Learning Initiative. Led by the Chief Nurse, Charlotte McArdle, the review considered the learning to date in relation to the transmission of Covid-19 into and within the Care Home population. The review brought together a wide range of stakeholders to consider the experience of residents, staff and families; symptom monitoring and intervention and care planning; infection prevention and control; and physical distancing. The report of the RLI identified 24 recommendations across six themes:
   - Technology: Leverage technology to keep people, knowledge and learning connected;
   - Information: Manage information and guidance to and from Care Homes more efficiently and effectively;
   - Medical support: Provide consistent medical support into the Care Homes;
   - Health and wellbeing: enhance the health and wellbeing interventions for residents, families and staff;
   - Safe and effective care: enhance safe and effective practices including access to training for Care Home staff;
   - Partnership; enhance partnership working across all organisations.

3. These recommendations have been used to shape a revised regional surge plan for care homes, which contains 56 actions in all. Actions in the surge plan are being delivered by the PHA, HSCB, Trusts, Department and care homes themselves. Progress against the surge plan is being overseen by a regional Adult Social Care Surge Group, jointly chaired by the Chief Social Worker and Chief Nursing Officer.

4. As set out in a previous Executive paper, Northern Ireland had relatively fewer excess deaths in care homes than other parts of the UK. That position has been confirmed again, with research from the Long Term Care Policy Network in late August showing that care home resident covid-19 related deaths as a share of registered adult care homes place averaged 4.05% across the UK, with 4.06% in England, 5.09% in Scotland, 3.23% in Wales and 2.63% in Northern Ireland.[1]

5. We continue to look across the UK, RoI and internationally for examples of best practice and recently refreshed our benchmarking against key actions being taken by other countries.

Data and infection levels

6. Valuable data continues to be collected through the RQIA facilitated care home portal which care homes are completing daily. Return rates are consistently at or above 95%. We are currently using this to complete an internal weekly dashboard report assessing homes, Trusts and Northern Ireland as a whole against agreed regional surge criteria. It should be highlighted that this is self-reported information and there are limitations associated with self-reported information. However, PHA and RQIA are progressing considerable work to ensure the information reported is as robust as possible.

7. Last week's dashboard report showed that for Northern Ireland as a whole we are currently in 'green' surge status, as is each Trust area. However, it is clear that the small number of homes in red surge status – because of the number of residents who are covid-19 positive or who are in acute decline or who face workforce challenges – is growing.

8. The publicly available covid-19 dashboard shows 83 confirmed covid-19 outbreaks in care homes and 10 suspected covid-19 outbreaks as at 21st October. This compares to 36 confirmed outbreaks on 9th October.

9. Outbreaks in homes have to date largely included asymptomatic staff and/or residents, with infections being picked up early through our regular programme of testing. The PHA has reported that around 80% of outbreaks were asymptomatic in nature, however this has recently started to change with an increased percentage of outbreaks in recent weeks involving symptomatic cases among staff and residents. In addition, we are starting to see a change in the number of cases involved in outbreaks. While the number of positive cases among staff and residents had been very low in each outbreak – typically in low single figures – we are now starting to see more substantial outbreaks in care homes. This reflects the increased rates of infection and transmission levels in the community.

[1] https://ltccovid.org/wp-content/uploads/2020/08/COVID-19-mortality-in-long-term-care-final-Sat-29-v1.pdf

10. We will continue to monitor both the number and nature of outbreaks carefully through the Chief Medical Officer's care homes working group.

Funding and support in kind

11. Executive colleagues will be aware that today I announced a package of funding to support care homes, which is subject to final agreement from DoF and Executive approval of additional funding for my Department.

12. 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. It is clear that this is therefore an important measure in providing stability to the sector, though one I intend to keep under review.

13. In addition, I announced up to £6.5m in additional payments to care homes in April (with payments based on the size of the home) and then in June up to £11.7m to support enhanced cleaning, improved sick pay and to fund key equipment.

14. It is difficult to estimate expenditure in some areas and there have, understandably, been some underspends against this expenditure. Nevertheless, we have continued to see evidence of the pressures homes are facing – not least as they implement a rolling programme of testing and seek to follow guidance on safe visiting and the creation of care partners.

15. As part of the ask within the £600 million held centrally for Covid health related costs I have identified care homes as an important component. I have therefore worked with the sector to develop the proposed additional £27m on top of previously announced support packages resulting in a consolidated package of £45.22m from the start of the pandemic. This includes £9m that will be paid directly to homes to ensure they can support testing and visiting. Trusts are also working on an approach to paying additional PPE costs, where homes have continued to source their own PPE, on a formula basis. The remaining funds can be claimed back by homes to support additional staffing costs (for instance, because of more acutely unwell residents or the need to support individuals self isolating), continue with enhanced cleaning and enhanced sick pay, support changes to the physical environment (to support safe visiting, for instance) and meet other increased costs, such as IT. Trusts will be provided with funds to administer applications to this fund in a regionally coordinated and consistent way. I have also asked officials to ensure 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.

16. 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. Other UK nations have all now followed our approach of ensuring that PPE is available free to providers where it is needed. We also continue to connect smaller local providers with homes, so that they can purchase their own PPE.

17. During the first surge Trusts also provided more than 26,000 hours of free staff time to work in care homes and fill gaps in rotas.

18. The Department is currently considering proposals to expand the support that Trusts provide to care homes. Each Trust has a dedicated care home support team in place, which has been consolidated and expanded. In addition, we are considering the case to create dedicated environmental cleanliness support teams. The PHA is also expanding its dedicated team of infection prevention and control nurses, who support care homes.

Testing

19. We continue to ensure our care homes are protected by requiring Trusts to ensure patients are tested for covid-19 before being discharged from hospital to a care home. This testing should take place 48 hours before discharge and the results should be available to inform discharge planning and related arrangements. All other residents entering a care home from their own home or from any other community facility must also be tested prior to moving into the care home. In addition, all new residents entering a care home (whether coming from hospital or home) should isolate for 14 days.

20. Figures show that during the first covid-19 surge discharges from Trusts to care homes were reduced by around 30%. Evidence from a study in Wales which is yet to be peer reviewed), and emerging evidence from the Vivaldi study in England, have failed to find any clear link between discharge of covid-19 positive patients and covid-19 outbreaks in care homes. The key risk factor seems to be the size of the care home, with larger care homes more likely to have a significant outbreak. However, we continue to keep the approach to discharge under close review.

21. More broadly, testing in care homes has been facilitated from the earliest opportunity during our pandemic response. On the 18 May I announced that the covid-19 testing programme would be extended with testing made available to all care home residents and staff across Northern Ireland. This included testing in care homes which did not have a covid-19 outbreak at that time.

22. The initial phase of the covid-19 care home testing programme completed in all care homes across Northern Ireland at the end of June 2020. A regular

programme of testing for all residents and staff in care homes commenced on 3 August 2020. As part of this testing programme, undertaken primarily through the UK National Testing Programme (Pillar 2), staff are currently tested every 14 days, and all residents are tested every 28 days. We are keeping the findings emerging from this testing programme under close review and I will be advised by the Chief Medical Officer regarding further enhancements to this programme.

23. The impact and importance of this rolling programme of testing has been noted at paragraph 9 above.

24. Reporting arrangements are in place to capture statistical information on this testing programme; including routine reporting on the uptake of staff and residents being tested and the outcome of the testing. This information is regularly assessed by the Chief Medical Officer through his care homes working group.

25. We continue to actively monitor and assess the current and emerging science and evidence relating to COVID-19, to further inform our approach to testing in care homes. The requirement to vary the frequency of the testing undertaken is kept under active review and will continue to be informed by emerging scientific evidence and other contributory factors, including local community transmission rates in Northern Ireland.

Workforce

26. As noted at paragraph 17, 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. This is partly a consequence of illness and requirement to self isolate but also reflects our determination to keep key services running, now that we have put in place plans for many of these services to operate safely.

27. Figures from NISCC demonstrate that between September 2019 and September 2020 an additional 4,500 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.

28. We are therefore considering what additional measures can be taken to address likely staffing pressures – and have been discussing these with sector representatives.

29. Colleagues 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 pipeline of job ready staff for the sector.

30. 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 recent correspondence to the Finance Minister on this issue and the fact there are thousands of hours of additional staff time that could be released if we are able to address this issue.

31. We also hope that funding the block booking of agency staff by homes will increase the resources available. Agencies and providers have confirmed to us that staff who are block booked tend to work more hours, and work more flexibly, than spot bookings.

32. Making the social care sector an attractive long term career is an important part of our approach to help reinforce the sector. The Power to the People report on the future of adult social care makes clear the need to invest in this workforce. That is why I have commissioned 15 places on the Open University's social work training programme for care workers – enabling front line staff to carry on working, providing vital care whilst training. This is a first step in improving the training and career pathways for care workers. Extending apprenticeships to include social care would be a further significant measure and is something I have recently written to the Economy Minister on.

33. While we are looking to ensure as many new entrants as possible to the sector, a key part of maintaining sufficient staffing levels will involve ensuring existing staff remain healthy and available for work.

Visiting and care partners

34. Revised visiting guidance was published on 22nd September. The guidance indicates that subject to the care home's risk assessment, number of residents and other environmental considerations, visits may have to be limited to maximum number per week per resident. This is to allow opportunity for every resident to avail of a visit where they wish to do so, assist the facilitation of an appointment system, facilitate visits, and implement appropriate enhanced cleaning measures between visits. We are currently operating at Alert Level 4 which further limits indoor visiting that due to exceptional circumstances can only take place inside a resident's room to one visit once per week. One hour should be allocated for each visit, although it is recognised that not all residents will wish to use the full visiting hour. A range of visiting options should be provided that include virtually supported visiting, which remains a key method for maintain connections whilst reducing footfall and outdoor visiting arrangements. Each care home has also been asked

to undertake a risk assessment to determine how visiting can be safely accommodated, to work in collaboration with residents and family/friend carers and to ensure that the detail of the visiting policy is communicated widely. As noted above at paragraph 15, this approach is underpinned by additional funding to care homes.

35. In addition, we have asked each care home to work to introduce and support "care partner" roles. This recommendation was made following consideration of the shared experiences of residents, families and staff and analysed to inform the Rapid Learning Initiative report, which the sector contributed to. While some homes already have these arrangements in place, we recognise that many are finding this challenging. Trusts have been asked to support care homes with this process. Care partners are defined as individuals who will have previously played a role in supporting and attending to their relative's physical and mental health, and/or provided specific support and assistance to ensure that communication or other health and social care needs are met due to a pre-existing condition. Without this input a resident is likely to experience significant and/or continued distress. That is why this role is important.

36. Guidance also makes allowance for end of life visiting, for instance, and is clear that visits from Ministers of Faith should be accommodated and should not count towards the one indoor visit per week which we have asked homes to apply.

37. We continue to work with the sector on the implementation of this guidance. We know that many homes wish to be cautious but that, as a society, we need to strike the right balance between protecting life and quality of life.

Training, advice and support

38. As noted in previous advice to the executive, guidance for the care home sector was first issued in late February. Current guidance has been updated regularly and is currently going through further revision to ensure it is up to date and to consider how to make it more user friendly for those on the front line. As noted above, guidance on visiting has also recently been updated and issued.

39. Paragraph 18 sets out how we are looking to enhance Trust and PHA support to care homes. In addition, the RQIA has continued to act as a point of contact for homes with questions or difficulties and they have recently increased the resource they deploy on supporting homes in this way. We are considering how that function should be further developed going forward.

40. Previous papers to the executive has set out how free training is being provided by both NISCC and the CEC on infection prevention and control, use of PPE and a range of clinical skills necessary to help manage patients with respiratory

conditions, for instance. In addition we have supported the development of leadership training - 'Leading in a Crisis'- for both care home and Trust staff and the development of the My Home Life Programme. Additional funding is available where care homes have additional training needs linked to covid-19 above and beyond what I have set out here.

41. My officials led by the CNO are also working on the enhancing clinical care framework for care homes. One of the key learning points from the pandemic has been the increased level of acuity that we face in our care homes and the need to ensure Trust services effectively wrap round, support and in-reach to care homes to help manage care as well as continuing to develop and strengthen the skills within the nursing home workforce. There has been some innovative work with enhanced care at home teams over the pandemic and closer work between Trust clinical teams and professionals working in care homes. In addition, we are now better aligning GP practices and care homes to enhance and ensure the consistency of the clinical support that is available.

42. I have noted above the importance of maintaining our current workforce, as well as expanding. Many in this workforce have gone above and beyond what could reasonably be expected of them and will continue to face significant challenges and pressures.

43. To help deal with this challenge we have made HSC Trust Psychological Support Helplines (which are staffed by psychologists and psychological therapists) available to staff in the independent sector. The CNO is now considering with the trauma network what other practical support can be put in place.

44. In addition, we were pleased to support an initiative to create 'Rainbow Rooms' in care homes. These provide a space for care home staff to go when they are in need of some solace and when the pressures of dealing with covid-19 become too much.

45. I hope that these initiatives will help to show how much we value our social care workforce and help to stabilise and maintain that workforce.

Personal Data

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