FROM: MARK LEE

DATE: 20 APRIL 2020

TO 1.RICHARD PENGELLY – RP 21/04/2020 - "This is clearly a very expensive intervention, and raised significant vfm concerns. While possibly a premature assessment on my part, I feel we would not be able to roll this out on a large scale basis, given the financial costs and logistical challenges (essentially staff availability). That said, given the unique circumstances we are in, and the particular vulnerability of care home residents, I think it is important to test alternative approaches such as this, with a view to ultimately developing a hybrid approach (somewhere between current practice and this) which better protects those vulnerable residents. In that context I am happy to approve, subject to some early work to sharpen our thinking on what aspects of the approach we want to pay particular attention to in the evaluation – to ensure we have appropriate baseline information and metrics in place to gauge success or otherwise of the approach."

2.ROBIN SWANN MLA, MINISTER

SUB/**/2020 – PREVENTING COVID-19 IN CARE HOMES: PILOT OF NEW SANCTUARY APPROACH**

SUMMARY

ISSUE:	This submission seeks your agreement to fund and initiate a pilot project aimed at reducing the risk of COVID-19 transmission from care home staff to residents. The pilot would run in at least two, but potentially three, homes run by Four Seasons Health Care, for a period of six weeks. During the pilot, staff would be rostered to live in the care home for a period of 7 days, followed by 7 days off work.
TIMING:	**URGENT** – approval in principle to proceed and fund this pilot is required in order to allow formal discussions to begin with staff and suppliers. It is expected that the pilot would start from Monday 4th May.
PRESENTATIONAL ISSUES	The impact of COVID-19 in care homes continues to attract significant media interest. The initiation of this pilot would represent positive action aimed at preventing the spread of infection and keeping residents and staff safe. Cleared with Press Office 20/4/20 (TS)
FOI IMPLICATIONS	Unlikely to be discloseable – policy under development.
EXECUTIVE REFERRAL:	Not required.

FINANCIAL IMPLICATIONS:	This proposal will have financial implications to meet the additional costs associated with staff salaries and overtime, as well as any additional costs which may be incurred. Running the pilot in two homes for six weeks will cost approximately **£480k.** Expansion and/or continuation of the pilot would generate significant additional costs. It would be expected that DoF approval in advance would be required for any expansion and / or continuation of the pilot. The Department has been allocated **£205m** of COVID-19 to date, a further allocation of **£49m** is anticipated. In addition, **£150m** is being held centrally by DoF to meet PPE requirements across the public sector; you will be aware that our estimated PPE requirements are significantly in excess of this. Cost projections and associated funding requirements are volatile due to the fluidity of the response to COVID-19. Latest cost estimates are in excess of **£574m** (Resource and Capital) excluding the proposal set out in this paper. You are asked to note the risks associated with this proposal, including the need for a clear exit strategy. Cleared by Finance 20/04/20 DM
LEGISLATION IMPLICATIONS:	None associated with this submission.
EQUALITY AND HUMAN RIGHTS IMPLICATIONS:	None associated with this submission. In implementing the proposal, full consideration will be given to ensuring that the rights of staff and residents are respected and protected.
RURAL NEEDS:	None associated with this submission.
SPECIAL ADVISOR COMMENTS:	
RECOMMENDATION:	You are asked to: i. Note the proposal set out in this submission; ii. Note the risks and mitigating actions required set out at paragraphs 15 to 20; iii. To agree to the proposal to test "live in" arrangements in selected care homes outlined in this submission and the attached Annex, and the associated resource requirements;

and

iv. If content, you are asked to agree to make the additional funding available and that we make formal preparations to begin this approach from 4th May.

Background

1. You are aware of the increasing concerns about the impact of COVID-19 on care homes and of the steps being taken to protect residents, support staff, and maintain the safe and effective operation of services.

2. All residents in care homes are now shielding, and therefore should not be leaving the home. COVID-19 can therefore only be introduced by someone entering the home or by being carried into the home on an object. The carrier could be a new resident, a visitor or a staff member. Visitors should already have been restricted to the absolute bare minimum (including visits from HSC professional staff).

3. There are however further steps that can be taken to seek to move closer to "cocooning" or "hermetically sealing" care homes from infection. Alongside other measures—including new protocols on potential step down from hospital and cohorting new admissions from the community—restricting staff movement in and out of the home could significantly contribute to a major reduction in the route through which the infection could be introduced to the home. It is suggested that this could be achieved by asking staff to work and live in the home for a period of time, accompanied by testing of staff and residents to monitor the impact of the approach in minimising the transmission of the virus. This submission provides information on plans to pilot this approach in two homes from 4 May—with the possibility of a third home entering the pilot at a later date. A more detailed outline is provided at the attached **Annex**.

Approach

4. It is proposed that staff would work a shift pattern of 7 days on and 7 days off. During the 7 day working period, staff would live in the home. Staff would be required to self-isolate for a period of 48 hours prior to beginning each 7 day working shift, followed by a combination of symptom self-reporting and testing prior to commencing "living in".

5. Enhanced monitoring of staff and residents will also help to ensure that any positive cases of the virus are identified at the earliest possible stage, even where residents or staff are asymptomatic, and swift action can be taken to minimise the risk of spread.

Testing

6. The proposed approach will involve additional testing of staff and residents to minimise the risk of spread and provide for ongoing monitoring. The proposal was considered by the PHA's Expert Group

on Testing on 17 April. Although it has requested some amendments to the proposal at the Annex to draw out the expected outcomes and the proposed approach to evaluating these, the PHA has confirmed in principle that it is content to support the pilot study in terms of the testing requirements associated with the approach.

Pilot sites

7. Discussions have been ongoing with the Managing Director at Four Seasons Health Care (FSHC), who has identified possible sites to run this pilot project – although subject to further discussion to finalise arrangements, potential sites include care homes in the Holywood and Portadown areas.

8. It may also be possible—subject to availability of funding—to bring an intermediate care home in Belfast into the pilot project (Lansdowne Care Home). This site currently has cases of the virus and, on the advice of the PHA, would not therefore be suitable for inclusion in the pilot until these have been addressed. However, the inclusion of an intermediate care facility in the pilot at a later stage would allow for testing the impact of this approach on patient flow out of hospital, as well as on the risk of transmission to care home residents.

Costs

9. It is proposed that staff participating in the pilot would work one week on, one week off, and would be required to self-isolate for 48 hours prior to starting each 7 day shift. While staff are participating in this model, they would be paid at double rate for the hours they work. To date, discussions with FSHC have suggested that staff would be paid at a standard rate for the hours they do not work. However, we recognise that this proposal will be costly; and arguably staff are already being compensated for this proposed new working pattern as they will be paid double time for the hours they do work. We will continue to work with FSHC to identify ways to reduce the costs. One option we will consider is that staff will be paid half time for the hours they are not working or moving to payment of a bonus per week or month rather than relying on hourly payments.

10. FSHC has advised that it would be reasonable to expect staff to work an 8-9 hour shift each day, with 15-16 hours rest time. With seven days in work and seven days not working, over the six weeks of the pilot staff would be paid at double time for 168 hours work and at normal rates for 336 hours. This would compare to 240 hours of pay at normal rate assuming a 40 hour week over six weeks.

11. Some form of on-call allowance would be needed for staff members who may be called in to replace staff in the home identified as symptomatic or COVID positive. FSHC advise two staff would need to be on call each 24 hour period (one for day shift and one for night shift) for each location. These staff would be paid an on call allowance of £30 each day. With two homes involved in the pilot, this would amount to an additional cost of £5,040. Subject to the approach taken to self-isolation in advance of shifts starting, staff may also be entitled to this

on call rate--for example, if staff were isolated from families for these 48 hours and were undertaking eg training.

12. FSHC has costed the model at two sites, based on actual hourly rates for the care staff and support staff working there. Assuming staff working at double time for 60 hours each week, with 108 hours rest time, FSHC has estimated costs for applying this staffing model to two sites for one week as £150k, of which it can pay £70k. Therefore additional funding of £80k per week would be required to fund the additional staffing costs associated with the model. On this basis, it is estimated that the costs for the six week pilot project would be in the region of £480k. Additional costs of around £5k would be required assuming four staff on call for the duration of the project at a daily rate of £30.

13. Assuming staff are on an hourly rate of £15, for illustrative purposes, and normally work 40 hours per week, over six weeks they would be paid £3,600 for working 240 hours. Based on this proposal and assuming three working weeks at 60 hours per week on double time and 108 hours rest time at normal rate of pay - over the six week period of the pilot staff would earn £5,400 for working 180 hours, and £4,860 for 324 rest hours in the home, giving total pay before any on call allowances of £10,260. To secure the 180 hours of work, on a 'cocooning basis' effectively means an hourly rate of £57, an increase of 380% per hour, using the £15 per hour illustrative rate. As at paragraph 9 above, we will continue to explore with FSHC options to reduce the costs. For example, if rest hours were paid at half time, the effective hourly rate would be £43.50 for 180 hours of work or an increase of 290%.

14. Were a decision to be taken to bring a third site into the pilot at a later date, this would obviously have further cost implications likely to be in the region of £240k for six weeks.

Sleep-in litigation

15. As you may be aware, there has been long-running litigation on a UK-wide basis in respect of whether time spent by workers "sleeping-in" on residential care premises is considered to be working time. The English Court of Appeal decided last year in the Mencap case that it is not working time. However this was appealed to the Supreme Court and the case was heard in February, with judgment currently reserved until (it is thought) early summer. Over 1,000 industrial tribunal cases against the HSC in Northern Ireland are stayed, pending the Supreme Court's decision. There is therefore a potential risk that the sanctuary arrangements could create a precedent whereby workers are paid for sleeping-in, but the Supreme Court upholds the view that sleeping-in is not working time and therefore should not be paid. This risk can be mitigated, however, by stating that the sanctuary arrangements are unique to the COVID-19 response, which is unprecedented in scale.

16. It should be noted that this proposal could have implications across the public sector – to other services (such as prisons) who may be considering sleep in arrangements. Again, we think the very limited

and short term nature of the pilots allow us to explain the uniqueness of these arrangements. Arguably given the novel and potentially repercussive impact of the proposals set out in this submission DoF approval should be sought in advance of any decision to implement the proposal. However, the proposal is for a pilot of six weeks duration. Should the learning be such to point towards a wider roll out over a longer timeframe DoF approval in advance will be required.

Working Time Regulations

17. The Working Time Regulations stipulate a maximum 48 hour working week. However this is calculated over a 17-week reference period. In practice this means that a worker can work more than 48 hours in one week as long as the average over 17 weeks is less than 48 hours a week. Some jobs have different reference periods, for example, where 24-hour staffing is required. As such, it is not envisaged in the shorter term that sanctuary workers will be required to opt out of the Working Time Regulations, but if the sanctuary arrangements continue over a longer period, it may become a live issue. Employers will be encouraged to seek their own HR advice on working time regulations, as each case will be different, depending on the circumstances.

Approach to wider rollout and exit strategy

18. Clearly this would be a very expensive model to scale up. Roll out to all 400+ care homes at c.£240k per home for six weeks, would over a 3 month period theoretically cost £192m which is clearly unaffordable. However, the focus of this pilot is to capture learning to establish the benefits of applying this approach. In parallel, we are also considering an approach to roll-out and how that could be done in an affordable way. One option may be to focus on a small number of homes, perhaps 10% of the most vulnerable. And rather than paying staff double time for hours worked, we could explore using bonus payments to staff participating in the sanctuary arrangements—perhaps in the region of £500 each month. Subject to your approval of the overall approach, we will continue to work through this and other options to develop a plan for an affordable roll out if this is indicated following evaluation of the pilot.

19. There may be some challenges when we come to the end of the six week period. If we have decided to move to a broader roll-out, there may be an expectation that has been created about the rates that we would pay. Moving these individual homes (and the staff within them) onto a less lucrative model could bring significant challenges. We think these can be messaged by clear up front messaging – recognising that sustainability would require a different financial model. Once we have tested the model we can begin broader discussions and make a wide offer to the sector as a whole which homes may choose to accept or reject. Nevertheless, you should be aware of the potential for this to become challenging in presentational terms if the model is deemed a success and the pilot homes do not wish to continue without the same level of remuneration.

20. For the pilot homes to continue for a period of three months on the same rates as set out in this submission would be £1m, increasing to

£2m over six months. A clear exit strategy for the pilot homes will be necessary, the staff and families would need to be assured as to the safety of residents to step back from a cocooning arrangement. Other families may press before the conclusion of the pilot for similar arrangements to be put in place in the homes in which their loved ones are resident and this could create significant additional cost pressures. You will be aware of the existing pressures on COVID-19 not just in this Department but across Departments. It will be important to manage expectations as not every intervention, notwithstanding the merits, can be supported.

Next steps

21. Some further work is required to refine the proposal at the attached annex and agree the final approach to testing and evaluation of the pilot.

22. In addition, FSHC has indicated that it will require some additional support in terms of beds and food supply, and we are working through the NI Hub and with colleagues in HSC Trusts to ensure that this is available to support the operation of the pilot.

23. At this stage, your agreement to the approach and the associated resource implications would allow for formal discussions to take place with staff and to put arrangements in place for the initiation of the pilot from 4th May.

Recommendation

24. You are asked to:

i. Note the proposal set out in this submission;
ii. Note the risks and mitigating actions required set out at paragraphs 15 to 20;
iii. To agree to the proposal to test "live in" arrangements in selected care homes outlined in this submission and the attached Annex, and the associated resource requirements; and
iv. If content, you are asked to agree to make the additional funding available and that we make formal preparations to begin this approach from 4th May.

Mark Lee

CC list:
Michael McBride
Sean Holland
Charlotte McArdle
Deborah McNeilly
Jackie McIlroy
Andrew Dawson
Gillian Armstrong
Carol Beattie
Jennifer Mooney
NR
NR

Press Office

COVID-19: The Sanctuary Model
Revised Draft 17/4/20

Context and need

1. International evidence is emerging to show that up to 50% of COVID-19 related deaths are happening in care homes (https://ltccovid.org/2020/04/12/mortality-associated-with-covid-19-outbreaks-in-care-homes-early-international-evidence/). Given that the death rate amongst the older population is significantly higher than the younger population, there is a particular need to protect care homes. Guidance is already in place asking homes to strictly limit visitors and to put in place infection prevention and control measures. Updated advice on testing confirms that residents of care homes who are symptomatic and meet the case definition of COVID-19 should be tested for COVID-19. When an outbreak occurs, expert advice is available from the PHA.

2. However, with COVID-19 now circulating widely in the community the risks of infection being introduced into care homes are higher and there is therefore a need to consider what additional measures can be taken. The number of care homes with flu like illnesses (FLI) or confirmed COVID-19 outbreaks continues to rise steadily and we must seek to stop or slow this increase as far as we possibly can, in order to both maintain the quality of life for residents, protect those most vulnerable and indeed save lives.

3. This work will take place alongside the development of revised regional guidance for care homes which will consider issues such as how discharges from hospital are managed for all care homes.

Rationale

4. All residents in care homes are now shielding, and therefore should not be leaving the home. COVID-19 can therefore only be introduced by someone entering the home or by being carried into the home on an object. The carrier could be a new resident, a visitor or a staff member. Visitors should already have been restricted to the absolute bare minimum (including visits from HSC professional staff). It is not possible to close homes completely to new residents without putting people too frail to be at home at risk and without significantly reducing the ability to discharge patients from hospital.

5. Care homes are therefore unique in that they face a number of risks that a normal home would not – with more movement into and out of the home than would be the case in a private household observing social distancing – and a very significant number of particularly vulnerable people closely co-located (and therefore vulnerable to any infection spreading and infecting a large number of people).

6. There are however further steps that can be taken to seek to move closer to "cocooning" or "hermetically sealing" the home from infection.

Alongside other measures—including new protocols on potential step down and accepting discharges from hospitals or cohorting of new residents from the community with dedicated teams, and restrictions on staff movement in and out of the home—this could significantly contribute to a major reduction in the route through which the infection could be introduced to the home. This could be achieved by asking staff to live in the home for a period, potentially after a period of self-isolation of 48 hours followed by a combination of symptom self-reporting and testing prior to commencing "living in". This approach may potentially reduce the risk of acquiring infection from the external environment and introducing this into the home. Enhanced monitoring of staff and residents will also help to ensure that any positive cases of the virus are identified at the earliest possible stage, even where residents or staff are asymptomatic, and swift action can be taken to minimise the risk of spread (through further isolation of the resident or the managed absence of a staff member).

7. While it is recognised that testing only provides reassurance at a specific point in time and that there may be instances where an affected individual does not test positive, testing may provide an additional level of assurance over and above symptom checking, particularly given that some affected individuals may be asymptomatic.

Objectives

8. In the context of the above, the objectives for this work are to:

   a) test a new, more rigorous approach to infection prevention and control which would include staff living in a care home for a period.

   b) understand the practical challenges, costs and requirements associated with such an approach.

   c) consider any evidence of infection prevention and control benefits.

   d) consider the scope for expanding this approach more widely, recognising that it may not be possible to implement the full model across the whole of NI.

Alternatives/options

9. We could seek to roll this out as an approach across NI; or to test it in a single home or very small number of homes first. Large scale rollout is likely to be challenging from both a staffing point of view and because we do not fully understand all the implications. An immediate roll-out NI wide is also likely to be expensive with uncertain benefit.

10. It would be possible to take forward, on a wide scale, a more simplified model – e.g. without enhanced testing or other enhanced infection prevention and control measures. However, most learning and potential benefit is to be gained from testing the most comprehensive model and considering where practical problems and challenges arise.

11. We therefore propose to test the model as fully as possible in a small number of homes initially.

Approach

12. A partnership would be created with a care home provider who would identify one or more homes where there are likely to be sufficient staff willing to test this model. Four Seasons Healthcare, the biggest care home provider in NI, has identified two or three homes where this approach could be tested.

13. There will be additional costs associated with this scheme – with a different staff rota and costs of e.g. providing meals to staff. There will also be some set up costs in planning and in procuring beds for staff to sleep on, etc. A standard environmental clean should be undertaken before the start of this new model. A full infection control audit of the care home should also be carried out prior to the commencement of the project. Shift patterns and associated costs are set out in the finance section below.

14. Staff would sleep either in spare rooms in care homes or, more likely given limited spare capacity in most homes, in communal areas on temporary beds. Beds and living areas must be configured in such a way as to ensure social distancing, and communal areas should already be largely out of bounds. The care home provider will need to provide an appropriate facility for staff down time, when they are off shift, as well as appropriate cooking and laundry facilities – alongside appropriate sleeping and washing/showering arrangements. Scrubs should be worn along with appropriate PPE. All scrubs and leisure time clothing will need to be laundered on site. Private male and female showering facilities should be provided for use after each shift. Daily handwashing audits will need to be maintained.

15. In addition to self-isolating for 48 hours prior to commencing their 7 day rota, staff would also be asked to self-screen during this time and have their temperature checked twice a day. This would be accompanied by routine testing with next day results to be facilitated for all staff entering the project. Staff would also be re-tested 5 days after the initial swab, providing a mid-week result. This would help us to understand more about the effectiveness of testing staff and about the number of people who may be identified as COVID positive despite being asymptomatic – as well as helping to limit the chances of the virus being introduced to the care home.

16. While self-isolating at home staff should refresh on-line infection and prevention control training and have access to further on line modules relating to management of deteriorating persons, respiratory distress, verification of death and end of life care.

17. We would also consider the benefits of symptom checking and testing all care home residents before starting the pilot, which would help identify any

asymptomatic residents who could pose a risk of spread – and in turn help us identify any benefits to wider scale testing and allow us to inform policy development more widely subject to advice on consent and ethical issues. Within the home, twice daily symptom checking (e.g. temperature checks) of both staff and residents would be undertaken, recorded and tracked against other clinical indicators. The Rockwood frailty assessment would be undertaken for each resident and Restore 2 used to monitor clinical presentation.

18. The home will need to have additional staff on standby, in case any staff members are identified as infected with COVID-19. It may not be possible to ensure that all staff self-isolate for 48 hours before they enter the home in these circumstances but they must ensure they are tested before doing so.

19. The home would institute strict infection prevention and control procedures, in line with existing guidance. This would include strict limits on visitors, an enhanced environmental cleaning regime, and use of PPE. They would also restrict residents to their rooms (special effort would need to be made to ensure continued physical activity). Strict controls would be put around deliveries to the home (e.g. of food and PPE supplies) to minimise the risk of the virus being introduced through that route. To minimise risk PPE should ideally be delivered for at least an 8 day period. Anything moved between rooms (for instance, tablets to speak to families) would be disinfected between rooms. Meals would be served in residents rooms. Affected residents' crockery and laundry will be managed separately as per PHA guidelines.

20. Any new residents arriving should be tested for COVID-19 before entering the home and cohorted for 7-14 days within the home. This would require staff, as far as possible, not to move between new isolated and existing residents. This approach would apply to both discharges from hospital and new residents coming from the community.

21. Should an outbreak occur in the home while this approach is being tested, it is proposed that all residents and staff would be swabbed.

22. Additional psychological support for staff and residents will be required. The Trust provided psychological first aid helplines are now open to all care home staff, and providers should also ensure that local support services are available.

23. We would test this approach for at least 6 weeks initially before a rapid evaluation to facilitate the decision whether to continue, expand or stop.

<u>Safeguarding arrangements</u>

24. Measures to safeguard residents against abuse or exploitation will be made explicit within the context of this model. Whilst shielding residents, there remains a need to uphold the individual's human rights and

autonomy and it will be essential to ensure that proactive, preventative and supportive strategies are fully implemented and adhered to.

25. We will ensure that staff work to minimise the impact on residents and to ensure that the residents lead as full a life as possible within these unique circumstances.

Costs and contracting

26. Staff would work one week on, one week off, and would be required to self-isolate for 48 hours prior to starting each 7 day shift. While staff are participating in this model, they would be paid at double rate for the hours they work and standard rate for the hours they do not work. FSCH has advised that it would be reasonable to expect staff to work an 8-9 hour shift each day, with 15-16 hours rest time. With seven days in work and seven days not working, over the six weeks of the pilot staff would be paid at double time for 168 hours work and at normal rates for 336 hours. This would compare to 240 hours of pay at normal rate assuming a 40 hour week over six weeks.

27. Some form of on-call allowance would be needed for staff members who may be called in to replace staff in the home identified as symptomatic or COVID positive. This would be set at £30 per day. Staff self-isolating from family members etc in their own homes before entering the care home, and using this time to complete training, would also need to be paid this on-call rate.

28. The total additional costs, based on an initial 6 week period are £500k for the two homes we expect to test the approach in.

29. Were a decision to be taken to bring a third site into the pilot at a later date, this would obviously have further cost implications likely to be in the region of £240k for six weeks.

30. Funding for this approach will be passed through Trusts.

Timelines

31. Agreement to the use of testing in this way has been sought and secured from the Expert Advisory Group at its meeting on Friday 17th April. Further work is required to refine this proposal and agree an approach to its implementation and evaluation.

32. FSHC also requires time to begin formal discussions with staff and put in place the necessary arrangements.

33. We would therefore expect this pilot to start in both homes on Monday 4th May.

Project management and oversight

34. A liaison group consisting of Sean Holland, Mark Lee and PHA infection control and nursing colleagues will meet with Four Seasons senior

management on a weekly basis to seek feedback. The Chief Social Worker will be the Senior Responsible Officer for this project.

Risks

35. One of the major risks is that we raise expectations but are unable to roll-out this out across NI. This will be mitigated through clear communication and – if the model cannot be rolled out across NI – consideration as to which elements of the model could be rolled out. Where cost is a limiting factor, different approaches to meeting costs could be considered.

Expected benefits and measures

36. We expect to:
    a. Help residents, families and staff feel reassured
    b. Gain knowledge of any disbenefits to patient wellbeing and physical health
    c. Provide wider public reassurance that we are constantly seek to improve infection control approaches and processes
    d. Gather learning on the workability of the model and issues that may need to be addressed
    e. Gather any evidence on the impact on infection control
    f. Gather evidence on asymptomatic carriers
    g. Help ensure care home shifts are covered
    h. Further build on a positive partnership with a major care home provider.

Monitoring and Evaluation

37. Qualitative evaluation taking feedback from residents, families and staff would be undertaken by the home. This would include a measure by measure assessment of the steps taken and the challenges in implementing them and any perceived benefits. The home would also be required to report any negative impacts on either resident or staff wellbeing using a standardised wellbeing questionnaire. Feedback would be sought on shift coverage. Feedback will also be sought on any ways in which the model could be further enhanced.

38. Any suspected or confirmed cases of FLI or COVID-19 (either staff or residents) should be reported to the liaison group led by the Department (alongside the usual reporting of outbreaks to the PHA and Trust).

39. Test results would be tracked by the home management using an agreed clinical assessment tool and provided to the liaison group to consider. The care home would need to identify if test results were from symptomatic or asymptomatic residents or staff. A reporting format will be agreed.

DoH
20th April 2020