SUBMISSION TEMPLATE

FROM Linda Kelly
Deputy Chief Nursing Officer

DATE 21 August 2020

TO 1. CHARLOTTE MCARDLE CNO
2. RICHARD PENGELLY
3. ROBIN SWANN MLA, MINISTER

SUB/**/2020 - REPORT OF THE RAPID LEARNING INITIATIVE INTO THE TRANSMISSION OF COVID-19 INTO AND WITHIN CARE HOMES IN NORTHERN IRELAND**

SUMMARY

ISSUE:	You asked the Chief Nursing Officer to establish a Rapid Learning Initiative (RLI) into the learning from the transmission of the first surge of Covid-19 into and within Care Homes and to provide recommendations to mitigate the impact of a potential second surge. This submission provides you with the Report and a summary of key findings.
TIMING:	**URGENT**
PRESENTATIONAL ISSUES	**Press office will liaise with officials on press release. This will be sent separately for consideration. Cleared press office RC 14/8/2020**
FOI IMPLICATIONS	Likely to be fully disclosable though there may be a potential exemption under Section 35 (1(a) Formulation or development of Government Policy
EXECUTIVE REFERRAL:	N/A
FINANCIAL IMPLICATIONS:	N/A
LEGISLATION IMPLICATIONS:	N/A
EQUALITY AND HUMAN RIGHTS IMPLICATIONS:	N/A
RURAL NEEDS:	N/A
SPECIAL ADVISOR COMMENTS:	
RECOMMENDATION:	That you

- Note the Terms of Reference for the RLI at **Annex A;**
- Agree the letter for issue to Care Homes thanking them for their participation and informing them of the planned release of the RLI Report attached for your consideration at **Annex B;**
- Approve the RLI Report at **Annex C.**
- Issue the thank you letter to the Subgroup Chairs attached for your consideration at **Annex D;**
- Issue the thank you letter to the Steering Group and Subgroup members attached for your consideration at **Annex E**.

BACKGROUND

1. The World Health Organisation (WHO) has identified people living in care homes as a vulnerable population, more susceptible to infection from COVID-19 and for subsequent adverse outcomes.[1] The level of risk most likely relates to age and associated underlying long-term conditions. This is compounded by the risks of communal living with unavoidable levels of physical contact from carers and consequent increased probability of contagion across residents and staff.

2. A review of international evidence and initial modelling was completed by the Public Health Agency (PHA) which predicted a potential outbreak of respiratory infections, all likely to be COVID-19 cases, in anything from 160 and 360 (i.e. 33-75%) of nursing and residential care homes here.

3. While the implications for Care Homes of a potential second surge of Covid-19 cases cannot be known with certainty at this time, there is no uncertainty about the longer term vulnerability of residents to the virus.

4. At your request, the Chief Nursing Officer undertook a Rapid Learning Initiative (RLI) to identify the learning from the transmission of Covid-19 into Care Homes during the first surge of the pandemic which I led on her behalf.

5. The definition of Care Homes for the purpose of this initiative is those registered with the Regulation and Quality Improvement Authority as a nursing home or residential Care Home, in accordance with the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. The Terms of reference for the RLI are attached at **Annex A.**

6. You have answered an Assembly Question on the RLI and the Health Committee has expressed ongoing interest. The Report will be shared with the Health Committee once the required approvals have been obtained.

[1] WHO 2020, Infection Prevention and Control guidance for Long-term care facilities in the context of COVID-19 Interim Guidance (21 March 2020)

COMMUNICATION ABOUT THE RLI

7. Members of the Steering Group from the independent Care Home Sector and the Chief Executive of the PCC collaborated with the DOH Press Office to develop a communication plan that helped to shape the communication and engagement actions undertaken during the RLI.

8. The Initiative was publicised through media messaging from DOH, including a press release, social media and a video message. In advance of the RLI work beginning, the Chief Nursing Officer also wrote to all Care Homes in Northern Ireland and conducted a series of online meetings for staff to inform them of the objective of the RLI and to encourage their participation.

9. The work of the RLI is on the DOH website and the Report, along with the underpinning Reports of each of the Subgroups will be also be published on the website following your approval. Under the communication plan, I will also liaise with the DOH Press Office to further highlight the release of the Report with the public.

10. The pandemic came on top of existing and long standing challenges faced within the Care Home Sector. You are asked to agree to issue the letter to the Care Homes following your approval of the Report attached for your consideration at **Annex B**. The letter will be issued through the RQIA to all Care Homes in Northern Ireland to thank them for their participation and inform them of the planned release of the RLI Report.

11. It has been made clear throughout the work of the Initiative that the RLI is not an Inquiry or an Investigation into Covid-19 in Care Homes, nor is it examining any other matter than the learning available from a quality improvement perspective from the transmission of Covid-19 during first surge in Care Homes that can be used to prevent or mitigate the impact during a potential second surge.

12. It has also been made clear that the learning identified is not restricted to the Care Homes but applies across all organisations involved in providing support to Care Homes during the first surge of Covid-19, including the statutory sector.

THE REPORT

13. A copy of the full Report is attached at **Annex C** for your approval. A wide range of stakeholders comprised both the membership of the Steering Group that provided strategic direction and the Subgroups who undertook the work of the RLI.

14. These included DOH officials, representatives from the HSCTs, the PHA, the HSCB, the PCC, the RQIA, the RCN, the CNMAC representative from the Independent Healthcare Sector, the CEO of the Independent Healthcare Providers on behalf of their members and representatives from the independent healthcare sector. Unison provided written input to the Initiative on behalf of their members.

15. The RLI established four Subgroups to look at the following four key areas in Care Homes:
    - The experience of residents, staff and families in Care Homes;
    - Symptom monitoring and intervention and care planning;
    - Infection Prevention Control;
    - Physical distancing of residents (e.g. isolation, cohorting, visiting restrictions, staff turnover, footfall).

16. All the Chairs of the Subgroups are registered nurses. The Chair of the Experience Subgroup is the Regional Lead for Patient Client Experience in the Public Health Agency and the Chairs of the other three Subgroups have considerable experience of working in the independent Care Home Sector.

17. Subgroups took their work forward through a series of surveys and interviews with Care Home residents, families and staff and Care Home Support Team staff in the Trusts. The decision was made to allow the Chair of the Experience subgroup to continue to gather stories until the 31 August 2020. This was to ensure all residents and families interested in sharing their views could do so past the tight timescale of the Initiative due to the richness of information in the experiences being shared and the need for some residents to have support in place to enable them to fully share their story.

18. You are asked to issue a thank you letter to the Subgroup Chairs attached for your consideration at **Annex D**.

19. The time available for gathering data was constrained by the timetable for the RLI. The Report makes clear that, as with any survey, the responses are representative only of the Care Homes who responded and cannot be taken to be representative of all Care Homes across Northern Ireland.

20. The data does, however, provide an indicative picture as data was gathered from both Residential and Nursing homes, across all five Trust areas and from the differing types of registered Care Homes, including Care Homes providing an intermediate care service and those providing care for residents living with Dementia, Learning Disabilities, Physical Disability, Frail Elderly and Mental Health.

21. The responses identified consistent themes to unpick the associated qualitative data that was collected to focus learning, to share good practice and improvement going forward and to highlight areas to explore further.

FINDINGS

22. The Subgroups identified 24 recommendations within the following six themes that can be used to focus learning from the transmission of Covid-19 into Care Homes during the first surge to mitigate the impact on residents and staff of a potential second surge:

- **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 medial 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.

23. The Initiative also identified three overarching structures and processes that will need to be established to support the delivery of outcomes and bring about a learning system that works across Heath and Social Care (HSCNI), including the independent sector and Trusts.

    - At strategic level, the collaborative partnerships established for the purposes of the Initiative should continue and develop further to support future development of Strategy and Policy;
    - A regional learning system should be developed. This should include identifying key quality indicators for Care Homes (led by frontline staff) using real-time data that can for continuous improvement;
    - A quality improvement learning system should include building the capability and capacity within Care Home staff to use continuous improvement methodologies to implement operational improvement as a system.

IMPLEMENTING THE FINDINGS

24. The Report acknowledges that the pathways to achieving many of the recommendations are as yet unclear, challenging in the current pandemic environment and potentially dependant on resources that are not currently available.

25. The timescale for implementation of the recommendations prior to a second surge is also short. Priority will be given to implementing those recommendations that can be done quickly and/or will have the most impact on preventing or mitigating the impact of a second surge of the pandemic in Care Homes.

26. The Report recognises that the desired outcomes will only be achieved with collaborative working with residents and their families, Care Home providers, managers, staff and the HSC organisations who support and commission care to the Care Home sector.

NEXT STEPS

27. In recognition of the rich information obtained through shared experience from residents, families and staff, supplementary information will be developed to reflect many of the stories shared for the purpose of learning and improvement and to provide the evidence base for the development of the recommendations.

28. Following your approval of the Report, the Chief Nursing Officer will write to the PHA/HSCB asking them to

- take account of the recommendations as appropriate to planning for second surge in social care
- adopt a co-production approach and work with the 5 Trusts, the Independent Sector and other relevant stakeholders to co-ordinate the implementation of the recommendations and report back on progress within three months.

INTERFACES WITH OTHER DOH WORK

29. There are a number of other strands of Departmental work that this initiative will interface with including:
    - Social Care policy for care home residents (lead Sean Holland)
    - Acute Care at Home/Care homes (lead Charlotte McArdle, supported by the initial work of Anne Kilgallen CEO Western Trust)
    - Framework to Enhance Clinical Care in Care Homes (lead Charlotte McArdle)
    - Urgent & Emergency Care (lead Alastair Campbell)

I presented the findings of the RLI Report to the Department's Rebuild Management Board on 12 August 2020. The RLI findings will inform their work around Acute Care at Home and the framework for the provision of clinical care in Care Homes. This will include examining how to expand nursing, medical and multidisciplinary support, clinical leadership and specialist skills in collaboration with Care Home staff and will also build on the important role of GPs in Care Homes.

RECOMMENDATIONS

30. That you:
    - Note the Terms of Reference for the RLI at **Annex A;**
    - Agree the letter for issue to Care Homes thanking them for their participation and informing them of the planned release of the RLI Report attached for your consideration at **Annex B;**
    - Approve the RLI Report at **Annex C.**
    - Issue the thank you letter to the Subgroup Chairs attached for your consideration at **Annex D;**
    - Issue the thank you letter to the Steering Group and Subgroup members attached for your consideration at **Annex E**.

Linda Kelly
Deputy Chief Nursing Officer
Nursing Midwifery and Allied Health Professionals Directorate
Extension Irrelevant & Sensitive

CC list: (Copied to relevant officials, and should include Press Office)
Special Advisor
Press Office
Charlotte McArdle

NR

COVID-19 Transmission to and within Care Homes - Rapid Learning Initiative

Task and Finish Group Terms of Reference

Contents

Background

The definition of Care Homes for the purpose of this initiative is those registered with the Regulation and Quality Improvement Authority as a nursing home or residential Care Home, in accordance with the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

International evidence is emerging to show that up to 50% of Covid-19 related deaths are happening in Care Homes[1]. Given that the death rate from Covid-19 amongst the over 70 age group is significantly higher than amongst those under 70, there is a particular need to protect people living in residential care and nursing homes, who are disproportionately drawn from the over 70 population, and frequently also have other underlying complex conditions which place them at higher risk from the effects of Covid-19.

As Covid-19 circulated widely in the community the higher risks of infection being introduced into Care Homes and the associated impact of that for residents and staff became a significant concern and the escalating number of Care Homes with flu like illnesses (FLI) or confirmed Covid-19 outbreaks needed addressed urgently. The implications for Care Homes of a potential second surge of Covid-19 cases cannot be known with certainty at this time. What is known is that Covid-19 represents an active longer term threat to Care Homes. It is therefore incumbent on the health and social care system to explore all options to manage the rate of infection in Care Homes as far as possible to protect those most vulnerable, mitigate potential harm and indeed save lives.

A review of international evidence and initial modelling was completed by the Public Health Agency (PHA) which predicted a potential outbreak of respiratory infections, all likely to be COVID-19 cases, in anything from 160 to 360 (i.e. 33-75%) of nursing and residential Care Homes.

Since the outbreak of the pandemic, a range of measures have been implemented in Northern Ireland to minimise the impact of Covid-19 in Care Homes and to protect Care Home residents and the staff working there. In addition, learning is applied on a daily basis in Care Homes through their ongoing connection with wider system learning via organisations such as the PHA, RQIA and the Trusts.

However, there has been variance in application of the policy and practice changes across the Care Home sector, as well as changes to the detail of formal guidance and advice issued by various sources since the start of the pandemic.

There is also recognition that there is learning for the Department of Health, the RQIA, PHA and the Trusts around support provided to date to Care Homes to manage the transmission of Covid-19 within that Sector.

Purpose of the Task Group

A Task and Finish Group (the Group) has been established to:

[1] https://ltcCovid.org/2020/04/12/mortality-associated-with-Covid-19-outbreaks-in-care-homes-early-international-evidence/

1. Consider the learning to date in relation to the transmission of Covid-19 into and within the Care Home population.
2. Identify the underpinning monitoring and measurement processes that will assist in both understanding the current system and in identifying the appropriate way forward.
3. On the basis of the evidence, to propose recommendations for improvement.

The Group will produce a Report on their findings and recommendations to go to the Chief Nursing Officer for further escalation and dissemination as appropriate.

Aims

Since the start of the pandemic there have been a number of policy and practice measures implemented to prevent Covid-19 transmissions and mitigate the impact of the disease. Further work is required to identify the effectiveness and outcomes of those measures and to identify other safety and experience indicators determined to be significant.

It is crucial that the HSC system examine the good practice that exists and where there are opportunities for improvement to inform policies and practice in Care Homes. To achieve this, the Group aims to:

- Ensure extant policies and practice remain fit for purpose
- Bring together the range of existing systems used to gather and interpret data/ experiences to produce a cohesive set of underpinning data to inform the Report and future monitoring
- Work in partnership within and across the stakeholder organisations to conduct the initiative
- Set out recommendations for improvement and how these can be taken forward collaboratively

The Group will provide their Report to the Chief Nursing Officer by 17 July 2020.

Objectives

Working with key stakeholders the Group will consider the following key areas in Care Homes.

1. The experience of residents, staff and families in Care Homes
2. Symptom monitoring and intervention and care planning
3. Infection Prevention Control
4. Physical distancing of residents (e.g. isolation, cohorting, visiting restrictions, staff turnover, footfall)

Through a number of subgroups the Group will:

- Review the development of extant policy and practice within Care Homes during the Covid-19 pandemic for relevant learning;
- Develop monitoring and measurement processes that will assist in understanding the current system;
- Develop a learning system that will facilitate scale and spread, seeking to identify early evidence as it becomes available, in real-time in order to scale and spread those measures which demonstrate impact in controlling Covid-19 impact on Care Home residents and staff;

- Produce a Report with recommendations going forward.

Working in partnership

The Department of Health launched its Co-production Guide "Connecting and Realising Value through People" in August 2018 and remains committed to partnership working.

Partnership working is a highly personalised approach, predicated on valuing and utilising the contribution of all involved and using their different strengths, knowledge, expertise and resources in order to work collaboratively and supportively to deliver improvements to personal, family and community health and wellbeing outcomes that can be embedded and cascaded to benefit everyone.

The Group commits to using a partnership approach.

The Steering Group

Details of the structure for the Initiative can be found at Annex A.

Responsibility for the progress and completion of Initiative and production of the report will lie with the Task and Finish Group.

A Steering Group has been established to provide advice and support and to monitor the work of the subgroups. The Steering group will be chaired by Linda Kelly DCNO and be comprised of the chairs of the subgroups ensuring key policy areas and organisations are represented. It will report to Charlotte McArdle CNO. Further details of the Steering Group can be found at Annex B.

Subgroups will be established to take the lead and provide expert advice to the Steering Group on the areas of specific areas of

1. The experience of residents, staff and families in Care Homes
2. Symptom monitoring and intervention and care planning
3. Infection Prevention Control
4. Physical distancing of residents (e.g. isolation, cohorting, visiting restrictions, staff turnover, footfall)

Where members are unable to attend they should nominate a suitable Deputy with the authority to speak and make decisions on behalf of their organisation.

The Chair of the Steering Group may establish any further Subgroups considered necessary as the work of the Initiative develops.

The Group will meet as required, but no longer than 14 days apart

Secretariat for the Steering Group will be provided from within the Nursing and Allied Health Professionals Directorate of the Department of Health.

The Subgroups

Subgroups will take the lead on their specific areas and provide expert advice and recommendations to the Steering Group.

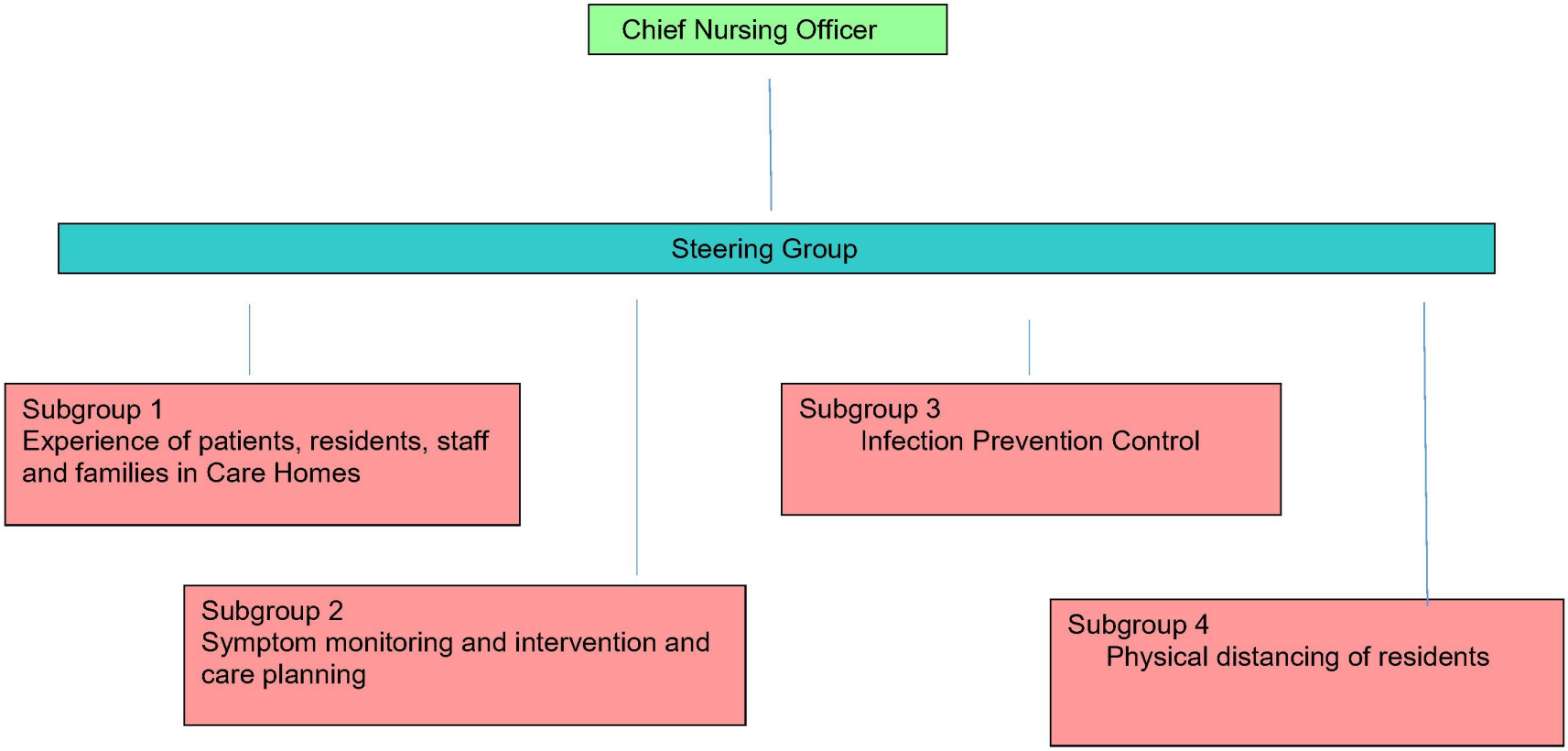
Further details of the Subgroups can be found at Annex C.

Where members are unable to attend they should nominate a suitable Deputy with the authority to speak and make decisions on behalf of their organisation.

Decisions should ideally be based on consensus but in absence of consensus will take decisions by majority vote

The Subgroup will meet as required.

STRUCTURE **Annex 1**



Annex 2

STEERING GROUP

Name	Role	Organisation
Linda Kelly	Chair	Deputy Chief Nursing Officer DOH
NR	Deputy Chair	Nurse Advisor DOH
NR	Member	NMAHP
NR	Secretariat	NMAHP
Aideen Keaney	QI Lead	HSCQI
Mark Lee	Member	Elderly and Community Care DOH
Names Redacted	Stats	IAD
	Sub-group Chair	Experience
	Sub-group Chair	Symptom monitoring and intervention and care planning
	Sub-group Chair	Infection Prevention Control
	Sub-group Chair	Physical distancing of residents
Kathy Fodey	Member	PHA
Deborah Oktar-Campbell	Member	Bloom Health and Wellbeing Hub
Pauline Shepherd	Member	CEO ihcp
Jennifer Mooney	Member	Elderly and Community Care DOH
Jillian Martin	Member	DOH
Cathy Harrison	Member	Chief Pharmaceutical Officer - DOH
Brendan Whittle	Member	Deputy Director of Children and Social Care – HSCB
NR	Member	HSCNI
Vivian McConvey	Member	Patient and Client Council
Pedro Delgado	Member	Institute of Healthcare Improvement
Susan Hannah	Member	Institute of Healthcare Improvement
Angela Zambeaux	Member	Institute of Healthcare Improvement
Name Redacted	Member	Assistant Director, RQIA – joined 23/6/2020

Annex 3

SUB GROUPS

Subgroup Name	Key actions responsible for	Members
Experience		NR, PHA Ruth Burrows, Four Seasons NR, NHSCT Bereavement Officer Name Redacted RQIA NR SET Nursing Governance Lead NR DOH NMAHP NR DOH NMAHP NR NHSCT Care Home Support Team Ruth Johnston, Nicholson House Aine Morrison, DOH NR HSCNI NR AD of Nursing Northern Trust Johny Turnbull, Involvement Services Programme Manager, PCC
Symptom monitoring and intervention and care planning		**Chair: Carol Cousins**, Independent Sector, CNMAC Names Redacted, BHSCT Care Home Support Team SET QI Lead AHP e-Health Professional Advisor SHSCT Care Home Support Team Linda Kelly, DOH DCNO NR PHA Health Protection Nurse NR WHSCT AD of Nursing Janice Brown, Four Seasons–Regional Ops Manager Cherith Rogers, Priory Group NR, HSCNI Jane Sagayno, Hockley Nursing Home Una McDonald, East Eden Group Susan Hannah, Institute of Healthcare Improvement

IPC		**Chair:** NR, PHA Nurse Consultant for Care Homes Names Redacted, AD PHA , AD of Nursing Northern Trust NR Dickson, SET Interim AD of Nursing NR DOH NR, SHSCT lead nurse IPC NR, WHSCT NR, SEHSCT Jonathan McCleery, Four Seasons - Health & Safety Manager Linda Graham, Spa Nursing NR NHSCT Innovation & QI Lead NR HSCNI Pedro Delgado - Institute of Healthcare Improvement
Physical distancing of residents (e.g. isolation, cohorting, visiting restrictions, staff turnover, footfall)		**Chair:** NR, Senior Nurse Professional Practice, RCN Aideen Keaney, HSCQI Director NR BHSCT NR DOH Elderly and Community Care NR, DOH Nursing Officer NR SEHSCT NR, SEHSCT AD Older Peoples Services Louisa Rea, Four Seasons Connie Mitchell, Aughnacloy House Jillian Martin, DOH Seamus McErlean, HSCNI Teresa McClean, Corriewood Nursing Homes

Annex B

Draft letter for issue to Care Homes

The people you provide care and support for every day are already among our most vulnerable in society. My respect for you and for the level of care and support you are providing to them during the unprecedented challenges of Covid-19 is a matter of record and I am pleased to have this opportunity to share that with you once again.

The impact of Covid-19 in countries across the world is unparalleled but that impact is about more than health and social systems, as critical as that impact has undoubtedly been. It is also about the impact on people who use them and who work in them.

As knowledge of the virus has grown, it has become all too clear from its global impact that people living in Care Homes are also among the most vulnerable to the devastating consequences of Covid-19. I truly understand that for residents, their families and staff in Care Homes the human cost of the pandemic has been overwhelming.

That is why I asked the Chief Nursing Officer for Northern Ireland to undertake a Rapid Learning Initiative into the learning from a quality improvement perspective from the transmission of Covid-19 into Care homes during the first surge of the pandemic that could be harvested and used to prevent or mitigate the impact of the potential second surge within Care Homes.

That learning simply could not be lost to the wider health and social care system, lives may literally depend on it. Your voice, as the people at the epicentre of working to manage the first surge of the pandemic in Care Homes has to be heard and I am grateful to all of you that took the time to share your knowledge with the Rapid Learning Initiative, particularly as you continue to face the challenges Covid-19 on a daily basis.

The Report of the Rapid Learning Initiative will be publicly available on the Department of Health website. The Report describes areas where you have said things worked well during the first surge of Covid-19 in Care Homes and where you have said improvement needs to happen prior to the next potential surge.

What you also said, very clearly, is that we must all work together and actively reach across boundaries between the independent and statutory sector and between professions and organisations to work in a new way to protect the health and wellbeing of our loved ones and those providing their care.

I wholeheartedly agree with you. The Chief Nursing Officer has asked the Public Health Agency to work in collaboration with Care Homes to take forward the recommendations of the Rapid Learning Initiative as a matter of urgency and I would encourage all of you to embrace this opportunity to be partners in that process.

The profound consequences of the first surge of Covid-19 for the physical and mental health of people living in Care Homes are at the heart of this Initiative. I want you to ensure that you inform them and their families of the release of this Report, how they can access it and, where needed, that you provide them with appropriate support to understand its findings and what the recommendations will mean for them.

Annex C

THE RAPID LEARNING INITIATIVE INTO THE TRANSMISSION OF COVID-19 INTO AND WITHIN CARE HOMES IN NORTHERN IRELAND

-REPORT OF THE TASK & FINISH GROUP

CONTENT

ACKNOWLEDGEMENTS

This Rapid Learning Initiative would not have been possible without the people who gave of their time, experience and knowledge to produce the Report.

The voice of residents, their families and staff in Care Homes was invaluable. Their experiences were powerful, and while often difficult for them to convey, we deeply appreciate their willingness to openly and honestly share their stories.

We also appreciate the willingness of all those who were involved in providing support to the Homes to share their learning or their views openly and honestly with the Steering Group, about what worked well and where improvements could be made prior to the predicted second surge of Covid-19 in Care Homes. We would like to thank the Department of Health, The Health and Social Care Trusts, The Public Health Agency, The Health and Social Care Board, The Patient and Client Council, The Regulation and Quality Improvement Authority, The Royal College of Nursing, the CNMAC representative from the Independent Healthcare Sector, the CEO of the Independent Healthcare Providers on behalf of their members, UNISON and representatives from the Independent Healthcare Sector.

We would also like to acknowledge the work of the Chairs of the four Subgroups and their members. Their commitment to the work of this Initiative was fundamental in enabling the learning from the transmission of Covid-19 into Care Homes during the first surge of the pandemic to be identified and used to mitigate the impact of a potential second surge on the wellbeing of residents and on the staff who are providing their care.

Linda Kelly, Deputy Chief Nursing Officer
Chair of Steering Group

1.0 FOREWORD

The global impact of Covid-19 is unprecedented as are the challenges it has placed on those providing health and social care and the wider network of systems they work within. Across the world, Covid-19 has proven to be particularly fatal for some of our most vulnerable in society, those with the characteristics that are typical of Care Home residents. That has equally been the case in Northern Ireland.

While we continue to manage the practical implications of Covid-19 for Care Homes going forward, we must never forget that at the heart of the impact of Covid-19 lies not systems but a very real human cost, of lives lost, of serious illness and the wider impact on their families and staff providing care.

This Rapid Learning Initiative considers learning that cannot be lost to the wider health and social care system as we seek to keep Care Home residents and staff safe, physically and mentally, in advance of anticipated further surges in Covd-19 infection. In seeking to improve we must not lose sight of what did work well. In particular, the commitment and professionalism shown by Care Home staff, those providing support to them and the standard of care and compassion provided to residents and their families by staff within the Homes, particularly around end of life care is widely acknowledged.

The voices in the system must be accessible to the system if we are going to deliver the improved experiences and outcomes that we need. I am on record many times saying how fundamentally important it is to work in partnership. The voices of residents, families, staff and those who provided support to Care Homes were invaluable in the production of this Report. I am also delighted at the wide range of organisations that took part, an indication of the willingness of all involved to reflect on the learning for their particular organisation.

I would like to extend my personal thanks to all those who provided their time and knowledge through membership of the Groups that undertook or guided the work of the Rapid Learning Initiative or provided the underpinning data in the surveys. My intention is that the partnerships that were built during this work will provide the foundations for increased collaboration as we go forward with other strategic work involving the Care Home sector, in particular this will include the work I am leading to develop a framework for a clinical care pathway for Care Homes.

Charlotte McArdle
CHIEF NURSING OFFICER FOR NORTHERN IRELAND

2.0 INTRODUCTION

This Report provides the findings of the Rapid Learning Initiative (the Initiative) with regards to the transmission of Covid-19 into and within Care Homes during the first surge of the pandemic, and makes recommendations on the way forward prior to further potential surges of infection.

At the request of the Minister of Health, the Chief Nursing Officer established a Task and Finish Group to take forward the Initiative to assist in both understanding the system going back to 6 February 2020 and in informing the appropriate way forward with policy and practice to protect those most vulnerable in society.

The Initiative adopted a collaborative approach between HSC organisations, the Independent Sector and Users to produce knowledge as quickly as possible over a three month period to identify recommendations for action.

There was a recognition that a tight timescale existed for the system to hear the voices of Care Home staff, families and residents to:

- Learn from the changes already implemented within the health and social care (HSC) system and the Independent Sector ;
- Identify the impact of the interventions to date on Covid-19 transmission within Care Homes
- Develop recommendations to spread and embed good practice across Care Homes across the region of Northern Ireland

The Initiative is a specific, defined exercise over a 3 month period and is in addition to ongoing improvement activity already being undertaken by Care Homes and Health and Social Care Trusts in relation to the first surge of Covid-19. The report has considered the information provided though listening to the experience of those who lived and worked in Care Homes and made recommendations for improvement. This information cannot be considered a full representation of all Care Homes across Northern Ireland but rather the experience of the residents/families and staff from the Care Home who responded to the survey.

3.0 DEFINITIONS

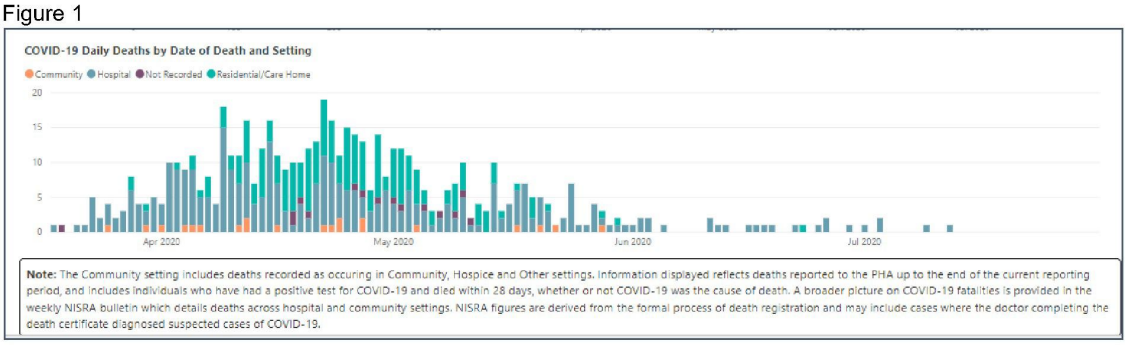
The definition of Care Homes for the purpose of the Initiative is those registered with the Regulation and Quality Improvement Authority as a nursing home or residential Care Home, in accordance with the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

4.0 CONTEXT

There is widespread recognition that the clinical presentation and related dependency of residents in our Care Homes have been changing and increasing in complexity for a number of years. This includes people who are receiving care in nursing homes that would previously only have been available in a hospital setting. There has been much debate about the nature, size and skills of the Care Home workforce needed to deliver this care, now and in the future. These pre-existing challenges, combined with the speed and impact of the transmission of Covid-19 within Care Homes as the first surge

took hold, has taken its toll on residents, families, and staff working in the Homes. Figure1 from the DoH NISRA Dashboard displays the deaths over time by setting.

Figure 1

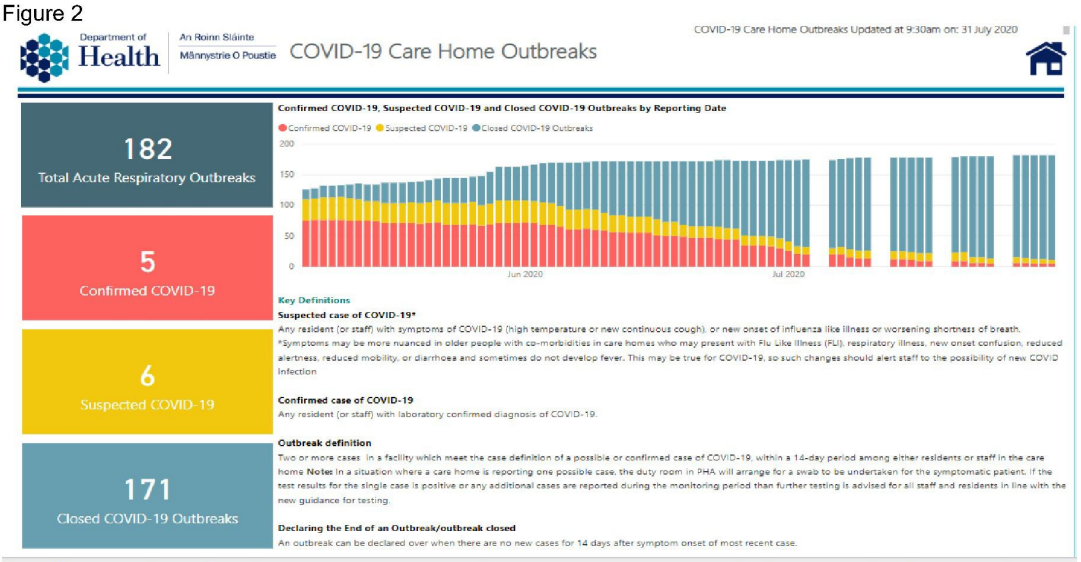


https://app.powerbi.com/view?r=eyJrIjoiZGYxNjYzNmUtOTlmZS00ODAxLWE1YTEtMjA0NjZhMzlmN2JmIiwidCI6IjljOWEzMGRlLWQ4ZDctNGFhNC05NjAwLTRiZTc2MjVmZjZjNSIsImMiOjh9

The impact of the virus on physical health has been matched by an increasing recognition of the negative effect on mental and emotional health across the world. In Care Homes, residents have been unable to receive visits from their loved ones to protect them from a virus that disproportionately targets their age group. Staff have met increased care needs with often reduced resources amidst the challenges of protecting themselves from infection and the possibility of transmitting Covid-19 to others.

Since the outbreak of the pandemic, a range of measures have been implemented in Northern Ireland to minimise the impact of Covid-19 in Care Homes and to protect Care Home residents and the staff working there. In addition, learning is applied on a daily basis in Care Homes through their ongoing connection with wider system learning via organisations such as the PHA, RQIA and the HSC Trusts. Figure 2 taken from the DoH NISRA dashboard demonstrates the journey the Care Homes have experienced in terms of cases of Covid-19 diagnosis as of 31st July 2020

Figure 2



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Whilst much good has been achieved, there has been variance in application of the policy and practice changes across the Care Home sector and HSC Trusts, as well as changes to the detail of formal guidance and advice issued by various sources since the start of the pandemic.
There is also recognition that there is learning for the Department of Health (DoH), the Regulation and Quality Improvement Authority (RQIA), the Public Health Agency (PHA), the Health and Social Care Board (HSCB) and the Health and Social Care Trusts (HSCTs) around support provided to date to Care Homes to manage the transmission of Covid-19 within that Sector.

5.0 AIM OF THE INITIATIVE

Prior to any potential further surges, it is critical that what has worked well and what can be improved is examined across the health and social care system as a whole to inform practice and policies going forward in relation to the transmission of Covid-19 into and within Care Homes.
To achieve this, the Group aimed to:

- Ensure existing policies and practice remain fit for purpose
- Bring together the range of existing systems used to gather and interpret data/ experiences to produce a cohesive set of underpinning data to inform the Report and future monitoring
- Work in partnership within and across the stakeholder organisations to conduct the initiative
- Set out recommendations for improvement and how these can be taken forward collaboratively

6.0 SCOPE OF THE INITIATIVE

The Initiative is not a research project, a Review, Investigation or an Inquiry into other matters relating to Covid-19 or to the Care Home sector. It is a first step to understand the impact of the range of interventions implemented aimed at preventing/mitigating the transmission of Covid-19 from a quality improvement perspective. Information and data gathered therefore will be indicative of personal experiences to identify practical recommendations to assist preparing for a second surge and managing the on-going pandemic

7.0 COLLABORATIVE WORKING

As described in Delivering Together, working in partnership is critical to delivering improvements in experiences and outcomes. Those with lived experience, their families and the communities they live within, those developing policy at regional and local level, those regulating and those supporting Care Homes must harness their individual strengths and knowledge to meet the needs of residents and the staff providing their care.

Governance was structured through a Steering Group and four supporting Subgroups. Three of the four Subgroups Chairs were selected because of their expertise in the

Care Home sector and the fourth Chair has expertise in capturing the service user voice. A representative membership was secured across a wide range of HSC and Independent organisations. The Steering Group and the Subgroup were supported by the Institute of Healthcare Improvement (IHI), a global organisation that applies and teaches the science of improvement to generate learning, innovation, and to improve health and health care in a sustainable way.

7.1 The Steering Group

The Steering Group had responsibility for the progress and completion of the Initiative and the production of report, for providing advice and support to the Subgroups and for monitoring their work.

7.2 The Subgroups

Four Subgroups were established to lead on specific areas of learning relating to management of the first surge of Covid-19 pandemic and provide recommendations to the steering group. Each Subgroup worked together to develop their Terms of Reference which were then approved by the Steering Group.

The four key areas of focus were:

5. The Experience of residents, families and staff;
6. Symptom monitoring, intervention and testing;
7. Infection prevention and control;
8. Physical distancing, reduced footfall and restricted visiting.

The details of the governance structure for the initiative, including the terms of Reference, and memberships of the steering group and Subgroups can be found on the DOH Website – https://www.health-ni.gov.uk/rapid-learning-initiative

8.0 COMMUNICATION AND ENGAGEMENT

A communication plan helped to shape the communication and engagement actions in collaboration with the DOH Press Office. The Initiative was publicised through media messaging from DOH, including a press release, social media and a video message.

The Minister of Health has made several references to the work of the Initiative, both in press releases and at formal briefings. The Chief Nursing Officer wrote to every registered Nursing and Residential Care Home to provide information about the newly announced clinical framework for Care Homes and the Initiative, and to encourage their participation. CNO letter to Care Home Sector.

In addition, every registered Care Home was invited to participate in one of a number of virtual briefing sessions regarding the Initiative. These were led by CNO and facilitated by IHI. There were 95 unique log-ins for the briefings, most which facilitated more than one person, so a conservative estimate of this aspect of engagement with the Care Homes sector is around 150 participants.

The work of the Initiative was taken forward through a range of surveys and interviews conducted in line with the guidelines in relation to Covid-19. (Online and hard copy)

1. **Experience Survey** This was undertaken using the established methodology used by the Public Health Agency - 10,000 More Voices. Through three separate bespoke surveys, this group sought the experience of residents, families and staff. At the outset it was recognised the experiences of Care Home residents and families during the first phase of the Covid-19 was critical. Due to the restrictions around access to Care Homes, gathering the views of residents was recognised as particularly challenging. A range of methods were used to ensure the voice of residents, relatives and staff was captured. This included a printed easy read version and an online survey.

2. **Citizens Space Survey**. Every registered Care Home received an invitation to complete the on-line survey which focussed on symptom management, infection prevention control and physical distancing. This Northern Ireland Civil Service survey tool was used to seek the views of Care Home managers and the Care Home Support Teams in the five HSC Trusts.
   Responses were received from Care Homes registered across each of the five HSC Trust areas. Annex 5 provides details of the number of responses from Nursing Homes and Residential Care Homes, both independent provider and statutory facilities, and the registration category which explains the type of care provided and the resident population of the Care Home.

   A total of 70 responses were received from registered Nursing and Residential Care Homes. Each respondent Care Home was then given the opportunity to indicate if they wished to participate further in a one to one qualitative interview. This aimed to gather more in-depth information to help shape the recommendations of the Subgroups. Approximately 60% of Care Homes indicated that they would like to participate further, and one to one qualitative interviews ("deep dive sessions") took place with 39.5% of those respondents.

9.0 UNDERPINNING DATA

The goal of the surveys was to highlight areas where learning could be identified: what worked well and didn't work well, plus what we could have done better during the Covid-19 outbreak. The desired outcome was to aid in the spread of good practice and to target improvement actions across all statutory organisations and the independent sector.

All 483 Care Homes were targeted with the questionnaires and all five Trust Care Home Support teams were approached

9.1 Response Rate:

Table 1.

EXPERIENCE SURVEY (on 27th July 2020)	RETURNS
Residents	385
Relatives	81
Staff	112

CITIZEN SPACE SURVEY	RESPONSES
Care Home Managers	70**
Care Home Managers -Indication for participation in second stage interview	42
HSCT Care Home Support Team	3

** 483 registered nursing and residential homes @ 01/06/20 – 14.5% response rate

Both surveys opened on 30th June 2020. The tight timescales of the initiative resulted in the Citizen Space survey closing on the 12th July 2020 and the Experience survey remained open for an extended period to ensure residents, relatives and staff had every opportunity to share their story through the survey.

9.2 How the data should be considered

As with any survey, the responses are representative of the Care Homes who responded. They cannot be taken to be representative of all homes across Northern Ireland. As indicative data it is very useful in highlighting areas to explore further and to unpick the associated qualitative data that was collected. The Citizen Space data was considered alongside the qualitative data received from the Experience Surveys and virtual face to face interviews with residents, families and staff. This provided an indicative picture and identified themes to focus learning, and to share good practice and improvement going forward. The responses collected should be considered in light of the following context.

9.3 Strengths

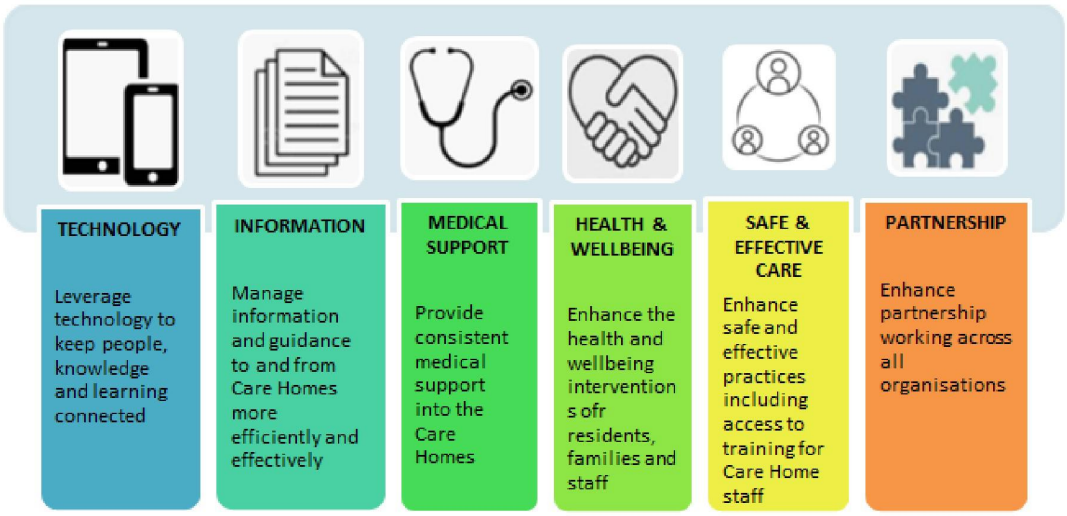
- The survey gathered responses from both Residential and Nursing homes, across all five Trust areas.
- These responses were received from the differing types of registered Care Homes, including those that provide care for residents living with Dementia, Learning Disabilities, Physical Disability, Frail Elderly and Mental Health. Responses from Care Homes providing an intermediate care service were also received. Unpicking qualitative data from these differing types of Care Homes may prove useful
- The survey provided the opportunity to identify operational issues as well as personal experiences of those working in services and from those recieving care
- Responses gathered help to highlight areas of interest to investigate further

9.4 Limitations

- Due to the rapid nature of the data gathering it was not possible to fully test the questions before the survey was issued. Questions were, however, checked with stakeholder representatives on the Subgroups and with existing patient experience stakeholder groups within Trusts to ensure they would be clearly understood by survey participants. The response rate for the Citizen Space survey was low in statistical terms however we recognise this was during a period of an on-going pandemic. The responses and the learning identified through those responses was consistent and has enabled the identification of themes that will form the basis of improvment opportunities going forward.

10.0 SUBGROUP OUTCOMES

The Subgroups identified the following six themes from the first stage of the Covid-19 that can be used to focus learning and relevant actions within the continued pandemic response. The key findings for each subgroup are illustrated using the words of residents, relatives and staff shared in the narrative of all the surveys.



10.1 SUBGROUPS OVERVIEW

Subgroup 1 – The Experience of Residents, Families and Staff

The work of Subgroup 1 was undertaken through the Public Health Agency "10,000 More Voices" initiative to gather the views of the public about the health and social care services provided to them. Three separate, tailored surveys were developed to obtain the views of residents, families and staff through a link hosted on the PHA website. All survey returns were anonymous with no personal identifiable detail recorded. All returns were collated on the Sensemaker® Analyst Online programme by 10,000 More Voices team to support the analysis and identify key themes shared by the residents, relative and staff.

It was recognised from the outset that obtaining the views of residents would be particularly challenging given the ongoing restrictions due to Covid-19. To enable as many residents as possible to participate, printed copies of surveys with stamped addressed envelopes were sent to every Care Home in Northern Ireland. They could be completed by residents; where required residents could be supported to complete the survey by a relative, their activity coordinator or any healthcare professional. The 10,000 More Voices team were also available to provide support in completing the survey through a telephone call or video conference. Relatives and staff were able to access the survey through the online product found at the website www.10,000morevoices.hscni.net. Printed surveys, easy read products and video conferencing were also available to support relatives. Emotional support and signposting were made available to relatives through the Patient Client Council Client Support service as many relatives shared personal emotional experiences, in particular in relation to bereavement.

The messages received through all the surveys were strongly expressed. The importance of the voices of the lived experience is recognised as being hugely important. For this reason the Experience Surveys will remain open until 31 August 2020 to provide further opportunity for residents, relatives and staff to share their

experiences. These additional responses will be captured in a published, comprehensive analysis report by the PHA 10,000 More Voices team.

Within the analysis of the surveys submitted there were very clear messages which resonated across the stories of the residents, relatives and staff. A primary challenge was the ability to stay connected with the resident. Throughout the stories shared by families, strategies embraced to ensure residents could stay connected with their families were celebrated – Care Homes offering telecommunications, alternative arrangements for visiting and regular updates from staff, provided reassurance around the health & wellbeing of the resident. However these opportunities were not always offered or available in all Care Homes due to limited access, technology or support; this intensified family concerns for the health & wellbeing of their relative in the Care Home, in particular for residents with complex communication needs.

"...The home instigated video calls quite early on, & later, visiting at the window, both of which were a huge relief to me, just to be able to see him & for him to know that I hadn't just disappeared."

-words of a daughter

"...It is difficult for residents in the Care Home who do not see their relative. Some residents feel abandoned. One in particular stands out. Her daughter would facetime her on the mobile, but when she saw her daughter, the memories seemed to flood back and she would begin to sob – 'is that my daughter''

-words of a Care Worker

Also challenges were evident in supporting residents with cognitive impairment (for example, dementia) where technology was not always an answer – relatives shared anxieties in relation to decline in health and wellbeing and intense frustrations they could not connect with the resident. There was also discontent at the inability to stay connected with the wider HSC system with frustrations around the lack of medical support and limitations in engaging with other healthcare professionals

"... many of our residents in Care Homes have dementia. They don't understand how to video call and face time. They can't focus to hold a conversation on the phone of any length or which involves coherent conversation. They did not have modern technology..."

-words of a Care Home Manager

... COVID-19 has made my experience more difficult ecause visits were stopped and I felt isolated. Other residents have been able to continue to connect with each other whilst abiding by social distancing rules but I need to lip-read.... I've been even more lonely than before, staying in my room for everything, including meals... I've also lost all access to my Church during COVID and my faith is not being nurtured..."

-words of a Resident

Another strong message was the importance of leadership by Care Home managers during the pandemic and the vital teamwork required by staff to support residents and relatives. A number of residents and relatives recognised the staff sacrifices to ensure best possible care was delivered; however where relatives did not receive communications from the Care Home manager or the wider system they felt ignored and disconnected. Staff responses also gave insight into the extreme challenges faced on a daily basis - areas for reflection and development include delays in guidance regarding PPE in Care Homes, challenges within the workforce and impact of death of residents on the staff. In these stories staff reflected upon both the support offered and the challenges faced by the Care Home Manager.

"...As a manager it was a terrible emotional and heart-breaking experience, I was making decisions for my whole home and lacking support and guidance. My major issues were the lack of PPE and ensuring my residents and staff were properly protected. It wasn't until the beginning of May when I had full PPE for a week. At the start, and somewhat still, being bombarded with emails and unclear advice, staff wanting me to answer all questions when I was very much scared too..."

-words of a Care Home Manager

"I have been well looked after – the girls and guys have done everything could possibly do in such awful times. They look so warm in all their PPE. I am very grateful for them. They have kept me safe."

-words of a Resident

"I missed seeing my family... my son is high risk so hasn't been to visit me since lockdown began. I've had a few social distance visits with my daughter, but it is not the same because she has to wear the mask and I hate not being able to hug her... the staff have been great and kept us positive.."

-words of a Resident

"We shut down early. Families worked with us and were super supportive. Families had such confidence in us especially after some bad media came out about some homes handling of the coronavirus".

-Care Home manager

"I only came to the Care Home in the beginning of the pandemic. It has changed my life a lot – I wasn't able to go through proper physiotherapy treatment because of restrictions of visitors (medical staff)".

-words of a Resident

"…Frustrating was how I/we as a family felt during the whole experience. We were getting mixed messages from the home depending on who was giving the information. We even wondered at times of they knew who the person was we were asking about. Even on the day she died the home caused additional anxiety which there was no need to do…"

10.3 Key Findings of Subgroup 1 as per theme

The following key messages represent the voices of the residents, relatives & staff who shared openly their experiences during the COVID-19 pandemic

- Strategies to support residents to remain stimulated and engaged with their environment are vital important to support their health and wellbeing. For relatives of residents with cognitive impairment this is highlighted as a priority.
- The use of technology during COVID-19 had both positive and negative impact upon residents, relatives and staff
- Strong leadership from Care Home managers & teamwork are essential in supporting the health & wellbeing of staff and to delivering safe & effective care
- Official information and guidance regarding management in the Care Homes was not consistently shared with residents and families
- Residents reflected upon the absence of medical support and management

Subgroup 2 - Symptom Monitoring, Interventions and Testing

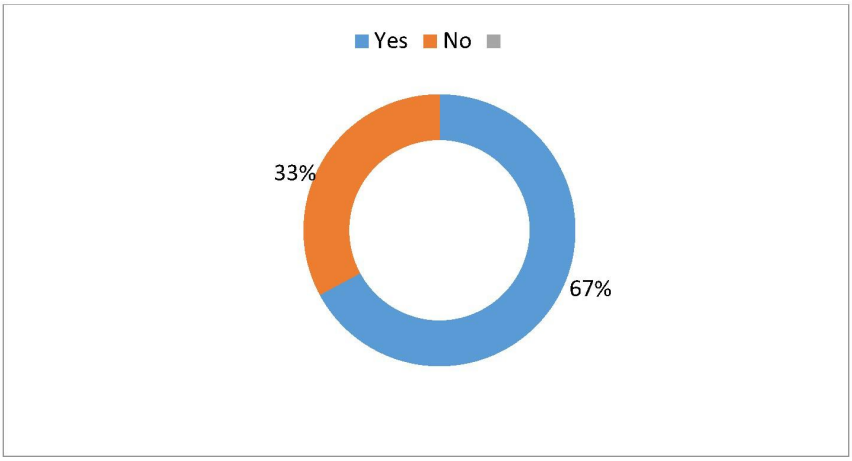
This subgroup looked at enabling appropriate clinical decision making, recognising signs of deterioration and providing care and treatment for Care Home residents during Covid-19. This was critical to the prioritisation and management of residents who became unwell.

Staff described how they managed individual resident's risk assessment and anticipatory care planning which included decisions on whether to transfer to hospital. The partnership working was considered between Care Home staff with GPs and Care Home staff and the Trust Multidisciplinary Care Home Support Teams and the impact of using a range of approaches including face to face, virtual and telephone discussions/consultations.

Many Care Home staff are skilled in managing acutely unwell residents but this is not universally the case, particularly in residential Care Homes which are not staffed by Registered Nurses. The PHA outbreak pack which provides guidance on identification and management of infectious/ virus outbreaks was revised on a number of dates with the latest update issued on 3 June 2020. A symptom identification checklist also issued on 3 June 2020 which indicated the subtle signs of deterioration to guide staff in the recognition of Covid-19. This was not within the outbreak pack and identified by survey respondents as being issued "too late"; Care Home staff indicated that at 3 June 2020, they had been caring for residents with a range of typical and atypical Covid-19 related symptoms for some time and that the peak of the pandemic had passed. Before the introduction of testing for residents being admitted to or returning to their Care Home, respondents indicated some newly admitted residents, and indeed some residents who remained within the Care Home did not present with typical Covid-19 symptoms set out by PHA. On reflection those "soft" signs of Covid-19 and the range of symptoms now known as indicators of Covid-19 may have been present with these residents.

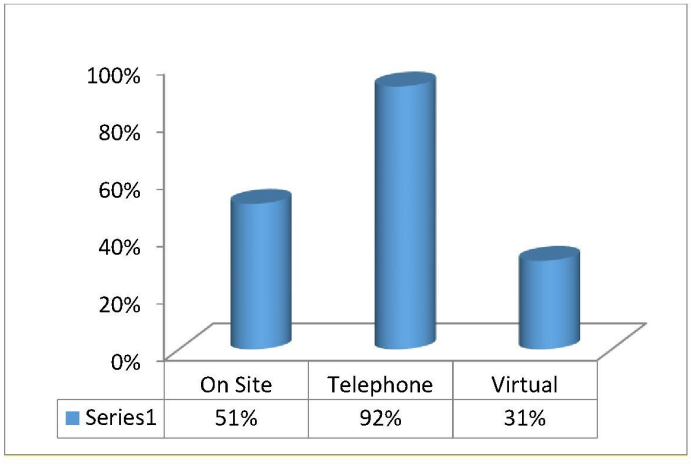
Of the 70 respondents to the survey, 67% indicated that their Care Home had the necessary clinical equipment in sufficient quantities to monitor clinical symptoms adequately. This included pulse oximeters and thermometers. Of those who did not have sufficient equipment 39% were Residential facilities. One respondent indicated that even when they got the equipment staff were unsure how to use it or interpret the results. This is illustrated in Figure 3.

Figure 3. Did the Care Home have the necessary clinical equipment in sufficient quantities to carry out clinical observations in suspected or conformed COVID-19 cases?



Care Home staff needed to feel supported in their decision making regarding residents who were unwell. Whilst the survey identified that 49 of the 70 Care Homes felt they had appropriate clinical support to meet the increased acuity of care needs for residents affected by Covid-19, a number of respondents told us that access to a GP was difficult particularly in the early days of the pandemic. Some respondents indicated they did not require assistance as they had no Covid-19 positive cases. Of those who did require assistance, 73% indicated they had timely access to medical support; however, the support offered was mainly via telephone. This is illustrated in Figure 4.

Figure 4. Method of Clinical Support provided

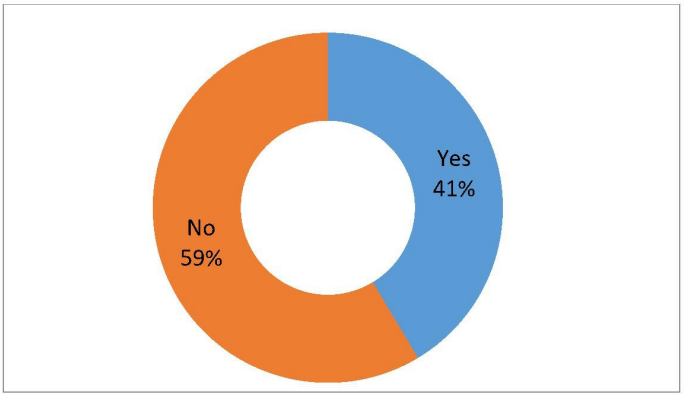


Dr's wouldn't come to see the resident and we asked to have resident admitted to hospital. This was declined. Oxygen concentrator was sent. I came across an email from SE trust with a level 6 nurse I knew, I rang her and she was absolutely brilliant"

-words of Care Home Manager

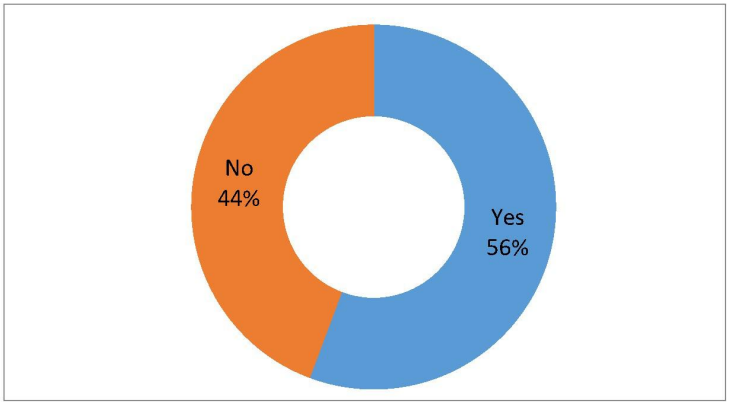
Of the 70 respondents to the survey 59% indicated that they did not receive guidance on formulating Covid-19 individual resident risk assessment and care plans as illustrated in Figure 5. Care related Covid-19 risk assessments and care plans are important as Covid-19 affects every person differently and needs to be considered in the context of their individual medical history. The care plan should set out the plan for symptom management, interventions, MDT input, outcomes expected and be shared with resident/family. This will be linked to an anticipatory care plan and any agreed End of Life plan.

Figure 5. Did your Care Home receive guidance on formulating COVID-19 individual resident risk assessment and care plan?



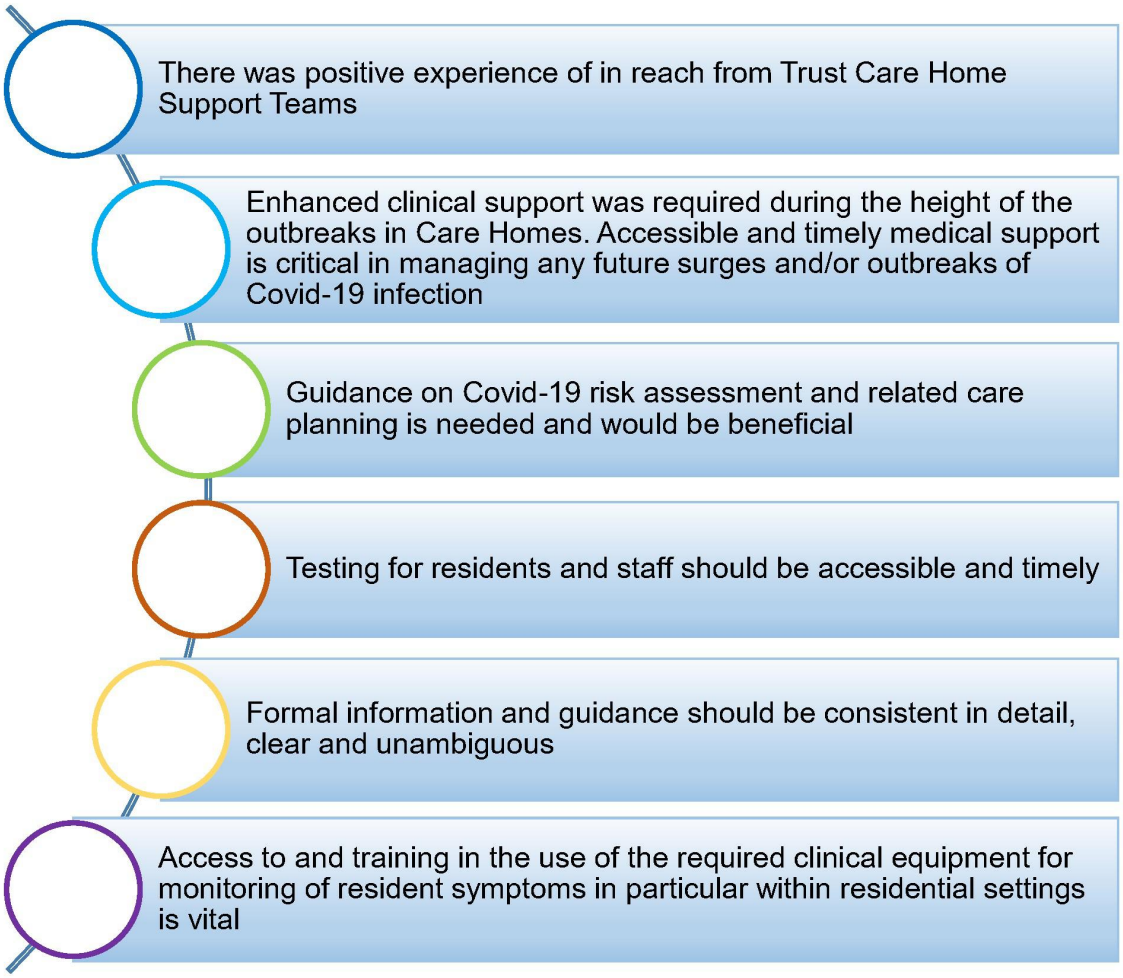
In relation to testing, if a staff member or resident are suspected of having Covid-19 swab tests for the SARS-CoV-2 virus should be taken and sent as soon as possible and the individual is required to isolate as per formally issued guidance. Illustrated in Figure 6 a number of Care Homes raised the issue regarding staff testing with just 56% having access to testing at the onset of first symptoms with one respondent stating that access to testing "was a major logistical challenge". Another respondent stated that "No testing was available for staff who were first symptomatic on 17.03.20, first staff member to access test was on 10.04.20". Once a testing regime for staff was introduced, the main challenge for Care Homes was the different and changing routes for staff testing referrals.

Figure 6. Access to staff testing at onset of first symptoms



10.5 Key Findings of Subgroup 2 as per Theme

The following key findings summarise the rich data explored as part of the survey returns and semi-structured interviews.

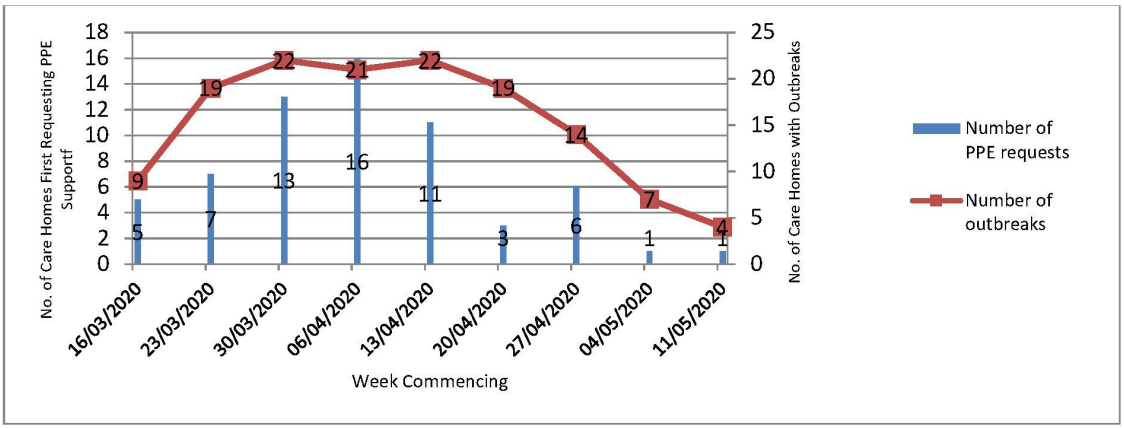


10.6 Subgroup 3 Report - Infection Prevention & Control

Subgroup 3 considered matters around Infection Prevention Control, including whether Care Homes had a stock of emergency PPE prior to the COVID-19 pandemic and when Care Homes first required support from a stock of PPE in Trusts. Good hand hygiene practice, sufficient access to hand hygiene facilities and enhanced cleaning procedures were also considered.

Of all respondents from Care Homes 86% had an emergency stock of PPE prior to the COVID-19 pandemic. This stock was mainly comprised of disposable gloves and aprons, 34% of respondents had fluid resistant surgical face masks and 27% eye protection/visors, included in the emergency stock. The median time an emergency stock lasted was 2 weeks. An overview of when Care Homes first requested support with PPE supply is shown in Figure 7 below along with the number of suspected or confirmed outbreaks of COVID-19 at that time. The outbreak statistics have been extracted from the Public Health Agency (2020) Monthly Epidemiological Bulletin.

Figure 7. Requests for PPE compared with the number of outbreaks



https://www.publichealth.hscni.net/sites/default/files/202006/Monthly%20Epidemiological%20Bulletin_week%2020.pdf

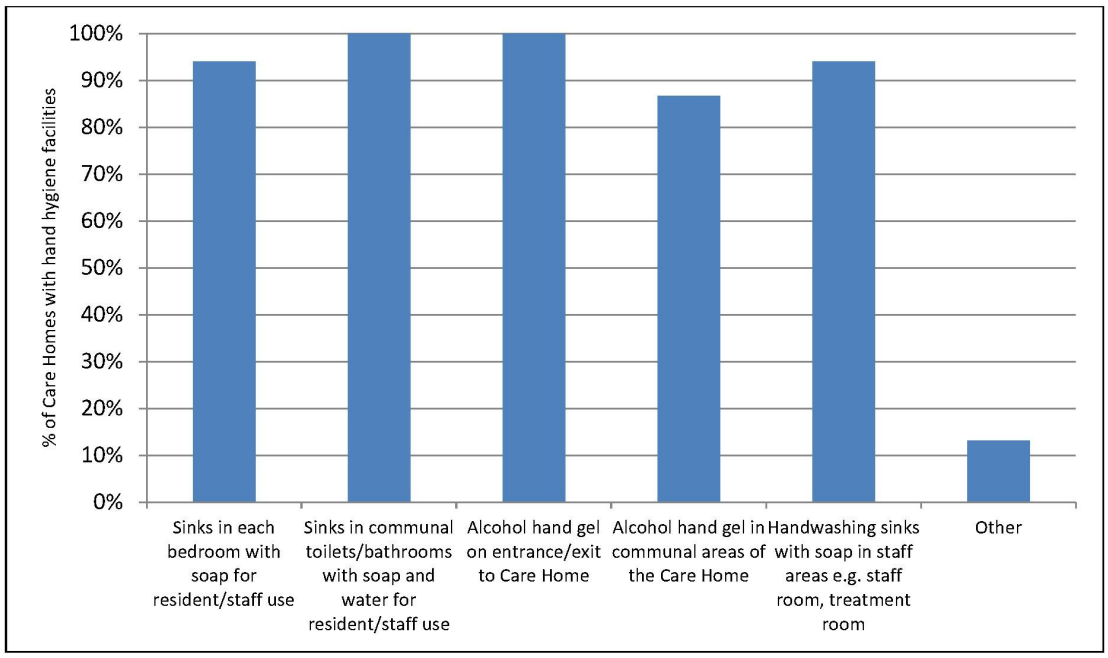
Respondents reported that PPE supply ran out quite quickly and where there was disruption to the PPE supply chain it was difficult to replenish. Guidance around PPE was confusing, it was often issued publicly with no prior communication to Care Homes. This resulted in Care Home managers having to manage staff anxieties along with attempting to revise any internal procedures.

> Our residents have dementia and many are independently mobile making isolation challenging, enhanced cleaning areas such as door handles, has been important so that residents in our Home can be protected as best possible"
>
> **-Care Home Manager**

A number of Care Homes identified that they would like enhanced cleaning procedures to remain in place to mitigate risk of infection transmission. Enhanced cleaning, particularly of touch points is crucial. Care Homes who increased domestic provision/altered shift patterns reported positive outcomes. There is no recognised regional training on environmental cleanliness which Care Home teams can access

Respondents reported the availability of hand hygiene facilities throughout the Care Home with the most common locations identified in Figure 8. 100% of Care Homes reported having hand hygiene facilities when entering and leaving the Care Home, providing an opportunity to reduce risk of transmission at these points in time. It was also identified that there were sufficient hand hygiene facilities in areas of the Care Home where staff were delivering direct care. A number of Care Homes identified that they did not have alcohol hand gels in communal areas, more exploration is required to better understand this response. Through a number of one to one qualitative interviews it was suggested that this may be due to the number of residents with cognitive impairment and form part of a risk management strategy.

Figure 8. Location of Hand Hygiene facilities in Care Homes



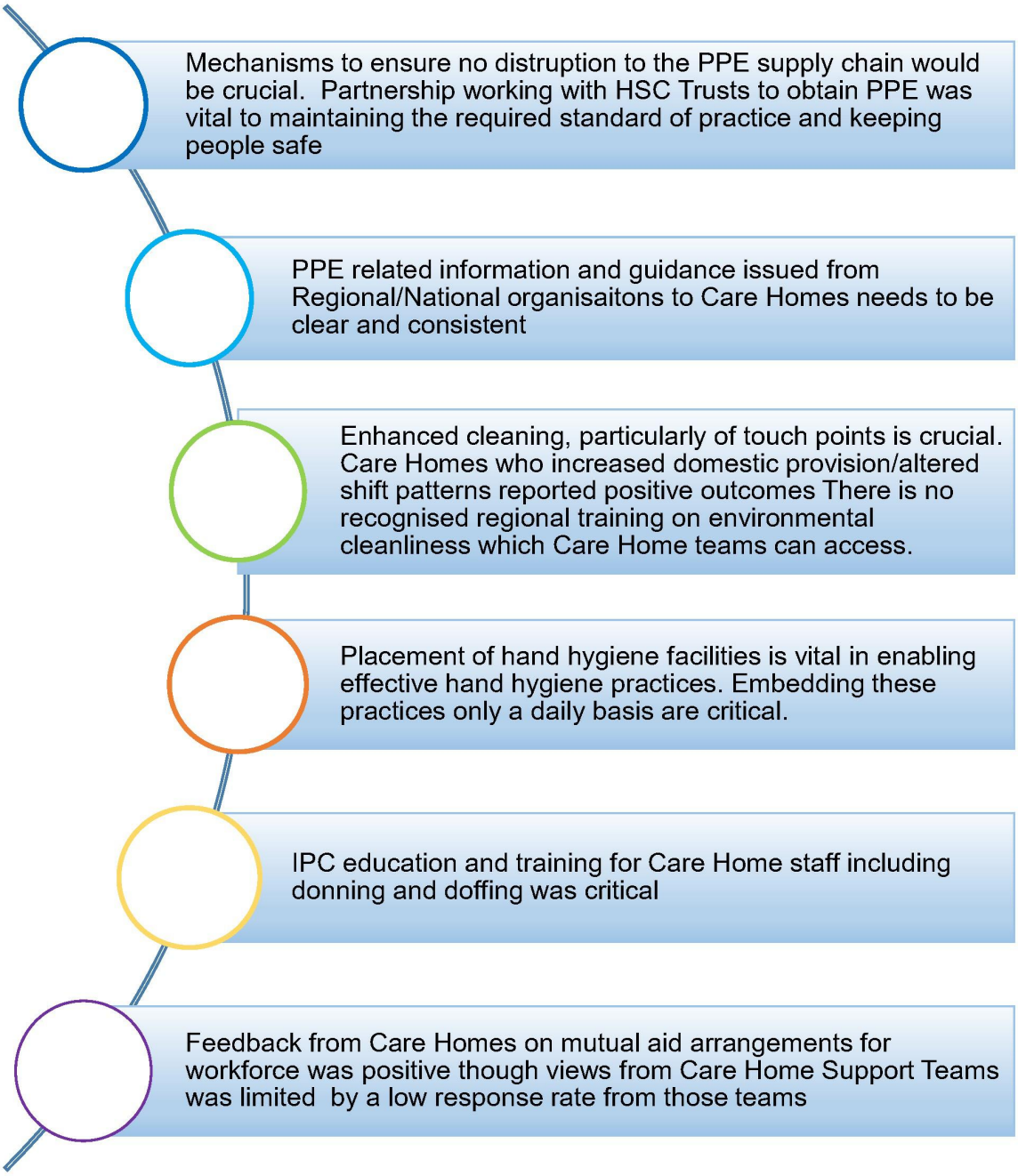
Access to training for Care Home staff was important. It was felt that a consistent 'education pack' was needed for Care Homes to access. An "education pack" is a COVID related IPC training pack that includes general IPC principals & practices, decontamination/environmental cleanliness, use of PPE & risk management.

Although 87% of respondents stated donning and doffing was included in mandatory training, further exploration is required to validate the training content.

Mutual aid support plans, whereby HSCTs and Care Homes could support each other with provision of PPE, workforce/staffing pressures and other critical needs through the pandemic, were developed. It was strongly conveyed through the qualitative interviews that these plans had a mainly positive impact on building a closer working relationship between Trusts and Care Homes and will assist in the operational sustainability of services during times of extreme pressures

10.7 Key Findings of Subgroup 3 as per Theme

The following key findings summarise the rich data explored as part of the survey returns and semi-structured interviews.



10.8 Subgroup 4 Report Physical distancing, reduced footfall and restricted visiting

Subgroup 4 considered the actions that were taken to protect residents and staff in Care Homes through restricting contact with residents and between residents using a range of physical distancing measures.

> *"We shut down early. Families worked with us and were super supportive. Families had such confidence in us especially after some bad media came out about some homes handling of the coronavirus".*
>
> **-Care Home manager**

The survey respondents reported that 82% of nursing and residential Care Homes restricted visiting prior to the issue of guidance issued on 17 March 2020. When the guidance advised ceasing visiting on the 26 April 2020, 92% of respondents reported they had already ceased visiting. Some reported ceasing visiting 6 weeks prior to the formal guidance been issued.

There was innovative use of technology to deal with the impact of restricted access and to enable Trusts multi-disciplinary teams and Care Home Support Teams to change how they interacted with the homes using a virtual platform for weekly meetings. In addition to being an effective measure to reduce footfall, it fostered better communication, relationships and provided an invaluable support for Care Home staff during the pandemic.

Many nursing and residential homes respondents reported reduced access to medical support both virtually and in person. Respondents also described where changes need to be made prior to the predicted further surges of Covid-19 including a pathway to access medical support for Care Home residents when required.

> *"Better medical support from the GP as they refused to provide medical support. GP's refusing to complete DNACPR's and difficulty completing advanced care plans with family and patients without medical input".*
>
> **Care Home Manager**

Families were understanding and supportive of the need to restrict visiting to reduce the risks to patients/residents however maintaining the communications of families with patients/residents proved a challenge and required additional resources and administrative support to do this well.

> *"Isolating in own bedrooms not possible, where higher supervision needed, need for higher levels of staff but can't sustain long term where resident's mental health impacted and needed company in the communal areas".*
>
> **-Care Home Manager**

There were significant challenges for the Care Homes in the overall planning to achieve physical distancing due to patients underlying health conditions, loneliness and the physical size of the home, which did not always support the requirement for physical distancing.

"Relatives understood the importance of NOT visiting, however some residents simply could not comprehend the situation and this caused them great distress. (Very sadly in one case a resident thought that his father was dead as he had stopped visiting)".

The respondents that participated in the qualitative interviews 'deep dives' reported that the support from the Care Home support team was beneficial however this would be required to be a consistent approach in all HSC trusts.

"Very difficult to get MDT access. This needs to be within a dedicated resource in the Care Home nursing support team to maintain direct input advice and specific team to relate to"

Respondents described the importance of identifying a cohort of staff to work in each individual nursing and residential home in order to reduce footfall. Staff working across a number of nursing and residential homes should be avoided, this includes bank staff and agency staff. Student nurses should be enabled to remain working in the nursing or residential home they are employed in. All Trust allocated staff should be designated to specific homes.

"Greatest worry staffing being depleted – amount of staff shielding and needing longer term staffing and enhanced number of staff in place. Need a steady, constant workforce to have availability and a pool of staff to ensure residents are kept safe..."

-Care Home manager

Challenges in relation to implementing physical distancing measures that were identified in this survey include:-

- Lack of testing of patients/residents prior to admission
- Residents underlying medical condition. For example isolation was particularly difficult for residents living with dementia and learning difficulties.
- Challenges posed by the environment: size and layout of some homes.
- Maintaining staff ratios in order to safely supervise residents was challenging some staff indicating that this needs address through a "Fit for purpose dependency tool…'

"No routine testing of patients discharging from hospital to a nursing home. General IPC guidance – should have had this sooner"

-Care Home manager

"Most difficult thing is social distancing due to environment, residents homes, other residents are close and feel like family so want to stay and be close together. Very difficult to isolate. Cannot do that or sustain that. Tried to move furniture apart but residents move closer and would want their individual seats".

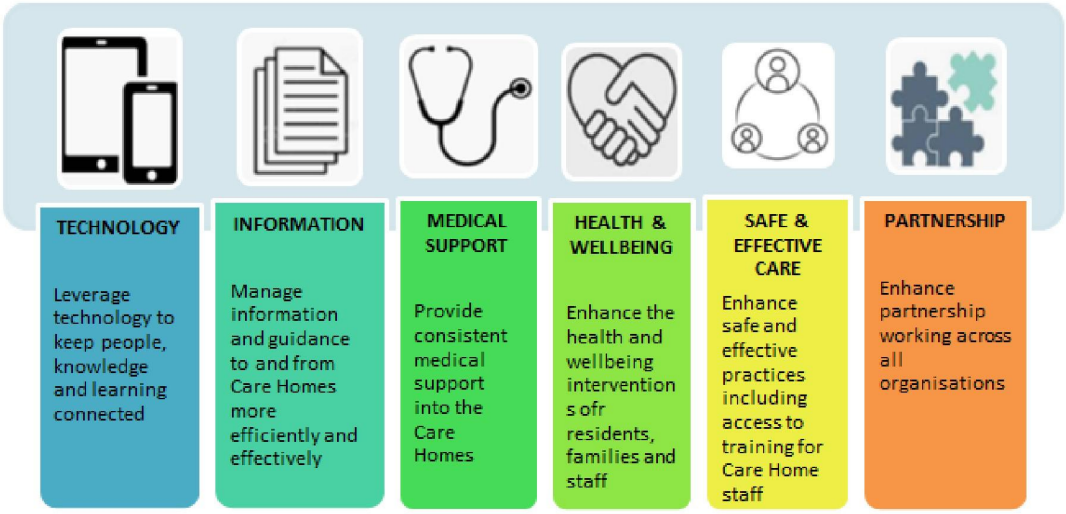
Many of the elderly were sensitive to a change in their routine and believed that the negatives of distancing residents outweighed the positives. Staff observed that separation was detrimental to the persons' emotional and mental wellbeing.

10.9 Key Findings of Subgroup 4 as per Theme

The following key findings summarise the rich data explored as part of the survey returns and semi-structured interviews.

- Formal information and guidance regarding visiting should be consistent in detail, clear and unambiguous and provide in a timely manner
- Additional technology was and will be required to facilitate virtual visiting.
- Accessible and timely medical support is critical in managing any future surges and/or outbreaks of Covid-19 infection
- Identification of a cohort of staff to work when required in individual nursing and residential homes will be beneficial in terms of reduction in footfall
- Student nurses should be enabled to remain working in the nursing or residential home they are employed in.
- An agreed and consistent process for testing of residents prior to admission to a Care Home is required
- Implementation of physical distancing measures were particularly challenging for a number of reasons. Guidance and training around dynamic risk assessment that considers human rights alongside risks of infection transmission would be beneficial

11.0 RECOMMENDATIONS



The following recommendations are informed by the findings described above, and seek to trigger immediate action in order to strengthen the system's response ahead of a potential further surges of infection

The recommendations fall under a number of action categories:

1. Guidance
2. Training
3. Supplies
4. Support Mechanisms

Addressing the recommendations will not be easy but over time the system must learn from the first wave and ensure the experience is improved where possible for the residents, their families and those who provide care to the Care Home sector.

Partnership working has been highlighted as a transversal action category across the system. This principle lies at the core of the regional Co-production Guide* and the Collective Leadership strategy**. The recommendations in Table 2 below are derived from the rich information gathered from our residents, families and staff. It is critical that their voice is reflected in how the report articulates through the 'recommendation' column what needs to be done and what the desired outcomes are as detailed as 'what difference this will make'.

There is an acknowledgement that the pathway to achieving many of the recommendations may be: 1. unclear; 2. challenging in the current pandemic environment and 3. potentially dependant on resources that are not currently available. They do however outlines the areas where commitment to improve should focus prior to potential further surges.

*https://www.health-ni.gov.uk/sites/default/files/publications/health/HSCB-Co-Production-Guide.pdf
**https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-collective-leadership-strategy.pdf

Theme 1	Technology	What difference will this make?
1a	Provide appropriate technology to enable virtual visiting	Opportunity for residents and families to stay connected using technology during access restriction
2b	Provide training on safe use and governance associated with the use of technology	Staff will be competent in safe use of technology
3c	Provide provision of technology to support virtual assessments with the multidisciplinary team	Residents will be able to access the right assessment and treatment at times of restricted access during pandemic
Theme 2	**Information and Guidance**	**What difference will this make?**
2a	Simplify information flow: RQIA to act as a single point of access to provide consistent information to all Care Homes	Care Home staff will receive information via a single point which should prevent duplication and enable better communication flow
2b	Provide guidance on the transfer of residents to and between hospital and Care Homes to reduce transmission of Covid-19	There will be clear and consistent application of protocols on transfers by Care Homes and Hospitals across the region
2c	Provide guidance on enhanced and terminal cleaning processes in Care Homes for application during a pandemic	Consistent understanding and application of enhanced cleaning processes
2d	Provide clear and consistent visiting guidance for Care Homes	Care Home residents, their families and staff will clear about visiting arrangements at the differing stages of pandemic and/or outbreak management"
Theme 3	**Consistent medical support**	**What difference will this make?**
3a	Provide critical, consistent medical support which is timely and accessible	There will be timely decision making regarding residents' medical treatment and care planning
3b	Complete advance care plans with individual residents which include conversations on DNACPR	Residents are involved in decisions regarding their future clinical pathways. Informed clinical care decisions will be clearly documented to inform the multidisciplinary team.

Theme 4	Health and Wellbeing	What difference will this make?
4a	Develop tools and resources in partnership with stakeholders to support communication skills and offer activities which stimulate all residents	Residents will be stimulated and engaged within their environment and mental health and emotional wellbeing supported
4b	Develop strategies to support residents with cognitive impairment to share their emotions and to connect, for example, talking mats	Residents with cognitive impairment will be provided with opportunities to connect with each other, staff and families
4c	Co-produce a communication strategy with residents and relatives to ensure all official information and guidance is cascaded directly to the residents & relatives	Residents and their families will be informed through timely access to information related to Covid-19 which may impact on their quality of life
4d	Offer leadership support for Care Home Managers and HSC Trust teams to enhance their abilities to manage effectively during high pressure times such as a pandemic	Care Home managers and HSC Trust staff will feel more confident in their management skills demonstrating strong leadership traits
4e	Promote the utilisation of the extensive range of initiatives already in place to support the mental health and emotional wellbeing of staff	Care Home staff will feel listened to and have support pathways which are easy accessible to all
Theme 5	**Safe and Effective Care**	**What difference will this make?**
5a	Provide Care Home staff with freely accessible regional IPC training e-learning module	Staff will be knowledgeable and competent against consistent regional standards, in applying infection prevention and control measures to manage transmission of Covid-19
5b	Establish a sustainable mechanism for supporting the supply of PPE to Care Homes in a pandemic	There will be no interruption to the supply chain for adequate provision of PPE to Care Homes enabling the maintenance of safe and effective practices for both staff and residents
5c	Provide training for the domestic staff response in a pandemic	Consistent and accessible regionally agreed training for

		domestic staff on cleaning and hygiene standards in Care Homes in Covid-19 pandemic
5d	Undertake and prioritise anticipatory care planning in advance of the second Covid-19 surge	Residents will have up-to-date person centred care plans and will be empowered to make critical decisions about their healthcare
5e	Develop a regional standing operating procedure for supporting the testing of residents and Care Home staff in conjunction with Care Home Providers	Staff and residents will have access to regular testing to ensure timely response and appropriate action. This will provide assurance of safe care environments for Care Home staff and residents and their families
5f	Provide Care Home staff with skills training for recognising the deteriorating resident - relevant to staff member individual role within Covid-19 response and with multidisciplinary approach	Staff will be confident and competent in timely intervention when a resident develops signs and symptoms of Covid-19 and escalate appropriately. Residents will receive access to safe clinical interventions from appropriately qualified staff
5g	Provide dynamic risk assessment training that enables Care Homes to manage a range of areas including safe visiting arrangements and implementation of physical distancing measures underpinned by a rights based approach	Care Homes will be able to respond to changing situations using a rights based and risk assessed approach
Theme 6	**Working in partnership**	**What difference will this make?**
6a	Continue to build on the important partnership working between Care Homes and Trust Care Home Support Teams	Respectful, multidisciplinary relationships will deliver safe and effective care outcomes for residents; those aligned to care delivery will feel confident about the experiences and skills of teams they work within
6b	Work in partnership with the universities to consider learning from first wave regarding student placement in Care Homes to inform pandemic response going forward	The possibility of continued Care Home placements for nursing students will be explored to determine how that continued placement can be facilitated to

		benefit both the student and the Care Home
6c	Provide guidance on the allocation of in reach support staff for Care Homes which minimises footfall and affords in reach staff support the opportunity to be familiar with Care Home operations in Covid-19 and residents care needs	Consistent and static groups of additional staff who may be required to be present in a Care Home will assist in reducing possible transmission of Covid-19 and will contribute to a more detailed understanding of the individual needs of residents within each home.
Recommendations to ensure System wide learning and sustainable improvement		
The initiative identified three overarching structures and processes that will need to be established to support the delivery of outcomes and bring about a learning system that works across Heath and Social Care (HSCNI), including the independent sector and Trusts. 1. At strategic level, the collaborative partnerships established for the purposes of the Initiative should continue and develop further to support future development of Strategy and Policy; 2. A regional learning system should be developed. This should include identifying key quality indicators for Care Homes (led by frontline staff) using real-time data that can for continuous improvement 3. A quality improvement learning system should include building the capability and capacity within Care Home staff to use continuous improvement methodologies to implement operational improvement as a system.		

Table 2 **RECOMMENDATIONS**

Health and Wellbeing 2026: Delivering Together, the then Minister of Health's ten year vision for health and social care, makes a commitment to reform adult care and support with the aim of bringing long-term stability and sustainability to that sector. The current Minister of Health has also asked the Chief Nursing Officer to co-design a new framework in partnership with the Care Home sector for the provision of clinical care. This work will include examining how to enhance clinical care in Care Homes. Many of the recommendations from this initiative will be progressed through the overarching framework.

12.0 NEXT STEPS

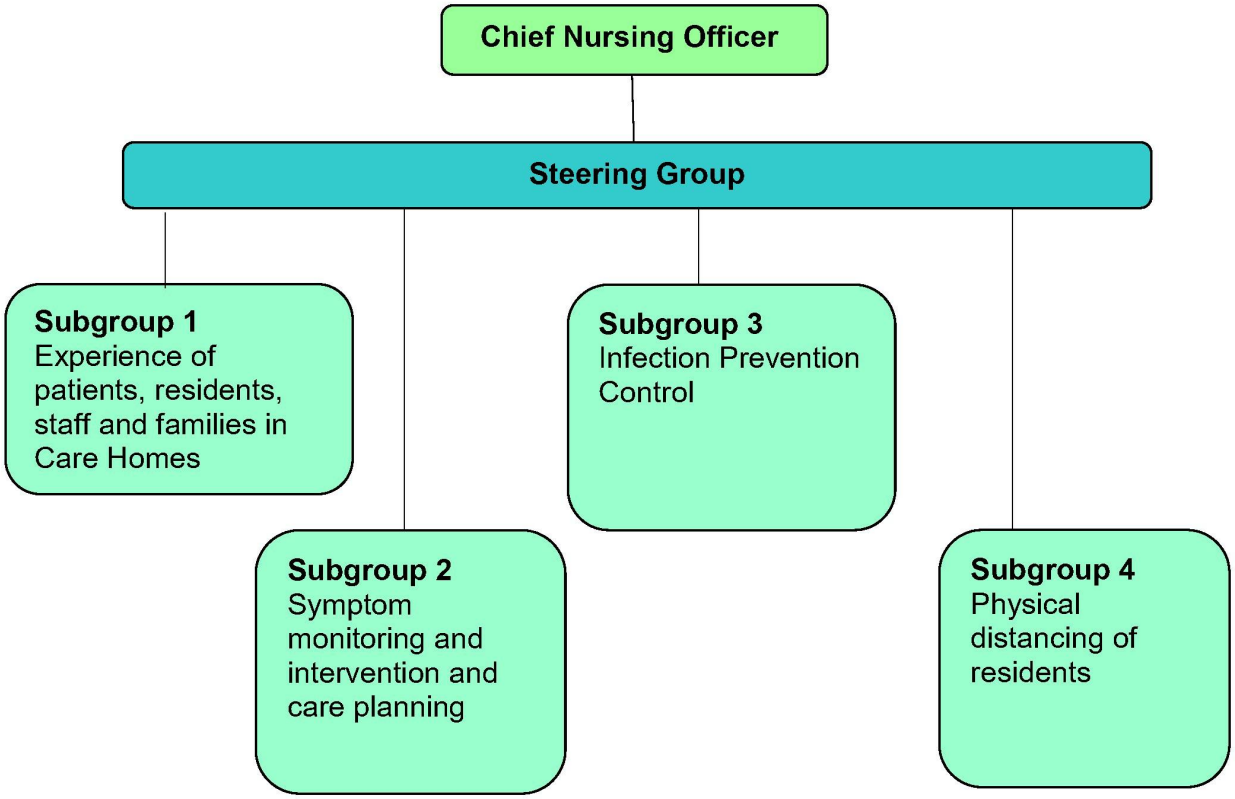
There is a recognition that the desired outcomes will only be achieved with collaborative working with residents and their families; Care Home providers; managers; staff and the organisations who support the Care Home sector. The action plan resulting from the recommendations of this report must adopt a co-production approach.

- The Chief Nursing Officer will present findings of the report to The Minister and DoH Management Board overseeing the rebuild of services

- Following approval, the Chief Nursing Officer will write to the PHA asking them to work with the five HSC Trusts the Independent Sector and other relevant stakeholders to co-ordinate the implementation of the recommendations and report back Chief Nursing Officer within 3 months

- In recognition of the rich information obtained through shared experience from residents, families and staff, the group commit to creating a supplementary report. This report will reflect many of the stories shared for the purpose of learning and improvement and provide evidence for development of the recommendations.

ANNEX 1. GOVERNANCE STRUCTURE



ANNEX 2. STEERING GROUP

Name	Role	Organisation
Linda Kelly	Chair	Deputy Chief Nursing Officer DOH
Names Redacted	Deputy Chair	Nurse Advisor DOH
	Member	NMAHP
	Secretariat	NMAHP
NR	QI Lead	HSCB
NR	QI support	Northern Trust
Mark Lee	Member	Elderly and Community Care DOH
Names Redacted	Stats	IAD
	Chair	Experience
	Chair	Symptom monitoring and intervention and care planning
	Chair	Infection Prevention Control
	Chair	Physical distancing of residents
Kathy Fodey	Member	PHA
Deborah Oktar-Campbell	Member	Bloom Health and Wellbeing Hub
Pauline Shepherd	Member	CEO IHCP
Jillian Martin	Member	DOH
Cathy Harrison	Member	Chief Pharmaceutical Officer - DOH
Brendan Whittle	Member	Deputy Director of Children and Social Care – HSCB
NR	Member	Programme Manager, HSCB
Vivian McConvey	Member	Patient and Client Council
Pedro Delgado	Member	Institute of Healthcare Improvement
Susan Hannah	Member	Institute of Healthcare Improvement
Angela Zambeaux	Member	Institute of Healthcare Improvement
Elaine Connolly	Member	Assistant Director, RQIA – joined 23/6/2020

ANNEX 3. SUBGROUP MEMBERSHIP

Subgroup	Members
1- Experience	**Chair: NR, PHA Regional Lead for Patient, Client, Experience** Ruth Burrows, Four Seasons NR, NHSCT Bereavement Officer Elaine Connolly: RQIA NR, SET Nursing Governance Lead NR DOH NMAHP NR DOH NMAHP NR NHSCT Care Home Support Team rep. Ruth Johnston, representative of RCN Independent Sector Nurse Manager Network Aine Morrison, DOH NR HSCB NR, AD of Nursing Northern Trust Johny Turnbull, Involvement Services Programme Manager, PCC
2-Symptom monitoring and intervention and care planning	**Chair: Carol Cousins, Independent Sector CNMAC** NR, BHSCT - Care Home Support Team NR, SET QI Lead NR AHP e-Health Professional Advisor, PHA NR, SHSCT Care Home Support Team Linda Kelly, DOH DCNO NR PHA Health Protection Nurse NR, WHSCT AD of Nursing Janice Brown, Four Seasons – Regional Ops Manager Cherith Rogers, Priory Group NR, HSCB Jane Sagayno, Hockley Nursing Home Una McDonald, East Eden Group Susan Hannah, Institute of Healthcare Improvement
3- Infection Prevention Control (IPC)	**Chair: NR, PHA Nurse Consultant for Care Homes** NR PHA Nurse Consultant NR AD of Nursing Northern Trust NR Dickson, SET Interim AD of Nursing NR DOH NR SHSCT lead nurse IPC NR WHSCT NR, SEHSCT Jonathan McCleery, Four Seasons - Health & Safety Manager NR Spa Nursing NR, NHSCT Innovation & QI Lead NR, HSCB Pedro Delgado - Institute of Healthcare Improvement NR – SEHSCT IPCT Lead
4- Physical distancing of residents	**Chair: Brenda Rushe, Senior Nurse Professional Practice, Royal College of Nursing NI** NR HSCQI Director NR BHSCT NR DOH Elderly and Community Care NR, DOH Nursing Advisor NR, SEHSCT NR SEHSCT AD Older Peoples Services Louisa Rea, Four Seasons – Regional Operations Manager Connie Mitchell, Aughnacloy House Jillian Martin, DOH Seamus McErlean, HSCB Teresa McClean, Corriewood Nursing Homes

ANNEX 4. ROLES & RESPONSBILITIES OF STAKEHOLDERS

Name	Roles and Responsibilities
DOH	Ultimate responsibility for delivery of the Initiative Liaising with Minister/ Executive/ DOH Committee Lead in answering Assembly Questions Providing Secretariat support to the work of the Initiative
NICS Departments (if appropriate)	Provision of input to the Initiative within their remit
HSC Service providers	Assign a lead person within their organisation to input/liaise/ with the Initiative Take ownership for their contribution to the overall objectives for the Initiative
Steering Group	Providing strategic direction and leadership for the Initiative to the Subgroups Agreement of Project management documentation Oversight/ management of work of Subgroups Approval of work products of Subgroups Resolving issues escalated by Subgroups Making decisions on recommendations made by Subgroups Preparation of the Report of the Initiative Involvement with liaising with Minister/ DOH Committee if required
Subgroup	Agreeing a Chair and deputy Chair Meeting/ Reporting to Steering Group as agreed Identify key objectives and actions Receiving direction from Steering Group as appropriate Collaborating to resolve issues Escalating as appropriate issues to Steering Group for resolution/ advice Managing, reviewing and prioritising their work to meet delivery deadlines/ finances.

ANNEX 5. RESPONSES TO CITIZEN SPACE SURVEYS

Table 1. Number of responses by HSC Trust

HSC Trust	Total responses
Belfast	13
Northern	16
South Eastern	23
Southern	10
Western	8
Northern Ireland	**70**

Table 2. Number of responses by Sector

Sector	Total responses
Independent Residential	26
Statutory Residential	1
Total Residential	**27**
Independent Nursing	42
Statutory Nursing	1
Total Nursing	**43**

Table 3. Number of responses by Care Home Type*

Care Home Type	Total responses
Frail Elderly	44
Dementia	30
Mental Health	12
Learning Disability	30
Physical Disability	32
Intermediate Care	8

*NOTE: More than one option could be selected by each Care Home, therefore the total and % responses could not be calculated.

Annex D

Thank you letter to Subgroup Chairs

I recently approved the Report of the Rapid Learning Initiative into the transmission of Covid-19 into and within Care Homes during the first stage of the pandemic.

The recommendations in the Report are based on the evidence gathered and interpreted by the Subgroups. That learning from the impact of the first surge of Covid-19 in Care Homes will support all of us in the wider health and social care system to do what we absolutely must do as we face a predicted second surge of the pandemic – harvest that learning to build on what is already being done and further protect the health and wellbeing of people living in Care Homes, their families and staff providing their care.

As one of the Chairs of the Subgroups established to take forward the work of the Rapid Learning Initiative, I am aware of the particular level of knowledge and skills that you personally brought to the Initiative both as a member of the Steering Group and as Chair of your Subgroup. I am also aware that you did so in addition to the existing work responsibilities you already carry.

I would like to extend my personal thanks to you for everything you contributed and achieved during the work of the Initiative.

As Chair of your Subgroup, the leadership you provided was critical to meeting the objectives of the Initiative within the challenging timescale set for delivery of the Report and also to supporting the forging of relationships across the organisations represented on your group, some of whom were meeting each other for the first time. This was particularly important for the representatives from the independent Care Home sector who have so often felt their voice has not been given its place with other organisations at strategic level.

What united all those organisations for the work of the Rapid Learning Initiative is their connection with the Care Home Sector. I intend to build on the partnership working during the Initiative to support other work going forward in the Care Home Sector, including the co-production of the framework to enhance clinical care in care homes which will be led by the Chief Nursing Officer.

Annex E

Thank you letter to Steering Group and Subgroup members

I recently approved the Report of the Rapid Learning Initiative into the transmission of Covid-19 into and within Care Homes during the first stage of the pandemic.

The recommendations in the Report about the impact of the first surge of Covid-19 in Care Homes will support all of us in the wider health and social care system to do what we absolutely must do as we face a predicted second surge of the pandemic - harvest learning from the first surge to build on what is already being done and further protect the health and wellbeing of people living in Care Homes, their families and staff providing their care.

I would like to convey my personal thanks to you for taking part in the work of the Initiative, particularly as many of you continue to carry the additional workload the pandemic has brought.

I am particularly pleased to note the wide range of organisations represented in the work of the Initiative. This is a visible recognition of the willingness of all of us to learn from, and with, each other. I look forward to building those partnerships further. By working across the boundaries between sectors and organisations we can deliver what lies at the heart of what we all ultimately want - people living in Care Homes to live their best life, thriving in the place they call home.