Witness Name: Donna Keenan
Statement No:1
Exhibits: DK1-50 INQ000000
Dated: 19 February 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF MRS DONNA KEENAN

I, Donna Keenan, will say as follows: -

I am Mrs Donna Keenan, and I held the position of Assistant Director of Nursing Services: Governance, Safe and Effective Care of the Western Health and Social Care Trust in Northern Ireland. I currently hold the position of Executive Director of Nursing, Midwifery & AHP Services of the Western Health, and Social Care Trust. I write this statement in response to a request from the Inquiry dated 14 August 2024. The statement has been prepared with the assistance of staff from the Trust, who had knowledge, experience, and access to documents pertinent to the information request. This is my first statement to the Inquiry.

WESTERN HEALTH AND SOCIAL CARE TRUST'S ROLE, FUNCTION AND AIMS

1. The Western Health and Social Care Trust (WHSCT) is one of five Health and Social Care (HSC) Trusts providing health and social care services across Northern Ireland.

2. The WHSCT provides a range of services to a population of over 300,000 people across a geographical area of 4,842 km^2 which is coterminous with three council areas – Derry City and Strabane District Council, Fermanagh and Omagh District Council and Causeway Coast and Glens Borough Council (for Limavady).

3. The services provided span acute and community care, mental health, learning and physical and sensory disability, children's services, and social care services.

4. We provide support to people in our communities through approximately:
    - 1,800 residential and nursing home placements
    - Domiciliary Care services to 3,890 people in their home
    - £4.5 million annual spend on community equipment
    - 218,000 community allied health professional contacts (e.g., physiotherapy, occupational therapy)
    - 17,000 social work contacts
    - 96,000 mental health outpatient contacts
    - 218,000 district nursing contacts. **("COVID-19 Response – Trust Board structure", exhibited to this statement – DK/01 INQ000520288)**; **("COVID-19 Response – PCOPS Organisational Chart", exhibited to this statement – DK/02 INQ000520299)** and **("COVID-19 Response – Women and Children's Directorate", exhibited to this statement – DK/03 INQ000520310)**.

5. The WHSCT has Care Management responsibility for residents / clients in need of social care services including residential and nursing homes both in the Statutory and Independent Sector (with the exception of those privately funded residents or residents from another jurisdiction), and also Domiciliary Care. *(Care Management is a whole concept that embraces the key functions of: case finding; case screening; undertaking proportionate, person-centred assessment of an individual's needs; determining eligibility for service(s); developing a care plan and implementing a care package; monitoring and reassessing need and adjusting the care package as required)*. The care management process including assessment and case management of health and social care needs; provision of services, including placement of service users in residential care homes and nursing homes and the service users' right to a choice of accommodation. The Trust also operate Charging for Residential Accommodation Guidelines when placing clients.

6. In relation to Statutory Residential Homes and in-house domiciliary care services, the WHSCT holds statutory responsibility for all aspects of the care provided. This includes Registered Manager, Named Individual, employment of staff and meeting statutory and regulatory requirements. In relation to Independent Sector providers for the provision of nursing, residential care and domiciliary care, the Trust is responsible for the placement and care management of residents. The Trust commission residential and nursing care via a regional contract and contracts and performance manage these. The Trust commissions domiciliary care provision from the Independent Sector via the Trust's own procured domiciliary care contract.

7. The WHSCT has annual contract review meetings with nursing, residential and domiciliary care providers and have in place a governance structure to monitor and oversee service delivery and quality and safety in the sector. The Trust Safeguarding service have in place an identified allocated social worker who visits a minimum of once a year to solely address the nursing and residential facilities safeguarding performance. Where there are concerns identified by the Trust, family members or the RQIA in relation to specific independent providers, the Trust undertakes enhanced monitoring and works with the provider to develop and implement an improvement plan. In some circumstances, the Trust may issue a formal performance notice to a provider under Clause 8 of the Regional Residential Care Home Contract.

8. The Regulation and Quality Improvement Authority (RQIA) was established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the 2003 Order). Registered establishments and agencies are required to comply with the 2003 Order and the associated service specific regulations. Other services including HSC Board, HSC Trust or special agency are required to comply with DHSSPS minimum standards (Article 39) (Article 35) of the 2003 Order. Failure to do so may result in enforcement action. Article 34 of the 2003 Order also places a statutory duty of quality on the Health and Social Care Board and on HSC Trusts in respect of the services they provide.

9. For all establishments/agencies/Trusts RQIA may:
    - highlight failings to comply with minimum standards and regulations.
    - hold a Serious Concerns Meeting.
    - hold an Intention to Serve an Improvement Notice Meeting.
    - serve an Improvement Notice.

10. For establishments or agencies registered or failing to be registered under Part III of the 2003 Order, RQIA may:
    - hold an Intention to Serve a Failure to Comply Notice Meeting.
    - serve a Failure to Comply Notice.
    - hold an Intention to Serve a Notice of Proposal Meeting.
    - serve a Notice of Proposal to:
        - grant an application subject to any conditions not agreed in writing between RQIA and the applicant.
        - refuse an application to register an establishment or agency to cancel registration of an establishment or agency.
        - vary or remove any condition in force in relation to the registration of the establishment or agency.
        - impose any additional condition in relation to the registration of an establishment or agency.

- refuse an application of a Registered Person under Article 16 of the 2003 Order for the variation or removal of a condition relating to registration.
- serve a Notice of Decision to adopt a proposal.
- use urgent procedures to apply for an order to cancel registration, vary, remove, or impose conditions on registration.

PRE-PANDEMIC STRUCTURE AND CAPACITY OF THE CARE SECTOR IN THE WESTERN HEALTH AND SOCIAL CARE TRUST

11. There are 31 Nursing Homes and 29 Residential Care Homes in the WHSCT area.

12. There are 8 statutory homes and 52 independent Nursing / Residential Care Homes.

13. There were 681 Residential Beds and 1,499 Nursing Care beds within the WHSCT.

14. During January 2020, there was a total of 2,018 WHSCT residents in Care Homes across the UK. Of this, 73 clients were deemed full cost residential therefore, all other residents had some form of public funding - a total of 1,945. Another 158 residents were 'full cost nursing' clients where the WHSCT contributed £100 only to their placement.

Total clients	2018
Residential Full Cost	73
Partially / Fully funded from Public Funds	1945
Nursing Full Cost (£100 Free Nursing Contribution)	158
Total clients not including full cost	1787

15. As at January 2020, the WHSCT used 8 Domiciliary Care providers - seven Independent Sector providers with whom we contracted with and the Trust's in-house service. All would have been registered with RQIA as homecare providers at the time. As of 31 January 2020, 3,890 individuals were in receipt of domiciliary care service provision from the WHSCT.

16. For the period 1 March 2020 to 28 June 2022 a total of 6,711 individuals received publicly funded homecare service, delivered by one or more of the providers referenced.

17. In March 2020, the WHSCT employed 612 frontline domiciliary care staff, [398wte] by June 2022 this had reduced to 575 individuals [348wte]. A number of staff who were required to shield in the early days of the pandemic

due to underlying health conditions and who did not subsequently return to work can account for the reduction. Given the difficulties within the social care sector during the pandemic, recruitment and retention of domiciliary care staff was challenging.

18. The WHSCT does not hold workforce information for the seven independent sector providers to provide an update from their perspective, although it should be noted the independent sector accounted for 75% of domiciliary care activity during the period in question.

19. Yearly contract review meetings were held between the Trust and providers.

20. Daily contact with nursing homes, as part of the care management process, indicated the Trust was aware of one home at that time experiencing financial pressures due to staff shortages, based on home perception of increasing complexity of need. The WHSCT reassessed all clients and provided a financial support package to the provider to enable them to stabilise its workforce.

21. For Adult Mental Health and Disability, pressures known to the Trust pre pandemic extended across the Care Sector in 24 hour, 7-day per week basis settings - including Care Homes, Residential and Regulated Supported Living. These pressures were linked to lack of availability in some cases, of suitable placements for complex cases across all areas of health and social care need. Pressures were being felt particularly in Adult Learning Disability and Physical Disability. There were recruitment pressures for providers in terms of both costs and suitable workforce.

22. Contract discussions and conversations with the Health and Social Care Board (HSCB), which was stood down on 31 March 2022 and then the Strategic Planning and Performance Group (SPPG) in respect of high cost cases and uplifts for providers were part of normal business linked to ongoing pressures and efforts to meet demand for bespoke arrangements. In some areas, there was ongoing discussion about the need to increase staffing due to individuals in care settings getting older and needs becoming greater.

23. The WHSCT had a Domiciliary Care waiting list, as of 9 April 2020 a total of 151 individuals were waiting for care totalling 1,300 hours. The Trust continued to engage with its Domiciliary Care providers to attempt to address this shortfall. However, the emphasis at this time had been on planning to sustain services during the pandemic.

24. The WHSCT was about to embark on its Homecare Optimisation initiative in 2019/20 however, this was delayed due to COVID-19. Some targeted

optimisation work was still able to be progressed for the period in question, with £425k of additional capacity generated.

25. Homecare Optimisation is a reform initiative under the auspices of the Trust's Delivering Value Programme. The objective of the project is the re-design of domiciliary care service delivery arrangements, with the aim of reducing the reliance on the spot-purchase element of the contract and the optimisation of service capacity within the block element of the contract. It was initially intended that the three-year process would begin in 2019/20. It was inevitably delayed by the pandemic, although some optimisation work was able to be progressed 2019 to 2021. The Programme began in earnest in 2022 and to date has generated 6,000 additional weekly hours of capacity. It is scheduled to be completed in summer 2025.

SUMMARY OVERVIEW OF PANDEMIC IMPACT

26. Trust statutory residential homes, in particular those with residential Dementia beds, had high levels of outbreak. It was challenging to isolate residents who were walking with purpose. *"Walking with purpose" is a term used when referring to residents with dementia looking for something/someone or purpose and reason in their day, within their ability to understand their situation at that time or moment. "Walking with purpose" replaced the term "wandering" as "wandering" suggested a person was walking for no reason. Residents with dementia lacked the understanding and ability to retain information regarding the spread of infection as in the case of Covid 19. The practice to isolate residents within their own rooms to prevent spread was not possible as residents with dementia often need to walk or pace. Residents with dementia may often feel bored as they are not doing daily tasks they may have previously done in their earlier life and are recalling those memories at that moment and time. Residents were also missing daily contact with family and friends and outings out of the home. These factors contributed to residents with dementia wanting to move and walk around the home environment looking for purpose. Preventing a resident with dementia from doing this would cause upset and undue distress to the resident.* Care Homes experienced this same challenge.

27. There were also staffing challenges due to the need for isolation and community nursing and social care staff were utilised to ensure safe care. Many staff had to self-isolate across the sectors during the time period and this would have placed additional pressure on the provision of safe care and the ability to attend training for Infection Prevention & Control (IP&C). Domiciliary Care also experienced these staffing challenges.

28. With regard to adverse outcomes, meeting the needs of individuals in residential and supported living for complex clients was highly challenging

during the pandemic. This was particularly the case in Adult Learning Disability when COVID-19 was at a peak and isolation and "bubbles" were necessary. Supported Living staff in some cases were required to remain in the client's home for long periods of time resulting in an impact on family life – this applied also when isolation was needed.

29. Individuals with physical disabilities reported a higher level of anxiety throughout COVID-19 due to their physical vulnerabilities, which is now evidenced in the Office of National Statistics **("ONS Disability, well-being and loneliness, UK: 2019", exhibited to this statement – DK/43 INQ000571516)**.

30. They expressed concerns regarding loneliness, cost of living and their future in relation to the negative news items regarding deaths in care homes.

31. Day Centre closures, while necessary, had untold impact on individuals and their carers.

32. Day-care transport was a particular challenge, and individual members had reduced day care placements as a result. As things progressed social distancing on buses also limited how quickly we could re-establish these supports to individuals and their carers from a day care perspective.

33. Day opportunities, which were reduced throughout, also affected individuals who were reliant on them for social contact/support.

34. Individuals with sensory loss were particularly negatively impacted e.g., lip readers (masks) and those with visual impairments when distance restrictions were imposed e.g., cane users.

35. The issues experienced by Adult Learning Disability service users and their families were similar to the issues noted for Physical Disability. In this case the impact on families was considerable and high stress and anxiety was a feature of ongoing conversations with carers and elderly parents. While people felt efforts were made by the Trust to keep them informed and to try to provide basic levels of support through Direct Payments (DP) where this was possible, the adverse impact of closure/reductions in day services facilities was significant.

36. There was significant impact on those providing social care also that could meet the NI Act 1998 and Equality Act categories. With regard to Direct Payment carers, for example, Personal Protective Equipment (PPE) was not readily available to them initially. There was a lot of uncertainty in general for these carers, and confusion around ever-changing guidelines. Laterally the difference between the different regions caused lots of confusion for managers about when staff could and could not return to work.

37. Additionally for health and social care staff who are informal/unpaid carers, there was high anxiety about going out to work and then inadvertently spreading infection to those who they cared for informally at home who were clinically extremely vulnerable as well as those they were visiting professionally.

38. What could be done for informal carers was limited. They wanted to protect their family member/s and therefore would often not engage with traditional carers' support due to fears about contracting COVID-19. Informal carers continued to adhere strictly to isolating themselves even when restrictions were relaxed and removed during the initial period – the psychological impact of this is difficult to quantify.

39. Also, from an HSC staff perspective, having to go into work while the rest of the country was off during the initial lockdown, HSC workers conversely had to continue going to work settings and work a high number of hours to cover gaps in rotas across some care homes also.

40. Breaches of COVID-19 restrictions by government ministers was morale zapping for staff. This has eroded trust on so many levels and could well impact public compliance with any future restrictions required to respond to any future pandemic.

41. With regard to morbidity and mortality RQIA monitored deaths within the care homes.

42. During this timeframe, and taken from data from Northern Ireland Statistics and Research Agency (NISRA), as referenced in 4d **("COVID-19 Response – Excess mortality and COVID-19 related deaths in Northern Ireland: March 2020 to August 2022", exhibited to this statement – DK/04 INQ000520311)** several inequalities were observed across Northern Ireland namely a higher death rate for people over the age of 65 years and more men than women died. The second most deprived quintile had the highest deaths with the lowest deaths in the least deprived quintile. Care Home deaths accounted for 20.8% and mainly in the first wave. Rurality may have been more affected by indirect effects of the pandemic.

43. Care Homes faced challenges in the earlier phase of securing PPE and the Trust supported them.

44. Day Care closures increased social isolation and disrupted routines for service users.

45. Access to healthcare was reduced to Care Homes due to minimal GP face-to-face visits, reliance on the District Nursing Team and Care Home Support Team was crucial to assess residents.

46. It was difficult to isolate some residents who 'walk with purpose' in care facilities. Due to visiting restrictions, alternative support solutions were implemented including virtual visiting and garden visits.

47. The Trust's main source of data for this information is via NISRA **("COVID-19 Response – Excess mortality and COVID-19 related deaths in Northern Ireland: March 2020 to August 2022", exhibited to this statement – DK/04 INQ000520311).**

LIAISON AND COMMUNCIATION WITH GOVERNMENT AND OTHER STAKEHOLDERS

48. The Ministerial Gold Command and the Trust's Silver and Bronze Commands were in place and information was shared through these meetings.

49. The Trust was connected through the formal Department of Health (DoH) Emergency Planning structures and their associated command and control arrangements. DoH established its Health Silver Command, and the Trust provided formal reports throughout the pandemic. **("Health Silver SitRep – Gold 18th April, exhibited to this statement – DK/31 INQ000571505) ("Silver SitRep 20 March, exhibited to this statement – DK/32 INQ000571524)** The frequency and format of these was determined by DoH, the HSCB and then SPPG. The schematic for the initial structure established including the specialist "cells" is set out below **("COVID19 Response - Planning Framework V2.1 (9.4.20), exhibited to this statement – DK/30 INQ000571504)**.

50. The WHSCT established its own Trust Silver and Bronze groups, which enabled the necessary rapid communication and decision-making processes, flowing to and from Health Silver. DoH "Cells" reporting to Health Silver had appropriate Trust officers as members or in attendance.

51. DoH were the authority in the issuing of formal instructions to Trusts via Chief Medical Officer (CMO) HSS (MD) Circulars. These were cascaded by the Trust through its Trust Silver and Bronze command and control structures, to specialist standing groups or Task and Finish Groups, or as more general Staff Communications, as relevant within the Trust.

52. From September 2020, there were weekly huddles with Trust Executive Directors of Nursing, Director of Nursing – Public Health Agency (PHA) and

the Chief Nursing Officer (CNO) to discuss COVID-19 incidences and any planned changes in IP&C guidance. Discussions included workforce changes to meet surge demand.

53. The Executive Director of Social Work met regularly with the Chief Social Worker during this period to discuss service delivery during the COVID-19.

54. The CMO met with Medical Leaders to provide updates.

55. The WHSCT Chief Executive attended weekly meetings with the DoH and regional decision makers, who were connecting directly into national decision-making.

56. The WHSCT worked collaboratively with the PHA on a number of groups. The Head of IP&C was a member of the IP&C Cell, Healthcare Associated Infections (HCAIs) Working Group and the Regional Product Review Group. These groups were facilitated with the PHA. The purpose of the IP&C Cell was to oversee the co-ordination of IP&C across the HSC systems, Primary Care, including services provided by community, voluntary and Independent Sector providers. The HCAIs and Outbreak Working Group was a regional group set up to examine opportunities to minimise the impact of COVID-19 on HCAIs through a combination of regular testing, high quality IP&C arrangements and supporting the effective management of outbreaks in health care settings. The PHA facilitated the IP&C Product Review Group. The scope of work was to ensure any new PPE and medical devices being issued to the health care system were fit for purpose tested and the Medicines Optimisation Innovation Centre (MOIC) had carried out reviews of the products. This was a formal process in collaboration with MOIC and the Business Services Organisation (BSO) to ensure new PPE and medical devices are reviewed, tested, approved, and procured going forward during the COVID-19 pandemic.

57. The Ministerial Gold Command and the Trust's Silver and Bronze Commands were in place and information was shared through these meetings. Members of the Care Home Support Teams would have been in contact with RQIA either directly or indirectly by their attendance at the same meetings. Other Trusts were in attendance at these meetings.

58. The WHSCT communicated with providers from 12 March 2020 and shared all relevant guidance, procedures etc. from DoH, PHA. The Trust established a Single Point of Contact (SPoC) on 20 March 2020 for Care Home providers on a 24 hour, 7-day per week basis. The Trust also requested providers to complete a daily return indicating the current situation

in regard to PPE Levels, Workforce and COVID-19 statistics such as number of clients positive, isolating etc.

59. The WHSCT established weekly Business Continuity meetings with all Care Home providers both Statutory and Independent commencing on 14 April 2020. These meetings were then reduced to bi-monthly or monthly and back up to weekly when required in line with COVID-19 surges.

60. The WHSCT attended regular regional meetings with representatives from DoH, CNO, PHA, RQIA, Patient Client Council, other Trusts, Independent Sector Care Homes, Independent Health and Care Providers (IHCP) representatives and the Royal College of Nursing (RCN). There would have been regular contact with BSO Procurement and Logistics Service to ensure PPE supplies were maintained and BSO payroll in relation to salary for Trust employed support staff working in care homes. Liaison with Health & Social Care Board (HSCB) Pharmacy Leads and Community Pharmacy in relation to the rollout of COVID-19 vaccination programme within the care home sector. **("COVID-19 Response – Health and Social Care Trust Record of Mobile Vaccination Clinics", exhibited to this statement – DK/05 INQ000520312)**; **("COVID-19 Response WHSCT Vaccination Uptake Rate", exhibited to this statement – DK/06 INQ000520313)**; and **("COVID-19 Response – Low Vaccination Uptake data by SOA and Council Area", exhibited to this statement – DK/07 INQ000520314)**. Over and above these meetings the Trust would have liaised and worked with these groups on an ad hoc basis depending on need, other organisations who the Trust would have been in contact with were GP practices, Nursing agencies, Higher Education Colleges, NHS National Testing Programme and Supported living facilities in WHSCT area.

61. The WHSCT worked together with all of the aforementioned organisations in an effort to disseminate information quickly to teams to ensure a consistent regional message. This enabled them to provide safe and effective evidence-based care available at that time during the pandemic to care facilities, clients, and families. **("COVID-19 Response – Report on the Learning from the Multi-Agency Group in Response to COVID-19", exhibited to this statement – DK/08 INQ000520315)** and **("COVID-19 Response – Proposed Operating Model for Council Co-ordination Hubs in Support of Vulnerable Persons", exhibited to this statement – DK/09 INQ000520316)**.

62. The structure in place ensured there was a mechanism to disseminate national and regional guidance down through the systems to front line staff and also raise emerging and escalating concerns back up through to Gold Command. **("COVID-19 Response – Shielding Packages for Vulnerable People Isolating at Home", exhibited to this statement – DK/10 INQ000520289)**.

63. The Trust and front-line staff relied on the updated information from these meetings to deliver on the initially ever-changing processes and advice as more information emerged globally regarding the pandemic due to the mutation of the virus and clinical research. **("COVID-19 Response – WHSCT Risk Report", exhibited to this statement – DK/11 INQ000520290)**.

64. The WHSCT has a very close working relationship with Independent Sector providers and RQIA and this proved invaluable to supporting care facilities in difficultly with staff at an early stage to enable the provision of safe standards of care to clients and residents. Open and honest communication and good working relationships were critical to the Trust with all organisations and in particular in relation to patient deaths. The Trust also had meetings with the Northern Ireland Pathology Network, where the Trust reported our position, number of tests carried out, new technologies and got feedback from PHA regarding such things as procurement. **("COVID-19 Response - CE Letter from RQIA", exhibited to this statement – DK/12 INQ000520291)** and **("COVID-19 Response –WHSCT Care Home Deaths Report", exhibited to this statement – DK/13 INQ000520292)**.

DISCHARGE POLICY

65. Hospital bed capacity was challenging both in terms of the number of physical beds available and the availability of staff to operationalise them. Bed capacity is also dependent on flow through the system and effective discharge processes. There were challenges to patient flow in Altnagelvin Hospital pre pandemic. A Project Team was established in January 2020 pre-pandemic to improve flow including streamlining discharge processes and focusing attention on complex discharges. Delayed discharges were reduced by 50%. In preparation for the pandemic, and a possible escalation in need for beds, the hospital took additional steps prior to 17 March 2020. A number of temporary placements were identified in community facilities for patients who were medically fit for discharge, however, for whom an appropriate package of care had not been sourced. Discharge planning continued in these step down facilities outside hospital. The Trust made no changes to its discharge policy.

66. The WHSCT complied with all PHA and CMO guidance regarding transfer to residential and nursing care.

67. Changes to practices, policy, and procedures in relation to discharges were made on a regular basis in response to PHA guidance, DoH guidance and correspondence from the then Permanent Secretary. Rapid dissemination of guidance was essential during the pandemic to ensure adherence to the changing guidance and peaks and flows in level of infections. This

information was disseminated through a range of methods. This included Silver and Bronze arrangements, which were designed to ensure cascading of information across the whole Trust and to all staff. Silver and Bronze were established on a 7-day per week basis to ensure all new guidance could be disseminated and acted upon promptly.

68. The Trust's Communication Team attended Silver each day and developed a communication plan, which included videos, posters, podcasts, IP&C and COVID-19 SharePoint sites and discussion boards.

69. The WHSCT complied with the Guidance for Nursing and Residential Care Homes in Northern Ireland issued on 17 March 2020, 18 April 2020, 19 April 2020 and 17 April 2020.

70. The Assistant Director of Primary and Community Care Services attended the regional Care Home COVID-19 Social Care Sub-Group fortnightly chaired by the DoH, on alternate weeks; the Assistant Director for Intermediate Care attended the Domiciliary Care COVID-19 Social Care Sub-Group. The decisions and updates were cascaded through our Community Planning Group and Bronze reporting structures.

71. The WHSCT engaged with all our Independent Care Home providers at weekly business continuity meetings where the most up to date policy and guidance was communicated, shared and discussed. This was always followed up with email correspondence to the providers with relevant documents contained to ensure providers who did not attend the meetings were kept fully informed.

72. The WHSCT did not amend or suspend any regulations with regard to admissions to residential or nursing homes to facilitate discharges.

73. The Trust has no concerns about the guidelines and followed these as required.

74. The WHSCT collaborated with PHA testing colleagues to establish local processes, which included issuing essential equipment, and documentation and facilitating training via the Trust's Care Home Support Team to ensure all Independent Sector providers were skilled to undertake the necessary testing. Furthermore, the Trust established swab collection and transport arrangements to local laboratory services to ensure timely processing of tests. The Trust's Care Home Support Team established a 7-day working pattern and as part of this was instigating a process to follow up all results and communicate results to Independent Sector providers.

75. The Trust followed DoH guidance regarding testing protocols for workforce, visitors, and patients, and this included testing capacity. The Trust

developed guidance for staff completing visits within Nursing and Residential Homes. **("COVID-19 Response – Guidance for Staff Completing Visits within Nursing and Residential Care Homes", exhibited to this statement – DK/14 INQ000520293)**.

76. All DoH guidance was disseminated to the Trust via regional forums on testing as well the strategic Trust Silver Forum with operational Bronze forums in place with daily Sit Rep reports.

77. The Trust followed DoH guidance regarding testing policies as they were updated from the Department.

78. The WHSCT was aware of concerns of providers at that time, such as the ability to isolate residents who would walk with purpose. They also had concerns regarding isolation required for staff and the impact on workforce availability. These concerns were escalated through SPoC arrangements and weekly continuity meetings. The Trust, where possible, worked to alleviate these concerns by supporting teams with advice from the IP&C Team, support staff to help fill gaps in the rota and general advice on managing situations as they arose regarding staff education by the Care Home Support Team and, if necessary, escalated concerns to Trust Silver. **("Action and Decision Log 071220 (Discharge Concerns) 1", exhibited to this statement – DK/33 INQ000571506)**. When homes were challenged for staff, the Trust provided staff. The Trust also provided equipment to facilitate residents who needed to isolate.

79. There was pressure on wards in relation to delayed discharges, caused by the need to have a test within 48 hours. Requests for patients to be discharged in the absence of a COVID-19 test were made, however these did not occur.

80. In order to facilitate safe discharges when the system was under pressure, the Trust utilised rapid testing at an additional cost.

81. No Care Home was requested by the WHSCT to accept a hospital discharge in the absence of the testing requirements.

82. As above, no Care Home was requested by the Western Trust to accept a hospital discharge in the absence of the testing requirements.

83. In Northern Ireland, the RQIA does not rate homes as "inadequate" however; they do issue "Failure to Comply Notices" which will result in the Trust having Enhanced Monitoring Arrangements, involvement of Adult Safeguarding and the development of an improvement plan in conjunction with the home. When there is a Failure to Comply Notice for any Nursing or Care Home, the

Trust will make a decision based on the nature of the concerns if admissions should be halted and if the Trust will issue an Improvement Notice.

84. During the period March 2020 until June 2022 there were nine homes issued with Failure to Comply Notices. Trust staff undertook enhanced monitoring visits to all homes subject to a Failure to Comply notice. One Home was closed by RQIA during this period, which necessitated the opening of a ward in the Waterside Hospital to facilitate a temporary move for the residents whilst alternative placements were identified. The Nursing Home staff with support from WHSCT staff, including ward management, infection prevention control supervision and training and ongoing monitoring visits staffed the ward. All residents were eventually relocated.

85. The WHSCT's understanding of the impact of the discharge policy is it facilitated the flow of patients through our healthcare system and ensured sufficient capacity was maintained to treat those who became acutely ill. The discharge policy supported the safe discharge of people from hospitals to care homes. The pre and post discharge testing policy was a key factor in mitigating further spread of infection. The policy took into consideration the potential for transmission of COVID-19 from those who were pre-symptomatic, and asymptomatic of infection and therefore protected the residents and staff within the care home sector.

86. The WHSCT is not aware of any adverse outcomes of the impact of the discharge policy.

MANAGEMENT OF THE PANDEMIC

87. The DoH issued the first COVID-19 Guidance for Nursing and Residential Care Homes Northern Ireland on 17 March 2020. **("Guidance for Nursing and Residential Care Homes Northern Ireland on 17 March 2020", exhibited to this statement – DK/34 INQ000571507)** The guidance was for all registered residential, nursing homes and Health and Social Care Trusts.

88. Separate guidance on advice for home isolation issued by the PHA advised individuals, their families and informal carers what they should do to maintain support in their own homes and keep themselves as safe as possible, if they are advised to isolate themselves. **("DoH The Rapid Learning Initiative into the Transmission of Covid -19 into and within Care Homes in Northern Ireland", exhibited to this statement – DK/44 INQ000256597 ("DoH COVID-19: The Safe at Home Model May 2020", exhibited to this statement – DK/45 INQ000553320); ("DoH Interim Guidance for social or community care and residential settings on COVID-19 at 12/03/2020", exhibited to this statement – DK/46 INQ000103696 ;** and

("Care Homes Briefing", exhibited to this statement – DK/47 INQ000425655).

89. The WHSCT is unaware of any specific information released for unpaid carers. Advice was released for the general public, which would include unpaid carers, on precautions to take in relation to regular testing, the use of PPE and encouraging them to follow standard and transmission-based precautions in line with the guidance at that time. Carers NI may have been able to offer more advice and guidance to unpaid carers at this time.

90. The Trust's IP&C Nursing Team provided advice, guidance, education and support to Trust residential homes, domiciliary care and Independent Care Homes and domiciliary care providers throughout the pandemic.

91. The IP&C Team carried out onsite visits, provided onsite training and specific virtual education to Trust residential homes. The Trust was also responsible for the management of any outbreaks within the Trust residential care homes.

92. The IP&C nursing teams also developed educational resources e.g., videos, leaflets, checklists to support staff in these settings.

93. Pre COVID-19 the responsibility for providing IP&C advice and management of outbreaks to the Independent Care Homes and domiciliary care providers was the responsibility of the PHA. Prior to COVID-19 the Trust IP&C Nursing Team did provide in reach support to care homes where there were concerns regarding IP&C practices from the PHA or others.

94. Following the issue of a letter from the CMO dated 15 May 2020; **("CMO Letter re Support to Care Homes (15May20)", exhibited to this statement – DK/35 INQ000515717)** there was a request for a Trust senior IP&C nurse to visit an Independent Care Home when a new outbreak was notified. The purpose of this was to maximise opportunities to control outbreaks through effective infection prevention and control practice and correct use of PPE. An onsite assessment of the home's IP&C practice and onsite support/ training was offered to the home and recommendations for practice were given. The management of the outbreak remained the responsibility of the PHA, and implementation of the recommendations was the responsibility of the home.

Infection Prevention and Control

95. The IP&C Nursing Team implemented a bespoke programme of additional support to specific nominated staff who became "PPE Safety Officers." The aim of the PPE Safety Officers was to promote safety across the organisation, to develop opportunities to help staff and patients/clients feel

safe and to promote a culture of safety and communication. The PPE Safety Officers were also a conduit for the giving and receiving of information between the IP&C nursing team and staff. This support and additional education were available to both Trust residential homes and Independent Care Homes.

96. The WHSCT followed DoH guidance regarding testing protocols for workforce, visitors, and patients this included testing capacity.

97. All DoH guidance was disseminated to the Trust via regional forums on testing as well as the strategic Trust Silver Forum with operational Bronze forums in place with daily situation reports (Sit Rep). **("COVID-19 Response - DoH COVID-19 Test, Trace and Protect Transition Plan", exhibited to this statement – DK/15 INQ000348966)**; **("COVID-19 Response – DoH Health and Social Care Summary COVID-19 Plan for the period mid-March to mid-April 2020", exhibited to this statement – DK/16 INQ000103714)**; **("COVID-19 Response – DoH HSS(MD) 91/2021 Updated Policy for the Management of Self-Isolation of Close Contacts of COVID-19 Cases – Additional Safeguards for Health and Social Care Staff", exhibited to this statement – DK/17 INQ000520296)** and **("COVID-19 Response – DoH HSS(MD) 2/2022 – Management of Health and Social Care Staff who are confirmed Cases of COVID-19 Updated Guidance", exhibited to this statement – DK/18 INQ000520297)**.

98. The Trust followed DoH guidance regarding testing policy. COVID-19 Test, Trace and Protect Strategy 27 May 2020, **("COVID-19 Test, Trace and Protect Strategy 27 May 2020", exhibited to this statement – DK/23 INQ000120704)** and COVID-19 Test, Trace and Protect Transition Plan 24 March 2022 **("COVID-19 Test, Trace and Protect Transition Plan 24 March 2022", exhibited to this statement – DK/37 INQ000348966).**

99. Trust Testing Protocols were in place. These would have been facilitated, either through the lab in Altnagelvin, the regional virus lab or through Trust private providers.

100. The DoH developed policies / guidance; regional forums were established and attended by Trust staff.

101. DoH policies were disseminated; the Trust then took forward the implementation of these as evidenced below.

102. DoH guidance was followed in relation to implementing testing regimes.

103. At the Direction of the DoH, the Trust allocated funding to homes with a one off payment depending on size of the home, during May 2020 to 3 July 2020 to providers to purchase the following equipment, tympanic thermometers

and disposables, tympanic thermometers disposables, oximeters, blood pressure monitors, blood pressure monitors additional cuffs and tablet/communication devices.

104. The PHA issued a symptom identification checklist and oximeters to enable care home staff to undertake symptom monitoring. The WHSCTs Care Home Support Team was SPoC for the care home staff and they remotely supported homes daily regarding residents' symptoms and the ongoing management of same.

Testing

105. In the statutory homes, any change in a resident's condition or wellbeing, staff automatically triggered a COVID-19 test. It was recognised early in the pandemic that the normal symptoms of COVID-19, i.e., cough, sore throat and elevated temperature did not always relate to older people. **("COVID-19 Response – PHA Updated Asymptomatic COVID-19 Testing Arrangements for Adult Day Care Centres from Monday 25 April 2022", exhibited to this statement – DK/19 INQ000520298)** and **("COVID-19 Response - PHA Updated Asymptomatic COVID-19 Testing Arrangements for Care Homes from Monday 25 April 2022", exhibited to this statement – DK/20 INQ000520300)**.

106. The main difficulty with this was that for care homes, private providers performed asymptomatic testing. If there was an outbreak declared this resulted in samples coming into the Trust lab. Private providers often used a bar code system, whereas the Trust lab needed to have a fully compliant request form to enable testing. This was very difficult to manage and led to samples not being tested or a delay in results. The Trust were often not aware of any outbreaks being declared, which resulted in potentially hundreds of samples arriving at the one time. This was very difficult to manage, especially for those staff who had to undertake the pre-analytical steps. Access to request forms and sample containers was difficult. The Trust provided guidance regarding testing, isolation and return to work toolkit for managers. **("COVID-19 Response – WHSCT COVID-19 Testing, Isolation and Return to Work Toolkit for Managers and Staff v17", exhibited to this statement – DK/21 INQ000520301)**; **("COVID-19 Response – WHSCT Testing Guidance: Actions from Task and Finish Group", exhibited to this statement – DK/22 INQ000520302)** and **("COVID-19 Response – DoH Guidance Testing Policy; COVID-19 Test, Trace and Protect Strategy 27 May 2020", exhibited to this statement – DK/23 INQ000120704)**.

107. Prior to the relevant period, Independent Care Home and domiciliary care providers were responsible for the supply of PPE within their organisations.

108. The WHSCT wrote to providers on 12 March 2020 **("WHSCT Letter to IS COVID-19 Homes 120320", exhibited to this statement – DK/38 INQ000571511)** outlining the then current guidance on PPE within the region and identifying the client's key worker as a point of contact should the providers face difficulties accessing PPE and also re-iterating advice on when to report incidents in regard to COVID-19.

109. The Trusts then Chief Executive, Dr Anne Kilgallen, wrote to providers on 20 March 2020 highlighting arrangements for the Trust to support providers with the provision of PPE. **("Ltr dtd 20 Mar 20", exhibited to this statement – DK/39 INQ000571512)** A SPoC was implemented for the Care Home providers on a 24 hour, 7-day per week basis, updated guidance was also shared. The Trust also requested providers to complete a daily return indicating current situation in regard to PPE Levels, Workforce and COVID-19 statistics, such as number of clients and staff positive, isolating etc. The Trust also provided Psychological Self Care support leaflet for Independent Sector provider staff.

110. The WHSCT established arrangements for the weekly distribution of PPE to the seven Independent Sector domiciliary care providers contracted at the time. The Trust provided sufficient PPE to each provider based on the number of scheduled weekly care contacts. Initially the care providers collected the PPE from the Trust, however, this changed after a number of weeks with the Trust delivering supplies to the providers' premises. This arrangement was maintained throughout the pandemic.

111. The DoH issued policy and guidelines, which the Trust implemented.

112. The WHSCT provided PPE to all Independent Sector Nursing/Residential Homes, Independent Sector domiciliary care providers, supported living facilities and Foyle Hospice. The Trust also provided PPE to the carers and clients in receipt of Direct Payments. The Direct Payment clients' social worker ordered the PPE items using the order form. The representative of the client or the client's social worker normally collected these items from the community stores.

113. PPE was delivered on a weekly basis by Trust transport to Nursing/Residential Homes and those domiciliary care providers who were not able to collect PPE. During COVID-19 outbreaks in Nursing & Residential Homes, an urgent supply of PPE was delivered by Trust transport to the Nursing & Residential Homes on the day. The Care Home Support Team liaised closely with the three community PPE stores regarding urgent supplies.

114. As far as the WHSCT is aware, there was adequate supply of PPE to the Independent Sector. There were times when substitute products were distributed, for example tie back masks rather than ear loop ones.

Personal Protective Equipment

115. The Chief Executive wrote to Independent Sector providers on 20 March 2020 and advised them there would be no difference made between Trust and Independent Sector staff when it came to the distribution of PPE. The Trust put in place a SPoC for Care Home providers on 20 March 2020 on a 24-hour, 7-day per week basis. This SPoC provided PPE to Care Home providers. Daily contact was also made via reporting and phone calls to providers on their PPE needs. This was also discussed at weekly business continuity meetings.

116. The WHSCT provided PPE to all Independent Sector Nursing/Residential Homes, and Independent Sector domiciliary care providers. The Direct Payment client's social worker ordered the PPE items using the order form. Modelling for the quantity of PPE required for each Nursing/Residential Home was undertaken based on occupancy and staff working on each shift. Relevant PPE was also distributed to all Nursing/Residential Homes for their emergency trolleys. Modelling for the quantity of PPE required for each domiciliary care provider on a weekly basis was also undertaken based on the number of clients active. This was to ensure adequate quantities of PPE were distributed on a regular basis, so the providers did not have to source somewhere to store PPE. PPE was delivered on a weekly basis by Trust transport to Nursing/Residential Homes and those domiciliary care providers who were not able to collect PPE. During COVID-19 outbreaks in Nursing & Residential Homes an urgent supply of PPE was delivered by Trust transport to the Nursing & Residential Homes on the day. The Care Home Support Team liaised closely with the three community PPE stores regarding urgent supplies. There was adequate supply of PPE to the Independent Sector. There were times when substitute products were distributed, for example tie back masks rather than ear loop ones.

117. Visiting restrictions had a detrimental impact on residents and their families including, in some instances, a deterioration in emotional and physical health. The Care Homes followed PHA and DoH guidance in relation to visiting, the WHSCT provided support and guidance to the Care Homes through daily contact with the Care Home Support Team and updates were provided through the weekly business continuity meetings and internal briefing sessions due to the frequency of changes.

118. Care Homes provided a number of alternative methods of contact such as; virtual visiting through telephone calls and video calls via handheld devices, window visits and screen protected visits with IP&C measures assisted by

care home staff and intercom systems as appropriate through scheduled appointments to accommodate loved ones, traditional contact methods such as cards and letters were encouraged through home based activities, and some homes facilitated drive through visiting. Due to the level of transmission risk, these methods were utilised by many families. End of life visiting was facilitated as per the most up to date DoH & PHA guidance at that time.

119. Visiting was reintroduced to care homes using the PHA dynamic risk assessment along with the up-to-date visiting pathway, initially this created anxieties for all however, as the principles were embedded their increased confidence in applying the guidelines.

120. A programme was offered to asymptomatic visitors to care homes to undertake twice weekly self-testing in their own home using LFTs prior to visiting the care home. If the visitor had a positive LFT result, they were advised to immediately self-isolate and book a confirmatory PCR test and advised not to visit the care home.

121. WHSCT provided support and guidance to the care homes through daily contact with the Care Home Support Team and updates were provided through the weekly business continuity meetings and internal briefing sessions due to the frequency of changes. Daily contact was by telephone and email. Weekly business continuity meetings were via Zoom/Teams. The internal briefing sessions were at times face to face meetings or via Zoom/ Teams.

122. This did not apply to the Trust.

123. Trusts were directed by the DoH to financially support providers to lessen the impact of COVID-19. Homes were issued with a one-off payment depending on the size of the home during May 2020 to assist with the increased costs incurred as a result of COVID-19. During July 2020, providers were also allocated further funding for the purchase of additional equipment which included communication device / tablet to assist the home with virtual visiting.

124. Trusts made available to homes, temporary additional funding to support the sector in addressing the increased additional costs associated with the response to the COVID-19 outbreak.

125. The funds were issued by the 15/05/20 and homes received a one-off payment based on bed numbers as follows:

NUMBER OF REGISTERED BEDS	AMOUNT OF ONE-OFF PAYMENT:
Up to 30 beds	£10,000
31 – 50 beds	£15,000
Over 50 beds	£20,000

126. Care Partners was placed on the agendas of meetings with the Independent Sector providers of Care Homes and Supported Living and information was shared regarding the scheme. It raised concerns for providers along the lines of the impact of having additional people involved and how this could impact on existing teams of staff in care settings and potential increased risk.

Visiting Policies

127. Initially the Care Partner Concept caused some confusion and concern with families and care home staff, this was alleviated through daily contact and regular business continuity meetings, and information sessions facilitated by the PHA on the ECHO platform. **("COVID-19 Response – Care Partner Leaflet", exhibited to this statement – DK/24 INQ000374211)**; **("COVID-19 Response - Visiting Leaflet", exhibited to this statement – DK/25 INQ000374210).**

128. Families and Care Homes were issued with Care Partner information leaflets; the WHSCT's Communications Team promoted and shared the care partner concept on the Trust social media platforms.

129. During the relevant period, Community Social Work followed the relevant guidance in relation to the completion of Annual Reviews and visits to residents in Care Homes. Social Work visits to homes were risk assessed using a tool based on guidance from British Association of Social Workers.

130. From 7 April 2020, the DoH suspended all requirements under Paragraph 27 of Circular HSC (ECCU) 1/2010, **("Letter to Marie Roulston, HSCB re Suspension of all Annual Care Reviews - April 2020" exhibited to this statement – DK/48 INQ000522016)** for the need to complete routine Annual Care Reviews in respect of residents of both Nursing and Residential Care Homes and of clients in receipt of care in their own homes.

131. This was reintroduced across the HSC on a risk assessed basis in December 2020 were a letter from Sean Holland, Chief Social Worker, dated 20 January stated "Trusts, along with Providers, still have a responsibility to both ensure and assure the quality of care being provided to all residents. **("Letter re completion of care assessment reviews during this phase of the pandemic" exhibited to this statement – DK/49 INQ000522017)** In addition, the decision to adopt a risk based approach to the completion of Care Reviews does not negate the need to undertake specific reviews that

are necessary, paying due attention to residents who are particularly vulnerable."

132. The Adult Safeguarding Team completed enhanced monitoring visits to nine homes about which there were concerns and or Failure to Comply Notices during the relevant period. There were also individual cases that necessitated face-to-face contact, however, meetings, staff interviews etc. were conducted via video to reduce footfall in the homes. **("COVID-19 Response - Face to Face Visits During COVID -19", exhibited to this statement – DK/26 INQ000520306)** and **("COVID-19 Response - Audit of Visits to Private Nursing Homes", exhibited to this statement – DK/27 INQ000520307).**

133. Virtual pre-admission assessments were enabled at ward level to reduce footfall and cross infection, care home providers across the Western Trust area engaged in this process to facilitate timely assessments and safe discharge practice.

134. District Nursing continued to support Independent and Statutory homes as normal with appropriate screening and IP&C measures during the relevant period. Hospital at Home and Rapid Response visited homes to support the management of deteriorating residents during COVID-19 outbreaks. The Care Home Support Team were in continual contact with the Care Homes to raise any issues with the relevant Trust teams.

135. There were occasions when homes were reluctant to allow health and social care professional's access to the care homes due to anxieties and fears regarding transmission rates and high risk of outbreaks. In order to alleviate concerns we regularly communicated with the providers and updated them on COVID-19 screening measures in place for WHSCT staff and compliance with same.

Orthoptics

136. Orthoptics never had any arrangements for the provision of care to Nursing homes

Speech & Language Therapy

137. From 31 March 2020, community dysphagia provided a service via telephone and introduced virtual clinics on 15 April 2020. The first Nursing Home face-to-face visit took place in December 2020 with a blended approach moving forward depending on whether the Nursing Home allowed access or response to COVID-19 questionnaire.

Dietetics

138. Moved to virtual

139. Referral criteria did not change, and the process was a phone call between the dietitian and the nurse in the respective care home.

Occupational Therapy

140. Occupational Therapy continued to attend Nursing Homes for Assessment/treatment if approved by the care home in advance. Appropriate PPE was used.

141. We had five staff volunteers to help out in care homes also.

Podiatry

142. Podiatry continued to support care homes by using podiatry images that were uploaded to an email address. Images triaged and appropriate care plans were provided. Wound care was supported virtually and if it was safe to do so treatment continued in the care homes.

Physiotherapy

143. At the start of the pandemic (March 2020) the Physiotherapy Department categorised each of its services 1-4, with the definition as follows:

1 Must do – critical, cannot be deferred
2 High priority – do not defer if possible or bring back as soon as possible
3 Medium priority – can wait if epidemic / pandemic is not too long
4 Low priority – can be brought back when the epidemic / pandemic is over

144. The Community Physiotherapy Service delivered a range of interventions in patients own homes, which were categorised 1, 2, or 4:

- Urgent respiratory intervention Cat 1
- Mobility assessment to enable walking aid provision Cat 2
- Orthopaedic/trauma rehabilitation Cat 4

145. Category 1 & 2 services continued to be delivered throughout the pandemic, both in nursing homes and patient's own homes. PPE was used in line with the guidance at the time and approval was given by the Nursing Home for admission.

146. Social Work visits were undertaken to ensure a balance of the risk of increased footfall into the homes as well as the need to ensure care was of a good standard. The Trust audited all requests for visits to residents.

147. Regional guidelines were issued that provided advice for all staff on the recommendations for self-isolating for staff to adhere to. A process was put in place for accessing funds for salary payments while staff are self-isolating, shielding, or ill due to COVID-19. There were specific arrangements for staff on zero-hour contracts. The DoH also increased the rate of pay per hour to providers to a regional rate. A similar position was adopted with providers of Supported Living Services who are registered as domiciliary care providers also.

148. Bank workers should have received full pay whilst self-isolating / off on COVID-19 related sick leave for all pre-booked bank shifts they would have worked had they not had to self-isolate and receive any regular enhancements they would have received had they been in work.

149. Consideration would have been given to paying bank workers who regularly undertook shifts, however, did not have pre-booked shifts, a 13-week average for a period of self-isolation / sick leave due to COVID-19. This would be assessed on a case-by-case basis dependent on the individual arrangements of the bank worker.

150. The WHSCT were directed at various intervals during January 2020 to June 2022 to provide financial support to providers to lessen the impact of COVID-19. The Trust was directed by the DoH to where, as a result of the COVID-19 outbreak a nursing or residential care home's income reduced by greater than 20% below the past three months' average, then Trusts would have had to block purchase 80% of the vacated beds at the regional tariff. The Trust would then fill these beds as required over the next three months. If beds were still vacant at the end of that period, a further review would have been undertaken by the Trust working with the HSCB. The DoH also advised providers on 3 June 2020 of an additional package of financial support. A process was put in place for accessing funds for salary payments while staff were self-isolating, shielding, or ill due to COVID-19, additional specialist equipment and environmental cleaning.

151. The Trust was also directed at various intervals during January 2020 to June 2020 to support providers of Domiciliary Care, payments were guaranteed based on 100% of the last three payment periods to allow for continuation of salary contributions, isolation, sick pay arrangements for staff. There were specific arrangements for staff on zero-hour contracts. The DoH also increases the rate of pay per hour to providers to a regional rate. A similar position was adopted with providers of Supported Living Services who are registered as domiciliary care providers also.

152. BSO's Internal Audit Team undertook a review of how providers were using funds administered by the Trust during COVID-19 to provide assurance funding was used in the way in which was intended. **("IH verification - final report," exhibited to this statement – DK/40 INQ000571513).**

153. The WHSCT is not aware of any discrimination by workers of particular groups. The Independent Sector would have managed their own individual staffing concerns.

154. The Trust had in place its formal Bronze and Silver Command meeting structure and any issues or concerns raised by the respective Bronze meeting would have been dealt with at Trust Silver or escalated promptly to the regional Gold Command for information or action.

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION ('DNACRP')

155. The WHSCT Do Not Attempt Cardiopulmonary Resuscitation ('DNACPR') Policy was implemented in 2012 and a number of key documents were used when writing the policy which included the guidance documents from the Resuscitation Council UK, British Medical Association and RCN **("COVID-19 Response - Do Not Attempt Cardiopulmonary Resuscitation Policy", exhibited to this statement – DK/28 INQ000520308).** Regional guidelines are awaited to update the extant policy.

156. The policy applies to "decisions regarding the appropriateness of CPR in adult patients within the care settings of the WHSCT" and provides clear guidance and support for staff when making a DNACPR decision. The overall clinical responsibility for the decision lies with the most senior clinician and in the Acute Hospital setting this may be the Consultant and in Community based hospitals, Care Homes or the patient's own home, the GP. It is a clinical decision based on the patient's condition and is tailored to the individual and not based on factors such as age or care setting.

157. Any DNACPR decision made whilst in the acute hospital setting within WHSCT is rescinded on discharge from hospital. The discharge letter should advise the patient had a DNACPR decision whilst in hospital and resuscitation status is to be reviewed within the community setting. During the pandemic, the Trust's Resuscitation Committee were not aware of any blanket use or misuse of DNACPR decisions. The Trust is unable to comment on how DNACPR decisions were made within the care home setting during this time.

158. The DNACPR Policy and COVID-19 were discussed at the quarterly Resuscitation Committee meetings during the pandemic and no changes

were made to the policy. **("COVID-19 Response - Do Not Attempt Cardiopulmonary Resuscitation Policy", exhibited to this statement – DK/28 INQ000520308).**

CHANGES TO REGULATORY INSPECTION REGIMES WITHIN THE CARE SECTOR

159. During 2020, the WHSCT established a Senior Community Governance Group (SCGG) as an oversight group for the governance of Community Services. The group consisted of senior multi-professional and multi-disciplinary managers across the directorates of the Trust. A Trust Assurance process was implemented and where necessary, implementation of an enhanced assurance process, which governs the Trust's work in care homes and other 24-hour, 7-day per week settings such as Residential Care and Supported Living. **("COVID-19 Response – Senior Community Governance Group, Terms of Reference 2020", exhibited to this statement – DK/29 INQ000520309).**

160. The plan of work for this group included strengthening governance, maximising efficiency and ensuring safe and effective personalised community care for the adult population.

161. A community risk matrix was developed as a central point for the reporting of activity against key domains identified within the RQIA App/Portal, PHA Outbreak Reports and local intelligence that consisted of safeguarding incidents for the previous 12 months; Failure to Comply status for the previous 12 months; Deaths per registered place (from 1 March 20 to date); Datix incidents reported in the previous week.

162. A threshold was established for each domain and a RAG rating applied. An overall Trust RAG rating was also determined based on the tolerance level for each domain. All relevant managers reviewed this information on a regular basis. If a Care Facility did not meet the required standard, enhanced monitoring was commenced by the Trust.

163. The Care Home Support Team was a crucial link between care facilities and the Trust for both sharing information and escalating concerns regarding equipment, PPE, care quality standards, patient safety, and training.

164. From a domiciliary care perspective, RQIA maintained its inspection obligations during the pandemic albeit the frequency of inspections was affected. RQIA also introduced virtual inspections via Zoom; feedback from providers was that the virtual inspection process worked well under the circumstances.

165. The introduction of the Trust's SCGG provided the Trust with oversight of all care facilities, and this ensured issues were highlighted early and support put in place to maintain patient / client safety and maintain the functionality of the establishment in question.

166. Going forward the expansion of the Care Home Support Team would be important so as to ensure more staff are available to support these care facilities. Social Care reviews should continue even if virtual and ensure staff training continued virtually during such times.

167. Dedicated Trust staff and RQIA staff to make physical visits adhering to the strict IP&C and regional pandemic guidance at that time. GPs also continued with their physical visits rather than nursing teams visiting and feeding back to the GP.

DEATHS RELATING TO THE INFECTION OF COVID-19

168. The impact of COVID-19 on care home residents is well documented in the RQIA publication "The Impact of COVID-19 on Care Homes in Northern Ireland February 2020 to July 2020 **("The-Impact-of-Covid-19-on-Care-Homes-in-NI,-Feb-Jul-2020", exhibited to this statement – DK/41 INQ000571514)** and Department of Health and Social Care Independent Report Chapter 8.2: Care Homes." **("DHSC Independent report Chapter 8.2 care homes," exhibited to this statement – DK/42 INQ000571515)**.

169. The impact of COVID-19 on older people living in care homes in Northern Ireland and the staff who support them has been severe. The majority of care home residents in Northern Ireland are older people, with complex clinical health care needs, presenting at increased risk of death from COVID-19 with spread occurring most readily in indoor environments. In addition, COVID-19 often presented atypically in the older population, and so there needed to be increased vigilance and a lower threshold for investigation. One of the single biggest reasons for needing long-term care is dementia, which is also an important risk factor both for SARS-CoV-2 transmission and poor outcome.

170. The mortality rate for COVID-19 in care homes is significantly greater than the general population across all UK countries.

171. The report's findings are concurrent with the experience of the Western Health and Social care Trust.

172. In one of the Trust's statutory residential homes, COVID-19 led to the death of six residents. In total, 22 residents and 19 staff contracted COVID-19. In another home, an outbreak led to the deaths of three residents. During the

outbreak, a total of 26 Trust staff and 18 residents in the Trust's statutory residential homes contracted the virus.

173. Both these outbreaks were subject to a Significant Event Audit (SEA) **("Covid Module 6 Rule 9 Request Learning Summary.pdf", exhibited to this statement – DK/50 INQ000571523)**.

174. RQIA monitored the deaths in the care homes. Through the Trusts SCGG process it identified early, any concerns regarding the number of deaths or care in any of the Independent Sector and Trust facilities and was able to take action swiftly. The rate of deaths of older people compared to the general population in general is a concern, rather than the quality of the data that the Trust had.

ASSESSMENT OF IMPACT OF MEASURES OF THE PANDEMIC ON THE CARE SECTOR

175. The Western Trust collated data on care homes from 23 March 2020. Providers were asked to submit daily returns to the Trust in the first instance to cover areas such as Workforce, COVID-19 Infection rates and PPE requirements. This return was later subsumed by the RQIA App, which launched on 22/04/2020.

176. The Western Trust then applied a risk matrix analysis to this data, alongside other data held by the Trust such as safeguarding referrals and incidents.

177. The Trust then RAG rated these homes and based on this status, a number of actions may have taken place such as an IP&C visit, support phone call from Care Home Support Team, enhanced monitoring visit from Care Manager/ senior manager within service.

178. Unpaid carers faced increased responsibilities and isolation due to the closure of support services. The need to protect their loved ones led to challenges in maintaining social connections. Many carers experienced high levels of anxiety and stress and financial strain due to the higher cost of living. The adult social care sector experienced staff shortages and often high workloads due to staff shielding and the implementation of new IP&C guidelines.

179. Higher mortality rates in Care Homes compared to the general population.

180. Increased isolation due to visiting restrictions, which may have had an impact on cognitive decline particularly in people with dementia.

181. Disrupted routine medical care and delayed treatments for non-COVID-19 conditions.

182. Mental health deterioration due to social isolation and anxiety due to lack of information and knowledge about the virus.

183. Reduced access to availability of day services and respite.

184. Increased dependency on technology for communication, creating barriers for those with limited digital access or skills.

185. Greater reliance on informal carers/family and recognition of the importance of family keeping in contact with family members in these care facilities.

186. For staff there was anxiety regarding PPE availability initially, the virus and access to the vaccination, testing, grief from the death of their patients/clients and workload challenges. Staff had to quickly adapt to the fast changing situations which all brought their own challenges including the additional IP&C responsibilities, more virtual and telephone meetings rather than face to face meetings and staff shortages identified the need for more community funding and the need to have agreed and tested protocols for future such situations with greater integration across all HSC services and teams.

LESSONS LEARNED

187. On 2 December 2020, the WHSCT reported Serious Adverse Incident SAI 83-20. This related to an outbreak of COVID-19 in a residential home for older people. A Serious Adverse Incident review was carried out and the report was completed on 26 April 2021 and included identification of learning to help prevent recurrence **("Covid Module 6 Rule 9 Request Learning Summary.pdf", exhibited to this statement – DK/50 INQ000571523)**. An action plan was developed and taken forward as a result. The outbreak led to the deaths of three residents. During the outbreak, a total of 26 staff and 18 residents contracted the virus.

188. On 12 January 2021, the WHSCT reported Serious Adverse Incident SAI 02-21. This related to an outbreak of COVID-19 in a residential home for older people with a dementia diagnosis. A Serious Adverse Incident review was carried out and the report was completed on 16 June 2021 and included identification of learning to help prevent recurrence **("Covid Module 6 Rule 9 Request Learning Summary.pdf", exhibited to this statement – DK/50 INQ000571523)**. The outbreak took place between the 7 December 2020 and 25 January 2021 and led to the death of 6 residents. In total, 22 residents and 19 staff contracted COVID-19.

189. The WHSCT did not carry out an analysis as to how the Care Sector coped or operated during the COVID-19 pandemic. BSO's Internal Audit team undertook a review of how providers were using funds administered by the Trust during COVID-19 to provide assurance that funding was used in the way in which was intended.

190. What Worked Well:

I have to highly commend the exceptional commitment and flexibility of all Trust staff, their ability to react quickly to the ever-changing guidance and situations that occurred. Their adaptability to work in care facilities to support their colleagues. The clinical expertise of staff guided the Trust and local community through this pandemic. The realisation only the people in the system could truly find ways to put systems in place that would protect as many people as possible and prioritising the most vulnerable. Our staff went above and beyond the call of duty to maintain and sustain services and care for the most vulnerable people in the community whilst often at their own personal expense. The expert clear guidance and professionalism of all the IP&C team and microbiologists was crucial to all teams to ensure effective implementation of ever-changing guidance. Enhanced IP&C awareness and knowledge across the Trust and local community.

- Public co-operation
- Trust communications to the team and general public
- Keeping the person at the centre of every decision
- Prioritising staff safety and ensure the proper PPE was available to them to meet their individual needs
- Dedicated COVID-19 Teams
- COVID-19 Testing Referral Pathway & Response
- Staff responsiveness & commitment [at all levels]
- PPE resourcing [once initial problems overcome]. Rapid establishment of work rounds to meet the needs of the IS providers to minimise disruption to them.
- Public Cooperation & Understanding
- Flexible Working Arrangements – Working from Home
- Out of Hours Response
- Regional Groups
- Daily Meetings with Independent Sector providers [now reduced to weekly]
- Cross Sector Dom Care Cooperation
- FAQ on PHA Website
- Infection Prevention & Control – Forum, accessibility, advice & support
- HR – specific COVID-19 advice & support
- Care at Home low infection & mortality levels
- Staff support – Staff care & counselling

- Domiciliary Care - 100% payment commitment to IS – ensured market stability
- Silver and Bronze reporting structures to region Gold Command
- Care Home Support Team support to care facilities
- District Nurse team support
- Vaccination programmes to the care facilities and house bound
- The introduction of the SCGG oversight group for enhanced monitoring
- Rapid and successful introduction of virtual monitoring
- Enhanced information sharing and analysis
- Improved emergency preparedness capabilities and need for future business continuity planning
- Enhanced focus on new ways to involve families in care
- Successful protection of many vulnerable service users and maintenance of essential services throughout the pandemic

191. Pandemic planning is critical in "peace times." Modelling for anticipated PPE demand should be taking place to create stocks and supply chains that ensure the safety of staff and patients in the future. The testing infrastructure needs reviewed to build capability, capacity and responsiveness. Constraints in testing and delays in accessing results impacted both patient care and staff capacity. Facilitation of visiting through a pandemic requires study to inform guidelines for the future. Appreciation of the impact on isolation is important going forward and that lessons learnt will not be repeated.

192. Establish planning and integration systems that fully integrate Care Homes, Residential Homes and Domiciliary Care from the outset and agree escalation frameworks across all relevant departments in the region.

193. Create centralised PPE and essential supplies and distribution systems specifically for the care sector. Clear supply chain contingencies and priority access for care providers. Implement standardised PPE training programs that can be rapidly deployed.

194. Staffing and workforce considerations regarding the development of emergency staffing pools that can be mobilised quickly to areas of greatest needs with clear protocols for staff moving between facilities.

195. For testing and surveillance consider creating dedicated testing programs for care settings with rapid turnaround times. Establish clear data sharing protocols between health and care sectors.

196. Clinical support is crucial to consider clinical in-reach services to care homes as the IP&C team demonstrated how valuable their expert knowledge safeguarded residents and staff. Establish clear pathways for specialist

support e.g., palliative care and mental health care. Consider creating dedicated clinical support teams for the Care Sector.

197. Streamline communication channels between health trusts and care sector providers and establish regular briefs for the Care Sector leaders.

198. Invest and support in technology and digital support for remote consultations and improve data sharing between sectors as mentioned.

199. Consider the mental health and psychology of Care Sector staff and create support services for care staff. For residents consider creating programs for residents facing isolation and develop protocols to maintain family contact safely.

200. Review the financial support and investment into the Care Sector and how to access additional resources in times of need and develop sustainable funding models for pandemic responses.

201. Governance and oversight are vital and establishing in advance clear monitoring and accountability systems to manage during a crisis that has protocols that support inspections in emergency situations will provide assurance to all.

202. The Trust would ask to consider the need for a specific resource of appropriately trained IP&C practitioners focusing on Independent Care Homes, Domiciliary Care Community services having responsibility for these services that have the governance arrangements in place to provide the necessary IP&C support within a strong assurance and accountability framework.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

PD

Dated: 19 February 2025