Witness Name: Mr Charles Martyn

Statement Module 6

Exhibits: 18

Dated: 14th February 2025

UK COVID-19 INQUIRY MODULE 6

WITNESS STATEMENT OF SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST

I, Charles Martyn, of the South Eastern Health and Social Care Trust will say as follows:

I took up post as the Medical Director of the South Eastern Health and Social Care in March 2008. In preparing my statement I have discussed the request with senior colleagues who assisted in the South Eastern Health and Social Care Trust's response to the COVID-19 pandemic. The contents of this witness statement are true and accurate to the best of my knowledge and belief.

OVERVIEW OF THE SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST RELATIVE TO THE ADULT SOCIAL CARE SECTOR

1. The South Eastern Health and Social Care Trust (SEHSCT) (hereafter referred to as the Trust or SEHSCT), provides integrated health and social care services to the communities of Ards and North Down, Lisburn and Castlereagh and Newry, Mourne and Down Council areas, serving a resident population of 361,191 including the provision of social care for Adults. This accounts for 19% of Northern Ireland's population. In addition, Acute services at the Ulster Hospital serve a wider population, including East Belfast, of approximately 440,000 people. The Trust employs just over 11,500 staff and manages an annual budget of approximately £1billion.

2. In relation to adult social care as of January 2020 the Trusts role included:

- Providing, commissioning, and overseeing care services, including nursing and residential care, for both publicly and privately funded individuals to maintain high standards of care, coordinate with private sector providers, and safeguard vulnerable adults, whilst ensuring resources and staffing were in place to meet demand across services.
- The delivery of integrated Healthcare and Social support to promote the well-being and independence of adults, to ensure the delivery of safe high-quality care across residential, nursing, and community settings.
- The Trust operated under the Department of Health in Northern Ireland and when necessary, intervened in care provision to ensure standards were met by the Independent Providers commissioned by the Trust, in accordance with regionally agreed standards and protocols.

3. In January 2020, the Trust had several key responsibilities in relation to adult social care, covering both publicly and privately funded care across nursing homes, residential care homes, and domiciliary care:

- The Trust directly managed certain publicly funded residential facilities, providing oversight, funding, and care coordination to ensure services aligned with established care standards. This was for individuals who needed assistance with personal care and daily activities like meal preparation, bathing and medication management but not require ongoing medical supervision.

- The Trust worked collaboratively with private residential and nursing homes to ensure they met health and safety regulations and provided quality care for residents, regardless of funding source. Nursing Homes regardless of the funding source provided 24-hour nursing care, for adults requiring medical or palliative care.
- Within Domiciliary Care the Trust provided and commissioned in-home care services for adults with varying needs, to help adults remain as independent for as long as possible in their own homes. This included assistance with personal care, meal assistance and household support.

4. The Trust works in partnership with our community, to deliver services to our older people, children and families, to those living with disability, including those with mental health needs. We put our patients, clients and families at the heart of everything we do, and we have created a culture, where everyone is valued, and our priority is to ensure the provision of safe, high quality and compassionate care for those we serve.

5. The Trust delivers integrated Health and Social Care across hospital and community services from over 100 facilities including:

- Acute Hospital (Ulster)
- Local Hospitals (Lagan Valley and Downe)
- Community Hospitals (Ards and Bangor)
- Community Facilities: health centres, adult day resource centres and children's and older people's residential accommodation, are located in many local towns and villages.
- Community health and social care i.e. Hospital at Home is delivered to residents in their own homes.

6. The South Eastern Health and Social Care Trust established Command and Control arrangements in response to the Coronavirus Pandemic. These structures were driven by the Joint Emergency Service Interoperability Principles (JESIP), like those that would be invoked during a Major Incident response. The Tactical Incident Control Room (ICR) and the Strategic Co-ordinating Group (SCG) were established and situation reports were returned to Health Silver as per their request schedule.

7. The SCG maintained ultimate responsibility for the Trust's response to the Coronavirus pandemic, acting as the Executive Decision maker. Responsibilities included:

- Continuously monitoring the impact of the outbreak to ensure delivery of key clinical services
- Addressing major issues and risks as they arose
- Allocation of resources, including finance, people, physical resources, as required; and
- Ensuring that there was a reliable system in place to keep the PHA, Health and Social Care Board (HSCB) and Department of Health (DoH), appraised of progress and for escalating issues as the threat of the pandemic increased.

8. The Strategic Coordinating Group (SCG) was chaired by the then Chief Executive, Seamus McGoran, (Roisin Coulter from July 2021) and comprised the Directors of the eight Directorates in place during the pandemic as below. Please note that the structure of the Trust has changed since that period.

- Medical Director Mr Charles Martyn
- Director of Planning, Performance and Information Roisin Coulter, (Naomi Dunbar June 2021 and Helen Moore from June 2022)
- Director of Finance and Estates Paul Morgan, (Wendy Thompson from September 2020)
- Director of HR and Corporate Affairs Myra Weir, (Claire Smyth from April 2021)
- Director of Adult Services and Prison Healthcare Don Bradley, (Bria Mongan from April 2020; Margaret O'Kane from May 2020)
- Director of Children's Services Bria Mongan, (Barbara Campbell from April 2020)
- Director of Hospital Services David Robinson
- Director of Primary Care and Older People / Executive Director of Nursing Nicki Patterson

9. The Trust also established a Coronavirus Liaison Group (CLG), on 5th February 2020. Initially, these meetings were held weekly to address the rapidly evolving situation, however by May 2020, as the pandemic evolved and the immediate crisis management phase passed, the Trust Coronavirus Strategic Liaison Group adjusted their meeting frequency to a fortnightly schedule.

10. The CLG was co-chaired by myself and the Director of Primary Care, Older People and Nursing, and comprised of the chair of ten workstreams.

- Workstream 1 – Human Resources
    - Chair: Noeleen McCreanor Assistant Director Employee Resourcing & Admin Services, (since retired)
- Workstream 2 – Communication
    - Chair: Jeanie Johnston Head of Communications, (since retired)
- Workstream 3 – Service Continuity
    - Chair: Naomi Dunbar Assistant Director Strategic and Capital Development
- Workstream 4 – Patient Experience
    - Chair: Jeff Thompson Assistant Director Patient Experience
- Workstream 5 – Clinical Services – Hospital
    - Chair: David Robinson Director of Hospital Services,
- Workstream 6 – Clinical Services – Community
    - Chair: Brenda Arthurs Assistant Director Primary Care, Mental Health Services Older People and Nursing, (since retired)
- Workstream 7 – Adult Services
    - Chair: Damien Brannigan Assistant Director Adult Mental Health, (since retired)
- Workstream 8 – Logistics
    - Chair: Paul Morgan Director of Finance and Estates, (since retired)
- Workstream 9 – Children and Social Services
    - Chair: Barbara Campbell Assistant Director Social Work, (since resigned)
- Workstream 10 – Nursing and Residential Home Support
    - Chair: Nicki Patterson Director of Primary Care and Older People / Executive Director of Nursing, (since retired)

11. Each workstream was responsible for the development and implementation of a Contingency Plan to respond to the pandemic and the assessment of the state of readiness to meet the demands of surges.

12. The Coronavirus Liaison Group:

- Ensured that robust reporting systems were in place to provide the SCG with the information they needed to implement decisions when activated
- Ensured that systems were in place to manage the workforce i.e. redeployment and absenteeism
- Helped to clarify the physical resource implications of dealing with and managing the outbreak
- Agreed and co-ordinated decisions on the location of known suspect cases, closure of wards and deferral of services as required and ensured that staff were relocated to areas of the Trust under pressure in consultation with SCG
- Disseminated regional direction and information to workstreams to ensure decisions were implemented
- Ensured that communication channels were established both within and outside the organisation
- Reviewed progress and monitored effectiveness of control measures
- Identified and progressed cross-cutting issues, risks etc. arising from workstreams
- Ensured all necessary steps were taken for the continuing clinical care of all patients and clients within the organisation through receipt of reports from each Directorate and in consultation with other key stakeholders e.g. General Practitioners (GP's); and
- Ensured the Trust was represented on any regional groups established and provided information and feedback.

An example of the Coronavirus Liaison Group Agenda can be found in **(Exhibit CM/01 – INQ000572444).**

13. There was also a Cluster Outbreak Working Group, established on 4th June 2020, to address the emerging Covid-19 cluster outbreaks. This group met weekly to coordinate and implement processes to manage the outbreaks. By the 8th July 2020,

successful processes had been implemented across the Trust, enabling this group to stand down.

14. On 20th March 2020, the Trust established an Incident Control Room (ICR). This Incident Control Room played a vital role in managing the pandemic.

- The ICR ensured that the latest guidelines and protocols from the Public Health Agency (PHA) and Department of Health (DoH) were promptly and effectively communicated to all relevant areas, including the Care Homes
- The ICR facilitated a coordinated response to the evolving situation, ensuring efficient resource allocation and alignment of all actions with the latest guidance.

15. This Trust structure was vital in maintaining an organised and effective response to the COVID-19 pandemic.

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

16. The Trust Pre-Pandemic Structure in relation to the operational teams who were involved in the Care Sector, is detailed in Organograms detailed in the exhibits; (**Exhibit CM/02 - INQ000553827)** and **(Exhibit CM/03 - INQ000553828).** The Trust Contracts Department is the corporate service that was responsible for all contracting, commissioning, procurement and governance oversight for externally contracted services with Independent Sector Care Providers. The Department had an overview of the performance of contracted providers and managed the interfaces between the Trust and all providers within the Trust catchment area.

17. During the relevant period the following contracts were in place for -

- Nursing and Residential Care Services, for the provision of Nursing Care and Residential Care across a range of independent sector care providers, registered with the Regulation and Quality Improvement Authority (RQIA). These services would have spanned all categories of care to include, older people, mental health, learning disability, physical disability and dementia.

- Domiciliary Care, for the provision of personal care in individuals' homes, across a range of independent sector care providers, registered with RQIA.

- Supported Living Services, for the provision of personal care in supported living premises, across a range of independent sector providers, registered with RQIA.

- Community and Voluntary Sector, for the provision of a wide range of general services such as counselling and day opportunities with a range of charities and non-regulated providers.

- Self-Directed Support, for the provision of a range of self-directed services, where an individual is allocated a budget as part of their assessment of need that they direct to a provider, for the delivery of a bespoke service that the Trust contracts on their behalf.

TRUST INDEPENDENT AND STATUTORY NURSING AND RESIDENTIAL HOMES

18. Within SEHSCT there were:

- 54 Independent Sector Nursing Homes, with a total bed capacity of up to 2,524 beds
- 49 Independent Sector Residential Homes, with a total bed capacity of up to 1,136 beds
- 8 Statutory Residential Homes, with a total bed capacity of up to 232 beds

There were 2,313 of 2,569 clients placed by SEHSCT in Jan 2020 whose placement was partly or wholly funded by the Trust.

DOMICILIARY CARE PROVIDERS USED BY SEHSCT AND NUMBER OF PUBICALLY FUNDED RESIDENTS

19. Within SEHSCT there were 34 Independent Sector Domiciliary Care Providers. There were 4,374 publicly funded recipients of Independent Sector Domiciliary Care provision, as at 23/09/2024. This figure will have fluctuated during the relevant period.

SEHSCT CARE SECTOR WORKFORCE

20. In Jan 2020 the number of SEHSCT Care Workforce employed were:

- the equivalent of 936 full time Domiciliary Care Workers
- the equivalent of 499 full time employees in the eight Trust Residential Care Homes.

21. TRUST SERVICE USERS IN RECEIPT OF A DOMICILIARY CARE PACKAGE PER PROGRAMME OF CARE

Programme of Care	Week Commencing 6 January 2020	Week Commencing 2 March 2020	Week Commencing 27 June 2022
Elderly	4116	4194	4208
Physical Disability	570	565	583
Learning Disability	251	249	234
Mental Health	55	56	73
Family & Child Care	4	4	2
Children with a Disability	31	31	19
TOTAL	5027	5099	5119

*Not Included – Service users in receipt of a Direct Payment package.

22. TRUST SERVICE USERS IN RECEIPT OF A DIRECT PAYMENT CARE PACKAGE PER PROGRAMME OF CARE

Programme of Care	Month Ending January 2020	Month Ending March 2020	Month Ending June 2022
Elderly	182	186	228
Physical Disability	266	270	319
Learning Disability	172	175	204
Mental Health	24	24	19
Family & Child Care	2	2	2
Children with a Disability	253	261	301
TOTAL	899	918	1073

PRE-PANDEMIC PRESSURES KNOWN TO SEHSCT IN THE CARE SECTOR

23. The Trust adopted a comprehensive strategy with providers to ensure effective communication, resolve issues and improve overall service delivery. The Trust holds annual contract reviews with independent providers as well as regular, Provider Forums and operational meetings. Providers in the Care Sector have the the opportunity to raise concerns, highlight challenges and collaborate on solutions. This structured communication enhanced service delivery and fostered a strong partnership between the Trust and Providers.

24. Nursing and Residential Home Pre-Pandemic challenges reported to the Trust included: Workforce issues such as staff recruitment and retention of staff, workforce issues and the number of beds required to meet demand

25. Domiciliary Care challenges recruitment and retention of staff, funding and in particular the hourly rate of pay for care staff. Providers felt the rate of pay was insufficient to attract new staff or retain existing staff. Many providers felt that the responsibilities placed on care staff were not reflected in the hourly rate of pay. Additionally they often lost care staff to the Trust or other providers as they could not offer more competitive terms and conditions within available funding. Before the pandemic, the Trust engaged several domiciliary care providers in HSCB led pilot projects to test new models of care. These projects aimed to address workforce challenges and test the use of self- autonomous teams to enhance to role of care staff.

26. To address issues, the Trust was proactive in fostering collaboration and communication amongst providers. The Trust invited private providers to join forums and workshops, which created opportunities to share best practice and address common challenges. The Trust identified relevant speakers and sourced information, to keep providers informed and engaged. In addition, the Trust linked in with regional colleagues and escalated concerns at the appropriate level, with the HSCB and the Strategic Planning and Performance Group (SPPG) DoH.

SUMMARY OVERVIEW OF PANDEMIC IMPACT ON ADULT CARE SECTOR

RISK OF INFECTION

27. Nursing and Residential Homes temporarily paused admittance of new residents during the early stages of the pandemic to help prevent virus transmission. The Trust collaborated with the homes to ensure Business Continuity Plans were initiated, providing support to ensure infection control protocols and social distancing measures were effectively implemented. As regional guidance was issued, it was shared with the homes, and protocols were adjusted to facilitate homes to open to new admissions. Daily reporting through the RQIA was established, allowing homes to update on bed availability, Covid positive case, staffing level and other essential information.

28. Many Nursing and Residential Care Homes closed their doors to visitors on 20th March 2020. These restrictions in the early stages of the pandemic, were decisions taken by individual homes before any formal regional guidance was issued. These restrictions affected families who could no longer visit their loved ones, even during end-of-life situations. Over time, some Care Homes adjusted their protocols to allow for limited or alternative forms of visiting, such as window visits or virtual communication. Some Care homes also temporarily paused admittance of new patients after 22nd March 2020, to prevent the transmission of COVID-19. The Trust does not hold detailed information on the number of care homes.

29. The Trust was directly responsible for providing guidance and support to its Statutory Homes. Additionally, the Trust provided support and training to private providers of Independent Sector facilities when needed. In Northern Ireland, guidance was issued by the DoH, PHA and Public Health England (PHE) ensuring a consistent approach across all care settings, including those in the Independent Sector.

30. Some providers operating services in Northern Ireland were based in England, where the guidance for social care settings differed from that of Northern Ireland. This sometimes led to confusion, as staff from Independent Sector Providers occasionally referred to English guidance instead of local guidelines. RQIA maintained a dedicated site for the Independent Sector to access the relevant local guidance. A centralised hub for communicating with Independent Sector Providers was crucial for effective information dissemination. The Trust already had a central point of oversight for all contracted providers before the pandemic, which was strengthened in April 2020, to manage all correspondence and communication oversight. This process was primarily conducted through email, using existing information related to provider contracts. The Trust shared guidance with all Independent Sector Providers on the day it was received.

31. There were instances when PHE guidance was updated, and it was unclear whether it had been approved for use in Northern Ireland. The guidance was reviewed for applicability by the PHA Regional IPC cell, with formal written approval provided by the DoH. Once the Trust received confirmation from the DoH that the guidance was applicable in Northern Ireland, it was implemented across the Trust as needed, including updates to Care and Residential Home guidance.

32. National and or regional guidance were on occasions issued late, for example on a Friday afternoon or a Saturday, which created challenges for review and immediate implementation. Implementing these changes to protocols in a healthcare setting, required careful planning and implementation by the Trust, to ensure the safety of both staff and patients.

33. Managing the quantity of guidance was a critical task for the Consultant Microbiologists Yuri Protaschik and Ciaran O'Gorman, and the IPC Leads Isobel King and Monica Merron (retired November 2020) in the Trust. When new guidance was received, it was reviewed and agreed by the IPC Lead(s) and Consultant Microbiologists. The extensive local review ensured that the guidance met the specific needs of various specialities and services across the Trust including community settings. The revised guidance was then considered at the Trust COVID-19 Liaison Group for approval and then implementation across the Trust. The IPC team worked with relevant clinical teams to review local protocols to align with updates. The guidance was effectively distributed by the Trust Communications Team for implementation, to maintain the safety of patients and staff. There was a dedicated site on the Trust Intranet for IPC which was updated regularly by the IPC team to reflect changes in guidance.

34. The Trust review process included:

- Identifying the necessary changes and planning how these would be implemented across the Trust, including Nursing and Residential Homes
- Ensuring compliance with the guidelines Trust wide
- Adapting to changing requirements as new information and guidelines emerged.
- Ensuring that staff were made aware of the guidance changes and the importance of these via a range of communication processes, including but not limited to
    - The visible presence of IPC staff in clinical settings
    - Provision of an IPC out of hours telephone help line
    - Consultant Microbiologist on call service for advice and support
    - Staff training
- Implementation and monitoring of the effectiveness of the guidance and adjustments made as required, based on observations and staff feedback.

This approach ensured a high standard of care and safety throughout the Trust, including within community settings.

35. The risk of infection and the impact of COVID-19 on the Care Home sector before vaccinations were available, was substantial. Despite the use of PPE, the high incidence of cross-infection in communities led to significant outbreaks in Care Homes. This resulted in devastating outcomes for residents and their families, as many Care Home residents were frail elderly individuals, with multiple health conditions. The restricted access for Care Home residents to their families and loved ones during the pandemic, undoubtedly had a significant impact on their wellbeing.

36. The social care workforce in Care Homes was also affected by community transmission and cross-infection rates, leading to reduced staffing levels. Additionally, many workers were either shielding or hesitant to come to work due to the risks associated with COVID-19.

OTHER CONCERNS THE TRUST MAY HAVE HAD WITHIN THE CARE SECTOR

CARE HOMES

37. The Trust had several concerns for the residents, families and staff in the Care Sector and Care Homes. The Trust were mindful that isolation was challenging for residents with cognitive impairments or a diagnosis of Dementia. Managing residents with Dementia in Care Homes and obtaining consent for testing also posed challenges. At the onset of the pandemic, individual homes made their own decisions regarding access in the absence of regional guidance. This restricting on visiting meant that Residential and Care Home residents potentially lacked family advocacy. The restricted visiting was especially significant during end-of-life situations. Additionally, there were the overall challenges of the physical, mental and emotional impact of COVID-19 and how this affected residents, their families and staff. The decision for staff to move into the Care Home to provide care to residents, due to workforce challenges as referenced in the letter of 15th May 2020 from DoH: Covid-19 Safe at Home Model **(Exhibit CM/04 - INQ000553829)**, led to the workforce in Care Homes isolated from their families. This likely had a disproportionate impact. Zero hours contracts for staff have a negative impact overall and there were also financial implications for Care Home owners, prior to the introduction of resilience payments and payments for sick pay. There was some reduction in the number of new referrals to Care Homes, which affected occupancy levels. This was largely due to families being home and able to provide care for their loved ones. Finally, there were

insufficient systems in place to support the notification of laboratory results, hindering timely responses and isolation for COVID-19 positive residents.

38. The Trust had concerns for Social Care settings which often lacked a healthcare professional. The Trust were conscious of the overall challenges of the physical, mental and emotional impact of COVID-19 and how this affected residents, their families and staff. There were also insufficient systems in place to support the notification of laboratory results, hindering timely responses and isolation for COVID-19 positive residents.

39. The Trust implemented the Northern Ireland Regional Mortality & Morbidity Review system (RM & MRs). All hospital deaths are discussed at specialty Mortality & Morbidity (M&M) meetings to facilitate learning, action and change in order to improve patient safety. Adverse outcomes, morbidity and mortality within the Care Sector are not considered at those meetings. Inpatient COVID-19 deaths were reported to the PHA via agreed reporting structures. The Trust did review all COVID-19 nosocomial inpatient deaths, categorised as definite or probable Healthcare Associated Infection (HCAI) in line with the guidance developed by a Subgroup of the Northern Ireland COVID-19 Nosocomial Support Cell (NSC). General Practitioners (GPs) are the primary point of contact for patients in the community, including those in the Independent Care Sector. GPs were responsible for providing ongoing medical care and health assessment of residents, to determine their medical needs, regularly reviewing and updating Do Not Resuscitate (DNR) orders and overall care plans, considering any changes in the residents' health status or wishes.

40. Care Home providers were required by legislation to report all resident deaths to RQIA as notifiable events; however, they were not obligated to report deaths of residents who passed away in hospitals. RQIA maintained oversight and communication with Care Homes to ensure timely reporting of incidents, including deaths related to COVID-19.

41. The Trust offered a dedicated bereavement service and counselling for families who could not be with their loved ones during their final moments in Care Homes and Hospitals. This service included support from a Bereavement Coordinator, who provided guidance and signposted families to appropriate counselling services. The Trust also provided information and organised remembrance events for those who experienced the loss of their loved ones.

HEALTH INEQUALITIES

42. In an effort to mitigate against health inequalities, and in accordance with DoH and SPPG direction, the Trust established three COVID-19 Primary Care Centres; based at Ards Hospital, Lagan Valley Hospital and Down Hospital. These centres were essential to maintain GP practices and an 'Out of Hours' service and were established in partnership with the four GP Federations, (group of general practices forming an organisational entity, working together within the local health economy).

43. The centres provided an in-reach service into the Care Home Sector and in addition, the Enhanced Care at Home Service (EACH), worked closely with the GPs employed directly by the Trust to assess and treat symptomatic patients in Care Homes. This service provision was critical to ensure that GP practices were able to effectively meet the increased demand and deliver timely treatment.

44. The needs of people with a Learning Disability were also considered by the Trust and every attempt was made to meet their unique complex needs. Close working between the Trust Community Nursing Learning Disability Team and Enhanced Care at Home Team, ensured that people with a Learning Disability received the same care as the general population.

45. Remote triage was further enhanced through collaboration with ProParamedics, (independent paramedic ambulance service) commissioned by the Trust to provide additional clinical assessments within the Care Home Sector

TRUST LIAISON AND COMMUNICATION WITH GOVERNMENT AND OTHER STAKEHOLDERS

46. The Trust worked collaboratively in partnership with key stakeholders, in response to the ever-changing landscape in 2020. This was to support the region with the management and planning, which was required during the pandemic, to safeguard patients, staff and the public. This included utilising and maximising resources, training and support for staff, the development of policies and protocols and communicating with staff, patients and the public.

47. In 2020, the South Eastern Trust along with other Trusts, collaborated with the Health Committee of the Northern Ireland Assembly in the preparation of the Inquiry Report on the Impact of COVID-19 in Care Homes by the Health Committee **(Exhibit CM/05 – INQ000572445).** The Trust contributed information about the Care Home

Sector's response to the pandemic and detailed the Trust's efforts to support the sector, emphasising the health and safety of residents. This collaboration involved sharing data and insights that were critical for understanding the challenges faced during the pandemic

48. The Department of Health (DoH), established a Strategic Cell, providing direction and leadership to Health & Social Care (HSC) organisations and other organisations including the Independent Sector, (IS), throughout the pandemic. The Strategic Cell was chaired by the Chief Medical Officer (CMO) or a deputy from the Department's Top Management Group, senior officials and the Department's professional officers from the medical, nursing and social care disciplines.

49. As the Trust Medical Director, I attended regional teleconference calls with the Public Health Agency (PHA), regarding modelling and surge planning for the pandemic. My office received evolving guidance and updates from the CMO, DoH and PHA on a frequent basis during the pandemic. These documents were appropriately assessed and circulated via the Incident Control Room, as the single portal for the Trust. These were distributed to all relevant directorates for action. In the initial phase of the pandemic, the formal Trust Medical Director face to face meetings were stood down with the DoH/CMO and reinstated in May 2020. There were however a number of update teleconference calls with my counterpart Medical Directors, to discuss evolving issues within the pandemic. Like all other Medical Directors, I participated on the HSC Silver teleconference calls daily with the region, to assess challenges and evolving guidance.

50. There was strong collaboration between the Trust and the IPC cell, led by the PHA. The PHA played a crucial role as the intermediary, between Trusts and the DoH. The role of this group was to ensure effective communication and coordination on all matters pertaining to Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE). This was a multidisciplinary group and was instrumental in fostering shared understanding and timely decision-making across the region. The Trust IPC staff also collaborated with the PHA on a Regional Product Review Group, a subset of the IPC Cell. The remit of this group was to review and trial samples of PPE that had been procured by BSO PaLs to ensure that they were fit for purpose. These products were CE marked which meant that they complied with European Standards. The Trust was also asked to test and trial products with clinical staff and provide feedback on the suitability of products. Items included visors, safety spectacles, aprons, gowns etc.

51. The Trust worked with the DoH, HSCB, PHA, RQIA and other Trusts collaboratively in relation to the Care Sector on staffing, access to PPE and improved access to health care services for residents, including testing, contributing to surge plans and reporting issues or concerns.

52. The Trust also worked in partnership with other Health and Social Care Trusts, the HSCB, the PHA, and the Chief Social Services Officer, within the DoH to implement regional guidelines for the Covid-19 Adult Mental Health and Adult Learning Disability Subgroup. This collaboration aimed to enhance communication between stakeholders, facilitate information sharing amongst various social care sectors and providers and clarify regional actions, relevant to social care settings. The primary goal was to establish a coordinated response to Covid-19 outbreaks across all providers.

53. The Trust collaborated with regional colleagues and RQIA to:

- Manage care partner arrangements ensuring that care partners could safely visit and support their loved ones in care settings, whilst following essential health and safety guidelines
- Develop an operational practice document for the Service Support Team in the Independent Sector (IS), to outline how they would coordinate with the Trust during the pandemicTop of FormBottom of Form
- Contribute to the creation of a centralised portal designed to streamline communication and facilitate the reporting of concerns or issues.

54. The Trust collaborated with the Patient Client Council (PCC) to address concerns related to visiting restrictions and the provision of personal protective equipment (PPE) during the pandemic. This partnership aimed to ensure that patients' voices were heard throughout this challenging period, allowing for feedback on their experiences and needs in care settings. By engaging with the PCC, the Trust sought to enhance communication and responsiveness to the issues faced by patients and their families

55. The Trust collaborated with the Independent Health and Care Providers (IHCP) on various social care issues, working alongside key stakeholders RQIA, the Commissioner for Older People for Northern Ireland (COPNI), the PHA, the DoH, the Northern Ireland Social Care Council (NISC), and other Health Trusts. This partnership aimed to address challenges in the social care sector, ensure effective communication

and coordinate responses to the needs of patients and care providers during the pandemic.

56. The Trust collaborated with the COPNI to address specific cases as needed, ensuring that the rights and needs of older individuals were prioritised during the pandemic. This focused on identifying and resolving issues affecting older people, facilitating access to necessary support and resources, whilst maintaining their well-being and dignity.

57. The Trust's senior management teams worked closely with both local and regional Trade Unions during the pandemic. Through regular meetings with key stakeholders, including the Trade Union Chairperson, the Trust was able to implement policy changes aimed at supporting staff. These changes included the introduction of remote working, local measures to assist staff with accommodation challenges and initiatives focused on staff well-being. Local Trade Union representatives played a pivotal role in the SEHSCT Health and Wellbeing Steering Group, which developed strategies to support staff during COVID-19. Initiatives such as well-being hubs, wobble rooms and dedicated staff helplines were established to provide resources and support to employees. Regional decisions also involved collaboration with Trade Union colleagues to shape key policy and practice changes, ensuring transparency and consistent application. This included efforts such as shielding measures and the development of Frequently Asked Questions to address staff concerns. The Trade Unions were supportive of the redeployment of staff to the COVID-19 Centre in Belfast, which facilitated a coordinated response during the pandemic. The strong working relationships with Trade Union representatives were viewed positively and provided welcomed support for both staff and management

58. The Medicines Optimization Innovation Centre (MOIC – an independent research group for NHS NI lead by Mike Scott), sat on the PPE Regional Product review group to check CE compliance.

59. The Trust worked with the Department of Infrastructure in the summer of 2020 to set up a COVID-19 Swabbing Unit in the Newtownards MOT Centre, for citizens and staff in the SEHSCT catchment area. The centre was also used to provide a phlebotomy service for pre-assessment patients who were having surgery.

60. The Trust participated in regional calls between Procurement and Logistics Service (PaLS) and all HSC Trust colleagues responsible for overseeing PPE ordering and distribution. These calls discussed sourcing options, regional stock levels and individual stock levels held by each Trust for all PPE products. PaLS delivered stocks of PPE twice daily at the onset of the pandemic to a SEHSCT designated warehouse facility and distribution centre

61. The Trust worked with the Northern Ireland Ambulance Service (NIAS) in regular teleconferences to enable a range of matters to be discussed and responded to, in partnership with other Trusts and the HSCB, to enhance capacity.

62. The Trust also commissioned services from Proparamedics, an independent ambulance service, to support clinical assessment and testing protocols within the Care Home Sector.

63. The Trust was asked by the DoH to provide PPE to the Marie Curie Hospice and approached by St John's Voluntary Ambulance Service for PPE supplies. The Trust supported these organisations in accordance with PPE Guidance.

DISCHARGE POLICY AND REGIONAL GUIDANCE

64. Prior to the relevant period, the Trust did not undertake any COVID-19 testing prior to patients being discharged. If a patient during their admission was identified on laboratory testing, as having a resistant bacterium or other micro-organism likely to cause infection, then the relevant Care Home would be informed by the discharging ward. This was to ensure the appropriate management of care was implemented within the relevant setting.

65. The Trust had an overarching discharge policy **(Exhibit CM/06 - INQ000553830)** that was due for review, however this was the extant policy during the relevant period. The aim of the policy was to inform staff of the principles underpinning good discharge planning and the steps they had to undertake. All patients discharged, including those to Care Homes, would have a discharge checklist completed by nursing staff. Medical staff would record in the discharge letter if a patient had an infection or was colonised with a resistant bacterium. Patients discharged to Nursing or Residential Homes received essential information and documentation upon discharge pertaining to the patient. This included relevant risk assessments (section 5.0 of the policy). The policy

and guidance were located on an iConnect page on the Trust Intranet for staff to access.

66. From March 2020 until 24th April 2020, COVID-19 testing was not required for hospital discharges and the Trust followed the existing discharge policy. The requirement to test each patient 48hrs in advance of discharge from hospital did not come into practice until 24th April 2020, with immediate effect. The letter stated 'that the testing requirement must not hold up hospital discharges.' Following discharge to a Care Home patients were to be isolated for 14 days, in accordance with infection control guidelines. If Care Homes were unable to isolate individuals, the Trust arranged for these patients to be isolated in dedicated Covid-19 positive discharge units (Rainbow Units), until they were able to be admitted to the Care Home. See Paragraph 90 for more details.

67. The PHA revised Guidance Version 2.4, issued on 16th July 2020, clarified that residents who attended the hospital for short appointments or assessments for non-COVID-19 symptoms and who were not admitted, were not required to isolate upon their return to the Care Home. This adjustment aimed to support the management of Care Home residents while minimising unnecessary isolation. Top of Form

68. The Trust further complied with the guidance on receipt of the letter on 14th December 2020 **(Exhibit CM/07 - INQ000553831)**, from the HSCB and PHA regarding the IPC Pre-admission / Admission Risk Assessment form. This letter clarified that all Trusts were required to use this agreed form when discharging a patient to a Care Home subsequent to discussions at the Regional Discharge Meeting, on 26th November 2020.

69. The PHA released COVID-19 Guidance for Nursing and Residential Care Homes in Northern Ireland Version 2.8 of the guidance on 21st December 2020. This outlined updated protocols relating to the discharge of patients from hospital settings back to Care Homes, designed to address safety concerns during the ongoing pandemic. Key aspects included:

- Revised Discharge Procedures: The guidance emphasised the need for thorough assessments prior to discharge, including COVID-19 testing and evaluating the patient's overall health status.
- Minimizing Transmission Risk: To facilitate a safe transition for patients while minimizing the risk of COVID-19 transmission within Care Homes.

The Trust complied with all the guidance issued, as detailed above.

70. During this period the Trust was not required to test prior to discharge, therefore the Trust does not have the number of patients discharged from hospital who were not tested for COVID-19 between March 2020 to 24th April 2020. After receiving the revised guidance on 24th April 2020, all patients were tested prior to discharge, as per the revised protocol.

TRUST COMPLIANCE WITH RELEVANT GUIDANCE

71. The Trust introduced changes to ensure compliance with the guidance and correspondence from the DoH:

- 13 March 2020 - 'Surge Plan: Social Care and Children's Services': This document outlined the immediate measures needed to manage increased demand on social care and children's services due to COVID-19, focusing on maintaining service delivery and safety for vulnerable populations. This included the anticipation of increased demand, workforce adjustment, PPE distribution and infection control measures. This was to coordinate efforts across regional services to manage the challenged posed by the pandemic.
- 18 April 2020 - 'Covid-19 Guidance for Nursing and Residential Care Homes in Northern Ireland': This guidance provided updated protocols for Care Homes, including infection prevention and control measures, safe visiting practices, and staff training requirements to protect residents during the pandemic.
- 19 April 2020 - 'Covid-19 Interim Protocol for Testing for Covid 19': This protocol established the framework for testing residents and staff in care settings, detailing eligibility criteria and procedures to ensure timely testing and reporting of results.
- 25 April 2020 - Letter from Richard Pengelly: this communication, provided updates regarding operational changes, emphasising the need to align efforts to support the social care sector effectively during this challenging time. The correspondence highlighted the allocation of resources to address the immediate needs of the sector, aiming to mitigate the impact of COVID-19 on Care Homes and other social care facilities. This included guidance on infection control measures, PPE distribution, and maintaining effective communication channels between the various health and social care bodies involved.

- 27 April 2020 - 'Covid-19 Guidance for Nursing and Residential Care Homes in Northern Ireland': This document served as a further refinement of previous guidance, incorporating lessons learned and outlining specific actions to enhance resident safety and care quality in light of the ongoing pandemic.

72. To comply with the guidance from the DOH, the Trust implemented several key changes throughout the COVID-19 pandemic:

TRUST WINTER RESILIENCE PLAN

73. In response to 13th March 2020 DoH Surge Plan, specifically section 4 on Regional Planning Assumptions, the Trust developed a Winter Resilience Surge Plan **(Exhibit CM/08 - INQ000553832).** The plan was subsequently published 6th October 2020, on the DoH website. The Trust Resilience Planning Framework outlined in the Winter Resilience Surge Plan, highlights the themes and objectives established to address the demands of Winter 2020, including moving to 7 day working. The Trust collaborated with the HSCB and RQIA, to ensure that Care Homes had the necessary support and guidance to manage the challenges. Additionally, the Trust worked on facilitating timely hospital discharges to free up acute care beds, aligning with the surge planning assumptions that projected an increased strain on hospital resources and the need for enhanced Care Home support. The response also included creating additional capacity in care settings, to ensure that staffing levels could cope with potential surge, and maintain continuity of essential services.

TRUST INFECTION PREVENTION AND CONTROL SUPPORT FOR CARE HOMES

74. In response to the guidance issued on 18th April 2020 regarding Infection Prevention and Control, the Trust strengthened its protocols within Nursing and Residential Care Homes. This included the implementation of strict hygiene measures, regular staff training and PPE usage to reduce the risk of virus transmission. The Trust IPC team contacted Care Homes by telephone and email to offer specialist advice and support around the prevention and management of COVID-19. During any visit or telephone contact by Trust staff, efforts were made establish that the relevant Care Home had an adequate supply of PPE and that there were satisfactory virucidal cleaning agents (having the ability to destroy or inactivate viruses) to aid effective decontamination of hands, environmental surfaces and equipment. The Trust provided

PPE and cleaning agents free to the Independent Healthcare Sector during the relevant period.

75. During the period 20 March 2020 to 30 September 2022 the value of PPE supplied free to Independent Sector Care Homes, Supported Living Providers and Domiciliary Care Providers, by SEHSCT was as follows:

2019/20 £0.1m (estimated cost). Data was not available for the period 20 March to 31 March and the Independent Sector were reimbursed for what they had procured during this period.

2020/21 £6.1m

2021/22 £5.6m

2022/23 £2.5m from 1 April to 30 September 22

Total £14.3m

76. The Trust's initial focus was the provision of assistance to Care Homes where an outbreak of COVID-19 had been identified in residents and / or staff. This evolved to include Care Homes that did not have outbreaks. Care Homes were made aware of the most recent PHE and PHA guidelines and each home was offered an opportunity to avail of a visit and / or on-site training. An initial telephone call was made to each Care Home, averaging 30 minutes. Some Care Homes declined visits, to reduce footfall in effort to remain COVID-19 free. These Care Homes were given IPC contact details, should their needs change. As these were Independent Sector Care Homes, the Trust had no right of entry to enforce visits.

77. A senior nurse from the PHA was redeployed on the 22nd April 2020 (three days per week) to the Trust IPC team, to assist with outreach support to the Independent Care Sector. The main objectives of this initiative were to provide advice, support and training to the Independent Sector. The training provided covered the following topics:

- Critical information regarding COVID-19, including the presenting signs and symptoms of the virus
- Any recent changes in regional or national guidance
- Main routes of transmission
- Risk assessment of residents and testing
- Correct use of Personal Protection Equipment – demonstrations of donning and doffing

- General IPC standard principles – including hand washing demonstrations
- Environmental cleaning and waste disposal, including choices of cleaning products
- Laundering of staff uniforms

78. A total of 389 people were trained face to face and considerably more participated in online sessions, however these numbers were not able to be captured due to the online mode of delivery. The range of staff trained included:

- Allied Health Professionals
- Domestic
- Laundry
- Nursing
- Medical

79. Support within the Care Home Sector was further supplemented on the 21st May 2020, when the PHA redeployed 13 dentists, who had received IPC training from the Clinical Education Centre. This training and role clarity were reinforced with a local induction by the Trust IPC Lead. It was challenging to maintain support from dentists due to their primary responsibilities within dental practices. The need for some dentists to return to their practices to provide essential services further affected the sustainability of this support. It also became apparent that the time spent contacting Care Homes to arrange visits and / or training, including travel time to the facilities, had been underestimated and in June 2020 a second IPC Nurse from the Trust was redeployed, to facilitate support to Care Homes in the **I&S** Sector.

80. The table below summarises the input into the Care Homes by the PHA and Trust IPC team. It should be noted some Care Homes received visits from multiple team members, which may not be captured below.

Team Member	Number Of Homes Supported
PHA Senior Nurse	61
IPC Lead Nurse	29 + 2 centres via Zoom (video call)
IPC Nurse	25 + 64 care staff via Zoom (video call)
Dentists	14

NURSING HOMES DEEMED INADEQUATE BY RQIA

81. During the relevant period the Trust was made aware of three Care Homes which were subject to regulatory action by RQIA. The three Care Homes were suspended to new admissions, therefore no patients were discharged from the South

Eastern Trust to those facilities during the period of this regulatory action. When the Trust received formal notification from the RQIA that the Care Homes had implemented the relevant required actions and reached compliance, admissions were resumed as necessary.

TRUST COMMUNICATION AND COLLABORATION CARE HOME SECTOR

82. Starting from 16th March 2020, the Trust initiated daily calls to Care Homes, to offer support and identify any issues that needed attention. The Trust could only address issues reported to them and collaborated with Care Homes to facilitate access for visiting professionals and coordinated with the PHA, RQIA and other statutory bodies to share information. PHA outbreak reports were used to stay informed about outbreaks. The Trust made individual contact with each Care Home on a case-by-case basis. Prior to entry into any facility Trust staff were tested for COVID-19 and adhered to PPE and social distancing protocols.

83. The Trust made formal notifications to Care Homes regarding entry of Trust staff, however some Care Homes restricted access for visiting professionals to reduce footfall and this was managed on a home-by-home basis.

84. In March 2020 following correspondence and direction from the DoH the Enhanced Care at Home (ECAH) service was repurposed to primarily provide support, assessment and treatment to patients in Care Homes. The ECAH team worked alongside the Primary Care Clinical Director to provide clinical in reach to Care Homes. The team conducted clinical reviews and assessments, triaging and prioritising residents for escalation, clinical interventions and end-of-life pathways. This initiative was linked to the Trust Care Home Response Hub. The team undertook daily telephone calls to all Care Homes, to assess the level of clinical support required. The specialist ECAH physiotherapist assisted by assessing positive COVID-19 clients and participated in multidisciplinary ward rounds, providing advice and support to Care Home staff.

85. Prior to Covid 19 the South Eastern Trust Community Palliative Education Facilitators (CPEF) had been facilitating two separate monthly palliative Extension for Community Healthcare Outcomes (ECHO) programmes, one for district nursing staff and one for Nursing Home staff. Video-conferencing technology was used for participants to access evidence-based, best practice guidance and case-based learning. During COVID 19 this platform was used to offer support, share information

and provide relevant education to Care Home staff and nursing staff working in community settings. Topics included Palliative Care and Covid 19, Anticipatory Prescribing, Self-Care Bereavement Support, Staff Support and Pandemic Medicine Packs. During the relevant period the ECAH service inputted into Project ECHO sessions for Care Home staff.

86. Through the establishment of this community knowledge network for nurses and support staff, they were able to gain knowledge and share their experiences of caring for patients/residents in a safe environment. This underpinned their ability to continue to deliver care effectively and safely to their patients / residents.

87. For Learning Disability clients exhibiting concerning behaviours, the Community Learning Disability Nurse would accompany ECAH staff into the Care Home to put a management of care plan in place and provide follow up as required.

88. A six-week ECHO programme was also developed for Residential Home staff to share relevant information and provide support and training. The Trust also piloted the PHA Virtual Wellness Checker in conjunction with the Trust ECAH service, district nursing teams and the staff across all Residential Care facilities were trained to undertake daily monitoring of residents.

ADAPTATION OF SERVICE PROVISION

89. In alignment with the 13 March 2020 Surge Plan, the Trust adapted service provision to meet the increased demand to ensure residents safety, facilitate hospital discharges and increase capacity. The Trust implemented protocols to manage admissions to Care Homes and designated COVID-19 positive units. Initially, the Trust secured block-purchased beds in Care Homes to prepare for increased demand and facilitate discharges from acute hospitals. However, it quickly became apparent that establishing a dedicated service specifically for COVID-19 positive discharges was more effective in managing infection prevention and control measures. This transition aimed to ensure that residents who tested positive for COVID-19 could be appropriately isolated and cared for in designated units, thereby reducing the risk of transmission within Care Homes. See **(Exhibit CM/09 - INQ000553833).**

90. The Trust established dedicated COVID-19 positive discharge units (Rainbow Units) within **I&S** (a

Trust-managed residential home), totalling 55 beds. These units facilitated the discharge of patients from acute hospital settings, admissions from the community to avoid unnecessary hospitalisation and the transfer of COVID-19 positive residents from other Care Homes. This approach helped to mitigate the spread of the virus within Care Homes and addressed situations where hospital admissions were not necessary, but the care needs exceeded what the Care Home could provide.

91. By transferring residents to specialised COVID-19 units, the Trust aimed to maintain an infection-free environment in Care Homes while ensuring residents' needs were met. This approach underpinned:

- Minimised Cross-Infection: By isolating COVID-19 positive residents from those who were not infected, the risk of virus transmission within care homes was significantly reduced.
- Supported Care Homes: This approach allowed Care Homes to maintain a safe environment for non-infected residents, thus enhancing overall safety and care quality.
- Reduced Strain on Hospital Resources: By providing appropriate care in the right setting, the Trust alleviated pressure on hospitals, allowing them to focus on patients who needed more intensive medical intervention.

See again **(Exhibit CM/09 - INQ000553833).**

92. In March 2020, The Trust's Adult Mental Health Service commissioned 21 Nursing Care beds with [redacted] (15 beds in the [redacted] and 6 in the [redacted]). The aim of this service was to provide slow stream mental health rehabilitation services, delivering effective and person-centred rehabilitation and recovery for people whose needs could not be met independently in the community. During the Covid-19 Pandemic, the Mental Health Senior Management and Care Management Teams provided regular support to the [redacted] through frequent phone/email contact and online meetings. The approach was consistent with the Trust's corporate approach, principally co-ordinated by the Trust's Contracts Department and facilitated through Mental Health Service representation at the Trust's Covid-19 Nursing & Residential Home Support Meetings.

See **(Exhibit CM/10 - INQ000553834)** that outlines the number and type of beds commissioned. Whilst some of these beds were primarily for SEHSCT, some were allocated for Belfast Trust patients.

VACCINATION SUPPORT

93. In December 2020, the DoH and the PHA directed the Trust to undertake the vaccination of all Care Home residents and staff, across the Trust catchment area, as well as to administer a second dose by January 2021. The Trust assembled a dedicated team to oversee and manage the vaccination process. The Trust completed the first round of vaccinations within a ten-day period, ensuring the protection of Care Home residents and staff. Approximately 12,000 doses were administered to residents and staff in 111 care homes, over a 425 square mile area. The Trust continued to administer booster doses as outlined by the PHA / DOH guidance until the role was transferred to Community Pharmacies in April 2021.

STAFF TRAINING AND SUPPORT

94. The IPC team provided specific training programmes to Care Homes both virtually in some incidents and face to face in care homes where needed. ECAH were in Care Homes daily and did provide opportunistic IPC advice to Care Home staff when visiting and to ensure best practice was adhered to. They also identified and reported poor IPC practice especially if advised improvements were not made, to the line manager the Permanent Placement and IPC team. This alerted the Trust to homes that needed further training and support.

95. The Trust invested in Chrome Books (laptop), to facilitate easy access to e-learning and video training modules. Additionally, there was investment in 'Text Burst' Platform (SMS message sent to a large group of people, simultaneously). The Trust circulated guidance, access to training and offered bespoke training as appropriate. Videos on doffing and donning of PPE and laminated A4 posters for correct wearing of PPE were provided to Care Homes.

96. Training for staff in Domiciliary Care adhered to all infection control protocols, including within the service user's home environment included:

- Awareness sessions focused on mindfulness, mental wellbeing, resilience and stress management
- A staff helpline was also in place offering psychological support
- HR advice regarding the management of staff.
- IPC training in hand washing, respiratory hygiene, the wearing and disposing of PPE.

97. The Trust's Permanent Placement Team played a crucial role in managing and coordinating placements for individuals needing care. Key aspects of their responsibilities were:

- Facilitating Care Home Placements: The team worked to ensure timely placements for individuals requiring long-term care
- Risk Assessments: They conducted thorough risk assessments for potential placements to ensure that the needs of residents were met, whilst minimising the risk of COVID-19 transmission
- Collaboration with Care Homes: The team worked with Care Homes to monitor capacity, support admissions and ensure that homes had the necessary resources and protocols in place to manage new residents safely
- Communication and Support: The team provided communication and guidance to families and individuals regarding the placement process, care options and specific measures being implemented to protect residents from COVID-19
- Monitoring and Review: the team continuously monitored placements and undertook reviews of individual care plans which helped residents and families adapt to changing circumstances for care needs.

  This work was integral to managing the care needs of vulnerable people during COVID-19.

EQUIPMENT SUPPLIED TO CARE HOMES

98. The HSC Care Homes Surge Plan, Section 2, tasked the IS to *'continually augment existing supplies and delivery of clinical equipment and PPE in line with additional demands linked COVID19 such as oxygen, drugs, hydration, nutrition, equipment'.* Care Homes could claim additional financial support for equipment costs. The PHA completed a survey across the Care Homes to determine what equipment each Care Home might need. This information was shared with the Trust, who communicated to the respective Care Homes within the Trust catchment area, issuing a claim form to be submitted for equipment purchased.

99. In addition, due to the need for remote and virtual in reach to Care Homes from different professional groups, as well as the need to maintain social connections between residents and their families, tablet devices were identified as a requirement. There was also significant support for the provision of Defibrillators coming from a number of professional groups including NIAS and the DoH, linked in some cases to concerns around CPR as a high-risk IPC intervention. The table below is the equipment required in Care Homes within SEHSCT.

	Thermometers	Blood Pressure	Pulse Oximetry	Automated External Defibrillator	Tablet Device
NURSING	345	297	317	47	102
RESIDENTIAL	180	0	200	38	51
TOTAL	525	297	517	85	153

The Trust provided training and education on a wide range of topics including symptom monitoring to the Care Home Sector.

COVID-19 TESTING PROCEDURES

100. Trust received a letter from the HSCB on 3rd April 2020 **(Exhibit CM/11 - INQ000553835)** stating:

> *'There is no expectation that patients are tested for Covid-19 before discharge from hospital to a Care home'.*

From March 2020 until 24th April 2020, COVID-19 testing was not required for hospital discharges and the Trust followed the existing discharge policy. The requirement to test each patient 48hrs in advance of discharge from hospital did not come into practice until 24th April 2020, with immediate effect. The letter stated 'that the testing requirement must not hold up hospital discharges.'

101. The Trust received the 'Covid-19 Interim Protocol for Testing for Covid 19' on the 19th April 2020. This protocol established the framework for testing residents and staff in care settings, detailing eligibility criteria and procedures to ensure timely testing and reporting of results. The Trust then established clear testing procedures for both residents and staff as per the guidance. This included testing, processes for timely reporting of results and protocols for isolating individuals who tested positive.

102. If Care Homes were unable to isolate individuals, the Trust arranged for these patients to be isolated in an appropriate setting for 14 days. Following this period residents were readmitted to their relevant Care Home in accordance with infection control guidelines.

103. The Trust Care Home Response Hub was established in March 2020, acting as a Single Point of Contact (SPOC) for all Care Homes. This was the dedicated repository where concerns were raised in terms of symptom management or specific clinical issues. The primary advantage of this approach was the robust collaboration between operational and corporate departments, which facilitated effective information sharing and intelligence gathering and ensured a targeted response. This single point of access was subsequently extended to include all Independent Sector Providers across the Trust.

104. Care Home staff made contact via the SPOC and if COVID-19 symptoms were suspected, the Trust testing team would be deployed. Test swabs would be dispatched to the laboratory and results matched against the referrals. Positive results would then trigger full home tests for staff, residents, care partners and family members. Positive results were communicated by telephone from the laboratory to the Trust. Depending on the results, individuals or groups might then be transferred out of the home to special COVID-19 units see paragraphs 89 to 92, or in the case of staff, sent home to self-isolate. In addition, the Trust set up a BT text network to manage communication of results to Care Home staff.

105. Initially mobile units were set up for Care Home staff at various Trust sites, this expanded to mobile units visiting each Care Home to test residents, families, care partners and staff. The Transport Department repurposed vehicles, for rapid deployment to assist in mass testing in Care Homes, when outbreaks were suspected or confirmed. All drivers received IPC training and advice on handling testing samples.

106. The Trust developed a tailored, effective, and efficient response to the COVID-19 pandemic. By repurposing clinical staff and adapting administrative processes, a seven-day testing service was established to deliver timely and consistent testing, vital for controlling the spread of COVID-19 in Care Homes.

107. Additionally, the Trust established working processes with the NIAS to enhance capacity and also commissioned services from Proparamedics, an independent

ambulance service, to support clinical assessment and testing protocols within the Care Home Sector.

108. The Trust provided training and education programmes to Care Homes, empowering them to conduct testing within IPC guidelines. Delegating testing responsibilities to an external workforce proved challenging. It was a significant endeavour to make Care Home staff self-sufficient in testing. See **(Exhibit CM/12 - INQ000553836)** Algorithm for Coronavirus testing in Care Homes. The Trust is not aware of any formal consultations regarding the policy or guidance. However, Trust representatives participated in regional meetings with key stakeholders to support regional planning and protocols.

109. The Trust did not conduct any formal consultations with Residential or Care Home providers regarding the operational guidance issued by the PHA on the 17th and 26th April 2020 (Covid-19: Guidance for Nursing and Residential Care Homes In Northern Ireland). However, the Trust facilitated virtual provider forums, where providers could voice their concerns or raise questions about the relevant policies and guidelines. Additionally, providers had the option to request one-on-one sessions through the Trust Contracts Department to discuss any issues.

110. The Trust cannot quantify the impact of the discharge policy on adverse outcomes, as it was impossible to determine the source of infection due to the high community transmission rates during all surges.

PERSONAL PROTECTIVE EQUIPMENT

111. Immediately prior to the pandemic the Trust did not provide any PPE to independent residential care or nursing homes or domiciliary care providers. The Trust received its first PPE guidance on 10th January 2020. This guidance was issued by PHE, the PHA and the DoH. The DoH directed the Trust to provide PPE for the Private Care Sector, including Domiciliary Care, across its geographical area on 23rd April 2020 **(Exhibit CM/13 - INQ000553837).** The Trust complied with the guidance issued by DoH with immediate effect. PPE was supplied free to the Care Home and Domiciliary Care Sectors. See paragraph 75 for breakdown of PPE provided to the Independent Sector.

112. The Trust's Contracts Department was responsible for distributing PPE to Independent Sector Care providers, Direct Payment recipients and Trust facilities.

Initially due to limited PPE stocks, distribution was rationed, based on the prevailing regional guidance at that time, prioritising Care Homes and Domiciliary Care providers. The Trust participated in twice-daily regional calls with PaLS and other Health and Social Care Trusts to discuss sourcing options and stock levels. Trusts also collaborated to share stock, especially when critical shortages occurred.

113. As the guidance evolved, the Trust established an ordering system for Independent Sector providers based on current PPE guidelines. Orders were validated against forecasts and available stock, with providers collecting their supplies during the initial months. As the pandemic progressed, Trust transport began delivering PPE directly to the providers' premises. As referenced in the Northern Ireland Audit Office Report paragraph 3.9, there were significant challenges in maintaining an adequate supply of various models of FFP3 face masks and Type II Fluid Shield Masks, at this point in time all sectors including Trusts, struggled to access PPE in the volumes required to meet demand. The fluctuating availability of masks occasionally necessitated rationing masks to clinical settings based on need. The Trust calculated the required volume based on the weekly number of residents that required PPE. During surges additional PPE needs were assessed individually and provided in line with the current guidance at that time. To manage this the Trust issued small volumes against all orders to ensure that private care providers received sufficient supply to last for the next 24 hours until greater volumes could be procured.

114. Additionally, unpaid carers, particularly those receiving direct payments, had access to personal protective equipment (PPE) through designated keyworkers. They could place orders for PPE via contracts established by the Trust. This initiative was crucial for safeguarding both carers and those they cared for, promoting a safer environment while facilitating essential care services during the COVID-19 pandemic.

115. The Trust created a centralised access point for Care Homes, including contractual agreements, which enhanced collaboration between operational and corporate departments. This facilitated better information sharing and intelligence gathering, leading to a targeted response. The initial access point was later expanded to encompass all independent sector providers across a variety of services. A collaborative modelling process was established with providers to ensure sufficient PPE levels, along with an ordering and delivery system. Providers received weekly updates, and regular forums were held to facilitate knowledge sharing and address any issues.

116. The Trust established distribution systems to ensure timely PPE deliveries to Independent Sector Care providers. Domiciliary Care providers could collect PPE from mobile units at designated times. At the onset of the pandemic, PaLS delivered PPE supplies twice daily to a designated SET warehouse and distribution centre. Independent Sector Providers that had purchased PPE before the Trust began providing it free of charge could submit claims for reimbursement. These claims covered the increased volume and costs of the PPE acquired. The first claims received by the Trust were for the period from 1st April 2020 to 31st January 2021.

117. The DoH did not consult with the Trust regarding the PPE guidance issued, nor were they included in discussions with the Private Care Sector about the challenges faced in purchasing PPE supplies. Infection Prevention and Control teams from the Trust were instrumental in the practical training and support to Care Homes in the appropriate use of PPE and this was an ongoing requirement due to the high turnover of staff in this sector. The Trust was not informed of any Care Home or Domiciliary Care Provider using excessive quantities of PPE.

118. The Trust worked alongside other Trusts and the Regulation and Quality Improvement Authority (RQIA) to develop a dataset that care homes could submit via an app, which aided decision-making processes. This dataset evolved over time based on learnings, enabling more targeted responses to emerging needs. The centralisation of data and actions was seen as a significant advantage of this approach.

119. Challenges emerged particularly in the early stages of the pandemic due to insufficient PPE stock. This limitation necessitated selective distribution of PPE to Independent Sector Providers, based on existing guidelines at that time. As a result, some Care Home staff expressed concerns over their limited access to PPE amid uncertainties regarding the virus' impact on health and safety.

VISITING POLICIES

120. In response to the COVID-19 pandemic, prior to any regional guidance being issued and in an effort to reduce transmission of COVID-19, many Care Homes implemented individual protocols and closed their doors to visitors on 20th March 2020. This restriction significantly affected residents and their families, particularly in end-of-life situations where family members could not be present. Some Care Homes facilitated window visits, but this was not universally available. Social isolation became

a significant concern, especially for COVID-19 positive residents who were confined to their rooms and particularly for residents with cognitive impairments or dementia.

121. The restrictions on family visits in Residential and Care Homes led to a potential lack of advocacy for residents, as families were unable to be present to support their loved ones during critical times. This potentially may have posed challenges for residents' well-being and access to necessary support, especially for those who were vulnerable or required assistance in navigating care decisions.

122. During COVID-19, the Trust provided significant support to Care Homes by establishing clear communication channels, facilitating access to PPE and implementing infection control measures. Support and guidance were offered to manage COVID-19 cases, coordinated vaccination efforts for residents and staff and support was provided by facilitating virtual visits between residents and their families. The Trust also helped develop protocols for admissions and discharges to minimise the risk of virus transmission, ensuring that Care Homes could maintain safety while addressing the needs of their residents. The Trust provided iPads to Care Homes to facilitate contact amongst family and residents.

123. As time progressed, alternative arrangements such as outdoor visiting huts, pods and shielded visiting rooms inside Care Homes were introduced by the IS. These measures varied by home and were implemented after the initial wave of the pandemic subsided and the vaccination program was in place. Additionally, some homes facilitated end-of-life visits for their next of kin in an effort to minimise footfall. The introduction and support of Care Partner arrangements also played a crucial role. A Care Partner is a close family member or friend who has a long-standing relationship with a Care Home resident and plays an essential role on a regular basis.

124. Visiting guidance restrictions varied across the Care Home Sector, leading to instances where Health and Social Care staff were categorised as visitors and at times denied access to Care Homes. This inconsistency posed challenges in ensuring that essential health services could continue while maintaining safety protocols.

125. The Trust, along with RQIA, issued and disseminated regional guidance on visiting as it became available. However, throughout the pandemic, each Care Home maintained its own policy, which sometimes differed from the regional guidance. When non-compliance with the regional visiting policy was reported to the Trust, the Trust endeavoured to support both residents and families. The Trust did this by seeking

assurance that policies were being implemented within the Care Home and that families could visit their loved one. This approach was similarly applied to Care Partner arrangements.*Top of FormBottom of Form*

126. Balancing the risk of infection transmission with the negative impact of resident's potentially not seeing family members for many months was difficult for providers. In particularly challenging cases, where it was brought to the Trust's attention, the Trust provided support through the resident's key worker and the Trust Permanent Placement Team. A total of 78 Trust staff were deployed into care homes out of 125 members of staff that volunteered to assist. In addition, 2 agency staff offered support and a number of Trust Patient Experience staff were involved in deep cleans. Members of the Trust Infection Prevention Control team also provided training and advice within the care homes

127. The Trust supported Care Partners, by testing Care Partners and supplying testing kits until Care Homes were in a position to do their own testing. In addition, the Trust supplied PPE for informal carers or families upon request. Trust staff attended meetings with statutory bodies, including the DoH, where information was relayed to Trusts. The guidance was shared with all Care Homes and they were asked to complete a return to provide a number of assurances in relation to the guidance, this included confirmation of the arrangements in place to recognise and facilitate the role of Care Partners. Concerns received noted:

- Lack of department consultation with the Independent Sector
- The role of Care Partners could not be achieved without improvements in testing, funding support and a co-production approach to the role of Care Partners
- Restrictive timeframe to implement the changes

Homes were advised that their concerns had also been raised with the IHCP and the DoH.

128. On the 29th July 2020, the Trust provided training and education to the Care Home Sector on 'Balancing the Risk and Rights of Residents during the COVID-19 Pandemic'. The training aimed to support appropriate individual risk assessments, to facilitate visiting by relatives. The Trust also managed any concerns raised by families on a case-by-case basis.

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REDUCED ACCESS TO PODIATRY, OCCUPATIONAL HEALTH AND OTHER CARE.

129. The Trust has no awareness of issues relating to NHS support.

130. Initially the Trust Primary Care staff provided remote triage, leading the Trust to repurpose its ECAH team to support all residents in Care Homes clinically.

131. In the early days of the Pandemic, some Care Homes restricted access to visiting professionals to reduce footfall. This was managed on a case-by-case basis to ensure staff could access the homes. The Trust during COVID-19 stood down all routine and non-urgent clinics for all Allied Health Professional services. The Trust made sure Speech and Language Therapists, Physiotherapists, and Occupational Therapists were available to Care Homes for assessment and treatment. They contacted Care Homes to schedule visits and made follow-up calls to ensure access.

132. AHP triaged all referrals into urgent and routine. This ensured that all appropriate residents were seen by at least one AHP professional who signposted patients to other services as appropriate. During the first surge, AHP staff were redeployed to Care Homes to assist in homes experiencing high staff absences. Over 30 staff members regularly performed care shifts, including washing, changing, toileting, and feeding residents. They also supported existing Care Home staff by ensuring best practices in manual handling, promoting safe feeding, and maintaining residents' independence and comfort. Signposting to relevant professionals where risks were identified, significantly benefited residents.

133. Other support provided to Care Homes by AHP staff included:
Speech and Language Therapy who provided advice and support regarding dysphagia (difficulty swallowing) training. They also provided virtual consultation and education sessions for Care Home staff.
Dietetics teams who provided telephone advice and support. Dietetic teams also developed regional Care Home guidance regarding nutritional support.
Podiatry teams communicated with Care Home staff re wound care and treatment.
Physiotherapy colleagues provided additional manual handling equipment to assist with increased levels of frailty. They also updated manual handling and fall prevention guidance and created teaching resources. The respiratory lead ensured appropriate supply of oxygen in keeping with SEHSCT protocols which included the distribution of oxygen saturation monitors and instruction to staff in their use.

Occupational Therapists provided postural management/seating and specialist equipment. See **(Exhibit CM/14 - INQ000553838)** which demonstrated the AHP contacts with Care Homes during the relevant period.

Workforce

134. Care Homes often struggled to find alternative staffing, and given the immediate nature of the crisis, the Trust attempted to provide staff whenever possible. Care homes were required to consider their own contingency plans, such as seeking agency cover or staff from other local providers.

135. The Trust was proactive in identifying staff who supported Care Homes where they were unable to sustain services. Processes were put in place to ensure, where possible, that Trust staff were deployed to cover uncovered shifts in Care Homes. During the 1st wave this was facilitated in part through stepping down some Trust services, thus creating capacity for Trust staff to undertake these duties. The Trust are unable to provide figures of the number of staff who were deployed to assist in Care Homes.

136. From March 2020, the Trust addressed workforce needs within Care Homes by establishing a Care Homes Response Hub as a single point of access. The Hub managed Trust staff who were either redeployed through the Trust workforce appeal or willing to work shifts in Care Homes. During the 1st wave this was facilitated in part through stepping down some Trust services, thus creating capacity for Trust staff to undertake these duties. These staff members predominately came from Community Nursing, AHP's and Social Care. The goodwill afforded by these members of staff to assist Care Homes saw them taking on additional roles beyond their regular duties. Trust staff were reminded that they must only undertake duties they were competent in and was within their scope of practice. Despite these efforts, the high demands across all Trust services made it difficult to meet all staffing expectations, as providers informed the Trust. During this period, the Trust provided 483 shifts within the Care Home sector.

137. The Trust had significant concerns that providing this level of support during a potential second surge would have been considerably more challenging. Several factors contributed to that concern:

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- Increased testing and contact tracing have reduced the overall pool of available staff.
- Staff who supported care homes during the first surge had resumed to their substantive roles to rebuild service provision.
- Potential need for staff to be allocated to other initiatives, such as the Whiteabbey Nightingale, the accelerated opening of the Acute Services Block at the Ulster Hospital, and the BCH Tower Block Nightingale, all of which were competing for staff.
- Redeploying HSC contracted staff to support Independent Sector Homes was a voluntary arrangement.

138. Top of FormThe DoH implemented measures to support Care Home staff during the pandemic, ensuring they received 80% of their average salary if they had to self-isolate. The DoH instructed Private Care Homes within the Trust's catchment area, to submit claims to Trust for these staff members, ensuring they were paid 80% of their average salary earned between 1st December 2019, and 29th February 2020. The Trust complied with this directive from the DoH.

139. The Trust is not aware of any unequal impact or discrimination against specific groups with no recourse to public funds. Bottom of Form

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

140. The Trust had a DNACPR policy in place for hospital settings which predated COVID-19; this did not change. The Trust did not have a blanket approach to DNACPR during this time. Decisions were made on a case-by-case basis by the medical staff, taking into consideration factors to include, but not limited to age and comorbidities (two or more diseases or conditions which affect a patient's health). Within the Care Home sector, GPs were responsible for providing ongoing medical care and health assessment of residents, to determine their medical needs, regularly reviewing and updating DNACPR orders and overall care plans, considering any changes in the residents' health status or wishes.

CHANGES TO REGULATORY INSPECTION REGIMES WITHIN THE CARE SECTOR

141. The DoH directed the RQIA to reduce its inspections of services, including those provided in Care Homes from 20th March 2020 – 22nd June 2020. The Trust used the Regional Care Home monitoring matrix and proactively engaged with Care Homes to understand their ongoing status and requirements for support.

142. The Trust implemented a clinical support team to advise and support escalated decision making within Care Homes, which the Trust monitored daily in relation to a wide range of issues which included staff, PPE, testing, clinical support, cleaning, IPC advice and other general issues. As per paragraph 103 redeployed Trust staff, along with testing teams and visiting professionals within the Care Homes escalated any concerns via the Care Home Response Hub. The Trust Patient Experience Quality Performance team did not audit cleaning standards within the Independent Sector. The Trust provided domestic staff to the Independent Sector during outbreaks that affected the availability of their own cleaning staff. From 20th March 2020 to 22nd June 2020, the audit team was unable to access South Eastern Trust-operated residential facilities to minimise footfall between units. However, domestic supervision continued, albeit at a reduced frequency.

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

143. The Trust compiled with the regional guidance in relation to shielding and lockdown in the Care Sector.

144. The Trust did not undertake any specific quality improvement work or research during the relevant period.

145. Individual residents experienced physical deconditioning and reduced mobility due to the confinement to their rooms or restricted spaces.

146. The Trust used the Regional Care Home monitoring matrix and proactively engaged with Care Homes to understand their ongoing status and requirements for support in relation to a wide range of issues which included staff, PPE, testing, clinical support, cleaning advice. Infection prevention control advice and general issues. As per paragraph 103, the Trust was proactive in identifying staff who supported Care Homes where they have been unable to sustain services. The Trust implemented the regional package of support for Care Homes to enable staff pay to be guaranteed.

147. The COVID-19 pandemic may have had a disproportionate impact on those receiving and providing adult social care in Northern Ireland under the Equality Act 2010 and the categories under the Northern Ireland Act 1998:

- Older Adults faced higher risks due to age-related vulnerabilities, cognitive impairment and underlying health conditions.
- People with Learning Disabilities experienced reduced access due to service disruption and the need for consistent support.
- Mental Health challenges for care staff and recipients: isolation, lack of family visits and uncertainty may have heightened anxiety amongst Care Home residents. Staff faced fear of infection in their role caring for residents.
- Rural areas may have had difficulties accessing PPE and testing supplies.
- Research shows that workers from ethnic minority backgrounds experienced higher rates of infection and experienced worse outcomes during COVID-19.
- Some Care Homes had difficulties in maintaining staffing levels and access to resources including PPE.

148. The Trust submitted 3 Case Study publications to the Queen's Nursing Institute:

- Creating a Care Home Testing Team
- Community Nursing Covid-19 Innovation/Best Practice
- ECHO Video Conferencing Telemonitoring Performance

LESSONS LEARNED BY SEHSCT FROM COVID 19

149. In response to the first surge of COVID-19 the Trust Executive Management Team commissioned the development of an Organisational Learning System to understand the changes made to services and learn lessons relevant to the second surge of the pandemic. A 90-day harvesting methodology was adopted involving three phases: capturing the changes; exploring the projects and recommending innovations to be supported and embedded in the Trust. **(Exhibit CM/15 - INQ000553839) and (Exhibit CM/16 - INQ000553840).**

150. Phase one was a broad sweep across the Trust to collate the changes made. A system survey focused on changes made and reported impact. 289 submissions were made across all directorates in the Trust. Changes submitted varied from free catering services, prison healthcare remote triage, new social worker's virtual

induction, palliative care referral pathways and theatre utilisation; a testimony to the ingenuity of teams facing the pandemic. The submissions were stratified into changes specifically related to COVID-19 and those that could be applied beyond the pandemic. An inductive thematic analysis was conducted on all the submissions and data weighting applied.

151. Phase two Trust Directors using the Learning Framework weighting, focused the submissions down to 23 change initiatives for further exploration. Deeper dive methodology was conducted by 17 Trust Quality Improvement Learning Leads and involved interviews with change owners, teams, service user feedback and service data. This information was triangulated with Trust surveys and 10000 Voices Staff Stories.

152. The challenge of the Trust-wide response was to structure these submissions in a meaningful way for the Framework output. Methodology was developed for assessment of impact of submissions to the framework. We incorporated a thematic analysis with data impact measured against the IOM 6 Domains of Quality. It was our aim to introduce an objective evaluation of the changes made and verification beyond impact self-reporting. The 6 domains enabled a comprehensive exploration of issues of safety, productivity and equity. As an organisation it also highlighted the need to develop a more mature system for data to be integrated in service design. The final scoring of the framework was against the innovation's purpose, systems thinking and evidence of scalability. This methodology has enabled a robust exploration of the changes made across the organisation, amplified key lessons to be disseminated and embedded into Trust Culture, Structure and Practice.

153. Alongside the 23 change projects focused on the deeper dive, learning was gained by understanding Trust-wide responses such as ICT innovations, Infection Protection Control and COVID-19 Testing processes and hospital outpatient changes. The challenge was to distil the depth of information and knowledge from the harvesting exercise into something tangible and accessible but without losing meaning. We have developed an interactive report using a page tiger platform. Each of the 23 projects has their own page. The change owner has a video to describe the innovation. The impact of change has been assessed through the weighting formula. The project measures and the established impact on the 6 domains of quality is reported in the boxes and relevant data is then displayed in a popup. The main learning

and recommendations are highlighted on each page, these are not only specific to the projects but can also be applied across the organisation and beyond.

154. Alongside the main learning, each slide has thematic sections these are symbolised by the icons along the side. We were interested in what facilitates successful change, highlighting the enablers and barriers to change, communication, staff requirements, PPI and decision making. Example of COVID-19 Learning Framework Report Project Page. See **(Exhibit CM/17 - INQ000553841).**

155. The Trust key learning is highlighted in 5 Domains. Key learning highlights the importance of positive culture and leadership in the organisation for creating the conditions for change. It also challenges service design focus at a systems level, coordinating pathways. Informatics and data analysis were key to successful innovation. There is a great need to reflect on the equity of service delivery and include service user verification and co-design of change. Finally, this report is a celebration of the depth of creativity, adaptability and commitment demonstrated by the staff of the Trust. Their response has been remarkable, and learning has highlighted the importance of ongoing recognition and psychological support for teams across the organisation.
This report is one of the outputs of Phase 3 analysis and recommendation phase.

- COVID-19 Repository. A central repository of the 289 changes made across the Trust, with shared learning **(Exhibit CM/18 - INQ000553842).** To help plan more effectively in this current time of pandemic.
- SEHSCT Organisational Learning Report. A formal report focusing on the thematic learning in relation to the structural response to COVID-19 to be completed.

The challenge is to embed the key learning into organisational practice during the current pressure on health and social care services. Meetings with senior management teams and workshops across the Trust are currently being conducted to enable ownership, adaptation and implementation of the lessons. Evaluation of this new methodology and approach to health organisational change assessment is being undertaken by the Quality Improvement team at SEHSCT. The COVID-19 Framework is the first iteration for the Trust towards establishing an

organisational learning system. The excel spreadsheet is appended in response to questions 29-30.

156. To enhance the response of the Care Sector in the event of a future pandemic and improve responsiveness, SEHSCT suggests the following is considered to address gaps and challenges observed during COVID-19:

Communication: Establishing robust channels of communication between relevant authorities: DoH, PHA, Trusts and IS Care Home Providers would improve decision-making processes, enhance partnership working standardise processes and underpin the provision of safe and effective care.

PPE: A system, with clear distribution processes, would ensure that IS Care Providers could access resources as required.

Workforce Strategy: An integrated approach to workforce planning that includes the Independent Sector which would include staff training and development.

Digital Infrastructure: Development of a regional data-sharing platform for all IS Care Providers to share information in real-time, would streamline decision making and resource allocation.

Infection Prevention and Control: A continuous focus on training and resources for IPC in the IS Care Homes, would ensure that the workforce and environment is prepared for any future challenges.

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: **14 February 2025**