Witness Name: Natalie Magee
Statement No.: 1
Exhibits: 43
Dated: 19th March 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF NATALIE MAGEE

I, Natalie Magee, Co-Director for Adult Community and Older Peoples Services, Belfast Health and Social Care Trust, will say as follows:

1. This is my first witness statement to the UK COVID-19 INQUIRY.

2. The documents that I refer to in this statement can be found in the exhibit bundle marked "NM".

3. I have been asked by the UK COVID-19 INQUIRY to address a number of questions set out in a Rule 9 request dated 14 August 2024. I endeavour to address those questions in this witness statement.

4. I have structured my statement as follows:
   - Overview Pre-pandemic
   - Overview of Pandemic Impact
   - Guidance, policies and procedures
   - Discharges from Acute settings into Community
   - Management of IPC, PPE and Testing

- Visiting and Care Delivery
- Workforce
- Advance Care Planning and Covid-19 Deaths
- Disproportionate Impacts of Pandemic
- Quality Assurance and Oversight
- Assessment of Impact of Measures of the Pandemic on the Care Sector
- Successes, Identified Learning and Recommendations

OVERVIEW PRE-PANDEMIC

Remit of the Trust

5. The Belfast Health and Social Care Trust ("the Trust") is the largest integrated health and social care Trust in the United Kingdom and delivers a wide array of health and social care and support to the citizens of Belfast, as well as providing most regional specialist services for Northern Ireland.

6. The Trust's statutory duty to deliver social care is outlined in:
   - Health and Personal Social Services Order (1972), specifically Articles 15, 36 and 99
   - Chronically Sick and Disabled Persons (NI) Act 1978
   - The Mental Health (NI) Order 1986
   - Disabled Persons (NI) Act 1989
   - Northern Ireland Act 1998, specifically section 75
   - Human Rights Act 1998
   - Health & Social Service (Quality, Improvement and Regulation) Order (2003)
   - Care Management Circular (2010)
   - Health & Personal Social Services Order (Assessment of Resources) Regulations (1993)
   - Carers and Direct Payments Act (NI) 2002
   - HPSS Payments for Nursing Care Circular, ECCU 1/2006
   - Charging for Residential Accommodation Guide 2015
   - Adult Safeguarding Policy (NI) 2015
   - Adult Safeguarding Operational Procedures (NI) 2016
   - Mental Capacity Act (NI) 2016
   - Health and Social Care Act (2022)

7. The aforementioned documents outline the Trust's statutory responsibility to make available advice, guidance and assistance, and to provide and secure social care supports including residential accommodation and domiciliary care to adults with an assessed health or social care need who reside in the Trust's geographical area.

8. In meeting its statutory responsibilities, the Trust engages with a range of adults including older adults living with frailty, adults living with a physical disability, long-term condition, mental illness and a learning disability to identify social care needs, mitigate assessed risk and arrange the delivery of social care based on assessed need.

9. Each adult referred for social care support will have an individual assessment of need. Those meeting the criteria for services within the scope of this Inquiry will have a care/ support plan developed and care commissioned in line with their assessed need. The service user's assessed need and care commissioned is subject to review in line with the Care Management Circular (2010).

10. The Trust employs Care Management, Social Work, Social Care and administrative staff to enable it to meet its statutory responsibilities under the aforementioned legislation, in line with their professional standards where applicable.

11. In addition, care management and social work support the Trust's finance teams to undertake the financial assessment of those living in a care home in line with the Health & Personal Social Services (Assessment of Resources) Regulations (1993).

12. There is a dedicated resource within the Trust's Contracts Team to ensure business conducted with independent sector providers, is done so in line with the Regional Domiciliary Care Service Contract and Service Specification (2015/16) and the Regional Residential and Nursing Provider Specification and Contract (2018/19).

13. The Trust's Care Bureau oversees the commissioning of domiciliary care.

14. A dedicated finance team works closely with administrative and social work teams to manage the funding and financial processes associated with commissioned care for independent sector providers.

15. The Trust has a professional structure in place, with operational teams reporting through the Divisional Social Worker to the Executive Director of Social Work. This

professional framework provides assurance that all staff employed in social care are appropriately registered with their professional body, the Northern Ireland Social Care Council (NISCC) and have the necessary skills, knowledge, training, and competencies to undertake the role in which they are employed. The Trust, through its Human Resources (HR) and training teams, supports all social care staff to maintain compliance with their professional standards for practice. Nurses working supporting the delivery of social care have a professional structure which reports through the Divisional Nurse to the Executive Director of Nursing. Other professionals employed to deliver aspects of social care are afforded the same levels of professional support through their professional line to enable them to maintain compliance with their professional registration requirements.

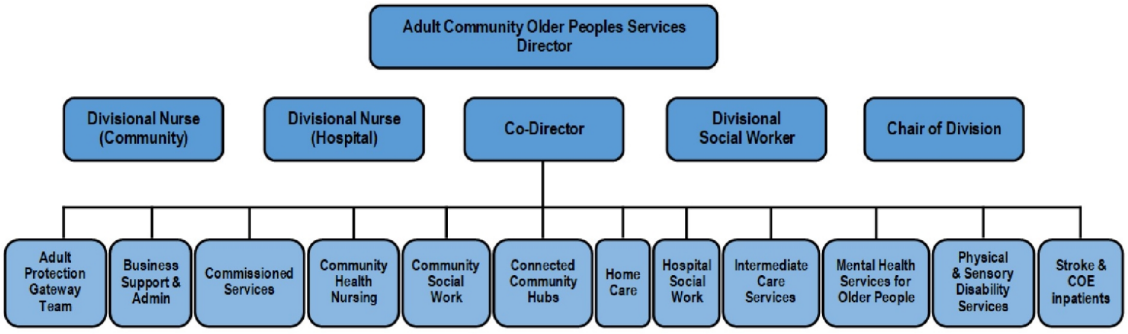
Trust management, administration and oversight of the Care Sector

16. The Trust is a large and complex organisation with eight service directorates, each led by a service Director.

17. In January 2020, the management, administration and oversight of the Care Sector sat across two directorates: the Directorate of Adult Community Older Peoples Services (ACOPS) and the Directorate of Mental Health and Learning Disability (MHLD). A Collective Leadership Team (CLT) consisting of a Chair (a doctor), Co-Director (operational lead), Divisional Social Worker and Divisional Nurse led these directorates. The Directorate of Mental Health and Learning Disability was sub-divided into two divisions, each with a dedicated CLT.

18. The internal structure for the administration and oversight of social care sits within the commissioning directorate. A copy of the structure for each Director is detailed below:

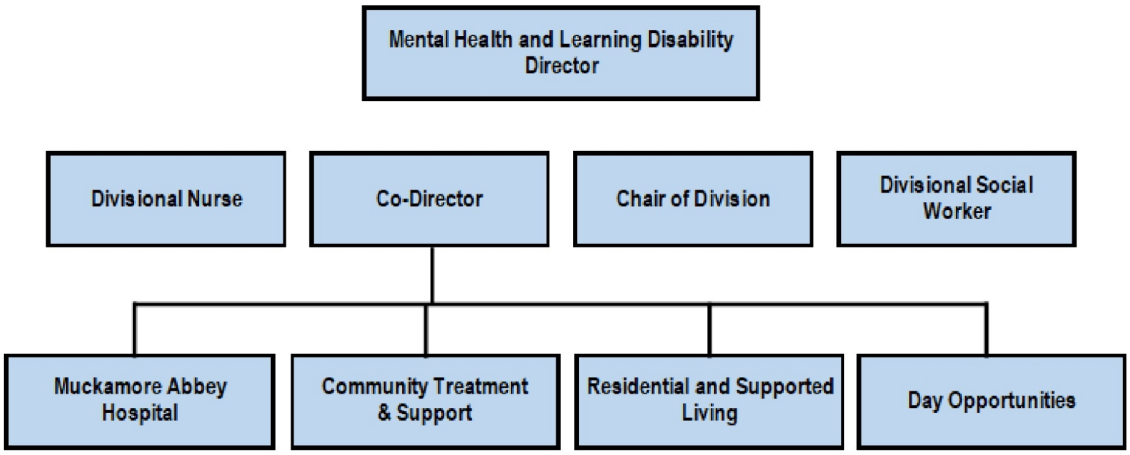
Directorate of Adult Community Older Peoples Services (ACOPS)



Directorate of Mental Health and Learning Disability Services

Structure for Mental Health& CAMHS

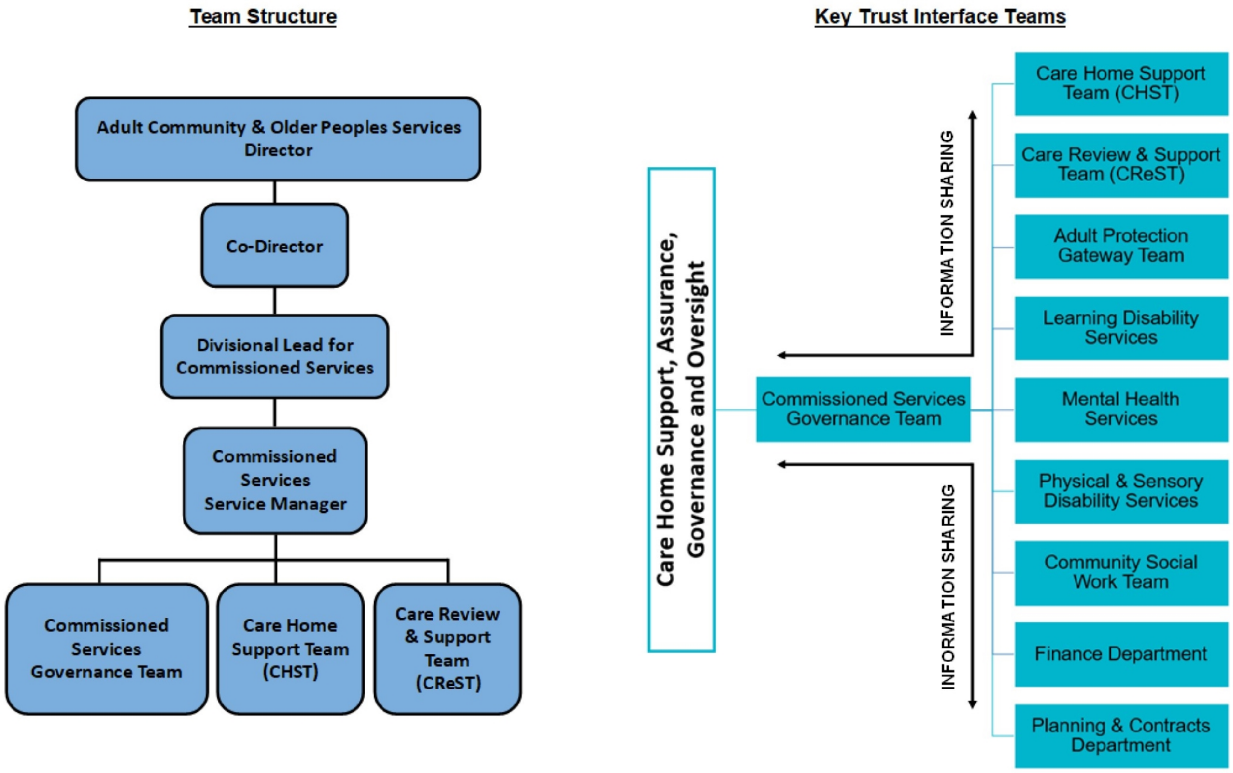
Structure for Learning Disability Services



19. In 2020, ACOPS was the largest directorate delivering social care, with 9 distinct Service Areas dedicated to service provision:

- Adult Protection Gateway Team
- Commissioned Services
- Community Social Work
- Connected Community Hubs
- Home Care Service (statutory)
- Hospital Social Work
- Intermediate Care Services
- Mental Health Services for Older People
- Physical and Sensory Disability Services

20. Commissioned Services was responsible for providing the governance and accountability assurance for care delivered by independent sector providers on behalf of the Trust in line with the Trust's Integrated Governance Assurance Framework. The service worked in partnership with relevant stakeholders from across the Trust to oversee the safety and quality of care delivered by independent sector providers. As part of its governance and accountability processes, the Trust had in place draft governance and escalation frameworks for care homes and domiciliary care providers. The diagram below outlines the structure of the team and key internal interface teams:



21. The Trust is both a provider and commissioner of social care. Within the relevant period, the Trust commissioned care through statutory and independent providers. In total, within the Trust's geographical area, there were 88 registered care home providers (11 statutory and 77 independent) and 49 domiciliary care providers (5 statutory and 44 independent).

22. As a provider of social care, the Trust directly delivered a range of social care services including domiciliary care, home based rehabilitation and reablement services, residential care for people with dementia, people with a learning disability, residential

care for a small number of frail older people, bed-based rehabilitation within a statutory residential home and one registered nursing home providing assessment and treatment of people with mental illness.

23. The Trust has 10 statutory residential homes and 1 statutory nursing home in which it provides social care to individuals meeting the criteria for admission under the following Regulation and Quality Improvement Authority (RQIA) categories of care:
    - DE: Dementia (x4 statutory residential care homes)
    - I: Old age not falling within any other category (x1 statutory residential care home)
    - MP(E): Mental disorder excluding learning disability or dementia – over 65 years (x1 registered nursing home)
    - LD(E): Learning disability – over 65 years (x5 residential care homes)

24. The Trust has 5 statutory domiciliary care agencies registered with RQIA as follows:
    - Intensive Home Care
    - Home Care (North & West)
    - Home Care (South & East)
    - Rehabilitation services
    - Reablement services

25. All Trust statutory social care facilities and services are subject to registration and inspection by RQIA in line with their relevant regulatory category.

26. In the relevant period, the Trust further commissioned domiciliary care, residential and nursing care from a range of independent sector providers. During this period the Trust commissioned care from 77 registered independent sector care home providers and 44 registered independent sector domiciliary care agencies.

27. The Trust Board Assurance Framework, presented as Exhibit [NM/01 – INQ000581090] supported oversight and delivery of safe, effective, efficient, timely, equitable and person-centred care. Throughout the pandemic, the Trust worked in partnership with RQIA and was mindful of the following documents when monitoring the performance of the quality and safety of care delivered and commissioned from independent sector providers:
    - Domiciliary Care Agencies Minimum Standards (2011)
    - Domiciliary Care Agencies Regulations (2007)

- Residential Care Homes Minimum Standards (2011)
- Residential Care Home Regulations (2005)
- Care Standards for Nursing Homes (2015)
- Nursing Home Regulations (2005)

28. The contractual arrangements for commissioning domiciliary, residential and nursing care from independent sector providers was guided by the Regional Domiciliary Care Service Contract and Service Specification (2015/16), presented as Exhibit [NM/02 – INQ000581134], and the Regional Residential and Nursing Provider Specification and Contract (2018/19), presented as Exhibit [NM/03 – INQ000581135].

29. The management of the performance of independent sector providers was supported by the Trust's draft domiciliary care and care home escalation frameworks. Please see Exhibits [NM/04 – INQ000581094], [NM/05 – INQ000581118] and [NM/06 – INQ000581093].

30. A care home category is predetermined by the RQIA regulatory process. The Trust will commission a care home placement in a care home registered with the appropriate category of care to meet the assessed need of the service user.

31. In January 2020 there were 88 residential and nursing home registrations in the following regulatory categories in the Trust geographical area:
    - I: Old age not falling within any other category
    - DE: Dementia
    - MP: Mental disorder excluding learning disability or dementia
    - MP(E): Mental disorder excluding learning disability or dementia – over 65 years
    - LD: Learning Disability
    - LD(E): Learning disability – over 65 years
    - PH: Physical disability other than sensory impairment
    - PH(E): Physical disability other than sensory impairment – over 65 years
    - D: Past or present drug dependence
    - A: Past or present alcohol dependence
    - TI: Terminally ill
    - SI: Sensory impairment

Care Sector structure, capacity and pressures pre-pandemic

32. The tables below reflect data relating to care home and domiciliary commissioning in January 2020. Table 1 outlines the breakdown of residential and nursing homes:

Table 1

Care Home Registrations in Belfast Trust Catchment Area (ISP and Stat) as at Jan 2020	
Category of Care	**No of Registrations**
NH	45
RH	43
TOTAL	88

33. Table 2 provides a breakdown of the care homes by category of care and by independent and statutory provider in January 2020:

Table 2

Care Home Registrations in Belfast Trust Catchment Area by Sector & Category Jan 2020		
Sector	**Category of Care**	**No of Registrations**
IS	NH	44
IS	RH	33
IS Dual Registration	*NH/RH*	*(6)*
Stat (MH)	NH	1
Stat (Dementia)	RH	4
Stat (OPS)	RH	1
Stat (LD)	RH	5
TOTAL		88

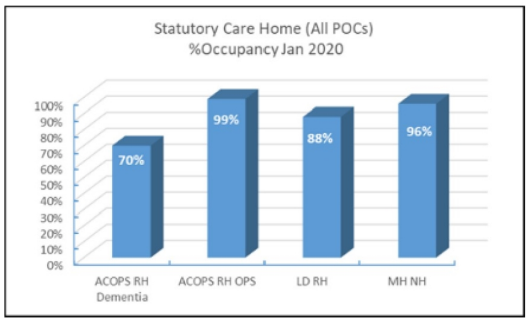
34. Table 3 outlines the bed-based rehabilitation commissioned and provided by the Trust in January 2020:

Table 3

Occupancy in Rehab Beds (ACOPS only)	Jan 2020
Beds available	51
Days available	1581
Days Used	1469
%Occupancy	93%
Ave LOS	38
Admissions	36
Discharges	43
Clients using beds	98
Average Daily Delays	2

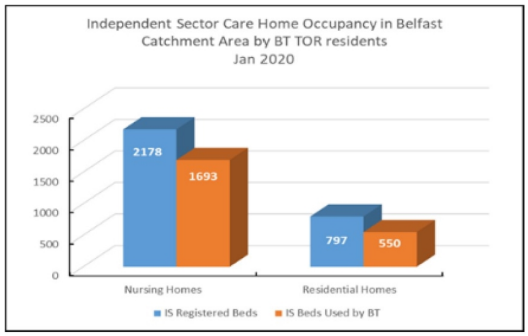
35. Chart 1 provides the percentage occupancy in the Trust statutory residential homes in January 2020:

Chart 1



36. Chart 2 provides the number of BHSCT service users occupying the independent sector care homes across the Trust's geographical area in January 2020. The total percentage occupancy cannot be provided as care homes can also be occupied by privately funded residents and residents from other Trusts.

Chart 2



37. In January 2020, the Trust was commissioning a total of 6122 domiciliary care packages weekly equating to 49,364 hours. The Trust commissioned 78% of its domiciliary care from the independent sector providers.

38. Chart 3 outlines the number of hours being delivered by postcode (eg BT1) across the Trust's geographical area, whilst Table 4 outlines the number of care packages and weekly hours being delivered by each provider.

Chart 3

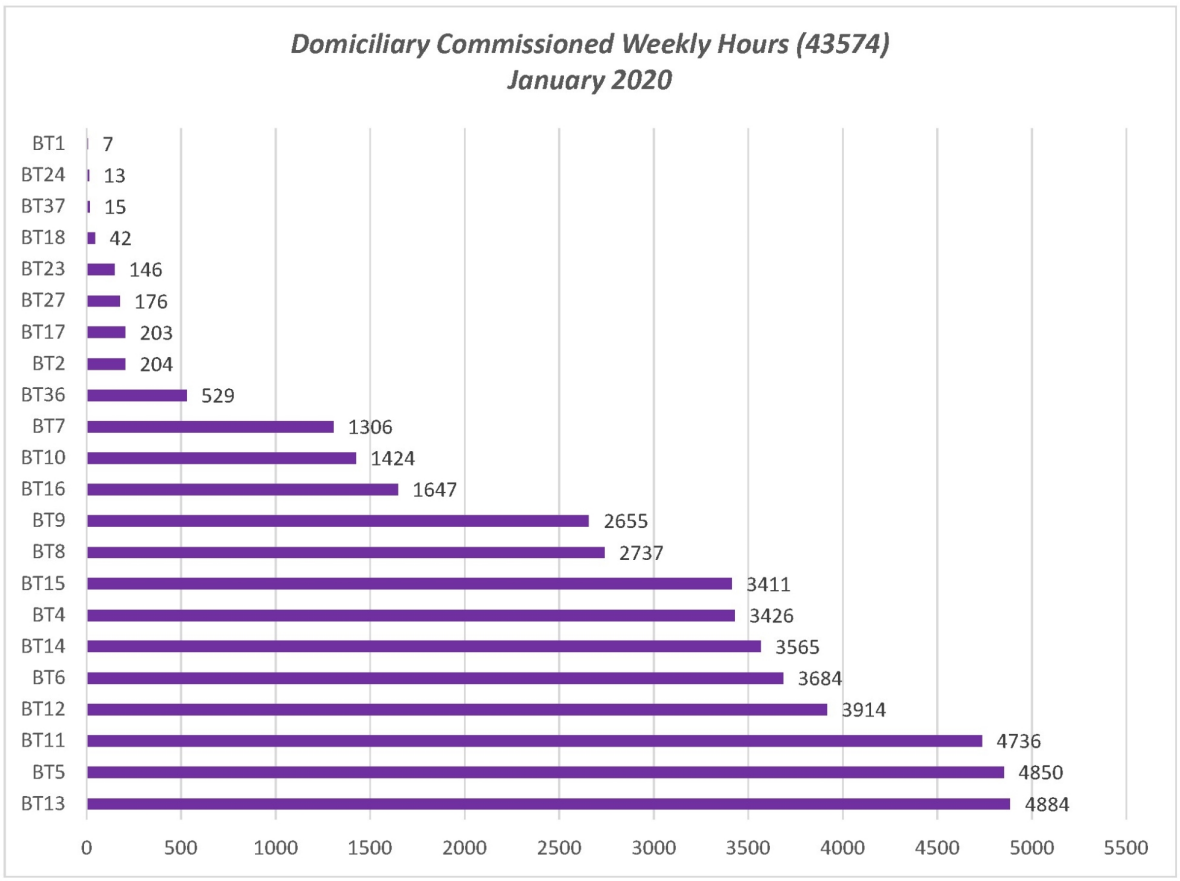
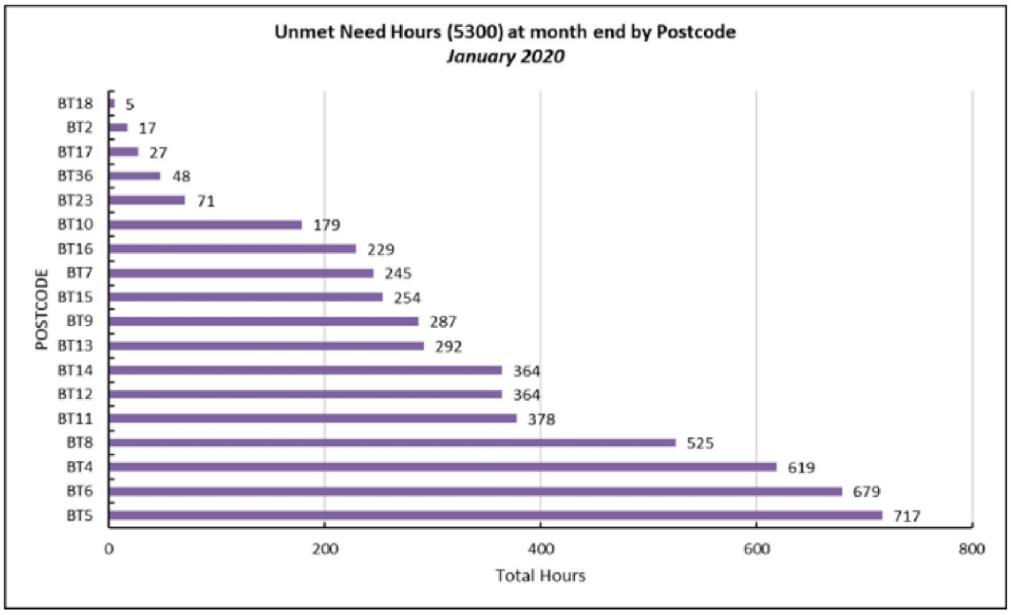


Table 4

PROVIDER	Total Packages	Total Weekly Hours
I&S	2	30
	118	1232
	30	167
	28	241
	10	52
	131	990
	29	366
	15	658
	22	309
	1	0
	179	1977
	61	531
	34	801
	14	348
	2	16
	3	19
	202	1918
	66	810
	396	4147
	140	644
	1	7
	48	529
	915	3563
	159	1309
	16	102
	1005	4079
	58	732
	92	1743
	48	1041
	79	564
	543	4827
	66	488
	9	113
	64	837
	332	2150
	51	532
	156	1212
	99	623
	3	207
	30	422
	445	4255
	146	1265
	75	982
	232	2846
	1	6
	5	103
	7	45
	1	54
	17	247
	2	40
TOTAL	**6122**	**49364**

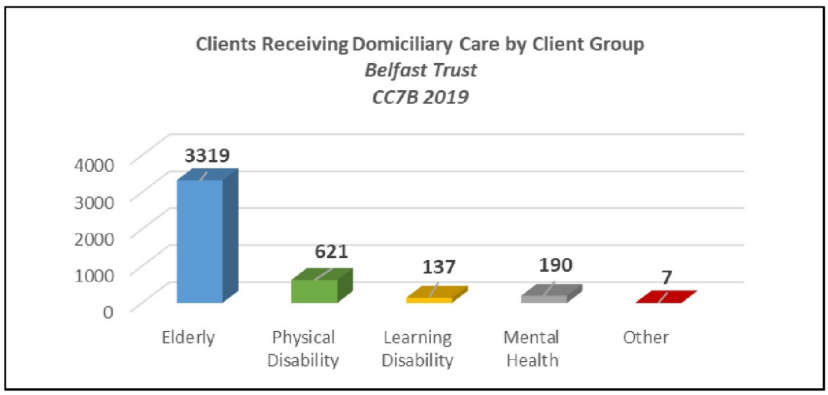
39. In January 2020, in addition to the domiciliary care packages being delivered, there were 735 people awaiting the provision of a domiciliary care package to meet their assessed need. This equated to 5299.50 hours of unmet need. Chart 4 outlines the unmet need across the Trust's geographical area by postcode.

Chart 4



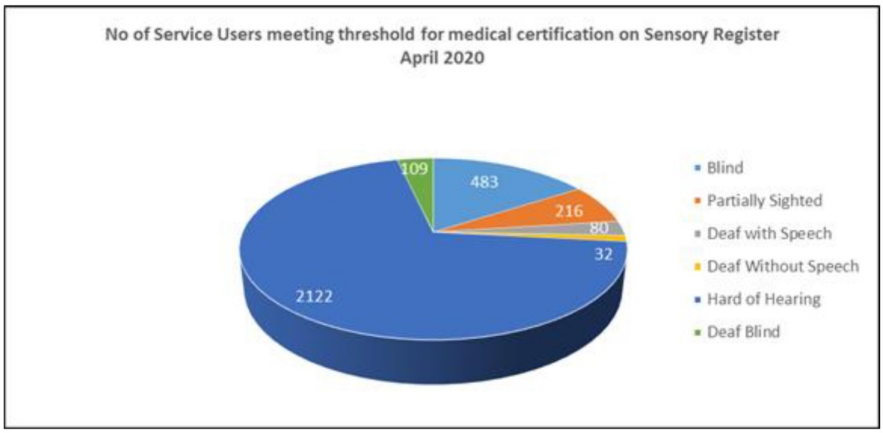
40. Chart 5 below outlines the breakdown of service users receiving domiciliary care by client group as reported to DoH in 2019 as per the annual management return. This demonstrates the majority of domiciliary care is commissioned by the Adult Community Older Peoples Services Directorate.

Chart 5



41. Chart 6 outlines the number of people registered with the Trust who have a physical and/ or sensory disability.

Chart 6



Trust Social Care Workforce immediately prior to the relevant period

SOCIAL SERVICES WORKFORCE											
Adult Community Older Peoples Services				Learning Disability Services				Mental Health Services			
	Sum of FSL	*Sum of WTE*	*VARIATION*		*Sum of FSL*	*Sum of WTE*	*VARIATION*		*Sum of FSL*	*Sum of WTE*	*VARIATION*
Total	403.63	339.97	-63.66	*Total*	59.58	34.56	-24.719	*Total*	91.85	59.84	-32.01

FSL = Funded Staff Level WTE = Whole Time Equivalent

42. Immediately prior to the pandemic, the social work workforce across ACOPS, Mental Health and Learning Disability was at a deficit of -63.66 WTE; 65% of this deficit (-41.23 WTE) was within the Band 6 Social Work role. Where possible, posts were backfilled by agency staff. This key role is responsible for the assessment, care planning, monitoring, review and commissioning of social care in line with the Trust Delegated Statutory Functions. The role also facilitates communication links between independent sector providers, the wider Trust and service users/ families on matters pertaining to service user care in the community.

NURSING WORKFORCE												
Adult Community Older Peoples Services				Learning Disability Services				Mental Health Services			
	Sum of FSL	Sum of WTE	VARIATION		Sum of FSL	Sum of WTE	VARIATION		Sum of FSL	Sum of WTE	VARIATION
Total	11.67	8.70	-2.97	Total	18.20	14.39	-3.81	Total	2.00	4.00	2.00

43. The nursing workforce delivering social care within the Trust is a small resource. In January 2020 this resource was further impacted due to vacancies across ACOPS and Learning Disability Services equating to -6.78 WTE vacancies. This reflects the ongoing challenges the Trust was experiencing recruiting nurses into social care posts.

ALLIED HEALTH PROFESSIONAL WORKFORCE							
Adult Community Older Peoples Services				Learning Disability Services			
	Sum of FSL	Sum of WTE	VARIATION		Sum of FSL	Sum of WTE	VARIATION
Total	29.16	21.56	-6.60	Total	6.85	0.16	-6.69

44. The Allied Health Professionals workforce across ACOPS and Learning Disability Services pre-pandemic was also experiencing staffing challenges that equated to -13.29 WTE. The majority of this deficit related specifically to the Band 6 professional workforce which the Trust endeavoured to backfill through the introduction of skill mix.

Known pressures on the Care Sector pre-pandemic

45. The pandemic occurred at a time when the social care sector in Northern Ireland was already very stretched and under extreme pressure due to a growing older population, a growing complexity and higher acuity of service users receiving community care, high levels of unmet need for domiciliary care and the impact of industrial action from the end of 2019 until it stood down to support the Trust's response to the pandemic.

46. There were unrelenting pressures in Acute and Unscheduled Care and for community services to support hospital flow by facilitating timely hospital discharge through the provision of social care to meet the assessed needs of patients medically optimised for discharge.

47. Pre-pandemic both the Trust and the independent sector providers were experiencing significant challenges with the recruitment and retention of staff.

48. Statutory and independent sector domiciliary care providers had an older workforce and were experiencing significant challenges with recruitment and retention of staff due to poor terms and conditions, the increasing price of fuel and a lack of career structure making domiciliary care an unattractive career choice.

49. The care home sector equally faced recruitment and retention challenges. The shortages in the registered nursing workforce across Northern Ireland, career pathways and professional structures within the care home sector, resulted in staffing shortages and high use of agency staff. In an effort to stabilise staff teams, many of the larger independent sector care home providers had invested in international recruitment.

50. Following publication of the Commissioner for Older People Northern Ireland (COPNI) Home Truths Report in 2018, provided as Exhibit [NM/07 – INQ000581095], public expectation and scrutiny on the quality and safety of care within care homes had increased, without additional investment into Trusts or the independent sector. The regional care home contract was outdated and not fit for purpose in supporting Trusts to performance manage underperforming homes and the 'Delivering Care' workforce model for care homes had not been progressed. Independent sector providers were repeatedly raising the disparity between the regional rate for care home placements and the actual cost of care.

51. The Regional Care Home Contract is currently under review and the deficits in the contract were widely recognised by the Health & Social Care sector pre-pandemic. Section 8 of the contract details the management of unsatisfactory performance. The contract references 'material' and 'immaterial' breaches but what constitutes such a breech is not defined leaving the application open to interpretation. How the Trust should manage quality of care and safety concerns regarding residents is not defined and consequently the Trust had to develop its own escalation framework to manage these, which currently sits outside the contract. The sanctions available to the Trust are limited.

52. The contract does not support management of systems pressures such as discharge flow as it lacks detail regarding timescales for decision-making regarding new admission, enhanced care/ 1:1 care and placement costs in excess of the regional rate.

53. Due to the unrelenting pressures in Acute and Unscheduled Care, care homes operated at high occupancy rates, although there was often disparity between the registered and available beds due to staffing pressures. Delayed decision-making by care homes following pre-admission assessments and reluctance on the part of care homes to admit residents at weekends impeded timely hospital discharge.

54. Timely discharge of people with dementia (suspected and diagnosed), and acquired brain injury resulting in people with delirium presenting with complex needs and associated behaviours, was a key challenge for the Trust due to limited availability of suitable beds and the absence of a suitable discharge pathway for people with delirium.

55. Within domiciliary care, demand outstripped capacity resulting in a high level of unmet need. There was a growing complexity and acuity of service users being cared for at home and more extensive care packages being commissioned. A lack of domiciliary providers in a number of postcode areas across the city and a high level of care packages split across multiple providers to enable packages to be covered, created issues with continuity of care.

56. At this time, the social work profession was unstable, with high numbers of vacancies and sickness absence and an overreliance upon agency usage across services. This resulted in a workforce which felt overstretched and overwhelmed.

57. Within Care Management and Community Social Work teams, casework was more complex. Front line staff felt like they were constantly firefighting as they balanced caseloads which were high risk and high acuity without the required resource to effectively meet service user needs.

58. The roll out of the Mental Capacity Act (NI) 2016 began in late 2019, which increased anxiety with social work and care management staff, as staff required intense periods of training and the legislation had been introduced without additional resource. Several staff in the Trust were temporarily removed from their substantive posts to become trainers for Mental Capacity Act (NI) 2016. From October 2020, an immense amount of time was required from staff to scope caseloads, to identify service users who required Deprivation of Liberty Safeguards (DoLS) and to undertake the DoLS assessments from January 2021. This added additional pressures to professional staff working in community teams.

59. In addition, the relatively new Adult Safeguarding recording processes had been implemented within the Trust social care digital recording system (Paris), with no additional workforce.

60. The multifactorial challenges on the social care system were well recognised at a strategic and political level. The Trust endeavoured to work with the Health and Social Care Board to escalate funding and resource concerns and with independent sector providers to improve the quality and safety of care, to progress commissioning of specialist beds and to expand domiciliary care provision.

OVERVIEW OF PANDEMIC IMPACT

61. From March 2020 the Trust had to adapt rapidly to meet the changing needs of service users as a result of the pandemic. Covid-19 was severely challenging to an already stretched workforce across the social care sector and particularly in services providing support to care homes.

62. A number of rapid service changes and developments were required in adult community services. This was to ensure that, as far as possible, the almost 7000 vulnerable service users in Adult Community Older Peoples Services, Mental Health Services and Learning Disability Services, already known to the Trust, as well as those not yet known, but who may become known and who might be symptomatic or ill with Covid-19, could receive safe, compassionate and effective care.

63. The response of all social care staff, in providing care and support to care home residents, in developing Covid-19 pathways and sustaining service delivery to people living in their own home and in care homes was remarkable.

64. Trust staff aligned to care homes demonstrated incredible resilience and flexibility, adapting a “can do” attitude and a willingness to do the best for our service users. Teams worked collaboratively, were receptive to change, building upon their pre-existing relationships and pre-existing knowledge of individual care homes to provide timely advice, support and guidance.

65. Key challenges the Trust faced in March 2020 with the delivery of social care included:

- Absence management of the workforce who were self-isolating or shielding;
- Stepping down key services, ensuring "keeping in touch" and other alternative measures were working, to ensure core service provision to the most vulnerable service users continued;
- Putting in place an IT structure to enable staff to follow government guidance and work from home;
- Supporting staff who remained at work to overcome their fears of catching or transmitting the virus by ensuring they had the appropriate psychological supports, IPC training and access to PPE;
- Ensuring effective social distancing protocols were maintained in staff teams and statutory services, whilst maintaining strong communication links;
- Maintaining a domiciliary care service in an evolving and changing situation. This required constant oversight and management of rotas, standing up and down of domiciliary runs, while also ensuring services were maintained to the most vulnerable service users;
- Supporting the residents and staff in the independent care home sector who were dealing with escalating levels of Covid-19 acuity and deaths amongst their residents, often presenting in atypical ways, alongside increasing staff absences;
- Identification of a workforce to ensure there was adequate staff in care homes to care for residents when a home went into a Covid outbreak;
- Reconfiguration of teams and development of structures to support independent sector care homes and domiciliary care providers in line with IPC, PPE, Testing and Vaccination guidance (this was particularly challenging between March and June 2020);
- Supporting staff through fatigue and burnout;
- Developing and implementing a communication strategy for service users and their families;
- Communication and implementation of the ever-changing guidance as services operated in an evolving situation.

66. Pre-existing staff shortages in the Trust and across the independent sector were further exacerbated due to staff absence through sickness or self-isolation. Trust community social work and social care teams had developed business continuity

and surge plans and RAG (Red/ Amber/ Green) rated cases in terms of risk, to ensure services and supports were maintained to the most vulnerable.

67. The need for social distancing led to an increase in remote working and the use of technology such as Microsoft Teams for videoconferencing and online meetings. Trust HR and IT staff helped directorates provide appropriate training and guidance to support new ways of working, however, the required infrastructure took time to embed for front line community staff.

68. Covid-19 brought into sharp focus the challenges the care home sector faced such as the availability of nursing staff, the high acuity and complexity of patients cared for in care homes, and the limited multidisciplinary team support available. Care homes were heavily reliant on agency provision to support their staffing complement.

69. The limitations of the care home staffing resource were further impacted by the need for enhanced levels of supervision for assisting in social distancing and isolation of residents, particularly in dementia facilities

70. The speed at which many homes went into crisis, the absence of robust business continuity plans and the high level of dependency on mutual aid staffing support from the Trust highlighted the fragility of the independent care home sector.

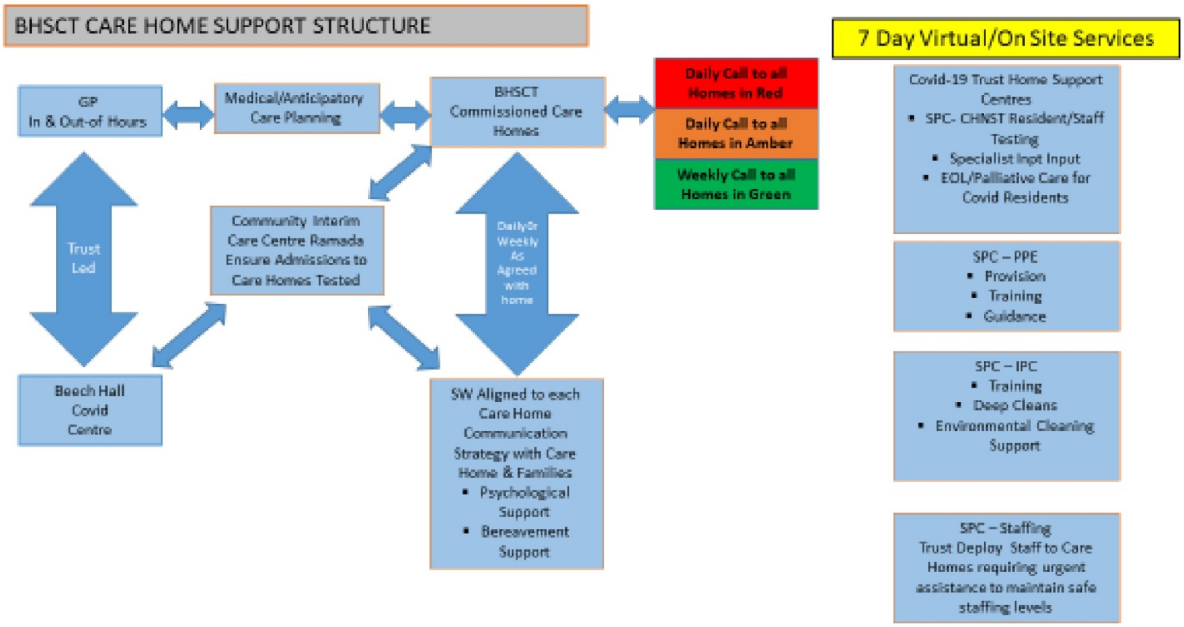
71. The Belfast Trust Care Home Support Team proved to be an effective and resilient team who responded at pace to the changing requirements throughout the relevant period and particularly from mid-March 2020 to the end of June 2020. They were robustly supported by their Senior Leadership Team who were committed, both prior to and throughout the relevant period, to working in partnership with the care home sector to promote the safety and wellbeing of residents. This ensured a timely response and implementation of DoH/ PHA/ Trust directives, escalation of concerns to Silver Command and articulation of the challenges and experiences of care homes to all key stakeholders.

72. Internally, the Trust adapted processes to maintain oversight of Covid outbreaks and to ensure care homes were effectively supported. These included:
    - a daily safety huddle which coordinated communication from the front line to the Trust Executive Team Covid-19 Oversight Group;

- a cross-directorate daily senior management care home briefing meeting;
- development of data sets to enable the Trust to maintain oversight of outbreaks and support being provided to care homes;
- daily circulation of the Covid-19 Care Home Outbreak report (this report was modified during the course of the relevant period);
- a RAG rating system to monitor the severity of care home outbreaks.

73. Systems and processes established by the Trust in March/ April 2020 to support care homes included:
    - daily telephone review of homes in outbreak;
    - a single point of contact for information and advice;
    - onsite clinical assessment and treatment;
    - weekly wellbeing and support telephone calls to all care homes in the Trust's geographical area;
    - the provision of a range of training and educational supports to care homes;
    - access to Trust IPC resources;
    - facilitation of testing of residents and staff;
    - facilitation of FIT testing;
    - mutual aid support;
    - development and delivery of an induction programme for mutual aid staff;
    - ordering and distribution of PPE to independent sector providers.

74. The Care Home Support Team rapidly developed a new service model to become the single point of contact for care homes who had a Covid-19 related concern. From 19 March 2020 the team provided clinical support and facilitated testing in care homes, while delivering training to upskill staff on their IPC knowledge, PPE 'donning and doffing', and the assessment and management of symptomatic residents. Despite being a small team of nurses which was expanded though staff redeployments during the course of the pandemic, the Care Home Support Team adapted an extended 7-day service working flexibly.



75. The lack of a dedicated multidisciplinary resource to support the Care Home Support Team quickly became apparent. The Acute Care at Home Team and the Community Respiratory Team adapted new ways of working, and in partnership with the newly established Primary Care Covid-19 Centre, were engaged to support symptomatic residents in care homes. There was a daily safety huddle for the Care Home Support Team to maintain oversight of the support required to care homes, with representation from the Acute Care at Home Team and Community Respiratory Team during the first wave. The presence of a medic and Advanced Nurse Practitioner supported case finding for the Acute Care at Home Team and ensured residents had timely access to the right care by the right team.

76. The Community Respiratory Team provided support to care homes as part of the Trust response. Two Respiratory Nurse Specialists were on every shift from 8:00am – 10:00pm, 7-days per week in the Primary Care Covid-19 Centre. Respiratory Nurse Specialists attended every GP home visit and were involved in

calls to nursing home residents where they took the lead regarding respiratory assessment and management, oxygen therapy and palliative care anticipatory prescribing for residents. They also completed the Home Oxygen Order Forms (HOOF A) and sent them to the British Oxygen Company (BOC).

77. This clinical support was maintained throughout the relevant period. The role of the Care Home Support Team remained central to the co-ordination of support for residents in care homes. This included but was not limited to:

- Clinical in-reach;
- Coordination of response from the Trust's IPC Team;
- Coordination of response from the Testing Team;
- Coordination of Mutual Aid;
- Facilitation of training programme relevant to the management of Covid-19 positive residents, Covid-19 outbreaks.

78. However, the support provided by this team was not without cost as by the end of the pandemic the team had lost the majority of its original workforce due to burnout and trauma.

79. Through the relevant period, community teams adhered to DoH and PHA guidance in relation to care homes. As homes went into lockdown, core community teams such as Care Management, Community Social Work, and Allied Health Professionals had to adapt practices and work flexibly to support residents and their families. Referral pathways and key workers remained accessible. Teams developed action cards to support decision-making to manage the various eventualities that could arise in daily practice, provided telephone professional advice on individual residents and endeavoured to undertake remote assessments and review (the success of which was variable due to a lack of IT infrastructure and/ or staffing resource). Community Social Work and Care Management teams put processes in place to maintain regular contact with families, while Allied Health Professional colleagues developed and provided resources to the care homes to support them to care for residents.

80. The Commissioned Services Governance Team also introduced 7-day working patterns to support independent sector care homes and domiciliary care providers with access to non-clinical Covid-19 supports including PPE and to ensure effective communication and escalation of the Covid-19 related issues.

Risk of Infection

81. Residents in care homes were a frail vulnerable group with complex physical and mental health conditions, living in shared living facilities with multi occupancy, which increased the risk of viral transmission. It was particularly challenging for some care homes to ensure adequate staffing levels due to the high dependency on agency staff and the need to minimise staff movement across multiple homes to reduce the risk of transmission.

82. A number of care homes in the Trust geographical area were impacted by the Covid-19 pandemic from mid-March 2020. The Trust responded quickly and proactively with practical and accessible supports to keep residents safe and sustain service delivery. In the absence of guidance to cover all eventualities, Trust teams adapted to emerging situations by placing the safety and needs of residents at the centre of decision-making. As guidance emerged, Standard Operating Procedures were adapted to ensure practice reflected the current guidance. Please see Exhibit [NM/08 – INQ000581115] for an example of this.

83. A letter from the Chief Medical Officer dated 15 May 2020, provided as Exhibit [NM/09 – INQ000581126], outlined the expectation upon the Trust to address the challenges faced in the care home sector and to maximise opportunities to control outbreaks through effective IPC and correct use of PPE. It should be noted that the Trust had been providing IPC support, PPE and training from March 2020, prior to this guidance being issued.

84. When an outbreak was notified, a Senior IPC Practitioner from the Trust IPC team had a telephone consultation with the care home and, if the home was agreeable, the IPC practitioner visited the care home where they made an onsite assessment of the care home's IPC practice. A written report on the telephone consultation and the care home visit was provided to the care Home Manager and the Care Home Support Team. When necessary, the IPC team attended the Care Home Support Team's daily outbreak meeting.

85. Care home staff had access to the training delivered by the Trust IPC team. This was followed up by supplementary support from the Care Home Support Team.

86. Historically the Trust had not provided IPC support to care homes and was not resourced to do so. Initially staff redeployed to the IPC team were trained and

utilised to assist with the provision of IPC support to care homes but did so under the guidance and support of the IPC Team. However, when the PHA requested the Trust to support care homes, experienced staff from the IPC team had to be deployed into these roles as IPC knowledge did not exist outside the team. This placed pressure on an already overstretched workforce.

Adverse outcomes due to infection

87. The Trust commenced testing of care home residents with suspected Covid-19 on 19 March 2020.

88. By April 2020, independent sector care homes were coming under increasing pressure due to both the number of residents with Covid-19 (or displaying symptoms of Covid-19) and staff absence.

89. On 23 April 2020, the Trust commenced a pilot to test asymptomatic care home staff and residents in settings that were deemed to be Covid-19 free.

90. On 24 April 2020, testing commenced for all service users admitted to, or returning to, care homes as per guidance from the DoH Permanent Secretary. Prior to this, testing guidance had been to test symptomatic patients only.

91. Between 1 April 2020 to 30 June 2020, the number of residents in care homes testing positive increased month on month, however, the number of deaths during this period decreased month on month.

92. The percentage of Covid-19 positive residents in care homes (as a percentage of bed occupancy) in April 2020 ranged from 1% to 67% with the average number of positive residents across Belfast Trust homes in outbreak being 23%. This increased through May 2020 (average 32%) and June 2020 (average 33%).

93. The Trust kept a daily record of the number of positive residents within each care home. The information presented below is as of a date in time, however, the number of deaths recorded is a cumulative figure:

Date	**No. of care homes in outbreak**	**No. of residents testing positive**	**No. of care home deaths** (cumulative)
As of 30/04/2020	24	303	75
As of 31/05/2020	25	371	118
As of 30/06/2020	22	333	119

Excess deaths

94. As previously referenced, the Trust put in place responsive clinical support systems to ensure that residents in care homes received timely assessment, treatment and care. Residents in care homes were provided with robust clinical supports from experienced teams whose priority was to preserve life and support recovery.

95. The Trust also put in place a system to 'RAG rate' care homes in outbreak based on the number of residents infected. However, the communal living nature of care homes and the care home population being frail with co-morbidities and suppressed immune systems, created the perfect storm for the transmission and impact of the virus.

96. Between 16 March 2020 and 24 April 2020, 33% of the care home population in the Trust geographical area went into outbreak with 507 residents testing positive. Of those that tested positive, 10% (53 residents) died.

97. The period between mid-March and end of April 2020 was when the highest number of deaths of residents from care homes occurred.

98. Prior to the pandemic, the Trust was not informed of all deaths in care homes. Without accurate data on care home deaths, it is not possible for the Trust to calculate if there were excess deaths in care homes during the pandemic. The Trust now has a robust system in place to collate this information.

GUIDANCE, POLICIES AND PROCEDURES

Working with NI Executive, DoH, PHA, HSCB, RQIA, PCC and HSC Trusts

99. The Trust's social care services worked closely with the entire HSC system, including DoH, PHA and HSC Trusts throughout the relevant period. The Trust was in regular two-way communication with PHA, HSCB and DoH via Bronze/ Silver/ Gold command structure with daily sitreps and regular meetings.

100. The Trust had a Senior Leader from Adult Social Care represented on the Trust's Covid-19 Oversight Group.

101. The Trust implemented all guidance from DoH, PHA, Chief Medical, Nursing and Social Work officers within social care and community services. Any points of clarity required on guidance were escalated through to the Trust Covid-19 Oversight Group for further escalation to the relevant HSC partner. Examples of issues escalated are available via Exhibit [NM/10 – INQ00058116].

102. Recognising that HSC partners endeavoured to work collectively, and that we were in an evolving and unprecedented situation, more consultation regarding key decisions involving the care sector, and timely communication regarding implementation of guidance, would have been helpful.

103. Between March 2020 and June 2020, a number of policy decisions and guidance documents were communicated at short notice which, while understandable, presented challenges to both care homes and Trusts to operationally respond in an effective and timely way, particularly in those areas which required a workforce.

104. Communication of key changes requiring urgent action on a Friday led to confusion with limited opportunity for clarity and implementation due to the reduced staffing complement at weekends. Examples of this can be found at Exhibits [NM/11 – INQ000581130], [NM/12 – INQ000370972], [NM/13 – INQ000477522], [NM/14 – INQ000581131], NM/15 – INQ000581127], [NM/16 – INQ000581129], and [NM/17 – INQ000581128].

105. As the care home sector went into crisis during the first wave of the pandemic, the Care Home Support Team maintained daily contact with the PHA Control Room regarding declared outbreaks and risk assessments. They also worked in collaboration with colleagues from across the Trust to develop and implement the various testing protocols and processes to manage Covid-19 test results.

106. As the pandemic progressed, the Care Home Support Team engaged in regional meetings with the PHA Nurse Consultant for care homes and colleagues regionally to reflect on learning, share knowledge, experiences and challenges. This enabled action plans to be developed and implemented. They also worked in partnership with the PHA to deliver regional care home training via the Project ECHO platform.

107. Senior Leaders from Adult Community Older Peoples Services engaged regularly with HSCB, RQIA and other Trusts to provide a sitrep, to escalate concerns and share learning. The frequency of meetings varied and evolved during the pandemic. From September 2020 onwards, the Trust completed a weekly surge plan update report, provided as Exhibit [NM/18 – INQ000581139], for submission to HSCB for independent sector and statutory care homes.

108. In response to DoH developing a regional response plan to stabilise the care home sector during the first wave, the Trust carried out a modelling exercise to inform the development of a coherent workforce support plan to respond in the event of 25%, 50% and 75% of care homes across the Trust geographical area needing support.

109. In early May 2020, the Trust became dissatisfied with the performance of an independent sector care home within its geographical area, during their first Covid-19 outbreak. The Trust took immediate action to address the issues, implemented immediate learning and worked with HSCB, DoH, RQIA and the Health Minister to escalate, respond and provide assurance of the safety of residents within the care home. This included placing a team onsite in the care home to oversee the care of residents and having an independent nursing review of each resident and their care plan. The Trust notified the performance concerns as an SAI, provided a daily sitrep to HSCB and commissioned a Level 3 Serious Adverse Incident review into the care home management of the Covid-19 outbreak.

Working with Independent Health and Care Providers (IHCP) Group

110. The Trust engaged early with independent sector providers holding pandemic preparedness workshops on 11 March 2020. The independent sector domiciliary care workshop achieved 61% attendance. The independent sector care home workshop achieved 86% attendance. From the end of March 2020, the Trust facilitated regular partnership meetings with independent sector providers to ensure effective communication and support to these sectors for the duration of the pandemic. The frequency of these meetings varied during the course of the pandemic, however, there were retained throughout and continued beyond the relevant period. This allowed two-way communication between the Trust, care homes and domiciliary care providers; it enabled the Trust to be responsive and to articulate and advocate for independent sector providers during regional discussion. The Trust was responsive to specific queries or concerns raised by IHCP representatives and individual providers.

111. At the end of March 2020, the Trust received compliments from multiple Independent Sector Providers and via the IHCP Chief Executive directly to the Senior Leadership Team in Adult Community Older Peoples Services for the partnership approach and support it was providing to independent sector domiciliary care and care home providers.

Working with the Commissioner for Older People (COPNI)

112. The Trust did not routinely engage with COPNI during the relevant period in relation to the Covid-19 pandemic regarding social care.

Working with any other stakeholders

113. The Trust engaged with Primary Care colleagues from March 2020 onwards on a number of matters including the Primary Care Covid-19 Centre and the clinical care of residents in care homes. These meetings continued during the course of the pandemic and developed into a monthly Trust and Primary Care Interface meeting that has been sustained as part of normal business.

A summary of the matters worked on with the bodies identified above

114. As previously indicated, the Trust worked collaboratively with HSC partners to achieve the best possible outcomes for service users. In the main, the DoH, HSCB and PHA roles were consultative and facilitative. There was a high level of expectation on Trusts in relation to the co-ordination and delivery of support to independent sector care homes despite the Trust facing their own staffing challenges.

115. The Trust worked with PHA, HSCB, RQIA and other Trusts on a range of matters including implementation of testing in care homes, managing outbreaks, improving IPC, delivering care home training, manager update meetings via virtual platforms, and the roll out of the vaccination programme.

116. A wider range of regional working groups were established during the pandemic to support building on learning from each wave, improve communication, and the safety and quality of care delivered in care homes. This list below provides an example of the range of groups the Trust was represented on. Whilst not exhaustive, it aims to offer an example of the complexity and breadth of the response required and provided from Trust social care community services to support the care home sector throughout engagement with all HSC partners during the pandemic:

- Development and implementation of a Regional Surge Plan for care homes. Following implementation, Trusts submitted a weekly return for independent sector providers and statutory care homes;
- A Care Homes Data QI Project to support the verification of the RQIA Surveillance Report;
- Surge Planning meetings;
- Mutual Aid Support work stream;
- Rapid Covid-19 Care Home Learning work stream;
- Care Home Information Analysis work stream;
- Care Home Teleconference work stream;
- A work stream to develop a wellness checker to support residential homes;
- Care Partners work stream;
- A Transfer of Care work stream focused on developing guidance for admission to a care home from hospital or community, based on the varied Covid-19 related scenarios that presented;

- No More Silos bid to secure funding for a multidisciplinary Care Home Support Team;
- Roll out of the Vaccination Programme;
- Development of Enhanced Clinical Care Framework;
- Visiting Arrangements in Care Homes.

117. The Trust collaborated with independent sector providers throughout the course of the pandemic to sustain service delivery and is proud of the support it provided in an unprecedented and unpredictable situation.

118. The Trust quickly developed a 7-day single point of contact for providers to seek guidance, advice and support for non-clinical Covid-19 related issues. By the end of March 2020, the Trust had in place a process for the distribution and provision of PPE for both care homes and domiciliary care providers.

119. The Trust worked collectively with care homes to support them during periods of outbreak and established a single point of contact for accessing clinical support. The Trust provided clinical assessment for residents 7-days per week, established a clinical care pathway and supported care home staff with palliative, end of life and advance care planning.

120. The Trust ensured providers received all relevant DoH, PHA and relevant Trust guidance to ensure they were working to the most recent guidance and had the necessary skills and knowledge to deliver safe and effective care.

121. Education and training were routinely offered in care homes through regular sessions held via virtual platforms and bespoke onsite training in care homes where a specific training need was identified.

122. All care homes that went into outbreak were contacted by the Trust IPC team and IPC advice, guidance and support was provided. IPC and environmental cleanliness audits were offered, and the Trust Patient, Client and Support Services (PCSS) teams were made available to support homes to improve environmental cleanliness when required.

123. Mutual Aid support was offered to care homes to ensure there were adequate staff to care for residents during outbreaks. The staff delivering mutual aid support were

made up of redeployed staff, bank and agency staff. A very minimal number were identified via the workforce appeal.

124. Prior to the pandemic, the Trust had aligned Care Review and Support Team key workers to all care homes, and this service provided a direct line of communication and access to support residents, care homes and families.

125. During periods of outbreak, Trust teams offered daily support to care homes and endeavoured to maintain daily contact with families of residents in homes of outbreak.

126. The Trust worked collaboratively with care homes in implementing testing for residents and staff, including the PHA surveillance testing, and delivered the vaccination programme for staff and residents.

127. Throughout the pandemic, the Trust Occupational Health service offered wellness checks to care home staff who were Covid-19 positive and who were physically or psychologically unwell. The Trust made available to them the same range of psychological emotional supports that were available to Trust staff.

128. The Trust Finance and Contracts teams facilitated care homes accessing the finance package provided by DoH to support homes to maintain stability and manage cost pressure associated with the pandemic.

129. The Trust supported the implementation of Care Partners across care homes to ensure both the care home and resident's families understood the roles and responsibilities within this arrangement. Where families faced challenges with becoming a Care Partner the Trust advocated for them.

130. The Trust and Primary Care colleagues worked collaboratively to develop the Primary Care Covid-19 Centre, operationally managing and centralising the service within a Trust facility for the duration of the pandemic. The Trust provided clinical teams and administrative resource to support Primary Care to deliver a responsive and timely service.

131. In addition, the Trust engaged with Primary Care in April 2020 to discuss and agree a clinical care pathway for residents in care homes, which laid the foundation for the Trust collaboratively developing the No More Silos bids for care homes.

132. Whilst GP practices retained pre-pandemic medical responsibility for their residents in care homes, clinical teams from the Trust, including the Acute Care at Home Team, Care Home Support Team, and the Community Respiratory Team delivered the clinical care, advance care planning, palliative and end of life care to Covid-19 positive residents.

133. From July 2020 Trust teams had embedded the required systems and processes to support independent sector providers and these continued to be provided throughout the course of the pandemic, with all processes updated to ensure they reflected the most recent guidance.

DISCHARGES FROM ACUTE SETTINGS INTO COMMUNITY

Discharge practices, policies and procedures immediately pre-pandemic

134. The Trust has in place a management structure to oversee hospital discharges. Discharges from Belfast Trust hospitals can be facilitated through a number of processes. Patients requiring no support to return home were discharged directly from the ward. Patients considered to be complex discharges were referred to either the Discharge Hub or Hospital Social Work team. Complex discharges were those patients who had no rehabilitation goals but assessed as requiring social care supports – a domiciliary care package or care home placement – to enable them to be discharged from hospital.

135. Immediately prior to the relevant period, the Discharge Hub and Hospital Social Work team facilitated discharges across all four Belfast Trust hospital sites, 7-days per week. The Trust also operated a Discharge Hub in the Ulster Hospital (South Eastern Health and Social Care Trust) 7-days per week.

136. The patient's ward-based multidisciplinary team completed regionally agreed transitional discharge forms which outlined the patient's needs, and the identified discharge team quality assured the recommendations and worked in partnership with patients and families to facilitate discharge.

137. The Discharge Hub operated a discharge to assess model, aiming to discharge patients within 48 hours of being deemed medically fit by restarting their existing domiciliary care package or with the appropriate supports to allow further assessment and rehabilitation of the patient in the community, either within their own home or a dedicated rehabilitation bed in a care home environment.

138. In January 2020, the Trust commissioned 51 rehabilitation beds across 3 care homes to facilitate bed-based rehabilitation. The Trust also had an additional 81 interim care beds which were used for further multidisciplinary assessment and care planning of patients who were medically optimised to leave hospital but required further assessment to determine their longer-term care needs. The commissioning of these beds was fluid and determined by Trust demand and available capacity in independent sector care homes. In addition, the Trust commissioned a rapid response domiciliary service from three independent domiciliary care providers totalling 820 hours per week. This service on average facilitated 100 discharges per week. The Discharge Hubs screening process determined if patients required home or bed-based rehabilitation. Coordinators in the discharge hubs identified the rehabilitation bed and facilitated the discharge and the pre-admission screening.

139. Hospital Social Work teams facilitated the more complex discharges for patients with no identified rehabilitation goals, who required a new care home placement or domiciliary care package (new or reviewed) to be discharged from hospital.

140. In January 2020, patient's families were asked to identify three care homes for their relative and to place their name on the care home waiting list if no beds were immediately available. The Hospital Social Work team would have facilitated the sharing of the patient's multidisciplinary assessments with the care home to enable them to screen the referral and complete the pre-admission assessment to determine suitability for placement. The care home determined if the patient was accepted for admission. The patient remained in hospital until a bed became available in their identified home. If assessment was significantly delayed the patient and their family would have been encouraged to discharge to a home with an available bed.

141. Discharges of patients requiring core domiciliary packages were referred by Hospital Social Work to the relevant Community Social Work team who facilitated the commissioning of the care package in partnership with the Trust's Care Bureau. If family were unable to provide the required support to take the patient home to

await commencement of the care package, the patient remained in hospital until the care package became available.

Changes introduced to discharge practices, policies and procedures

142. Covid-19 testing of patients discharging from hospital to a care home commenced on 25 April 2020, in line with regional guidance. At this time, the regional transitional forms shared with care homes included a section on breathing and the nursing pre-admission assessment included sections for the recording any hospital acquired infection, including respiratory conditions.

143. As part of its Business Continuity Planning and Preparedness for the Covid-19 pandemic, the Trust had to make a number of changes to inpatient care to maximise patient safety and to create the capacity to respond to the modelling predications on the numbers of people who would require inpatient care. This included designating the Mater Hospital as the 'Covid-19 hospital' and the Belfast City Hospital as the 'Nightingale hospital' where all Covid-19 ICU beds would be consolidated. To free up bed capacity, the Trust had to prioritise the discharging of medically fit patients from these sites and the transfer of non-Covid-19 clinically unwell patients to the Royal Victoria Hospital site.

144. The guidance of the 13 March 2020, 17 March 2020, 18 April 2020, 19 April 2020, 25 April 2020, and 27 April 2020 all emphasised the importance of timely discharge of patients and importance of maintaining hospital flow.

145. The Trust endeavoured to maximise its discharge capacity by taking a number of measures to create capacity for Covid-19 positive and non-Covid-19 patients in the community. Between March and June 2020, the Trust:
    - Discharged 44% more patients to home based rehabilitation services;
    - Remodelled the Community Reablement Service into a domiciliary care service for Covid-19 positive patients;
    - Worked in partnership with an independent sector provider to remodel the Ramada Hotel into an interim stepdown facility offering 150 stepdown beds.

Consultation from DoH with BHSCT regarding policy or guidance

146. Given the rapidly changing and evolving situation, the Trust was not consulted before DoH guidance was issued. Points of clarity on all guidance issued were raised through Silver Command. Examples previously provided at Exhibit [NM/10 – INQ000581116].

147. At regional forums, the Trust articulated the challenges of balancing hospital discharges with care home concerns regarding re-admitting patients from hospital. The Trust and care homes were faced with a number of scenarios associated with discharge:
    - Patients discharging Covid-19 negative, care home not in outbreak;
    - Patients discharging Covid-19 negative, care home in outbreak;
    - Patients discharging Covid-19 positive, care home not in outbreak;
    - Patients discharging Covid-19 positive, care home in outbreak.

148. The frequency of these meetings fluctuated throughout the duration of the pandemic and representation from the Trust varied. Initially meetings were up to three times per week but were reduced as the pandemic progressed. The examples provided in Exhibits [NM/19 – INQ000581102], [NM/20 – INQ000581106] and [NM/21 – INQ000581096] articulate the discussion at meetings and challenges faced.

149. Each scenario was risk assessed based on the patient's Covid-19 status and care home outbreak status. In November 2020, the Trust worked with the HSCB on a Transfer of Care Plan based on these scenarios.

150. From October 2020 the Trust was fully engaged in the DoH led work in relation to achieving the objectives of 'No More Silos'.

Consultation between BHSCT and care homes on the operation of policy

151. RQIA as the care home regulator was responsible for issuing all guidance to care homes during the pandemic. The policy and guidance issued by DoH, PHA, Chief Medical, Nurse and Social Worker Officers were not the Trust's policy documents to consult on. However, the Trust shared all guidance with care homes and domiciliary providers and supported care homes understanding their responsibilities to operationalise the policies.

152. The Trust facilitated separate workshops for independent sector domiciliary and care home providers on 11 March 2020 and thereafter met regularly with them to discuss the most recent guidance, and the Covid-19 related challenges care homes were experiencing, which included operationalising the guidance and wider challenges regarding the impact of the virus.

153. The Trust also engaged with care home providers to determine their capacity to create discharge pathways to support hospital flow.

Amendments/ Suspensions of regulations or practice to facilitate discharges

154. In response to the 13 March 2020 Surge Plan, provided as Exhibit [NM/22 – INQ000581136], correspondence to RQIA dated 25 March 2020 and correspondence from DOH NI Permanent secretary, Richard Pengelly 26 March 2020, the Trust worked to communicate to patients and families the importance of timely discharge from hospital. Furthermore, the Trust worked to introduce a discharge escalation framework, which evolved over the course of the pandemic. This included advising patients that if a bed was not available in their home of choice, then they would be asked to discharge to a care home where there was an available bed to await their home of choice.

155. Hospital Social Work teams engaged patients and families in these discussions, supported by ward teams and their line management structure. Patients were only discharged to care homes with the registered category of care to meet their needs.

156. The correspondence from HSCB on 27 March 2020, previously provided as Exhibit [NM/12 – INQ000370972] outlining that Trusts could place people with dementia and delirium into beds registered for other purposes had very limited impact on discharging this patient group, as the Trust was dependent on care homes being agreeable to implement this guidance. In practice, the guidance was met with a high level of resistance from care homes.

BHSCT concerns regarding policy/ guidance

157. The Trust endeavoured to work in partnership with care homes to balance the challenges they were facing within maintaining hospital flow and timely discharge. The situation was challenging for Trust and care home providers as the pandemic was unprecedented and staff were working in a rapidly changing situation. Guidance was being developed based on the modelling prediction and the impact this would have on capacity within the acute hospitals and the need to maintain discharge flow in order that inpatient beds were available for the sickest was being widely communicated in the media. For people who required 24-hour care, the care home sector was an essential element of the Trust's discharge contingency plan. The Trust worked in partnership with care homes throughout the pandemic to provide support, to address concerns and to articulate the challenges they were experiencing at a regional level.

158. Some of the challenges with discharge reflected pre pandemic challenges regarding timely decision-making, the availability of a decision maker over 7-days and the ability of the care home staffing resource to accommodate timely discharge. However, the aforementioned Covid-19 related scenarios added to the complexities of discharging patients to care homes. These concerns were escalated through Silver Command and via engagement meetings with HSCB and PHA.

Availability of testing (March – April 2020)

159. Version 3 of the *Covid-19 Interim Protocol for Testing for Covid-19* (19/04/2020) guidance, provided as Exhibit [NM/23 – INQ000581123], detailed the requirement to test patients being discharged to a care home, within 48 hours of discharge. This was highlighted to the Trust in a letter from DoH NI Permanent Secretary Richard Pengelly dated 25 April 2020. Testing guidance up until this point had been to only test symptomatic patients within acute hospitals.

160. Between 27 February 2020 and 24 April 2020, 405 patients were discharged to care homes, 22% (89) of which were tested for Covid-19. Of those tested, 9% tested positive for Covid-19.

Care home concerns regarding policy/ guidance set out above

161. The Trust facilitated a workshop with care homes on 11 March 2020 to support care homes with contingency planning. At this stage, care homes were in the same position as the wider population in relation to the evolving situation. At this workshop the Trust provided information on the latest advice and guidance, an opportunity for discussion on a number of key areas around management of Covid-19 and how care homes would be supported. As outbreaks in care homes escalated from mid-March 2020, care homes became increasingly concerned regarding admissions and the associated risk of introducing the virus into the home. These concerns were escalated through Silver Command and via engagement meetings with HSCB and PHA.

162. The Trust continued to work to the relevant guidance for hospital discharge. Ultimately, the Care Home Manager made the final decision regarding a new admission or re-admission to the care home. Where care homes refused to accept a new admission or a patient returning to the care home, the Trust negotiated discharge and pre-discharge testing in line with guidance. It is important to reflect that Trusts were working in fluid and unprecedented circumstances.

163. Prior to 24 April 2020, increasing numbers of care homes expressed a reluctance to take residents back without testing. Once the testing guidance was implemented, care home misinterpretation of the guidance, or applying their own requirement, led to delays in care homes accepting patients for admission.

164. Examples of how care homes adapted the guidance regarding hospital discharge to a care home included:
    (i) Care homes requesting additional swabbing of patients that sat outside the guidance;
    (ii) Refusing to take patients back if tests were not negative, even when the patient had completed the recommended period of isolation and had not been symptomatic for recommended timeframe;
    (iii) Refusing to take patients back to the care home who they could not be confident would stay in their room, without the Trust financing a one to one carer, even if the patient was testing negative.

165. Paragraph 200 of the *Report on the Impact of Covid-19 in Care Homes* relates to the period prior to discharge testing guidance being implemented.

Discharges to care homes assessed as 'inadequate' by RQIA

166. The Trust has interpreted the term 'inadequate' to mean 'enforcement' action was being taken by RQIA.

167. No care homes in the Belfast Trust geographical area were subject to RQIA enforcement immediately prior to the relevant period. During the relevant period the Trust raised concerns in late April regarding an independent sector care home within its geographical area, which resulted in enforcement action being taken by RQIA. In line with the Trust Commissioned Services Governance Framework, and under its performance management procedures, the Trust closed the care home to all new admissions.

Step Down Facility (Ramada Hotel)

168. In March 2020, when transmission modelling was predicting a Covid-19 surge across the Northern Ireland population in April/ May 2020, one of the key messages for the HSC Trusts was to have contingency arrangements in place to support acute hospital flow. As part of its contingency planning throughout the course of the pandemic, the Trust developed a number of Covid-19 pathways to support hospital flow. During the first surge, the Trust entered into a partnership agreement with Health Care Ireland to open the Ramada Hotel at St Anne's Square, as an interim step-down facility.

169. A significant amount of work was undertaken to convert the hotel into an appropriate caring environment and to develop operational protocols. RQIA and DoH were consulted on this development. RQIA inspectors subsequently visited the hotel and, although they recognised they had no regulatory role in the facility, they expressed their satisfaction with the environment. RQIA confirmed that it would be content for this service to be considered as an innovative 'sand box model' to support the Trust's response to the pandemic.

170. The purpose of the Ramada Hotel as an interim care facility was to increase step down bed-based capacity to address Covid-19 contingency scenarios. The hotel had a capacity of up to 150 beds for a temporary period of three months. The facility was open between 17 April 2020 to 11 June 2020. When established, it was envisaged the facility would be primarily used for patients discharging from Belfast

Trust hospitals, who had a Covid-19 positive diagnosis and were in the recovery phase of the illness. However, the service, once established, was also used to support the discharges and recovery of patients who had been admitted to hospital with other conditions and to accommodate regional patients who had been admitted to a Belfast Trust hospital.

171. Standard Operating Procedures and a robust governance assurance framework were implemented. A dedicated multidisciplinary team were redeployed to work in the facility. An admission criterion formed part of the governance assurance processes and this was shared with discharge teams

BHSCT understanding of the impact of the discharge policy on infection rates

172. The Trust followed all DoH/ PHA Covid-19 discharge guidance issued in relation to discharging patients from hospital to a care home environment. Prior to 25 April 2020 the guidance advised only symptomatic patients should be tested, prior to discharge to a care home.

173. On 25 April 2020, testing commenced for all residents admitted to, or returning to, care homes as per guidance from the DoH NI Permanent Secretary. The data the Trust has, available through analysis completed as part of an FOI request, indicates that low numbers of Covid-19 positive patients were discharged to a care home Covid-19 positive. The Trust recognises the high risk associated with a patient who was Covid-19 positive being transferred to a care home that was not in outbreak.

174. From 25 April 2020 to 16 June 2020, 340 patients were discharged to care homes, of which 309 were tested. Of the 309 tested, 87% (297) tested negative, 3% (10) tested positive and 0.6% (2) tests were inconclusive. Further analysis of the 31 who did not appear to be tested, indicated 7 did not discharge to a care home, 9 were tested within 48 hours of returning to the care home, 3 were not tested within 48 hours of discharge as they were known to be Covid-19 positive during admission and therefore assumed to be positive, 9 were tested within 72 hours of discharge, 2 were not tested and Covid-19 status is unknown, and 1 patient was discharged prior to change in testing guidance.

BHSCT understanding of the impact of the discharge policy on care recipients

175. From 25 April 2020, all patients discharged to a care home had to be tested 48 hours before discharge and, from then on, this formed part of the discharge planning process and the pre-admission assessment of patient being discharged to a care home. Whilst mitigating the risk of spread of Covid-19, this requirement had an impact on the timeliness of the discharge pathways due to the varying discharge scenarios which arose. These included:
    - Covid-19 positive patients who were within the self-isolation period;
    - Covid-19 positive patients who were discharging to a care home that was not in outbreak;
    - Covid-19 positive patients whose care home was in outbreak;
    - Patients who had been exposed to Covid-19 during their inpatient admission;
    - Patients who had been Covid-19 positive but were outside of the isolation period but still testing positive.

176. The decision of care homes to accept patients for admission was influenced by the patient's Covid-19 status, the care homes outbreak status and staffing levels within the home. Some of the challenges with discharge reflected pre-existing pandemic challenges of a lack of timely decision-making, the lack of availability of a decision maker over 7-days and the ability of care homes' staffing resource to accommodate timely discharge. However, the aforementioned Covid-19 related scenarios added to the complexities of discharging vulnerable patients to care homes. This contributed to patients being delayed in hospital, which placed them at increased risk of unnecessary exposure to hospital acquired infections including Covid-19, increased risk of decompensation and the added discomfort of additional Covid-19 swabbing.

177. Where a patient tested positive but was clinically stable, care homes expected the patient to complete their isolation period in hospital prior to returning to their care home, where, in line with guidance, they would have then had to complete a further period of isolation in the care home. At its maximum, the combined isolation period was 28 days, resulted in the risk of social isolation and loneliness, lack of physical and psychological stimulation and deconditioning.

MANAGEMENT OF IPC, PPE AND TESTING

Care sector guidance on IPC measures for care homes

178. There was a range of specific guidance in relation to care homes issued by DoH and PHA during the pandemic. Initial guidance was issued on 12 March 2020, provided as Exhibit [NM/23 – INQ000581123], 17 March 2020 and 26 April 2020. The PHA established a helpline for support and advice for independent sector providers.

179. It was the remit of RQIA to communicate all guidance issued by the PHA regarding management of Covid-19 in care homes to independent sector care homes. However, during the course of the pandemic the Trust also issued all relevant guidance and links to HSC training they received via the Commissioned Services Governance Team.

180. The Trust communicated to independent sector care home providers on 3 March 2020 reminding them of the emerging position with regards to Covid-19, requesting they review their Business Continuity Plans with specific reference to a pandemic, PPE and IPC training. The Trust facilitated a workshop for independent sector care homes on 11 March 2020. This workshop provided an overview of the latest guidance, the range of guidance available at that point, drew out key discussion points from this guidance, and communicated plans the Trust were putting in place to support care homes. Following this workshop, the Trust met with independent sector care home providers on a regular basis. The frequency of these meeting varied during the course of the pandemic, however, these meetings were initially weekly.

181. One of the challenges experienced by the Trust was that there was no funded IPC resource to support care homes and therefore the support provided was in addition to the IPC role within the Trust.

182. The Trust IPC Team followed national and regional guidance and in response to the pandemic developed a Standard Operating Procedure for independent care home teams within the Trust's geographical area to assist with pandemic preparedness and Covid-19 outbreak management. This was reviewed and updated as the pandemic evolved to ensure it reflected most recent guidance.

183. All care homes received a preparedness visit and, on declaration of a new Covid-19 outbreak, the IPC Nurses followed the Covid-19 Outbreak Standard Operating Procedure by providing a supportive telephone call, followed by a written report to the home reflecting the discussion and advise provided. All care homes were offered a follow up support visit from an IPC Nurse. All accepted visits were followed up by a written report reflecting the findings and discussion during the visit. A copy of the report was also circulated by email to the Care Home Manager and Trust Care Home Support Team.

184. Whilst it is important to acknowledge that the Trust could not enforce visits, and there were care homes which refused visits, from November 2020 to June 2022, in addition to providing pandemic preparedness visits, it is estimated the IPC Team provided 166 Covid-19 outbreak visits to independent sector care homes.

185. For one home of particular concern, the IPC Team undertook an audit of the environment using a shortened version of the RQIA Regional Healthcare and Cleanliness Audit Tool.

186. Non-IPC Nurses assisted the IPC Team during the first surge to provide PPE training and IPC education.

187. All Trust IPC resources were emailed to independent sector domiciliary care providers on 17 March 2020 and independent sector care homes on 23 March 2020 with hard copies also provided to each care home. This included information on zoning posters, audit tools, hand hygiene posters and PPE posters.

188. A representative from the Trusts IPC Team attended the Care Home Support Team's daily safety huddle regularly (frequency was determined by presenting need) to maintain a close oversight of care homes in outbreak.

189. A mainly claims based process for care homes within a financial envelope of £11.7m was announced by the Health Minister in June 2020. One of the three key areas that this financial package supported was increasing environmental cleaning hours. The availability of cleaning staff during period of outbreak formed part of the Trust's assessment when a home when into outbreak and were the home did not have adequate resource the Trust offered to support via their Patient Client Support Services team.

Care sector guidance on IPC measures for domiciliary care providers

190. DoH/ PHA shared Covid-19 Guidance for Domiciliary Care Providers in Northern Ireland on 10 April 2020, presented as Exhibit [NM/24 – INQ000581105]. The PHA established a helpline for support and advice to independent sector providers.

191. It was the remit of RQIA to communicate all guidance issued by DoH/ PHA to independent sector domiciliary care providers. However, during the course of the pandemic the Trust also issued all relevant guidance and links to HSC training they received via the Commissioned Services Governance Team.

192. The Trust's IPC Team followed national and regional guidance. The Trust shared IPC guidance with all domiciliary care providers.

Care sector guidance on IPC measures for unpaid carers

193. The Trust is not aware of any specific guidance issued for unpaid carers. Unpaid carers would have been caring for loved ones within their own home and would have been subject to the advice issued to the general public. The Trust provided PPE to staff commissioned through Direct Payments to deliver care.

IPC Guidance, support, advice and training provided by the Trust

194. Statutory services, including the Trust's Home Care service, Reablement team and statutory care homes had access to all Trust IPC training and staff were required to attend a range of training programmes including:
    - Donning and Doffing (PPE)
    - Hand Hygiene

195. Although independent sector providers did not have access to the Trust intranet, all relevant Trust guidance and information was shared with independent sector providers by the Commissioned Services Governance Team, an example of this is provided as Exhibit [NM/25 – INQ000583064]. The Trust IPC Team also circulated guidance to care homes via email and delivered copies of IPC guidance during onsite visits. In effect, independent sector providers had access to all the same IPC guidance as Trust staff. All internal IPC guidance and training was modified by the

Trust teams as the pandemic progressed to ensure it reflected the most recent guidance.

196. From February 2020 to April 2020, the Trust IPC Team supported pandemic preparedness and implementation of guidance in a number of ways including offering a minimum of weekly in-person education sessions, which moved to an online platform as the situation changed.

197. From April 2020, the IPC Team commenced a 'zoning' strategy which was implemented across all care homes in the Trust geographical area via an onsite visit to provide practical advice, guidance and relevant resources.

198. In the event of an outbreak, the Trust's Care Home Support Team and IPC Team provided follow up. This enabled a risk-based support response to be in place for individual care homes.

199. The established relationships and training programme that were central to the role of the Care Home Support Team prior to March 2020, were built upon during the pandemic as Commissioned Services coordinated the Trust response to supporting independent sector providers

200. During the relevant period, the Care Home Support Team remained the single point of contact for all care home outbreaks and coordinated the support for care homes from other Trust teams. They were supported in this role by the Commissioned Services Governance Team who provided a single point of contact for all independent sector providers on all non-clinical Covid-19 related matters. Both teams adapted their working hours to provide this support 7-days per week.

201. From March 2020, the Care Home Support Team complimented the training delivered by the Trust IPC Team by providing IPC training specifically for care homes both onsite and via video link on 'Donning and doffing', 'Hand Hygiene' and 'Social Distancing'. From 19 March 2020, the Care Home Support Team also shared written guidance on these topics and PPE via email and discussed them at the twice-weekly virtual sessions with independent sector care homes.

202. As residents presented with symptoms, the Care Home Support Team visited each care home to provide clinical assessment, advice and direction regarding the clinical

care of residents. Additionally, onsite training for 'PPE', 'IPC', 'Donning and doffing', and 'Isolation and cohorting of residents' was offered and delivered.

203. The Care Home Support Team attended care homes and facilitated testing of symptomatic residents until care home staff had become competent in completing tests. The Care Home Support Team facilitated face-to-face swabbing training whilst completing testing onsite and online testing training via virtual platforms, which was accompanied by the provision of written guidance.

204. In addition to providing clinical support into care homes during outbreaks, the Care Home Support Team provided a rolling programme of training during the pandemic via the twice-weekly virtual training sessions. The team worked in partnership with other Trust teams to draw on their expertise, coordinated and reviewed training to ensure it reflected the current guidance and met the training needs of care home staff and residents. The Teams also worked in partnership with PHA to deliver some regional training to care homes and Primary Care colleagues. Topics covered during training sessions included:
    - IPC and PPE for Covid-19
    - Palliative Care Update and Advance Care Planning
    - Deteriorating Patient and Sepsis
    - Anticipatory Care & Advance Care Planning
    - Dementia Care during Covid-19
    - Verification of Life Extinct
    - Pharmacy Update during Covid-19
    - PHARMACY: Guide to use the pandemic box
    - Respiratory Support of Residents during Covid-19
    - RQIA Update & Pharmacy: Unused Medication
    - Use of Oxygen
    - Environmental Cleaning during Covid-19
    - Health and Wellbeing of Staff during Covid-19
    - Training to Staff Working in Residential Care Homes in the Respiratory Assessment and Use of Pulse Oximeters

205. While all care homes had access to this training, there was considerable variability in attendance. Those who did attend benefited from the shared learning these sessions offered.

206. Where the Trust identified that a care home required additional equipment to support the safe delivery of care, this was provided.

207. The level of anxiety that existed in the care home sector when an outbreak was declared was significant and required the onsite support referenced to assist in facilitating all required actions. Onsite support proved effective and was evidenced in the feedback from providers expressing the huge benefit of this approach in assisting them at times of crisis.

208. In June 2020, care homes were offered the opportunity to take part in a PPE audit on a weekly basis for 4 weeks; 60 care homes agreed to take part. Based on the findings of the audit, additional training was provided to the staff on duty. This approach, as outlined below, evidences improved effectiveness in PPE compliance during the audit period.

Number of Homes

	Week 1	Week 2	Week 3	Week 4
100%	13	25	38	43
95%	15	19	15	12
90%	5	5	6	3
85%	6	4	0	1
80%	11	2	1	1
FAIL	10	5	0	0
	60	60	60	60

Overview of testing arrangements for adults in care homes

209. From 17 March 2020, when the Trust identified its first Covid positive resident in a statutory care home, the Trust facilitated resident testing onsite. The Trust had its first testing protocol in place for resident testing from 19 March 2020, which was updated regularly to reflect the guidance.

210. The testing policy evolved as the pandemic progressed, with a range of Trust teams supporting the testing of care home residents and staff.

211. The Trust opened its testing centre at the MOT Centre, Boucher Road on 6 April 2020.

212. As part of the evolution of care home testing, the Care Home Support Team worked with the MOT Testing Centre and the Occupational Health Department to develop an in-reach service for the testing of care home staff and residents. This involved the further development of the original Standard Operating Procedure to guide processes related to referral, triage, testing arrangements, delivery of testing packs, collection of completed swabs, delivery to Trust laboratories, sharing results and ongoing clinical support.

213. These Standard Operating Procedures were modified throughout the relevant period to reflect the most up to date testing guidance.

Overview of testing arrangements for adult social care workforce

214. The Trust implemented all PHA guidance regarding testing in care homes.

215. Care home staff had access to all national and Trust testing sites.

216. From 24 April 2020, the Trust introduced whole home testing for care home residents and staff in all independent sector care homes when a new outbreak was declared. The onsite testing of staff was initially facilitated by the Care Home Support Team but evolved as the pandemic progressed and was eventually taken over by the MOT Centre, Boucher Road Testing Team.

217. A team within the Trust Occupational Health team was established to specifically manage communication of test results to staff, to undertake wellness checks, provide practical advice regarding symptom management and an Advice Line for Trust employees and staff working in the independent care home sector. These services were available to care homes from March 2020 to June 2022 and were operational 12 hours per day. 7-days per week.

218. The Trust tested and provided 23,495 results to staff working in independent sector care homes during the course of the pandemic.

219. Information on supports available to care homes from the Trust Occupational Health team was communicated to care homes via the Commissioned Services Governance Team and to each home as they went into outbreak by the Care Home

Support Team. The twice-weekly virtual training was facilitated by the Care Home Support Team, enabled the testing centres and Occupational Health team to deliver training on the process for accessing resident and staff testing, communicating results and the range of supports available for managers and staff. Initially test results were communicated verbally before moving to communication by text message.

220. The Trust Occupational Health team faced a range of challenges in supporting staff testing in care homes including:

- Poor quality handwritten lists that were often detailed with inaccurate and duplicate information which was time intensive to cleanse;
- Timely receipt of staff lists;
- Care homes lacking clarity on the process for testing residents and staff;
- Delays in labs processing results;
- Covid-19 tests getting lost during transit or within labs resulting in tests needing repeated;
- Managing unpredictable demand, volume and frequency of testing in care homes;
- Monitoring of test results for 14 days (remaining negative);
- Availability of Care Home Manager to accept test results;
- Obtaining direct contact with relevant Care Home Manager when there were difficulties contacting an individual staff who tested positive;
- Staff not on shift on day of testing;
- Staff not consenting to testing;
- Care home staff changing shifts without this information being shared;
- Difficulty contacting individuals (not all mobiles were set to receive calls from withheld numbers or individuals not answering unknown numbers).

221. The same testing processes were implemented for staff working in statutory care homes.

222. All Trust staff employed to work in adult social care had access to all Trust testing sites throughout the course of the pandemic.

Overview of testing arrangements for unpaid and domiciliary carers

223. Domiciliary care staff employed by the Trust had access to Trust testing sites and the Occupational Health supports available to all Trust employees.

224. Independent sector domiciliary care staff had access to the national testing programme, practice was guided by PHA and DoH guidance and they had access to the PHA helpline for advice and guidance.

225. The Trust did not put in place specific arrangements for independent sector domiciliary care providers or unpaid carers.

Overview of testing arrangements for visitors (both family and professionals)

226. All Trust staff worked to the most recent DoH guidance with regards to visiting care homes. Initially, Trust statutory care homes introduced temperature checks and screening of any person entering the care home. Where they were identified as being symptomatic, they were asked to isolate at home. A surveillance questionnaire was later developed and implemented for staff and visitors visiting statutory care homes which also included the temperature check.

227. At the workshop on 11 March 2020 the Trust discussed the most recent visiting guidance with Care Home Managers .

228. When lateral flow tests became available, these were ordered as part of PPE orders via Trust Estates services and supplied to staff. The advice and guidance as per the Trust IPC Team was to complete a lateral flow test prior to commencement of shift, however, this was not mandatory and therefore records were not maintained.

229. LAMP testing was also made available to Trust staff as the pandemic progressed at various Trust locations.

230. Where staff tested positive, they were advised to go home and isolate in line with government guidance.

231. Where professional staff were required to attend residents in care homes, the general practice by care homes was to request that professional staff completed a lateral flow test and provide evidence of this to gain entry.

Overview of testing arrangements for recipients of care in their own home

232. Testing of recipients of domiciliary care was not undertaken routinely. The management and testing of symptomatic service users would have been managed through their GP.

233. Action cards were developed for Trust staff who delivered domiciliary care, which considered the various situations that they may face when entering a service user's home and the actions they should take.

234. Service users were advised on actions being taken by independent service providers to safeguard service users and staff. This included but was not limited to:
    - Advice on handwashing to avoid the spread of infection;
    - Providing access for care staff to wash their hands;
    - Advice on how care might be affected for service users.

235. Service users were also asked to advise domiciliary care staff if they, or a family member, were symptomatic, or had been exposed to Covid-19 and if they were to make contact with their GP.

Capacity and adequacy of testing

236. The Trust response to supporting care homes with testing was robust and timely.

237. The first Covid-19 positive resident in a statutory care home was on 17 March 2020 and in an independent sector care home on 19 March 2020. All testing of residents was initially undertaken by the Care Home Support Team until nursing home staff were trained and competent. Testing of staff in independent sector care homes in outbreak commenced on 30 March 2020 and this was facilitated by the Trust.

238. From 24 April 2020, in line with the Regional Testing Protocol, outbreak testing was facilitated by the Trust. At the point of outbreak, at Day 4-7 and Day 28, all residents and staff were tested. A dedicated team from the MOT Testing Centre,

Boucher Road, worked with the Care Home Support Team to support the testing requirement for care homes in outbreak.

239. The policy to retrospectively test all staff and residents in care homes which reported outbreaks prior to 24 April 2020 was introduced the week commencing 11 May 2020. In line with the regional whole home testing initiative and testing protocol updated in May 2020, provided as Exhibit [NM/26 – INQ000581140], all nursing and residential homes were to ensure staff and residents were tested by the end of June 2020. By 22 June 2020, testing in 72 out of the 88 care homes registered within the Trust geographical area had been tested and data shared with PHA as requested. Testing in the remaining homes was completed by the PHA's testing initiative within the required timeframe. This was a significant achievement by the Care Home Support Team and the MOT Testing Centre, Boucher Road, who worked collaboratively to complete testing within the required timeframe.

Consultation on testing policy/ guidance

240. The Trust was not consulted on the implementation of the Testing Guidance. As previously indicated, the guidance was developed in an evolving and unprecedented situation and the normal consultation processes would not have allowed for the timely decision-making required.

241. The Trust, through their weekly meetings with care homes, listened to feedback and advocated at a regional level regarding the lack of capacity within care homes to undertake their own testing.

Implementing a testing regime in line with policy/ guidance

242. The testing in care homes was coordinated by the Care Home Support Team from March 2020 to June 2020 which allowed oversight and co-ordination of the implementation of testing in line with the changing guidance.

243. The Trust had developed and implemented its first testing protocol on 19 March 2020. During the course of the pandemic, testing was facilitated by a range of teams. Initially, the Testing Pod, Crumlin Road, facilitated testing for care home staff and this later transferred to the MOT Testing Centre, Boucher Road, who tested both residents and staff. All teams, including the Trust's Occupational Health

team, worked collaboratively to update protocols based on changes to the guidance and the testing processes implemented for care homes.

244. Standard Operating Procedures and flowcharts were developed to guide practice and information on referral processes which were shared with care homes. Training on referral processes, communication of results and supports available for care home staff was delivered via virtual platforms facilitated by the Care Home Support Team. The Trust updated training to ensure changes in guidance were accurately reflected.

245. The implementation of the testing regime in care homes was not without its challenges. The availability of multiple testing centres and the right of staff to choose which they attended made it difficult to get a comprehensive overview of the number of staff impacted by the virus. Staff refusal to consent to testing, which may have been associated with the financial consequences of isolating, was an identified risk.

Role played by the Care Home Support Team

246. The Care Home Support Team played a lead role on the implementation and co-ordination of the testing of residents and staff in care homes throughout the pandemic. The first Covid-19 positive resident in a statutory care home was on 17 March 2020 and in an independent sector care home on 19 March 2020. Testing of staff in independent sector care homes, facilitated by the Care Home Support Team, commenced on 30 March 2020.

247. During the first surge, all testing of symptomatic staff and residents in the 88 care home registrations in the Trust geographical area, was either completed or coordinated by the Care Home Support Team. This team ensured that there were clear pathways in place for testing, sharing and management of individual results for staff and residents, and that arrangements were in place for data collection, reporting and surveillance.

248. At this time the Care Home Support Team consisted of 6.4 WTE nurses which was enhanced by redeployed staff and NIAS personnel. During the first wave of the pandemic, between March and June 2020, the Care Home Support Team facilitated the testing of 2602 care home residents.

From 24 April 2020, the Care Home Support Team supported the introduction of the rolling programme of testing in care homes delivering 46 educational sessions, which included demonstrations on swabbing techniques and the provision of a swabbing protocol, to support care homes to undertake their own testing. However, care home feedback was that testing was labour and time intensive.

249. The Care Home Support Team worked in partnership with key internal and external stakeholders to implement care home testing in line with guidance. An initial Standard Operating Procedure for testing was created on 19 March 2020. Over 20 processes were developed during the course of the pandemic to cover key activities associated with swabbing, including referral of residents and staff, triage, testing arrangements, deliver of testing packs, collection of packs, delivery of swabs to labs, sharing results and ongoing clinical support. Standard Operating Procedures were modified throughout the relevant period to meet the requirements of DoH testing guidance.

Ability of staff in care homes to engage in symptom monitoring

250. When care homes went into outbreak, they found it challenging to undertake enhanced clinical monitoring of residents due to a range of factors such as:
    - Lack of staff resource;
    - Equipment required cleaning between uses extending the length of time required to complete observations;
    - The number of residents requiring observation;
    - The associated risk of infection moving equipment between units and cohorted areas.

251. Residential homes would not all have had pulse oximeters nor would the staff within the home have been trained to complete clinical observations.

252. Some care homes would have limited equipment available for the monitoring of vital observations, which impacted the time it took to complete observations of residents and the IPC Team advised all equipment must be cleaned after each resident.

253. Significant training was provided by the Trust to care home staff throughout the pandemic on symptom management and recognition of a deteriorating resident. This was coordinated through the Care Home Support Team who engaged key

stakeholders as required. Training delivered relating to the recognition and management of a deteriorating resident included:

- Palliative Care Update & Advance Care Planning
- Deteriorating patient and Sepsis
- Anticipatory Care & Advance Care Planning
- Dementia Care during Covid-19
- Verification of Life Extinct
- Pharmacy Update during Covid-19
- PHARMACY: Guide to use of the pandemic box
- RQIA update & Pharmacy: Unused medication
- Use of Oxygen

254. The skills and competencies of nurses to recognise and manage a deteriorating patient varied across the sector. The fact residents didn't always present with recognised symptoms compounded early recognition of symptoms. While the Care Home Support Team offered a comprehensive rolling programme of training throughout the pandemic, there was considerable variability in staff working in independent sector care homes attending training.

255. During the first wave of the pandemic, the Trust ordered defibrillators and pulse oximeters for care homes, as well as additional stocks of syringe drivers to have available to support care homes as required.

256. Part of the financial package announced by the Health Minister in June 2020 to support care homes was to enable them to purchase the required equipment to effectively monitor residents. The Trust coordinated the roll out of this package.

Overview of changes introduced to supplying PPE to the independent sector

257. Prior to the relevant period, the Trust did not supply PPE to independent sector providers. In line with the regional contracts, previously provided as Exhibits [NM/02- INQ000581134] and [NM/03 – INQ000581135], and the regulatory standards, provided as Exhibits [NM/27 – INQ000581121] and [NM/28 – INQ000581132], independent sector providers were required to ensure all staff had IPC training and access to PPE as part of IPC processes. As detailed in the

regional contract, the independent sector providers were responsible for supplying their own PPE to staff.

258. Any concerns identified in relation to IPC practices, use or quality of PPE, either by service users or through the Trust quality monitoring processes, were investigated through the Trusts independent sector governance assurance framework. Prior to the relevant period there were no independent sector providers subject to ongoing investigation regarding IPC processes or PPE compliance.

259. Statutory domiciliary care and statutory care home providers worked to the Trust IPC policies, were provided with IPC training and PPE by the Trust.

260. The Trust worked to all PPE guidance issued by DoH and PHA. Although it was the responsibility of RQIA to share all guidance with independent sector providers, the Trust also shared all guidance via its Commissioned Services Governance Team.

261. The Trust IPC Team developed posters on 'donning and doffing' and these were shared with independent sector providers on 17 March 2020 and 23 March 2020 respectively.

262. At the pandemic preparedness workshops the Trust facilitated with independent sector domiciliary care and care home providers on 11 March 2020, information on the most recent PPE guidance was provided as per the guidance issued on 10 March 2020. It was further acknowledged that the Trust was aware that some independent sector providers in the Trust geographical area were experiencing difficulty with ordering and the delivery of PPE. The Trust communicated they had been directed to supply relevant PPE and advice to independent sector providers and described the ongoing work being undertaken in relation to establishing processes for supply and distribution.

263. On 16 March 2020, the Trust emailed the PPE guidance released on 13 March 2020 to independent sector domiciliary care and care home providers.

264. On 18 March 2020, the Trust emailed independent sector domiciliary care providers requesting they update their action cards to reflect guidance issued on 13 March 2020, providing a document named 'Tips for putting on PPE' and advising masks and visors were available for collection from a central point on the Trust Knockbracken Healthcare Park site.

265. On 19 March 2020, the Trust emailed a PPE questionnaire, presented as Exhibit [NM/29 – INQ000581089], to independent sector care home providers, with a request it was returned by 20 March 2020. A remainder email was sent requesting those outstanding to be returned on 20 March 2020. On 24 March 2020, a further email was sent to independent sector care home providers requesting they update their local action cards with details of Trust PPE single point to contact. The communication outlined that due to limited stock, prioritisation of the provision of PPE would be to domiciliary care and care home providers who were actively managing an outbreak.

266. On 24 March 2020, emails were sent to independent sector care home and domiciliary care providers advising of PPE collection arrangements, the 7-day single point of contact number for ordering PPE, and arrangements for the distribution of starter packs to all providers.

267. Weekly engagement meetings were established with independent sector care home and domiciliary care providers from 31 March 2020, where any concerns regarding PPE could also be discussed.

Extent of consultation from DoH with regards to policy or guidance

268. Points of clarity on all guidance issued were raised through Silver Command. Given the rapidly changing and evolving situation the Trust was not consulted before PPE guidance was issued. Please see examples previously provided as Exhibit [NM/10 – INQ000581116].

Steps taken by Trust to ensure independent providers had access to PPE

269. In March 2020, the Trust were directed by DoH to provide PPE to the care sector. This involved setting up full receipt and distribution processes, with appropriate governance to manage the administration and logistics for PPE distribution.

270. From mid-March 2020, the Trust actively engaged with independent sector providers to understand the challenges with PPE and to communicate the evolving processes regarding the supply and distribution.

271. To support the supply and distribution of PPE to independent sector providers, the Trust established a central team to organise and distribute PPE and a 7-day single point of contact for independent sector providers to order PPE.

272. In March 2020, the Trust had to limit the distribution of PPE due to challenges in the supply chain. Independent sector providers actively managing a Covid-19 outbreak were prioritised for distribution and a minimum of a 48-hour supply was provided. The risk of a provider running out of PPE was mitigated by the accessibility of Trust staff over seven days via the single point of contact.

273. By 24 March 2020, the Trust had arrangements in place to provide all care homes with a PPE starter pack.

274. By April 2020, community PPE stores had been established and a process for ordering PPE supplies put in place. Initially, independent sector providers collected the PPE supplies weekly, however, as the processes evolved, weekly ordering of PPE was established which was distributed directly to the independent sector provider.

275. The Trust calculated the quantities of PPE for distribution to independent sector domiciliary providers based on the number of service users multiplied by the number of calls per week. This was followed up with a check-in call to ensure all domiciliary care providers had an adequate supply of PPE.

276. In June 2020, the Trust's IPC Team put in place a supportive programme of PPE auditing for care homes which evaluated PPE usage and compliance over a 4-week period; 60 care homes agreed to participate in the audit. Areas for improvement and further face-to-face PPE training was provided by auditors based on audit findings which resulted in an increase in compliance with PPE requirements over the 4-week period. The audit report has been presented as Exhibit [NM/30 – INQ000581124].

277. When the BSO PPE supply centre was opened in Falcon Road, on 7 June 2021, the ordering, supply and delivery of PPE was undertaken by this service.

Independent sector concerns in access in PPE or support from the Trust

278. The Trust worked in partnership with care homes throughout the pandemic to provide support, address concerns and to articulate the challenges independent sector providers were experiencing at a regional level.

279. The Trust acknowledged that it was aware that some independent sector providers were experiencing difficulty with accessing PPE, provided assurance they were aware of the DoH directive to supply PPE to independent sector providers and were actively working to put these arrangements in place at an independent sector pandemic preparedness workshops facilitated by the Trust on 11 March 2020. The issues being reported by independent sector providers included not being able to order PPE due to suppliers directing stock to NHS, the escalating cost of PPE and a general shortage of PPE (specifically masks and visors).

280. Statutory domiciliary and care home services had access to PPE via internal Trust processes. Following a communication from the Health and Safety Executive NI (HSENI), arising from an anonymous complaint the HSENI had received, provided as Exhibit [NM/31 – INQ000581122], the Trust's Chief Executive, replied on 27 March 2020, outlining the approach to PPE for those in community settings, such as domiciliary care staff. The issue was taken very seriously. The letter from the Chief Executive is provided as Exhibit [NM/32 – INQ000581125]. This letter was followed up with bespoke communication to Trust staff to provide reassurance on the issue of PPE, provided as Exhibit [NM/33 – INQ000581114].

Reports of independent sector providers making their own PPE

281. The Trust is not aware of any independent sector provider making their own PPE. The Trust was cognisant of charitable appeals via media outlets but was not aware of any independent sector providers working in the Trust's geographical area making such appeals.

Steps taken by Trust regarding concerns outlined by COPNI in Module 2C

282. As previously outlined, from 11 March 2020 the Trust actively engaged with independent sector providers to understand the challenges with PPE and to communicate the evolving processes the Trust established regarding the supply and

distribution of PPE. The Trust established a dedicated team to oversee the ordering and distribution of PPE and established a 7-day single point of contact for receipt of requests and queries from care homes and domiciliary care providers who required PPE.

283. The Trust issued a questionnaire to independent sector care homes on 19 March 2020, with a return date of 20 March 2020, to determine their PPE needs. By 24 March 2020, the Trust had issued their first communication on the supply and distribution of PPE. Care homes actively managing an outbreak were prioritised for distribution of PPE and all care homes were issued with a starter pack. While the supply was limited to a 48-hour supply initially, having this single point of contact for provision assisted in ensuring supplies were secured, issued and the providers in outbreak had access to the required resource.

284. By April 2020, robust processes for the ordering and distribution of PPE were established which included weekly reporting to DoH on the quantity of PPE being supplied.

285. While the Trust is aware that some providers continued to try to source their own PPE, they are not aware of any care home making their own PPE.

286. With the benefit of hindsight, the reflections made by COPNI in Module 2C may be helpful in preparing for another pandemic, however, at that time the Trust was working in a rapidly changing situation, adapting and responding to the frequent issuing of guidelines, while trying to ensure that appropriate governance assurance processes were in place.

Concerns regarding the quantity of PPE being used by independent providers

287. The Trust did not identify any concerns regarding the quantities of PPE used by independent sector providers. The Trust made calculations determining amounts of PPE that should be shared with providers. Based on this calculation, the Trust provided and then had weekly check-ins with providers to ascertain if they needed top-ups or if levels provided was sufficient. Generally, calculated amounts were appropriate and providers did not require top-ups.

VISITING AND CARE DELIVERY

Impact of the restrictions on visits by loved ones on recipients of care

288. The visiting restrictions were difficult for care home residents and their families and undoubtedly impacted on their sense of well-being.

289. For residents who had capacity they may have been able to understand the unprecedented times we were facing and recognised that it was for their own safety but this would not have stopped them missing their relative's visits or experiencing increased feeling of loneliness and isolation.

290. A significant population of residents in care homes live with a cognitive impairment or dementia and would not have had the capacity to understand or retain the reason for the restrictions. The absence of family visits may have caused feeling of fear, distress and feeling of abandonment and resulted in an increase in distressed behaviours.

291. The implementation of alternative visiting arrangements was not always effective as residents with cognitive deficits or dementia were not able to understand why families were visiting via virtual means or at windows. Residents with dementia or an underlying cognitive deficit were not able to engage appropriately, and at times this caused distress to some residents and/ or families.

292. People transferring to a care home for the first time or to a new care home, often rely on family to support them during the transition. This not being available would have led to enhanced fear and anxiety in a new environment and the residents may have missed the advocacy, support and assurance of their loved one. This may have adversely impacted the resident's ability to settle, and feel safe and secure in their new environment. For people with dementia, or an underlying cognitive deficit, this may have led to an increase in them displaying distressed behaviours.

293. For many residents, family are the only therapeutic social interaction they experience and the restrictions on visiting would have led to social isolation and feeling of loneliness, especially as during period of outbreaks residents would have been isolated in their room.

294. Not being able to visit their loved one caused many families high levels of distress and concern. Particularly as it was evident during the first surge that care homes were challenged in providing and using technology to support virtual visiting and enhance communication with families. Difficulties experienced by families with maintaining contact with care homes added to the frustration and distressed experience. Where service users were admitted to care homes for the first time, it was upsetting for families not to be able to view the home or prepare their loved one's bedroom. It was traumatising for families not to be able to be with their relative during the last days and at the end of their life to provide comfort, reassurance and support. Once visiting resumed it was distressing for some to observe the deterioration that had occurred in their loved one during lock down.

295. The distress of families was compounded by them being unable to oversee the care of their relative, as many families view their ability to advocate for their relative as central to maintaining the quality of care. While relatives understood the priority was to preserve life and keep their loved one safe, this had to be balanced with the fear they experienced from witnessing the transmission of the virus across care homes.

296. Following the first wave, as society opened up again, the delay in visiting guidance being updated and the misinterpretation in some home implementation of the guidance was a further source of frustration.

Alternative methods of contact between loved ones and recipients of care

297. The approach taken by care homes to offer alternative methods of visiting, was very much directed by the care home. The Trust was aware of some innovative practice such as tents/ pods in car parks, visiting via windows, virtual visiting and the care home providing telephone calls. However, the frequency of visits and calls were influenced by the availability of care home staff to accommodate and limited to accommodate all families receiving a call. An additional challenges was not all relatives would have been physically or cognitively able to engage in these alternative forms of contact.

298. Visits of any type were also impacted by outbreaks and staffing levels in the home.

299. As the pandemic progressed some care homes permitted visiting when their loved one was in the last days of life.

300. With the benefit of hindsight it is recognised that, the alternative approaches adapted by care homes were never going to replace face-to-face visits and the benefits of loved ones spending quality time together. However, the pandemic was not considered to be 'normal times', the situation was fast moving and unprecedented, and decisions were made at haste with the intention of protecting this vulnerable group. The risks associated with transmission of the virus, and the government messaging that the priority was to preserve life, instilled fear and influenced decision-making. The people living in our care homes were frail with multi co-morbidities and therefore highly susceptible to infection. The impact across the care home sector is now evidenced and reflection should consider the risk and benefits of these decisions.

Reintroduction of visits by loved ones to recipients of care during the pandemic

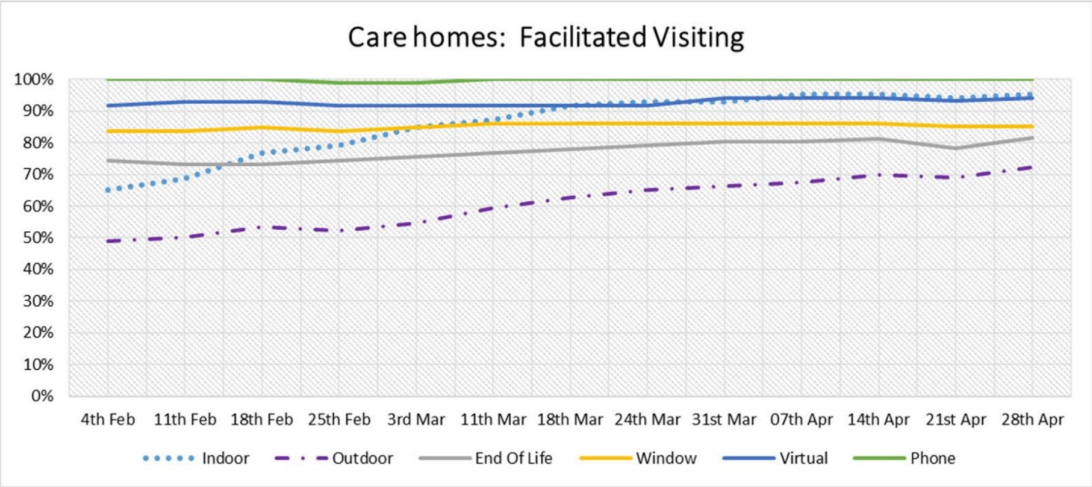
301. The regional principles for visiting were subject to individual care home interpretation which led to inconsistent practices across the sector. Care Home Managers were fearful that increased footfall in the home would equate to increased outbreaks. Some care homes applied a restrictive approach to visiting practices and facilitation of virtual, onsite and indoor visiting. The key challenge the Trust identified was that visiting guidance was open to interpretation by Care Home Managers, which led to confusion and the genuine fear of an outbreak. The decision on how to implement the guidance was the Care Home Manager's decision, based on a dynamic risk assessment.

302. Achieving a balance between the rights of the residents and families with minimising the risk of transmission and compliance with IPC measures, while also maintaining a homely environment for residents was extremely challenging for care homes. Higher staff ratios, the availability of individual visiting areas, ability of families to be trained and receive training in IPC/ PPE and processes to oversee robust testing may have enabled more frequent visiting. However, the limitations in the workforce and footprint of many care homes impacted the ability of the care home sector to achieve these conditions within their existing resource.

303. In November 2020, the Trust used the twice-weekly virtual training sessions established by the Care Home Support Team to engage care homes in discussion and shared learning regarding the visiting guidance and Care Partner role. In addition, the implementation of the visiting guidance was a regular agenda item on the Care Home Managers Meetings that had been established in March 2020, the frequency of which varied throughout the pandemic based on identified. The implementation of visiting guidance was monitored by key workers during their engagement with families and via Trust quality monitoring visits to care homes.

304. In October 2020, the Trust sent a questionnaire, provided as Exhibit [NM/34 – INQ000581119], to care homes regarding visiting and Care Partner arrangements. Of the 69 homes who responded, 88% had arrangements in place for inside visiting and 100% had engaged residents' families regarding visiting arrangements.

305. From 4 February 2021, the Trust introduced a weekly dashboard for monitoring compliance with visiting and Care Partners based on information provided by the RQIA portal. This data indicated all homes offered indoor, outdoor, end of life, window, virtual and telephone visits, with telephone visits being the most popular. However, with ongoing monitoring, and support from the Trust, indoor visiting gradually increased between the beginning of February 2021 and mid-March 2021.



Consultation/ Communication with recipients of care about visiting restrictions

306. As far as the Trust is aware, recipients of care were not consulted on the decision to close care homes to visiting. However, the Trust is aware that HSCB/ PHA launched the 10,000 Voices project in June 2020 into the lived experience of care

home residents and their families during the first wave of Covid-19, as part of the Rapid Learning Review facilitated by the office of the Chief Nursing Officer. The Patient and Client Council sought feedback from service users and their families in order to provide a response to the Health Committee Inquiry into the impact of Covid-19 in care homes. These processes demonstrated a willingness to learn and shaped the development of future visiting guidance, including the development of the Care Partner model.

Actions taken by RQIA to address or escalate concerns

307. The Trust escalated concerns regarding the performance of care homes to RQIA during the pandemic. Failure of care home to implement visiting guidance and the Care Partners concept was considered a performance issue and escalated to RQIA. The Trust used the RQIA portal to populate the aforementioned dashboard on care home's compliance with guidance on visiting and the Care Partner concept. The Trust then uses this data to engage with homes regarding progressing implementation of the guidance. The Trust is unable to account for the actions taken by RQIA to address or escalate concerns.

Steps taken to ameliorate the impact of a lack of visits for care recipients

308. At the pandemic preparedness workshops held on 11 March 2020, the Trust discussed with care homes the most recent visiting guidance and at this point how to facilitate safe visiting. Following lockdown the Trust put a range of measures in place to ameliorate the impact of a lack of visiting in care homes.

309. The Trust was aware the impact a lack of visiting would have on residents and their families and aimed to work in partnership with residents, their families and care homes to support effective communication and oversight of the care provided. Prior to the pandemic, practitioners working in the Care Review and Support Team had been aligned to care homes, and during the pandemic they were tasked with maintaining weekly contact with care homes to offer support and maintain oversight of the health and wellbeing of residents. Action cards were developed to guide staff practice.

310. Resident aligned key workers were tasked with maintaining a minimum of weekly contact with families; with the frequency of contact adapted to accommodate

individual family requests. Where residents were confirmed Covid-19 positive, this contact increased to daily contact.

311. A Rainbow Room was established in the Mater Infirmorum Hospital, which was the Trust's dedicated Covid-19 hospital. The key remit of this service was to maintain contact with the families of people admitted to hospital, to provide an update on their relative's condition, and to provide emotional and psychological support. If the patient died while in hospital, follow up bereavement support was offered to families. The families of residents admitted to the hospital from care homes were supported by this service. Engagement with families allowed social work staff to work in partnership with families to develop a one-page profile of 'what mattered' to the patient to support ward staff to understand and communicate effectively with them whilst in hospital.

312. As previously indicated on receipt of the revised visiting principles on 24 September 2020, the Trust engaged with all care homes in the Belfast locality to determine their visiting arrangements and compliance with the Care Partner concept. From this point the Trust worked with the care home sector to ensure family and resident engagement was maximised in a meaningful way, subject to the Covid-19 status of the care home at any point in time. The Trust put in place arrangements for monitoring implementation of the visiting guidance and Care Partner guidance and actively advocated for families to have visiting and Care Partner access in care homes who did not immediately adapt the guidance.

313. The Trust facilitated the payment of the financial support package issued by the Minister for Health/ DoH during the course of the pandemic. Between March and June 2020, the Minister for Health announced two financial packages. The first in April 2020 was to meet the cost pressures of the pandemic. The second in June 2020 identified key areas for essential equipment expenditure, including tablets and communication devices. The Trust facilitated the distribution of this funding to independent sector providers to enable the purchase of essential equipment to the value of £113,067.52.

Consultation by DoH with the Trust regarding concept of Care Partners

314. The Trust were not involved in the development of Care Partners guidance. This was led by DoH/ PHA, with support from service user representatives.

Concerns regarding the concept raised by care homes

315. The key challenges the Trust identified was the definition of a 'Care Partner' was not clear and open to interpretation by Care Home Managers, which led to confusion. The decision to implement the approach was the Care Home Manager's decision, based on a dynamic risk assessment.

316. The initial feedback from independent sector care homes was they remained concerned it would result in increased footfall and spread of infection. Achieving a balance between the rights of the residents and family, with minimising the risk of transmission and compliance with IPC measures, while maintaining a homely environment, was extremely challenging for care homes. This created an inequity of opportunity for families who wished to adapt a Care Partner's role as the decision ultimately was down to thecare home. A range of explanations were offered by care homes regarding the lack of or delay in implementation which included no requests, residents not meeting the criteria, time, testing issues, insurance issues, further explanation or support required.

317. There was also confusion for families in the interpretation and implementation of the Care Partner's role. One of the key challenges was families understanding the purpose of the Care Partner role and providing clarity that it was not just an opportunity to visit their relative.

Action taken by the Trust to assess, address or escalate concerns raised

318. The Trust undertook a range of actions to support independent care homes with the implementation of the Care Partner role.

319. In November 2020, the Trust used the twice-weekly virtual training sessions that were established by the Care Home Support Team to engage care homes in discussion and sharing of learning regarding the experience of care homes who had adapted the role.

320. The Trust used the monthly Care Home Manager Meetings to discuss with Care Home Managers their concern regarding the implementation and to build confidence regarding the concept.

321. The Trust circulated the PHA leaflet on 'Care Partners' to the families of all relatives. The Trust monitored implementation of the concept across homes and key workers, through their communication with families and care homes, promoted the role of care partners. Where families brought to the Trust's attention that they were facing challenges with being permitted to become a Care Partner the Trust engaged directly with the care home to advocate on behalf of the family.

322. In October 2020, the Trust sent a questionnaire to care homes regarding visiting and care partner arrangements. Of the 69 homes who responded to this questionnaire, only 48% of homes had arrangements in place to recognise and facilitate the Care Partner role.

323. The Trust monitored the RQIA app on a weekly basis to determine care homes with no current arrangements or intentions to implement the Care Partner role. The Trust engaged with care homes on a regular basis to determine the rationale for a lack of implementation. On 4 February 2021, the Trust introduced a weekly dashboard to monitor Care Home compliance with the Care Partners concept.

324. The Trust also monitored the implementation of the Care Partner role through the annual review process and quality assurance visits in care homes. Continued non-compliance of care homes was considered a performance issue, and this was discussed at the Trust's weekly care homes governance assurance meeting. Concerns regarding care homes which continued to refuse to progress the Care Partner approach were also discussed with RQIA and HSCB during interface meetings.

325. Through these combined approaches, there was a gradual increase in care homes adapting the Care Partner model. By the end of April 2021, 68% (60 of the 87 eligible homes) had a Care Partner arrangement in place; 1 residential home was a respite facility and therefore exempt from the Care Partner concept. Most homes had opportunities available for visiting (subject to guidance and outbreak status) and therefore families may have lacked motivation to undertake the Care Partner role.

Trust steps taken to ensure continued access to patients by HSC professionals

326. The Care Home Support Team provided the frontline enhanced clinical support to the care home sector through a 7-day single point of access service during the first wave of the pandemic. Through the redeployment of staff, the team remained in consultation with Primary Care, and the development of direct pathways for enhanced medical care via the Acute Care at Home Team was agreed. The streamlined clinical pathway enabled timely clinical assessment, treatment, care planning and escalation of resident's care ensuring the right care was provided, in the right place by the right person. A daily oversight meeting commenced 21 March 2020 which provided oversight of care homes in outbreak and ensured timely delegation of clinical care.

327. The Trust's Acute Care at Home Team and the Trust Community Respiratory Team also provided a high level of support regarding the clinical care of residents. These teams provided onsite face-to-face clinical assessment, implemented treatment plans and provided directed care planning for clinical unwell residents.

328. Nurses from the Community Respiratory Team accompanied GPs from the Primary Care Covid-19 Centre on all domiciliary visits, including those to care homes, leading the respiratory assessment of patients and providing advice on the management of respiratory symptoms. The Team also coordinated the ordering, provision and retrieval of oxygen concentrators to and from care homes and provided onsite education to care home staff on respiratory assessment and administration of oxygen therapy.

329. All care homes in the Trust's geographical area were provided with a direct contact number for the Community Respiratory Team which enabled them to refer directly to the team, to seek timely advice or request a home visit.

330. The Care Home Support Team provided advice, support and training to improve the knowledge, skills and capacity of the care home nursing teams to care for residents with complex and frequently changing needs, including those who were palliative and at end of life care. Enhancing the skills of care home staff to equip them with the skills and competencies to enable timely recognition and escalation of a deteriorating resident, was an important aspect of the team's role.

331. Following the workforce appeal, the Care Home Support Team received an Allied Health Professional resource. This enabled the team to put in place a weekly multidisciplinary team meeting to undertake post covid review of residents who did not return to baseline.

332. For non-Covid-19 related matters, the care of residents remained with Primary Care. Care homes reported challenges throughout the pandemic with accessing Primary Care for telephone consultation. They also experienced long ambulance waits when escalating patient care to hospital. One of the impacts of this was residents who fell often experienced long lies while waiting on an ambulance to arrive.

333. With the exception of the Community Physiotherapy Team, who under DoH direction was redeployed to the Belfast City Hospital (Nightingale Hospital), all community social care and Allied Health Professional teams remained operational. While routine review of residents from core social care and Allied Health Professional teams were stood down by DoH, arrangements for urgent and emergency care provision remained in place. All teams' pre-pandemic referral, triaging and duty processes remained operational, however, practice was adapted to reduce footfall into care homes.

334. All teams developed action cards to guide staff practice. Active caseloads were RAG rated to identify high-risk cases. Alternative approaches to triaging new referrals and monitoring high-risk residents were introduced including telephone consultations, virtual reviews and emailing of photographs. Verbal and written advice, guidance and treatment interventions were provided for individual residents.

335. Onsite visits were risk assessed with the care home. All staff undertaking domiciliary care or care home visits were required to comply with DoH guidance on IPC and PPE, however, even with this assurance, care homes were reluctant to provide access for face-to-face visits due to the fear of transmission. Virtual visits were of limited benefit due to the lack of availability of mobile technology and staff resource to accommodate virtual assessment.

336. The Podiatry service was maintained for all patients with active foot disease and those at risk of ulceration.

337. Speech and Language Therapy designated staff acted as a point of contact for the care home and these staff remained in regular contact with the care home. Speech and Language Therapists tried innovative approaches to assessment, including distance assessment and virtual assessment, with limited success. Where face-to-face visits to care homes were required, efforts were made to cohort assessments by the care home, so multiple assessments in the home could be undertaken during the same visits and these tended to be completed at end of day to reduce risk of transmission across multiple care homes.

338. The Community Physiotherapy Team recommenced domiciliary care and care home visits in June 2020 and again efforts were made to cohort referrals by care home in an effort to reduce footfall.

339. Speech and Language Therapy and Dietetics professionals across Northern Ireland provided regionally agreed, evidence-based information for staff working in care homes for managing residents with Covid-19, as it had been well established that these residents may present with nutrition, eating, drinking, swallowing and communication difficulties exacerbated or caused by Covid-19. This professional guidance contained strategic information and a single point of contact for care home staff to access support for further advice and specialist assessment.

340. Physiotherapy worked with PHA to coordinate the development of literature for care homes, the roll out of which was led by PHA. This included the development of a Falls Prevention Exercise video which was uploaded to YouTube on 26 May 2020 and Falls Prevention Staying Safe and Staying Well at Home video uploaded to YouTube also on 26 May 2020. As the pandemic progressed and learning was identified, the Rapid Learning exercise emerged where Trust had representation on all work streams.

341. Social care teams undertook onsite visits to complete urgent care reviews, to complete quality assurance visits in care homes where practice concerns had been identified, and from October 2020 completed DoLS assessments in line with the Mental Capacity Act.

Paragraph 47 of the Committee for Health's Inquiry Report

342. As detailed above, all Trust staff who supported care homes were available to respond to urgent and emergency visits. Prior to all face-to-face visits being undertaken, visits were risk assessed by telephone with the care home.

343. Professional visits were guided by the triage process which relied on the accuracy of information provided by the care home. With the benefit of hindsight, the ability of care home staff to accurately articulate the presenting issue and risk may have impacted decision-making.

344. When the initial guidance was issued, Trust staff raised concern through their line management structure and via regional meetings regarding the impact the decision would have on the health and wellbeing of residents. When access to homes for face-to-face assessments resumed, their assessments indicated residents had been impacted as they were more deteriorated, presenting with symptoms that were more complex. Community Physiotherapy reported that treatment plans took longer to implement and in some cases, the presenting resident's deterioration was beyond the point of being treated or rehabilitated. The lack of movement due to residents isolating in their room and residents being nursed in bed to manage isolation requirements contributed to their deconditioning.

345. All professionals who supported care homes reported a reluctance of the care home to permit access. During periods of outbreak, onsite visits were not permitted by core Trust teams, only teams providing clinical support to residents infected by the virus were permitted access. All face-to-face visits to care homes were risk assessed with the care home, however, there was a strong sense in many cases that the care home felt the risk of transmission outweighed the risk to the resident requiring assessment and treatment.

Steps taken by the Trust to address the concerns above

346. The Trust worked in partnership with care homes to build confidence in the accommodation of onsite assessment. This included complying with all DoH guidance on IPC and PPE and accommodating the required pre-visit checks. For some homes this was a temperature check and for others it was evidence of a negative lateral flow test result. Some teams adapted a policy of daily lateral flow tests.

347. A range of approaches were adapted to try to reduce the risk of transmission from professional visits and to reduce the level of footfall into care homes. Services cohorted referrals and spent longer periods in care homes assessing multiple residents. Domiciliary visits were avoided prior to visiting a residential home; initially teams wanted to undertake morning visits to care homes but worked with care homes who requested afternoon visits. When undertaking afternoon visits, Trust staff tried to complete administrative tasks in the morning to avoid same-day multiple site visits. Teams also worked to provide a range of regional and local literature to support care homes to care for residents and twice-weekly virtual sessions were used to provide guidance and training.

348. As there were no registered nurses employed within residential homes, the Care Home Support Team and Acute Care at Home team worked in partnership to provide focused training on assessment and recognition of the deteriorating patient.

349. The Trust developed Nursing Home Virtual Multidisciplinary Team reviews from May 2020 as a response to the Covid-19 pandemic. Face-to-face visits from the Trust multi-disciplinary team members were restricted due to the pandemic and as a result, Virtual Multidisciplinary Team (VMDT) reviews were commenced weekly from May 2020 with reducing frequency until they ceased at the end of 2022. Individual homes who had experienced Covid-19 outbreaks were invited to single meetings to present resident cases for discussion.

350. The VMDT group included a Geriatrician (May/ June 2020), Dietitians, Physiotherapists, Occupational Therapist, Registered Nurses under the BHSCT Care Home Support Team, MOOP (Medicines Optimization in Older People) Pharmacists, Speech and Language Therapists, Nurses from individual Nursing Homes

351. The VMDT focussed on residents in independent sector Nursing Homes either recovering from Covid-19 or who had deteriorated from their baseline. The VMDT addressed clinical profile/issues such as loss of appetite, weight loss, swallowing difficulties, residual respiratory problems, decreased mobility, fatigue, lethargy, altered sitting balance, acute kidney injury (AKI), skin problems including pressure damage and palliative care / end of life. In addition to this, current medication optimisation review was often required.

352. As the Health Service began transitioning from the acute phase of the Covid-19 pandemic towards a more sustainable and integrated approach to Covid-19. Independent Sector Nursing Home residents were once more accessible for face-to-face visits from Trust healthcare professionals.

353. As part of mutual aid support, there were Allied Health Professionals redeployed to care homes. These staff would have used their professional skills and knowledge to guide care homes on meeting the specific needs of residents who were brought to their attention.

354. The previously mentioned meetings with Care Home Managers provided a forum for discussing any issues or concerns regarding onsite visits. These meeting were initially weekly but the frequency varied during the pandemic depending on the height of various surges.

WORKFORCE

Workforce conditions that may have impacted ability to self-isolate or shield

355. The Trust was involved in developing the terms and conditions of employment for staff employed by the independent sector domiciliary or care home providers. Until the financial package for Covid-19 related absences was announced in April 2020 access to sick pay for independent sector domiciliary or care home staff was in line with the terms and conditions of their employment. The Trust would not be familiar with the terms and conditions of employment held by individual agencies, however, the Trust is aware that many staff working for independent sector providers would be paid statutory sick pay.

356. Independent sector care home providers were highly dependent on agency staff who may have been reluctant to shield or self-isolate due to the potential loss of income. The Trust did experience staff in care homes refusing to be tested during the pandemic, however, as testing was not mandated, the Trust could not enforce testing. Staff non-compliance with testing was raised with the Care Home Manager, who was both the employer and the person responsible, under the regulatory standards, for the safety and governance arrangements in the care home.

357. The funding issued by DoH to assist domiciliary and care home providers to pay staff from April 2020, in line with regionally agreed principles, should have promoted compliance with the guidance. However, staff who had worked for independent sector care homes and domiciliary care agencies for less than three months were not have been paid through this scheme whilst self-isolating or shielding. This may offer an explanation as to why staff refused testing.

358. The Trust is not aware of any specific cases of discrimination or unequal impact on these groups.

Steps taken by the Trust to address, escalate or mitigate concerns above

359. The Trust escalated concerns through Silver Command and through meetings with HSCB and PHA.

360. A regional frequently asked questions document was developed to provide clarity and support understanding of the principles by which payments would be made to independent sector providers in relation to the Financial Aid package provided by DoH to support staff being paid during shielding, self-isolation and Covid-19 related absence.

ADVANCE CARE PLANNING AND COVID-19 DEATHS

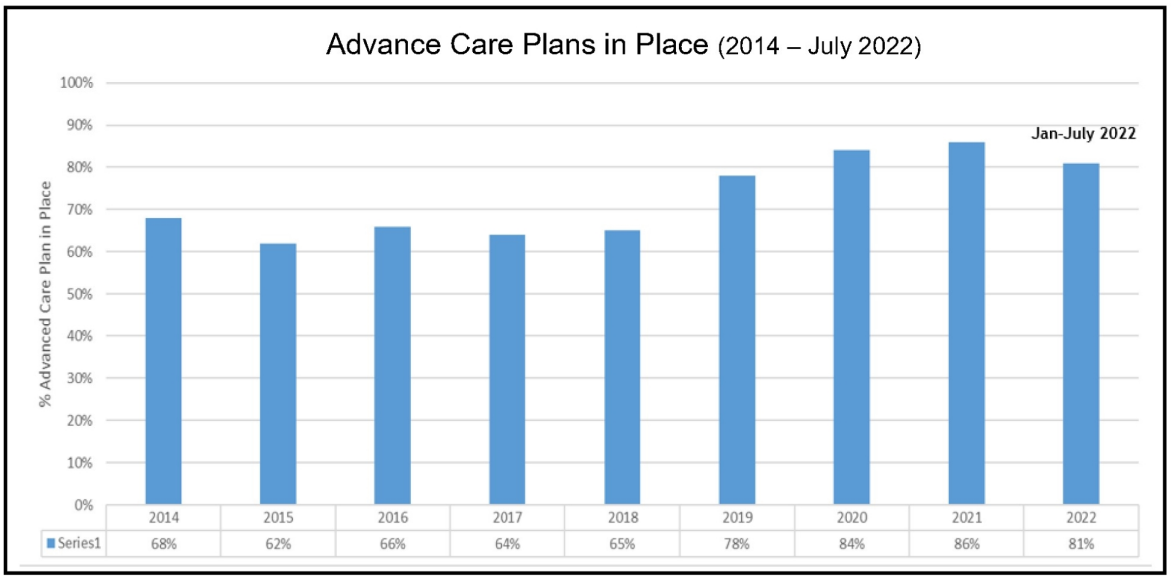
Advance Care Planning

361. The Trust is not aware of any policy, or direction of DoH, for the Trust to develop a DNACPR policy to include a 'blanket use', or misuse of the DNACPR decisions in care homes. Throughout the pandemic, the Trust decisions regarding DNACPR focused on the best interests of the individual resident in care homes based on their clinical representation.

362. Prior to the pandemic, the Care Home Support Team had already commenced advance care planning training for care home staff. As part of the training, and in line with best practice, the team encouraged care home staff, in partnership with the resident, their family and their GP, to consider advance care planning.

363. The team continued to provide training throughout the pandemic including training on 'recognition of the deteriorating patient', 'advance care planning', 'palliative care', and 'end of life care'.

364. The graph below evidences that in 2019 there had been an increase in advance care plans being implemented which is likely to have been in response to focused training in this area pre-pandemic. There was no significant spike identified during the relevant period, although the level of compliance remained between 80-85%.



365. When a care home went into outbreak, the Care Home Support Team, as part of their clinical assessment, reviewed which residents had an Advance Care Plan in place and ensured this was well communicated within the care facility. Due to the risk of sudden deterioration, advice was provided to consider beginning conversations with the resident, family and GP to ascertain their wishes for future hospital admissions, treatment options, end of life care decisions and DNACPR should their condition deteriorate. The resident's GP was the responsible clinician for recording of the DNACPR decision although the Acute Care at Home Consultants were also involved in discussions for residents they were providing clinical support to.

366. The Trust engaged with Primary Care in March 2020 to discuss how the care needs of residents in care homes would be met and agreed clinical escalation pathways. The Care Home Support Team led the Trust clinical response to Covid-19 outbreaks. Processes were put in place for the Care Home Support Team to link

directly with Clinical teams, including the Acute Care at Home Team and the Community Respiratory Team.

367. All residents in care homes received oxygen therapy if clinically indicated for symptom control even if there was a DNACPR in place. Care home residents were escalated to hospital if clinically indicated in line with their Advance Care Plan. Marie Curie nurses were engaged in supporting end of life care in care homes.

Deaths related to the infection of Covid-19

368. A domiciliary care worker employed by the statutory Home Care Service sadly died as a result of Covid-19 on 11 December 2020. The Trust commissioned a Level 1 Serious Adverse Incident review, however, the Review Team was unable to confirm if the employee contracted Covid-19 from work or home.

369. Three recommendations were identified following this Serious Adverse Incident review. These were confirmed as:
    (i) The Home Care service and Infection Prevention Control Team need to review and develop infection control training which incorporates Doffing and Donning competency checks.
    (ii) The Home Care service should have 90% of staff in work with up to date infection control training.
    (iii) The Home Care service should ensure all staff have annual doffing and donning spot checks carried out by their line manager and recorded within their staff record.

370. Care home residents in the Trust geographical area had the same equity of access to clinical support and treatment as other Trust service users. Throughout the pandemic, the Trust worked in partnership with care homes to achieve the best possible outcomes for residents. The Trust put in place a robust plan to support care homes led by the Care Home Support Team, who coordinated escalation of care ensuring residents had timely access to the right care by the right clinical team. This included clinical care and treatment interventions from Care Home Support Team, the resident's GP, Acute Care at Home Team, and escalation to hospital if clinically appropriate. The Trust is not aware that the deaths in care homes in the Trust geographical area were more excessive than the rest of the region.

371. Covid-19 brought into sharp focus the challenges the care home sector faces with the availability of nursing staff, the high acuity and complexity of patients cared for, and the limited multidisciplinary team support available. The Trust observed variation in practice across the care home sector with the level of outbreak and ability of care homes to manage during an outbreak. The Trust further observed wide variation in the skills and competencies of nursing staff with regards to the recognition of the deteriorating patient, the delivery of end of life and palliative care, and IPC and PPE compliance. Without the wrap around support provided to care homes, it is likely the death rate would have been higher.

Issues concerning the quality of data relating to the above

372. From 24 March 2020 the Trust implemented a daily Covid-19 Care Home Sitrep which provided an overview of homes in outbreak, the number of residents infected, and the number of deaths recorded. Please see Exhibit [NM/35 – INQ000581113].

373. During the first wave, the Trust, via the Care Home Support Team, collected data on Covid-19 related care home deaths; however, this data was not verified via review of death certificates. When the RQIA app was developed, the Trust took the care home death data from this app. The Trust is unable to confirm how this information was verified by RQIA, however, this was the most appropriate method available to collate this information at that time.

374. The collection of accurate data from care homes is challenging as the data collator is dependent on accurate information being uploaded or being communicated during a telephone ring around.

DISPROPORTIONATE IMPACTS OF THE PANDEMIC

375. The pandemic had a significant impact on all of society and across the health and social care staff working in the statutory and independent sectors. Prior to the pandemic, social care services had been delivered in a climate of under investment and poor workforce planning with a growing older population and increasing complexities of need and risks being met in the community. The impact of lockdown is well recorded and had no less impact on the citizens of Belfast.

376. Throughout the pandemic, there was a very high level of expectation on the Trust from HSC partner organisations, independent sector care homes and domiciliary providers with no recognition that Trusts were also facing their own pandemic related staffing issues. Trust teams had to manage the human anxieties regarding the virus with reconfiguring services at short notice, adapting new patterns of working and working over their contracted hours to respond to the needs of care home and domiciliary providers. Trust staff teams, particularly those supporting the independent sector care homes, had to balance the competing demands of providing practical and clinical support to care homes over extended periods, leading to emotional exhaustion and burnouts.

377. For care homes, the pandemic brought into sharp focus the instability of staffing, the lack of availability of registered nursing staff, the high acuity and complexity of residents, and the limited multidisciplinary team support available. The speed at which many care homes went into crisis, the absence of robust business continuity plans and the high level of dependency on mutual aid staffing support from the Trust highlighted the fragility of this sector. The pandemic further shone a light on the inadequate investment and resourcing of care homes, the inadequate staffing resource, the heavy reliance on agency provision and that a high portion of the workforce were from black and ethnic minority backgrounds. It highlighted a significant variability in the skills and competencies of staff working in the sector, particularly in relation to IPC practices, PPE compliance and recognition of the deteriorating patient. As outbreaks emerged and homes struggled to cope, the expectation was that the Trust provided the required support to care homes to get them through the crisis.

378. The mutual aid response was particularly challenging, as the Trust was facing its own nursing workforce challenges prior to the pandemic and the identification of registered nurses for care homes competed with internal nursing priorities and staff reluctance to be redeployed to care home environments. As care homes went into crisis, particularly during the first wave, the provision of mutual aid support to care homes required constant oversight due to the rapidly changing situation to ensure adequate staffing levels were maintained and Trust staff were appropriately trained and supported. Many of the staff who provided a mutual aid response were shocked by the vulnerability and acuity of residents. Post pandemic, many teams experienced higher than normal staff resignations with many staff leaving health and social care altogether.

379. For older people living at home and in care homes, there was a significant impact. The extended period in isolation and restricted movement led to physical deconditioning, deteriorated mobility, increased falls, social isolation, loss of confidence and general decline in physical and emotional wellbeing.

380. The fear and anxiety in care homes regarding transmission of the virus prevented timely referral to appropriate professionals. Even when referrals were made, there was a reluctance of care homes to permit access. When community physiotherapy services resumed, they found service users to be far more complex than they had previously managed and presented much worse on assessment than was indicated on referrals, resulting in multiple members of staff being required to undertake basic assessment and treatment plans. Treatment interventions were required for longer periods. A lack of contracture management meant that referrals were not made until the contractures had developed to a point that they were fixed and could not be reversed.

381. Across social care services, there was a decline in Adult Safeguarding referrals received in March and April 2020, with evidence during the pandemic suggesting an increase in incidences of domestic violence. The Trust put a range of measures in place to raise awareness of domestic violence and to ensure victims had access to timely support.

382. The increasing demand on urgent and emergency care led to delayed responses from NIAS. This meant if a person fell at home or in a Care Home they may have been lying for a prolonged period awaiting an ambulance. This led to poor experiences for service users and additional pressures on an already overstretched social care system.

383. For the families of residents there was a high emotional cost of not being able to visit, particularly when their loves ones were ill. Not being able to be with loved ones when they were at the end of their life will have undoubtedly impacted the grieving process. The lack of clarity and inconsistent implementation of the care partner and visiting guidance led to further anger and frustration.

384. For Community Social Work teams, the standing down of non-urgent reviews created non-compliance with the Trust's delegated statutory functions. The ongoing social work workforce crisis has meant that the Trust has struggled to recover compliance.

385. The implementation of the guidance and of lockdown has had longer-term ramifications for the Trust in relation to internal operations and the enhanced expectations of care homes. The expectation that residents with complex needs and who experience behavioural disturbance receive enhanced levels of supervision, mainly one to one care, has continued. This has had a significant financial impact for the Trust in balancing timely discharge from acute hospitals with a social care environment in which demand is outstripping capacity.

386. Post pandemic, public expectation is higher, casework is more complex, care home places and top-up fee' are inflated in excess of what many families can afford and staff shortages across the social care sector create challenging and unrelenting budgetary and workforce pressures for the Trust.

QUALITY ASSURANCE AND OVERSIGHT

Assurances of the quality, performance and safety of care homes during reduced inspections by RQIA

387. The Trust was not consulted on the decision to stand down regulatory inspections. The Trust followed all DoH guidance regarding visiting care homes. The absence of onsite visits from Trust staff and RQIA created significant challenges with maintaining oversight of the quality and safety of care in care homes and the early identification of risk, particularly during the first wave of the pandemic.

388. During this period, the Trust adapted a range of approaches to monitor the quality, performance and safety of residents in care homes, however, the Trust recognises these would not have been as robust as we would have wished. Care homes in outbreak had a daily call from the Care Home Support Team, and the outcome of this call may have initiated an onsite visits. The Acute Care at Home Team and Community Respiratory Team would have also been in homes regularly delivering clinical care. Other Trust staff such as IPC teams and testing team would have also been in care homes. These teams would have escalated concerns observed during visits via the service's daily safety huddle.

389. All care homes that went into outbreak were offered an IPC visit. The Trust monitored the level of transmission during an outbreak and used transmission rates

within individual care homes as a potential red flag regarding the care home's IPC and PPE compliance. The IPC team would have also escalated concerns regarding IPC and PPE compliance. Where concerns were identified, the Trust provided additional onsite training. Where poor environmental cleanliness was identified, or the care home reported challenges with the availability of cleaning staff, the Trust offered support via their PCSS services. From July 2020 the Trust had also resumed quality assurance visits to care homes of concern.

390. Trust staff provided mutual aid support to care homes, and these staff were trained to escalate concerns either during onsite placements or as part of the placement debrief.

391. Where families raised issues of concern, these were addressed with the care home and an onsite visit quality assurance visit may have been triggered. The Trust also undertook analysis of adverse incidents and where patterns and trends were identified, this would have triggered an onsite visit.

392. The Adult Safeguarding Team remained operational during the pandemic and continued to undertake visits to care homes as the investigative processes determined.

393. All Trust staff who visited care homes during the pandemic were professionally registered where necessary and were required to work in line with their respective code of conduct. A daily safety huddle for frontline staff was in place for staff to escalate concerns and seek guidance on required action in respect of any concerns they raised.

394. The Trust had a draft escalation process in place as part of its Governance Assurance Framework. At the beginning of March 2020, in line with this framework, the Trust had 5 care homes of concern; 3 homes on Level 1 escalation and 2 homes on Level 2 escalation. The Commissioned Services Weekly Governance Meeting was maintained throughout the pandemic. This was the forum where care homes of concern and/ or were on the escalation framework were discussed and reviewed. Care homes were kept under review throughout the pandemic via the triangulation of information including adverse incidents, family feedback, Trust Quality Assurance Visits and Adult Safeguarding Referrals.

395. Key workers maintained weekly telephone contact with the families of residents in homes on the escalation framework. Weekly telephone contact was also maintained with Care Home Managers. Where appropriate, the Trust requested information from the care home which would have been reviewed from a patient safety perspective. When required, the Manager of the Care Review and Support Team would have contacted the Care Home Manager and/ or Regional Manager to discuss issues of concern. The Trust had recommenced Quality Assurance Visits to care homes by July 2020.

396. Statutory care homes worked to the same guidance and restrictions as independent sector care homes. The main difference was that the Trust could maintain oversight of the quality of care and governance arrangements within statutory care homes. The statutory care homes also had a readily available resource in relation to IPC measures to draw from. Staff had access to Trust training on IPC and Covid-19 preparedness.

Reflections on changes to inspection activity during the relevant period

397. The Trust was not consulted on the changes to inspection activity during the relevant period. The Trust is of the view that the standing down of regulatory inspections, alongside closing care homes to non-urgent visits, created a situation whereby the Trusts, as commissioners, were unable to obtain robust assurances regarding the safety and quality of care provided to residents.

398. The Trust governance and assurance processes for care homes relies on a range of information from a number of sources which include RQIA regulatory inspections, Quality Assurance Visits, resident's reviews, feedback from families, complaints, adult safeguarding referrals, and monitoring of adverse incidents. Suspending regulatory activity, family and routine visits from healthcare staff in effect shut down many of the Trust's quality assurance processes. While the Trust acknowledges these decisions were made to preserve life and reduce the risk of transmission of the virus, removing independent oversight of the quality, safety and lived experience of residents, introduced different risks that were potentially detrimental to resident wellbeing.

399. If a further pandemic occurs, careful consideration should be given to balancing the risk of infection transmission with continuing to implement processes that provide

oversight and assurance of the quality and safety of care provided to residents. The Trust would be of the view care home visits from professional staff and families should not be stopped and that regulatory inspections should continue. These measures did not effectively protect care homes given the level of outbreaks observed across care homes in the first wave.

400. Alternative processes for protecting residents should be considered such as mandatory daily testing for care home staff, HSC staff and families who visit care homes. Guidance should be clear and specific to avoid misinterpretation. When guidance is being developed it should balance the risk of infection transmission with the wider risk to the safety and wellbeing of residents. Alternative measures such as offering families the opportunity to remain in the care home with their relative, merging the roles of the Trust and Regulator regarding quality assurance and compliance with minimum standards, and having an identified cohort of Trust staff aligned to care homes may be a more effective way of balancing conflicting risks.

External reviews, reports, lessons learned exercises

401. Detailed below is a list of Serious Adverse Incident (SAI) reviews commissioned by the Trust for the identified period relating to the matters outlined in the scope of practice:

- BHSCT/SAI/20/045: Independent sector care home/ Covid-19 outbreak
- BHSCT/SAI/20/112: Stat domiciliary care provider/ Covid-19 outbreak
- BHSCT/SAI/20/133: Stat care home/ Covid-19 outbreak
- BHSCT/SAI/20/141: Stat care home/ Covid-19 outbreak
- BHSCT/SAI/20/145: Stat care home/ Covid-19 outbreak
- BHSCT/SAI/20/161: Stat domiciliary care provider/ Covid-19 death
- BHSCT/SAI/21/004: Stat care home/ Covid-19 outbreak
- BHSCT/SAI/21/008: Stat care home/ Covid-19 outbreak
- BHSCT/SAI/21/013: Stat care home / Covid-19 outbreak
- BHSCT/SAI/21/014: Independent sector care home/ Covid-19 outbreak
- BHSCT/SAI/21/029: Stat care home/ Covid-19 outbreak
- BHSCT/SAI/21/143: Independent sector care home/ Covid-19 outbreak
- BHSCT/SAI/21/182: Independent sector care home/ Covid-19 impact
- BHSCT/SAI/22/014: Service user's own home/ Covid-19 impact
- BHSCT/SAI/22/091: Non Healthcare setting/ Covid-19 impact

402. Due process was followed in relation to outbreaks notified as SAIs and once completed five key themes of learning were identified, which included recommendations relating to:

(i) IPC Management
(ii) Local audit
(iii) Training
(iv) Governance, Management and Oversight
(v) Development of local guidance

403. Operationally, when an outbreak occurred, immediate assurance was sought regarding service user and staff safety, compliance with Covid-19 guidance and IPC management. The identification of early learning was recognised as being key to preventing the spread of the virus and resulted in rapid learning reviews and dynamic risk assessments being undertaken to provide assurance of compliance with IPC management and relevant Covid-19 guidance. Where learning was identified this was immediately implemented. This may have included:

(i) Retraining of staff in donning and doffing of PPE;
(ii) Introduction of an audit process in relation to donning and doffing or environmental cleanliness;
(iii) Development of local guidance within the facility.

Additional recommendations emerging from SAI reviews were implemented once available.

Analysis as to how the care sector coped or operated during the pandemic

404. The Trust did not undertake a formal review of how the care home sector coped with the pandemic. However, the Trust collated a range of data and used it for ongoing analysis of how the care home sector operated and coped during the course of the pandemic. This included:

- Data on care home outbreaks to include the number of residents infected and the number of deaths experienced;
- Data on the number of staff tested, the number of results communicated to homes and range of advice and data provided to care home staff;
- Data on the number of homes that required mutual aid support and the level provided;
- Data on the PPE provided to care homes;

- Data on care home compliance with visiting guidance for a defined period;
- Data on care home staff who attended training facilitated by the Care Home Support Team;
- Data and reports on IPC team interactions with care homes;
- Report on the evaluation of PPE compliance in care homes (June 2020);
- Care in Crisis – Evaluation of bereavement and staff support provided during Covid-19 (June 2020), presented as Exhibit [NM/36 – INQ000581091];
- SAIs were completed for care home outbreaks in which the Trust had concerns regarding the management of the outbreak. In the main, these were completed statutory homes which reflects the robust oversight the Trust management structure had in these homes;
- Two SAIs were commissioned in response to complaints raised by families;
- Presentation to BHSCT Senior Leaders Group (12 June 2020);
- Domiciliary care demand and capacity data;
- Analysis of compliance with testing prior to discharge (FOI response);
- Trust response to Health Committee Inquiry (October 2020);
- Data on allocation of finance package to care homes and domiciliary care providers;
- HSCB Surge Plans;
- Care home survey (February 2021);
- QMS presentations for relevant period;
- HSCB Care Home Actions reporting returns;
- BHSCT Care Homes Action Log;
- Care home outbreaks data review (April/ May 2020);
- BHSCT Prevention and Management of Covid-19 in the Care Home Sector monitoring template;
- Maintaining Good Governance, Quality and Safety during Covid-19 (updated paper to Trust Board June 2020);
- BHSCT Covid-19 Response – Trust mutual aid to care homes (6 August 2020).

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

405. As previously indicated, due to the rapidly evolving situation, the Trust was not consulted on the development of guidance, and it was therefore not possible to do any pre-assessment of potential impact. Workshops undertaken with the independent sector domiciliary care and care home providers in March 2020 focused on pandemic preparedness, communication of the most recent guidance and discussion regarding their concerns and how the Trust would work in partnership to support them. However, the reality was we were all facing an unprecedented and unknown situation and responded to situations as they emerged.

406. The Trust put in place daily safety huddles based on the Charles Vincent Model, which ran for the course of the pandemic. These huddles provided a forum for the escalation of concerns from the frontline to the Covid-19 Oversight Group and Trust Executive Team. They provided effective oversight of the daily risks to service delivery and were a supportive forum for staff to escalate concerns.

407. The Trust established a Community Co-ordination Centre for vulnerable people who required social supports such as food shopping and emotional support. This service, provided through a 7-day helpline, operated an open referral system with all referrals followed up by an experienced social worker or social care staff member who worked with the person to support resolution to their identified need.

408. The evidence which emerged through lockdown indicated an increase in domestic violence and a reduction in referrals to the Adult Safeguarding Team. The Trust used social media to promote an awareness of domestic violence and the role and contact details of the Adult Safeguarding Team as a service to support victims. The Trust also wrote to care home providers to highlight the reduction in referrals and to remind them of their responsibilities under the Adult Safeguarding Policy.

409. The shielding guidance impacted workforce availability across the social care workforce. The Trust and independent sector providers complied with this guidance and accommodated staff who were advised to shield due to underlying medical conditions. For Trust staff, a daily reporting structure was put in place through the Trust's HR structures to record all staff absent from work due to shielding or self-isolation. Where it was possible for staff to undertake their role from home, and

they were well enough to do, the Trust provided the ICT resource to accommodate home working.

410. The shielding guidance placed significant pressure on the staff who remained in work as these were the only staff available to undertake face-to-face visits. All teams RAG rated caseloads and work was prioritised in line with business continuity plans based on the workforce available on a given day. This often meant that only emergency and urgent tasks were completed.

411. The shielding guidance had a significant impact on statutory and domiciliary care providers as the domiciliary care workforce tends to be an older workforce. Implementing this guidance alongside managing staff self-isolating and normal sickness created significant time intensive challenges with the reconfiguring of domiciliary care calls.

412. Social care teams RAG rated cases and worked with providers to identify service users who would be at significant risk if they did not receive their domiciliary care calls. Calls were prioritised based on the service users RAG rating. When a call could not be completed, the service user and their family were contacted and advised.

413. When society went into lockdown and the general population was furloughed, many families chose to care for their relatives and suspended their existing care packages. This decision, alongside independent sector domiciliary care providers experiencing an upturn in recruitment, enabled the Trust to reduce its domiciliary care unmet need list to the lowest level it had been since June 2017. The Trust experienced a rapid increase in unmet need from July 2020 once society reopened. From January 2022 the Trust experienced an increase in independent sector domiciliary care providers handing back care packages due to recruitment and retention challenges.

414. Throughout the pandemic the Trust implemented processes for data collation and analysis to monitor the impact of the pandemic on service delivery and/ or the impact or compliance with guidance.

415. A daily report was introduced to monitor outbreaks in care homes across Belfast. Data collated enabled the Trust to have daily oversight of outbreaks, the number of residents impacted, and the number of deaths recorded. This provided the Trust

with live data on the impact of the pandemic on the care home sector on a given day but also data collated over time which enabled analysis on the impact of testing and the vaccination programme.

416. The Trust implemented systems and processes to ensure that staff had access to the required support to ensure care home residents needs were effectively met. This included a scoping of Care Homes providing an aerosol generating procedure for resident(s) and subsequently arranging FIT Testing and supply of appropriate masks for staff.

417. The Trust complied with the provision of all monitoring requests from HSCB, including the submission of surge plans, workforce model for the provision of mutual aid support to care homes based on percentages of care homes that went into outbreak, Covid-19 action plan – initially a local action plan, followed by a regional action plan from September 2020 onwards, presented as Exhibit [NM/37 – INQ000581133].

418. The Trust engaged in a research pilot which involved using Lumira Dx SARS-CoV2 antigen (LIAT testing) test for patient discharge. This pilot was implemented from 1 March 2021 to 23 March 2021 and as a result of the pilot, same day discharge testing using Lamira Dx was implemented across the region.

SUCCESSES, IDENTIFIED LEARNING AND RECOMMENDATIONS

Successes

419. It would be the view of the Trust that in the main, the practical and clinical support provided to the independent sector care homes and domiciliary providers was robust, responsive and placed the service users at the centre of decision-making. Teams from across the Trust pulled together and worked collaboratively to provide timely clinical support for care home residents, guidance, support and training to care home staff and emotional support to families of residents to facilitate testing, communication of results, safe IPC practices and to roll out the vaccination programme for care homes.

420. Equally, the support provided to independent sector domiciliary providers ensured timely support, direction and the promotion of safe IPC practices. The development of a single point of contact for clinical and practice support ensured independent sector domiciliary providers accessibility to timely and responsive 7-day services.

421. The professionalism, commitment, flexibility, and 'can do' attitude of Trust staff in operationalising the Covid-19 response to independent sector providers was both humbling and inspiring.

422. The Care Home Support Team coordinated the clinical response to care homes, building on existing working relationships to ensure a compassionate, professional, collaborative and timely response to care homes in the event of a suspected or confirmed outbreak. The effectiveness and resilience of this team was remarkable. The development of an escalation pathway in partnership with Primary Care, Acute Care at Home Team and Community Respiratory Team, the expansion made up of redeployed staff, and communication strategies implemented ensured timely response and escalation of treatment to the appropriate practitioner for sick care home residents.

423. In a care home survey undertaken by the Trust in February 2021 one home commented "*without this team over the past year, we may not have survived this pandemic, I have found it invaluable as a manager of a small independent home. The rapport and team building between the Care Home Support Team and ourselves has been the greatest achievement in the development of the private care home sector*". The results of this survey are provided in Exhibit [NM/38 – INQ000581092] whilst general feedback/ comments were obtained separately.

424. The Care Home Support Team were ably led by a supportive and committed Senior Leadership Team who understood the area, the risks and the response required to enable timely decision-making, clear direction, timely response and implementation of DoH and Trust guidance. The need to respond to a rapidly changing situation promoted responsive decision-making, innovative thinking and freed leadership teams from the bureaucracy that can impact change.

425. Regular engagement with independent sector providers via the weekly meetings ensured timely escalation of issues and a collaborative approach to resolution and escalation of concerns. Independent sector providers recognised and appreciated the Trust being open, receptive and willing to work collaboratively.

426. The operational model adapted for care homes by the Care Home Support Team, Commissioned Services Governance Team and Care Review and Support Team ensured effective communication, the availability of 7-day support and a calm, controlled and co-ordinated response that provided assurance and support to care home staff, service users and their families at a time of crisis. Sustaining the model and delivering the supports would not have been possible without the dedication and commitment of Trust staff who used their professional skills and knowledge to support both service users and staff.

427. An unintentional benefit of the mutual aid support to care homes was the educative role it provided to care home staff in promoting a better understanding of the role of Allied Health Professionals in supporting care home residents.

428. The staff care model adapted by the Trust's Occupational Health team ensured that care home staff who became unwell with Covid-19 had access to the same supports as Trust staff. Care homes having access to the Trust's IPC resources and expertise of the IPC team offered each care home access to the most up-to-date IPC advice, guidance and resources.

429. The Training model adapted by the Care Home Support Team via the twice-weekly virtual training session ensured that care homes had access to training that would equip them to practice safely in the event of an outbreak. The team co-ordinated training for care home staff into this central forum bringing together practitioners from across the Trust to deliver training, and on occasions worked in partnership with PHA to deliver regional training.

430. Additional Covid-19 related service developments, led by the Adult Community Older Peoples Services directorate, to respond to the independent sector included the:
    - Primary Care Covid-19 Centre
    - Rainbow Room at the Mater Infirmorum Hospital
    - Community Co-ordination Centre

431. The Primary Care Covid-19 Centre was developed in partnership with Primary Care to co-ordinate the Primary Care response to people living in the community who were unwell with suspected or confirmed Covid-19.

432. The Rainbow Room at the Mater Infirmorum Hospital was developed in partnership with the Trust Bereavement team to provide telephone updates, advice and support to the families of patients admitted to hospital with Covid-19, and bereavement support to relatives of patients who died.

433. The Community Co-ordination Centre provided outreach support and practical help to vulnerable people who lived alone but may not have been known to Trust services.

434. Whilst it is regrettable that enforcement action was required from RQIA in April 2020 regarding an independent sector care home within the Trust geographical area, the Trust response to the identified risks, escalation of concerns and implementation of governance assurance processes was swift, decisive and timely. The Trust worked in partnership with HSC partners and the new home management team to bring the care home back into compliance.

435. The Trust is also of the view that as the pandemic progressed there was collaborative working between HSC partner organisations on the rapid learning work streams, the development and implementation of the Enhanced Clinical Care Framework, the Catheter Passport, the Falls Pathway, Frailty and the introduction of the Rockwood Frailty Score. Allied Health Professionals worked with HSC partners to develop learning aids and guidance and to address issues such as the need for clear masks.

Identified Learning and Recommendations

436. Independent sector providers play an integral role in the delivery of social care. The suggested learning the Trust would respectfully ask the Chair to consider has been broken down into four themes (Care Home Staffing, Business Continuity Planning, Support to care homes, Infection Prevention and Control) that consistently presented through the pandemic.

Care Home Staffing

437. The pandemic highlighted the need to consider the care home sector as an area of specialist practice with a specific career pathway. There is a need for further definition and enhancement of the leadership and management roles and for implementation of a structure that provides visible leadership over 7-days. Enhanced role and responsibilities in key patient safety areas such as Adult Safeguarding, Infection Prevention and Control, environmental cleanliness, dementia champion and tissue viability need to be developed to ensure the delivery of safe and effective care. These roles should be supported with competency frameworks which detailed the qualifications, knowledge, skills and training required to undertake the roles.

438. The terms and conditions of employment within the many employers within the independent sector urgently need reviewed and reformed to achieve a sustainable skilled workforce. The pandemic brought into focus the fragility of the workforce within care homes and the high dependency on agency staff. The pay and conditions for staff working in the independent care home and domiciliary care sectors undoubtedly impacts on recruitment and retention. This is an area that requires much needed reform to ensure staffing requirements, qualifications, training, development opportunities, equitable pay and conditions are in line with the public sector. Staff being paid for sick leave (prior to the implementation of the financial aid package or for those not meeting the criteria for this package) would have reduced the risk associated with staff refusing Covid-19 testing or returning to work when symptomatic.

439. The identification of registered nurses to work in care homes as part of the mutual aid response was particularly challenging given the Trust was also managing internal workforce challenges. The Trust would suggest review of the registered nursing workforce across HSC partner organisations with a view to redeployment in the event of a further pandemic.

Business Continuity Planning

440. The rate at which care homes went into crisis evidenced the lack of robust business continuity planning within care homes. Robust business continuity plans should be considered a priority for the Responsible Person and Registered Manager. The Business Continuity Plan should be considered a live document and the staffing profile RAG rated within this document. The regulatory process should be reviewed to consider the staff ratio in relation to permanent and agency staff.

441. Experience has indicated that care homes were not always familiar with best practice IPC measures. It was evident care homes had not considered, as part of business continuity planning, IPC measures, PPE station locations, waste management, zoning of residents, enhancing cleaning schedules in the event of an outbreak or continuity planning if domestic staff were impacted by the pandemic.

442. Guidance and training for Care Home Managers on the content of business continuity plans should be developed and the robustness of the plan externally evaluated as part of the regulatory process.

Support to care homes

443. During the first surge, a number of policy decisions and guidance documents were communicated at short notice which, while understandable given the pace of change and learning in the first surge, presented challenges to both care homes and Trusts to operationally respond in an effective way, particularly in those areas which required a workforce. The Trust would suggest that all guidance issued should be clear, directive (to avoid misinterpretation) and clearly outline roles and responsibilities for implementation. Communication of key changes requiring urgent action across the sector should be avoided at the end of the week, as implementation then falls to a reduced staffing complement. Where possible, more consultation around key decisions relating to this sector, timely communication and appropriate lead-in times for implementation should be prioritised.

444. It is the Trust's view that the stopping of professional visits to frail older people living at home or in care homes was detrimental. Learning from this pandemic should be used to inform future decision-making. The potential harm to the health, safety and wellbeing of service users associated with stopping professional assessments and

reviews should inform the risk assessment. Alternative approaches to managing the risk of infection should be considered prior to blanket decision-making. A similar risk-based approach should be adapted for regulatory inspections and family visiting in care homes. Placing a care home in lockdown should be the final option rather than the first.

445. The multidisciplinary resource to care homes should be reviewed and a minimum regional standard agreed. The effectiveness of the GP Care Home LES should be evaluated as part of this review.

Infection Prevention and Control

446. The communal living environment within care homes contributed significantly to the rapid spread of the virus in care homes. Future design models should consider how the care home could cohort smaller groups of residents in the event of another pandemic. The care home's Business Continuity Plan should consider the staffing resource required to cohort residents.

447. IPC guidance should include how care homes care for residents during a pandemic to reduce viral transmission, as experience would indicate that in some care homes the staffing resource was so inadequate that it led to staff providing care to both Covid-19 positive and Covid-19 negative residents. IPC training should promote consideration of the likely scenarios that may occur and how the three potential groups of residents (positive, exposed and negative) should be cared for.

448. The care home regulatory standards should be reviewed with a view to identified learning regarding availability of equipment that can impact infection prevention and transmission. Care homes are multi-occupancy dwellings where care involves 'toileting' practices that are associated with a risk of environmental contamination. The vast majority of care homes in the Trust geographical area did not have access to an automated washer for bedpan or commode receptacle decontamination. Infection Prevention and Control Nursing observations noted that existing washing practices for commode pans and bedpans were ineffective at decontaminating these items effectively and did not render them safe for reuse. Effective decontamination of these reusable items is essential to contain transmission of infection. Current regulations do not require care homes to have automated bed

pan washers installed, however, this should be given consideration as a mechanism to reduce this risk.

449. A number of care homes did not have access to industrial style automated washing machines that can carry out a wash cycle option for appropriate laundry disinfection in wash cycles at 40°C or lower when thermal disinfection is prohibited for certain types of clothing. Existing guidance for healthcare laundry services, HTM 01-04 (DoH 2016), requires that where thermal disinfection cannot be achieved, an alternative chemical disinfection option should be in place. There is no regulatory requirement for the care home sector to follow this guidance.

450. Care homes would benefit from a formal recommendation of a standardised design for enclosed PPE stations e.g. a range of photographs of appropriate PPE station designs that could inform care home sector staff on how to lay out PPE appropriately with a visual aide.

451. It was noted during Infection Prevention and Control Nurse visits to care homes that several care homes used vinyl gloves for the provision of personal care to residents. The tensile standard in vinyl gloves is not adequate for care that involves healthcare workers dealing with bodily fluids. Nitrile or neoprene gloves should be used for care of this nature. While this was addressed, a formal recommendation from the regulator would embed best practice in relation to the quality of gloves provided for care staff in care homes.

452. Clarity of roles and responsibilities for independent sector providers regarding monitoring and accountability with IPC practices is required. Some care homes refused Trust visits and unannounced inspections/ visits from Trust staff were discouraged. The role and responsibilities of the regulator, RQIA and the Trust in relation to monitoring and accountability regarding IPC practices requires clarity, particularly when care homes refuse unannounced and announced visits.

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 trust without an honest belief of its trust.

Signed: **Personal Data**

Date: 19th March 2025