Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Inquiry into COVID-19 and its Impact on Care Homes: Independent Health and Care Providers

22 October 2020

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Gerry Carroll
Mr Alan Chambers
Mr Alex Easton
Ms Órlaithí Flynn
Mr Colin McGrath
Mr Pat Sheehan

Witnesses:
Ms Pauline Shepherd Independent Health and Care Providers

The Chairperson (Mr Gildernew): I welcome by video link Ms Pauline Shepherd, who is the chief executive of Independent Health and Care Providers (IHCP). Good morning, Pauline. It is good to see you. Thank you for coming along to the Committee this morning. I invite you to go ahead and brief the Committee.

Ms Pauline Shepherd (Independent Health and Care Providers): Good morning, everybody. Thank you very much for the invite to address the Health Committee. I have followed the guidance that you sent out in relation to headings and subheadings, and I have tried, where possible, to focus on the steps that are necessary to minimise infections in care homes and care for those infected in treating the well-being of residents and staff. I have also included references to home care or what is commonly called domiciliary care, on the basis that we believe that that is very relevant. We see those services as being an integral part of the connected plans going forward, so I have referred throughout the briefing to home care or domiciliary care services.

The first topic is discharges from hospitals to care homes. Testing is required 48 hours prior to discharge from hospital to a care home. The results of those tests are not always available on discharge, so care homes isolate all new residents for 14 days. In spring, there was evidence that there was pressure on care homes to continue to support discharge pathways for older people out of hospital, and there is a concern that there may be pressure again to do that. Not all trusts have discharge pathways to accommodate those who have tested positive for COVID and either continue to test positive or are medically fit for discharge but remain in the infected period. Some care homes are providing step-down facilities completely separate from the main care home residents so that there is an opportunity for patients who have tested positive to be discharged into a unique safe environment. There is no universal approach and no safety net of retesting residents discharged after the four to

seven days to ensure that they have not contracted the virus in hospital. To cover that, hospital discharges to home care services are not tested, and we believe that testing should be carried out for any discharge to a home care setting.

I am moving on to access to PPE. PPE continues to be supplied where necessary by health trusts, and there have been no recent concerns about availability. We have been advised that the support to supply will continue, but an assurance on the continuity of supply and how long it will last would be of benefit, particularly with the increasing pressure on hospital settings. The cost of procuring PPE on an individual basis is significant, with prices soaring across all PPE products. We need to be mindful that any change to the PPE guidance needs to be communicated early to care homes and home care providers. Consistency of approach to the guidelines across all the trusts needs to be assured.

On testing in care homes, staff are tested every 14 days and residents every 28 days. These routine tests are carried out by care home staff, using the national testing system. There have been considerable problems with delays in getting results, the IT system and the courier service. In the past week, there has been an improvement in the results turnaround but, as more testing is being carried out, there remains a concern about the capacity of the system to deliver.

At present, an "outbreak" is two symptomatic cases, so homes can get into an outbreak before positive tests are confirmed. Repeat positive tests are also putting homes into outbreak. This stops admissions and curtails visiting. The Public Health Authority (PHA) and trusts take over the testing in the case of an outbreak, with the tests being carried out locally. However, recent feedback indicates that the trusts are starting to struggle with the capacity to complete the repeat testing at days 4 to 7 in care homes, due to resourcing issues. This results in a delay in completing this repeat testing process, and subsequently a delay in identifying positive cases.

The trust polymerase chain reaction (PCR) test appears to be a more sensitive and reliable test than the national testing system. There are monitoring systems in place but, as you are aware, many of the positive tests are now from asymptomatic people. Symptom monitoring guidance from PHA needs to be revised. We are aware of ongoing engagement around the wellness checklist, which is referenced in the care home guidance, but this needs to be progressed. Staffing problems arise from the additional resource required to undertake these tests, and I have covered this in more detail under some of the later headings. Resident consent is a topic that is dealt with in the brief. Not all residents, or their representatives, agreed to testing. IHCP has asked the PHA what monitoring system is in place to quantify the number of untested people and what that risk is. As yet, we have had no response, so I cannot answer that question.

Footfall into care homes has increased, with allied health professionals and inspectors now accessing for visits. We have asked that any footfall into a care home should fall within the routine testing protocol. It is the sector's view that testing should be carried out weekly for staff and every two weeks for residents. All those professionals who interface with care homes, including the Regulation and Quality Improvement Authority (RQIA), trust teams and agency workers, should be required to undertake the same mandatory testing as care home staff. As mentioned previously, discharges from hospital to home care services or, indeed, the home care staff, are not included in the routine testing protocol. Home care providers are finding it difficult to access timely testing, and that also applies to supported living settings, where staff have to travel some considerable miles to get tested, and that takes them away from an already depleted resource.

With regard to funding and increased costs for care homes, the increased resource demands have been created by the routine testing process and the visiting monitoring and supervision, which is compounded by reduced staffing levels due to isolating and a lack of childcare due to school class closures. Grant funding has been made available for enhanced cleaning, staff sick pay and technology, but it has been significantly under-claimed and underutilised, due to the eligibility criteria and qualification time limits. In addition, there has been support for care homes that have been under-occupied as a result of COVID. However, not all these payments have been processed, and there is a delay in sorting out the blockage for payment. There have been ongoing meetings with the Department of Health since July regarding funding pressures, with continued commitment for submissions to be provided to the Health Minister. Obviously, the Minister made an announcement yesterday in relation to funding being released to support care homes. We very much welcome that and look forward to finding out the detail about what that will translate into. Therefore, we are aware that the Department is considering the funding pressures.

On staffing issues and levels, additional tasks have been added to current staffing levels, including those that I have already mentioned, of routine testing and visiting. Other resource pressures have

arisen as a result of additional monitoring, assurance, surveys, audits and assisting with virtual visits and GP consultations by video, and those have all added to the staffing challenges. Staff shortages are a challenge to cover, and agency staff are being used, at considerable additional cost. Concerns have been raised by IHCP about agency staff and, in the past, student nurses who move from care home to care home and to trusts, and the transmission that that could create. We are very concerned that all of the expectations of controlling footfall into care homes are being left with the care provider and that other stakeholders are not being set requirements to follow, or supporting solutions to cover staff gaps.

There are also problems attracting new recruits. A number of our members have stated that there has been a very poor response to recent recruitment campaigns. If we look back to the first wave, we see that there was a very low number of volunteers during the national appeal for the independent sector. That is becoming a critical concern. There was a meeting just this week with the Department of Health to try to resolve some of the barriers to recruitment processes, but we are concerned that the feedback is that the trusts are facing the same pressures and will not be able to provide support to the independent sector in a similar capacity to what it was able to do in the first wave.

I move now to training and guidance. We very much appreciate the access to online learning that has been opened up to care homes and home care providers via trusts and the clinical education centre. Attendance at those sessions is important in embedding the key knowledge and learning regarding COVID, but it requires the release of staff from hands-on care, which there has been no recognition for. Trusts have also been completing infection prevention and control (IPC) monitoring and audit visits, support of which also requires resource. It seems that there is an expectation that all of those important and valued interventions can be delivered at a time when care homes have less resource. I appreciate that the Minister has made an announcement about support for testing and visiting, but that funding needs to translate to bodies on the ground. Our difficulty is in getting the staff to carry out the tasks.

Staff terms and conditions vary from employer to employer. Support to top up statutory sick pay has been made available to staff in home care services, but was limited to a time-specific period for care home staff. We have sought to address the inequality between those two workforces, as well as the inequality of compensation being available for those in care homes who were off in the latter part of the pandemic, but not for those who were off at its peak. Recently, there has been movement in extending that sick pay scheme for care homes. There is a considerable pressure and cost in addressing such issues as staff who are off isolating or who need to remain at home because their children are isolating and they have no childcare.

Staff have been managing through particularly difficult and challenging times, and many are very tired. That is further impacted by reduced resource. Many of the staff who continued to work through the experience of losing multiple residents due to COVID are afraid of going back to that position, and those care homes that have not had that experience are afraid of being impacted with the second wave. Does the Health Committee intend to take evidence from front-line key workers — care workers — or residents to assess the impact, or are you already doing so? Care home providers and staff are doing all that they can to reduce the risk of COVID entering their homes.

You also sought feedback on staff changing facilities. Care homes have worked hard to ensure that the IPC measures around uniforms and PPE are adhered to. That has required a review of areas in care homes where staff can safely have space to achieve good compliance. Bedrooms in some care homes have been taken out of use to accommodate the donning and doffing of PPE. Other support has included the psychological support services from trusts being made available to the independent sector. That is welcome. I am unsure of the uptake levels for that service, but I am aware that the trusts' psychological support teams provided additional support to the care homes that faced multiple COVID-related bereavements. We hope that that support continues. However, morale remains generally low, and staff are tired and worried. They feel that the system is working against them as they try to keep COVID out of care homes. I will move on to that when I talk about visitors.

There has been a range of innovative ideas to assist with family visiting. They include video calls, Zoom calls, garden visiting and visiting pods. However, the restrictions are putting serious pressure on residents and families, and moving into colder weather impacts on the outdoor visiting solutions. The recent visiting guidance has caused concern, particularly against the backdrop of the worrying increase in community transmission. We fully accept that there is considerable pressure on families and residents, and that it is having a detrimental impact. The care partner idea was included in the guidance but not discussed with the sector. Many problems in the policy were not foreseen, not least insurance and regulatory requirements. We have flagged the issues that need to be addressed to

mitigate the risk of increased footfall, which could be as high as two care partners for each resident with unlimited access. Those include routine testing being increased in frequency, and results delivered on time; staffing issues addressed; appropriate funding support; and recognition for staff. Until those are addressed, it is unlikely to be assessed as appropriate to increase footfall into care homes while the community transmission rate increases. I wrote to the Chief Nursing Officer a number of weeks ago in relation to the visiting guidance, and received a response late last evening. I am hoping to pick that up with the Chief Nursing Officer to follow through and see if we can get solutions to some of the problems that this has created.

The wider impact of the pandemic on residents has been significant, going much further than visiting restrictions. Normal life in a care home has been greatly impacted by such things as isolation, additional IPC requirements and reduced services — simple things such as podiatry. All of those have an adverse impact on people, even those not directly impacted by COVID.

With regard to regulation, the RQIA has commenced a mixed approach to inspections and has indicated that it is doing that on a pilot basis. There are concerns that the virtual visits are actually more resource-intensive than on-the-ground visits, because all the documents have to be scanned, uploaded onto a system and then gone through within the virtual visit. There remain a number of avenues for care homes to raise concerns via the PHA and RQIA. However, reports are that access to advice out of hours is challenging. I have been speaking regularly to Dr Tony Stevens, head of the RQIA. I raised that issue, and there are plans within the RQIA to move to out-of-normal-hours support. I spoke to the PHA late last night, and it too is trying to extend its support outside office hours.

There was a question here on HSC-run versus privately run homes. IHCP has been asking for many years for an independent economic review to identify the true cost of care. In addition, we have suggested that that could be supported by a financial regulator. On the basis of a full financial and economic analysis, a full comparison could be carried out between public and private provision of services, and they could be appropriately assessed. Until that is done, there is no real assessment measure.

I now turn to medical care within care homes: the in-reach teams, support from GPs and advance care plans. While each trust had a COVID response plan in the first surge, those differed in composition. The interface with the residents' own GPs, who know them best, was almost non-existent. Those COVID response teams seem to have been stepped down in some areas, and the commitment to completing advance care planning for all residents has not been fully achieved. Again, some trusts have advanced their plans through virtual reviews. The Northern Health and Social Care Trust has made considerable progress in that area.

With regard to preparedness within health and social care and care homes for future requirements, there have been a myriad of work streams on planning and reviewing, including surge planning, rapid learning, keeping COVID out of care homes and psychological support for staff. If the care home surge plan is to be the overarching document that connects all stakeholders in the safe and effective management and delivery of care, there needs to be an urgent commitment from the Department of Health to address the queries that we have raised with the surge plan, including the requirements levied on care providers to confirm that they are meeting the actions listed. We are concerned that the resourcing and funding to deliver on the surge plan is not in place across all stakeholders. IHCP has continued to emphasise the need to integrate the home care services into the reviews and forward planning. A home care surge plan is not yet in place, and there is a need to utilise the potential capacity of the home care workforce. We are seeing shifts in the landscape from the first wave to the second, and those two areas of care overlap. We are also aware that referral mechanisms to home care services remain at a virtual standstill, and we are aware that there are people in need in their own homes.

IHCP members have advised that they are very concerned about the capacity to continue to deliver care, together with the expectations placed on them, facing the continuing increase in COVID transmission. IHCP has observed that there is, and has been, significant activity within many areas of the public health and social care system. Much of that has resulted in surveys, guidance that is sometimes contradictory, assurance-seeking reports, contingency plans etc all being targeted at care homes and home care providers. Much of that has also resulted in significant work for the independent sector. Much of the work is embarked on and then seems to fade into the distance and, in several cases, we have urged for completion without success. That scattergun approach leads to multiple lines of advice and fragmented learned best practice, contingent pandemic planning and effective COVID-19 management. We wish to see a more targeted, connected approach under the control of a single body, preferably with a single lead person on the health and social care side. We believe that

that would drive a more apt response and better integrate and dovetail the independent sector's COVID-19 response with that of our public services. It would also assure residents and citizens in Northern Ireland that the sectors are inextricably linked and are working efficiently for the best patient outcomes.

That concludes my brief. Thank you very much.

The Chairperson (Mr Gildernew): OK. Thank you for that comprehensive briefing, Pauline. On your question about our engagement with families and workers, we have heard from workers via their unions and from residents' families through an informal Zoom meeting. We have run a survey, which has had hundreds of responses from workers, managers, families and residents.

I am just going to check quickly if Paula is there on the line with a question.

Ms Bradshaw: Apologies; I have to go in a few minutes to meet the Communities Minister. My question is really about the attitude of your organisation to the proposal in the guidance for the introduction of care partners. A lot of the relatives of residents whom we have spoken to were very keen to see that introduced, but when we spoke to union representatives the other day, particularly the representative from the Royal College of Nursing, they were not so keen because there is no regional framework, policies etc. Where are you on that proposal?

Ms Shepherd: We have said that we are very supportive of trying to increase and relax visiting in care homes — we see the need for that from the point of view of residents and families — but only when we have the proper controls and measures in place to mitigate any risks. At the minute, there are issues that we feel need to be addressed before we can move in that direction. We have developed proposals for visiting pods and having safe places where people can visit. If those all move forward, we could move in the right direction. Part of the resistance that we have experienced so far is around insurance issues and health and safety. I think that we could resolve those, but the issue was that it was more or less put into guidance with the need to have care partners in place by 5 November. That created difficulties.

Ms Bradshaw: OK. As a quick follow-up, has the Department asked you to sit down and look at the policy and some of the potential barriers to introducing it?

Ms Shepherd: We had an initial meeting a few weeks ago. That led to the letter that I referred to from the Chief Nursing Officer, Charlotte McArdle, late last night with a view to whether we can now talk about some of the proposals and move them forward. I am hopeful that we might be able to resolve some of the issues quickly. We do realise that there is a need for families to visit. However, there are also lots of families out there who have expressed the view that they do not want risks to be increased and that they are happy with visiting the way it is. It has to be balanced with everyone's needs and expectations.

Ms Bradshaw: Thank you very much.

The Chairperson (Mr Gildernew): Thank you, Paula and Pauline. A couple from me, Pauline, before I go to Pam and Colin on the phone, and then Alex in the room here.

You said that there is no universal approach to the discharge policy and no safety net of retesting residents who are discharged from hospital after four to seven days. The discharge policy is an area of concern. From the outset of the pandemic, very many COVID-positive patients were potentially discharged from hospitals into care homes. Given your concerns in that area, what are your recommendations for how we might do that better in the time that we are facing?

Ms Shepherd: Currently, if someone is discharged from hospital into a care home, they get the test 48 hours before they are discharged, but then they fall within the normal routine test in the care home, and that is every 28 days. What we are asking for is that care home residents are tested more regularly, and that those discharged from hospital should be tested again within a short space of time of actually coming into the care home so that it can be identified whether they had COVID when they came from the hospital setting or whether they contracted it in the care home. That would help to identify COVID more quickly, and it would actually identify the source more easily as well.

The Chairperson (Mr Gildernew): What is your view on the preparedness of care homes to deal with COVID-positive residents who have been discharged into care home settings?

Ms Shepherd: There are some care homes that will not accept COVID-positive residents or discharges. There are some that have set up specific facilities to accept residents who have COVID into a separate and completely safe unique system. We have been asking about the Nightingale at Whiteabbey Hospital, because that facility could be used to step down people with COVID who are still infectious, rather than bring them into a care home. Care homes will not accept COVID patients unless they can do it safely and separately from the other, non-COVID areas.

The Chairperson (Mr Gildernew): Are you satisfied that the majority of care home settings can safely isolate residents?

Ms Shepherd: Some of them have facilities and can manage it, but not all of them have. That is why I was concerned previously that care homes in the first wave were put under pressure to accept discharges from hospital without even having been tested. Those discharge pathways between trusts and care homes need to be clarified. We need to sit down and talk about them and get them clear because, as the hospitals come under pressure, the pressure will revert to discharges into care homes. We need to get those discharge pathways completely clear, and we need to get a testing system in place that meets the requirements.

The Chairperson (Mr Gildernew): Finally for now from me, you said during your presentation that the system is working against us. Can you elaborate a bit on that? How is the system working against you, and what needs to change?

Ms Shepherd: I expressed that as the feeling from staff and the low staff morale. Staff are so worried about COVID getting into care homes that it has not been in that, when the guidance went out on visiting and, indeed, in relation to having to have care partners in place by 5 November, a lot of staff felt very worried about that. They felt that, in all of the work that they are doing to try to keep COVID out, the system was nearly working against them to say, "Well, you need to now increase footfall. Therefore, we are increasing the risk and telling you to increase the risk." That is where that feeling came from.

The Chairperson (Mr Gildernew): I will now bring in Pam Cameron by teleconferencing.

Mrs Cameron: Thank you, Pauline, for your attendance once again. I certainly do not envy your role in all of this, and we understand that it is a very difficult time and that there is a need to strike that balance in the care setting. You certainly have all our thoughts around this issue, because it is a very difficult time.
I will briefly touch on the points made by Paula and Colm, and I will then ask my own question. You mentioned Nightingale 2 at the Whiteabbey site. I will maybe ask if the Health Committee can follow up on this with the Department to get clarity, but it was my understanding that that facility could have been used for those purposes in between discharge and going back to the residents' own home, which is in a care setting. However, I am also aware that there is a gap for those who have had a recent visit to A&E and were not actually admitted to a ward. There is nothing around that to allow for a wait, and there is no facility for that time to allow the test result to come back before, not discharge, but letting them go back home to the care setting. That is another issue. I am also concerned about visits. I have had complaints from families whose loved ones have COVID and are suffering from it right now, and, because of the pressure on the staff, they are unable to get answers to phone calls. My office staff have tried to phone many times, and they cannot get answers to emails. Any responses that they get are of the order of, "Please stop calling, we don't have time to answer you". That is very concerning, and I do not know how you meet the need and deal with that balance. We need a more compassionate care model, where emotional well-being and mental health are also being cared for in what is a very stressful time for residents, especially those who are suffering from COVID.

My final question is about the need for increased testing. It seems pretty clear to me that testing needs to be increased, both for residents and staff. I am aware that that puts great administrative pressure on the care home staff and that they may feel that they are not able to manage that. Do you have any concerns or worries about bringing in mutual aid in order to deal with testing to take the pressure off those care settings?

Ms Shepherd: The issues around visiting and staffing are our main worry. When test results come back, staff who test positive have to leave the care home. Getting replacement cover is becoming increasingly difficult, so the amount of additional work that has been put on care homes, given the reduction in staff, is causing grave concern. I have been pressing the Department to get some sort of resolution. I understand the pressures on families who, maybe, are seeing those pressures and difficulties. We need to find a solution for visiting, and we need to find a way to support care homes.

I am worried that, during the discussions that I have had with the Department, it is clear that the support that was given in the first wave appears not to be available this time around. I have been asking questions about what is going to be prioritised. If we go back to the same situation that we had earlier in the first wave, with care homes facing the really difficult end of this, where are the resources going to come from to support them and what other services will be stopped in order to redeploy staff? My whole concern is around the redeployment of people to manage where the virus presents in its most difficult format. To me, those are the very difficult questions. I do not have answers for them, and I am not yet sure that the Department has either.

We would welcome any support for an increase in testing. Again, however, anything that increases footfall also increases the risk of transmission into a care home. I was appreciative of the comments made by the Minister and the chief social worker, in a press conference yesterday, that made it clear to the public that it is impossible to keep COVID out of care homes and that, no matter what is done, if it is being transmitted in the community, it will get into a care home.

Part of our concern is about having the proper data and intelligence, working with the PHA, in order to identify hotspots in the community. We are pressing the PHA to advise care homes and let them know if there are problems in that area so that they can take appropriate steps. At the moment, we do not believe that we are getting the appropriate intelligence and data to be able to make those informed, dynamic risk assessments.

I am sorry; that was a long answer to your question.

Mrs Cameron: Thank you.

Mr McGrath: Thank you, Pauline, for your presentation. You are representing a sector that has had a very difficult time and has been at the front line, certainly through the first wave, and it is very much in a defensive position now. From our interactions with staff in the homes, it is obvious to us that it is causing fatigue and stress. That is all being heaped onto people who are meant to be working in a caring role. That must be incredibly difficult for them, and I am sure that all members will recognise and appreciate that.

I now turn to a couple of issues you mentioned. Am I correct in my understanding that care home staff are not considered under pillar 1 for testing? In other words, they are not considered part of the heath service, and in some instances that can cause some additional delay in getting responses.

If we are to take in good faith the comments of Health Minister and others in the Executive that people who work on the front line in care homes are truly part of the response to COVID, we need to include them in the pillar 1 response so that we can get much quicker turnaround for their test results.

You mentioned that the consistency of PPE is not the same across all trusts. Are you finding that any particular trust is being more difficult than others in helping secure PPE? I am hearing anecdotally, from people in the sector, that they are only able to access PPE when they actually need it, which is probably nearly 24 hours too late. They need it whenever they are preparing to go in and do their work, whereas they only find out that they need something when they are on the ground, and then they have to ring up for it and there is a delay in getting it. There seems to be some sort of issue on that. You referred to inconsistency across trusts. Is there a particular trust that we need to seek out to try to get some help for?

I reiterate the remarks about visiting. We should not just leave it to the care home sector to try to crack. The entire health and social care family needs to work on it. I use "family" because article 8 of the European Convention on Human Rights (ECHR) says that there is a right to family life. When some of our elderly, vulnerable people are in homes, near the very end of their lives, and we are not able to let their families come in and visit them, I wonder whether we are robbing them of that article 8 right in the ECHR to family life.

Ms Shepherd: You are right about pillar 1 testing, Colin. Care home staff and residents are classed as pillar 2 and therefore go to the national testing. I also have been asking your question of the PHA, because I do feel that if we were in pillar 1, we might get test results back more quickly. However, there may not be capacity in pillar 1 to do that extra testing. It may just shift the problem into pillar 1, and the capacity is not there. There is the issue of the resource to actually carry out the testing, whether it is in Northern Ireland or at a national level, but I agree totally.

Home care is a critical issue as well. Staff who provide home care need to be tested as well. Why are we testing only in a care home environment and not testing people who are discharged into their own homes?

On PPE, the inconsistency I referred to was not in relation to supply. The supply of PPE is continuing. The inconsistency is around the guidance, in that we seem to have different trusts giving different guidance on what PPE to use and when to use it. We have had that right from the beginning. We need a consistent approach to the guidance on when you use particular PPE. The inconsistency is in the guidance.

On your final question, on visiting, I fully accept the issue in terms of human rights. Care homes do allow visitors at the end of life, and visitors will get in. It may not be completely open, but end-of-life circumstances are an issue. There are other issues where visitors are allowed in for particular circumstances. It is not a complete lockdown on visits. It may vary, depending on a number of factors: community transmission; if there is already COVID in the care home; and whether it is safe because there are enough staff to manage it. There are a number of variables, Colin.

Mr McGrath: I will finish with a statement, rather than a question, Pauline. I do not think it is fair that it has almost moved into a space where care homes are blamed for not providing visiting. Care homes are trying to do what they can to provide a safe environment, and they have concerns. All of us, as a health and social care family, from legislators, Ministers, the Committee, right down to providers and trusts, need to work together to try and resolve this. If we all come together, we should be able to resolve it.

Ms Shepherd: I could not agree more, Colin.

Mr Easton: Thank you for your presentation. I want to touch on the issue of staffing levels, but, first, I want to say that I am a bit concerned that patients moving from hospitals into homes are not being tested. Do you know whether those doing inspections in homes are being tested? Obviously, there has been quite a rise in the number of cases in homes in the past week or so, and that is a concern.

As regards staffing, can you tell us about the adequacy of staff numbers in care homes presently? Is there support from the trusts in that regard? Thank you.

Ms Shepherd: On the first one, testing is being carried out on those going into care homes, but it is not being carried out on people who being discharged from hospital into their own home, where there is the provision of home care/domiciliary care services. We have requested that people who are being discharged into their home, where domiciliary care supports are given, be tested as well. Everyone coming from a hospital into a care home is tested 48 hours before they are discharged. Someone coming from their home into a care home also requires a test. Those tests are being carried out.

In relation to the RQIA, we have asked that any person coming into a care home, be it an allied health professional, an RQIA inspector or someone providing any sort of intervention at all, should be routinely tested. We have asked for that as well.

Your final question was about staffing and support. Just remind me what the third one was about, Alex.

Mr Easton: It was about staffing numbers and whether you are getting support from the trusts to help with any shortfall.

Ms Shepherd: There have been issues in the last few weeks, particularly over weekends, where positive test results have been reported and affected staff in the care homes have had to go home. There is difficulty in getting additional cover at weekends. A care home will look for agency staff, and if it cannot get agency staff, it will seek cover from the trusts. It has been reported to me in the last few weeks that trusts are saying that they cannot provide staff either, because they are having the same

difficulty. There are problems, and there have been problems with nurse numbers for a long, long time, and I see that continuing. There has to be a staffing level that is set by the RQIA, and that has to be met. I have mentioned to Tony Stevens the fact that inspections will be picking up on the shortage of staff. In my view, the RQIA then has an obligation to flag up where it sees pressures.

I am also being told by care homes that there is an increase in the number of instances of non-compliance. Now, if care home managers are trying their best to get staff, but they cannot get them, and if staff have to go home because they have tested positive, I have asked the RQIA, "What more can people do, if they have sought staff through every route possible?". I think that the RQIA needs to look at the issue of compliance on staffing.

Mr Easton: That seems to be a big issue. Thank you.

The Chairperson (Mr Gildernew): I will go to Órlaithí on the phone, and then I will go to Pat and Gerry. I advise members that Alan Chambers has been on the line for some time, so I will keep an eye on the screen for a hand up from him. For now, I will go to Órlaithí Flynn on the phone. Órlaithí, are you there?

Ms Flynn: Yes, I am. Thank you, Chair. Thanks, Pauline. I will make a comment, and then I will ask a question. I suppose that the most worrying —.

The Chairperson (Mr Gildernew): You are little bit faint. Can you turn up the volume a little, Órlaithí?

Ms Flynn: Sorry. Is that better?

The Chairperson (Mr Gildernew): Slightly. It is OK; we are getting you.

Ms Flynn: OK. One of the most worrying things in your presentation is the fact that the trusts are starting to struggle with repeat testing, due to possible resourcing issues, and that might cause a delay in residents being tested and identifying residents or staff who are positive. If testing is not being done, there could be asymptomatic, COVID-positive people spreading the virus around a care home. If that is the case, it is a worrying development. Local discrepancies between pillar 1 and pillar 2 testing models have been raised with me, Pauline. We have had some difficulties that I have raised with the PHA, not only around the time but around discrepancies between someone testing negative on one model and then testing positive on another. I am happy to share that correspondence with you outside of today's meeting, Pauline.

Can you describe how the additional funding for care homes was worked out during the first COVID-19 surge? It is not a good sign if it was significantly underutilised. I am conscious of how we can support the care homes if there is going to be further funding to support them. Is there a process in place to help the care homes with the applications? Is the biggest financial pressure PPE, lower admissions coming in from hospitals, or staff sickness? Is there one area of concern for care home finances, or is it a mixture of all of those things? Thank you, Pauline.

Ms Shepherd: Thank you for the offer to share that information, Órlaithí, it would be useful.

We are seeing that trusts are struggling with testing capacity. In the last week or so, there have been problems with a number of lost tests that had to be redone. There are certainly some cracks showing in the capacity.

This time around, although there are positive tests coming back, the feedback is that we are picking up asymptomatic people who are testing positive who would not have been picked up the first time around. I have been pressing the PHA that we need to start sharing that data and information, because when you look at the dashboard you think, "There are 80-odd care homes in outbreak". However, we do not have the lower-level information to actually say, "Well, that is not a direct comparison to 80-odd in the first wave" because of the number of those who are asymptomatic. There is a lot more data that, if shared, would be valuable.

We have struggled with false positives and false negatives, you are right. I do not profess, in any way, to understand why there are false positives and false negatives. I have asked the PHA if they can give guidance from their virologist on why that is, and to try to give guidance or understanding to care homes about false positives and false negatives, but we are still awaiting that. At the minute, if you get

a false positive or a false negative, the safe thing to do is to treat it as positive, so we need to iron out some of those issues.

Another issue that we are having some difficulty with his the actual app. The app is notifying people that they have come into contact with people who supposedly have COVID, but it is not sophisticated enough to identify whether you are a member of the public or whether you are a care worker. It may identify that you have come into contact with somebody, but it is your job to come into contact with somebody. There are nuances within the app in that there are possibly people off at home because they have been notified by the app, but who, strictly speaking, do not need to be because they have had full PPE. That has caused some difficulties, so we have flagged that up as well.

Moving on to your question on funding. There was £6·5 million in the first funding pot. That was split between all of the care homes on a basis of their bed numbers, split into allocations of £20,000, £15,000 and £10,000. There was a second pot of £11·7 million, separated into three discreet areas: support for sick pay; IT and support technology or medical things, such as oximeters, to help with care; and enhanced cleaning.

From the beginning, we have flagged up difficulties around claiming that money. It was very bureaucratic. There were a lot of time restrictions, and that the eligibility was only for a set period. We did not have the flexibility, for example, to say that a care home did not need iPads and the technology to help with visits but did want to create a different access area to the home, which required them to build steps and a handrail to provide that access. That was not eligible. There were various things that could have been more flexible, but, obviously, there needs to be governance and the controls, and the people who are in the trusts have to work within the parameters there are set for them. In his briefing yesterday, the Minister mentioned widening out the eligibility to include possible adaptations to buildings, which are small changes. So, they have taken that on board, and they have also taken on board that the system needs to be streamlined. Therefore, the fact that it was underspent did not at all mean that the money was not needed; it is just that it was impossible to claim all of it because of the system and the red tape that was put around it.

The biggest issue on the staffing and funding is actually around paying for and trying to obtain those resources, be they agency nurses or whatever, and having to pay agencies extremely high fees for filling posts. We have pressed the Department and asked it a few times about capping, or some sort of regulation with regard to agencies to cap those rates, because the amount of money that is going out to agencies to fill positions is astronomical.

Mr Sheehan: Thank you, Pauline. Órlaithí jumped in with the question that I was going to ask you. However, I want to ask you about patients who are discharged from hospital back into a home care setting. Do you have any data on the percentage of domiciliary care workers who may have contracted COVID or are self-isolating because of close contact?

Ms Shepherd: I do not have the data. Although the IHCP is a representative body, we do not have all care homes and home carers as members, so we do not have the complete data across that. The PHA has the data. Our home care providers say that the infection rate for care workers is very low. I know that work is being carried out on a rapid learning and surge plan for the home care and domiciliary care services, and they are looking at that data. We are trying to feed in and trying to encourage them to use Northern Ireland data, rather than the UK-wide source. That is because we believe that Northern Ireland's home care performed considerably better than the broad home care services that they are looking at across the UK, so infection rates have been low for home care workers.

Mr Sheehan: Thank you for that. I just have a quick second one.

The Chairperson (Mr Gildernew): Yes.

Mr Sheehan: We know that, during the first surge, care homes were being pressurised by trusts to take patients who were COVID-positive, and we know that some patients, who are COVID-positive, are still being discharged back into care homes. Has any more pressure been exerted in that regard onto the care homes from the trusts?

Ms Shepherd: A number of members have contacted me about something that happens at weekends. Trusts have been ringing care homes over the last few weekends, and they are under serious pressure to discharge people because of the pressure of COVID within the hospitals. I am

aware that there have also been late-night calls to say, "Look, we really need you to help us", and care homes always feel that they want to help. However, they also have an obligation to keep the current residents safe. I am worried that the pressure will increase on hospitals to discharge more people as the capacity in hospitals reduces. So, that is where we are.

Mr Carroll: Thank you, Pauline. The recommendations out of the inquiry are essential for everybody. I am quite concerned about the system of care and how it is formulated. Obviously, the term "independent care" is used, but it is a bit of a misnomer because the care home sector is heavily reliant on trusts and the Department of Health for staff, funding and whatnot. How safe and sustainable do you think this model is, especially when, in the last few weeks, we have seen Four Seasons Health Care announce the sale of 42 of its homes?

Ms Shepherd: On the first point about the independent sector being heavily reliant on trusts, that has been the case to backfill posts and provide support, but only during the pandemic. I do not know of any country that would expect care homes to continue to operate their normal business-as-usual activity and support whilst extending their capacity to cope with the pandemic. Likewise, the health system would not have been able to cope with the pandemic without stopping various services to redeploy resources. So, I do not see that you can say that care homes are generally heavily reliant on resources from trusts; that has been a pandemic issue rather than an ongoing one.

In terms of various shifts in the market, the IHCP has made a proposal every year to the Health and Social Care Board on the need to review the tariff model, look at the reform of adult social care and carry out an independent economic review of the model of care and the funding to identify whether they are fit for purpose. We still are requesting that, but there is a need to sit down and look at it from the roots up and do that economic and business analysis. So, I agree with you that there is a need to do that.

I have been saying for many years that the system has been underfunded. There has been an increase in pressure due to the complexity of care. I would suggest that it is only because of the pandemic in the last number of months that attention is being given to us and government has been saying, "We accept that complexity of care in care homes is now identified and we need to work to enhance clinical care in those care homes to support that". That needs to be taken forward as well. I am glad that more attention is being given to it, but I am concerned that it has taken a pandemic to identify the complexity of care within a care home environment. The people who are now being cared for in nursing homes would have been cared for in a hospital setting only a short number of years ago.

Mr Carroll: The question that I am trying to emphasise is this: do you or your organisation have an opinion on publicly run care homes along the principles of the NHS? I am concerned that care homes, at least the big ones, are primarily responsible to shareholders. We have seen that, in Canada, the number of deaths in private sector care homes was four times that of public care homes. I am concerned about that model and how it exists. Do you have any opinion on extending the NHS model for care homes in general?

Ms Shepherd: That is not an issue that we, the IHCP board of directors, have been considering or talking about. The model needs to be reviewed. However, if you look at the costs of running a care home in the statutory sector, which we have done through a freedom of information request, and compare them with the costs of running a care home in the private sector, you will see that costs are considerably higher in the statutory sector. There are lots of other factors that need to be considered. However, that independent economic review should take those factors into account. Let us look at care homes that are run by the statutory sector, let us look at the model, let us look at the funding and let us do an economic analysis. That is exactly the type of information that we have been asking for.

The Chairperson (Mr Gildernew): I am just going to check in with Alan. Alan, are you on the line and do you have a question? If so, make sure you take yourself off mute.

Mr Chambers: Can you hear me, Chair?

The Chairperson (Mr Gildernew): We are hearing you loud and clear, Alan.

Mr Chambers: I did have a question, but Pat asked it so it has been answered. Thank you very much. Sorry for coming in late this morning; I was struggling a bit with the new technology, Chair.

The Chairperson (Mr Gildernew): You seem to be doing fine with it at the minute, which is good.

Pauline, thank you for coming in this morning and going through such a comprehensive range of issues. At this stage, we are focused principally on the inquiry into care homes, but we note your comments around home care issues as well, and it is something that the Committee is interested in. Your contribution to our inquiry into care homes is appreciated, and we wish you and the people whom you represent well in the time ahead. We recognise that we are coming into a difficult period. These are unprecedented times, and it will take a massive effort once again. We appreciate that and thank you for your contribution today.

Ms Shepherd: Thank you very much for the opportunity.