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Committee for Health

OFFICIAL REPORT (Hansard)

COVID-19 and its Impact on Care Homes: Regulation and Quality Improvement Authority

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 Emer Hopkins	Regulation and Quality Improvement Authority
Dr Tony Stevens	Regulation and Quality Improvement Authority

The Chairperson (Mr Gildernew): I welcome Dr Tony Stevens, who is interim chief executive of the Regulation and Quality Improvement Authority (RQIA), and Ms Emer Hopkins, the RQIA's interim director of improvement. You are both welcome to the Committee this morning. We appreciate you appearing before us. Go ahead and brief the Committee on the RQIA issues.

Dr Tony Stevens (Regulation and Quality Improvement Authority): First, thank you very much for the invitation and this opportunity. I hope that we can provide some useful information to you as part of your inquiry into care homes. I have a short opening address, which I will go through, and then we will pick up questions.

Everybody is very conscious of the significant challenges that all our people face in managing through the pandemic, particularly those who have suffered loss. The team at RQIA shares many of those challenges and is focused on making a positive contribution to the management of this new and, as is becoming increasingly apparent, distressing disease.

Over the past six months, the RQIA has played its role in the wider health and social care response to the pandemic, but our contribution should not be seen in isolation. We have worked closely with partners in the statutory and non-statutory sectors across health and social care. In May, my colleague Dermot Parsons gave evidence to the Committee describing the RQIA's repurposed role to provide enhanced support to health and social care services during the pandemic. A significant part of that work was to support the care home sector.

In common with the approach across the UK and Ireland, from late March to June, the RQIA was directed to step down its regular inspections programme, which reduced the number of on-the-ground inspections that we conducted, but those did not, in fact, stop.

As part of our new role, we established a service support team. That functions seven days a week. We provide a single point of contact for care homes where our inspectors and other staff, specialist staff in particular, can provide advice, direction and support, and, sometimes, just a listening ear. We did that for care homes and domiciliary care services, and the advice that we gave was in line with departmental and public health advice.

Over the pandemic period, some 200 separate pieces of guidance have been issued to care homes, focusing on PPE, staffing, testing, medicine management, palliative care, visiting and training. On behalf of the Department of Finance, we also played an important role in providing the latest details on personal protective equipment supplies and how these could be sourced.

As a regulator, we place a clear focus on enabling improvement in services. During the pandemic, RQIA's inspectors provided focused professional guidance to support quality care provision. We have a particular focus on infection prevention and control, and we do that in partnership with the trusts, which have brought a significant infection control resource to support care homes.

During the first wave of the pandemic, our inspectors handled about 3,500 contacts with care homes. Over the summer, the number of contacts tailed off, reflecting, I think, the reduced pressure, but we have noticed an increase in calls again. Over the summer, we had moved to a five-day help desk service, but we are returning to a seven-day service and putting increased resources into that support desk. That has been an important aspect of the service that we can provide as part of the integrated health and care service.

I note that there are a number of issues that the Committee seeks to address for the inquiry. I will focus on those that fall, I believe, within the remit of RQIA.

In March, we were all learning about COVID-19 and its impact. Today, we are, effectively, in the second wave of the pandemic, and I can talk with a little more experience about how we apply that learning. As part of our evidence, I have provided the Committee with RQIA's overview report on 'The Impact of COVID-19 on Care Homes in Northern Ireland: February 2020 to July 2020'. Analysing our data, we can identify the common characteristics of homes that have experienced an outbreak of COVID-19. This is important because it helps us both to work with those homes and to identify homes that may be more at risk of an outbreak in the future. We can provide additional support to them or help to direct trust support to them.

Homes that had outbreaks in the first wave tended to be from the larger provider groups and to be larger homes. That is not really surprising. The more people you have, the more likely you are to have an outbreak. They tended to have experienced recent leadership change, particularly at manager level. They were more likely to serve areas of deprivation, which is, I think, a really important issue. This disease does not evenly affect our population. Those affected were twice as likely to be nursing homes as residential homes, which is another important point, and they were more likely to have been identified as having challenges in meeting care standards. Therefore, we were more likely to be in these homes, supporting them and, potentially, taking enforcement action against them. We can apply that important learning in the second phase.

During the summer, we engaged with service providers, seeking their views on the support and guidance that RQIA provided during the first wave. Daily status reports are submitted to RQIA from care homes: initially, that was done from an app; now it is done from a web portal. Ours is a risk-based approach to inspection, which I will talk a little more about in a second. Feedback on those issues was generally and almost overwhelmingly positive. Generally, we feel that the support that we provided has been well received.

We have access to a wealth of information about every care home in Northern Ireland. This includes our inspectors' knowledge of the service. It is important to emphasise that our inspectors work at a local level and rely on local knowledge. We get daily status updates, statutory notifications, intelligence through notifications from other services, contact from concerned families, whistle-blowers and, indeed, trust staff, from whom we have had considerable contact.

In planning our work, we are refining a risk-based assurance framework. That is the other thing that I want to emphasise to the Committee. We are moving away from a traditional, on-the-ground

inspection process, which is what we see in Ireland and the other United Kingdom jurisdictions. We are now better able to direct our resources to areas of highest risk. This may involve support and advice, or it may require specific interventions, such as a comprehensive on-site inspection, a short, focused on-site inspection, a remote inspection involving staff and service user interviews, contact by phone or video link, manager self-assessment submission or materials of self-declaration, or meetings with the provider or with the trusts.

One of the important things that we have learned is that remote inspection, which seems attractive because it reduces footfall, increases the administrative burden on nursing homes. We are trying very hard to strike a balance between avoiding putting too much pressure on nursing homes and, at the same time, making absolutely certain that we know what is going on and can provide the necessary support. We see providing support as much more important than enforcement at the moment. If we have to move to enforcement, all the other actions that the trusts, the Public Health Agency (PHA) and the RQIA are taking have not worked.

The interventions that we have made allow us to require and support change and improvement. That blended approach may represent the future of regulation in a post-COVID world. It is difficult for anybody to say that there may be an upside to COVID. However, like most of the health service, we are testing new thinking and new ideas. We may well be coming back to the Department of Health, and, indeed, to the Health Committee, to describe how we might do things differently in future, when time and the virus allow us.

As I said earlier, and as Dermot Parsons detailed, we significantly curtailed our inspections in the first part of the year. However, from April to September, we undertook 185 on-the-ground inspections. The majority of those took place from July onwards, so we did not waste the summer; we got out and about. We have also undertaken 22 remote inspections and a small number of inspections using a combined approach. Almost half of those inspections have been in response to concerns raised, intelligence received or issues identified in previous inspections. Our assurance framework — our risk-based approach to where we target our efforts — is paying dividends.

Twenty people in our care homes team contribute to the process of inspection of over 480 nursing and residential homes. There is a significant pressure on that team, and we are supplementing the number working in it, reflecting where the pressures and priorities are. We are, however, keeping a similar focus on supported living and domiciliary care services. Since April, we have taken formal enforcement action in relation to eight care homes where we identified significant concerns.

On behalf of the Department of Health, the PHA, the Health and Social Care Board (HSCB) and the trusts, we coordinate the collection of daily status reports from care homes, which helps to inform regional responses to issues in the sector and allows the daily dashboard to be produced. We have a key role in pulling together all the information and intelligence that the entire system and, indeed, the Health Committee, will use. We are, again, providing information to the silver command in a daily situation report.

The issues around personal protective equipment supplies and testing arrangements have largely been resolved or addressed. There are continuing issues and questions but they are not the major issues of the day. Staffing remains an issue. Visiting is clearly a concern for the public and the Department, and we are bringing a focus to both of those issues as we go forward. I am conscious that, today, 80 care homes are dealing with COVID-19 outbreaks or flu-like illness. It feels slightly different from the last time, and, possibly, the questioning may look into that. We will continue to work with the whole system, and as part of the whole system, to support homes and to prevent, where possible, further outbreaks.

The Chairperson (Mr Gildernew): Thank you, Dr Stevens. The repurposing of RQIA in the first surge was a significant issue. What have you learned from that first period? What did you do well? In that period, what may not have worked? What failed? Are you taking a different approach to inspections in this phase of COVID-19?

Dr Stevens: The issues are different. For example, the focus on PPE and on supplies generally is not the same. When it comes to funding, the Executive and the Minister have made significant investments in the sector, so those things have changed. Testing is bringing up a different set of challenges from the first time. The first time was about getting testing in place. Now, testing brings up a different set of challenges, with, for example, the number of staff who are sidelined. Yes, we have learned from what we have done and are changing our approach.

I think that the repurposing of RQIA at the beginning of the pandemic was the right thing to do. In all conscience, we could not allow our inspectors to continue their on-the-ground inspections and follow their normal routine while ignoring the outbreak. We had to put significant resource into our support team, which took away from our inspection process. This time around, we do not have to put the same resource in. That is partly because we have learned a lot of lessons, partly because the questions that we are being asked are different and partly because the trusts are putting in a huge amount of support. Also, our inspectors on the ground are working at a local level. Rather than centralising everything in a central support team, we know the important issues. The inspectors are working locally with the homes that they are familiar with and still providing support, be it through telephone calls or the inspection process.

We also learned that doing everything remotely increases the burden and does not necessarily fix the problem. Getting out on the ground allows us to provide practical and real support. It enables us to deal with issues that are being brought to our attention, nip things in the bud earlier and get a real sense of what is going on. It does not mean that we can fix all the problems — RQIA does not have the resource to fix all the problems.

The initial response, the repurposing, was the right thing to do. We learned from it, and, rightly, after discussion with the Department, we are not pulling back as far as we did the first time. We are providing more of an on-the-ground resource, but it is still focused on support and trying to encourage, improve and enable homes to do the right thing. We are still trying very hard to do everything that we can, along with the trusts, to avoid the need for enforcement, because enforcement takes huge energy. It distracts us, and it distracts the homes.

We learned, and we are working slightly differently. I hope that that answers your question.

The Chairperson (Mr Gildernew): Thank you. While we acknowledge that very many families are extremely happy with the care that their relatives have received in homes, we have taken evidence from families in recent times. It was very emotional evidence that was, at times, very distressing, and we are very conscious of the need to balance the protection of homes with the right of people, under article 8, to enjoy family life. What role does RQIA play in monitoring the implementation of the guidance? We have heard of a postcode lottery and families experiencing difficulties when challenging home managers. What role does RQIA play in ensuring access, via multidisciplinary professionals, to the visiting guidance and the introduction of care partners etc?

Dr Stevens: I will look to Emer to fill in a little of the detail on that. The Department has issued visiting guidance, and it is our role to ensure that that guidance is implemented effectively. We are very much taking a quality-based approach to it.

Visiting is very challenging. We have found that many relatives and families want more access, but some are very anxious about access. It is about balancing those different views. Some homes, for a variety of reasons, are better able to offer visiting in a safe way. Those reasons include the layout of homes, whether they have an outbreak and whether they are adequately staffed at a point in time.

I declare an interest. I have an elderly relative in a home, and I have been frustrated by the relative inability to visit. First and foremost, we do not want to cause harm, but I am equally conscious that we want to provide support. I, and others in RQIA, feel that it is not the frequency of visiting but the quality of visiting that is important. In the summer, we were able to have garden visits and window visits, but they are not practical now. Can homes put in a pod for visits? Can they have a segregated area where they can do things differently? Is the home laid out for that? Can they use the increased investment from the Department and the Executive to put in pods? Are they making best use of IT — iPads and suchlike? Are people looking at other initiatives that are going on? That is important. They could use the community and voluntary sector to work with families to produce memory boxes, for example, that families could bring in to help with more positive interaction.

I will hand over to Emer to talk about this, because she has a focus on the area. RQIA is doing a piece of work on best practice in care homes, because our inspectors can identify where there is good practice and see whether we can encourage a spread of that, rather than trying to enforce something. It is a very difficult area in which to try to enforce.

Ms Emer Hopkins (Regulation and Quality Improvement Authority): RQIA inspectors have a relationship with the homes, and there is potential for interaction with residents and families on the quality of visiting. Inspectors can take the guidance and policy position and work with providers to

make that work in practice as best they can. As they visit multiple establishments, they can identify best practice and share that between providers.

I met Pauline Shepherd from IHCP and Vivian McConvey, who is from the Patient and Client Council, to hear the different perspectives from care home providers and families on how visiting guidance is being implemented in practice. We can work through practical solutions and share that. That is one area in which RQIA can make a positive contribution. We see the in-practice piece, and the quality of it, and RQIA has the opportunity to influence the applying of that policy. Our inspectors make themselves experts in every piece of guidance as it is developed.

The Chairperson (Mr Gildernew): We will go to members' questions, starting with those on the phone. We will have Colin, Órlaithí and Paula, and then come back to the room.

Mr McGrath: I have a quick question, Chair. I was pleased to hear Tony detailing what was almost a demographic of the homes that were impacted last time. Is that information being used to profile homes that are at potential risk? Will special measures come in on the back of that information? You said that homes most affected in the first wave were more likely to have had a change in leadership, be in an area of deprivation and twice as likely to have been a nursing home than a residential home. You said that those factors were causing challenges. Is profiling being done to target your work so that you are able to respond and try to prevent further outbreaks during the second wave?

Dr Stevens: Again, I will hand over to Emer, because she is leading on this piece of work. The short answer is yes, absolutely. That is the great value of the intelligence that we are gathering. We are targeting our resources. We have used the intelligence from the first wave to focus on homes that, we think, are most at risk of an outbreak. That is paying dividends. We are not doing it alone; we are doing it with the trusts, which have used their infection control teams and managing support teams.

Ms Hopkins: We identified six or seven characteristics by diving in detail into the data that we hold in our internal databases. The homes affected were the larger homes; those run by larger providers; homes with two or more changes of manager; homes that identified as having more than 40 registered places; older homes that had registered 10 years ago — one imagines that the infrastructure and state of those homes can be more challenging — and homes with previously identified infection prevention and control (IPC) areas for improvement. In developing the profile of a home that might be more likely to experience an outbreak, we were able to target those homes with specific offers of more detailed preparedness support by our expert inspectors. That was one thing. The second thing was that, as we ramped up our programme of on-the-ground inspections, we were able to visit those homes first and bring them to the forefront of our programme so that, in the gap between the two surges, they had an opportunity to have improvement work done as part of that inspection. We found in the first big batch of inspections during June and July that those homes were sometimes more likely to have failure-to-comply notices applied. That was a good test of our model, as it meant that it was proving to be reliable and was reliably identifying risk.

We have also shared the data with trust providers and the Department of Health. We presented it to the directors of the trusts so that it could inform how plans would be targeted for the second-surge response in the regional surge plan. Where we do pieces of work to dive deeply into the information that we hold, it is very much about sharing it and making sure that we use it collaboratively across the system and not only to target RQIA's programme of work.

Mr McGrath: That certainly sounds proactive, very responsive and strategic. It is a vast improvement on the updates that we got earlier in the year. I thank Tony and Emer for that.

Ms Bradshaw: Thank you for your presentation today. I want to make a comment before I ask my question. I will put on record how disappointing it was to find out after the previous RQIA presentation to the Health Committee that the RQIA board resigned because it was unhappy with the suspension of the inspections. It undermined, in some ways, the evidence that was given. You have been more candid and open this morning, which I appreciate, but I would like you to note that that dented confidence.

My question is about the guidance. A particular area that I am looking into is the care partners. In many ways, I appreciate that your inspectors are gathering a lot of evidence and an understanding of how the sector works. Are you working with the Department now to put out a regional framework for care partners so that the guidance can be rolled out? I know that a lot of the relatives of the residents are very keen to see that operational.

Dr Stevens: I will start and will then maybe look to Emer. Working with the care partners is a very important initiative, but the early intelligence that we are getting is that it is a little bit of a challenge for the care homes; it is throwing up issues like liability insurance and the use of personal protective equipment. I am aware that Pauline Shepherd gave evidence this morning, and we are working with Pauline and others to work out the practical issues at the moment about how we advise. The Department has issued the guidance, and we are working out, effectively, how to implement it practically and support it. We see it as a vital part of the overall initiative. We will work to support, rather than enforce, its implementation at the moment; I think that we are still very much at the sensitive stage of working out how best to make it happen. Emer, do you have any comment?

Ms Hopkins: In reality, Paula, we have had a limited involvement in the development of that framework, although we are very aware of it and are very keen for as much detail as possible to be provided, because that makes the job of the inspectors in supporting the homes to implement it much clearer. We await further clarity on what the framework will look like, but, in the meantime, the principles of the care partners of involving families, of protecting well-being and access to the communities under article 8 for residents is something that we can still actively work on while the framework is being developed. RQIA is involved in regional planning groups at the Department. It will attend a meeting this afternoon where this will be one of the issues that are discussed. We very much welcome the development of that framework and of further clarity on its implementation.

Ms Bradshaw: I have just a quick follow-up on the common features that you said were in those care homes that had outbreaks and unfortunate deaths, and you mentioned how you analysed those. How much is that feeding into the Department of Health and the Health and Social Care Board for future contracts and commissioning services? We do not necessarily want to penalise those care homes that try to sort out the issues, but if there are perennial and perpetual issues in certain care homes, in what way are your inspectors' reports and observations feeding into future contracts?

Ms Hopkins: The contracting of care from care homes is, in the main, a responsibility for trusts, although the RQIA has regular liaison with the trusts. Where we have particular issues with or concern about the quality of care across any provider groups, that information is shared transparently with the public as well as with the trusts.

My answer is that the contracting and commissioning of the care is more a matter more for the trusts than the Health and Social Care Board.

Dr Stevens: Equally, it should be remembered that registration issues lie with us. When we are dealing with groups of homes, we will consider that as part of the registration process. In the post-COVID world, assuming that we reach that happy state, the information that we are gathering now and the way that we are working now will inform a different approach to driving quality in care.

You are asking an important question for us, which is this: what will regulation look like in the future? What would modern 21st century regulation look like if the purpose was to truly drive up quality rather than to enforce basic standards? If we changed our approach to regulation, it would provide that intelligence network and that basis upon which trusts could do smarter commissioning, as could the Department and the board.

You are touching on a really important issue for us.

Ms Flynn: Thank you, Tony and Emer. My first question is about the different approach to inspections, where you identify homes that are at high risk. How many homes fall into that high-risk model?

The Committee had a session with union representatives earlier this week. Their feedback was that the support from the RQIA in the first wave was really good but that they had concerns that the same level of support and contact are not there at present. How can you reassure them that the same level of support will be provided coming into the winter?

I am conscious that your briefing paper states that your support service was reduced to five days over the summer but that it is going to step up to seven-day support. Are there other practical measures or proactive steps outside that support service team that you can put in place to reassure staff in the homes that the support is there?

Dr Stevens: I will pick up the second question first, because it is probably the easier one. We have had the feedback that you have had that the support service was valued and useful. We reasonably

and necessarily reduced it during the summer. The message is, "Please, can we have it back?". That is the message that we have had from Pauline Shepherd.

I have a weekly meeting with Pauline to go through her issues. This week, we have taken the steps to go back to seven-day-working shift resource. We are stealing resources from a number of places to try to make sure that we do not diminish our inspection team to quite the extent that we did the last time. It is a bit of a balancing act for us. We want the support desk to be available, providing that advice and that friendly ear. We feel that its role is now part-mentoring. It is not merely about providing advice; it is almost a mentoring role, and we encourage our team on the support desk to see it as a mentoring role. If the inspectors are out on the ground, we will also reinforce with them that they should take that same mentoring and supportive approach.

In a previous life, I was involved in setting up the arrangements for psychological support for healthcare workers. We made sure that that covered the independent sector as well. In preparation for coming today, I checked with colleagues in trusts that have put up their support helplines for staff, and I have been reassured that those helplines are still there and available for independent sector and non-statutory staff. We are working very hard not only at the practical support but at the emotional support. I assure you that, as far as we can shift resources to support that, we will.

Going back to your first question about high-risk homes, I should say that all homes are at risk. It would probably be wrong for us to identify and give you a shortlist of high-risk homes. I mentioned that we have taken enforcement action against eight homes. They are an obvious eight that will be at higher risk, and they are getting a lot of our attention, but we need to see it as a gradation of risk. Some are at higher risk than high-risk. Our job is to get that risk down. I will resist the temptation to give you a list of high-risk homes other than to say that the information is entirely open about which ones have enforcement action against them. Emer, do you want to add anything to that?

Ms Hopkins: We do not categorise it in a binary way as high-risk and low-risk. It is a dynamic thing, because the enforcement action and the status of the homes are constantly changing, so the level of risk in the system is changing all the time. However, I have been reassured by my inspection teams that, of the 180 or so inspections that we have done in the first months since the pandemic started, they have now covered those that they deem to be in the highest-risk categories and that they are moving now into scheduled inspections in the low- to medium-risk category. However, as risk changes constantly, any home can become a higher risk at any point in time.

Mr Easton: Thank you for your presentation. We have heard concerns that, despite guidance to the contrary, some homes are refusing access to social workers, OTs and podiatrists. First, what can you do to address that? Secondly, how does the RQIA engage with families when conducting inspections? Finally, how are families informed of the outcomes?

Ms Hopkins: I will take the family question first, if I may. We are absolutely fully committed to trying to strengthen how families and, indeed, residents can input to our inspection and have their views and experiences reflected in our assurance and reports. One of our points of learning that we did not cover in the Chair's opening question was about the fact that our move to support and our reduced number of inspections gave us a concern that the strength of that resident voice and family voice was somewhat diminished. Indeed, we took the opportunity during several interviews to call out to the public to keep making contact with the RQIA if they had any concerns about care.

During the inspection process, inspectors will engage with residents and ask them questions about their lived experiences of living in their homes. We will also engage with other partners. We will engage regularly with the Patient and Client Council (PCC) and will be forwarded any intelligence that it has. We see a great opportunity in this area for RQIA, so we are setting up a number of projects in order to strengthen the role of our lay inspectors. We are also looking to capitalise on the intelligence that is gained through initiatives such as the 10,000 Voices and the Care Opinion initiatives that are being run through the Department. There is so much information that an inspector is required to gather during a single inspection, and our view is that relying on that alone is not sufficient to accurately represent the lived experience, so we will undertake a number of projects in order to fully capitalise on and exploit all the intelligence that is available to us to give a reflection of what it is like for a person living in a home.

Dr Stevens: We are focusing in particular at the moment on visiting and on seeing whether we can really test innovative ideas and good practice. With visiting, we are never going to meet the demands

of some families. There is always going to be a challenge. Working with families and care homes to try to address that particular issue by spreading good practice will be a real focus for us.

Mr Easton: Can I ask a quickie about your inspections? We heard during the previous presentation that some care homes are not able to meet the required staffing numbers because of COVID and that trusts are not able to help out because they are having the same problem. Will nursing homes get penalised if that problem arises?

Ms Hopkins: We are looking to see that nursing homes are managing the problems to the best of their ability and are taking every possible practical step that they can to safeguard residents in the home. If, at times, that requires interventions from RQIA, working together with trusts, to help to make sure that resource is targeted where it is needed, we will do that. It is not always possible, so they will not be penalised if we believe that they are acting responsibly and balancing risks to the best of their ability.

Mr Easton: OK. Thank you.

Mr Sheehan: Thanks to both of you for coming in. You have, rightly, been able to identify the care homes that have been problematic during the pandemic. The reason why you were able to do that is because they were problematic before the pandemic, and unless there are major changes, they will continue to be problematic after the pandemic. You, rightly, point out that the problematic ones are usually from the larger provider groups and are the homes where there have been frequent or recent changes in leadership and so on. We know that from our engagement with RQIA and stakeholder groups and from our observations. We know that the care homes that fall into those categories are those where there will be serious problems with infection control, negligence of residents and abuse of residents and so on.

I want to go back to your point, Tony, about what quality improvement will look like in the time ahead and about how we change the system whereby the RQIA goes in and gives an enforcement notice, the provider ups its game to reach minimum standards and then trundles along the bottom for a period of time until it again falls below the required standard, at which time the RQIA comes back in again and issues a new enforcement notice, and we go on in the same cycle.

No one really expected the pandemic. We thought that epidemics and viruses of this nature were confined to Asia and would not hit us. Now we know that the world is a different place. The weak link in our care provision is care homes, particularly the ones that are not cutting the mustard. I am asking you to outline how, in the time ahead, we will change that. If another pandemic arises, we cannot allow the same system to continue. We have had some evidence from places such as Hong Kong where there have been zero deaths in care homes. I am not suggesting for a second that the situation is the same. However, the care homes there have properly trained infection controllers who regularly throughout the year have infection simulations and drills so that infection control becomes second nature to everyone in the homes. Even in the context of the current pandemic, there are measures that can be taken, but I am more interested in the future and the role that the RQIA has in all that.

Dr Stevens: Pat, you raised a lot of big issues there. It is difficult to know how well or badly we are doing, but there are some reasons for us to be reasonably optimistic about the quality of care that we are providing through the pandemic. We can look at deaths in care homes or, more particularly, excess deaths in care homes. I know that that is an ugly expression, and the public will probably feel that it is an inelegant expression. It is difficult to compare excess deaths with those in Ireland, but, compared with the UK jurisdictions, Northern Ireland has probably done better than anywhere else. That suggests that our collective approach to supporting people in care homes has been reasonably successful. We have everything from having a Health Committee at a local level that is taking an interest in it, to having a Department of Health that is focused on it, to having the trusts and the RQIA working together with the PHA in order to provide advice and significant support on infection control.

My first answer to you is this: I cannot comment on Hong Kong. If they have managed to have no deaths from COVID in care homes, they have done something amazing, and I must go and find out about it. There is something about what we are collectively doing that has probably protected our elderly people in care homes at least as well as, if not better than, other places on these islands. What is it that we are doing, and how do we capture that going forward? I think that that is a big part of your question, and it is about the blended approach that we are taking, which is that RQIA moves away from simple enforcement. It never was just about enforcement, in fairness, but the "I" for the "improvement" piece in RQIA becomes prominent. We are working collectively with all parts of the

system in order to drive improvement and are seeing how we can support the independent sector on an ongoing basis and how that becomes almost a contractual part of what we are doing.

I think that there is something about working in a different way, but it is not just us; it will be the way that the trusts contract and about the services that they support. It will be about primary care and some of the fantastic initiatives, like acute care at home, that were going on before COVID and that are paying dividends now. It will be about anticipatory care initiatives in the Northern Trust area. All those need to be scaled up.

There is a big issue —I think that I have to put this back to you collectively, as our representatives — to decide how we want to fund and contract for the care of the elderly and what proportion of our spend goes on that. That is way beyond my pay grade, so I will park it. There is that wider strategic policy issue to consider, and then, for us, it is about how we can work in a more collegiate way. It is not about setting a contract and leaving the home to get on with delivering the contract; it is about being on a continuum and working collectively as a multidisciplinary team in order to provide support wherever the person is living. I do not know whether that answered your question, but it is my best attempt.

Mr Sheehan: It does not really answer the question, but a much longer discussion is required than the one that we will have here this morning.

I will make one final comment. There is a lack of ambition when our benchmarking is done across these islands. If we are going to benchmark against how Boris Johnson has dealt with the pandemic, we are aiming very low. If we are going to benchmark, we need to use international best practice. Which countries have done best? South Korea, Vietnam, Hong Kong, Taiwan and so on. We should learn from them. They had experience with other epidemics, such as MERS, SARS, avian flu and others. They were prepared for what came this time: that is the point. Let us learn from them and what they have done, rather than benchmarking just across these islands. It is no great encouragement to anybody that we are doing better than England. That is a comment; I am not asking for a response.

Mr Carroll: Just on that point from Pat, we have 336 excess deaths in care homes. That could not be described as a good result or as in any sense positive. As Pat indicated, compared with the Tories in Britain, anything looks good. The people who were failed before COVID-19 were the ones failed during it, and the figures are testament to that.

There was a bit of back and forth between Colin McGrath and a previous representative of RQIA in one of the previous sessions about whether inspections were stepped down, or how it should be described. However, to all intents and purposes, inspections effectively stopped for the first 40 days of the outbreak. More inspections, done in a way that was safe for staff, would have been a better approach. Since you took up your position, Tony, how many on-site inspections have been carried out? We have been told about phone calls in previous correspondence with RQIA, but families are asking me how many on-site inspections have happened since you took up your position.

Dr Stevens: Gerry, thank you. My mind has gone blank, but Emer will rescue me with the numbers.

Ms Hopkins: I think that the number of on-the-ground inspections is 185; it is in the statement. There were also 22 remote inspections and a small number of blended inspections. We recognise some of what you say, in that we are now very focused on the necessity to balance the need for support, which, you heard this morning, is very great, and the need for the public to be assured about the quality of care. We seek to strike that balance. However, 185 is not an insignificant number of inspections to have carried out at a time when our workforce experienced the same challenges being faced across the system.

We retain the position that we did not stop inspections, Gerry, if you do not mind, although the number was reduced. However, I accept that the number was small. The reduction in inspections enabled us to provide welcome and needed support and guidance to the system. That may have contributed, in some way, to how well some of the homes were able to manage in that early stage of the pandemic.

Mr Carroll: Thanks for that. Just one quick question for clarification. Is that 185 separate, on-site inspections?

I want to tease out what Paula said. What does the RQIA plan to do as regards sanctions or punishment, or any other term you want to use, for care homes that repeatedly breach infection

control plans? There are repeated complaints about them. It seems to have been a bit of a merry-go-round before COVID-19, where care homes were complained about but still got contracts and funding. It seems to me that no lessons have been learned and the cycle will not be broken. What does the RQIA recommend with regard to sanctions or punishment?

Dr Stevens: We should avoid the word "punishment": we enforce regulation. The most severe form of enforcement would be to remove registration. As I have said, there are eight homes at the moment where we are in an enforcement stage. Our focus is still on highlighting the issues to homes and getting them to fix problems themselves. The ultimate punishment is to close, or deregister, a home. That does not necessarily solve the problems; it creates massive disruption for very frail people who will not necessarily do well if they have to move. Everything that we, the trusts, the board and the agency do should be geared to trying to avoid getting into that situation. That is the first point that I would make. That is really where we are with that, Gerry.

Picking up on the other point, there was a good reason for stepping down our inspections at the beginning of the pandemic. There was real anxiety that our putting inspectors in would mean more strangers entering homes at a time when there were issues with PPE and we did not know how the disease was being transmitted. It was not just about stopping them for no other reason than we were diverting resources. It was about trying to avoid possibly making the situation worse. We learned rapidly that the risk from our staff going into homes was minimal, particularly if they wore all the proper personal protective equipment. The scientific advice that we have now is that they do not present a risk if they wear that. Hence, we are going back into homes with great confidence, and the homes are much more comfortable with us coming in.

We are all learning. Do not assume that every decision that we made was for negative reasons; we were trying our best. An old adage in medicine is that, if you do nothing else, do no harm. We were trying hard to follow that advice.

Mr Chambers: My recollection is that there was a number of deaths in care homes in Hong Kong, but their big success was that no staff members contracted COVID-19 in them. All the countries that are doing well have learned from previous epidemics and invested heavily in their health services. They are now reaping the rewards of that investment.

Dr Stevens, do you have a sense that care homes were in a good place in their preparedness for reactive infection control prior to the pandemic, with particular attention to staff training and logistics?

The Chairperson (Mr Gildernew): For information, I think that the figures that we heard during the evidence session about Hong Kong were that they had 30 to 40 deaths out of a population of 7·5 million. It was significant and bears some examination. Go ahead with your answer to Alan's question, please.

Dr Stevens: I will start but will again look to Emer, who has much more expertise on that than I do. There are two aspects to it. Good infection control is not something that we had to put in place for the pandemic; we have always had good infection control in hospitals and all other care settings. We are well aware that we get the winter vomiting bug and flu every year, and trying to prevent the winter vomiting bug requires good infection control practice. The RQIA, together with the trusts, would have worked with care homes in the past to make sure that there was good infection control practice for a whole range of diseases and infections that can get into care homes. Therefore, to the extent that it was something that we were already dealing with, there was preparedness. We can explore whether that was adequate.

As for preparedness for the pandemic, clearly Western society was not ready for it. The fact that, internationally, we were scrabbling about looking for sufficient supplies of personal protective equipment — and the right type of personal protective equipment — indicates that. The other thing that we need to bear in mind is that dusting off our epidemic flu plans, which we do every year, was not sufficient. I have been around long enough and was chief medical director in 2007 when we had the swine flu. I recall all the work that went in to preparing for that, and it came to nothing. A couple of other scares came to nothing as well.

Over the past 10 years, a huge amount of work has been done on preparing for pandemic flu and the seasonal flu, on planning flu vaccines and dealing with the winter vomiting bug and trying to prevent that and keep it out of hospitals and homes. A huge amount of work has gone on. Is it enough? Probably not. Will we learn from it in future? I very much hope so. Are we providing a vast amount of

support? Yes, we are. However, I take you back to initiatives such as the award-winning responsive education and collaborative health (REaCH) model that was being rolled in Northern Ireland pre-COVID-19, where dedicated trust teams went into nursing homes to skill up the staff in a whole range of issues, not just infection control. That has been scaled up. The work going on with acute care at home was a scaling up of the support that was going not just into nursing and residential care but into people's personal homes. An awful lot was going on, but the scale and scope of the coronavirus pandemic has probably tested us beyond what we were expecting.

Emer, do you want to add anything to that?

Ms Hopkins: It is difficult, Alan, to say whether we were prepared enough. The fact that we had over 3,500 contacts with the services suggests that we worked together to get prepared very quickly in the early stages. The more important question for us is whether we did the best we could with what we knew at the time. Did we respond quickly? In my view, RQIA responded very quickly, adapted how it worked, and worked with the system and providers in a very new way. That was a positive thing. This surge feels like a very different set of challenges. More adaption and change will be needed, and we will continue to evolve and incorporate that learning. That is the best answer that I can give.

Mr Chambers: Thank you.

The Chairperson (Mr Gildernew): Thank you. I mentioned earlier that we met families, and they have expressed very clearly that they continue to feel that their voice is not heard or involved in a very central way. I want to run through some of the things that were raised because it is important that the families' voices are part of this conversation.

Some of the issues raised were the lack of family involvement in high-level decision-making, such as the rapid learning initiative, and a desire to see families represented on boards. I think that the appointment of the new RQIA board following what happened with the resignation of the previous board was a missed opportunity, to a degree. I will come back to that in a minute.

The families said that no one advocates for families when care homes do not follow the guidance. There is frustration about the lack of information and communication from care homes. There is a general feeling that complaints are often not taken seriously, and a general feeling that care homes are sometimes are not being held accountable and relatives feel helpless to challenge.

What recourse is available to families to challenge care homes on the application of the guidance?

Dr Stevens: Families can raise issues with us, make formal complaints, make complaints to the trusts, and they can use their public representatives. Long experience has taught me that families have a number of routes in, through their representatives. Families can do that, but it is a question of whether they feel empowered to. The routes to raise and escalate issues are there. However, the issue is whether they feel empowered to act and whether they know how to. I suppose that that is a question not just for RQIA but for the Patient and Client Council and for trusts as well.

We have genuinely taken that on board, Chair. There is a danger that I could sit here and give you a spiel. I hear what you are saying; we are very sensitive to the need to find creative ways of knowing how families feel. As I said at the beginning — I did not say it with any lack of sincerity — I am a member of one of those families. I have the advantage of knowing how the system works, and I still find it frustrating. We are all in the same boat here; we all have elderly relatives. All I can say is that I hear what you are saying. We are actively, almost daily, in RQIA thinking about how we can reach out and think creatively about that. Working with the Patient and Client Council provided us with one of the obvious early opportunities, using lay assessors.

Things will be easier in a post-COVID-19 era because we will be able to use lay assessors to engage with families in a more meaningful way. One of the problems at the moment is that it is very hard to engage with people. I cannot sit down and have a chat with people; we cannot do the things that we used to do. All I can give you is an absolute assurance that RQIA has heard this directly itself and that it is very focused on meaningful engagement and on finding creative ways during the pandemic to do that.

The Chairperson (Mr Gildernew): We heard evidence from Pauline Shepherd earlier. Emer, you said that there is a different set of challenges. In the earlier session, Pauline flagged up that there may be issues where, because of that different set of challenges, a trust may not be able to provide the same

support this time round. We are all very conscious that there has been a doubling of care home cases over a very short period. Those settings are, once again, looking very vulnerable.

My question goes back to the unresolved, or not yet fully understood, events that led to the unprecedented resignation of the entire board. Do you feel that you have the independence and the rigour to hold the Department, the trusts, the HSC and the PHA, and whoever else is involved, to account to ensure that they provide support to the care home sector and that we do more to protect it?

Dr Stevens: I would be careful about the phrase "holding to account"; I am not sure that it is our job to hold people to account. It is our job to gather information and provide it as widely as possible, to inspect, to regulate, to support people to improve and, where necessary, to enforce change and improvement where we cannot get it voluntarily and quickly.

I certainly feel no constraints on my independence as the interim chief executive of RQIA. We have a very small interim board at the moment, and I do not think that our chair feels any constraints on her independence either. Like everyone else, we are feeling our way into how we do our job best. I hope that, today, we have given you some evidence that we are being flexible and creative. Emer answered a question about staffing: Alex's worry about whether we would come down hard on employers who were struggling to staff their homes. Our answer to that is no; we are looking for people to make honest endeavour, and we will support them in that.

RQIA is functioning properly as an independent regulator. We are working closely with the other regulators in these islands, in Ireland and in the rest of the UK. We have a close affiliation with Scotland and Ireland because of size and the similarity of approach, and we are learning from international practice. Our job, ultimately, is to take the guidance and regulation that comes from the Department and from our Executive and ensure that it is implemented. We are doing that as best we can in these strange circumstances, but we are being flexible.

One of the expressions that I have used internally is that we have hard power and soft power. Our hard power is the ability to regulate. We can take people's livelihoods away from them — we can close a home — but that is not useful at the moment. We have to maximise the use of our soft power, and that comes from having credibility, being trusted, having expertise that people value, and being flexible and responsive to what people need. I hope that we have demonstrated today that we are doing that.

The Chairperson (Mr Gildernew): I have a final comment. I was struck by what you said about seeking to find how you can drive up quality. We support that drive. I take you at your word when you say that you are trying to enable family voices to be heard as one of the key components of driving up quality is listening to family voices in a meaningful way.

There is another leg to it. As part of the inquiry, we have heard from trade union representatives. That is the other part of cracking the nut. There has been quite a bit of engagement with the care home sector, but there has not been the same level of engagement with staff representatives, via their unions. That is another important piece of the jigsaw of driving up quality.

I thank you for coming today and for answering members' questions. I wish you and your staff all the best in the challenging and difficult times that we are in, and which we will face over the next period. Good luck.

Ms Hopkins: Thank you.

Dr Stevens: Thank you. We wish you well too.