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Note Verbale No. 232

The Permanent Mission of the United Kingdom of Great Britain and Northern Ireland presents its compliments to the Office of the United Nations High Commissioner for Human Rights and has the honour to submit the response to communication AL GBR 5/2020, further to the letter dated 9 June 2020 from the Special Rapporteur on the rights of persons with disabilities; Special Rapporteur on extrajudicial, summary or arbitrary executions; Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context; and Independent Expert on the enjoyment of all human rights by older persons.

The Permanent Mission of the United Kingdom of Great Britain and Northern Ireland avails itself of this opportunity to renew to the Office of the United Nations High Commissioner for Human Rights the assurances of its highest consideration.



Geneva, 11 August 2020

Special Procedures Branch
Office of the United Nations High Commissioner for Human Rights

**REPLY BY UK GOVERNMENT AND DEVOLVED ADMINISTRATIONS TO JOINT
COMMUNICATION OF 9 JUNE REGARDING COVID-19 DEATHS IN CARE HOMES**

Catalina Devandas-Aguilar

Special Rapporteur on the rights of persons with disabilities

Agnes Callamard

Special Rapporteur on extrajudicial, summary or arbitrary executions

Dainius Puras

Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Balakrishnan Rajagopal

Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context

Claudia Mahler

Independent Expert on the enjoyment of all human rights by older persons

Dear Ms Devandas-Aguilar, Dr Callamard, Mr Puras, Mr Rajagopal, and Ms Mahler

Thank you for your letter dated 9 June 2020, regarding concerns about deaths of persons with disabilities and older persons in adult care homes and other residential institutions during the current COVID-19 pandemic. Our observations on the points raised in your letter are provided in the attached annex.

COVID-19 continues to present an unprecedented challenge for social care. Since this pandemic began, we have been making use of all available resources to help support the social care sector and social care providers to look after the people in their care. I hope the further detail set out in the annex addresses your concerns regarding the allegations you received. The UK Government reiterates its strong support for the work of the Special Procedures of the Human Rights Council and the Office of the High Commissioner for Human Rights.

Yours sincerely,

JULIAN BRAITHWAITE

Annex

Response of the Government of the United Kingdom of Great Britain and Northern Ireland to Communication AL GBR 5/2020, received on 9 June 2020 from: the Special Rapporteur on the rights of persons with disabilities; the Special Rapporteur on extrajudicial, summary or arbitrary executions; the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context; and the Independent Expert on the enjoyment of all human rights by older persons.

1. Please provide any additional information and comments you may have on the above-mentioned concerns.

The UK Government and the Devolved Administrations are committed to protecting life, and to ensuring the protection of the right to life, and that lifesaving health interventions are available on an equal footing for all.

The UK Government and Devolved Administrations have co-ordinated the response to the COVID-19 pandemic in the social care sector to protect citizens and prevent loss of life, while ensuring that human rights, personal choices, safety, and dignity are upheld at all times.

As was the case before COVID-19, decisions about the best course of action, treatment, and care pathway for people should be made between the individual, their families, and the professionals providing their care. Care providers must always seek fully to protect the rights of people, now and throughout the course of this global pandemic. We are absolutely confident that sufficient safeguards remain in place.

Co-ordination of response across the UK administrations to COVID-19:

The United Kingdom is comprised of England, Wales, Scotland, and Northern Ireland, which each have Devolved Administrations with responsibility for deciding the policy and priorities of its own health systems. The UK Government has closely co-ordinated the response to COVID-19 with the Devolved Administrations through a number of intergovernmental forums.

The UK-wide action plan for COVID-19 was jointly produced by the four administrations and published on 3 March.¹ The Coronavirus Act,² which received Royal Assent on 25 March, was

¹ <https://www.gov.uk/government/publications/coronavirus-action-plan>

² <https://www.legislation.gov.uk/ukpga/2020/7/contents/enacted>

likewise preceded by close consultation and joint working between the UK and Devolved Administrations.

The four Governments have continued to co-ordinate in other devolved areas, such as on coronavirus testing, although each Government remains responsible for testing in its area, and there are some differences, for example in the timing of the launch of test-and-trace strategies.

Social care in England:

The Department for Health and Social Care (DHSC)³ is a ministerial department, supported by 15 arm's-length bodies and a number of other agencies and public bodies. DHSC supports ministers to lead England's health and social care, deliver agreed plans and commitments, and act as guardians of the health and care framework, making sure the legislative, financial, administrative, and policy frameworks are fit for purpose and work together. DHSC is responsible for the operation of the health service directly. In the case of social care, DHSC is responsible for the legal framework and guidance, not for the delivery of social care. The difference in legal responsibilities means that central Government has a limited role in the social care sector.

The Care Quality Commission (CQC)⁴ is an independent regulator that registers health and adult social care service providers in England, and checks that appropriate standards are met through inspection and ongoing monitoring. During the initial outbreak of COVID-19, the CQC played a leading role in the facilitation of initial testing.

Public Health England (PHE)⁵ is an executive agency of DHSC, and a distinct organisation with operational autonomy. PHE provides Government, local government, the NHS, Parliament, industry, and the public with evidence-based professional and scientific expertise and support. PHE leads on testing when an outbreak in a care home is reported.

Commissioning social care services is a matter for local authorities, who are best placed to understand the needs of local people and communities, and how best to meet them. For this reason, the Care Act 2014 places duties on local authorities to shape their local markets so there is an adequate supply of provision to ensure all adult social care service users have a choice of high-quality services.

Social care in Northern Ireland:

Northern Ireland has an integrated system of health and social care. Section 2 of the Health and Social Care (Reform) Act (NI) 2009 ('the Reform Act')⁶ places a general duty on the Department of Health to promote an integrated system of:

- i. health care designed to secure improvement:
 - in the physical and mental health of people in Northern Ireland, and

³ <https://www.gov.uk/government/organisations/department-of-health-and-social-care/about>

⁴ <https://www.cqc.org.uk/>

⁵ <https://www.gov.uk/government/organisations/public-health-england>

⁶ <https://www.legislation.gov.uk/niu/2009/1/contents>

– in the prevention, diagnosis, and treatment of illness; and

- ii. social care designed to secure improvement in the social well-being of people in Northern Ireland.

In terms of service commissioning and provision, the Department of Health⁷ discharges this duty primarily by delegating the exercise of its statutory functions to the Health and Social Care Board (HSCB),⁸ the Public Health Agency (PHA),⁹ and to a number of other Health and Social Care (HSC) bodies created to exercise specific functions on its behalf, including five HSC Trusts. These HSC bodies may also contract with other non-HSC organisations for the provision of services, including for example independent sector care home providers.

Latest published information indicates that there are 482 adult nursing and residential homes registered in Northern Ireland, of which 234 (49%) are residential facilities, and 248 (51%) are nursing home facilities. 98% of nursing homes and 82% of residential care facilities are run by independent sector providers. Of the 12,154 residential and nursing care packages in effect at 30 June 2019, 96% were delivered by the independent sector. The elderly programme of care (POC) accounted for 80% of all care packages in effect, learning disability POC accounted for 11%, mental health 5%, and physical and sensory disability 3%.¹⁰ The Regulation and Quality Improvement Authority (RQIA)¹¹ registers and inspects a wide range of health and social care services in Northern Ireland, including nursing and residential homes, against minimum care standards, to ensure that both the public and service providers know what quality of service is expected and delivered.

Social care in Scotland:

In Scotland, health and social care is integrated to ensure coordination of care for people, including those in care homes. Since 2016, Health and Social Care partnerships (HSCPs)¹² are responsible for planning and coordinating care using a pooled budget. HSCPs have continued a policy in Scotland of enabling people to live in their own homes for longer. This means that those requiring admission to a care home tend to be older, with greater needs. Therefore, the current care home population has higher levels of acuity and dependency than it did 10 years ago, and care home residents are inevitably at greater risk of a poorer outcome if they contract COVID-19 because of conditions such as frailty, multiple co-morbidities, pre-existing cardio-respiratory conditions, or neurological conditions.

COVID-19 has brought with it challenges to well established processes for providing care and support to residents in care homes. The five key principles of our Health and Care standards remain, but given the particular impact of the pandemic on care homes, this has required us to take a different approach and different actions, often at a different pace from before. This includes additional staffing, expansion of infection prevention and control processes to minimise

⁷ <https://www.health-ni.gov.uk/>

⁸ <http://www.hscboard.hscni.net/>

⁹ <https://www.publichealth.hscni.net/>

¹⁰ *Statistics on Community Care for Adults in Northern Ireland 2018 – 2019* <https://www.health-ni.gov.uk/sites/default/files/publications/health/cc-adults-ni-18-19.pdf>

¹¹ <https://rqia.org.uk/>

¹² <https://www.nhsggc.org.uk/patients-and-visitors/community/health-and-social-care-partnerships/#:~:text=Health%20and%20Social%20Care%20Partnerships%2C%20%28HSCPs%29%20are%20the,partnerships%20between%20health%2C%20social%20care%20and%20hospital-based%20services>

transmission, and increased clinical input to support any affected residents, and identify and manage any deterioration in their condition. The overarching aim of the Scottish Government has been to deliver whole system support and assurance to care homes in Scotland, such that they are able to provide a safe setting for their residents and staff throughout the COVID-19 crisis.

Adults living in care homes have multiple health and care needs, and many are frail with varying levels of dependence. Current estimates are that over 40,000 residents live in 1,082 adult care homes across Scotland. The vast majority of adult care homes are for older people (75%), but they also include those for people with learning disabilities (14%) and physical disabilities / sensory impairment (3.3%).

Social care in Wales:

The Regulation and Inspection of Social Care (Wales) Act 2016,¹³ the Regulated Services (Service Providers and Responsible Individuals) (Wales) (Amendment) (Coronavirus) Regulations 2020,¹⁴ and the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017,¹⁵ provide a framework for regulated services, including care homes and domiciliary support in Wales.

One of the effects of the 2020 Regulations is that the provision of accommodation, together with nursing or care, where the accommodation and nursing or care are provided to adults and are needed as a result of the spread of coronavirus, is not a “care home service” and is therefore not a “regulated service” under the Regulation and Inspection of Social Care (Wales) Act 2016. The purpose of carving these services out of regulation is to enable emergency, short-term care and support services for adults to be established quickly should increased capacity be required in the care sector in response to the pandemic.

The above exception applies to services that are provided or commissioned by a local authority, or a local health board in Wales and are provided by a service provider who is already registered with either Care Inspectorate Wales (CIW)¹⁶ or the Care Quality Commission. Providers who wish to set up a temporary COVID-19 care and support service must first notify CIW of their intention to do this. If CIW is not satisfied that the exemption applies it is open to them to pursue prosecution for operating without registration, should the provider proceed to provide the service.

The 2020 Regulations also relax pre-employment checks for staff. Regulation 6 of the 2020 Regulations amends Regulation 35 of the 2017 Regulations, which relates to fitness of staff. Regulation 35(2)(d) of those Regulations requires a person who works for the provider of a regulated service to give the provider full and satisfactory information in respect of particular matters. The effect of the amendment is that in some circumstances, the regulation 35(2)(d) requirement is treated as being met even if a person who works for a provider of a care home service wholly or mainly for adults or a domiciliary support service to adults does not provide full and satisfactory information about some of those matters. If the person cannot reasonably provide full and satisfactory information as a result of the spread of coronavirus, the requirement will be treated as

¹³ <https://www.legislation.gov.uk/anaw/2016/2/contents/enacted>

¹⁴ <https://gov.wales/regulated-services-service-providers-and-responsible-individuals-coronavirus-regulations-2020>

¹⁵ <https://www.legislation.gov.uk/wsi/2017/1264/contents/made>

¹⁶ <https://careinspectorate.wales/>

being met if the person provides as full and satisfactory information as is reasonably practicable and the information is available for inspection by the service regulator.

However, the above relaxations do not remove the responsibility from care providers for safeguarding vulnerable individuals in their care. They are required to undertake a risk assessment and record details of their actions for scrutiny and inspection at a later date. These amendments will be revoked once the emergency situation is over.

Earlier this year, the Welsh Government introduced a requirement that where a person is employed or engaged under a contract for services, by a service provider, to provide care and support in connection with a domiciliary support service, that person must be registered with Social Care Wales (SCW)¹⁷ within 6 months from the date on which they commenced their employment. From 1 April 2020, all domiciliary care workers are required to register with SCW and, as at 31 March, over 20,000 current domiciliary care workers had voluntarily registered prior to the mandatory registration date. However, in light of the current exceptional circumstances, to reduce pressures on new entrants during this emergency period the timescales for domiciliary support workers to register with Social Care Wales has temporarily been extended from six to twelve months.

The Welsh Government has instigated an appeal to health and social care workers who have left the service to return on a voluntary basis for the period of the pandemic to help provide resilience to the system. More than 2,500 former health and social care professionals registered an interest in returning to work in Wales to use their skills to support the health and care system.

To support the need for speed of deployment of experienced clinical staff, most Health Boards boosted capacity by using their own bank staff to work additional shifts, and supplementing this with experienced staff working through agencies. This allowed for a speedy deployment of staff with up to date skills and experience.

Testing for COVID-19 in England:

The UK Government is fully committed to protecting its citizens. Care homes are on the frontline in the fight against COVID-19, and we are determined that staff have everything they need to keep themselves and their residents safe. Testing is a crucial part of this. It helps prevent and control outbreaks and means steps can be taken to reduce the spread of the virus and protect the most vulnerable.

Testing is available for:

- Everyone in the UK with symptoms through the NHS portal (including domiciliary care staff, volunteers, and unpaid carers).¹⁸
- All asymptomatic residents in care homes and asymptomatic care home staff through the whole care home portal - following an initial round of testing in May and June, a programme of regular re-testing is being rolled out. It began with care homes for over 65s and those with dementia in July and will be expanded to all care homes at the end of August.

¹⁷ <https://socialcare.wales/>

¹⁸ <https://www.nhs.uk/ask-for-a-coronavirus-test>

- All patients discharged from hospital into care homes.

Testing for COVID-19 in Northern Ireland:

On the 18 May 2020, the Northern Ireland Health Minister announced that the COVID-19 testing programme would be further extended, with testing made available to all care home residents and care home staff across Northern Ireland. This included testing in care homes that do not, and have not had, a COVID-19 outbreak. Before this announcement, the policy position had been to test all residents and staff in any care home identified as having a potential outbreak or cluster of infection.

As of 30 June 2020, staff and residents in all care homes in Northern Ireland have been offered COVID-19 testing.

All domiciliary care and other frontline community healthcare workers, with symptoms of COVID-19, are eligible for testing. Family members who have symptoms which necessitate these workers to self-isolate are also eligible for testing.

Testing for COVID-19 in Scotland:

The Scottish Government has put in place a comprehensive strategy for testing that involves the testing of all residents and staff in care homes that have a single case, and the testing of care workers in homes where there is no case. In addition, all people transferred and admitted to a care home from hospital or the community are required to undergo COVID-19 testing beforehand, and are routinely isolated for 14 days upon admission. At all times, the guidance has emphasised the importance of clinical assessment before and after admission.

Testing for COVID-19 in Wales:

The Welsh Government confirmed in a Written Statement¹⁹ on 16 May that testing would be offered to all symptomatic and asymptomatic staff and residents who have never tested positive for COVID-19, even where the home has not reported possible or confirmed cases.

The Welsh Government is implementing a three-stage testing and rapid response plan to help care homes deal with coronavirus – this is a mixture of testing and environmental and hygiene support measures. It does not rely on testing alone.

Since 15 June, following an initial testing program for all care home staff and residents, staff in care homes are tested on a weekly basis whether they are symptomatic or asymptomatic. Where there is an outbreak in a care home, all staff and all residents are tested whether they are symptomatic or asymptomatic.

Additionally, all people discharged from hospital to live in care homes are tested, whether or not they were admitted to hospital with COVID-19; and all people transferred between care homes, or admitted to care homes from the community, are tested whether they are symptomatic or asymptomatic. The standard outbreak control procedure for Public Health Wales is to declare an

¹⁹ <https://gov.wales/written-statement-covid-19-testing-care-homes-update>

outbreak over after a minimum of two incubation periods of the disease (a total of 28 days in the case of COVID-19). Therefore, care homes are generally not permitted to admit new residents until 28 days have elapsed since the last confirmed case. However, there is scope to consider a care home's individual circumstances, depending on factors such as the particular set-up of the home, and the specifics of the individual outbreak.

COVID-19 statistics in England:

All COVID-19 deaths are a tragedy. While it has been a relief to see the number of care home deaths falling in line with overall COVID-19 deaths, they sadly continue to make up a significant proportion of COVID-19 related deaths.

We are transparent in how COVID-19 deaths are reported in the UK. The Office for National Statistics'²⁰ death registration figures include all deaths, from all causes, with clear information on those cases that involve COVID-19.

The latest figures published by ONS show that from early March to 10 July there were 57,553 excess deaths in England and Wales. Of those, ONS report 50,505 deaths involving COVID-19 in that period. That leaves 7,043 additional and unexplained deaths.

A separate report by ONS published on 5 June gave clearer information on deaths not directly related to COVID-19. Two thirds of those deaths were due to dementia and Alzheimer disease, and symptoms or signs indicating old age and frailty.

The UK Government disagrees with the assertion that the *'COVID-19 pandemic has spread to the majority of the UK's institutions and care homes for persons with disabilities and older persons, resulting in significant high numbers of deaths'*.

As of 19 July, in England 6,811 care homes had reported a suspected outbreak of COVID-19. That is 44% of the total 15,476 care homes in England.²¹

For the week commencing 13 July, the number of new care home outbreaks or incidents related to COVID-19 reported to Public Health England (PHE) Health Protection team was 38 outbreaks, which is a decrease since the week commencing 25 May when 125 cases were reported.

An update to the latest statistics of COVID-19 related deaths

The UK Government is committed to recording and publishing daily data on the number of infections and deaths resulting from the virus, to ensure transparency.

As of 22 July 2020, there have been 296,377 lab-confirmed COVID-19 cases in the UK and 45,432 deaths of people who have had a positive test result confirmed in hospitals and other settings.²²

In reference to the paragraph in your letter which refers to the latest death data for England and Wales as of 15 May 2020, the Office for National Statistics provides weekly death data for England and Wales where COVID-19 was mentioned on the death certificate.

²⁰ The Office for National Statistics (ONS) <https://www.ons.gov.uk/>

²¹ Any individual care home will only be included in the dataset once. If a care home has reported more than one outbreak, only the first is included in this dataset. New outbreaks are those reported in supported living facilities that have previously not reported an outbreak.

²² <https://coronavirus.data.gov.uk/>

It was not accurate to state that:

As of 15 May 2020, ONS reported 14,573 deaths of residents in care homes, of which 65.1% occurred in hospitals, 28.3% in care homes, 4.6% in private homes and 1.3% in hospices.

To be clear, 14,573 is the total England and Wales deaths (all places and causes) to the week ending 15 May. 11,650 is the correct England and Wales cumulative COVID-19 deaths in care homes number for 15 May 2020.²³

We have been notified of 76 deaths that mental health providers indicated were suspected or confirmed to be related to COVID-19 from 1 March to 3 July 2020. A further three COVID-19 related deaths of detained patients were reported by other (non-mental health) providers.²⁴

COVID-19 statistics in Northern Ireland:

The letter from the Special Rapporteurs notes: *“The Department of Health of Northern Ireland publishes daily data on COVID-19 related deaths, which stood at 536 on 5 June 2020. The number of deaths of care home residents is not available. However, out of a total of 4,776 individuals with a positive lab test for COVID-19, 170 were confirmed or suspected COVID-19 cases in adult care homes.”*

The reference to the total number of deaths reported for 5 June 2020 in the Department of Health’s daily dashboard (published on 6 June 2020) is accurate. The dashboard provides information based on deaths reported to the PHA as individuals who had tested positive for COVID-19 and died within 28 days, whether or not COVID-19 was the cause of death.

The figure of 4,776 individuals with a positive lab test for COVID-19 was reported in the Department of Health’s daily dashboard as the position at 4 June 2020. It is not accurate to state that, of these 4,776 individuals with a positive lab test for COVID-19, 170 were confirmed or suspected COVID-19 cases in adult care homes. The Department of Health daily dashboard for 5 June 2020 reported 170 acute respiratory *outbreaks* in care homes – of these 61 were confirmed COVID-19 outbreaks, 32 were suspected COVID-19 outbreaks, and 77 were closed COVID-19 outbreaks. An outbreak is defined as two or more cases in a facility which meet the case definition of a possible or confirmed case of COVID 19 within a 14-day period, among either residents or staff in the care home. An outbreak is declared closed or concluded when there have been no new cases for 14 days after symptom onset in the most recent case.

Up to 5 June 2020, there was a cumulative total of 186 deaths reported in a residential / care home setting, out of a total of 537 deaths reported in all settings. As above, these figures relate to deaths reported to the PHA of individuals who had tested positive for COVID-19 and died within 28 days, whether or not COVID-19 was the cause of death.

In addition to the daily COVID-19 dashboard published by the Department of Health, the Northern Ireland Statistics and Research Agency (NISRA) also publishes data and analysis on COVID-19 in

²³ This data is from the 1 June revision from the ONS:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales/2020>

²⁴<https://www.cqc.org.uk/sites/default/files/20200715%20COVID%20IV%20Insight%20number%203%20slides%20final.pdf>

Northern Ireland. Published information includes a weekly bulletin which provides statistics based on registered deaths in Northern Ireland. This bulletin includes information on deaths of care home residents by place of death.

As at 17 July 2020, there were 556 COVID-19 related deaths reported on the Department of Health's daily dashboard. Of these, 187 took place in a residential care or nursing home setting.

Information published by NISRA for the week ending 10 July 2020 reports that the provisional total number of COVID-19 deaths registered in Northern Ireland for the calendar year 2020 was 844. A COVID-19 death includes any death where Coronavirus or COVID-19 (suspected or confirmed) was mentioned anywhere on the death certificate.

Of the 844 COVID-19 deaths registered, 426 (50.5%) were care home residents. Of these 426, 347 (81.5%) occurred in a care home, and 79 (18.5%) occurred in hospital. This refers to cases where either (a) the death occurred in a care home, or (b) the death occurred elsewhere but the place of usual residence of the deceased was recorded as a care home. The statistics will not capture those cases where a care home resident died in hospital or in another location, and the usual address recorded on their death certificate is not a care home. In relation to part (b) of this definition, no assumptions can be made about where or when the deceased contracted COVID-19 (and all figures include probable or suspect cases).

Since the beginning of the pandemic, there have been a total of 178 confirmed or suspected COVID-19 outbreaks in care homes in Northern Ireland. As at 17 July 2020, 156 of these had been concluded. Of the 22 remaining active outbreaks, nine were confirmed as COVID-19, and 13 were suspected COVID-19.

In relation to COVID-19 deaths of people detained under the Mental Health (Northern Ireland) Order 1986, information provided to the Department of Health by HSC Trusts indicates that fewer than five people have died having previously tested positive for COVID-19.

COVID-19 statistics in Scotland:

The letter from the Special Rapporteurs notes: *"According to the National Records of Scotland, as of 31 May 2020, out of a total of 3,911 registered deaths where COVID-19 was mentioned on the death certificate, 91% (i.e., 3,546 deaths) were residents of adult care homes."* This is an incorrect interpretation of an ad hoc data release from National Records of Scotland.²⁵ The figure 3,546 quoted in that table relates to all COVID-19 related deaths as at the week 20 publication, and not deaths of care home residents. Correct and updated analysis is as follows:

According to the National Records of Scotland, as of 28 June 2020, out of a total of 4,155 registered deaths where COVID-19 was mentioned on the death certificate, 47% related to deaths in care homes, 46% to deaths in hospital, and 7% to deaths at home or in non-institutional settings. National Records of Scotland do not routinely analyse numbers of deaths of care home residents; however, an ad hoc publication by them on 3 June showed that 154 of the people who had died in hospital were usually residents of a care home.

²⁵ <https://www.nrscotland.gov.uk/files//statistics/covid19/covid-deaths-care-home-residents.xlsx>

Since 11 April 2020, the Care Inspectorate²⁶ has collected data on adult care homes with reported suspected COVID-19. As of 2 July 2020, a total of 6,621 suspected COVID-19 cases had been recorded in 689 adult care homes, comprising 64% of all adult care homes in Scotland.

COVID-19 statistics in Wales:

The Welsh Government publishes Care Inspectorate Wales (CIW) data²⁷ regarding deaths that have occurred in adult care homes in Wales based on notifications made by these institutions. Between 1 March and 10 July 2020, CIW has been notified of 3,382 deaths of adult care home residents, out of which 734 (22%) were suspected or confirmed COVID-19 related deaths. The overall number of deaths is 74% higher than deaths reported for the same time period in 2019, and 46% higher than for the same period in 2018.

CIW also collect data on the notifications of cases of COVID-19. On 22 July 2020, 347 adult care homes in Wales had reported a confirmed case of COVID-19. This represents 33% of adult care homes registered in Wales.

The Office for National Statistics (ONS) also release data on deaths due to COVID-19.²⁸ Data for registrations up to 10 July 2020 show that a total of 2,484 people in Wales have died due to COVID-19. Of these, 692 (28%) of them had occurred in Care Homes.

Comment by the UK Government on international comparisons:

Comparing data across countries is challenging and not always representative, because of differences in the ways that countries record deaths, and differing definitions of what constitutes a care home.

Published research from the International Long Term Care Policy Network on 26 June 2020²⁹ and similar updates from the European Centre for Disease Prevention and Control³⁰ support the view that the proportion of COVID deaths taking place in care homes is lower in the UK than in many other European countries.³¹

Comments regarding the Care Quality Commission:

It is a legal requirement under the Care Quality Commission (Registration) Regulations 2009 for providers³² to inform the CQC without delay of deaths that have occurred while services were being

²⁶The regulatory body charged with ensuring that care standards are met in Scotland.

²⁷<https://gov.wales/notifications-deaths-residents-related-COVID-19-adult-care-homes-1-march-3-july-2020>

²⁸<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/weekending26june2020>

²⁹<https://ltccovid.org/wp-content/uploads/2020/06/Mortality-associated-with-COVID-among-people-who-use-long-term-care-26-June.pdf>

³⁰<https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-long-term-care-facilities-surveillance-guidance.pdf>

³¹30% of such deaths took place in care homes in England and Wales while, on an equivalent basis, the figure was 35% in France, 50% in Belgium, and 59% in Norway.

³²A provider in this context is an individual person, partnership, or organisation registered with the CQC to carry on one or more regulated activities, including social care.

provided in the carrying on of a regulated activity,³³ or have, or may have, resulted from the carrying on of a regulated activity. As part of CQC's regular work, they collect this information through statutory notifications relating to regulation 16 of those Regulations.³⁴ This information is used to inform CQC's monitoring of individual locations.

Providers have always been able to tell CQC about COVID-19 related deaths through an existing free text box on the notification form when registering deaths, and this was available to the inspector³⁵ for the service. However, because it was included as free text, providing timely, accurate analysis was difficult. To resolve this issue, on 9 April, CQC changed the way providers tell them about COVID-19 related deaths through the introduction of tick boxes for COVID-19 confirmed and suspected cases. This made it easier for COVID-19 deaths to be identified and reported on. CQC began providing daily updates to DHSC on the number of death notifications by local authority on 23 March.

CQC also introduced a new way of processing place of death information to be able to separate deaths in hospitals from those in care homes. The place of death information was also available to the inspector previously. The new approach makes it easier and more accurate to record relevant data, which takes about four days on average to collect and verify. This allows CQC to offer a more responsive collection of data.

CQC has worked with the Office of National Statistics (ONS) to provide a more detailed and timely picture of the impact of COVID-19 on adult social care, using the data on deaths of people with suspected and confirmed COVID-19 that they collect from providers. This also provides a regional view of which areas are being most impacted and may need additional support as a result. This data has been published as part of ONS' weekly reporting on deaths from 28 April.³⁶

CQC also agreed to analyse information taken from the NHS capacity tracker, which is a similar tool for care home providers, and also includes information about PPE stock. CQC provide this information regularly to DHSC for further escalation and resolution.

PHE's Health Protection Teams have, from the outset, been testing residents when an outbreak is reported at a particular care home, and DHSC are leading on the test and trace programme. CQC has no remit in these areas, but at the start of the pandemic agreed to play a leading role in the *facilitation of initial testing*.

CQC paused its normal routine inspection activity of providers in March, to help prevent the further spread of COVID-19 across health and social care providers. However, CQC continued to inspect responsively where concerns were raised. They developed an Emergency Support Framework (ESF)³⁷ to support the regulatory response during the crisis, which provides a structured framework

³³Regulated activities are listed in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Examples of regulated activities include personal care, nursing care, and the provision of accommodation for people who require nursing or personal care.

³⁴<https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-16-notification-death-service-user>

³⁵Each CQC inspector is responsible for monitoring whether the services in their portfolio are meeting the standards. In addition to scheduled inspections, the CQC inspect at any time where there are concerns that a service may no longer be meeting one or more of the standards set by the CQC.

³⁶<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases>

³⁷<https://www.cqc.org.uk/guidance-providers/how-we-inspect-regulate/emergency-support-framework-what-expect>

for the regular conversations that inspectors and providers have, and covers the following four areas:

- Safe care and treatment
- Staffing arrangements
- Protection from abuse
- Assurance processes, monitoring, and risk management.

The information gathered through this route is a further source of intelligence that is used by the CQC to monitor risk, identify where providers may need extra support to respond to emerging issues, and ensure they are delivering safe care which protects people's human rights.³⁸

During this crisis, CQC inspectors have been in contact with over 20,400 providers to offer support, advice, and guidance, including help accessing PPE and advice on infection control. While the number of physical inspections was reduced in order to limit the number of people going in and out of care homes, CQC has continued to inspect where they have serious concerns about care, and have conducted 113 inspections during the crisis period. In some of these cases, action has been taken in response to poor care, but we have also seen lots of examples of staff going to extraordinary lengths to protect the people in their care. CQC will be increasing its inspection numbers over the coming weeks.

2. Please provide information on the measures taken to guarantee persons with disabilities and older persons their right to life and to have access to lifesaving health interventions on an equal basis with others, and to prevent further deaths.

The UK Government and the Devolved Administrations are committed to protecting life, ensuring protection of the right to life, and ensuring that lifesaving health interventions are available on an equal footing for all.

As was the case before COVID-19, decisions about the best course of action, treatment, and care pathway for people should be made between the individual, their families, and the professionals providing their care. Care providers must always seek fully to protect the rights of people, now and throughout the course of this global pandemic. We are absolutely confident that sufficient safeguards remain in place.

Social care legal framework in England:

Under the Care Act 2014,³⁹ local authorities have a legal framework to carry out their care and support functions. These include requirements to carry out a needs assessment to establish where

³⁸The CQC lists the human rights definitions which it uses in this document, in addition to the legal obligations which it abides by.
<https://www.cqc.org.uk/sites/default/files/20190228%20Our%20human%20rights%20approach%20post%20consultation%20document.pdf>

an adult may have needs for care and support in some form, and whether the local authority has a duty to provide this care.

The Coronavirus Act 2020 is emergency legislation which was expedited through Parliament and received Royal Assent on 25 March 2020. The provisions relating to social care came into force in England on 31 March 2020. This amends the Care Act 2014 temporarily, allowing local authorities which feel that it is necessary to choose to operate under ‘easements’⁴⁰ to delay carrying out certain needs and financial assessments until after the end of the emergency period.

Of the 343 local authorities, only 8 have required the use of easements under the Care Act. Since 29 June 2020 no local authorities are operating under easements. DHSC has worked with partners to publish a list of local authorities that have notified DHSC of their use of easements, at www.cqc.org.uk/CareActEasements. Partners, including the Association of Directors of Adult Social Services (ADASS) and Think Local, Act Personal (TLAP), are leading a piece of work to consider the lessons that can be learned from the use of easements and the impact on people.

Easements were created under this Act to help the care system manage the growing pressures as more people needed support during the pandemic.

The Coronavirus Act requires local authorities, even when operating under easements, to continue to meet needs where not doing so would breach an individual’s human rights under the European Convention on Human Rights.

The Coronavirus Act enables local authorities to make and apply person-centred decisions about who is most in need of care, and who might need to have care and support temporarily reduced or withdrawn, in order to make sure that those with highest need are prioritised.

Such decisions will in some cases be challenging, and therefore should always be made within the remit of the Department of Health and Social Care Ethical Framework.⁴¹ It is essential that services are not withdrawn without clear risk planning.

Easements are temporary. The Secretary of State for Health and Social Care will keep them under review and terminate them, on expert clinical and social care advice, as soon as possible. All assessments and reviews that are delayed or not completed will be followed up and completed in full, once the easements are terminated.

Chief Social Workers are satisfied that those decisions have been made according to the principles of the ethical framework, and that the guidance issued by the DHSC has been followed.

Any assessments or reviews of people’s care and support needs which are delayed or not completed while a local authority is operating under easements should be completed, once the local authority is again able to comply with their Care Act 2014 duties in full.

³⁹ <https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

⁴⁰ Examples of the Care Act easements and how they may be implemented are available in the following guidance: <https://www.gov.uk/government/publications/coronavirus-COVID-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities#oversight>

⁴¹ <https://www.gov.uk/government/publications/COVID-19-ethical-framework-for-adult-social-care/responding-to-COVID-19-the-ethical-framework-for-adult-social-care>

Complaints and escalation procedures remain the same as under the Care Act. Under the Coronavirus Act, once the emergency period has ended, if local authorities do not comply with their duty to carry out a relevant assessment within a reasonable period, action can be taken in court.

DHSC is working with the CQC, ADASS, and TLAP to understand the impact of the Care Act easements. TLAP and CQC are working with those local authorities operating under easements to understand what this means for adults with care and support needs. A TLAP Insight Group meets regularly to coordinate intelligence of TLAP partners on the impact and views of people with lived experience.

Social care legal framework in Northern Ireland:

The Care Act 2014 does not extend to Northern Ireland. There are a range of legislative provisions in place to support and protect persons with disabilities in the social care system, and which provide the framework for the provision of social care services in Northern Ireland:

- Health and Personal Social Services (Northern Ireland) Order 1972 places a duty on the HSC Board and HSC Trusts to provide or secure integrated health and personal social services to promote the physical and mental health, and social welfare, of the people of Northern Ireland;
- Chronically Sick and Disabled Persons (Northern Ireland) Act 1978 identifies the need for and publication of information about services to promote the social welfare of chronically sick and disabled people; and relates to the provision of services to chronically sick and disabled people.
- Mental Health (Northern Ireland) Order 1986 outlines the general duty of the HSC Board and HSC Trusts to make arrangements designed to promote mental health, to secure the prevention of mental disorder, and to promote the treatment, welfare, and care of persons suffering from mental disorder. The Mental Capacity Act (Northern Ireland) 2016 provides a statutory framework for deprivation of liberty outside the Mental Health Order. Both pieces of legislation provide vital safeguards for persons' human rights, including the protection of rights in European Convention of Human Rights Articles 2, 3, 5, and 8.
- Disabled Persons (Northern Ireland) Act 1989 relates to appointment of authorised representatives of disabled persons, the assessment of needs of disabled persons, and the duty to take into account the abilities of carers of disabled people.
- The Health and Personal Social Services (Assessment of Resources) Regulations (Northern Ireland) 1993 sets out the legislative context for the financial assessment of an individual's resources, in order to determine how much they can contribute towards the cost of personal social services provided in residential care and nursing homes.
- The Carers and Direct Payments Act (Northern Ireland) 2002 gives carers the right to an assessment of their own needs and allows HSC Trusts to provide personal social services to carers directly. It also gives services users with assessed eligible needs the right to receive a Direct Payment to commission and directly arrange their own care, in lieu of provision of a social care service.

In addition, Section 75 of the Northern Ireland Act 1998 places a duty on public authorities to have due regard to the need to promote equality of opportunity between persons with a disability and persons without, as well as between persons of different age, religious belief, racial group, political opinion, marital status, or sexual orientation.

As well as specific legislative provisions, there are a number of policy and guidance documents in place in Northern Ireland which aim to support and protect people in the social care system, or people with disabilities. For example, *People First: Community Care in Northern Ireland for the 1990s* remains the underpinning policy framework for community care assessments of need.

A Department of Health policy circular (HSC (ECCU) 1/2010) provides guidance to the HSC Board and Trusts on:

- the care management process in Northern Ireland, including assessment and case management of health and social care needs;
- the provision of services, including placement of service users in residential care/ nursing homes, and the service user's right to a choice of accommodation; and
- charging for personal social services provided in residential care homes and nursing homes.

The practice of adult safeguarding in Northern Ireland is currently underpinned by the regional policy 'Adult Safeguarding Prevention and Protection in Partnership' (published jointly by the Northern Ireland Departments of Health and Justice in 2015).

The Northern Ireland Social Care Council was established in October 2001 as a non-Departmental Public Body of the Department of Health in Northern Ireland to strengthen public protection, and to raise standards within social care through a system of statutory regulation with three fundamental aims as follows:

- to protect users from poor practice;
- to set standards for the conduct, practice, and training of social workers and social care workers; and
- to support the demonstration of continued competent and safe practice through post-registration training and learning requirements, workforce regulation, and the regulation of social work education and training.

To achieve these aims a Code of Practice and agreed standards of conduct for social workers, social care workers, and employers were developed. Breaches of the Code by registrants are enforceable by the use of sanctions.

There has been some relaxation of requirements set out in policy and legislation as part of the response to COVID-19, to ensure that available resources are targeted at those most in need, and that essential health and social care services could be maintained. The requirements under the Departmental policy circular ECCU 1/2010 to complete routine annual reviews of residents in nursing and residential care homes, and clients in receipt of care in their own homes, were suspended in April, for a period of three months. HSC Trusts retain the responsibility for working with independent sector providers, to ensure and assure the quality of care being delivered, and to undertake such reviews as are considered necessary, paying particular attention to the needs of vulnerable individuals. The Department of Health also agreed that the timescales for processing

new direct payment applications could be relaxed, and that carers' needs assessments and reviews could be deferred.

In Northern Ireland, the Mental Health (Northern Ireland) Order 1986 provides a statutory framework for the compulsory admission, detention, and treatment of patients suffering from mental illness. The Mental Capacity Act (Northern Ireland) 2016 provides a statutory framework for deprivation of liberty outside the Mental Health Order. Both pieces of legislation provide vital safeguards for persons' human rights, including the protection of rights in ECHR Articles 2, 3, 5, and 8.

During the COVID-19 period, amendments have been made to the Mental Health (Northern Ireland) Order 1986 and the Mental Capacity Act (Northern Ireland) 2016, through sections 10(3) and 10(4) in the Coronavirus Act 2020. Amendments have also been made to the Mental Health Order through the Mental Health (Amendment) Order (Northern Ireland) 2020 and the Mental Capacity (Deprivation of Liberty) (Amendment) Regulations (Northern Ireland) 2020.

The amendments widened the scope of the persons who can carry out certain functions, and extended some timelines. The aim of the amendments is to ensure that all people can receive safe care and treatment, even during unprecedented pressures associated with a pandemic.

To ensure appropriate implementation of the amendments, the Department of Health has monitored their usage, and has committed to return to the original statutory functions after the pandemic. The Coronavirus Act provision relating to the Mental Health Order will be suspended with effect from 10 August 2020. Further amendments to the Mental Health Order will also be reversed on the same date. Regulations amending Mental Capacity Act provisions were revoked on 10 July 2020.

Social care legal framework in Scotland:

Sections 16 and 17 of the Coronavirus Act 2020 allow Scottish local authorities to dispense with particular social work assessment duties where "it would either not be practical to comply, or where to do so would cause unnecessary delay in providing services, support, advice, guidance and assistance". The provision covers social care for adults and children, and support for carers. It is intended to allow local authorities to provide urgent care without delay.

Guidance on these powers was issued on 3 April, and the Deputy First Minister and Cabinet Secretary for Health and Sport wrote jointly to key stakeholders ahead of their commencement on 5 April.⁴² These communications made clear that the power to disregard assessment duties would remain in operation only while absolutely necessary to protect people.

The guidance stated that local authorities should keep a record of decision making during this period, including decisions to dispense with the duty to assess, decisions to conduct full or partial assessments, and decisions about the provision of support. The letter highlighted that we would gather information from local authorities and partners such as COSLA and Social Work Scotland to inform Ministers' decisions on use of the powers.

⁴²Guidance is available here: <https://www.gov.scot/publications/coronavirus-COVID-19-changes-social-care-assessments/>

The provisions allow local authorities the flexibility to focus on prioritising the most urgent need and protecting the lives of those who are most vulnerable, while ensuring effective safeguards. Local authorities are still expected to do as much as they can to meet people's needs. While the provisions soften assessment duties, the main duties on authorities under section 12 of the Social Work (Scotland) Act 1968 remain in place.

A survey of the use being made of these powers by local authorities was undertaken in May. The results were fed into a report on the use of the powers which was presented to the Scottish Parliament on 9 June.

The outcome of this is that, while few local authorities were using them, these emergency powers will remain available for a further period subject to continued monitoring. The end of the next statutory two monthly reporting period is 31 July, with the requirement to lay the report in Parliament within 14 days thereafter. A further survey will monitor use of the powers during this period.

Social care legal framework in Wales:

The Social Services and Well-being (Wales) Act 2014⁴³ and the Regulation and Inspection of Social Care (Wales) Act 2016⁴⁴ ("The 2016 Act") and their associated regulations, are the key legislative structures which form the basis for the statutory framework for social care in Wales. The 2016 Act reforms the regulation and inspection regime for social care in Wales and provides the statutory framework for the regulation and inspection of social care services and the social care workforce. It also enables the Welsh Ministers to put in place a number of items of subordinate legislation through the making of regulations, the publication of guidance and the issuing of codes of practice.

Care home services in Wales are regulated principally through the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017,⁴⁵ as amended, alongside associated statutory guidance, both made under the 2016 Act. The guidance is available at: <https://gov.wales/sites/default/files/publications/2019-04/guidance-for-providers-and-responsible-individuals.pdf>.

The purpose of these regulations and guidance is to ensure that providers of social care services, including care homes achieve the required standard of care and support so that people's well-being and safety is maintained. Care Inspectorate Wales inspect against the requirements set out in these regulations.

Further measures taken by the UK Government to guarantee persons with disabilities and older persons right to life and access to health saving interventions:

NHS England and Improvement issued guidance, 'Supporting patients of all ages who are unwell with coronavirus (COVID-19) in mental health, learning disability, autism, dementia and specialist

⁴³<https://www.legislation.gov.uk/anaw/2014/4/contents>

⁴⁴<https://www.legislation.gov.uk/anaw/2016/2/contents/enacted>

⁴⁵<https://www.legislation.gov.uk/wsi/2017/1264/contents/made>

inpatient facilities’ on 30 April.⁴⁶ This was produced in collaboration with the Royal College of Nursing’s Mental Health Programme, the Royal College of Psychiatrists, and Unite in Health. It provides clear guidance to the managers of these facilities, stating that, “People with mental health needs, a learning disability, autism or dementia may need additional support, including by making reasonable adjustments to care systems and clinical practice”, and that, “Inpatient settings should reorganise wards/bays/en-suite facilities and staffing arrangements to separate” cohorts of patients with and without confirmed COVID-19, “to maximise protection for the maximum number of patients.”

NHS England and Improvement, with DHSC, also published ‘Legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic’ on 19 May.⁴⁷ This included guidance on the use of video for doctors and Approved Mental Health Professionals when making assessments for the purposes of the Mental Health Act, setting out that this may be appropriate during the pandemic period, in the interest of infection control. The Mental Health Tribunal, and the Care Quality Commission’s Second Opinion Appointed Doctor service have made similar arrangements during the pandemic period.

Liberty Protection and Safeguards:

The UK Government is aware of the pressures that COVID-19 is exerting on the health and social care sector. A Liberty Protection and Safeguards (LPS)⁴⁸ law has been published; however, in light of the pandemic, this will be implemented in April 2022.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Emergency Guidance:

We have published an update of our Emergency Guidance,⁴⁹ including an easy-read version,⁵⁰ and provided an editorial note explaining where the changes were made.

DHSC has also published a supplementary document which addresses questions and comments we received in response to the first version of the guidance.⁵¹

⁴⁶https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0290_Supporting-patients-who-are-unwell-with-COVID-19-in-MHLDA-settings.pdf

⁴⁷<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0454-mhlda-spec-comm-legal-guidance-v2-19-may.pdf>

⁴⁸ <https://www.gov.uk/government/news/new-law-introduced-to-protect-vulnerable-people-in-care>

⁴⁹<https://www.gov.uk/government/publications/coronavirus-COVID-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-COVID-19-pandemic>

⁵⁰https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/888422/emergency-mca-guidance-COVID-19-easy-read.pdf

⁵¹<https://www.gov.uk/government/publications/coronavirus-COVID-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-COVID-19-pandemic-additional-guidance>

3. Please provide information on measures taken to:

- a. prevent the exposure to COVID-19 of persons with disabilities and older persons in residential institutions, and**
- b. prepare and manage COVID-19 infections in institutions**

Response of UK Government:

The UK Government is committed to preventing the spread of COVID-19, especially to its most vulnerable citizens. Since this pandemic began, we have been using all available resources to support the social care sector, in order to help social care providers look after the people in their care.

We know that care providers across the country have been doing their utmost to keep those they look after safe and well in the most challenging of circumstances.

Personal protective equipment:

Personal protective equipment (PPE) is necessary to stop the spread of infection in the wider community, which is why we have produced extensive guidance on when and where PPE should be used, including pharmacies and clinical, community, and social care settings.⁵²

PPE to the care sector is fundamental for the good care of individuals with suspected symptoms of COVID-19. It is equally vital to protect the care workers who are providing personal care for vulnerable individuals in the social care sector.

We are working to ensure that those working in social care receive the PPE they need, and we are responding to a significant spike in demand for PPE in this sector to ensure that some of the most vulnerable in our communities are protected.

Before COVID-19, each care provider was responsible for sourcing their own PPE from wholesalers and distribution centres. While this was effective and appropriate before the outbreak, it became clear that this fragmented system would be slow to get PPE where it needed to be. To address this, the UK Government stepped in to support the emergency supply and distribution of PPE to the care sector. We have focused on ensuring that there is an emergency supply in place, while building a longer-term solution for distribution to the sector. These include:

- Consistent messaging on PPE guidance
- Supply routes of PPE
- Emergency drops of PPE
- A response system to monitor emergency PPE requests

Guidance:

The care sector has asked for there to be consistent messaging across the NHS and care sector about PPE, so that everyone is clear about when to use PPE.

⁵²<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/COVID-19-personal-protective-equipment-ppe>

Working with care sector representative bodies, PHE published tailored resources on the use of PPE in care homes and domiciliary care settings.⁵³ These include summarised tables, Q&A, and a specialised training video on donning and doffing PPE in social care settings. These resources also include advice on how to provide support to people with learning disabilities and/or autism. These are the main sources of PPE guidance for the care sector.

Supply routes for PPE:

We are supporting the existing supplier network by providing stock of PPE to designated wholesalers. As of 17 July, we have released 168.5 million items of PPE to designated wholesalers for onward sale to social care providers. This includes 13 million facemasks, 58.86 million aprons, and 96.6 million gloves. We continue to work with wholesalers to support this route of access to PPE.

Between 6 April and 18 July we have authorised the release of over 151 million items of PPE to local resilience forums to help them respond to urgent local spikes in need across the adult social care system and some other front-line services, where providers are unable to access PPE through their usual, or dedicated wholesaler routes.

To further strengthen the resilience and responsiveness of our supply chain operations, we have mobilised a National Supply Disruption Response (NSDR) system⁵⁴ to respond to emergency PPE requests, including for the social care sector.

Since the 24/7 NSDR helpline went live on 16 March, we have received nearly 40,000 calls. Call volumes have now stabilised after a period of decline. We are currently seeing an average of just under 50 calls per weekday, down from a peak of nearly 1,500 calls per weekday at the end of March.⁵⁵

Between 13 and 17 July, we received a total of 249 calls, compared with 7,329 in the week 30 March-3 April.⁵⁶

To support these efforts further and make it easier to get PPE, we have developed a new online PPE Portal to enable primary, social, and community care providers to request critical PPE.

Preparing for and managing infections in institutions:

Throughout our response to COVID-19, we have worked with the care sector and public health experts to explore all measures possible to reduce transmission and save lives.

The UK Government's top priority for adult social care is that everyone who relies on care should get the care needed throughout the COVID-19 pandemic.

In the face of an unprecedented global pandemic, since the start of this outbreak the UK Government has been working closely with the social care sector and public health experts to put in place guidance and support for adult social care, and we will continue to ensure they have what they need to respond.

⁵³<https://www.gov.uk/government/collections/coronavirus-COVID-19-personal-protective-equipment-ppe>

⁵⁴Any organisation running critically short of PPE, and which has exhausted other supply routes, can phone the National Supply Distribution Response (NSDR) for an urgent delivery.

⁵⁵Average figures from 13-17 July and 30 March – 3 April

⁵⁶Not including weekend calls which are currently very low.

All our guidance⁵⁷ is designed with care users in mind, to ensure that individuals are treated with dignity and respect, and that their particular needs are addressed.

Examples of UK Government interventions and support are listed chronologically below:

On **10 January**: PHE published guidance on use of PPE by healthcare and social care workers in the context of COVID-19.

On **25 February**: PHE published 'Guidance for social or community care and residential settings on COVID-19' which was intended for use during the phase of our response when there was no transmission of COVID-19 in the community (the contain phase). In this document, we set out that care homes should contact their local health protection teams in advance of any outbreak of the disease. This guidance was withdrawn on 13 March.

On **12 March**: the UK Government announced that we were moving our COVID-19 response from the 'contain' to 'delay' phase, after the UK Chief Medical Officers raised the risk to the UK from moderate to high. The decision to do this was based on the clinical and scientific research at the time, and on careful modelling of the COVID-19 situation.

The following day (**13 March**) new guidance for care homes was published on the Government website, which had been co-developed by DHSC and PHE.⁵⁸ This included action to be taken in the event of a staff member or resident displaying COVID-19 symptoms, and guidance on infection control within the home, including advice on isolation. Care home providers were advised to review their visiting policy, by asking no one to visit who had suspected COVID-19 or was generally unwell, and by emphasising good hand hygiene for visitors. Guidance stated that "the review should also consider the wellbeing of residents, and the positive impact of seeing friends and family."

On **19 March**: the Government announced a £2.9bn package to help strengthen care comprising of:

- £1.6bn to local authorities, unringfenced, and available for use across all the services they deliver so they can address pressures on local services caused by the pandemic, including in adult social care. Of this, £1.39bn was distributed to Adult Social Care using the relative needs formula,⁵⁹ reflecting our expectation that adult social care would be the greatest area of pressure for local authorities.
- £1.3bn via NHS Clinical Commissioning Groups for the NHS discharge process.

On **23 March**: the UK Government announced that people "must stay at home", with only a few limited exceptions.⁶⁰

On **2 April**: DHSC co-published 'Admission and care of residents in a care home during COVID-19'.⁶¹ This set out further advice on infection control procedures, e.g. limiting visits to essential visits only unless there were exceptional circumstances, and providing advice on isolation, decontamination,

⁵⁷<https://www.gov.uk/coronavirus>

⁵⁸<https://www.gov.uk/government/publications/COVID-19-residential-care-supported-living-and-home-care-guidance>

⁵⁹The relative needs of local authorities are determined by the use of funding formulas, which incorporate relevant local demographic or other data, thought to predict the relative demand councils face when delivering different services. In order to reflect the fact that some 'cost drivers' are more significant than others in determining authorities' 'need to spend', each cost driver is 'weighted' in the formula to reflect its relative importance. The formula can then be adjusted for other factors which affect the relative costs of service delivery – such as salary or property costs.

⁶⁰<https://www.gov.uk/government/speeches/pm-address-to-the-nation-on-coronavirus-23-march-2020>

⁶¹<https://www.gov.uk/government/publications/coronavirus-COVID-19-admission-and-care-of-people-in-care-homes>

cleaning, and protective measures for staff. We recommended all symptomatic residents in care homes should be immediately isolated for 14 days from the onset of symptoms, including patients discharged from hospital.

On **15 April**: we published our detailed Adult Social Care Plan,⁶² setting out how the Government and other parts of the system are supporting people who receive adult social care, both at home and in other settings. This included a commitment to all patients being tested before discharge to a care home, with responsibility being given to councils to identify alternative accommodation where care homes are not able to provide appropriate isolation for people who have tested positive for COVID-19. We also strengthened our advice around isolation. The Plan includes information on supporting people to maintain their independence and responding to individual needs.

On **18 April**: MHCLG announced a further £1.6bn for local authorities so they can address pressures on local services caused by the pandemic, including in adult social care.

On **15 May**: the Government published a support package for care homes backed by a £600 million Infection Control Fund. This was the next phase of our response for care homes, using the latest domestic and international evidence brought together by Public Health England, and drawing on the insights of care providers. The document set out the steps that must be taken to keep people in care homes safe, and the support that brought together across national and local government to help care providers put this into practice. The package outlined further infection prevention control measures, including advice for reducing the rate of transmission in and between care homes, such as restricting staff movement between care homes comprehensive testing, and additional clinical support, with a named clinical lead for every care home.

On **19 June**: we published our updated guidance for care homes. The guidance was updated to align with policy changes, including publication of the Adult Social Care Action Plan on 15 April, and the care homes support package on 15 May. It includes updated information, including on testing for residents and staff, and isolation procedures.

The Government, working with Public Health England, is closely monitoring the international evidence, to ensure best practice is reviewed and can be applied. We keep our policies under constant review and are continuing to seek further evidence as national and international experience accrues and is published.

On 2 July, the Government announced an additional £500m for Local Authorities for COVID-19 pressures including adult social care.

Response of Northern Irish Government:

A range of actions have been taken and many interventions have been put in place since the outset of the pandemic aimed at mitigating the risks of COVID-19 to persons with disabilities and older persons, whether living in the community or in residential care settings.

Planning:

⁶²<https://www.gov.uk/government/publications/coronavirus-COVID-19-adult-social-care-action-plan>

The Department of Health in Northern Ireland approved the execution of a surge plan for social care and children's services on 18 March 2020, to ensure that during the pandemic services remained targeted at people in need and those most vulnerable, and that essential social care and children's services would be maintained in the event of a major surge.

Surge planning for social care services has continued to be kept under review throughout the pandemic as the situation has developed. A regional surge plan for the Northern Ireland care home sector was approved on 4 May 2020. The objectives of this plan are to reduce the number of outbreaks in care homes in Northern Ireland, and the number of individuals in each outbreak; to provide robust integrated medical, nursing, and social care responses; and to support partnership working between the HSC service and independent sector care home providers, to ensure that person-centred care is delivered to all residents, irrespective of whether they have COVID-19.

In addition to this regional plan, each HSC Trust has its own individual surge plan to support, monitor, and respond to the needs of the care home sector during the pandemic. Similar plans are also in place for mental health and learning disability services.

Guidance:

COVID-19 guidance for community/social care and residential settings in Northern Ireland was first published on 27 February and has been frequently reviewed and updated since then. Specific guidance for (i) nursing and residential homes, and (ii) domiciliary care settings, was first published on 17 March, and has been regularly updated since then.

This guidance provides advice on infection prevention and control measures, including advice on the use of PPE; testing arrangements; arrangements for the admission of residents to care homes from other settings – including discharges from hospital; advice on isolation requirements for care home residents; advice on recognising and identifying symptoms; and actions to be taken in the event of an outbreak in a residential setting.

Key infection prevention and control measures required by the guidance include:

Visiting restrictions – guidance published on 17 March advised that care homes should restrict visits. Guidance issued by the Chief Nursing Officer for Northern Ireland on 27 March confirmed that visits to all care settings should cease, other than in a small number of exceptional circumstances. Visiting arrangements for all care settings have recently been revised and updated, to support some limited visiting on a risk-assessed basis.

Arrangements for admissions to care homes – guidance published on 26 April confirmed that all new or returning care homes residents should be tested 48 hours before admission to a care home, and should be subject to isolation for 14 days, to reduce the risk of infection entering homes via this route.

Symptom monitoring – guidance published on 26 April recommended that homes should check staff and residents twice a day for symptoms, including temperature, recognising that symptoms in care home residents may be atypical.

Staff training – guidance has emphasised the need for staff to have updated and recurrent training (including bespoke training where indicated) in PPE and infection prevention and control – something that we have been tracking through a daily app that all care homes are asked to complete.

PPE – As detailed in response to question 1a, HSC Trusts have been supporting independent sector care home and domiciliary care providers through the supply of PPE. Up to the week ending 4 July, information provided by HSC Trusts indicates that they have supplied 20.6m items of PPE to independent sector care homes free of charge, at an estimated value of almost £7.7m. This is in addition to almost 13m items of PPE provided free of charge to domiciliary care providers, at an estimated value of £5.8m.

Specialist advice and support:

The Northern Ireland Public Health Agency (PHA) has provided specialist advice and support to care homes to help prevent the transmission of COVID-19, and to manage and take action to minimise the impact of COVID-19 outbreaks in care homes.

Specialist support to care homes through the redeployment of HSC Trust infection prevention and control nurses, and multidisciplinary acute care at home/enhanced care home support teams provide additional support to homes in caring for residents with COVID-19 and providing advice on necessary measures to reduce the spread of the virus in care home settings.

The body responsible for regulating care homes in Northern Ireland, the Regulation and Quality Improvement Authority (RQIA), also provided a dedicated support team for independent sector care home providers to discuss any concerns or issues experienced in responding to COVID-19, and to liaise with the HSC service as necessary to resolve those issues as quickly as possible.

Financial support:

Additional investment has been provided to help care home providers meet the additional costs associated with responding to the pandemic, and to put in place the necessary infection prevention and control measures. In April, the Northern Ireland Health Minister announced £6.5m of additional funding for care homes, with payments of £10k, £15k, or £20k allocated to homes depending on their size. In June, the Minister announced an additional care home support package of £11.7m. This funding will be used to reimburse providers with up to 80% of salary costs for staff who are ill, isolating, or shielding as a result of COVID-19, in order to reduce the risk of staff who are unwell continuing to work; will support additional enhanced cleaning for care homes; and will provide specialist equipment to help track and monitor atypical symptoms among care home residents.

Measures to support the financial resilience of both care home and domiciliary care providers have also been put in place since mid-March, to try to minimise the effect of COVID-19 on their ability to provide care. For domiciliary care providers who have a contract with an HSC Trust, income has been guaranteed based on 100% average of the last 3 months payment periods. For care homes, if, as a result of the COVID-19 outbreak, a nursing or residential care home's income reduces by more than 20% below the average of the last three months, then HSC Trusts will block purchase 80% of the vacated beds at the regional tariff.

Workforce support and training:

Significant levels of staffing support have been provided to independent sector care home providers during the pandemic. As well as providing specialist care and advice, HSC Trusts have also provided more than 20,000 hours of direct staffing support to cover shifts in independent sector care homes. In addition, infection prevention and control training has been provided to care home staff.

Evaluating and learning:

On 2 June 2020, the Minister for Health in Northern Ireland established a Rapid Learning Initiative, led by the Chief Nursing Officer, to identify important learning from the care home experiences of COVID-19. A task and finish group, comprising key stakeholders from across Northern Ireland Health and Social Care services, representatives from the care home sector, and other sector representatives, has been established to complete this work. The group's terms of reference are to:

- Consider the learning to date in relation to the transmission of COVID-19 into and within the care home population.
- Identify the underpinning monitoring and measurement processes that will assist in both understanding the current system, and in identifying the appropriate way forward.
- On the basis of the evidence, to propose recommendations for improvement.

The Chief Nursing Officer is also developing a framework for the future provision of clinical care in care homes. This will include an examination of how nursing, medical and multidisciplinary support, clinical leadership, and specialist skills can be expanded in care homes, learning from the experience of the pandemic and in recognition of the increasing complexity of need among care home residents in Northern Ireland.

Support for people with sensory disability:

Actions have also been taken to support people with a sensory disability or communication difficulty. For those who are blind and partially sighted, the Department of Health Northern Ireland, in collaboration with the Department for Communities, Guide Dogs Northern Ireland, and the Royal National Institute for the Blind, published an information sheet highlighting key contact numbers and advice on how blind and partially sighted people can access support during the pandemic in their local community.

For people with a hearing impairment or who are deaf, information and advice has been made available in response to COVID-19 in the form of videos in British and Irish Sign Language (BSL and ISL). In addition, the Department of Health working closely with the HSC Board and the Department for Communities have put in place an innovative, remote sign language interpreting service for BSL and ISL users in Northern Ireland. This service is providing the deaf community with access to NHS 111 and all health and social care services during the pandemic.

The HSC Board has been working closely with the Department of Health and has developed plans for the recovery of regional physical and disability services as we emerge from the COVID-19 pandemic.

Response of Scottish Government:

The Scottish Government has been clear about the importance of protecting those living and working in care homes, which includes those with disabilities and older people. These measures have focused on: guidance to support Infection and Prevention Control (IPC) measures; detection and surveillance; support for and assurance of care homes; and provision of Personal Protective Equipment (PPE).

Guidance:

Pre-existing guidance was available through the NHS Scotland National Infection Prevention and Control Manual, first published in January 2012. In the context of COVID-19, the Scottish

Government along with Health Protection Scotland first issued clinical and professional guidance on COVID-19 for care homes in March; this guidance has been regularly updated based on growing international understanding of the pandemic (links to Health Protection Scotland [guidance](#) and SG [guidance](#)). The guidance sets out the IPC measures to prevent exposure to COVID-19, including hand hygiene and use of PPE; cleaning and waste management; restricting visits to essential visits only, and reduction in communal activity with residents remaining in their rooms as much as possible; and screening of individuals. Advice also includes measures for the prevention of transmission where there are people with COVID within the setting – for example, isolation of residents, and cohorting of staff teams in line with IPC measures.

Detection and surveillance:

In Scotland, we have put in place a comprehensive strategy for testing that involves the testing of all residents and staff in care homes that have a single case, and the testing of care workers in homes where there is no case. In addition, all people transferred and admitted to a care home from hospital or the community are required to undergo COVID testing beforehand and are routinely isolated for 14 days upon admission (see answer to query 2a). At all times, our guidance has emphasised the importance of clinical assessment before and after admission.

Support for and assurance of care homes:

As described above, Directors of Public Health have been tasked with providing enhanced clinical leadership for care homes and have put in place clinical and professional oversight with professional leads from the National Health Service and local authorities. This oversight allows daily contact with care homes, to ensure that they are supported to adopt IPC measures and have sufficient staff, and to provide safe and effective care and prevent the exposure of COVID-19.

Sufficient staffing levels are essential in protecting residents and staff and a safety huddle tool has been developed to support care homes to identify residents' care need and associated staffing requirements. This is being used by care homes on a daily basis to enable them to identify and escalate concerns including staffing with NHS Boards, local authority and Care Inspectorate partners, enabling early intervention and support where appropriate. In many places, additional staff including nurses are being deployed either as in-reach support or directly working within the care homes. Finally, the care regulator in Scotland the Care Inspectorate have been given greater powers to carry out their assurance role and are working alongside Directors of Public Health to ensure that care homes are following correct IPC measures and are providing care in line with our national health and social care [standards](#).

Provision of PPE:

The Scottish Government has intervened to engage in the direct provision of personal protective equipment from 19 March, when it was clear that the provision of PPE to care homes through private routes was failing. This is outlined in Q1A.

Response of Welsh Government:

PPE:

Wales continues to work with the other UK nations, identifying opportunities to combine our procurement efforts to bring in vital new stocks and to secure better-value PPE purchases. Given

the relative strength of the NHS Wales stock and supply position, we have been able to support the other UK nations by issuing significant volumes of PPE through mutual aid in the last three months.

The Welsh Government is also working with our partners in industry to supplement the production of supplies through innovation and new manufacturing routes. The very positive response to the First Minister's call on Welsh industry to help produce extra supplies of PPE for the NHS and social care has resulted in face visors, scrubs, aprons and hand sanitiser being produced by Welsh manufacturers currently, with more products expected to come on stream in the coming weeks.

The Welsh Government has developed and implemented a robust system for NHS Shared Services to provide personal protective equipment (PPE) directly to local authorities on a twice weekly basis. Local authority social services departments then co-ordinate the onward distribution of PPE to organisations providing social care.

Local authorities have been working closely with care providers to ensure that the onward distribution anticipates the stock levels needed to ensure the staff are safely provided for. Local authority reports ensure that the PPE provided is sufficient to meet demand.

In Wales, the vast majority of PPE issued to the health and care sectors in Wales has been directly sourced by the NHS Wales Shared Services Partnership (NWSSP), through both national and international procurement routes.

While the current PPE situation in Wales remains relatively stable, we have been working to increase the number and volume of forthcoming orders to ensure a reliable pipeline of vital PPE for our frontline health and social care workers over the coming months.

As we move from our initial emergency response to establishing a secure position over the longer term, we are working closely with the NWSSP to enhance our data and planning capability to ensure PPE is distributed where it is needed as quickly as possible and to build resilience ahead of potential increased demand in the autumn. Using increasingly refined demand and supply analysis (by product and sector), our procurement efforts are looking to factor in an expected growth as health boards and trusts build up routine inpatient and outpatients services.

Action to restrict visitors:

The Deputy Director General, Welsh Government Health and Social Services wrote to Registered Providers and Responsible Individuals of care homes on 23 March 2020, setting out that visits to a care home should now only take place when absolutely essential and not as part of routine visiting. This decision was taken as a result of the increasing pace of the transmission of COVID-19 in the community at the time. The letter also set out a series of infection control measures to be followed by those making essential visits.

As well as placing restrictions on care home visits, the letter recognised the importance of ensuring opportunities for social contact for those living in the care home, highlighting the importance of regular telephone calls with family and friends, and videoconferencing technologies such as Skype and FaceTime. As such, we have been supporting care homes to use technology to improve interaction between people and their families and friends, as well as with medical professionals. We have provided additional funding to our *Digital Communities Wales: Digital Confidence, Health and Well-being (DCW) procured programme* to purchase and distribute 1,100 digital devices (tablets) to care homes across Wales.

Step down/step up care:

Comprehensive guidance was developed regarding transfer to step down care facilities, to limit the exposure to COVID 19 of those in care homes. To limit the risk of exposure to COVID-19, the guidance on COVID-19 Hospital Discharge Service Requirements⁶³ was updated on 29 April to clarify that all potential new care home residents, and those returning to care homes from hospital, should be tested for COVID-19. The guidance also specified that people who test positive, or are still infectious, will move to step-down care to be supported, before being able to move to, or return to, a care home. It also specified that a negative test was required prior to admission to a care home.

Local Health Boards, Local Authorities and their partners are responsible for identifying suitable facilities in their areas for step-up and step-down care, and where necessary, to support the necessary isolation period prior to moving to a care home. These facilities must be appropriate to meet the needs of all individuals who may need them, including people living with dementia.

Dragon's Heart Hospital⁶⁴ has been used as a step-down facility for patients recovering from COVID-19 since it opened in April, with rehabilitation therapy available to patients 10 hours a day, seven days a week. This helps to shorten their length of stay, providing good experiences and outcomes.

New admissions from the community:

Alongside a requirement for a negative test before readmission back into a care home from hospital or a step-down setting, testing was also extended to people who are being transferred between care homes, and for new admissions to care homes from the community.

Guidance has been issued on the Public Health Wales website on managing outbreaks in care homes.⁶⁵ It provides advice on the admission and care of residents during the outbreak, the reporting of cases, testing, and advice for staff.

Shielding:

On the 4 June, the Chief Medical Officer spoke to the Deputy Minister and Chief Whip's Disability Equality Forum. A commitment from that meeting was for officials within the Chief Medical Officer's department to engage with Forum members prior to the next 21 day shielding review on the 16 August. This will ensure we are considering the issues which matter most for disabled people.

Welsh Government, local authorities and the third sector are already providing support to many vulnerable groups including disabled and older people. Solutions identified and put in place to date include access to food for those in supported housing and identifying accommodation for a range of vulnerable groups. We have worked with local authorities and Community Voluntary Councils (CVCs) to understand fully the support they are providing for non-shielding vulnerable people who are isolated

From the information shared, whilst there are some variations in local services, we are confident that local authorities have effective provisions in place to support non-shielding vulnerable people. This includes access to food and wider befriending/virtual companionship support. Local authorities

⁶³<https://gov.wales/hospital-discharge-service-requirements-covid-19>

⁶⁴<https://www.wales.nhs.uk/news/52434>

⁶⁵<https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-healthcare-workers-in-wales/prevention-and-management-of-infection-and-outbreaks-of-covid-19-in-residential-settings-in-wales-version-3-2/>

are providing these services using their own staff and linking individuals up with volunteers who can help them. Our national volunteer prescription delivery scheme also specifically supports those who are self-isolating with no wider social network.

Some local authorities have acted proactively to reach out to isolated vulnerable people, but all have provided services when they know of someone in need. From discussions with both local authorities and CVCs, it is apparent that systems were put in place quickly to provide support for wider vulnerable people. They tell us that there is adequate resource in place to meet the current demand, with some capacity to increase the level of support (as demand rises). Most local authorities are using existing employees and redeployed staff to deliver their support arrangements. Whilst some are already supplementing their current resource with volunteers, through their links with CVCs and wider community support, it is acknowledged that the sustainability of the provision of support (and any significant increase in demand) will be further reliant on the support and availability of volunteers. Particularly with the demand for local authority staff to be deployed to Test, Trace and Protect.

We have committed to undertake a 3 month stage review of the provision of support from local authorities and CVCs. The review will focus on the current state of play, including ongoing capacity, sustainability and resilience of the support for non-shielding vulnerable people in the short/mid and longer term.

c) reduce the number of deaths in residential institutions and of institutions' residents

Response of UK Government:

For people with a learning disability, NHS England and NHS Improvement publish data on the number of COVID-19 related deaths of people with a learning disability notified to the Learning from Deaths Mortality Review. An analysis of 200 deaths that have occurred during the COVID-19 pandemic will be undertaken by the University of Bristol once the individual reviews have been completed.⁶⁶

PHE is undertaking a thorough analysis of data on the deaths of people with learning disabilities. This will draw on data published by NHS England and CQC to understand the impact of COVID-19 on this group of people and the specific risks that they may face from the virus.

Our data shows that 5 people with a learning disability, autism, or both have died within a specialist inpatient setting between 1 March and 31 May 2020.⁶⁷ We have included people who were transferred from a specialist inpatient setting to an acute setting and who subsequently died. The number of deaths for June is reported as being less than 5, as for months prior to April.⁶⁸

⁶⁶<https://www.england.nhs.uk/publication/COVID-19-deaths-of-patients-with-a-learning-disability-notified-to-leder/>

⁶⁷Suppression of small numbers means that the precise figure is not presented but rounded to the nearest five.

⁶⁸Numbers below five are marked with an * so that no individuals are identifiable.

Response of Northern Irish Government:

The Department of Health in Northern Ireland is working closely with the HSC Board and Trusts to help us better understand the impact of COVID on the learning disability population in Northern Ireland. Largely anecdotal evidence suggests that the impact in terms of cases/deaths may not be the same as in England. The Department is working to identify data to confirm whether this is the case, and to inform any future decisions that might need to be taken in mitigation/prevention in relation to people with learning disability.

In Northern Ireland, the Public Health Agency has been coordinating a number of workstreams since around 2014 to improve health care provided to people with learning disability under the auspices of the Regional Learning Disability Health Care and Improvement Group. Key achievements to date include the appointment of Learning Disability Health Care facilitators in each Trust and the development of a regional hospital passport for people with learning disability.

Acknowledging the additional pressure placed on many families as a result of the closure or reduction in service within the special school system, a joint Health and Education Oversight Group was established alongside local Trust Panel Discussion meetings to deliver on a collaborative basis an integrated support programme for vulnerable children, and their families, throughout the pandemic.

The Oversight Group convened on a weekly basis and local panels also met regularly to manage children's needs proactively and subsequently reduce the likelihood of deterioration relating to individual children, and provide timely support for those families in greatest need.

Response of Scottish Government:

Scotland does not have an initiative like the Learning from Deaths Mortality Review which is in place in England and Wales. The Scottish approach includes the Scottish Learning Disability Observatory based at Glasgow University, which is working to improve the health inequalities of people with learning disabilities and autism through research and data improvements. In terms of the collection of death data in Scotland, this data is not routinely collected on death certificates. However, the Scottish Learning Disability Observatory have begun a study to investigate the number of deaths linked to COVID-19 of people with learning disabilities. This important study requires a complex linkage of National Records of Scotland (NRS) and NHS controlled datasets, to enable the investigation of the impact of COVID-19 on the learning disabilities population in Scotland.

Response of Welsh Government:

In Wales, all health boards are required to undertake a systematic review of unexpected deaths in services and report to Welsh Government where the death is unexpected or potentially due to an adverse event; this includes individuals with a learning disability. We are currently working to strengthen that process in terms of COVID-19 and non-COVID-19 related deaths in the context of the new Medical Examiner role.

- 4. Please provide information on any plans to move towards a deinstitutionalization process in close coordination with persons with disabilities, aimed at reducing the number of persons with disabilities in institutions and replacing such institutions with community-based services that support their right to live independently and to be included in the community.**

Response of UK Government:

The UK Government is committed to community-based adult social care and deinstitutionalisation of the care system.

The NHS Long Term Plan 2019 sets out commitments to reduce the number of people with a learning disability, autism, or both in a specialist inpatient setting, so that, by 2024, there will be no more than 30 adults with a learning disability, autism, or both in an inpatient setting per million adults, and no more than 12-15 children and young people with a learning disability, autism, or both in an inpatient setting per million children. This ambition is supported by cross-Government action, investment, and service transformation focused on new models of care designed to support people with a learning disability and autistic people to live the lives they choose, in communities close to family and friends, and in homes not hospitals.

The commitments are underpinned by the joint strategic plans Building the Right Support 2015, Building the Right Home 2016, and the National Service Model 2017,⁶⁹ which set out the frameworks for the development of community services as alternatives to inpatient care for people with a learning disability and autistic people with complex care needs. A new Action Plan is in development to support delivery of Building the Right Support. The Assuring Transformation dataset⁷⁰ measures and publishes progress on these commitments.

Response of Northern Irish Government:

Supporting people to live independently in the community has long been a priority for the Northern Ireland Executive.

One area of particular focus is the resettlement of long stay mental health and learning disability patients from hospital into the community. A Priority Target List was drawn up in 2007 which comprised 819 mental health and learning disability patients (children and adults) who had been admitted to hospital on or before 31 March 2006, and who were still in hospital at 31 March 2007, but assessed as ready for discharge. Of those, 347 were learning disability inpatients and 472 were mental health patients. As of May this year, 12 learning disability patients remained to be resettled. Fewer than five mental health patients are waiting for resettlement. This population of patients has complex needs, requiring bespoke placements in the community and appropriately trained staff. Work is continuing to address the obstacles/barriers around the completion of the resettlement process and the future model of assessment and treatment for learning disability in Northern Ireland.

⁶⁹<https://www.england.nhs.uk/learning-disabilities/natplan>

⁷⁰<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/assuring-transformation>

Response of Scottish Government:

In Scotland, Ministers and COSLA⁷¹ have established a Short Life Working Group (SLWG)⁷² to look at possible solutions for people who are lengthily delayed in speciality hospital beds, or placed in out of area placements and with priority to return. The SLWG has identified areas for further work based on the discussion and barriers relating to finance, including models of care and infrastructural requirements in relation to people delayed in hospital and inappropriately placed in out of area placements. The SLWG will report in August.

Response of Welsh Government:

In-patient settings for people with learning disabilities have been managed within the COVID-19 restrictions. This has required reconfiguration of wards to enable isolation and testing on admission/discharge. The NHS in Wales also adjusted admissions pathways to reduce bed occupancy and discharged patients with appropriate community support, where safe to do so, to create capacity to manage COVID-19 patients. To support this, we also purchased additional in-patient bed surge capacity. We have ensured interventions, including restrictive interventions, are undertaken with due regard to PPE, social distancing and other national guidance.

The Integrated Care Fund (ICF)⁷³ directly supports people with learning disabilities by helping to prevent unnecessary hospital admissions, inappropriate admissions to residential care and delayed transfers of care, and crucially provides care at or close to home. This has continued during the current pandemic. The ICF capital fund is a three-year programme that provides assistance totaling £105 million in Wales to groups that support older people, people with learning disabilities, children with complex needs and carers.

The Welsh Government has recently completed a systematic review of all Welsh adults with a learning disability in both NHS settings and the Independent Sector. The report has been published and prior to the pandemic, health boards in Wales were preparing local plans to implement the recommendations; this includes assessing a number of patients for a move to step-down services.⁷⁴

The Welsh Government is determined to do everything we can to address the unacceptable inequalities in health outcomes between Wales' most and least deprived communities. Reducing inequality is a central ambition of 'Prosperity for All', which demands that we work in a more integrated and collaborative way, with a shift towards prevention. The approaches we are taking through the 'Well-being of Future Generations Act' and 'Prosperity for All' provide new impetus in tackling the stubborn underlying causes of health inequalities, through working differently with partners, intervening early, and promoting better integration between services.

Lifestyle factors are a contributory factor to health inequalities and the Welsh Government will continue to promote healthier lifestyles including by encouraging people to achieve and maintain a healthy weight, be more physically active and through the implementation of our tobacco control delivery plan.

⁷¹<https://www.cosla.gov.uk/>

⁷²<https://www.skillsdevelopmentscotland.co.uk/what-we-do/scotlands-careers-services/16plus-data-hub/case-studies/information-sharing/short-life-working-group/>

⁷³<https://gov.wales/integrated-care-fund-2020-guidance>

⁷⁴<https://gov.wales/national-care-review-nhs-learning-disability-hospitals-provision>

Wales' involvement with the WHO's European Health Equity Status Report (HESR) will facilitate the sharing of expertise with our European partners so that we can continue to develop and refine our approaches to tackling health inequalities for the benefit of all the people of Wales.