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DHSC webinar on changes to COVID-19 measures in Adult Social Care services- Care Homes

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Alison Phillis- IPC lead, UKHSA

Introduction

Deborah Sturdy
Good afternoon everybody, and welcome to this afternoon's webinar on living with COVID-19 in adult social care. We're going to talk specifically about the changes to COVID-19 measures in care homes. Tomorrow there's another webinar for other settings.

Thank you for joining us and we are hoping to be able to answer some of your questions as we go through this afternoon, so it's really important that you put any questions that you want to pose to the team in the chat and we will gather those together. We appreciate there's not much time for Q&A, so we're going to gather those together and publish those questions. So just for you to be mindful of that at the start of this.

I want to introduce two of my colleagues who will be joining us this afternoon. Jennifer Firth, who is a policy lead within the Department of Health and Social Care and my colleague Alison Phillis from UKHSA (UK Health Security Agency).

One of the things that we have found with some of our previous webinars is that people have had problems with buffering, so we suggest that you use Google Chrome if this is the case.

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But this will be available after the transmission this afternoon. This is a 45-minute webinar, so hopefully you'll be able to use it with your staff as well as it's a fairly short session.

Jennifer is going to explain the policy to us and the changes that have happened and Alison will be here then to be part of the panel and to pick up the issues around IPC (Infection Prevention and Control).

Moving on, in terms of the context of this afternoon, on the 30th of March changes were announced on the living with COVID-19 strategy and that was published on the 21st of February.

This webinar, as I said, is going to set out those changes. We've seen the benefits of the vaccine program and we have new therapeutic drugs that are available to us as well. We want to talk about the changes that we've decided upon as a result of the world coming to terms with COVID-19 as we move to a different way of being and living with it. This means we're able to scale back COVID-19 measures to allow as much freedom as possible for you, your residents and families who come and visit.

But we want to ensure that we retain appropriate protections and strong responses to outbreaks. That's vital and I know all of you have been working incredibly hard over the last two years to actually maintain that and you've done a huge, huge amount to protect those in your care. But as we ensure that we retain appropriate measures, we want to make those changes where possible for that greater freedom.

Although COVID-19 prevalence remains high and we see that with the daily information we're all receiving through the press and other means, we are seeing fewer hospital admissions for residents and many less people dying from the virus. The residents we are seeing with COVID-19 have a milder infection and are recovering. Most residents now have been fully vaccinated.

Everybody has done a phenomenal job in ensuring that as many residents as possible, and indeed staff, are being vaccinated. We've seen high uptake of the two vaccines and the boosters. We now ask you to really encourage people within your care to take up the next round of spring boosters that are being planned at the moment, because this really helps to reduce hospital admissions and further protects individuals.

We're also able to better treat COVID-19 now in terms of antiviral medications which are available for some who test positive. So again, it's with your local GPs to actually help you manage those outbreaks and manage that antiviral opportunity that we now

have. In this last year, the phenomenal amount of effort that's been put into both developing antivirals and vaccines is really outstanding.

As the scientists have been doing that behind the scenes, I know that you've been delivering appropriate responses and support to the people in your care. So, with the impact of these measures in place, we are now moving to adopt and adapt our policies around COVID-19 measures and that balance of protection and freedoms for everybody.

We've been working with our clinical partners in terms of adjusting and adapting the policies that we have and that's why this afternoon Alison has come to join us. The guidance will continue to be reviewed in light of latest advice that comes to the fore as throughout the whole of the pandemic, and clinicians and experts have been meeting to make those adjustments and give us advice - some of the best available evidence.

We will continue to do that, but we intend to be offering fewer adjustments to the policy- we want to make less frequent changes so that life becomes a steady state for the remainder of the pandemic. I'm now going to hand over to Jenny Firth, who will take us through the changes in the policy document.

Policy changes

Jenny Firth
Thank you, Deb. As we know, there's been some really key changes to the guidance on the management of COVID-19 within care homes and what I wanted to do was just talk through those changes and to make sure that you have those details. It's obviously all set out in the guidance, but it's all summarised in the following slides. I'll start with talking about staff and then I'll move on to talk about residents and then visitors.

Just one thing to note- we talked in quite a few places in the guidance about certain parts of the testing regime only to be carried out during periods of high prevalence. I just wanted to be clear today on the webinar, that we are currently in a period of high prevalence, so the testing will continue at the moment as set out in the guidance. We will be able to provide further guidance in due course about exactly when that guidance might change and when we might be able to turn off some of this testing. But as it currently stands, this testing should continue so I'll take you through the key points.

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Staff testing

First of all, as it relates for the testing for staff, asymptomatic staff testing has changed. Previously we were asking staff to test every day before they come to work - we are now asking them to test twice per week and that is only during the periods of high prevalence. So, as I say, that testing will continue now but there may come a point that we will ask for that to be switched off, but at the moment that should continue.

For symptomatic testing, we are changing from a PCR test to two lateral flow tests that should be taken 48 hours apart. So, staff, if they experience symptoms, should stay at home and take a lateral flow test at home and then they should take a second one 48 hours after. If both of those tests are negative, then they can return to work. If either of them is positive, then they should follow the guidance for staff who have tested positive. If the first test is positive, there's no need to do the second test- they should just act as though they are positive. If they do test positive, they should stay away from work for 10-days but we have continued to make available tests within care homes for members of staff to start to test again on day five, and if they get two negative lateral flow tests at least 24 hours apart then they can return to work once they've registered that second lateral flow test.

If we move on to talk about rapid response testing, tests have continued to be made available for staff to do rapid response testing for five days if there is a case of COVID-19 found within the home. Also outbreak testing is still available and that remains unchanged.

I'll just touch on staff movement.

Staff movement

As we know the movement of staff has been restricted up until now- those restrictions have now been lifted. We recognise that has made it difficult for providers to maintain adequate staffing levels, so we are now lifting those restrictions. That means that people can move freely between providers if that's required.

PPE (Personal Protective Equipment)

And then finally on PPE, the guidance has changed so staff now only need to use an FFP3 mask when they're carrying out an AGP (Aerosol Generating Procedure) on someone that they know or suspect to be COVID-19 positive, or is a confirmed case or a suspected case of another infection that could be spread by the droplet or aerosol routes. If no infection is suspected or confirmed, type IIR mask can be used instead for AGPs and this is all very clearly set out in the COVID-19 supplement to the IPC guidance that was published last week.

Testing for residents

If we now move on to residents. I'll start again with the changes to testing. There is no longer any regular asymptomatic testing for residents. So that has now been removed.

Symptomatic testing is continuing, but in line with staff we are changing to two lateral flow tests. So again, if a resident has symptoms of COVID-19 then they should take a lateral flow test and then they should take a second one 48 hours after and they should remain isolated between these tests. They only need to take the second one if the first one is negative and obviously if the second one is also negative then they can just return to normal life within the home. But if either the first or the second is positive, then they do need to isolate for ten days. But again, in line with staff testing, we have made lateral flow tests available so from day five they can start to test and if they return two negative lateral flow tests 24 hours apart then they can be released from isolation.

Outbreak testing remains unchanged as it does for staff. Residents on admission should continue to be tested. This is through a PCR and lateral flow test. Residents who have been discharged from hospitals will be eligible for free testing from the NHS and then all other residents on admission should be tested by the care home and tests will be available to the care homes for this. So that's any other residents that are coming from the community or another care setting. Care homes are now able to admit residents who are COVID-19 positive if they feel comfortable in doing so.

We are lifting all self-isolation requirements for residents other than where the resident has been tested and found to be positive for COVID-19. There are now no other reasons that residents need to isolate*.

[*Clarification: We are still recommending that residents discharged to a care home from a location in a hospital where there was an active outbreak are isolated for 10 days from the date of admission.]

Visitors

Finally, I will move onto visitors. The most significant change here is that most visitors to care homes are no longer being asked to test before they enter. We do absolutely encourage visitors to take reasonable and sensible precautions to keep themselves and their loved ones safe, that includes staying away from the setting if they're experiencing any symptoms. And of course, if they've tested positive, they absolutely should be encouraged to stay away from the care home.

There are, however, a small number of visitors who provide personal care and we are still asking those people to test, and they will be asked to test up to twice a week if they are visiting more frequently and tests will be made available through the care homes for those individuals. They are free tests. They don't have to pay for them.

NHS staff, CQC inspectors and social workers- they continue to have access to free testing during periods of high prevalence and they will need to show evidence of those negative tests before they're able to enter the care home.

Visiting professionals who provide personal care will also continue to test before they enter the care home and free tests will be made available for those people. Again, if they're frequent visitors, they only need to test twice a week. They don't need to test on every visit.

And then finally, end of life visits should be allowed to continue and supported in all circumstances and no testing is required for those.

So that's the end of the detail of the guidance. I'm now going to pass over to Alison who can talk to us a bit more about the importance of following those measures.

Alison Phillis
Thanks Jenny.

We have been fairly instructive over the course of the pandemic in relation to the infection prevention and control measures that we are asking you to take, and we recognise that actually the testing and the infection prevention and control elements have been a critical part in reducing the risk of transmission and containing the spread of COVID-19 within care homes. We do recognise that we have high vaccination rates amongst our residents in our care homes, we have a reduced number of people being admitted to hospital, we now have availability of treatments, and therapeutics for people who do test positive for COVID-19 and we've seen a reduced death rate amongst the most vulnerable people in our communities.

But the infection prevention and control and testing you're doing continue to be really important to reduce the risks. The remaining protections we're asking you to keep are proportionate to the risk of serious illness from COVID-19 for those who are the most vulnerable. We're balancing that with factors such as enabling people to have as much freedom as possible in their place of residence, and also recognising the challenges of any restrictions we put on workforce and how that tends to impact on the ability of people to be able to do their job and for providers to be able to provide

the service. There is a balance there that needs to be managed and we hope that we are managing to achieve that with this next round of guidance.

We need your help still- we need to ask you to ensure that you remain vigilant and adhere to the package of measures we're recommending, to ensure that outbreaks in care homes are identified rapidly and then timely measures can be put in place to continue to protect the most vulnerable. It is important that not just staff are vaccinated, that all doses that can be scheduled into COVID-19 vaccination schedules are taken by our staff and colleagues, but also that our residents are well protected, and those that come into our care settings, such as visitors and professional colleagues who also will be attending.

Vaccination is a concept we need you to continue to be promoting and be part of if that's something that you feel comfortable doing. We know that vaccination is a sure-fire way of reducing the risk of severe illness for people who are vaccinated. We are continuing with the spring booster program and delighted that, although only three weeks into that, that is a program that has been enabled in the care home setting.

We're asking you to continue with your PPE adherence, so staying close to your risk assessments about what PPE is required to interrupt the risk of transmission of infection from one person to another, or to protect yourself as a care worker.

We want the continued symptomatic testing of residents and staff to be at the forefront of your mind, so people who start to develop symptoms, whether that is yourselves or someone that you're caring for, get testing involved very, very early in that process so that we can start the identification of potential risk of infection, and we react accordingly to reduce the risk of it getting a hold within the care home.

Asymptomatic testing of staff remains a key mitigation, a keyway that we've put a ring around that vulnerable setting to ensure that if there are staff members who are positive but without symptoms, then we can identify them early and we can stop that risk of bringing it into the care home.

We are asking you to act promptly on results, and that means that if required and if indicated, then people are under conditions of isolation. That also might mean that staff members don't come into work because they've tested positive or because they've got symptoms, including a high temperature, that would make them think that they might have COVID-19. So, identifying symptoms early, getting those tests done early and then responding to those test results remains really important. It also means that those who are vulnerable to severe illness of COVID-19 will have early

and prompt access to intervention- the treatments that are required to reduce the impact of that infection they've tested positive for.

Outbreak measures are going to continue, and we're really pleased that the testing for outbreak has been maintained. It is an important part of being able to identify the extent of an outbreak and to enable us to respond in a timely and proportionate manner to the risks that we're seeing during that exposure. That timely response to outbreaks does require maintaining really good communication with your health protection teams who I know that you've developed amazing links and relationships with over the course of this pandemic. We recognize that there is a challenge in terms of the volume of calls that come in during high prevalence and we are during that high prevalence time now. We would still encourage you, where you suspect that you've got an outbreak- you've got two or more linked cases within 14 days, we really do want the health protection teams to be able to engage and support you in that outbreak management.

Visiting remains an absolutely critical part of the quality of care that we can provide for people who are in residential settings. Even during outbreak, it's important that we enable visiting to take place as regularly as required by the care home residents wish. But we need to be managing that and it's already been mentioned earlier on that, although we're not asking visitors to test, what we would say is we should continue to educate people about the fact that symptoms of an infection including respiratory symptoms, really, really mean that you shouldn't be visiting your loved one. It represents a huge risk, and we are going to be asking people to continue to be vigilant with their symptoms and their behaviours to ensure that they are safeguarding the protection of those who are resident in care homes. It's important that if people are wanting visitors that they can still have one and that can be enabled during outbreak and there's plenty of detail within the guidance to support you to enable that visit to happen.

I think it's really significant that we recognise that there are some differences in our management and our guidance for care homes versus that for the general public. And this is part of the education piece, I think, around how we explain to visitors why we have more restrictions around the care home, and we enable our care home residents to understand why this level of protection is still perceived to be required for their safety and those with whom they live. And that is because the homes of residents are their long-term place of stay. Unlike a hospital type setting, where it's a short-term placement and short-term contact with staff in the majority of cases, it's not the same for care home residents who may be there for the duration, it’s for longer periods and even people in respite will be in for several weeks, two weeks as a minimum in all likelihood.

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Care homes are not always designed with infection prevention in mind and I fully recognize that this gives some significant challenges in terms of how we can mitigate. It may well mean that we have to apply additional controls to prevent the incursion-the bringing in of infection into the care home- because it's so much more challenging on occasions to control depending on the layout, the fabric of the environment in which the people are being cared for. Care homes, their nature as shared accommodation, means they're closed settings. That means that once you're in that setting, your vulnerability because of your close living arrangements with other people means that if somebody is harbouring infection it can transfer very, very easily through the hands of staff and through equipment etc. And therefore, we need to be really mindful of the fact that COVID-19 is a respiratory borne infection and in most cases we are expecting people to share living spaces, so the risks are much higher to them.

These people who live in our care settings generally do so because they have care needs and that may well make them more vulnerable to infection either physiologically or because of emotional state or cognitive dysfunction or impairment. And actually, we have a duty of care to protect them from an infection coming in and then to reduce the risk of transmission once within that residential setting.

I don't want to ignore the fact that our workforce have been absolutely phenomenal during this period. The social care workforce, who are unsung heroes of the pandemic, have continued to deliver an amazing quality of care and expertise in relation to infection prevention control. We remain entirely grateful for that and the flexibility that you've shown in being able to adjust to the differing guidance that evidence has suggested we've needed to change and amend. I want to say thank you for that, on behalf of all of my colleagues, but also to recognize that because of the place of work, we want to protect the workforce as well. The mitigations and the additional measures that we have in care home settings which feel different to the general public and other settings, including education or retail, are because we have a valued place of work and we are caring for the most vulnerable people in society in many situations, but also because you as a workforce also matter to us hugely.

So, thank you.

I'll hand over to Deborah now for the question and answers and thank you for listening.

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Deborah Sturdy
Thanks, both Alison and Jennifer for that helpful setting of the scene.

There have been numerous questions and as I said, we're not possibly going to get through a third of them, never mind all of them. So, we will be putting them together, writing those answers, and getting those out to you. And there's also been a number of questions in the chat about the presentations and I'm sure we're going to be able to share those because I know you will want to share those with colleagues. So, we'll get those out to you as well.

I'm going to invite Jennifer and Alison now to answer some of the key questions that we've been asked.

Q1 – Outbreak testing

Q:
Deborah Sturdy
There's been a number of questions asked about outbreak testing. So, when the guidance changes to care homes and about people who are actually forced to close to admissions after two positives. Alison, do you have any indication about when that might actually change?

A:
Alison Phillis
The decisions about the mitigations that need to be taken locally in response to an outbreak are managed much more closely with health protection teams now. We wouldn't necessarily be demanding that a care home closes, but certainly in terms of business in and out, they may well need to be more restricted. And I think you need to be working very closely with your health protection colleagues to ensure that you're actually responding appropriately.

Because of the variety of different sized care homes, different organisation of work, different organisation of residents within the care home, it really does need to have a much more individualized and nuanced approach going forward. And we want to enable that.

We are very clear that there are testing processes that we would want people to undertake in terms of their rapid response testing among staff if we had an individual case that was reported. But we also would be clear about whether or not the whole home requires outbreak testing and then mitigations put in appropriately or whether that is compartmentalized. I think we do need to be fairly nuanced and working

closely with our health protection colleagues to ensure that the right approach is taken for the care home in question.

Q2 – Prevalence

Q:
Deborah Sturdy
Thanks. And the next question is about prevalence. Jenny, if I could come to you on this one. How will we know when we move out of a period of high prevalence, what's the threshold?

A:
Jenny Firth
Thanks, Deb. That is something that colleagues at the UKHSA are currently working up, so we can't give further information about that.

They've got all sorts of surveillance and data available to them and they are in the process of developing the framework. What I can say is that we will make sure that it is well communicated when we get to that point. We'd also encourage colleagues to make sure that the evidence base is very clearly understood, so that people understand not only when the decision has been taken but also what has formed the basis of that decision. We hope to have some information available fairly soon on what the framework will be. And that will help to give you an indication of what the kind of scenarios might look like.

Q3 – Antivirals

Q:
Deborah Sturdy
Thank you. I mentioned at the start about antivirals being available. There seems to be a variability in access to antivirals. Alison, have you got anything to say and perhaps Jenny could pick up as well?

A:
Alison Phillis
I think it's very difficult to comment on an individual situation because I don't have that detail, so apologies to the person that's asked that question. What I would say that if you are struggling to get antivirals or you're struggling to get therapeutics, I think you need to really be referring to the individual's GP in the first instance. And then if you're still struggling, I think you need to be talking to the HPT because actually there's a variety of means and mechanism of access for therapeutics and it will very much depend on the scenario and the individual concerns.

Most people who would be requiring antiviral treatment specific to COVID-19 would already be within the system and registered, but actually if it's a more generic question around antivirals and then we really need to be speaking to your local facility, primary care provider and check that you've got access for the individual or for the home generally.

So, I'm sorry I can't comment specifically on the specifics of that question but there are a variety of means of access. So, start off with the individuals GP if it is about an individual care issue.

Deborah Sturdy
Thanks very much. Have you got anything to add, Jennifer?

Jenny Firth
No.

Q4 – Face masks

Q:
Deborah Sturdy
OK, I think that covers that one. An IPC question now Alison, do people need to be wearing masks all day long in a care home or just when giving personal care?

A:
Alison Phillis
That's a good question and are we are continuing to research and search out the evidence base for the precautions and the mitigations we ask you to undertake. We are specifically interested in care home dynamics, but the nature of the contact at the moment within residential settings is still close. It's still closed. We don't have gusts of wind coming through. There's no airflow that is so active that actually we're going to have hefty dilution in this space.

We are clear that we are in a period of high prevalence as you will all be very aware of in the community and therefore the wearing of a face mask protects not just your resident and your colleagues from cross transmission of asymptomatic infection risk, but it also protects you as a care worker from your colleagues and from your residents were there to be asymptomatic infection within your place of work. So, in health and social care at the moment, we are still asking people to retain mask wearing as a form of source control.

Other indications for wearing face masks in care have been covered in the business as usual guidance and also specifically within the COVID-19 supplement.

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I would say at the moment we still want you to retain that level of protection for you and to prevent cross transmission from asymptomatic infection to your care home population.

Q5 – Testing for professional visitors

Q:
Deborah Sturdy
And there's a question about professional visitors needing testing. Jenny have you got anything you want to say around that?

A:
Jenny Firth
Happy to clarify the position there. Visiting professionals, that's anybody who's coming into the care home to provide a service, fall into a number of categories.

You'll have visiting professionals coming from the NHS and they have their own testing regime- you want to make sure that they are providing evidence to you that they've had a recent negative lateral flow test, and they will be testing twice a week in the same way that care home staff will be. And then you've got other social care workers or people coming for the purpose of social care such as CQC inspectors or social workers. They are given free tests too, twice weekly tests, so again you'll want to ask them for evidence.

Then you'll have a group of visiting professionals who are coming in who are providing personal care, such as a hairdresser, but aren't able to access tests by any other route. They are the people that you will need to provide tests for and ask them to actually take a test on site. So, they're the people who you will need to treat a bit differently and to ask them to come in sufficient time to have the test and get the result back before they go and deliver the services that they've come in to deliver.

And then you'll have visiting professionals who don't provide any personal care- a plumber may be coming in to do some service work, won't be providing personal care, and they are people that you don't need to ask to test any longer.

Q6 – PCR testing

Q:
Deborah Sturdy
Thank you very much. There's another concern about testing which is around false positive lateral flow tests which have been negated by PCR tests in the past. The person asking this question is concerned about PCR tests being stopped. Will there be PCR testing available at all?

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And if you want to take that, Alison.

A:
Alison Phillis
There is still availability of PCR testing, but not necessarily for routine general population access. But we are retaining PCR as you will be aware within our outbreak testing management protocols. So, PCR testing is still there as a smaller proportion of the tests. And from that we are still intending to ensure that we have the surveillance that gives us in terms of potential development of other variants happening across the across the country, or if we're starting to see particular behaviours from an organism.

PCR testing does still exist, and we anticipate that will continue, but it's a much more tailored approach to PCR testing and it's very much to do with informing the surveillance program, where PCR is happening. And as I've said, outbreak management.

Q7 – Self-isolation pay and funding

Q:
Deborah Sturdy
One of the other questions has been about the cessation of the pay and funding that we've had in place for the workforce for self-isolation. Jenny can you respond to that one please?

A:
Jenny Firth
I can clarify the position there. Up until the end of March, we had the infection control and testing fund which had provided some significant resources to the sector to help them to support the COVID-19 response.

A decision has now been taken that rather than have that very generic funding stream, the government would invest in specific interventions instead going forward. PPE will remain free until next March and testing, as we've just set out, remains free for large parts of the sector and of course the vaccination offer. That's where the government is now investing resource- into those specific interventions rather than the broader funding.

That does mean that there is no longer any specific funding to cover self-isolation pay for people who are asked to stay away from work because they've tested positive. Nonetheless the rules do remain and, as I've said, if a member of staff is positive then they should remain away from work for 10 days, but they can start to access the free lateral flow tests from day five and return to work once they've had the second negative test, at least 24 hours apart.

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Q8 – Isolation periods

Q:
Deborah Sturdy
There's another question around the 10 days isolation periods. Alison, I wonder if you could pick this up. If everyone is negative at day five and six, do they need to continue to remain closed for the 10-day period?

A:
Alison Phillis
I think we're talking about within an outbreak situation here from reading between the lines a little bit.

In terms of the fact that you will have people who potentially have been exposed within that period of time, then it's likely that the HPT would want you to continue managing that as an outbreak situation.

So, let's just be really clear about the definition of an outbreak and this is where you've got 2 cases that occur within the defined period of time of two weeks, so 14 days, that are linked to the setting and that's really important. So, we're not talking about when people are coming in who have been discharged from hospital positive or coming in known positive into the care home- they shouldn't be included in your positive figures. If you're managing positive cases within an outbreak situation, because of the potential transmission risk that has already happened, then it is highly likely that the outbreak management protocol will continue to be applied.

We would want people to be clear on the required time period before that outbreak would be reduced. We need to be really, really mindful about how and what we are managing at that time. If it's individual cases versus an outbreak, then there would be different approaches taken and that is to safeguard the wellbeing of everybody within that setting.

[In the recording of the webinar the below clarification comes after Q10]

Alison Phillis
Can I just check my response to the last question because I'm not sure whether it was about people coming out of isolation on day five and six when they had been tested positive. So, if they come out, they have tested negative on their test release, residents could come out. So, I just wanted to check that I had answered that one.

Deborah Sturdy
The question was, if everyone is negative on day five and six, why do you need to retain that 10-day period of isolation?

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Alison Phillis
If these are people who have tested positive and they are testing negative now, they can come out of isolation. But if you're managing an outbreak, the home may well have restrictions applied which have to do with the outbreak restrictions. So, if you're in an outbreak, then you would still have various restrictions possibly being managed, even if the resident has left isolation.

Q9 – CQC inspections

Q:
Deborah Sturdy
Thank you. Jennifer, one for you. Should CQC be informing homes before they come in to do inspections on the basis of the continued concerns around COVID-19?

A:
Jenny Firth
Yes, that's a good question and I'm not an expert in CQC policy, so I'm not the most qualified person to answer that. What I would say is that, in terms of testing and the protections that are in place, we are continuing to provide free tests for CQC inspectors, and they will be expected to demonstrate that they are following that testing regime and that they have got a recent negative test result.

Q10 – Non-vaccinated residents

Q:
Deborah Sturdy
Thank you. I think this is for you Alison, about residents who are not vaccinated. When they go out, do they need to self-isolate still when they come back?

A:
Alison Phillis
There is no distinction now between vaccinated and unvaccinated people in terms of our management. What I would say is I think you need to be risk assessing the visit for that individual and obviously known contact might be something that you want to be managing.

Q11 – People who can't be tested

Q:
Deborah Sturdy
The next question is how do we best manage people who are unable or refuse to be tested?

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A:

Jenny Firth

It's a tricky one, the difference between not wishing to be tested and not being able to be because of a particular condition.

I think all you can continue to do is work with residents and their families so that they understand the importance of testing and why it is in place and that it's there to protect them.

Clearly, there's also cohort of people who, without a test, don't then necessarily get access to the treatments that would be important to them should they test positive. So that's something to emphasise. Deb, I don't know whether there's anything from your experience that you might be able to comment on?

Deborah Sturdy

I think it's a case-by-case basis and it's back to what Alison saying about all those IPC measures that protect us all, be you a resident or a visitor or somebody who's working in that environment. Those IPC measures are universal precautions for us all, so it's putting those in place. And you're always going to get people who either can't or somebody with a cognitive impairment who has no understanding of what you're asking them to do.

And that's why IPC has to continue, and I think one of the things that we've learned huge amounts about during the last two years is how those universal precautions have mitigated the kind of outbreaks of other infections during this period, so absolutely critical that we do that, and that people modify behaviours around those particular individuals to minimise their risk.

And also, as we've seen with changes to the symptoms list- my experience the beginning of COVID-19 when I was working in practice and looking after a care home was that we saw people falling and with eye infections. Those were the biggest indicators before anybody was even tested. So, I'm sure the expertise of people on this call during the last year of actually knowing those individuals and the fantastic thing about social care is the relationships we build.

We know those individuals, so we know when things aren't right. I think it's looking at that symptomology. I don't know, Alison if there's anything to add to that. But IPC is critical.

Alison Phillis

Absolutely. And it's so important- the educational piece. We've mentioned the fact that people have been on this huge journey as a workforce, but you also have relationships with people that are incredibly influential. Everything is advisory, it's all recommendations. We really do need to maintain a hearts and minds approach with

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our visitors and with our residents because we're asking people to still comply with what can feel really quite tough measures at times, and I do recognize that.

But it is about that longer term protection of this population to ensure that people are protected adequately. But IPC is a package. You're absolutely right. It's a package of measures so applying all of those principles and consider what the interaction is, consider what the needs of that resident are - they must be taken into account when you're when you're applying that risk assessment.

Conclusion

Deborah Sturdy
Thank you. And we're running out of time fast here.

I just want to say thank you to Jennifer and to Alison. I know there are masses more questions that we will get written up and out to you as soon as possible. Also, this session will be available via this link for your teams after the end of the session today. I know this has been an incredibly challenging time and none of us thought we'd be here two years later.

But thank you all for what you're doing. You're making a massive difference every day to those that you care for and those that you work with. So, thank you very much.