



‘Protect the NHS’ at the cost of care homes?

A look behind the death rates in care homes during the first wave of the Coronavirus pandemic’.

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Globally COVID 19 has impacted disproportionality on older people and particularly on care home residents. Analysis of COVID 19 mortality in 21 countries during the first wave of the pandemic points to care home residents accounting for 46 per cent of deaths (Comas-Herrera and Fernadez (2020). Northern Ireland Statistics and Research Agency (NISRA) data shows that of the 866 deaths linked to coronavirus up to August 14, nearly half (431) were care home residents. As the first wave of the pandemic emerged, UK governments sought to ‘protect the NHS’ by placing their focus firmly on hospitals with little mention of social care. As infection rates and death rates increased commentators highlighted how the problems in care homes were, at least in part, exacerbated by the pre pandemic crisis in that sector. Like many ageing societies, the Northern Ireland’s policy-making has failed to keep pace with demographic change. As a result, social care systems are under-funded and privatized, operating as a kind of poor relation to the core health system (Phillipson, 2020).

Bell (2020), commenting on a UK wide analysis of excess deaths in care homes has argued that *“given the variation in testing and death registration practices across the UK, it will never be possible to unequivocally assign care home deaths during the pandemic to COVID-19 or other causes. Therefore, measuring excess deaths presents the most reliable approach by which to assess the relative failure or success in handling the pandemic in care homes”*. The delays in providing PPE, staffing shortages and the problems accessing testing experienced by care homes was indicative of the historic failure of governments throughout the UK to prioritise social care and had consequences with regard to the spread of infection.

A large scale survey of care homes in England (ONS, 2020) found significant correlation between infection rates in staff and infections among care home residents and between the use of agency and bank staff. There was also some evidence that in homes where staff received sick pay there were lower levels of infections in residents. At the start of the first lockdown, across the UK thousands of older people were discharged from hospital to care homes without being tested for COVID 19. The extent to which this was a major source of infection is difficult to quantify. Hodgson et al (2020) offer a clear and useful account of the difficulties faced by researchers and doctors in quantifying the impact of the virus on the mortality rates of the most vulnerable. They conclude that it is likely that some of these discharges could have represented an infection risk, particularly in March and early April. In Northern Ireland, a report commissioned by the Department of Health on hospital discharge (Dept of Health, 2020) and studies in Wales and Scotland (Burton et al, 2020) found no clear evidence between discharge from hospitals and infection rates. Instead, they identified care home size as the strongest predictor of outbreaks.

Meanwhile, researchers in the United States have found incidence in the community around the care home as the best indicator of death rates in the care homes (Konetzka, 2020), also a conclusion of the Northern Ireland report. There is no doubt that protecting care homes from COVID was a challenge. Nevertheless, the repeated failure of governments around the world to keep residents safe suggests that when

it came to emergency planning, care homes residents were somehow overlooked. With the benefit of hindsight, and from what we now know about the spread of the virus on cruise ships, we should have foreseen that care homes present the perfect breeding ground for the spread of infection.

Analysis of care home deaths has revealed how other 'risk factors' associated with COVID, such as the prevalence of ageism in society (Fraser et al, 2020) underpin the high death toll. Excess deaths in care homes are likely to be impacted by the age discrimination faced by older people in relation to decisions on medical care and/or as a result of the scaling back of non-COVID related services (United Nations, 2020). A survey by the Queen's Nursing Institute (Queen's Nursing Institute, 2020) reported that, at the height of the first wave of the pandemic care homes were told to introduce blanket 'do not resuscitate' orders for all residents. The lack of protection afforded care home residents has led Carney and Nash (2020) to argue that care home residents who died during the pandemic experienced a basic violation of their human rights on the grounds that they were not seen as worthy of protection. Compounding the impact on care home residents was the loneliness resulting in isolation from family and friends and from other residents within the home, and the withdrawal of many social activities within the care home.

Now, as we are firmly in the second wave of the pandemic what has been learned and how prepared are care homes? Not much, it would seem. The infection rate in care homes is increasing. As of 18th November there were confirmed outbreaks of COVID 19 in 163 of Northern Ireland's 481 care homes. Despite the evidence on the impact of the isolation during the first lockdown it appears that with regard to preparing the home care sector it is a case of too little, too late. Given the strong correlation between community transmission rates and

care home infections, testing has been seen by many as the single most important measure in reducing the spread of infection in care homes and in allowing visits to be maintained. Weekly testing of staff is seen as the best option. Under new testing protocols introduced in August staff are tested every 14 days and residents every 28 days. However, evidence to the NI Health committee by the Association of Independent Care Providers cited delays in staff testing results (due to them not being considered Pillar 1 frontline staff – yet another indication of the status of this sector) and the continued lack of a universal approach in terms of discharge pathways for people testing positive.

Guidance issued on 16th October by the Northern Ireland Executive recommended that visiting in care homes once again be restricted with the exception of end of life care. Investment in and preparations made by care homes to facilitate safer visiting, and indeed to maintain contact with families, varies considerably across the sector. The care sector in Northern Ireland, as elsewhere in the UK is the hands of private care companies. Of the 482 residential and care homes, only 48 are run by the statutory sector. This is not in and of itself a problem, but it does offer some explanation. The push for profit tends to necessitate larger homes and diminished security of tenure and continuity of care for residents. Operating outside the NHS also means that care homes were last in line for PPE and other crucial resources.

The diversity and ongoing precarity of this sector is a major challenge. On 13 October, Four Seasons, one of the largest care provider chains operating in Northern Ireland announced that it is selling off more than 40 of its homes after its parent company went into administration. Four Seasons had previously bought some of the Southern Cross homes when that company collapsed. The work of care staff might be better recognised but the poor pay (often minimum

wage) and working conditions have not changed. Despite efforts to recruit more care workers, providers have had little success and a reliance on bank and agency staff has remained. Some carers will be working across several facilities – a risk factor in the spread of infection.

The lessons to be learned from the pandemic are not new – we need a properly funded, regulated and state-guaranteed system of social care. Residents of care homes should have the same status as any citizen using the NHS. Their carers should have the same status as ‘NHS heroes’ and their families deserve the opportunity to offer love and support when they are ill or frail. Unfortunately, until we close the gap between health and social care in the UK, we can expect the vicious cycle of low pay for precarious workers and high death rates for care home residents to continue. Let’s hope that the legacy of the pandemic will be the abundance of political will needed to fix social care.

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