

## Disability centres – Response to request for information from the Special Committee on COVID-19 Response

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### Background

In census 2016, circa one in seven people in Ireland, or around 643,000, self reported as having a disability or long-term condition. Taking a ‘mainstream first’ approach, underpinned through the Disability Act 2005 by the legal requirement for public bodies like the HSE to include people with disabilities in their mainstream services, over 90% of those with a disability are supported through general community health and social services.

General health services are complemented by specialist community-based disability services, delivered to about 9% of those with a disability (circa 56,000 people), through a suite of interventions including early intervention, multi-disciplinary therapies, habilitation, rehabilitation and behaviour support, staffed supported housing, specialist end of life care, respite/short breaks to support carers, day services and support for community engagement, personal assistance, home help and assistive technology. Access to disability support services is based on need, not on a specific diagnosis.

### Residential Services

There are currently circa 8,400 people with disabilities living in 1,300 HIQA registered disability centres. It is Government policy to close residential institutions and campus settings for people with disabilities and transition their residents to ordinary homes in the community. This is in line with Article 19 of the UN Convention on the Rights of Persons with Disabilities, which Ireland has ratified, and the clear evidence from international studies that ordinary housing in the community provides a better quality of life. As at the beginning of 2020, there are 2,000 living in congregated settings (institutional style shared accommodation or campus based mixed dwellings including bungalows/apartments) while the majority (6,400 people) live in group homes in the community. Providers of Disability Services have made huge strides in the last few years in “de-medicalising” the services and ensuring that people with disabilities are integrated into their communities and live a meaningful life and one that is of their choosing.

Under the 2007 Health Act, all disability centres must meet certain regulatory standards in order to be registered to operate. The Act (as amended) empowers the Chief Inspector, a statutory officer within the Authority, to carry out this function through the processes of registration, continual monitoring and inspection and, where necessary, the application of its powers of enforcement (S.I. No. 366 of 2013). HIQA has contributed to on-going risk assessment and support of disability residential centres in their implementation of control measures throughout the pandemic.

HIQA’s 2018 *National Standards for infection prevention and control in community services*<sup>1</sup> are particularly relevant in this regard including ensuring availability of PPE.

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<sup>1</sup> <https://www.hiqa.ie/sites/default/files/2018-09/National-Standards-for-IPC-in-Community-services.pdf> [accessed on 14/06/2020]

Members of staff in disability residential centres are core to ensuring safe care and support are provided to the residents who live there. Given the nature and importance of the role of staff in delivering this care, significant provisions are included in regulation and national standards. Service provider, for example, must ensure that *“at all times there are sufficient numbers of staff with the necessary experience and competencies to meet the needs of residents...Contingency plans are in place in the event of a shortfall in staffing levels or a change in the acuity of residents.”*

It is recognised that the impact of COVID-19 on society in general as well as on those living in disability centres has been considerable. The introduction of physical distancing, isolation, reduced social activities and restricted contact with family and loved ones has changed the usual dynamic of social interaction. The focus on interrupting the transmission of the virus is part of a wider requirement to prioritise the wellbeing of residents of disability centres, remain person-centred, be cognisant of their rights as citizens, and to be vigilant that in seeking to prevent infection that these rights are not infringed upon to an extent, or in a manner, that is disproportionate.

### **COVID-19 Pandemic**

2020 has brought with it the most serious global pandemic in a century – something that was unimaginable a few short months ago. Since COVID-19 emerged first in China at the end of December last, the World Health Organisation (WHO) and individual countries have been monitoring the rapidly evolving situation and initiating and updating preparedness. During January the health service and the Government stepped up national public health and emergency responses. The National Public Health Emergency Team (NPHE) and HSE National Crisis Management Teams for COVID-19 were convened and commenced their work.

### **Vulnerable Populations**

NPHE considers one of the most effective ways of protecting vulnerable populations is suppressing the virus in the community. People living in long term residential care (LTRC) settings, which include disability residential settings, are considered vulnerable populations and on 21<sup>st</sup> March were identified by the WHO to be at a higher risk of being susceptible to infection from COVID-19 and for subsequent adverse outcomes<sup>2</sup>. This can be attributable to age, the prevalence of underlying medical conditions and in the case of people with disabilities, where high care support with the activities of daily living is required in collective high physical contact environments. There are characteristics of disability residential care in Ireland, including in some cases, congregated living environments where the nature of care involves regular carer/resident contact, that make them high-risk for COVID-19 outbreak and contagion across residents and staff. However, for those with a disability living in residential centres many live in houses in the community with no more than 4 people sharing a home meaning these live in an arrangement similar to a ‘family cohort’ living together.

NPHE advice focused on all LTRC settings and its recommended actions were relevant for all residential care services - older people, disability and mental health.

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<sup>2</sup> WHO 2020, Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19 Interim guidance (21<sup>st</sup> March 2020)

## **NPHET Vulnerable People Subgroup**

The National Public Health Emergency Team (NPHET) established the NPHET Vulnerable Peoples Subgroup, which has broad membership from across Government Departments, Agencies and key stakeholders. This Subgroup was established to provide oversight and assurance with regard to the specific preparedness, measures and actions that need to be taken to protect vulnerable groups and individuals in society. The specific needs of vulnerable groups, including those with a disability, are being considered at a national level with representation from all Government Departments with responsibility for disability issues as part of an integrated cross government response. The Subgroup held its first meeting on 6th March and across Government Departments such as Education and Justice, the HSE and Disability Federation Ireland the interests of people with disabilities on the group were represented.

### **Public health led response**

The response to COVID-19 in Long Term Residential Care (including disability residential settings) is based on preparedness, early recognition, isolation, care and prevention of onward spread. This involves case recognition, testing, contact tracing and examining disease patterns including mortality. During February and early March 2020 local public health departments were both proactively and reactively interacting with residential settings. Initially the seasonal influenza guidance for LTRC was used as the source of advice; this guidance evolved to focused public health and infection prevention guidelines on the prevention and management of COVID-19 cases and outbreaks in residential settings.

Prompt, effective public health surveillance and response is critical to the identification and control of outbreaks in healthcare settings. Ireland has a national public health surveillance system, called CIDR (Computerised Infectious Disease Reporting) in place to manage the surveillance and control of infectious diseases in Ireland. Ireland is in a stronger data collection position than a number of other countries as CIDR captures data (cases, clusters and deaths) from both the community as well as acute hospitals and has done so since the commencement of the pandemic.

Mortality rates have been the subject of much international discussion. Unlike Ireland, official data on the numbers of deaths among LTRC including disability services linked to COVID-19 for many countries is not available. In addition, international comparisons are difficult due to differences in testing availability and approaches to recording deaths. In order to be assured that all deaths were being captured in LTRC in Ireland, both lab confirmed and probable, the Department undertook a mortality census of all LTRC facilities mid-April. Data was compared between the census of mortality and other sources of mortality data including the Health Information and Quality Authority (HIQA) NF02 notifications and CIDR. This comparison demonstrated that the number of cases matched closely between the sources.

On 28th May NPHET published "*COVID-19: Comparison of Mortality Rates between Ireland and other countries in EU and Internationally*". (link attached.)

The approach has been clear and consistent in recording COVID-19 cases and deaths in LTRC settings from the beginning of this pandemic. This places Ireland as one of the very few countries to take a comprehensive approach and use this data to inform public health actions in a measured, decisive and scientific manner.

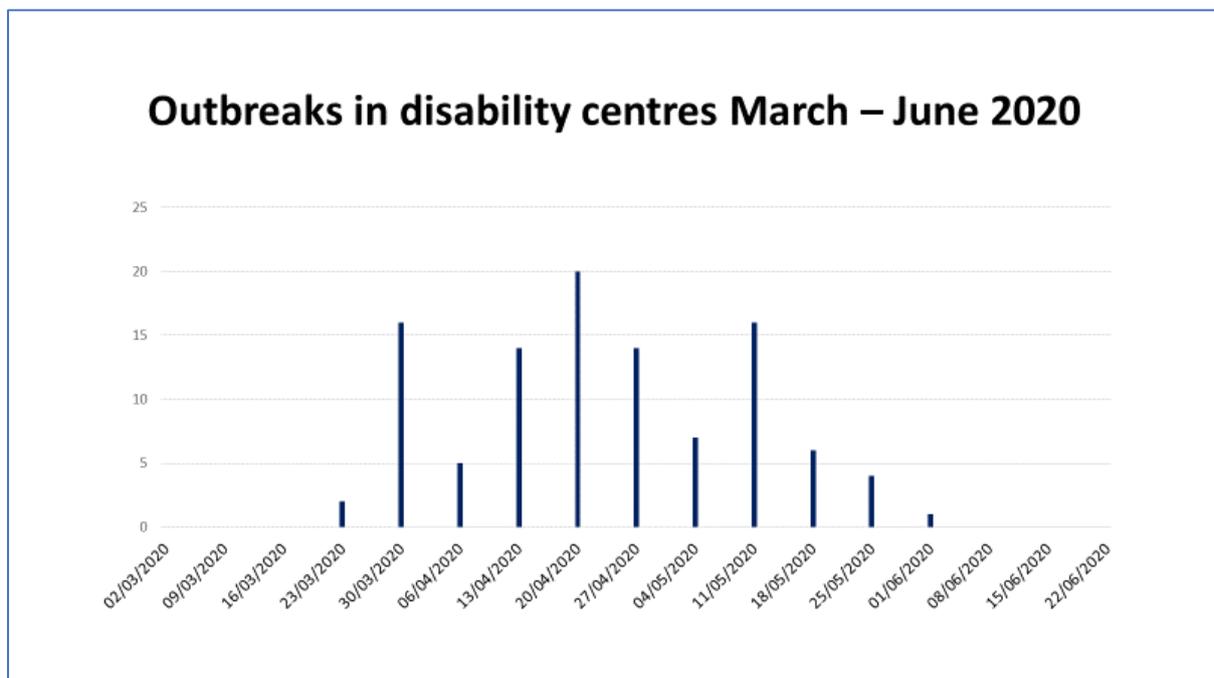
### COVID-19 Disability surveillance information

On 23rd March 2020, the HPSC was first notified of a cluster in a disability residential centre. As of midnight 26 June, the HPSC has reported 98 clusters in disability centres. 79 of these clusters are now closed (79% of such outbreaks). A cluster is closed once there is no case for 28 days following the last case.

These clusters are associated with 521 laboratory confirmed cases, 2% of all such cases. Of these, about 230 were of residents (0.9% of all cases). 36 residents of disability centres were hospitalised, while sadly there were 13 deaths associated with disability residential centres.

In addition, as of 22nd June, three residents aged under 50, four aged between 50-54, five age between 55-59 and eight between 60-64 living in nursing homes have died where COVID-19 was confirmed or suspected. Some of these may include younger people with disabilities living in these homes.

**Graph 1: Number of COVID-19 Outbreaks in Disability Residential centres**



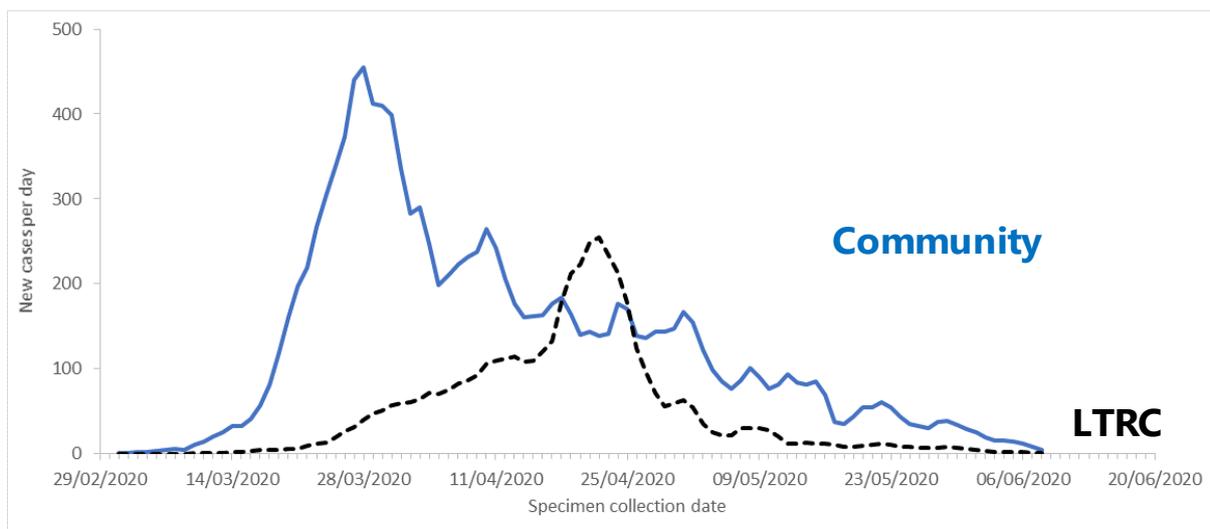
Notifications for the week beginning

Official data from the Computerised Infectious Disease Reporting system (CIDR) of the Health Protection Surveillance Centre (HPSC) is provided, on a daily basis, under 'outbreak and mortality for all Long Term Residential Settings' – this includes Nursing Homes, Disability Residential Settings, Mental Health facilities, prisons, immigrant reception centres, Homeless Hostels etc . This data is provisional and subject to ongoing verification. Table 7 on page 8 provides a list of clusters/outbreaks at of the latest data available.

[https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/epidemiologyofcovid-19inireland/COVID-9%20Epidemiology%20report%20for%20NPHET%2020200425\\_website.pdf](https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/epidemiologyofcovid-19inireland/COVID-9%20Epidemiology%20report%20for%20NPHET%2020200425_website.pdf)

Analyses of the trajectory of the epidemic among the general population, healthcare workers and LTRC residents has been conducted by the Irish Epidemiological Modelling Advisory Group. Graph 2 shows that the peak number of new cases in the general population was on 28<sup>th</sup> March. It was only when this peak was reached that the number of cases in long-term residential care settings began to increase. The peak in new confirmed cases in these settings in mid-April coincided with the expanded testing undertaken across the sector.

**Graph 2: Number of COVID-19 rolling average cases in LTRC by date**



Data 5-day rolling average. Community: all cases excluding healthcare workers, and cases associated with outbreaks in LTRC. LTRC: all cases associated with LTRC outbreaks.

The peak in cases in LTRC in late April may be due to targeted testing in these facilities.

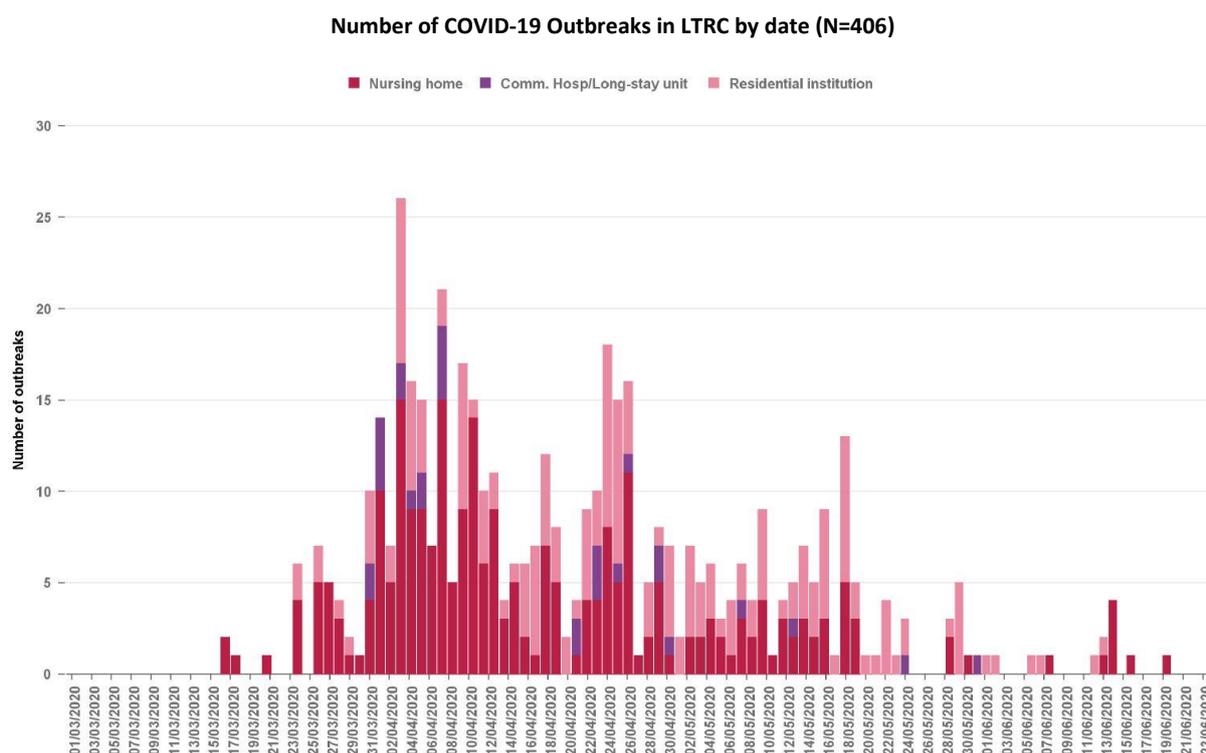
Source: Irish Epidemiological Modelling Advisory Group, 11<sup>th</sup> June 2020

Graph 3 provides a view of the number of COVID-19 outbreaks by date in LTRC settings. The first outbreak in a disability residential centre was identified on the 23<sup>rd</sup> March – 11 days after the implementation of visiting restrictions (12<sup>th</sup> March<sup>3</sup>).

The graph shows the timeline along which new clusters in nursing homes, residential institutions (including disability residential centres), community hospital/long stay units were identified and notified to the HPSC by local Departments of Public Health. Note the time at which the first public health measures, including the restriction of visitors to residential care facilities, were implemented was mid March and the implementation of the expanded testing programme of residents and staff in residential care facilities commenced mid April.

<sup>3</sup> Implementation of NPHE recommendations from meeting 11<sup>th</sup> March were announced by the Taoiseach on 12<sup>th</sup> March

**Graph 3: Number of COVID-19 Outbreaks in LTRC by date**



### Impact of COVID-19 and disease progression in Ireland

The impact of COVID-19 in LTRC facilities has, like many other countries, been considerable. There are a number of reasons why LTRC have been more severely impacted in this COVID-19 pandemic and these lessons are becoming more evident as epidemiologists and public health experts have learned more about the transmission of this novel virus over the preceding weeks and months.

This virus is much more infectious than influenza. A recent review of 12 modelling studies reports the mean basic reproductive number ( $R_0$ ) for COVID-19 at 3.28, with a median of 2.79.<sup>4</sup> The median  $R$  value for the pandemic of influenza H1N1 2009 was 1.46 and for seasonal influenza was 1.28.<sup>5</sup> This means that every person with COVID-19 spreads the infection to double the number of people as a person with influenza.

The ECDC in its 5<sup>th</sup> Rapid Risk Assessment of 2<sup>nd</sup> March 2020, stated that there remains no strong evidence of transmission preceding symptoms onset. However, in their 6<sup>th</sup> Rapid Risk Assessment released on the 12<sup>th</sup> March 2020 ECDC described a case report where possible asymptomatic transmission had occurred and advised that major uncertainties remain in assessing the role of pre-symptomatic transmission.

The serious impact on LTRCs was subsequently identified by ECDC in their 9<sup>th</sup> rapid risk assessment of 23<sup>rd</sup> April 2020. Internationally the role played by those with asymptomatic or very mildly symptomatic disease in spreading infection is now much more clearly recognised. Such asymptomatic transmission

<sup>4</sup> Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK – eighth update 8 April 2020

<sup>5</sup> Estimates of the reproduction number for seasonal, pandemic, and zoonotic influenza: a systematic review of the literature Matthew Biggerstaff, Simon Cauchemez, Carrie Reed, Manoj Gambhir and Lyn Finelli

adds significant challenge to public health and infection control strategies. An important component of such strategies is to achieve overall reduction and control of virus levels in the community so as to avoid unwitting spread by those that are asymptomatic into vulnerable settings, including disability residential settings. Within registered disability centres testing to ascertain asymptomatic cases is now a core strategy. Ireland's testing of all staff in all facilities and all patients in affected facilities contributed to the identification of asymptomatic cases and the interruption of transmission.

In addition, a clinical picture in vulnerable and older populations has emerged that did not meet the case definition as established initially through the WHO. Evidence has emerged that presentation of COVID-19 in LTRC can differ from that of the general population from no temperature to confusion and the pace of progression of disease is much faster, likely due to the age and frailty of older people in particular.

The Department of Health and other agencies have been engaging with the research community on an ongoing basis to identify information, guidance and evidence internationally on COVID-19 and LTRCs, including in relation to impacts, management and interventions. A substantial package of guidance has been published and continues to evolve and be updated in line with new national and international evidence. Regular research is undertaken of national and international literature, such as rapid reviews of public health guidance on protective measures for vulnerable groups from COVID-19, to ensure that the best available information and evidence is considered in this rapidly evolving environment.

### **Summary Timeline of Response**

By the 27th of January 2020 NPHE had been established and held its first meeting. At this meeting NPHE noted that "the ECDC's risk assessment for the EU / EEA is now 'moderate' but that, subject to appropriate control measures being in place, the risk of onward transmission is rated as 'low'." At this meeting the HSE briefed NPHE about the HSE's High Consequences Infectious Diseases Group, which had already had several meetings and had produced algorithms/procedures for all key sectors. On 30th January 2020 the HSE circulated guidance and posters on coronavirus to various settings, including disability residential centres.

The public health advice during Ireland's containment phase was in line with ECDC guidelines and sought to reduce the risk of transmission through personal hygiene and respiratory etiquette while remaining vigilant regarding the identification of cases. Ireland recorded its first confirmed COVID-19 case on 29 February.

On 6<sup>th</sup> March the Vulnerable Subgroup of NPHE was established and held its first meeting.

On 10<sup>th</sup> March Interim Guidance on Transfer between Care Facilities was disseminated and through HIQA was circulated directly to all LTRC registered centres.

On the 11th March NPHE recommended that Ireland move to "delay phase" and social distancing measures were recommended and announced, including:

- Visiting restrictions in long-term care facilities;
- Individuals who have symptoms should self-isolate for a period of 14 days.

The Government's COVID-19 Action Plan was published on 16th March and included key actions relating to the protection of vulnerable groups in community settings, including long-term care settings, through maintenance of existing services and enhanced support actions.

Preliminary Clinical and Infection Control Guidance for COVID-19 in Nurse-led Residential Care Facilities (RCF) was published by the HSE and circulated to registered disability centres on 17th March 2020. The document provides guidance on general measures to reduce the risk of accidental introduction of COVID-19 into a LTRC, procedures to be followed for clinically suspect residents, guidance on clinical investigations and monitoring and on IPC. The document also provides detailed step-by-step instructions across a range of scenarios.

On the 24th March HIQA issued to all designated centres and registered provider's COVID 19 guidance on sector wide preparedness arrangements.

On 25th March 2020 ECDC published its 7th Update which upgraded the risk of "severe disease associated with COVID-19 for people in the EU/EEA and the UK is currently considered moderate for the general population and very high for older adults and individuals with chronic underlying conditions." In respect to long-term care facilities, the RRA outlined the following specific measures:

- Long-term care facilities should implement infection prevention and control measures
- Social distancing measures affecting multiple people can include measures to limit outside visitors and limit the contact between the residents of confined settings, such as long-term care facilities;
- Long-term care facilities should implement the baseline options for preparedness for COVID19 described in an ECDC guidance document, given that the rapidity of an onset of a COVID19 outbreak may result in insufficient time to implement the necessary infection prevention and control (IPC);
- The ECDC guidance document 'Infection prevention and control for the care of patients with novel coronavirus in healthcare settings – first update' highlights best practices for PPE and options for hospitals and long-term care facilities that have limited access to such materials;
- Testing all cases of acute respiratory infection in hospitals or long-term care facilities in order to guide infection control and PPE use to protect vulnerable persons and healthcare staff; testing of symptomatic healthcare staff, even those with mild symptoms, to guide decisions on exclusion from, and return to, work;

At its meeting of the 27th March 2020, the NPHE discussed infection prevention and control in community and acute settings, in particular in relation to vulnerable people, and the group noted the necessity for the HSE to ensure the establishment of individual Outbreak Control Teams with appropriate public health input in respect of each such setting where clusters of infection are identified. On foot of the latest national data and the updated ECDC risk assessment, the group considered the existing policy and the related public health measures currently in place and agreed that a package of additional measures should be recommended to slow the spread of COVID-19 with particular focus on those aged over 70 years and the extremely medically vulnerable groups – introducing "cocooning" for these groups.

Guidance on cocooning to protect people over 70 years and those extremely medically vulnerable from COVID-19 was published by the HPSC on the same day, including specific reference to the application of the guidance to those in residential care facilities.

On 31st March, NPHET considered a specific paper on LTRCs and made a series of recommendations in relation to LTRC facilities comprising six national public health actions (see paper attached). The objective was to support the maintenance of residents in LTRCs unless there is clinical or other advantage, and to interrupt transmission of the disease and prevent onward spread in LTRC and the community.

On 3rd April 2020 the NPHET recommended that the HSE should immediately deploy an integrated outbreak crisis management response across LTRC settings, home support and acute hospital settings, to drive the infection prevention and control and the public health measures agreed by NPHET at the meeting on Tuesday, 31st March.

HIQA issued a regulatory notice to service providers regarding the establishment of the Infection Prevention and Control Hub for designated centres on 6th April.

On 7<sup>th</sup> April the HSE COVID Residential Care/Home Support COVID Response Teams Operational Guidance issued.

On 10th April, it was agreed at NPHET that there should be continued focus on the long-term residential care sector and to continue to collect, expand and monitor data. The NPHET considered that mortality data should be further refined including specifically categorising COVID-19 deaths as suspected or confirmed. Data on identifying place of death and more timely data on confirmed cases among staff would also be important to get a more complete picture.

There was continued focus on LTRCs at NPHET's meeting on 14th April where it was agreed that the HSE was to put in place a coordinated national process for carrying out prevalence surveys across residential healthcare settings including registered disability centres, with a particular focus on detecting COVID-19 infections.

On 17th April NPHET considered and endorsed a further set of immediate additional actions focused on long term residential healthcare settings, to further inform and direct the public health response including:

- a) a survey of mortality to be conducted to collect data on the total number of deaths (January 2020 to present), the number of laboratory confirmed COVID-19 deaths (March 2020 to present) and number of possible COVID-19 deaths (March 2020 to present). The survey to commence on 17th April;
- b) national testing of staff across all settings with an initial widespread approach and thereafter ongoing testing, which may include both staff and patients, to be conducted on a rolling basis;
- c) the publication and assessment of a COVID-19 quality assurance regulatory framework for LTRCs by HIQA;

- d) the implementation of previous recommended actions with enhanced reporting through an expanded 'Nursing Homes/LTRC settings Actions Tracker', which is to include the roll out of the Contact Management (CRM) system.

### **Covid-19 Testing in Disability Residential settings**

As Ireland sought to scale up testing for COVID-19 nationally, the National Ambulance Service (NAS) initially offered a home-based testing service to all patients who met the case definition criteria set out for COVID-19 by HPSC/NPHET including residential care facilities. As the 'home-based' testing model transitioned towards community-based testing centres of larger scale a dedicated pathway for nursing home testing was established with NAS. Since 18th April, testing was being rolled out across all disability residential centres. In addition, a large scale Covid-19 testing programme commenced on May 18<sup>th</sup>, on the recommendations of the National Public Health Emergency Team (NPHET). The programme of testing applied to Long Term Residential Care Facilities including Nursing Homes and residential services for older people, mental health residential facilities and residential services for people with disabilities. There are a total of 2,242 long term residential care facilities in Ireland including registered disability centres. Testing was identified as a requirement for 2,171 of these locations. Testing of residents and staff was undertaken in locations with a confirmed or suspected outbreak of Covid-19. Testing of staff was conducted for all other locations. Testing of staff in these locations was undertaken either on –site in the work location, or in Community Testing Clinics. The programme of mass testing in residential care facilities was undertaken by CHO Testing teams, National Ambulance Service staff, staff in the residential care facilities, or by a combination of these staff groups.

Of the 1,287 residential care facilities in Disability Services in Ireland, mass testing was indicated for 1,242 locations, as 45 of the 1,287 locations were low support community residences which do not have staff on site. Available data indicates that large scale Covid-19 testing has taken place in all locations.

<b>CHO</b>	<b>Total Number of Disability Service Sites</b>	<b>Total Number of Disability Service Sites Testing Undertaken</b>	<b>Total Number of Disability Service Sites to test</b>
1	114	106	0
2	139	139	0
3	136	129	0
4	144	143	0
5	152	152	0
6	86	83	0
7	151	151	0
8	225	245	0
9	140	124	0
<b>Total</b>	<b>1,287</b>	<b>1,242</b>	<b>Testing Complete</b>

### **COVID-19 operational responses**

As the disease has progressed and new information emerged, a range of enhanced measures for these settings were recommended by NPHET on 31<sup>st</sup> March 2020 and 3<sup>rd</sup> April 2020. These enhanced measures build on actions already adopted for registered disability centres, at the initiation of the

relevant Outbreak Control Teams and the existing infection prevention and control advice provided by the HPSC, including general and specific infection prevention measures, specific public health and clinical COVID-19 guidance, social distancing measures, visitor restrictions and cocooning. A substantial package of focused guidance for LTRCs has been put in place and continues to evolve and be updated in line with new national and international evidence and guidance.

The State's responsibility to respond to the public health emergency created the need for the HSE to stand up a structured support system in line with NPHET recommendations. This has been a critical intervention in supporting the resilience of the sector in meeting the unprecedented challenges associated with COVID-19. In addition to public health support, in line with NPHET recommendations and in order to enable continuity of service delivery and infection prevention management, support for registered disability centres over the last three months has encompassed:

- Enhanced HSE engagement;
- Multidisciplinary clinical supports at CHO level through 23 COVID-19 Response Teams;
- Access to supply lines for PPE;
- Access to reassigned staff;
- Suite of focused LTRC guidance;
- Temporary accommodation to staff;
- HIQA Infection Prevention Hub and COVID-19 quality assurance regulatory framework.

### **International guidance**

The Department of Health and other agencies have been engaging with the research community on an ongoing basis to identify information, guidance and evidence internationally on COVID-19 and LTRCs, including in relation to impacts, management and interventions. Regular research is undertaken of national and international literature, such as rapid reviews of public health guidance on protective measures for vulnerable groups from COVID-19, to ensure that the best available information and evidence is considered in this rapidly evolving environment. Where learning has been identified from other jurisdictions it has been rapidly incorporated within advice and supports being made available.

In this regard HIQA provides a weekly review of public health guidance for residential care facilities. This review notes a range of guidance has been issued internationally to protect residents and staff of LTRCs in the context of COVID-19. Guidance includes recommendations on testing, screening, monitoring, isolation, cohorting, social distancing, visitation, environmental cleaning, immunisation, providing care for non-cases, caring for the recently deceased, and governance and leadership. Many similarities exist between guidance documents, including recommendations to screen people entering facilities, to monitor staff and residents for new symptoms, to restrict visitation except on compassionate grounds, to isolate suspected and confirmed cases, to cohort symptomatic residents, to regularly clean frequently touched surfaces and to develop outbreak management plans.

The latest advice from the WHO and ECDC has been tracked daily and public health and operational advice and supports for LTRCs have been revised as evidence has emerged. It was mid to late March 2020 before specific guidance for the LTRC sectors was produced by the WHO. The serious impact on

LTRCs was subsequently identified by ECDC in their 9<sup>th</sup> rapid risk assessment of 23<sup>rd</sup> April 2020. In its special technical report of 19<sup>th</sup> May, *Surveillance of COVID-19 at long-term care facilities in the EU/EEA*,<sup>6</sup> ECDC identified that the high COVID-19 morbidity and mortality observed among residents in long-term care facilities in EU/EEA countries poses a major challenge for disease prevention and control in such settings. This report outlines a set of multiple factors that may be contributing to spread including asymptomatic staff and residents and atypical COVID-19 clinical presentations or the absence of evident signs or symptoms until the patients' conditions deteriorate.

The timeline set out in the “*Overview of the Health System Response to date Long-term residential healthcare settings*” (26<sup>th</sup> May 2020) (Page 2) and summary table in Appendix 3 outline from the first COVID-19 case onwards the actions taken and how each actions, if not already in place, commenced swiftly and decisively following recommendations from both ECDC and the WHO.

### **Communication and access to public health information on COVID 19**

Ministerial meetings took place with advocacy groups, service providers and service provider representatives to ensure a two way communication process was available. The following Ministerial meetings were held:

- Inclusion Ireland on 27th April and 3rd June
- National Federation of Voluntary Service Providers, 20th May
- Disability Federation of Ireland, 20th May
- Disability Action Coalition, 20th May
- Inclusion Ireland, 3rd June
- National Disability Inclusion Strategy Implementation Group, 12th May
- HSE hold separate weekly tcons with umbrella groups and service providers to ensure two-way communication. Targeted disability specific communication work highlighting the supports in place were developed, a Youtube video from the Head of Disability Operations Cathal Morgan and a FAQ for people with disabilities and family carers providing information and contacts for 8 helplines was prepared

<https://www.hse.ie/eng/services/news/newsfeatures/covid19-updates/partner-resources/approved-communication-supports-for-deaf-patients-in-healthcare-settings-during-covid-19.pdf>

See Appendix 1 for full list of guidance available on HSE website.

### **Services for people with a disability post COVID-19**

A joint Department of Health and HSE Community Capacity Working Group has been established to oversee the development of a plan that sets out the specific timelines, service objectives and dependencies associated with the phased resumption of services over the period ahead including social care services.

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<sup>6</sup> <https://www.ecdc.europa.eu/en/publications-data/surveillance-COVID-19-long-term-care-facilities-EU-EEA>

The Group's work is aligned with - and has informed - the HSE's development of a "Service Continuity in a COVID Environment – A Strategic Framework for Delivery". This Framework is intended to set the vision and direction for the service continuity programme. This work will consider the effectiveness of changes in work practices and new methods in the delivery of services in this period e.g. use of technology systems, telehealth and assistive technology, integrated working across the community, Clinical Assessment Hubs, COVID-19 Response Teams in CHOs, and developments of clinical, palliative care and infection prevention supports and infrastructure, as well as their potential for continued application in resumption of services. The plans will also need to consider the appropriate responses to the operational challenges that the system will face in resuming services within the context of COVID-19 and the disease trajectory. These local plans, once complete, will be submitted centrally and consolidated into a single overview by the HSE which will provide more detailed information on the expected timeframe that individual services will resume, across location and service type.

### **Guidance on resumption of disability services**

Processes are underway in order to plan for the reintroduction of non-Covid-19 services against the backdrop of the publication of the Governments 'Roadmap for reopening Society & Business' as well as the 'Return to work safely' protocol. In that regard the HSE has now developed a number of important guidance documents to assist disability service providers including:

1. Framework for Resumption of Adult Day Services
2. Reshaping Disability Services From 2020 & Beyond.

These are now available on at:

<https://www.hse.ie/eng/services/news/newsfeatures/covid19-updates/partner-resources/>

This guidance is interim and subject to change in line with the overall management of the COVID-19 pandemic and in accordance with contemporary Public Health Guidance.

The HSE continues to plan the re-establishment of vital non-COVID-19 supports and services. This includes very careful and detailed work on the part of the Disability Sector with national guidance and will result in directing how all funded agencies can deliver services on a medium to long-term basis. Plans have to comply with guidance as set out by the National Public Health Emergency Team as well as Public Health specialists in the HSE.

In addition, the Disability Sector is re-establishing a number of structures including the National Consultative Forum as well as other operational structures that will co-ordinate and support the sector as we continue to navigate this pandemic and make every effort to deliver supports and services in line with Public Health Guidance.

A National Group, representative of service users and families, Service Providers and HSE are working together to prepare for the resumption of day service supports in line with COVID-19 guidance. The HSE and its partner Service Providers will also continue to communicate with school-leavers and their families to plan and organise for September. Staff and Service User training will be made available.

Guidance on resumption of children's therapy services is also being developed in line with public health guidelines. It is expected that a clearer picture will emerge shortly as to when services are likely to be reinstated and how the service will be delivered taking account of Public Health Guidance and COVID-19 restrictions.

A cross sectoral initiative involving the Departments of Health, Education & Skills and the HSE is being rolled out next month to support children with complex needs and children in DEIS schools.

This Summer Provision 2020 will include a HSE led, activity based respite / summer camp programme for prioritised children with complex needs. The ultimate goals of the programme are to

- Provide short respite breaks for families
- Facilitate children with complex needs to begin the transition from their homes to re-engaging with their communities and schools
- Provide safe opportunities for children with complex needs to engage with their peers.

### **Impact on disability sector**

#### **Funding in context of COVID-19**

The Government has agreed to allocate substantial additional funding to the Health Vote to meet the costs associated with the implementation of the measures outlined in the National Action Plan in response to COVID-19. In this context, the HSE Executive Management Team has agreed a structured approach to addressing the financial challenges of Section 39 Agencies due to COVID-19. The objective of the programme is to provide a structured governance process and modus operandi through which Section 39 partners experiencing financial difficulties due to the COVID-19 Public Health Emergency can engage through the HSE to ensure, where appropriate, continuity of essential services provided by these agencies. The HSE has also developed a methodology to provide a pro forma approach to support decision making in respect of Section 39 Organisations that have made submissions to the HSE for both financial and non-financial supports during the COVID-19 pandemic.

The HSE has advised the Department that it has given Section 38 and Section 39 providers of disability services and supports assurance that budget allocations confirmed to each provider via the relevant CHO, will remain in place to year end, subject to co-operation with the HSE and compliance with the relevant Service Arrangements.

Other supports provided by CHOs to S39/38 organisations providing disability specialist services between March and May 2020 include PPE; Infection Prevention and Control support, advice and training; Public Health advice/support with regard to suspected/positive cases; Isolation facilities allied to testing, funding for emergency residential placements, logistics in the form of transport and Accommodation. In addition, COVID response teams were put in place to assist and support residential service providers during the pandemic. These teams will now oversee and support the reshaping of disability services as a result of COVID 19.

### **Planning for the future**

Since the onset of COVID-19 the focus of the Disability Unit of the Department of Health has been to mitigate its immediate impact on the disability community. It is anticipated by the WHO that COVID-19 will be with us for further 12-18 months. In line with the Sláintecare vision it is essential, that over the next number of years, the State moves to a population-based planning approach, based on demographic and geographic considerations, that reflects both the health and social care needs of those within our population, including those who require specialist disability services. This will afford the opportunity to prioritise and design the health and social care services that need to be developed

for each region, so the population can get the right care, in the right place, at the right time in line with HIQA standards and available resources.

### Attachments

1.	Overview of the Health System Response to date <i>Long-term residential healthcare settings</i> (26 <sup>th</sup> May 2020) <a href="https://www.gov.ie/en/news/7e0924-latest-updates-on-covid-19-coronavirus/#overview-of-the-health-system-response-to-covid-19-ltrcs">https://www.gov.ie/en/news/7e0924-latest-updates-on-covid-19-coronavirus/#overview-of-the-health-system-response-to-covid-19-ltrcs</a>
2.	List of HSE Disability Guidance documents - Appendix 1
3.	<i>COVID-19: Comparison of Mortality Rates between Ireland and other countries in EU and Internationally.</i> (28/05/2020) <a href="https://www.gov.ie/en/publication/84bc5-covid-19-comparison-of-mortality-rates-between-ireland-and-other-countries-in-eu-and-internationally/">https://www.gov.ie/en/publication/84bc5-covid-19-comparison-of-mortality-rates-between-ireland-and-other-countries-in-eu-and-internationally/</a>

## Appendix 1

Guidance on a number of COVID related topics has been developed by the HSE in collaboration with service providers in the voluntary sector to support people with disabilities, families and staff.

### List of guidance documents below and their target audience

1. COVID-19 Contingency Plan Home Support Services Disabilities (PDF, 450 KB, 18 pages)
2. Guidance for COVID-19 in Social Care Group Homes and Residential Services – Disabilities (PDF,)
3. COVID-19 Guidance for Nurse-Led Residential Disability Services (PDF, 1.48 MB, 30 pages)
4. Guidance for testing for COVID-19 in Disability Services (PDF, 358 KB, 5 pages)
5. Guidance of COVID-19 testing in Disability Services Easy Read Version (PDF, 685 KB, 7 pages)
6. Guide for Supporting adults in a community residence/at home Easy Read Version (PDF, 1.67 MB, 30 pages)
7. Guide for Supporting children in a community residence/at home Easy Read Version (PDF, 1.88 MB, 32 pages)
8. Streamlined hospital passport for people with disabilities who are admitted to hospital (PDF, 82 KB, 1 page)
9. Guidance to support a person with additional needs who becomes distressed and angry when you try to engage with them (PDF, 439 KB, 2 pages)
10. Support Coordination in a Pandemic – A practical checklist to avoid stressors for service users (PDF, 249 KB, 2 pages)
11. Guidance for Alternative Models of Care (non-residential) (PDF, 1.05 MB, 12 pages)
12. Guidance on the use of Personal Protective Equipment (PPE) in Disability Services (PDF, 672 KB, 20 pages)
13. Coronavirus (Covid-19) Frequently Asked Questions for people with disabilities and family carers (PDF, 391 KB, 10 pages)
14. Staff Guide on Easy Communication with People with Intellectual Disability or Autism (short) (PDF, 1 page)
15. Staff Guide on Easy Communication with People with Intellectual Disability and Autism (PDF, 269 KB, 2 pages)
16. Staff Guide on communicating with Deaf and Hard of Hearing people (PDF, 188 KB, 1 page)
17. Staff Guide on working with an ISL or English interpreter (PDF, 207 KB, 1 page)
18. COVID-19 Guide on how to stay connected using communication apps Easy to Read Version (PDF, 40 pages)
19. COVID-19 Test Process explained for Deaf and Hard of Hearing people (PDF, 198 KB, 1 page)
20. A message from Cathal Morgan, Head of Disability Operations, HSE for people with disabilities and their families. (YouTube video link)
21. Clinical Pathway – Clinical Consultation required – disability services (PDF, 456 KB, 1 page)
22. Clinical Guide for hospital clinicians when supporting a person with a disability (PDF, 192 KB, 1 page)
23. Pathway to HIQA Registration and model for developing an Enhanced Support Facility for people with disabilities during COVID-19 (PDF, 308 KB, 4 pages)
24. Webinar on Prevention and Preparedness for COVID-19 in a Residential Service for People with Disabilities, held on 27/04/2020 and hosted by the HSE Disability Quality Improvement Office in collaboration with the AIHPC, for providers of services to people with disabilities.  
Webinar - Prevention and Preparedness in Disability Residential Facilities (YouTube video link)
25. Guidance on End of Life in social care-led disability centres during COVID-19 (PDF, 722 KB, 7 pages)
26. Appendices to accompany Guidance on End of Life in social care-led disability centres during COVID-19 (PDF, 1.54 MB 19 pages)
27. COVID-19 FAQs for people with disabilities and their families - Easy Read version (PDF, 2.3 MB, 24 pages)
28. Questions and Answers from Disability Services Webinar (PDF, 444 KB, 11 pages)
29. Guidance on communicating with families (PDF, 76 KB, 1 page)
30. Supporting a person in isolation (decision tree) (PDF, 268 KB, 1 page)
- 30a. Activities to support a person in isolation (UK doc) (PDF, 1.49 MB, 22 pages)
- 30b. Risk assessment tool for people in isolation (PDF, 546 KB, 2 pages)

- 30c. Disability Pathway for people who may need to isolate (PDF, 72.2 KB, 3 pages)
- 31. Approved Communication Supports for Deaf patients in healthcare settings during Covid-19 (PDF, 1 page)
- 32. Framework for Resumption of Adult Disability Day Services (PDF, 770 KB, 23 pages)
- 33. Reshaping Disability Services - From 2020 and beyond (PDF, 819 KB, 37 pages)