THE CARE HOME COVID–19 STORY

IN EAST SUSSEX

An account of the challenges for care homes and their role in the epidemic

Dated: August 2020

EXECUTIVE SUMMARY

This document is an account of how care homes in East Sussex dealt with the epidemic of the Coronavirus from the first recorded case through to the end of May.

It discusses the inadequate response from the government to the Covid-19 pandemic in relation to the care home sector.

It records the impact of national guidelines and the local partnership arrangements introduced to keep residents and staff safe.

It reviews the successes, identifies the improvements required and gives recommendations for future planning at both local and national level.

It has been produced by a Healthwatch East Sussex volunteer as an activity when volunteers were unable to go about their normal engagement and undertake Enter and View functions.

The Conclusions and Recommendations are those of the author only.

Healthwatch East Sussex, as the independent local guardian of health and care services on behalf of East Sussex residents, believes that the report highlights issues that should be considered by all partners, especially health and social care commissioners and system leaders.

PART A describes the government guidance and support offered to care homes across East Sussex and the perceptions and impact they had on care home providers and staff. It outlines the intentions of government with some indications as to how these initiatives were received by the care homes as they attempted to action them.

PART B contains the Conclusions and some national and local Recommendations made by the author.

PART C describes, in some detail, the timeline of significant events from 1st January to 31st May, and provides a context from which various national and local actions have been taken. This covers the period in which care provider representatives were informed that there was 'nothing specific' that they needed to do, through to the requirement for all local authorities to submit a Local Care Home Support Plan, made on the 14th May.

Attributions

The Timeline has been built using the contemporaneous Wikipedia website Timeline of the Covid-19 pandemic in the United Kingdom but any dated statements have been checked for factual accuracy by referring to the original source such as reputable UK news organisations, only using news reports rather than opinion pieces.

Specific national and local events can be traced back to publications made at the time. These are not only news sources but from national non-government bodies such as the Association of Directors of Social Services [ADASS], the Local Government Association [LGA], the Care Quality Commission [CQC], the Care Provider Alliance [CPA] and the Care Association Alliance [CAA].

References to national and local events have been taken from original papers issued at the time and by joining relevant daily government briefings and video-conferenced meetings whenever they have been made available.

Opinions expressed about the situation for local care providers have been harvested by joining webinars and video conferences attended by local care providers across the whole of Sussex. It is calculated around 600 delegates participated to exchange views and plans.

PART A

Impact of the GUIDANCE and SUPPORT given to CARE HOMES in EAST SUSSEX

A Plea for Understanding

The most serious issue to emerge from this story is the apparent lack of understanding by anybody in central government or NHS England/Improvement (NHSE/I) of the social care sector and, in particular, the independent care home provider market, which largely consists of over 15,000 very fragmented small businesses. The sector has faced continuing challenges over the years, including changes to general and sector specific legislation and regulation, financial crises due to lack of funding, on-going recruitment difficulties due to the poor wage structures and the long-term increase in dependencies of its client groups. The most damaging of all is the poor public perception, especially when compared with the NHS. This is demonstrated by the length of time that it took for 'Clap for the NHS' to change to 'Clap for Carers' and the launch of the CARE badge by the Secretary of State in mid-April 2020 when it had been in use since June 2019.

The coronavirus pandemic has condensed many years of the normal challenges of care home services into four months of an unrelenting struggle to survive. No manager or provider of a typical home, especially where they are relatively isolated and without the experience or training, will emerge unscathed. For the many who have had to cope with an outbreak, or even those who have not but are worried that it will happen to them, the past months have been too much. There has been little respite and there is already planning in hand by the NHS for a second Covid-19 wave to be at least twice as large and over a longer period than the first, raising concerns and pressures that disease outbreaks will need to be managed until a suitable vaccine is found. Managers and owners are broken physically and mentally, close to burn-out and many will choose to leave the sector and look for a less responsible position. For others, seeking to retire, this may have bought forward the decision.

The number, scale and complexity of policy documents and the frequency of changes to guidance have made a difficult time, more challenging.

The key documents received and acted upon include:

1. Bespoke Care Home guidance
2. PPE guidance
3. Infection Prevention and Control guidance
4. Guidance for testing staff
5. Guidance for testing residents
6. Guidance on Verification of Death

7. Guidance on Re-use of Medication
8. Capacity Tracker
9. Use of NHS Mail
10. CQC Emergency Support Framework
11. possible Personal Injury claims from staff who have contracted the virus
12. Statutory Sick Pay for staff if asked to self-isolate
13. Isolation and Social Distancing
14. Shielded staff
15. Risk assessments for staff
16. Policy on Receiving Visitors

This list is not exhaustive.

Implementing the policies and guidance, many of which were complex, at such pace was hard. The manager had to understand and distil reams of information into a policy for the home, communicate this to staff, residents and families, then train the staff and monitor the implementation - alongside their normal duties.

Policy and guidance notes are often very lengthy with hyperlinks to other documents with changes/updates from previous versions not highlighted, resulting in a need to trawl to identify the changes/updates. Quite frequently they are issued in the evening or on Friday afternoons.

Most care homes do not have a policy lead, HR, procurement facility, safety officer or ready access to legal advice. These roles reside with the manager who then worries that they have missed something, made the correct interpretation and are concerned about short time scales.

Dealing with an outbreak, or even worse the death of a resident, places even more strain on the manager. Unlike a hospital, residents are well known and regarded as part of the family, as well as the families of residents. Their untimely death has a detrimental effect on the manager, the staff team and atmosphere of the home. It is the manager who provides the counselling to staff, family members and other residents, while probably grieving themself.

In such circumstances, they may have to manage the “blame game” and in some cases there are already warnings of legal action.

It is against this background that this review of the Guidance and Support provided to care homes should be considered.

REVIEW of Covid-19 GUIDANCE and SUPPORT

There was a plethora of government guidance and expectations issued to manage the national coronavirus crisis. This was in addition to professional bodies, local commissioning and provider organisations and partnerships that supported the Care Home sector.

[1] Support for rapid and regular communication and decision-making

The **dedicated e-mail address** for care providers was a lifeline to care homes and was constantly used covering all manner of issues.

The **Adult Social Care COVID-19 bulletin** proved to be extremely useful and informative to all social care providers from the onset of the pandemic. Many pieces of useful guidance and general information were transferred to the ASC&H section of the ESCC website in the "Providers and Professionals" segment.

The NHS and ESCC COVID-19 Update for Residential and Nursing Homes **virtual huddles** were routinely attended by approximately 30 providers. Attendees were invited to contribute any ideas on topics pertinent to their service. For those that attended there was always something of interest. *It is strongly hoped that the bulletin will continue.*

There have been a number of provider **webinars** for care homes across Sussex attended by over 100 providers plus officers from all three upper tier local authorities. *Queries were always responded to with helpful information and clarity from the ESCC representative.*

The Chair of the Registered Care Association (RCA) for East Sussex and Brighton attended the **Strategic Commissioning and Supply Management meetings** weekly to discuss matters such as PPE, Testing, the Capacity Tracker and dispersal of the Infection Control grant. Senior local authority staff were in daily contact to discuss matters of a more immediate nature and information gathered from national provider associations. *These links contributed towards the very speedy formulation of the East Sussex Covid-19 Care Resilience Plan.*

[2] COVID-19 Hospital Discharge Service Requirements

The actions for Care Providers included implementing NHS Mail and to opt into the Capacity Tracker by 23rd March.
300 out of 307 care home providers in East Sussex are now fully committed to both, including those who do not admit publicly funded residents; though many are signed up because there was no other alternative mechanism to access the funds.

A Trusted Assessor scheme had been the subject of a six-month pilot between ESHT/ASC and care home providers, *but it was found by all partners, not to be suitable for local conditions.*

Various elements of the Enhanced Health in Care Homes Framework have been in routine use in different parts of the county for some time. For example, the Community Frailty team has assisted greatly to introduce Advanced Care Plans in care homes while the Medicines Optimisation in Care Homes (MOCH) teams routinely work with care homes, producing worthwhile savings on the drugs bill. Doctors 'home rounds' have been in existence in a number care homes in conjunction with individual GP practices. Elements of the EHCH that have been in use are also believed in previous years to have 'flattened the curve' for the avoidable admission to hospital from care homes.
Care homes are enthusiastic about the introduction of the full EHCH framework across the whole county because this is what they have been seeking for some years.

[3] DHSC guidance Covid-19: Our Action Plan for Adult Social Care

This 24-page document was published on 15th April, after 21 deaths from Covid-19 occurred in care homes in East Sussex.

Provision and use of PPE. The action plan promised to provide specialist training videos for donning and doffing of standard PPE and a tailored insight into how the PPE guidance applies in care homes.

It acknowledged that care homes were finding it extremely hard to source supplies of Personal Protective Equipment (PPE) from their normal suppliers. It outlined plans for the distribution of PPE to meet immediate needs with deliveries of 300 masks to every CQC registered provider; that supplies will be made available to seven named wholesalers for sale to CQC registered providers. Supplies were released to Local Resilience Forums (LRF) to supply those in highest need and a National Supply Disruption Response (NSDR) system was mobilised to respond to emergency PPE requests from those unable to receive supplies from wholesalers or LRFs. Finally, to scale up the logistic capacity of the supply chain, the Department for Health and Social Care (DHSC), NHSE&I, the NHS Supply Chain, Clipper Logistics and the Armed Forces would work together to develop a Parallel Supply Chain to support the normal supply chain.
The reality was that care home providers scrambled to actually locate a reliable supplier who would accept an order and deliver in a reasonable time. The more quotable comments used were "the wild west" and "omnishambles". It is impossible to estimate the time spent in dealing with obtaining supplies, and there is evidence that, initially, local care homes could not maintain a stock of PPE, particularly masks.

The commercial supply chain was still not stable at the end of May, and not surprisingly, prices and availability were subject to wild fluctuation.

Managing outbreaks. The guidance provided clear advice on what to do in the event of a suspected outbreak consultation with local Public Health colleagues. The policy was to test only the first five symptomatic residents in a care home with plans to move to testing all symptomatic residents in the home.
*For providers, while the advice on notifying an outbreak was clear, there was no local published plan on how providers and ESCC work together to deal with a catastrophic outbreak which threatens the **viability** of a care home. Although this may seem an extreme scenario, it happened in East Sussex.*

Safe discharge from the NHS to social care settings. The action plan set a policy of testing all residents prior to admission to care homes, or if a result is awaited then they should be cared for in isolation as with any resident who is Covid-19 positive.
This policy was introduced one month after instructions to move people out of acute hospital to free beds ready for the expected influx of coronavirus patients.
Care providers questioned why this patient cohort was being treated differently to the well-established local system whereby discharges were delayed to ensure the patient was clear of respiratory infections and norovirus. Why was there was any difficulty in getting the tests done before discharge?

S**upporting the workforce.** The plan included increasing the workforce through the recruitment of returners and appropriately skilled new care workers.
Care providers responded that these tactics had been tried for years to little effect.

Ensuring we have the staff that we need. The guidance stated that care staff will now be designated as “key workers”. To manage the coronavirus challenge, they promised further guidance would be issued on the re-deployment of staff, that a national campaign will be rolled out to recruit more staff to the sector with a fast track DBS clearance system and Skills for Care would offer rapid on-line induction training for new staff. They indicated some returning nurses will be deployed to social care and work was underway to enable NHS Volunteers to carry out appropriate tasks in social care.
Care staff were prioritised, promising those that are symptomatic [and their families] would be tested, by arrangements through CQC.
In urban areas the testing sites do not necessitate extreme distances, but this is not the case for rural locations. There were a number of instances of staff finding it difficult to access travel arrangements due to shifts and public transport timetables.

Funding. Monies from the £1.6bn fund provided to local authorities were welcomed by providers to pay for the back filling of shifts for those that are unable to work as a result of public health advice and other social distancing measures. In

addition they welcomed the provision of statutory sick pay that could be claimed from the first day of sickness, the Universal Credit and Working Tax Credit that was increased by £20 per week, and that those who were unable to work for a long period of time because they are in high risk group or because they are shielding during the outbreak, could be furloughed up to 80% of their normal wage. It was a particularly welcomed by providers who received the 10% premium on fees for any publicly funded residents.
It is unfortunate that it was not applied universally and that it was only for three months with no indication about the position after this time.

Wellbeing. The action plan intended that social care staff, importantly Registered Managers, could access the same package of support that is available to NHS staff. These are being put in place by Skills for Care recognising that they are facing particular challenges and by the local 'Health in Mind' scheme.
There is evidence that while many managers have found support through many WhatsApp groups, there will be significant need to provide long term support once the immediacy of the current epidemic has passed. Available support will need to widely publicised.

Appreciation. The action plan was unequivocal in the appreciation of social care staff. ''We want to make it clear that those working in social care are heroes on the frontline too. We must ensure that social care gets the recognition and parity of esteem that it deserves. An important legacy of this crisis must be the value we put on social care as an essential service, core to delivering the frontline response to his crisis, and to ensure everyone understands that people who work in social care are key workers in every sense."
Providers will expect the sentiments expressed to be delivered by local and national leaders through actions, present and future in the promotion of the CARE brand.

Using technology to support social care and the quality of life. The plan states the importance of care homes being able to communicate to other social care professionals, clinicians and close friends and families of those that they care for. Many care homes have been using mobile devices for their residents to communicate with the outside world and many local GP practices have been using these devices to carry out "virtual home rounds".
Locally, after a slow start, the majority of homes are now using the NHS mail service. One of the most enlightened local approaches has been from Bexhill Primary Care Network on 9th June when they announced that they were planning to equip, with the support of Digital Eagles, care homes in their area (about 30 in all) with a iPad to facilitate discussions with healthcare professionals and for residents to keep in contact with friends and families

Supporting Local Authorities and the Providers of Care. Additional funding allocated to local authorities was intended to reach the front line as quickly as

possible to protect providers' cash flow, to monitor the ongoing costs of delivering care and adjust fees to meet care costs, and to facilitate local authorities to monitor pressures in the NHS and local government with a commitment to keep future funding under review.
It would be churlish for providers not to recognise that ESCC acted much more quickly than many authorities but nevertheless the funding was only available to about 30% of the resident population in care homes for Older People and was only available for a three-month period. The premium payments made do not cover all the extra costs involved but this is no fault of ESCC.

Collaboration across Services. GPs and community health services were instructed to work together to identify those at risk in care homes to deliver a comprehensive health and care support package with regular care home rounds and/or their multi-disciplinary teams (MDTs) should be delivered virtually where possible.
Fortunately, much of the preparatory and pilot work for the system envisaged had already taken place across East Sussex so that there was a level of understanding across the social care, primary and community health services and this was shared quickly.
Sustainability and continuity of care. The action plan gives local authorities and CQC the role to ensure that services remain sustainable and continuity of care is maintained. This is delivered through the East Sussex Covid-19 Care Resilience plan.
It recognises that there are concerns regarding indemnity cover for social care, stating the government will review this and, if issues are identified, will respond in due course.
This greatly concerns providers in the light of reports that court actions are already in place and no government action has been announced.

Communication. The action plan summarised the government's good intentions, including recognition that many providers have limited time to read and react to changing, and will ensure any guidance is clear and practical and messages are joined-up and non-duplicative. As evidence, local care homes were asked to name their three largest challenges during the pandemic:
20% named lack of clear and consistent national messaging across health and social care
15% named reading and understanding guidance
15% said PPE
12% identified hospital discharge
12% named financial viability
The remaining 26% was made up of dealing with relatives, staff shortages, recruitment, accessing testing, infection control and accessing primary care.
Care providers across the county consider the government failed in their intention to provide communications that were clear and practical, joined-up and non-duplicative.

[4] Covid-19 Response: Primary care and community health support for care home resident's guidance.

In East Sussex much of the model expected of providers had already been established in most parts of the county. What was new was that all patients being discharged into care homes will be tested prior to discharge, that training in infection prevention and control will be provided by nurse specialists and support given for different staff groups to take up opportunities in care homes.

Care homes welcome this initiative and wanted more joint working in the future. Although Skills for Care publish a flow chart for care homes on how to help them understand the nurse deployment process, there seems to no evidence that any care home has availed themselves of the opportunity.

[5] CQC Emergency Support Framework

This initiative required a monthly structured telephone conversation to focus on Older Peoples services because they are at the highest risk. The discussions centred on managers concerns about PPE, staffing, use of expensive agency staff, testing, the number of infected of residents and staff, the health and wellbeing of residents and how the families of residents are reacting to the visiting restrictions.

Feedback from providers suggests the telephone calls were useful and supportive.

[6] Infection Control Fund Grant

Funds from Local Authorities was given to care homes on a 'per bed' basis whether these are publicly or privately funded. The funding had to be used for Infection Control and was only to be used for purchases after 23rd May. Surprisingly, the purchase of any PPE was not permitted. Not surprisingly the Association of Directors of Adult Social Services (ADASS) wrote to the Minister of State expressing in the strongest terms stating how complex and restrictive the grant conditions were, causing great confusion to providers.

For most providers it merely reinforces the impression that central government just does not understand the problems that frontline social care services have been facing since the crisis began.

[7] East Sussex Healthcare Trust Covid-19 Support to Care Homes

This initiative provided support to care homes such as the 'named nurse initiative as required by NHSE/I from community health providers from May. Sussex Community Foundation NHS Trust (SCFT) took responsibility for the areas of the county covered by them. The dedicated Covid-19 Home Support Team re-enforced the Enhanced Health in Care Homes (EHCH) workstream that has been in existence for some time.

Providers welcomed these arrangements and looked forward to joint working to establish and improve the EHCH using a Primary Care Network (PCN) footprint in the future. A web-based Directory of Support Services for care homes was

discussed some years ago but other more compelling issues precluded further development. They consider 2020 is the time for re-visiting the proposals.

[8] The ESCC Covid-19 Care Home Resilience Plan

This plan reflects the essential workstreams in a live working plan:
(1) Infection Prevention and Control, covering training in infection and control, PPE, reducing staff movement between care homes, quarantining and building scientific understanding and sharing good practice
(2) Stepping up NHS support
(3) Comprehensive testing
(4) Building the workforce
(5) Communication and engagement.

It was compiled using local partners, including care home provider representatives and reviewed at regional and national level to identifying good practice and consider steps necessary to ensure every care home is receiving the right support.
It is not surprising that care providers wholeheartedly welcomed this plan, wanting full implementation and modification in the light of experience, with expansion into future activities. They especially welcomed the intention to explore ways to further understand the experience of Registered Managers because they have been in the eye of the storm.

PART B

CONCLUSIONS and RECOMMENDATIONS

CONCLUSIONS

1. National government has failed local care home providers. It has failed by words, actions, tardiness of reaction, advice and guidance to understand the culture of the long-term care home provider sector
2. It has failed to recognise that the market is made up from thousands of small providers with each employing tens of staff, and not a few hundred statutory bodies with each employing thousands of staff
3. It does not understand that it is the Registered Manager and/or the owner/provider who receives, interprets the voluminous documents sent by the national government or its agencies, many with hyperlinks to further documents, and then must write a policy/procedure, train the staff and monitor its implementation. Frequent changes merely made matters worse.
4. It did not realise the catastrophic effect on elderly vulnerable residents of the six week delay between the statement that 'there was sustained transmission in the community and 'severe cases are more likely in the older age groups' on 2nd March and the publication on 15th April of the Covid-19: Our action Plan for Adult Social Care.
5. It did not offer, or show, any parity of esteem of social care with health in any of its messaging strategies. While encouraging "Protect the NHS" and "Clap for the NHS" the social care sector was not mentioned until the lame attempt of exhibiting the "CARE" badge on 15th April. "Too little. Too late" was the overall riposte.
6. It did not recognise that the main relationships of care homes are with local primary care and community health services, not acute hospitals
7. It did not recognise that care homes are part of the local community where communal areas are for socialising and activities and where isolation is not a common occurrence
8. Regardless of the view of NHS England regarding the effect of the Covid-19 Hospital Discharge Service Requirements document on care home residents, it will remain the view of the vast majority of care home providers, that their concerns were not taken into account. Any future review will apportion responsibility for consequences; there are already legal actions pending from families of deceased care home residents against the Secretary of State seeking an acknowledgement that the treatment of care homes, in particular guidelines allowing patients being discharged into homes without being tested for coronavirus, was unlawful.
9. The Bed Capacity Tracker which became the Capacity Tracker has improved through questions raised at the regular local webinar sessions and user groups

into a tool of some use to care providers. The scheme promotes itself as 'the voice of the provider' claiming that it is the 'shop window for providers'. It is not however, open to the public and as 70% of the placements in East Sussex are privately funded, it is of use to statutory body commissioners, but it is of no value to providers in promoting the care home to the public.

10. The restrictions imposed by time periods and conditions on the use of the Infection Control Fund has confused local authority officers and care providers. While conversations may have taken place with large national providers, it is obvious that no such consultations took place with the backbone of the sector which is the thousands of smaller independent providers
11. There are significant on-going costs to providers, especially of PPE which are not covered by the Infection Control Fund. The time-limited 10% premium for state funded residents has expired but there is no indication of any future grants from central government
12. PPE is now more widely available, but it remains costly; sourcing and purchasing from multiple suppliers is very time consuming. Regular supplies through the "Clipper" system are available to a number of smaller homes but supplies are restricted and insufficient to meet demand
13. There is still no local coherent multi-agency plan for any catastrophic second wave, that covers resources for additional staff, PPE, deep cleaning and training, to support care homes enduring a severe outbreak and for post outbreak recovery
14. The local care sector is very fragile and at risk from the predicted second wave at a time of winter seasonal influenza bringing high staff absences through sickness and self-isolation and staff burn-out at a time of deteriorating finances
15. There is a great absence of new placements, either state or privately funded to replace the deaths from whatever reason, that have occurred. This, together with the significant on-going extra costs, is placing many homes in financial jeopardy leading to instability in the market. The future sustainability of the market is in question
16. There is an issue emerging surrounding the wellbeing of care home staff particularly managers/providers in the front line which has fortunately been recognised locally. This support will become increasingly important as the crisis in care homes lingers at a time when the remainder of society returns to normal
17. On a positive note, the East Sussex Care Home Resilience Plan is an excellent example, when compared with other local system responses, of the strength of local health and social care system partners working jointly in a collaborative fashion to provide some way forward through and past the present crisis engulfing local care homes
18. Locally the strong working relationships between care provider representatives and ESCC ASC&H officers enabled NHS organisations to join and speedily build a coherent local multi-agency response to care homes. The Chief Executive of ESHT stated publicly that 'relationships with care homes will improve as a result of Covid-19'

19. Local GP Practices and through their PCNs were involved in rapidly building the patchy Enhanced Health in Care Homes programme into a functioning countywide system. This has been to the benefit of care home providers; the appointment of a senior ESCC ASC&H officer, who has a significant level of knowledge of the local market, to oversee the system transformation of the programme is welcomed by care home providers

RECOMMENDATIONS

National recommendations

1. National government should ensure that a clear message is delivered offering parity of esteem to the social care sector. Their titles should reflect the status of their role. Social care workers should have the same recognition, understanding and reliability as healthcare workers. This would benefit clients, patients, carers, employers and the workers themselves. The title 'social care worker' should replace 'care worker' to avoid confusion regarding the role.
2. National government should consult with the social care sector before rolling out plans, guidance and advice to be confident that they can be understood and implemented by front line care home managers
3. National government should ensure that grants for investing in social care should be clear in timings and conditions to eliminate confusion, such as that caused by the introduction of the Infection Control Fund.
4. If national government believes that one of the reasons for outbreaks in care homes is the widespread use of temporary staff working in multiple care homes, then it should bring forward urgently a means of resourcing care homes to a sufficient level at which the widespread use of temporary staff can be eliminated. This means raising the level of esteem and making it more attractive by staff remuneration, training and prospects for career progression.
5. If national government is planning for a second wave of Covid-19 of any size then frontline social care providers should be regarded as part of the response and not treated as an afterthought, ignored or forgotten. In particular, there needs to be a robust plan for the supply and distribution of PPE to front line social care providers
6. The DHSC needs to be realigned to reflect that 90% of the contacts between the public and the NHS are not through acute hospitals. The drive towards integration of community health and social services needs to be accelerated towards a place-based integrated care system and an organisational and funding structure needs to put in place to accommodate this. These organisations should be separate to NHS England within the DHSC.
7. PHE needs to be re-organised into a unit that is aware of issues emerging from the rest of the world and to identify any pertinent to this country. It should also be a central collection point of data having consulted with local Directors of Public Health, properly resourced, so that the data is presented is of use to them to activate their local Outbreak Control plans in a meaningful fashion

Recommendations for East Sussex

Within East Sussex, many good standard practices and arrangements are already in the East Sussex Care Home Resilience plan.

1. The daily ASC&H Covid-19 bulletin should continue, and the ASC&H website updated. It would be useful if this could be a permanent repository to access previous versions of the Virtual Care Homes huddle, with a video recording of the Infection Prevention and Control training sessions and any other audio/visual events. It is suggested that the wider dissemination of the local and national information, advice and guidance covered could be improved if all the videos remained on a dedicated site. This would provide a valuable permanent reference to assist understanding and share good practice.
2. The training offer offered by ESCC ASC&H to social care providers is wide-ranging and welcomed by the sector. However, there are two main barriers to attendance, which are poor accessibility by public transport of the training venues creating long travel times and expensive staff back-fill costs. The provision of a full audio-visual facilities within the Training and Development Centre would enable remote training sessions to be delivered. It would also be helpful if management training could include modules on risk, crisis management, local outbreak procedures and staff/manager wellbeing as these issues have emerged over the coronavirus challenge
3. ESCC ASC&H is re-evaluating their engagement strategies in the light of what has been learnt during the crisis. Once an outline strategy has been agreed, the opportunity to involve the independent social care sector should not be missed. Frontline care home line managers in East Sussex regard joint working with health to create an integrated system, as being the most important issue to be addressed
4. The Chair of the RCA has become a recognised and valued partner to statutory organisations during the crisis, but it is a voluntary role. There are parts of the wider social care sector e.g. supported housing, extra care, domiciliary care and personal assistants, which do not have a local representative organisation. A means should be found to secure their representation. The RCA does have a structure that could accommodate this, but the current cohort who manage the RCA do not have sufficient resources to make the group more representative. There needs to be a frank and fundamental discussion on how ASC would like work with an organisation that represents the whole independent social sector and consider a contribution to the costs of this wider provider voice.
5. There should be appropriate representation from care homes on any programme or oversight board of the Resilience Plan during its implementation and there should be a User Group formed to ensure that the plan is meeting the needs of those who will be affected.
6. All sections of the health and social economy have been on a very steep learning curve during the pandemic and experienced the consequent turmoil. A series of structured conversations locally between all the organisations involved to discuss what has been learnt and to enable everybody to recover and move forward

together and/or to prepare for a second wave, should take place. There is an appropriate mechanism for Care home providers for this in the vision outlined in the East Sussex Care Home Resilience Plan. Such an opportunity should be seriously considered by ESCC ASC&H and its partners.

PART C

The PANDEMIC TIMELINE

On 31st December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause in the city of Wuhan, in Hubei province in China, with the first hospital admission occurring on 1st December.

January 2020

12th	A novel coronavirus [SARS coronavirus-2 (SARS-CoV-2)] was subsequently identified from patient samples. The virus is now referred to as SARS–CoV-2. The associated disease is Covid-19
22nd	There were 5 cases in 4 countries outside China. Public Health England (PHE) raised the risk level from very low to low
23rd	The WHO announced that 'the virus does not constitute a public emergency of international concern as there is no evidence of human to human transmission'
25th	Government guidance was finally issued on 25th February and bore a relaxed tone, In late January the CPA (Care Provider Alliance, made up of national care home provider organisations) contacted the Dept. of Health and Social Care (DHSC) to ask if there were any specific actions that providers should be taking and were advised that there was 'nothing specific'. A week later the CPA specifically asked the DHSC about how care homes should isolate infected residents and restrict visits and who would supply Personal Protection Equipment (PPE).
30th	When there were about 80 cases in 18 countries outside China, the WHO declared a global public health emergency
31st	Two Chinese national visitors tested positive for coronavirus and admitted to the Royal Victoria Infirmary in Newcastle

February 2020

6th	The first British national had tested positive for coronavirus; there were 84,090 confirmed cases spread across 56 countries
10th	The Scientific Advisory Group for Emergencies (SAGE) stated 'It is a realistic possibility that there is already sustained transmission in the UK and that it will become established in the coming weeks'
24th	Public Health England (PHE) advised that contact tracing should be abandoned
24th	PHE National Infection Service issued guidance suggesting that it was not safe to discharge untested patients to care homes from hospitals. It advised

	no discharges to care or residential homes and patients who are not cases, do not have Covid-19 compatible symptoms, and are medically fit for discharge could be discharged to their own home with quarantine
25th	Advice previously sought by the CPA was published; PHE stated that face masks do not need to be worn by staff, there was no block on visits and there was no need to do anything different in any care setting that it remains unlikely that people receiving care in a care home or in the community will become infected. This was withdrawn on 13th March.
29th	Positive cases had risen to 23 and a UK citizen on board a cruise ship off Japan had died. After testing the genetic code of some 20,000 samples from UK cases, it was established that the virus had 1356 origins, with over 90% originating from six European countries and about 80% of the initial cases had arrived in UK between 29th February and 29th March, according to a report published in early June by the Covid-19 Genomics UK consortium

March 2020

1st	First case in UK of a person who has not travelled to any country previously affected by the virus. This brought the number of cases in the UK to 13
2nd	Scientific Advisory Group for Emergencies (SAGE) reports it is highly likely that there is sustained transmission in the community and severe cases are more likely in older age groups
3rd	Chief Medical Officer (CMO) defends the lack of specific measures to protect care homes, saying 'One of the things we are keen to avoid is doing things too early'
5th	UK government announced Coronavirus Action Plan: 1. Contain; to detect early cases, follow up close contacts and prevent the disease taking hold for as long as is reasonably possible 2. Delay: to slow the spread and if it does take hold, to lower the peak and push it away from the winter 3. Research: to better understand the virus and the actions that will lessen its effect on the population, innovate responses including diagnostics, drugs and vaccines and use the evidence to inform the development of the most effective models of care 4. Mitigate: to provide the best care possible for people who become ill, support hospitals to maintain essential services and ensure ongoing support for people who become ill in the community to minimise the overall impact of the disease on society, public services and on the economy
5th	First death from Covid-19 announced; number of cases rose to 115 CMO tells the DHSC Select Committee the UK has moved from contain to delay

8th	This is the largest one day rise in cases in the UK, bringing the total to 273 deaths. Representatives of national care home provider representative organisations began to make public their concerns. Namely, that the virus will spread vigorously in care homes, outlining the government's ignorance of social care and its importance, that they were excluded from the system that appeared to be preparing for an NHS response and not a whole system response and the lack of detailed plans
11th	With a total of 11,8319 cases and 4292 deaths in 114 countries, the WHO declares a world-wide pandemic
12th	CMO raises the UK risk profile from medium to high. PHE advised to reduce the testing in the community: care homes informed that if one person was tested as positive then no more tests would be carried out. This was despite observations that residents were exhibiting loss of appetite and sudden confusion, different to the standard symptoms of cough and fever. It was known that at a care home in Seattle, USA where 50% of the residents had died of Covid-19, only half showed any symptoms
13th	PHE advised care homes to keep out unwell visitors and those with suspected Covid-19. DHSC said it was following a science-led action plan. In European countries care homes were being advised to lock down, quarantine infected cases in hospital or isolate possible or probable cases as well as symptomatic cases. PHE were advising care homes that if any resident became ill, they would not be allowed to go to hospital but rather that the home should provide end of life care. A number of local care homes independently started to refuse referrals for hospital discharges to the chagrin of statutory bodies
14th	Retailers asked the public not to panic-buy products, including hand gel, pasta and toilet paper. The immediate effect for smaller care homes that shopped at local supermarkets or on-line was an inability to source normal supplies. In East Sussex, the Registered Care Association (RCA) identified local wholesalers and distributors who were willing to assist and provide speedy credit clearances. PPE wholesalers indicated their available supplies were being commandeered for the NHS. NHS England, on observing disturbing television images from acute hospitals in Italy, instructed acute hospitals to discharge 15,000 patients within two weeks to make beds available as part of a national effort which will help save thousands of lives and that all non-urgent operations should be postponed from 15th April. It is not known how many were discharged into care homes. Providers were told that there was no need to test Covid-19 patients because they can be safely cared for in a care home, without recognising that care homes lacked the clinical expertise or medical equipment, that homes are designed for communal living not isolation, that staffing levels

	were stretched by absences and there was already a chronic lack of suitable PPE. There was a risk that patients free of Covid-19 could be discharged into care homes where the virus was already present. The bed occupancy in ESHT general and acute wards on 15th March was 94.6% and by 29th March it had dropped to 69.3%
19th	Government issued the COVID-19 Hospital Discharge Service Requirements. It allocated ASC departments responsibility for setting up joint working arrangements with health commissioners and providers to ensure that hospital discharges can be achieved 7 days a week and to provide an almost on-demand service. From Monday 23rd March care homes had to adopt and implement the Capacity Tracker to make real bed availability information for NHS and ASC, implement NHS Mail, and implement Trusted Assessor arrangements. At this point independent care providers are strongly encouraged to be put under what they perceived as the centralised command and control system of the NHS rather than a local relationship with ASC commissioners. Previously, ASC had not encouraged providers to join the Bed Capacity Tracker and the Trusted Assessor arrangement, which had been trialled for six months and abandoned. The Integrated Community Equipment Service (ICES) was required to hold sufficient stocks of enablement and rehabilitation equipment and assistive technology to support discharge and have access to adequate stocks of PPE
19th	An allocation of £1.6bn, followed by a further £1.6bn on 18th April, was announced for local authorities with ASC and a further £1.3bn to the NHS and social care to facilitate15,000 people to be discharged from hospital. East Sussex had £26.1m, but it is estimated that £49m is required for 2020/2021
20th	A gradual lockdown commences with schools being closed, hospitality and leisure venues to shut down as soon as possible and by 23rd March all those able to work from home are told to do so, and to restrict their activities to a prescribed essential few. Those over 70 years were told to self-isolate and about 1,500.000 were told to “shield” themselves and remain indoors. The government implored people to stop panic buying as the supermarkets were struggling to keep up with demand. Anecdotes were spreading among care homes that hospitals were discharging patients and covering up infections. CQC took the matter seriously enough to start an investigation into claims that a patients positive Covid-19 status was known to a hospital but not disclosed at the point of discharge, a potential breach of the Health and Social Care Act. On 26th March, one national provider association wrote to both the Prime Minister and Secretary of Health and Social Care to warn that care homes were being put under pressure to admit hospital discharge patients who had not been tested for the virus even though they had symptoms.

24th	The slogan “Stay at Home, Protect the NHS, Save Lives” made its first public appearance and the government launched a call for volunteers to support the NHS, with 750,000 eventually signing up. With the NHS having block-booked almost all the services and facilities in private hospitals, it is announced a temporary Nightingale hospital will be built in London with a capacity of up to 4000 beds
30th	Chief Scientific Adviser (CSA) states that social distancing is beginning to work and that transmission in the community is thought to be declining with admissions to hospital not rising as fast as was expected

By the end of March there are 32,679 laboratory confirmed cases of coronavirus in the UK, with 2,425 deaths and over 10,000 in hospitals.

Remarkably, East Sussex does not seem to fare as badly as other areas. The number of confirmed cases of the virus was about half the average for the rest of the country when expressed as a proportion of the population (per 100,000).

There were 27 reported outbreaks in East Sussex care homes during the first four weeks of recording by PHE, slightly less than the national average. Deaths in care homes were not being reported separately but there were only four reported deaths from Covid-19 in the East Sussex Healthcare Trust (ESHT) sites.

Care homes were beginning to see shortages of basic essentials including food, PPE [or the need to purchase at prices in excess of fivefold the normal], and increasing levels of staff absences due to illness, family caring responsibilities or because some staff are in the shielded group. Absences were calculated to be between 10% and 20%. There was increasing evidence of the lack of suitable agency staff to fill rotas which were stretched in normal times.

Any kind of testing regime was sadly lacking leading to fears and anxieties among care staff and the families of residents.

As a whole health and social care system, it can be reasonably argued that East Sussex is better placed than many areas. There has been an historical and well established relationship between ESCC ASC&H and the Registered Care Association for East Sussex, Brighton and Hove (RCA), while there have been recent concerted moves towards integration between ESCC ASC&H and health commissioners and providers. This enabled a rapid and regular communication and decision-making process to be in place from early April.

These included:

- a daily ASC COVID-19 bulletin for providers (published since mid-March) with the updates loaded to the ASC&H pages of the ESCC website
- daily calls with commissioners and supply management teams including an RCA representative to raise issues and concerns
- a weekly Joint Approach to Supporting Care Homes call attended by CCG, ESHT, ESCC ASC&H, Public Health and RCA representatives to monitor resilience and delivery plans

• a weekly Care Home Virtual Huddle as a vehicle for care home providers to join and receive updates and ask questions of a panel of clinical and care operational representatives. • a number of provider webinars to ensure there is an opportunity for the broader independent care sector • a dedicated e-mail address for independent care providers which was monitored daily to ensure a rapid response to queries and concerns and a separate e-mail address to raise concerns about shortages of PPE • a dedicated section for providers on the ESCC ASC&H website, updated daily which covered Covid-19 • a RAG rating for Business Continuity was established to support any homes that were closed to admissions or where there were specific conditions for access

April 2020

3rd	The Nightingale hospital in London opened. There was an increasing frequency of reports from local care homes managers of the great difficulty in obtaining staff from any agency to complete staffing rotas, homes were being met by strong refusals from hospitals when seeking information of the Covid-19 status of patients being discharged, and were relying on small quantities of PPE from the Local Resilience Forum including deliveries being made by ASC&H staff in their own cars at weekends; these stocks, together with any obtained directly from ESCC were made at no cost to providers. *It is no wonder that ADASS wrote to the government complaining the 'shambolic' national delivery efforts had produced 'paltry' supplies of essential kit to a care sector treated as an 'afterthought'.* NHS contracted Clipper Logistics, a retail logistics company, to deliver PPE with an imminent start date; by mid-May the roll out was nowhere near complete
7th	CSA said deaths due to Covid-19 are not accelerating as fast as had been predicted but that it was too early to say that the outbreak was peaking
10th	A cross party government plan was made to ensure that PPE is delivered to NHS and social care staff. Guidance on PPE was frequently revised throughout the course of the Covid-19 outbreak, often in response to shortages as on 17th April
10th	CQC announced that care homes must report any deaths as a result of suspected or confirmed Covid-19 on Incident Reporting Forms, which were expected to be completed with 24 hours and would be included in the weekly ONS reports. Some two weeks later the ONS published data that showed for the year to 10th April, out of a total of 51 deaths in East Sussex due to Covid-19, 7

	occurred in care homes, 43 in hospitals and 1 in a hospice. Occupancy of critical care beds in England peaked at about 58% of capacity
15th	DHSC published Covid-19: Our Action Plan for Adult Social Care. It had 4 pillars: 1. to control the spread of the virus 2. to support the workforce 3. to support independence, support people at the end of their lives, respond to individual needs 4. to support local authorities and the providers of care It established testing would be rolled out to all symptomatic social care staff and their family members and care home residents: but testing could only carried out once for each person. Testing would also be carried out on all residents admitted from hospital and that they should be isolated whether they had been tested, were symptomatic or were asymptomatic or tested negative. New guidance issued to allow family members to visit their dying relative. A new CARE brand was exhibited at the daily No.10 briefing session. Plans announced to boost social care recruitment by 30,000 over next 3 months. Testing for staff in regulated services would be co-ordinated by CQC and staff would be referred to one of their local testing centres which were situated at the Amex stadium, Bexhill and Gatwick airport. CQC urged providers to continue to report their concerns, including lack of PPE so that they could escalate to local and central government.
17th	By negotiation with the RCA, ESCC informed providers that, in addition to an annual increase on the fees that they paid for those residents that they funded, they would pay a 10% premium on all the gross fees for a period of three months. Unfortunately, only about 30% of residents in care and nursing homes for Older People were funded by ESCC at that time. This was in line with many other Local Authorities, although some set up Covid-19 Hardship Funds, to which providers had to apply with authenticated invoices and some even insisted that premiums would only be paid to those who agree to accept residents with Covid-19
22nd	Health Secretary suggested that the peak of the disease had been reached and the NHS could start to re-open
22nd	Bexhill Care Centre, which closed in August 2019, was re-opened under a block contact for all 43 beds for an initial six month period for use by patients who had a clear negative Covid-19 test prior to admission, and for patients who had tested positive over the 7 day period but who were asymptomatic. A further 10 beds were block contracted in two care homes in Eastbourne and Hastings.
23rd	Coronavirus testing provided for all key workers and their families using drive-through centres, home testing kits and by mobile testing units.

	However, providers were unable to register for regular testing on-line because the app only allowed this a] if staff were symptomatic and, b] they could only be tested once unless the person subsequently developed symptoms. Furthermore, it became policy to test care home staff and residents once unless the contact subsequently develops symptoms.
27th	Families of NHS and care workers who die because of Covid-19 would be entitled to a payment of £60,000 the government announced
28th	Testing was expanded to all care home workers and people (and their family members) who must leave home for their employment or are aged over 65. First virtual NHS & ESCC Covid-19 Residential and Nursing Homes Updates was held to provide bitesize updates on relevant guidance, access to a clinical lead and the opportunity to have questions answered. These continued initially twice a week and then weekly. Regular panellists were GP Cancer Lead, Lead for End of Life and Palliative Care and the Head of Nursing for Community Planned Care at ESHT; it was chaired by an ESCC ASC&H Strategic Commissioning Manager
30th	171,253 laboratory confirmed Covid-19 cases and 27,510 deaths in the UK. In East Sussex, the proportion of the population with the virus was about half that in the UK with the proportion reducing in a south-easterly direction across the county, including Hastings borough with one of the very lowest in the country. During the four weeks of records for April there were outbreaks in 45 care homes, bringing the total to 72, out of a total of 314. This was 23% of the total but compared well with the national figure for England of 33%. Since the start of 2020 in East Sussex, there were 2764 deaths in all settings of which 1008 were in hospitals and 922 in care homes. 195 were due to Covid-19. Of these 126 occurred in a hospital setting, 61 in care homes. The spread of the care home deaths was the same geographical profile as the number of confirmed cases of coronavirus

May 2020

From the beginning of May support for care homes from health organisations started to be put in place despite it being publicly stated on 20th April that the number of coronavirus cases had started to flatten out alongside the number of people hospitalised for Covid-19 in the UK.

1st	NHSE/I sent a letter to all GP practices, Primary Care Networks, community health providers and CCG Accountable Officers about the Covid-19 response: Primary care and community health support for care home residents In addition to continued NHS testing of all patients prior to discharge to care homes, there was a requirement that:

	• CCG Directors of Nursing would assist Local Authorities with training in infection prevention and control • Primary and community services would support different staff groups to take up opportunities in care homes • requested primary care and community health providers to build on what GP practices were already doing to support care homes It required that immediate steps should be taken to: • deliver a consistent weekly "check in" to review patients identified as a clinical priority for assessment and care • develop and deliver a personalised care and support plan for care home residents • provide pharmacy and medication support to care home. In order to enable these services, it was expected that: • CCGs would take immediate steps to support individual GP practices and community health service teams to organise themselves if they were not already in full PCN operating mode • CCGs would ensure that clear and consistent out of hours provision for each care home • secondary care providers would accept referrals and admissions for care where residents were clinically appropriate • this support would be delivered to all care homes, be established within two weeks and NHSE/I would collect regular "sitrep" data alongside the impact these services were having
1st	CQC published the Emergency Support Framework, in which Inspectors would contact providers at approximately monthly intervals to have a structured honest and open conversation, thereby, not only to assess the service but to support managers by understanding their stresses, shortages of PPE, staffing issues, any lack of external support to enable escalation of these matters to local and national government
5th	7 Nightingale hospitals with a total capacity of 7500 – 8500 beds were built but no information on how many patients have been cared for at these sites
7th	ESHT published their Covid-19 Support to Care Homes covering those areas of the county where they provide community health services. This allocated a Named Nurse for each care home to support and develop good working relationships, a 7 days a week telephone contact for advice, support for training and development, support with Covid-19 symptom management and End of Life care including Advance Care Planning, discharge planning support and twice weekly virtual Care Home Huddles to proactively support staff. Later in the month Skills for Care published a flow chart for care homes on how to help them understand the nurse deployment process.
10th	Following an earlier ONS announcement that deaths per week in hospitals were falling but those in care homes were continuing to increase, the

	government changed the message from Stay at Home, Protect the NHS, Save Lives to Stay Alert, Control the Virus, Save Lives. A new alert scale system was also announced, from Green (Level 1) to Red (Level 5) Detailed evidence was growing that deaths due to all causes has been much higher than the five-year rolling average for this time of the year. Care providers were beginning to raise concerns that legal and regulatory risks and liabilities may arise in relation to Covid-19 and that insurers were at least doubling their premiums and would not take on any kind of pandemic risk
13th	NHS England published clinical guidance for supporting compassionate visiting for all health and social settings for those receiving care at the end of life
14th	Government announced a £600m Infection Control ring–fenced Grant for care homes: East Sussex to receive £10.6m. When the Local Authority Circular was published on 22nd May there were inordinately restrictive criteria and it could only be used to claim for expenditure after 23rd May
14th	DHSC sent a letter to all Local Authorities with Social Care responsibilities to work with their system partners, including care providers, to produce a Local Care Home Support Plan, to be returned by 29th May. These planning returns would be reviewed at regional and national level to identify good practice and consider further steps to ensure every care home was receiving the right support and implementing appropriate measures. ESCC submitted a draft Covid-19 Care Home Resilience Plan
15th	Secretary of State announced that all staff and residents in care homes would be tested for Covid-19 by early June. On 1st June, data supplied by Person Centred Software and gathered from 1800 care homes caring for 50,000 residents, indicated only 18% of residents and 15% of staff had been tested; by 18th June this increased to 53% of residents
18th	Loss of taste and smell added to the list of symptoms for coronavirus. Anyone over the age of five with symptoms could be tested for Covid-19
19th	Chair of Care England, a national provider representative organisation, in evidence to the DHSC Select committee, criticised the government for the way it had handled the outbreak in care homes and said they should have been prioritised at the start
20th	NHS England strongly advised those with diabetes to follow all the precautionary advice as recent analysis showed that a third of coronavirus deaths between 1st March and 11th May was linked to the condition
25th	Outbreaks in UK Care Homes indicated England had 6225 (40.1% of total). East Sussex had 97 (30.8% of total) with the highest proportion in homes in the Lewes area (19 =43.2%), followed by the Eastbourne area (28 =41.8%) and the Wealden area (26= 40.0%)

28th	All 4 national CMOs agreed that the Alert Level should remain at 4: Severe Risk-transmission levels were high and social distancing should remain in place
29th	NHS Seacole, a rehabilitation centre for Covid-19 patients, is opened at Headley Court in Surrey
29th	ADASS wrote to the Minister of State for Care in the strongest terms about their concerns at the confusion created by the development and roll-out of the Infection Control Fund The Minister issued a bulletin to all care providers on the same day at 5.17pm on a Friday, advising home care providers of the new guidance on a] how they should work to keep their clients safe b] that the new social care recruitment platform has gone live c] testing kits for care homes caring for those over 65s will be delivered by 6th June d] the national roll-out of the PPE portal for small providers had started
29th	East Sussex data from 1st January to 29th May the total number of deaths registered was 3,294 with 327 due to Covid-19. Of the total deaths, • 1152 occurred in a hospital • 1116 in a care home • 712 at home • 241 in a hospice The geographical data listed in order of all deaths • Wealden (897) • Lewes (657) • Rother (643) • Eastbourne (623) • Hastings (474). Of those deaths due to Covid-19 • 167 occurred in a hospital • 141 in a care home • 3 at home • 13 in a hospice The geographical data listed in order of Covid-19 deaths showed • Lewes (101) • Wealden (98) • Eastbourne (63) • Rother (47) • Hastings (18) At this time, in East Sussex, there were: • 127 Older Peoples Residential Homes with an average capacity of 27 with about 27% funded by ESCC

	• 76 Nursing Homes with an average capacity of 47 with about 21% funded by ESCC • 116 Younger Adult Residential Homes with an average capacity of 10
31st	There were 274,762 laboratory confirmed cases in England at a rate of 271.9/100,000. East Sussex had 716 at a rate of 129.1/100,000 with highest rate in Lewes District Council area and a decreasing trend south eastwards to Hastings Borough council area at a rate of 59.2/100,000

END

Author Contributions

Marilyn Eveleigh, Phil Hale, Jacob Lant and Michael Trevethick revised THE CARE HOMECOVID–19 STORY IN EAST SUSSEX as conceptualised by John Curry in June 2020.

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