



Learning From the Impacts of COVID-19 on Care Homes: A Pilot Survey

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1. Abstract

Background: Care home residents in England now account for over 40% of known COVID-19 deaths in England. Care homes are people's homes and are not intended to replicate the clinical environments in a hospital, so that transmission of COVID-19 between some of the frailest members of society are especially difficult to prevent. In this paper, we report how the lived experiences of care home providers can provide important insights that inform a whole system response that will be required to prevent future avoidable fatalities in care homes in the event of a second wave of infections.

Methods: We conducted an anonymous online pilot survey of care home managers and directors across England, surveyed between May 15th and June 1st. We asked what challenges care homes faced during the COVID-19 pandemic, what strategies they used to mitigate them and what they would need in future to strengthen their response. The survey covered four key themes, including partnership working, infection control, workforce and wellbeing of residents. We received responses from 35 care home directors and 42 care home managers, of whom 34% had reported an outbreak of COVID-19; a similar proportion to the national average at the time.

Results:

Partnership working: The level of support obtained from local authorities and Clinical Commissioning Groups (CCGs) varied dramatically across the country and many providers had still received no financial support at the time of the survey. Some, but not all local authorities hosted daily calls with care homes and a handful provided PPE and financial support, but this was limited. Some felt that decision-makers in local authorities and CCGs were detached from the realities in social care, preventing opportunities for truly collaborative working.

The ask: *Respondents called for more accessible financial support, partnership working, and a supportive culture including the ability to co-design formal guidance and having sufficient warning to implement it, as well as support when facing staffing shortages and psychological support for their workers.*

Infection control:

Care home managers and directors reported that they were rarely unable to provide the PPE they required but faced immense challenges dealing with a chaotic supply chain and dramatically inflated costs. 30% also reported that it was not always possible to isolate residents, while 45% struggled to isolate residents who walked with purpose. Many described frustration with frequently changing guidance, with advice from different sources often conflicting and impossible to implement. Tests for residents and staff were often inaccessible, processes poorly coordinated, and results delayed. At the time of the survey only 40% of care homes had been able to access testing for asymptomatic residents.

The ask: *Care homes called for a well-resourced supply chain of PPE; joined up, timely, and coherent guidance that is feasible to implement in long-term care settings, access to regular and efficient testing for all staff and residents and accurate clinical information on hospital discharges.*

Workforce:

More than 70% of care home managers reported that they had concerns about staff morale and their mental health and wellbeing. They described a fearful and overworked workforce who felt the pressure of responsibility to protect residents from becoming infected at all costs. Many managers and directors described their frustration at the lack of parity between the NHS and social care and their struggles to maintain morale. 43% of managers also described staff shortages and 30% of care homes still depended on staff who worked across sites, with some reluctantly having to use agency staff at inflated prices to fill gaps. Peer to peer support, activities, community donations and letters of appreciation were the mainstay of support for staff and some providers also supported their staff with bonuses and enhanced pay.

The ask: *Care homes called for better team working between the NHS and social care, support with recruitment and, volunteers and, again, better access to testing.*

Wellbeing of residents:

Managers reported that isolation had impacted residents' mood in over 80% of homes, and almost all believed that the absence of visitors was a key factor, as well as the barriers created by PPE to maintaining relationships. Reduced oral intake was also reported in one third of care homes and this was most often attributed to isolation. Homes had used imaginative measures to keep residents informed, stimulated, and mobile despite social distancing policies and sought to facilitate virtual contact with relatives where possible.

2. Introduction

The cornerstone of pandemic and recovery plans in the UK was intended to be timely and co-ordinated multi-agency working^{1,2} and yet, the COVID-19 pandemic has only accentuated the profound gulf between health and social care. The first cases of COVID-19 were confirmed in England on January 31st, 2020. By the second week of March, the first care home outbreaks had been recorded and by the end of May there were over 6,000 care home outbreaks³ in England alone – affecting between 30 and 50% of homes. By the week ending 22nd May, the Office for National Statistics had documented nearly 13,000 deaths of care homes residents in England and Wales from COVID-19, accounting for 40% of all COVID-19 deaths in England.⁴ Most care home residents are frail and elderly, many have dementia, and all live in close quarters - a perilous combination for a virus that spreads by contact with contaminated respiratory droplets. This coalescence of risk factors is believed to be the reason that mortality rates more than doubled in care homes between March 20th and May 7th, 2020, resulting in 20,457 excess deaths. However intense scrutiny has surrounded the UK government's commitment to protect care homes and integrate them into the response, which has predominantly focussed, according to its own slogan, on protecting the NHS.

Despite increasing familiarity with the situation described by these mortality statistics, they do not capture the realities of the challenges that care home operators and managers have faced or the lessons that they have learned in trying to resolve them. Newly published guidance⁵ by the World Health Organisation (WHO) states that 'spread is not inevitable in care homes'. That guidance sets out ten policy objectives to prevent and manage spread of COVID-19 in long term care settings with specific attention to funding, infection control, workforce support and wellbeing of residents. In this small pilot study of English care homes, we sought to establish the impacts of COVID-19 on care homes with particular focus on these areas and asked those running homes what challenges they had faced, what had worked well, and what they would need to cope better next time.

3. Methods

We co-designed two anonymous pilot surveys for care home managers and group directors (usually responsible for a number of homes). The surveys were structured and included open and closed questions, focussing on partnership working, infection control, workforce challenges and wellbeing of residents. We adapted the questions to reflect the respective aspects of care and business continuity that managers and directors were likely to have oversight of. For each topic, the surveys explored (1) the challenges presented by the COVID-19 pandemic; (2) the ways they have addressed them and (3) the support that they feel they would need to optimise their response to future outbreaks. We used cognitive interviews with care home providers to refine the questionnaires, which were subsequently sent to two groups of care home providers, the Spectrum Consortium and the Care Leaders Network, whose membership is drawn from several hundred care home providers across England in May 2020.

4. Results

4.1.1. Care home Characteristics

35 managers and 42 care home directors responded between May 15th and June 1st from across England, although none were from the North East of England, as shown in Figure 1.

Figure 1 – Regional location of care homes that responded



Table 1 shows that most care homes represented were not part of a group (29% of directors and 47% of managers) or were part of a small group of 1 to 5 homes (47% of directors and 33% of managers). Managers reported a median total bed capacity of 27 beds (IQR 17-37). Most of the care homes included were non-nursing (64%) but cared mostly for adults over the age of 65 (88%) and with dementia (64%) and physical disability (62%). 93% relied on local authority funding and 86% also had self-funded clients.

69% of directors said that, overall, their bed occupancy had fallen, with 33% reporting that the decline was between 1 and 5% due to COVID-19 deaths. (Figure 2). Recognising that care homes do not always run at full occupancy, we asked managers about the change in occupancy. On average, they reported a fall from 89% between December 2019 and March 2020 to approximately 82% in the third week of May.

4.1.2. Confirmed Cases, Testing and Deaths:

55% of managers reported they had cared for a resident with suspected COVID-19, while 34% had had a confirmed case, and in 33% of homes COVID-19 had been mentioned on at least one death certificate. Managers from 17 homes (40%) reported that they had obtained testing for asymptomatic residents and 21 (50%) had tested asymptomatic staff.

Figure 2 Proportion of residents in a care home group who died of COVID-19

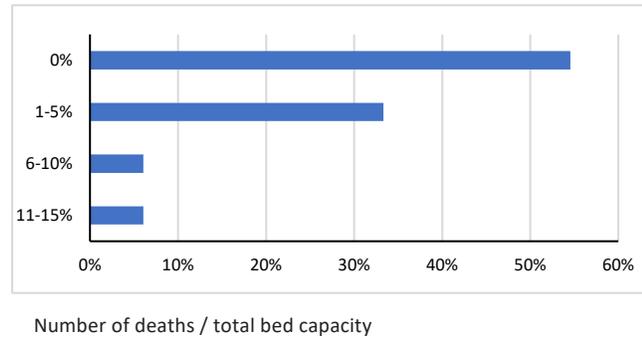


Table 1 – Care home characteristics

	Managers N=42
Group Size	
Not part of a group	18 (43%)
1-5 homes	14 (33%)
6-10 homes	7 (17%)
11-50 homes	3 (7%)
CQC Registration Type	
With nursing	15 (36%)
Without nursing	27 (64%)
Type of Services	
Adults under 65	14 (33%)
Adults over 65	37 (88%)
Physical disability	26 (62%)
Learning disabilities	11 (26%)
Mental health conditions	12 (29%)
Sensory Impairments	11 (26%)
Dementia	27 (64%)
Behaviour that can challenge	1 (2%)
Funding sources	
Local authorities	39 (93%)
NHS and clinical commissioning groups	23 (55%)
Self-funders	36 (86%)
Not for profit	1 (2.4%)
Occupancy	
Median bed capacity (IQR)	27 (17-37)
Mean average % occupancy (SD)	89% (11)
Mean current % occupancy (SD)	82% (12)
Mean drop in % occupancy (SD)	6% (7)
Closed before March 17th	18 (45%)
Resident cases and testing	
At least one suspected case	23 (55%)
At least one confirmed case	14 (34%)
At least one COVID-19 death	13 (33%)
Have tested asymptomatic residents	17 (40%)
Staff testing	
At least one staff member isolated with symptoms	27 (64%)
Have tested asymptomatic staff	21 (50%)

4.1.3. Partnership working

When asked about relationships with local partners, the most salient theme was the existence of much variability geographically, but most said relations were good or satisfactory. Many expressed frustration at how fragmented the response had been, describing very large differences in local authorities' responses.

Some managers commented:

- *'Contacts were disjointed, inconsistent, sporadic, frantic plus the requirement that you get things done immediately often without thought.'*
- *'We are an award winning home. The darling of the county council. Until the pandemic.'*
- *'Local Authorities and the CCGs need to embrace providers and provide direct practical support rather than trying to manage the market by financial strictures. In future the sector needs to be integrated into the NHS rather than LAs who have little or no understanding of the levels of dependency we deal with on a day to day basis and continue to deny to the reality of the true cost of care.'*

Local Authorities:

- While some mentioned that local authorities had **scheduled daily calls** or created helplines, **the support they were able to provide was described as limited.**
- **Others described variability between areas**, with some describing relationships as 'poor and very poor' and 'fraught'. Some felt that the local authority was promoting its own agenda rather than building relationships with the care homes themselves and said that the support from their local authority was ad-hoc.
- Many reported that funding made available by central government to local authorities had not reached their homes or that local authorities had only released it begrudgingly.
- **The feeling of being 'done unto'** also came through. Some homes had received safeguarding referrals, indicating regulatory concern, for not implementing guidance that was usually announced without warning and without an implementation plan. Managers described being encouraged to place blanket 'Do Not Attempt Resuscitation' orders on *all* the residents and then to ring the relatives to explain that they would not be admitted to hospital if they contracted COVID-19. One said of their experience with one council 'We all feel that our residents have been written off and do not believe this is fair nor individual care.'

The Care Quality Commission (CQC): Several mentioned that they had not had much contact from CQC and seemed disappointed by this, but others stated that they had not needed their support. Several also said that CQC had supported them in whatever ways it could when they had asked for help.

NHS Clinical Commissioning Groups (CCGs): Whether CCGs were seen as supportive was also very variable. Some were described as being engaged and responsive, but one manager described an 'eye watering ignorance of what life is like as a care provider'.

- One other described **duplication** between organisations, while another described how they had felt forced by the local authority and the NHS to accept untested hospital discharges in the care home leading to a **lack of trust** by homes, with staff never knowing whether a patient discharged from hospital might have undisclosed COVID-19.
- Another manager described their CCG as '**rigid and patronising**' and expressed frustration that they could not or would not adjust their processes during the crisis. One director commented that 'CCGs have been totally absent and most have not even agreed to any annual inflationary increases from April, never mind the effect of COVID-19.'

Table 2: Partnership Working

	Managers	Directors
The most helpful offers of support from key partners	(N=40)	(N=34)
Training (e.g. in pandemic preparedness, infection control)	13 (33%)	2 (6%)
Provision of emergency PPE	25 (63%)	12 (35%)
Financial Uplift	12 (30%)	22 (65%)
Supportive culture across organisations	15 (38%)	11 (32%)
Co-ordinated response between organisations	13 (33%)	10 (29%)
Access to psychological support for staff	6 (15%)	4 (12%)
Support with surge staffing	1 (3%)	0
Direct clinical support	9 (23%)	6 (18%)
Accurate clinical information on hospital discharge	6 (15%)	4 (12%)
None	3 (8%)	1 (3%)
Other	4 (10%)	2 (6%)
What do care homes feel they need most?	(N=41)	(N=33)
Training	12 (29%)	9 (27%)
Further provisions in PPE	28 (68%)	21 (64%)
Financial Uplift	30 (73%)	27 (82%)
Supportive culture across organisations	18 (44%)	19 (58%)
Co-ordinated response between organisations	16 (39%)	23 (70%)
Access to psychological support for staff	11 (27%)	10 (30%)
Support with surge staffing	7 (17%)	16 (47%)
Direct clinical support	14 (34%)	15 (46%)
Accurate clinical information on hospital discharge	18 (44%)	18 (55%)
Other	1 (2%)	0

4.1.3.1. Box 1: Partnership working – What worked?

Perceptions of helpful measures of support from key public sector partners varied slightly between managers and directors. These are described in Table 2.

- **Managers had found PPE the most useful offer** (63% of managers and 35% of Directors)
 - In some cases, local authorities had supported the costs of PPE.
- **Directors said the financial uplift was most helpful to cope with the increase in costs** (65% of directors compared to 30% of managers).
 - Some directors said that they had received a **5% or 10% fee uplift or a lump sum**, but also commented that in some areas they had still received no financial support and no information about intended payments. For many, the 10% was not enough. In some cases, funding was determined by the number of local authority funded beds a home had to start with, which was felt to be unfair.
 - **Some reported void payments** for NHS and social care funded residents, but 80% had not received this.
 - **Provision of electronic tablets** to help residents to keep in touch was valued.
- **A supportive culture** (38% of managers and 32% of Directors)
 - **Regular calls** and zoom meetings with councils provided frequent updates and assistance.
 - **Support from some specialised teams was welcomed, including** infection control team visits (CCG), dementia in-reach (CCG) and care quality teams (LA). One home received a thank you card from the local district nurses.
 - **Mutual aid.** Regular calls and communication between all the providers in the county.
- **A co-ordinated response** across organisations (33% of managers and 29% of Directors)
 - One NHS trust in London organised local multidisciplinary team meetings to discuss resident care in response to COVID-19. This was a unique and particularly good example of collaborative working.
- **Training** (33% of managers and 6% of directors)
 - **Skills for Care training.** Webinars allowed discussion amongst colleagues, which helped with the feeling of loneliness.
- **Access to direct clinical support** (23% of managers and 18% of Directors)
 - Online GP appointments were specifically mentioned.
- **Psychological Support** was reported by 15% of managers and 12% of Directors

Managers also drew attention to other sources of support, including support from relatives, local communities, care associations, and training organisations

- **Relatives** were mostly described as being understanding of the lockdown measures and had been a great source of emotional support to staff. There was fairly resounding appreciation of relatives whose messages of kindness and thanks had helped many with motivation. Relatives often sent supportive messages to all the residents and not just their own family and staff reported how even their own relatives were supportive. Managers described receiving letters, postcards and drawings, and thank you messages.
- **Local communities** brought weekly supplies of PPE and gifts in some areas.
 - Local schools, colleges, rotary clubs and businesses offered combinations of PPE and visors, cleaning materials, food, scrubs, letters of support and plants.
 - Local suppliers also brought gloves, disinfectants, wipes and masks to one home. In one area, the local farms had delivered food packages when food deliveries were in shortage.
 - A large supermarket chain had also offered food hampers in some areas.
 - One manager described how volunteers had come to socialise with residents and staff.
 - Several homes described receiving support from their local churches and a local charity providing support to local carers was also mentioned as a source of support.
- **Care consortiums and associations:** Many commented on how helpful their own consortia and associations had been, with many deriving great support from manager forums. For some, this had helped to relieve the sense of loneliness and it was useful to get guidance on documentation. Many emphasised how helpful it had been to share experiences between homes and also how important it had been that the teams had come together. Several mentioned their local care home association bodies had been helpful, including the Registered Nursing Home Association and Care England.
- **Training organisations:** Skills for Care webinars were also described as helpful for management and staff.

4.1.3.2. Box 2: Partnership working - Future need

As shown in table 2, when asked what they needed and from whom, managers and directors said:

- **Resources**
 - **Financial support** to reflect the cost of increased care, including additional PPE and staffing, including the rise in the living wage, rising standards of care and void payments to account for a drop in occupancy.
 - Some mentioned how VAT had been removed from PPE but needed to be backdated to account for sunk costs.
 - **Staffing support from Local Authority / NHS** – to fill rota gaps if large numbers of staff have to self-isolate (as well as recruitment support mentioned in Box 6).
 - **Access to a better supply chain for PPE.**
 - **Testing** (see Box 6).
 - **Psychological support for staff** – access to free or funded fast-track mental health and wellbeing referrals including support for occupational health.
- **Structural changes**
 - **Partnership:** Recognition and support from key partners rather than scrutiny. To be treated with respect as equals with a common goal to improve the health and wellbeing of the residents.
 - **A more co-ordinated response.** *‘A clear and concise protocol and simple means of working in partnership’* with more co-ordinated guidance across the board and more streamlined communication. To consolidate webinars, rather than multiple organisations giving them at the same time.
 - **Minimise red tape.** Support filling occupancy more promptly without the need to fill in endless duplicated forms.
 - **Preparedness.** Clear foresight of how the track and trace app will impact homes and how they can mitigate resulting staffing shortages.
 - **Hospital discharges.** Clear documentation and testing at the time of hospital discharges. Most assessments now happen on the phone and it was highlighted that it was even more important to have accurate information about residents.

4.1.4. Infection Control:

4.1.4.1. Challenges and Responses

The challenges that managers faced with respect to infection control are summarised in Table 3.

- **Personal Protective Equipment:**

Only 5% of managers reported that personal protective equipment (PPE) had ever been completely unavailable and 62% said that they had always had enough. However directors reported that this had been achieved despite pricing surges (83%), delays (60%), and challenges in sourcing PPE of sufficient quality (63%). The most common sources of PPE were the government wholesalers and other private UK sources, but 34% of directors had also sourced PPE from abroad and 29% from local resilience forums. 79% had struggled to source facemasks and around half had also struggled to procure gloves, aprons, hand sanitizer and eye protection.

Pricing surges and increased demand for PPE: These were raised repeatedly. Directors described paying 12 times the cost for buying PPE and having real concerns that neither quality nor urgency were always guaranteed.

Availability: As one director said *‘Finding reputable suppliers with supplies’* was the greatest challenge.

- **Government wholesalers.** Directors described having to bulk buy more stock than they needed because wholesalers’ supplies were limited and were allegedly being diverted to the NHS.
- **Local Authorities.** Some felt that their local authorities had not supported them to source PPE. Others said that they had been provided with Type IIR masks from local authorities that were not certified and were of poor quality. However, this was not universal, and one provider described how Somerset Local Authority had provided PPE and Devon had offered to reimburse PPE costs.
- **The National Supply Line** could only supply homes that had very low stock. This was not thought to be helpful to providers, whose goal was to avoid ever being in that position.

- **Isolating residents:**

Managers of only 1 in 3 homes reported that they had always been able to isolate residents with suspected COVID-19 and 45% reported that they had not been able to isolate residents who walk with purpose. The difficulties of isolating residents with dementia or those who were mobile were quite commonly reiterated and some also highlighted that residents often wanted to isolate with the door open but that other residents would sometimes wander into their rooms.

Not all homes had needed to isolate any of their residents: Only 55% of homes had a suspected case requiring isolation.

Structural limitations: not all homes could create separate units and isolate all residents if they did not have space. One home still had shared rooms, and another described how challenging was to move equipment across the home to enable cohorting.

Mental wellbeing: There was an emotional toll associated with isolation and managers described how residents had found it hard to be isolated from their loved ones. They also reported how it was particularly hard to isolate residents who fit the case definition of COVID-19, but it was clear that the underlying problem was unlikely to be related to it. Staff were also afraid of caring for residents with COVID-19 and managers had to support them to help them overcome this.

Table 3. Infection control challenges

	Managers
Concerns providing PPE	(N=42)
Always had enough	26 (62%)
Yes <7 days' supply at times	14 (33%)
Yes <24 hrs supply at times	0 (0%)
Yes – completely unavailable at times	2 (5%)
Isolation of residents with suspected COVID-19	(N=39)
Not able to	10 (26%)
Able to but didn't	3 (8%)
Able to and did but not always possible	13 (33%)
Able to and always did	13 (33%)
Challenges implementing PHE infection control guidance	(N=42)
Understanding and applying guidance	10 (24%)
Conflicting guidance from different organisations	28 (67%)
Keeping up with frequent changes to guidance	31 (74%)
Insufficient testing for atypical presentations	17 (41%)
Inability to isolate residents who walk with purpose	19 (45%)
Managing admissions from hospitals	10 (24%)
Managing visitors	6 (14%)

- **Guidance:**

Frequent changes: 74% of managers reported that they had found frequent changes in the guidance particularly challenging with 67% of managers reporting that guidance from different organisations had been conflicting. Directors also described how changes to the guidance had been issued without warning, leading to surges in the price of PPE. Others expressed confusion and frustration at the frequent and unannounced changes, having been told initially that they did not need to wear masks. One commented *'The number of sources and versions of guidance has been horrendous. We still have to do the "day job", support staff to a much greater level than usual and read all the guidance so that we can cascade it to staff.'*

Trust: Only 20% of directors reported low confidence in official guidance. However, others struggled to reassure staff that the government's advice was credible when it had seemed so delayed compared to other countries and changed so frequently. Some directors resorted to ignoring the guidance and put in place their own local measures to maximise precautions as described in Box 3.

Relevance: There have also been concerns about the potential lack of stakeholder engagement in developing guidance and 54% of directors said that they had found it difficult to interpret the guidance in a social care setting. Several commented that it was still unclear exactly which masks to wear and for how long.

- **Managing hospital admissions:**

Testing: 24% reported that they had found admissions challenging and several commented that even after the publication of the Adult Social Care Plan⁶, which stipulated that residents would be tested on discharge from hospitals - this was not always happening.

Anxiety: Managing admissions caused a degree of anxiety for staff who felt frightened to be accepting residents who could be carrying the virus. One manager described their internal struggle between wanting to bring residents back from hospital to a place of care but not wanting to bring the virus into an otherwise 'clean' home.

- **Staff working across sites:**

Managers of around 1 in 3 homes reported having staff working across sites, and this varied from 2 to 37% of their workforce.

- **Testing:**

There was general tone of despair among managers and directors about the lack of testing overall.

Access:

- **Testing centres were often inaccessible** to carers, few of whom drove. In one case, a staff member had to make a 80 mile round trip to access testing and others had no access to computers or smart phones to book the test in the first place.
- **Managers of care homes reported widespread confusion about who was eligible for testing** and explained that despite the government's pledge to make testing widely available to care homes; these promises were unfulfilled.
- **Only 40% of homes had obtained any testing for asymptomatic residents** at the time this survey was completed between May 15th and June 1st and one director expressed frustration that Public Health England would not test asymptomatic contacts when a case was initially notified.
- **41% of managers had also struggled to access testing for residents with atypical symptoms.**
- **Some directors expressed frustration that testing had not been available for people with learning difficulties** as whole home testing was limited to people over 65.

Co-ordination:

- **Managers reported poor co-ordination** between agencies with nobody taking responsibility. They described how this had caused upset and confusion with residents, staff and residents' families and had left them feeling let down.
- One provider was told that the local hospital would co-ordinate testing for staff, but this service was subsequently limited to hospital staff only.
- Another home commented that the .gov testing portal was not working and **there was no point of contact** to source advice about who could and could not be tested. Some commented that they had been given a helpline number, but **call handlers were unable to answer any questions.**
- **The testing process itself was described as chaotic.** One manager stated *'I felt under pressure from residents staff and families because of this wait and growing impatience.'* Echoing this, another director said *'It's been very frustrating when the government announced care homes could receive testing when in reality this wasn't the case, but families thought it was us holding out on the tests.'*
- **Delays** were also common with one manager reporting a three week wait to receive tests and others reported that results had been lost and delayed.
- **Reliability:** Managers described having little clarity about how to act on the results of testing, describing the tests as 'as good as the day they were taken.' Some homes opted to stagger testing their teams to avoid losing too many staff at once.

4.1.4.2 Box 3a: Infection control - What worked?

When asked what had worked well to address their infection control challenges, managers said that the most valuable things had been:

- **Good communication with their staff.** They raised awareness by providing daily updates, support, and supervisions. Other strategies to improve communications included notices, posters, daily reminders and audits. Teamwork was a theme that was prominent across all the responses. Some managers also emphasised that increasing infection control training for staff including donning and doffing PPE had been very important. In one case, the infection control teams from the local trust had come to the home to support training and this was very welcome.
- **Going beyond the guidance.**
 - Some managers reported that they had **decided to go against guidance** and started **using masks in the communal areas in early March**, before the guidance changed.
 - Others said they had **used more PPE than that specified in the guidance**.
 - 63% of homes had already closed to visitors by the 18th of March when this policy was announced by the Prime Minister, with one closing as early as February 5th.
 - Others **used reverse barrier nursing** for all residents; a process of isolating or shielding the vulnerable, rather than just those who are infected.
 - **One innovation was to install a 'first contact box'** in the reception area, which included a thermometer, alcohol gel, gloves, aprons and alcohol wipes to be used for COVID positive admissions.

Sourcing PPE was a huge challenge and providers '*worked tirelessly to source PPE*'. This often required trying many different sources, which was particularly time consuming.

- **Frequent cleaning** was also raised repeatedly. Managers increased training to cleaners, many of whom did 2 hourly disinfecting of communal areas, sometimes working additional shifts. Many had paid companies to come and deep clean. Some also had done handwashing audits.

Managers described several strategies to support isolation:

- **Explanation:** Some residents were more than happy to stay in their rooms when it was explained to them but sometimes it had to be explained several times.
- **1:1 Care:** *Some homes had had to allocate 1:1 care to residents* who needed extra support to isolate.
- **Cohorting:** *One home had created 3 separate wings for positive, suspected and non-suspected residents* and cohorted their staff to each wing for 2-3 weeks, using floating staff to deliver meals and supplies to each wing. Another had allocated space on a separate floor with a dedicated lounge to cohort COVID-19 positive residents so that they could still mobilize and interact. For many this involved keeping empty beds in case a resident developed symptoms or tested positive. Many did the same if residents were newly admitted from hospital or if they had to attend hospitals frequently, for example for dialysis. Some did this irrespective of the COVID-19 test results or of symptoms and others used single-use PPE for all new admissions.
- **Shielding:** One home reported that they had shielded all residents to their rooms as a precaution and one had asked residents to only come out of their rooms to use the communal areas and garden to exercise.

When asked what had worked well to obtain PPE, directors described several strategies:

- **Collaboration:** Directors described using networks and care home associations to help source stock. One director in Somerset had participated in a joint county council/CCG/NHS trust/provider working group - one of only 3 providers from Somerset.
- **Research:** Many described speaking constantly to suppliers and using several at once—a time consuming process.
- **Teamwork:** This was raised several times and one home had a dedicated person to source PPE and ensure compliance with the guidance.

4.1.4.2. Box 3b: Infection control - What worked?

When asked what had worked well to minimise staff transmission, managers described:

- **Policies and procedures:** Most managers stated that they had:
 - **Regular meetings** with staff to provide advice, support and training about the importance of social distancing in and out of work.
 - Many also had **isolation and distancing policies** in place, while one had created an isolation guide to support staff through isolation.
 - Another home had **created a risk assessment** of staff activities outside work to help minimise risk.
 - One home commented that if staff had to isolate, they had agreed to **pay their full salary** for 14 days. Several managers had daily health checklists for staff including temperature checks.
- **Providing support:** To minimise risks of staff transmission, some managers
 - **Gave staff masks and gloves** to use outside the care home and gave advice about minimising risks when shopping and filling fuel.
 - **Offered to purchase shopping for staff** or asked them to get their families to shop or to use key worker hours to minimise exposure.
 - **Asked staff not to travel in their uniforms** and encouraged staff to change at work. Others washed all uniforms on site for staff.
 - **Offered showering facilities** in the home and gave staff laundry bags to take their uniforms home to wash every day.
 - Several homes said that they had **offered staff accommodation** on site if they could but many were unable to. One had received help from the local parish to provide accommodation for staff.
 - In one case, a manager supported car sharing efforts to minimise dependence on public transport.
- **Smart Rostering:** To avoid further staff crossover, some managers:
 - Offered bonuses to staff who chose to do additional shifts to avoid the reliance on agency workers.
 - Changed shift patterns so that staff did 8-8 shifts, minimising the number of times staff would have to come in and out.
 - Asked the agency staff to offer all their hours to one single home to prevent cross-contamination.

4.1.4.3. Box 4: Infection control - Future need

When asked what would need to happen to optimise infection control, care home managers and directors said the following:

- **A well-resourced and sufficiently funded supply chain of PPE and cleaning products**, with price fixing to prevent over inflation
- **Clear, concise and consistent guidance** in a digestible format that staff can understand
- **Testing for staff and residents** with:
 - quick turnaround time
 - at regular intervals
 - irrespective of symptoms
 - including antibody testing
 - supported by LA and CCG
 - greater clarity around how this aligns with the NHS test, track and trace system
- **To continue lockdown** for longer and maintain staff vigilance and daily observations of residents
- **'A COVID cure'**

4.1.5. Costs

69% of directors said that their occupancy had fallen since February. Multiple deaths left homes with empty unfunded beds and 80% of managers reported that they had not received any additional funding to compensate for these reductions in income. When asked the same question, directors responded similarly but 27% also commented that this varied widely by area. According to one director 'many operators struggle financially and may go bust.'

When asked about their expenditure on PPE, directors reported that in the month of April alone they had spent a median of £4,000 (IQR £2000-£8420) overall and approximately £43 (IQR £25-£74) per bed. 91% said that the cost of disposable and reusable supplies had gone up. 63% also reported increases in staffing and agency costs with some commenting that agencies had increased their costs. One director said 'The cost of PPE has increased astronomically. For example, 800 aprons from our supplier used to cost approximately £9. 1000 of the same aprons now cost £43. These costs are simply not sustainable. Our usual provider is now unable to source some PPE and we are now forced to spend even more than the already inflated prices.'

4.1.6. Workforce:

4.1.6.1. Challenges:

- **Mental Health:**

Workforce challenges are displayed in table 4 and show that staff morale, mental health and wellbeing were the most common concerns and were reported by 75% of managers and 77% of directors. Some managers described staff's fears that they might bring the virus into the home but were still unable to access testing.

Fears: Managers described a fear of the unknown, particularly not knowing what would happen if someone in the home ever tested positive. There were a few themes that emerged about fear.

- **Health risks:** Some described how staff feared for their own health and the health of their families. Several felt that the media stories about care homes had inflamed these fears. With the passage of time, these fears had eased as PPE had become more available and staff grew more accustomed to taking precautions.
- **Morale:** Managers also describe their own challenges to keep up morale, and to reassure staff and relatives who were scared to come to work. One manager said '*Staff morale fluctuates and is hard to support when mine is also not stable. As a care home manager it has felt very lonely at times. Staff have pulled together to cover short fall, but they are now tired.*' Another said '*to the team it seems like there is no end to losing residents and not knowing if it was due to the virus.*' One manager said that staff felt they had failed if a resident's test came back positive and some had resigned or refused to come to work because of fears about coronavirus.
- **Trauma:** One director raised concerns about the future mental health of the care workforce and concerns about how they could plan to support staff at risk of developing post-traumatic stress disorder.

Table 4. Workforce challenges

- **Staff absence:**

A staff member had isolated with symptoms of COVID-19 in 64% of care homes (table 1) and 43% described staffing shortages (table 4). Shortages also arose from the need for some staff to shield and others to cease working across organisations. Many had no choice but to fill shortages with agency staff, creating anxiety and disruption and nearly half of directors stated that they needed support with surge staffing (table 2) and described their frustrations with being unable to routinely test staff. Many care homes still face ongoing staffing shortages as they cannot recruit temporary staff to fill the posts of individuals who are shielding.

Workload: Staff have continued to provide care despite these shortages and have had to take on new responsibilities including hairdressing, chiropody and coordinating activities on top of additional time for managing new infection control measures and new training. Directors commented that staff were overworked and outlined a number of measures they had taken to try to support them (Box 5), but many reiterated that they needed support with recruitment (Box 6).

- **Food Shortages:**

Many food suppliers limited their deliveries and in some cases, care homes could not access their usual supplies. One manager described how staff had helped to buy more food supplies for the home.

- **Training:**

Only 15% of managers reported staff training as the major challenge.

	Managers	Directors
Greatest workforce challenges	(N=40)	(N=34)
Morale, mental health and wellbeing	30 (75%)	26 (77%)
Staffing Shortages	17 (43%)	22 (65%)
Access to and interpretation of COVID-19 tests	21 (53%)	29 (85%)
Staff training	6 (15%)	4 (12%)
Provision of occupational health services	3 (7.5%)	1 (3%)
Providing accommodation for staff	2 (5%)	6 (18%)
Other	10 (26%)	1 (3%)
What worked well to address staff morale	(N=38)	(N=32)
Peer to peer support e.g. WhatsApp groups and staff engagement	33 (87%)	28 (88%)
Group activities and campaigns	5 (13%)	11 (34%)
Psychological services for COVID-19	5 (13%)	5 (16%)
Support from national bodies e.g. CQC	8 (21%)	4 (13%)
Mutual aid	2 (5%)	4 (13%)
Occupational health services	3 (8%)	0
Pay rise or a bonus	9 (24%)	2 (6%)
Other	4 (11%)	5 (16%)
What managers thought staff most wanted in recognition	(N=16)	-
Pay rise / bonus	11 (69%)	-
Acknowledgment from the organisation	10 (63%)	-
Acknowledgement form the public	11 (69%)	-
Discounts	7 (44%)	-
Better access to the shops for essentials	5 (31%)	-

4.1.6.2. Box 5: Workforce - What Worked?

When asked what had worked well to address their staff morale and wellbeing challenges:

Nearly 90% of homes managers and directors said that they found their own internal peer to peer support like WhatsApp groups most helpful, while 24% of managers reported that a pay rise had helped to boost morale and 21% had derived support from official organisations such as CQC or the local authority. 13% had benefited from using psychological services. Care home managers reported a number of methods to boost morale including:

Internal support:

- **In house welfare meetings, daily updates and regular training.** Several managers and directors described having daily meetings and welfare sessions to listen to staff concerns and provide updates and reassurance. Directors described the importance of leadership being present throughout and described small things, like calling the teams on the weekends when the managers were not there. However, the pressure to maintain morale weighed heavily on managers and one manager described the toll this had taken, saying *'this is mentally straining on management, but we feel we need to be there for the staff.'* The sentiment from directors was that their longstanding staff had been their core strength, and several had put up banners outside the homes saying *'Superheroes work here.'*
- **Peer to peer support:** Many homes described how staff provided each other with moral support, talking and expressing their fears to each other. The benefits of staff being able to see each other face to face was also mentioned. Many brought in treats to keep up morale.
- **Social media and chat groups** were both described as a platform for discussion, support and entertainment and one home even used WhatsApp broadcasts, but some also described how social media could at times be overwhelming, intensifying existing fears.
- **Events and activities** also helped to keep up morale including barbeques, tea parties, making a Tiktok video and posting events to their Facebook pages. As one manager put it, *'keeping fun at the front of the agenda.'* In one home, local celebrities also visited to show their appreciation.
- **Campaigns** including Sparkle for Social care – a dance-off campaign to promote social care.
- **Staff rewards:** Some care homes described how they had provided a bonus to staff to show their appreciation for their hard work and others had offered an annual pay rise to their staff. Others praised their staff and rewarded with gifts and some allowed staff to finish early when they were tired or take additional days off to relax. One manager installed a dehydration and food station for staff, and some offered staff access to an employee assistance programmes to provide wellbeing support.

Official organisations: One manager described a local authority as *'onboard from the beginning, with telephone calls and online meetings and updates....(They) offered staff for cover, PPE supplies, (and a) helpline.'* However, another said *'The local authorities and other agencies are big on rhetoric of support but don't come through in practice.'*

Local communities: Others described support from the local community and one home was part of an *'adopt a care home'* group, which had sent goody bags to staff. Relatives had also sent in thank you cards, emails, biscuits, cakes and chocolates. These things helped to lift staff morale. Local support and volunteers were helpful, but one director also commented that they had had to learn how to use them effectively.

When asked what had worked well to address other workforce challenges, managers said the following:

Teamwork: A committed and motivated team with consistent staff and flexibility where needed and good support from senior management who offered a clear plan of how the home intended to keep everyone safe. Some homes described working closely with other homes, including neighbouring homes or other branches in a group.

Recruitment: Several care homes stopped using bank and agency staff to minimise cross-cover between homes and recruited extra staff to ensure they always had sufficient cover. Some found ways of recruiting virtually, using Skype and taking advantage of the DBS amendments in the Coronavirus Act. Some homes actually found that there were more staff applicants from other industries. Others had worked with the local university to attract new bank staff.

Protecting staff time: Another home committed to not accepting new admissions despite working at a financial loss to maintain staff confidence. One manager introduced protected hours for meals and medication rounds to allow uninterrupted time with staff and set up a booking system to minimise time spent on reviews allowing time to be prioritised to speaking with relatives. Some mentioned that they had tried to offer accommodation to staff on site (with some even considering purchasing caravans) but faced barriers as many had family commitments.

Training: this was not mentioned as often, but one provider specifically mentioned the helpfulness of Skills for Care webinars, which they now used to provide all their training and staff updates.

4.1.6.3. Box 6: Workforce - Future need

When asked what would need to happen to minimise workforce challenges, care home managers and directors said the following:

Recruitment support. Support to attract and retain staff to the sector with financial support accounting for the drop in occupancy. One manager said ‘In social care we have always been treated as the poor relation. These staff are working on minimum wage doing the same as an NHS care workers on a lot less money. I feel social care needs to be given the same respect and same wage as an NHS worker.’

- Directors commented that they wanted the means to provide staffing at the same ratio as the NHS and one mentioned the Welsh model of giving a £500 bonus to care homes.

Teamwork between NHS and Social services

Testing (see infection control section)

Support with accessing technology e.g. tablets/mobile phones to support contact with families.

Access to volunteers

- Access to free training and wellbeing support

4.1.7. Wellbeing of Residents

4.1.7.1. Challenges

The challenges managers faced with respect to ensuring wellbeing of residents are summarised in table 5.

The impact of isolation on mood was widely reported (84%) and attributed predominantly to being deprived of visitors (98%) and fewer activities (54%), while 46% also commented on the impact of PPE on relationships with staff and 28% also reported reduced oral intake following isolation, and several also described weight loss.

Table 5: Wellbeing of Residents

	Managers
Have you observed any of the following in residents following isolation for COVID-19?	(N=32)
Low mood and agitation	27 (84%)
Pressure sores	1 (3%)
Increased falls	2 (6%)
Reduced mobility	3 (9%)
Reduced oral intake/weight loss	10 (31%)
None	3 (9%)
What factors have influenced resident wellbeing during the COVID-19 pandemic?	(N=41)
Reduced access to clinical support for residents	15 (37%)
Fewer activities	22 (54%)
Fewer social interactions from visitors and other residents	40 (98%)
Disrupted routines e.g. mealtimes	5 (12%)
Impacts of PPE on relationships with care staff	19 (46%)
Other	1 (2%)

When asked to elaborate on particular factors that had influenced resident wellbeing, the major themes described by managers were:

- **Loss of relationships:**

The lack of visits from and physical interaction with loved ones was believed to have lowered mood very quickly. Residents were said to be missing their families terribly, asking to see them and feeling abandoned without always being able to understand why they were alone. Some could not remember when they had been told why their families could not come and this would thought to have exacerbated the symptoms of their dementia. Activities and visits are usually a big part of the residents’ daily routine and the reduction in these had also contributed to low mood. Some also commented that residents struggled to understand staff when they wore facemasks, particularly those who were hard of hearing. One manager said ‘We have seen low moods but have a good team who do lift the moods in the home but we aren’t family.’

- **Poor oral intake:**

Reduced oral intake was mentioned several times as a major issue. Some residents did not like to eat or drink in their rooms but this improved when they came to the lounge. Several mentioned the challenges of enabling residents to eat in the lounge, by alternating residents in order to observe social distancing. In some cases, managers reported a higher rate of weight loss due to weather and residents missing their families.

- **Agitation:**

Managers felt that the loss of social interactions were confusing and had led to agitation, irritability and anxiety among residents, many of whom expressed wanting to see their loved ones. In some homes, residents were more subdued when they were in their rooms but trying to observe social distancing in the common areas led to heightened behaviours in some and one manager described the staff bearing the brunt of a lot of abuse.

4.1.7.2. Box 7: Wellbeing of Residents: What Worked?

Managers mentioned several strategies that they had used to improve wellbeing of residents

- **Use of technology to communicate with loved ones**

Telephone and video calls with families who wanted to keep in touch with residents. Most used a variety of different technologies including Skype, Facetime and Zoom as well as using Whatsapp and emails to keep in touch.

- **Increasing social activities**

Examples included garden games, sports, arts and crafts and cooking. Some homes bought additional equipment and encouraged residents to be involved in developing activities.

- **Recruiting volunteers**

Dedicated to socialising with the residents.

- **Window/garden visits**

Some families visited their loved ones through a window to keep in touch with social distancing in place.

- **Keeping residents informed**

Reassuring residents about what protection the home was offering.

- **Mobilising**

Some homes used physiotherapists to support residents to mobilise more. Others noted that 'bringing the residents out' had helped to encourage mobility.

5. Discussion:

5.1. Key findings

In this small pilot study of care homes in England, care home providers described marked differences in the support offered to them by local government and NHS organisations. While many had received supportive offers from local authorities, NHS Clinical CCGs and the CQC, this was not universal, and many received conflicting advice from different organisations, often sensing that their NHS colleagues were sometimes unable to identify with the daily challenges in care homes. Three quarters of managers and directors expressed concerns about staff wellbeing and reported how staff shortages had increased pressures on care staff, leading at times to an unavoidable reliance on agency staff. Residents had been impacted adversely by the prolonged absence of their loved ones, with reports of residents experiencing resulting deterioration in mood from 84% of managers and of reduced oral intake from 30%. Despite these challenges, it was clear that some providers had gone to great lengths to implement stringent infection control measures such as enhanced cleaning and restructuring or rearranging their homes to facilitate appropriate segregation of residents. Others closed to visitors and required facemasks in all communal areas before these were formally advised. Measures were also taken in many homes to support staff, while local communities and relatives also helped by providing food and Personal Protective Equipment (PPE) and letters of support. Yet the pandemic has revealed clearly a deep divide between health and social care that must urgently be addressed.

5.1.1. Implications for policy

Those interviewed describe a social care system that is fragmented, isolated, and under resourced. Their accounts reveal a situation that, at the best of times, is only just coping but which has buckled under the pressure of the COVID-19 pandemic. At a time of crisis, they turned towards their local authorities, which themselves have been weakened by a decade of austerity, to find that many of them are unable or unwilling to help. Some also turned to their CCGs, again finding little support. The situation was not uniformly bleak. There were examples of these organisations providing support in various ways, but these were the minority. However, when support was offered, it provided more than material help. It also conveyed the very important message that those struggling to care for some of the most vulnerable people in society were not on their own. The World Health Organisation has recently set out 10 key policy objectives to support countries to manage the COVID-19 pandemic in long-term care (LTC) settings⁷. They recommended that services must coordinate to ensure continuity of care including access to healthcare personnel. We found conversely, that relationships had somewhat broken down between some NHS and social care providers, both constrained fundamentally by a lack of testing. Although the chasm between health and social care dates back more than 50 years⁸, local pandemic plans are dependent upon effective integration between them.²

The WHO also advise that countries prioritise the maintenance LTC services through effective governance, mobilizing additional funds to support these settings. Our findings suggest that care providers have faced enormous financial pressures and while funding has been promised, it has not been received universally. If we are to mimic the protection afforded to the NHS, measures must be in place to ensure that homes are supported to continue to provide safe care despite the impacts of COVID-19. The problems that have become apparent during the pandemic, and in particular the fragmentation of the health and social care landscape, mean that legislative reform is almost inevitable, hopefully drawing on international experience from the many settings where these rules are integrated. However, that will take time and resources. For now, what is important is that there is a clear message to all of those involved about the importance of mutual support and communication. The fact that there are some places where this already happens shows that it is possible, even if it means overcoming organisational barriers. What will be more challenging will be the cultural and psychological barriers that clearly exist to prevent those with the responsibility from cooperating across these barriers.

As with the fragmentation described by interviewees, the reports of difficulties in sourcing PPE will come as little surprise. However, what may be more surprising is that many managers were able to obtain supplies, albeit by using considerable ingenuity. In guidance published on February 25th⁹, Public Health England advised care homes against the day to day use of facemasks and stated that if contacts were well, they were 'very unlikely to spread the infection to others.' Rather than warning care homes to stockpile PPE, this acted as a deterrent, whilst similar guidance to healthcare settings at the time conveyed a very different message.¹⁰ Access to adequate supplies of PPE of sufficient quality is fundamental to managing outbreaks and while it is inevitable that there will be challenges with procurement during a crisis such as this; the evidence from across the NHS and social care sector consistently highlights problems predicting need and obtaining everything from testing kits to ventilators¹¹, pointing to a need for a detailed investigation into systems of procurement in the UK. This is especially urgent given that many of the stockpiles built up for a no deal Brexit have become depleted, despite the risk that they will be required at the end of 2020 given the absence of progress of the Brexit negotiations.

Another finding that is, arguably, unsurprising is the struggle that managers faced with changing and often unclear guidance and in persuading their staff that advice from the government was credible. This points to a wider concern that has been voiced about the COVID-19 response in the UK, where trust in government advice is now the lowest in Europe¹². Rebuilding trust will be difficult but will be absolutely essential if policies are to be adhered to. Public Health England guidance¹³ published on April 2nd, emphasised that the care sector played a vital role in accepting patients from hospitals as part of the national effort and that negative tests were unnecessary for transfers from hospitals. Care homes were reassured that all symptomatic residents could be safely cared for in a care home if they were suitably isolated. Rather unsurprisingly, care homes told us that it was not always possible to isolate these residents, particularly those who walked with purpose. We now know that 40% of nosocomial outbreaks in hospital were occurring in psychiatric and dementia wards.¹⁴ Given the threat at the time that hospitals might be overwhelmed, these wards were most likely to discharge to long term care settings, where they could potentially seed transmission. These findings suggest an urgent need for care homes to access alternative settings where residents can be quarantined if necessary.

The situation with regard to testing was, perhaps predictably, seriously problematic, with a widespread sense of despair. There was a clear mismatch between ministerial reassurance and the reality on the ground. The WHO advises that testing and tracing must be prioritized among recipients of LTC. The inability to test widely in England has been one of the important challenges faced by frontline NHS and social care workers in the UK during the COVID-19 pandemic and we found that only 40% of care homes who participated had accessed testing for asymptomatic residents by the middle of May. The importance of testing to prevent presymptomatic transmission garnered attention after evidence¹⁵ was published in April showing that 56% of residents who tested positive in a LTC facility in Washington were asymptomatic, with most subsequently developing symptoms. Although asymptomatic transmission is still poorly understood according to the WHO¹⁶, the Scientific Advisory Group for Emergencies was presented with recommendations from Public Health England on the 24th February 2020 that asymptomatic contacts of a confirmed case should be tested in community outbreaks during the containment phase. Subsequent evidence was presented on the 19th April showing that batch testing (a strategy employed to facilitate whole population testing in China) may facilitate efficient detection of cases in long term care settings.¹⁷ Neither of these strategies have yet to be heeded in care homes, and this is an issue that must be resolved urgently to enable repeated testing in care homes.

The vast majority of the 1.5 million people working in social care are recognised as being committed to the well-being of the vulnerable people they are looking after, despite low pay and often difficult working conditions. Those interviewed described how their staff had pulled together in the face of the crisis but many were now suffering from exhaustion, raising questions about whether the situation was ultimately sustainable. Again, this is an issue that is almost certainly going to be examined in a future inquiry, reflecting a recognition that some of the most important workers in a crisis are among those that, in normal circumstances, are seriously undervalued. The government's commitment to recruit a further 20 thousand workers to social care is welcome, but given the 122,000 vacancies before the pandemic¹⁸, this will still be insufficient to fill the gap.

Faced with a highly transmissible virus, often spread by people who are presymptomatic, and with widespread testing still unavailable, it was inevitable that those living in care homes would face isolation. However, this has taken a dreadful toll on their physical and mental health. In recent years there has been growing recognition of the role of loneliness as a cause of illness and

premature death¹⁹. Many care home residents, and especially those with cognitive impairment, will have struggled to understand why they are being isolated. This is an area where research is urgently required to find ways of mitigating the effects of a lack of human contact.

Beyond the individual implications for policy listed above, the devastation wrought on care homes during the pandemic raises fundamental questions about how society treats some of its most vulnerable members. While some care homes provide welcoming and supportive environments, they do so despite facing severe financial constraints, while others do little more than store people. There are growing demands to bring care homes out of the shadows and to place them firmly on the policy agenda. The challenge will be how to keep them there.

5.1.2. Limitations

Our findings must be interpreted in the context of a number of limitations. This is a pilot study, intended to generate themes for more in depth exploration in future research, including for example views from both social care staff and residents. Future work should also endeavour to understand these experiences from the perspectives of local authorities, CCGs, the Care Quality Commission and PHE, though this might be expected to form a part of any future inquiry. Sampling was purposive and is not necessarily representative of all care homes in England and cannot therefore be generalised to all care homes in England. These findings also reflect experiences from providers that were current at the time, between May 15th and June the 1st and as some aspects of policy have changed since then, we would expect that the proportion of homes who have received tests would have increased. Some have also now received some additional funding since the announcement of the infection control fund, but anecdotally, this still appears to be inconsistent in different areas.

5.1.3. Conclusions

It is clear that care homes have faced immense challenges with creativity and resilience, and some have also responded to them admirably with the few resources available. The pandemic has had a tremendous impact on resident and staff wellbeing and organisations must now work together with a common goal to ensure a whole system response to future outbreaks. Managers ask for more PPE and both managers and directors ask for the financial support that would help them to provide it. Care home providers ask for clear lines of responsibility and better access to testing and to psychological support for their staff. There is a need for a more supportive culture to enable closer co-ordination between organisations to mitigate the impact of a potential second wave.

6. Disclosures:

Selina Rajan is an honorary research fellow at the London School of Hygiene and Tropical Medicine. She is employed by Imperial Healthcare Trust as a Specialist Public Health Registrar and also holds an honorary contract with Public Health England although receives no direct funding from them. Her family own 3 medium sized nursing homes in which she holds a small number of shares.

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