Northumberland
County Council

Helen Whately,
Minister of State for Care
Department of Health and Social Care

(By email c/o CareandReform2@communities.gov.uk)

From Daljit Lally,
Chief Executive
County Hall
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29 May 2020

Dear Minister,

I am writing in fulfilment of the expectations set out in your letter to all local authorities dated 14 May 2020. Along with the enclosed template, this constitutes the Care Home Support Plan required by DHSC.

To the extent which has been possible on the very tight timetable set by your correspondence and the circular setting out grant conditions for the Adult Social Care Infection Control Fund, I have prepared this plan in discussion with Northumberland Clinical Commissioning Group, as well as the Council's statutory Director of Adult Social Services and Director of Public Health. As required by your letter, the Accountable Officer and Director of Nursing for the CCG have had an opportunity to comment on the contents of this plan.

This plan is also being published on the Council website. It is available at www.northumberland.gov.uk/carehomesupportplan. In the interests of transparency, we have included in this letter some background information which you will already be well aware of, to assist others in understanding the context of what we are doing to support care homes.

1. Background

1.1 The Covid-19 pandemic has required care providers, and the local and national public sector bodies who commission, support and regulate care services, to adapt rapidly to risks and pressures which are outside any of our experience. We are all still learning about the disease and the best way to respond to its wide-ranging direct and indirect effects on vulnerable adults, care workers and care services, and the financial, administrative and legal framework in which all of us operate.

1.2 Nationally and locally, public sector bodies and care providers have been rapidly improvising their responses to a situation which nobody yet fully understands. Perhaps only in hindsight in future years will any of us become clear about what it would have been best for us to have done.

1.3 What is already clear is that, like many other countries, we have struggled during the first peak in the transmission of the virus to give the level of protection that we would have hoped for to people who live in care homes. Care home residents are especially at risk from the disease, because of the combined effect of the health

conditions which are the reason for them living in a care home, and the nature of care home accommodation, which brings residents and staff into frequent close contact with each other, while being designed to provide a homely rather than a hospital environment.

1.4 Since 28 March, 29 of the 69 care homes for older people in Northumberland have experienced one or more deaths of residents which have been formally identified on the death certificate as being associated with Covid-19. 103 deaths registered as associated with Covid-19 have occurred in the care home, 22 in hospital.

1.5 These figures understate the full impact of the disease on care home residents. In April, a total of 193 people died in a care home in Northumberland, when in a normal April the expected number of deaths would have been between 60 and 80. Only 53 of the 110-130 "excess" deaths were registered as associated with Covid-19. We believe that many of the others are likely to have been caused by Covid-19 but not recorded as such because the person had not been tested, or a test had produced a "false negative".

1.6 There are a number of reasons why it has proved harder than expected to protect care home residents. One factor which has become increasingly clear, but which was initially not well understood, has been the spread of infection by asymptomatic and pre-symptomatic care staff, who have unwittingly continued to work, sometimes across multiple care homes, while infectious.

1.7 This risk has been increased by the common practice, particularly among care home providers which operate multiple homes, of using "agency" or "bank" staff to provide flexible cover for staff absences by sharing resources across homes. This is not a criticism of the care home providers who have operated in this way. Indeed early guidance about Covid-19 for care home operators published on 16 March specifically encouraged all care homes to make arrangements for "sharing of the workforce between providers" as a way of managing the anticipated level of care staffing absence because of Covid-19 infection and self-isolation. In hindsight, it appears fortunate that no such arrangements were put in place in Northumberland.

1.8 Another difficulty so far has been the limited availability of tests for asymptomatic staff and residents. Now that tests for these crucial groups of people are taking place it is important that the long turnaround time for getting results back to the home is addressed.

1.9 If anything, these issues may now be diminishing a little in severity, since there are encouraging signs that the exceptional number of deaths of care home residents experienced in April has subsided in Northumberland, as elsewhere. However it is certainly not yet possible to be confident that there will be no more outbreaks in the next few weeks, and further waves of Covid-19 cannot be ruled out particularly over winter, so establishing safe staffing arrangements remains an important priority.

1.10 This plan sets out the current situation in Northumberland, and the steps which we are taking to support care homes to reduce the risk of further outbreaks, and the severity of outbreaks where they do occur. It is a snapshot of the position at the end of May; there are still many uncertainties about how the situation will develop over the coming weeks and months. Regionally, Directors of Public Health have also emphasised a number of risks which are outside the control of the local authority - summarised in section 5 below.

2. What we are currently doing

2.1 The County Council has been working closely with other organisations, in particular Northumberland Clinical Commissioning Group (CCG), the NHS body responsible for the overall planning of the use of NHS resources in our area, and Northumbria Healthcare NHS Foundation Trust, the NHS body which runs the acute and community hospitals, community health services, and which leads on infection prevention and control in our area, and has its own laboratory facilities capable of carrying out Covid-19 tests.

2.2 We have recently enhanced our joint working arrangements, setting up a group to coordinate support to care homes, which includes senior managers from adult social care, public health, the CCG, and the community health and infection control services in Northumbria Healthcare.

Monitoring the situation of care homes

2.3 The Council has been in constant liaison with care homes over the period of the crisis. A key mechanism for this interaction has been twice weekly structured calls from the Council to care homes for older people and the main domiciliary care providers to gather key information which is designed to help us to spot any service heading into difficulty dealing with aspects of the Covid-19 emergency which hasn't yet raised this directly with the Council. In addition, there has been constant ad hoc interaction with individual homes on specific issues throughout the crisis. This has been particularly but not exclusively focused on providing assistance with the management of outbreaks. The Council has also set up mechanisms such a PPE email address and helpline for urgent PPE issues for providers, and has circulated guidance about key issues such as hospital discharge arrangements, testing, and PPE.

2.4 We are monitoring daily data from a number of sources about what is happening in care homes. These sources include information provided directly by the home, either through the Capacity Tracker or in response to our own contacts; information supplied by Public Health England; information about publicly funded residents placed by the Council for social care or under its partnership with the CCG for NHS Continuing Healthcare; and data from the registrar about deaths in care homes.

Financial support

2.5 With effect from 1 April, in addition to a general uplift to the fees that we pay to care homes for older people for residents placed by the Council, which on average increased fee levels by 6.2%, we have been paying a temporary additional supplement of 5% on all elements of fees other than the nationally set funded nursing care contribution, in recognition of the increased costs which care homes face because of the direct and indirect consequences of Covid-19.

2.6 This temporary additional supplement, which we have initially committed to until the end of June, and will review before then, is being paid to all care homes and home care providers in Northumberland who provide Council-funded services, with no constraints on how the funding can be used. We recognise that all providers are likely to have additional costs because of the pandemic, and that these may arise in a variety of different ways, including higher levels of staff absence, and the need to provide more intensive support to residents who are infectious, or need additional precautions to protect them from infection. Higher costs for PPE were also an issue

for providers, though this is now offset by the substantial level of PPE being distributed to providers by the Council without charge.

2.7 We've made it clear that the 5% fee increase is not the limit of the financial support available to care homes, and that we will cover any costs above that level incurred by individual homes, if provided with reasonable evidence of these costs. While our financial support to date has focused on additional costs, the increasingly significant issue of reduced income because of rising vacancy levels is discussed below.

Returning clinical staff and volunteers

2.8 Currently the only form of support which we have arranged from a returning clinician is GP support for step-down beds in Morpeth from a retired GP returning to provide assistance during the pandemic. We would be interested to learn about examples elsewhere of successful use of returning clinical staff or volunteers to support care homes and reduce infection risks, and how any difficulties have been overcome.

3. Specific support with infection prevention and control

3.1 The "Care home support package" published by the Department of Health and Social Care on 14 May lists a series of key areas in which organisations in each local area should be working together to support care homes with infection prevention and control. The following paragraphs summarise what we are doing in each of these areas.

Training in infection control

3.2 The infection control team in Northumbria Healthcare NHS FT has offered infection control training to all care homes in Northumberland, working with the director of nursing at Northumberland CCG. This includes both webinars and the opportunity for face-to-face training, which can be tailored to the specific needs of individual providers, for instance to cover the special issues which can arise when working with people who have dementia, learning disability, mental health issues or autism.

3.3 By the end of the day on 29 May, 91 of the 100 care homes currently operating in Northumberland will have had training provided through this programme. Nine have said that they do not need the training. Some care home companies prefer to arrange their own in-house training programmes.

PPE (personal protective equipment)

3.4 Our experience to date has been that the national system for distributing PPE to care homes and other social care providers has not yet become sufficiently reliable for providers to be able to depend on it for all supplies which they cannot obtain from their usual sources. Supplies have been intermittent, often insufficient in quantity, and sometimes distributed in ways which have no relationship to the relative needs of different providers.

3.5 The Council identified at an early stage that the issue causing most difficulties for care providers was their problem in securing sufficient supplies of standard fluid-resistant face masks. Care home and home care providers raised this repeatedly as a key concern. The national emergency supply distributed through the Local Resilience Fund was not coming close to the numbers needed by providers in order to meet public health recommendations, with an average of less than 10,000 masks per week being delivered through that route.

3.6 Since mid-April the Council has directly procured and supplied all of the masks of this kind needed by care homes in Northumberland. On average, the Council is delivering close to 100,000 masks per week, of which between 40,000 and 45,000 masks are being supplied to care homes, and the rest to domiciliary care providers. Deliveries are adjusted where necessary each week to match each provider's current needs. The Council is making no charge to providers for these masks.

3.7 The need for additional supplies of other forms of PPE has not been as great, but the Council has generally been able to ensure that these are available when a provider has had an issue.

Reducing workforce movement between care homes

3.8 An annex to the care home support package published by the Government on 14 May helpfully summarised what appears to be direct evidence that there is a significant issue of transmission between care homes by asymptomatic staff working in multiple homes simultaneously, or moving between homes as part of a flexible use of a bank of employed staff or of staff employed by an agency.

3.9 Prior to this, we have on occasion made specific decisions aimed at reducing the need for this kind of mobile additional staffing, such as making an alternative arrangement when a care home told us it was unable to take a potentially infectious resident back without additional funding for temporary extra staffing, and have monitored the use of agency staff as a potential indicator that a home is struggling. The Government has now made substantial additional funding available specifically to address issues about workforce arrangements which may lead to care workers unknowingly carrying Covid-19 between homes. With hindsight, it would have been more valuable to have had this funding at an earlier stage, before the peak of care home outbreaks in April, but we recognise that at that point less evidence was available to support the need for these measures.

3.10 Because of the very rapid timetable on which this plan has had to be prepared, we have not yet been able to discuss in detail with care home providers how they will be able to make use of this funding. We will be doing so intensively in the next week or two, as well as ensuring that the funding is transferred to care homes as quickly as it reasonably can be. There may, however, need to be a brief delay while we ensure that the legal issues which the grant directions bring to our attention have been addressed.

Quarantining

3.11 Acting as an agent of Northumberland CCG, the Council commissioned four care homes to provide a total of 63 block booked "step-down" beds from early April, mostly in physically separate areas of a care home where it would be possible to provide separate care staffing, so as to minimise the risk of cross infection between the stepdown unit and the long-term residents in the home. This capacity was funded by the NHS, as part of its programme to ensure that people who for whatever reason were not yet ready to return home from hospital, though they were "medically optimised", could move quickly into alternative accommodation to reduce the pressure on hospitals.

3.12 We have agreed with Northumbria Healthcare Trust an approach in which some of these beds will if necessary be used to quarantine discharged patients until there is a high level of confidence that they can return to their care home, or in some cases move into a care home for the first time, without the risk that they might be carrying

Covid-19 into the home. In practice, this resource has so far been used less than anticipated, because there has often been sufficient capacity in the hospitals for patients to rehabilitate there rather than needing a short-term move to a step-down bed in a care home.

3.13 In ordinary circumstances, it has been a long-standing aspiration of the Council and local NHS organisations to enable patients in acute or community hospitals who are care home residents to return quickly to their care home; and short-term stays in care homes have also been seen as preferable to remaining in hospital for some other patients who are not immediately able to return home. Covid-19 has temporarily shifted the balance of advantage in some of these cases. Care homes are currently less homely environments than usual, with staff generally having to provide personal care wearing face masks and other PPE, and with visits from family and friends generally not possible. The advantage of a return to a more normal life outside hospital is therefore at present less than it usually would be; and at the same time the benefits of being cared for in a hospital environment, where infection control may be easier, are greater than they usually would be.

3.14 We will be reviewing shortly with the CCG the future of the block funded step-down arrangements. At the point when they were initially commissioned, it was unclear to what extent they would be needed as a form of quarantine, or whether they would primarily be accommodating patients believed not to have Covid-19 who needed to move on rapidly from hospital once medically optimised, and required some further support before they could return home. Decisions on future arrangements will take account of what we have subsequently learned about these issues, though there is likely to continue for a while to be some uncertainty about how the use of hospitals will change over the coming weeks and months.

3.15 It will remain essential to be able to offer care homes an alternative to early readmission of a resident who may still be infectious, if they are not confident that they can safely care for the resident in isolation. One important issue is care for potentially infectious older people with dementia, who may be unable to understand or retain in mind the reasons for isolation or social distancing, which can make it very difficult to isolate them in some care home environments.

NHS clinical support

3.16 Named clinical leads have been identified by the CCG for all care homes. These are either GPs or nurses - community nurses in the case of care homes for older people, and specialist nurses in the case of some working age services.

3.17 The CCG has recently rationalised a situation in which some care homes had different identified clinical leads from different parts of the health service. Where care homes have indicated on the Capacity Tracker that they do not have a clinical lead, this is likely to reflect confusion resulting from that previous position.

Comprehensive testing

3.18 As at 27 May, 47 care homes in Northumberland had applied for comprehensive testing of all their staff and residents. The Council does not automatically receive data about the outcomes of testing, but we will be seeking this information.

3.19 There continue to be a number of problems with the national system for testing, summarised below in paragraph 5.8.

4. The national Adult Social Care Infection Control Fund

4.1 The Prime Minister announced on 13 May that the government was allocating an additional £600m to support care homes with infection control. Further details were published on 15 May, including the requirement for local authorities to produce and publish a plan. The funding allocation to Northumberland County Council was £4,388,508.

4.2 The detailed grant conditions for the use of this grant were circulated to local authorities on 22 May[1]. The key provisions are:

a) The funding is being paid to local authorities in two instalments, in May and July. 75% of this funding (the "bed-based" element) must be paid to care homes in the county, in proportion to the number of registered places in each care home, whether or not these care homes accept publicly funded residents.

b) No distinction is made in the allocation of the "bed-based" element between care homes for older people and care homes for other groups. To date all Covid-19 outbreaks and deaths in Northumberland have been in care homes for older people, but we know that providers of care homes for other client groups have been very concerned about infection prevention and control.

c) The "bed-based" element of the grant can only be used for one of a list of specified purposes, all of which relate to staffing arrangements in the care homes.

d) The remaining 25% of the grant can be allocated between providers as the local authority judges appropriate, but both elements of the grant can only be used "to support care homes and domiciliary providers to tackle the risks of COVID-19 infections".

e) The local authority must confirm that the first instalment is being used for infection control, as a condition of receiving the second instalment.

f) The local authority is not permitted to allocate the first instalment of the "bed-based" element of the grant to any provider which has not at least once made a return on the Capacity Tracker, and "committed to completing the Tracker on a consistent basis". The Council is also not permitted to allocate any of the "bed-based" element of the July funding to any provider which has not "consistently completed the daily Capacity Tracker". The Capacity Tracker is a national online system which the Government intends to use as a means of monitoring nationally an increasing number of aspects of the operation of care homes.

g) Providers must keep records of their spending from the 75% of the grant allocated automatically according to the number of registered places, and local authorities are required to take steps to ensure that they can recover any funding which has not been used for infection control purposes.

h) The grant may not be used for "expenditure already incurred".

i) There must in no circumstances be "any element of profit or mark-up applied to any costs or charges incurred".

j) Providers must confirm by 23 September that they have spent all of their 75%

[1] The grant conditions document does not yet appear to have been published on the Government website; we have published it on our website alongside this document for information.

allocation on the specified infection control measures, or return the money. DHSC reserves the right to ask to see receipts to prove that spending has been incurred.

4.3 The Council will be discussing with care home providers how they can best use the funding within the quite tight constraints of the grant conditions. One issue for discussion will be how to ensure that changes in staffing arrangements funded through the grant can as quickly as possible be reinstated if there is a second wave of the pandemic after the period during which the grant has to be spent.

5. Risks not fully under the control of the local authority

5.1 Regionally, Directors of Public Health have advised us of a number of significant risks which are outside the immediate control of local authorities. The following paragraphs comment on each of these risks in a Northumberland context.

Hospital discharges

5.2 Government guidance published on 19 March, and still in force, set out a policy on discharge from acute hospitals designed to remove all legal and organisational obstacles to discharging patients from hospital within three hours of the hospital multidisciplinary team confirming that they were "medically optimised", and within two hours of the ward having all necessary documentation and medications ready. The guidance was a response to experience in Italy, which had made apparent the risk that a rapid surge in Covid-19 cases could overwhelm hospital capacity.

5.3 While there was an obvious rationale for this approach, given the alarming potential for an exponential increase in the number of Covid-19 patients needing hospital treatment, it also reflected a limited understanding at the time of what could reasonably be expected of care homes. In hindsight, it perhaps too much treated them as an extension of the hospital system, rather than as the long-term homes of their residents, and assumed that they would be able to provide the kind of medicalised environment which would be expected in hospital.

5.4 With hindsight, this may have led to over-optimistic assumptions about what level of infection control care homes would be capable of. For instance an FAQ document issued on 30 March by NHS England included the following advice:

> **How are the current stocks of PPE going to be enough? When should we be using them?**
>
> - Advice from the Chief Medical Officer is that, for people who are asymptomatic and have no positive diagnosis, it is not necessary to use full PPE.
> - From 19 March, Coronavirus is no longer classified as a High Consequence Infectious Disease. This means that, provided normal infection control is exercised, it is unlikely to spread.

5.5 As it turned out, it has often proved to be difficult to prevent the spread of Covid-19 in care homes, partly because of limited availability of testing and the problem of transmission of the disease by asymptomatic staff and residents.

5.6 There has been much speculation nationally about whether the programme of rapid discharges from hospitals has contributed nationally to some of the outbreaks of Covid-19 in care homes. We have not yet seen clear evidence either way about this, and we are not aware of any obvious reasons to believe that outbreaks in

Northumberland began in this way. However we agreed in the second week of April with Northumbria Healthcare, the NHS Foundation Trust which operates acute hospitals in the county, that no care home will be expected to admit or readmit residents who have tested positive or had Covid-19 symptoms unless they are confident about their ability to isolate them, before 14 days after the onset of symptoms, or 48 hours after the person ceases to have a fever, whichever is later. The Government's Adult Social Care Action Plan published on 16 April reached similar conclusions, and set broadly similar expectations nationally.

5.7 At present, hospital capacity in Northumberland is sufficient for it often to be possible to provide ongoing support for potentially infectious patients in a hospital setting, which will generally be better able to maintain rigorous infection control of this highly transmissible disease than a care home. In other cases, stepdown capacity in care homes commissioned by the local authority on behalf of the CCG provides the capacity to care for potentially infectious patients in a physically separate part of a care home, with precautions to minimise the risk of cross infection. However if there is a return in the next few weeks or months to exponential growth in the number of people requiring hospital treatment for Covid-19, or if the combined effect of other pressures on hospitals with Covid-19 strains the capacity of the county's hospitals, it may become more difficult to maintain these arrangements.

Testing

5.8 The current national testing programme is continuously evolving, but at present there are limitations to the support it provides for a programme of infection prevention and control. Among the key issues are:

a) The Whole Care Home Testing offer for asymptomatic care home staff and residents commits to providing results within 72 hours of the swab reaching the laboratory. In practice this is often longer and the lengthy turnaround time means that by the time that the home is notified that a pre-symptomatic member of staff or resident is potentially infectious, that person will have become symptomatic. The local testing facilities available in Northumbria Healthcare would be a faster alternative, but cannot at present be used because insufficient reagents and kits have been made available. We understand that this may be because of the priority given to the "Pillar 2" nationally commissioned laboratories. Current arrangements also create difficulties for the role of Directors of Public Health in carrying out their role of coordinating and prioritising whole care home testing. There was a problem with lack of notice of the launch of the Whole Care Home Testing portal and its promotion by the CQC.

b) The tests currently in use have a proportion of false negatives – most obviously, cases where clinicians believe that a person is highly likely on the basis of their symptoms to have Covid-19 though a positive test result cannot be obtained, but presumably also cases where asymptomatic staff or residents in care homes would test negative but in reality be infectious. This means that staff may return to work with vulnerable residents whilst still infectious.

c) It is not yet clear when frequent repeat testing of staff and residents will become possible. Without this, the reassurance provided by testing will remain short-term, and only applicable to the day the sample is taken, even if the previous issues can be resolved.

Community admissions

5.9 Routine testing of prospective residents who plan to move into a care home from the community rather than at the time of hospital discharge remains unavailable, though we have managed to arrange tests in some specific cases.

5.10 While we are conscious that, for the reasons described above, a negative test result gives no firm assurance that a new resident will not be carrying the disease, some care home providers are understandably reluctant to admit new residents without a test result.

Workforce issues

5.11 To date, care homes in our area which have had outbreaks have managed to continue operating despite the absence of significant numbers of care staff. However there is some reason to think that the simultaneous pressures of there being a significant number of residents and staff with Covid-19, together with the presence of some asymptomatic staff who are unknowingly carrying the virus, may have contributed to rapid spread of infection within a home.

5.12 The Adult Social Care Infection Control Fund will assist care homes in developing staffing arrangements which increase their resilience against this risk. However experience suggests that it remains difficult to contain an outbreak in a care home after it has spread beyond a small number of residents and staff. We hope that further research on this, and dissemination of any lessons learnt elsewhere, will support us in working with providers on this issue.

5.13 Another issue is that the Infection Control Fund is time limited one-off funding, available at a time which currently appears to be near the end of the first phase of the crisis. It will be valuable for homes who are still dealing with infection, or if there are further outbreaks in the next few months, but the ability to strengthen staffing resilience was in hindsight probably most needed earlier in this crisis. If, as some modelling predicts, there is a second wave of infection, possibly in the winter, there may be a need for further funding, since the current Government grant must be spent by the end of September.

PPE

5.14 We are at present cautiously optimistic that we will be able to continue to ensure that all care homes and home care providers in Northumberland can obtain the PPE that they need, at least for the remainder of this first wave of the Covid-19 crisis.

5.15 However the experience of the early weeks of the pandemic demonstrated the fragility of current arrangements for securing supplies of PPE, at a time when much larger quantities than normal were needed. Care providers found in some cases that their usual sources of supply were not even able to maintain existing levels, and the systems for delivering PPE from the national stockpile proved to be inadequate and unpredictable.

5.16 We have been fortunate more recently in our ability to procure substantial quantities of fluid-resistant face masks, the form of PPE which was particularly difficult for care providers to obtain, but our experience, and the experience of a regional procurement initiative in the North East, made clear to us the extent to which supply depended on an international market which became chaotic when demand was rapidly increasing. We cannot be certain that supply problems may not re-emerge if

the pandemic situation deteriorates internationally, or if there are further changes in national recommendations about what PPE is needed in what circumstances.

Financial viability of care homes

5.17 It is increasingly clear that a short to medium term consequence of the pandemic will be that many care homes have substantially higher levels of vacancies than normal. In Northumberland vacancies in care homes for older people have risen from 8% of registered places in early March to over 16% now, and seem likely to increase further. In part, this is a consequence of unusual numbers of deaths of residents, and in part it reflects an understandable perception of many older people and their families that care homes are currently risky places to live.

5.18 In a guidance document about support for care homes published on 14 April, the Government indicated that in addition to the announced so far "We are separately considering how we can support the sector over the medium term, in light of the consequences of COVID-19, and will involve partners in the discussion." Our assumption is that this indicates a national intention to provide medium-term financial support to ensure that high levels of vacancies do not make the care home sector unsustainable. We think this is likely to be necessary, since the costs involved are potentially very high, and the duration of the period when funding may be needed is currently unpredictable.

5.19 In the short term, if any care home provider tells us that it is likely to fail without financial support, because of a high level of vacancies which it believes are a temporary consequence of the Covid-19 pandemic, we will discuss with them urgently what support we can provide. We would expect to require a provider in this situation to give us full access to its financial accounts.

5.20 We do not, however, expect to be in a position to establish an ongoing scheme across all care home operators to compensate them for high levels of vacancies, partly because of the potential cost involved and partly because of the risk that this would cut across any forthcoming national scheme.

Community transmission

5.21 The regional group of Directors of Public Health has emphasised to us that it will be hard to avoid further transmission of Covid-19 into care homes from the community as a result of transmission within the community until it becomes possible to establish robust contract tracing arrangements. We welcome the steps being taken to establish these in our area, noting that contact tracing started on 28 May, but remain uncertain at present about how quickly these will become effective.

Information

5.22 Regionally, Directors of Public Health are also concerned by the incompleteness and limited quality and availability of information about positive test results, and therefore about local hotspots and trends.

Communications

5.23 One problem in recent weeks has been multiple overlapping initiatives from different parts of the public sector, including national and regional bodies, which have meant that care homes have been bombarded with overlapping and sometimes conflicting advice. We see it as an important role of our strengthened local coordination arrangements to try to act as a single channel for advice and guidance. However there is some tension between this aspiration and top-down national initiatives.

6. Next steps

6.1 Our immediate priorities in the coming weeks will be:

- Clarifying the legal issues raised by the grant circular about the Adult Social Care Infection Control Fund, and distributing the money to and distributing the first tranche of money to care homes
- Discussing with care home providers how we can provide the level of assurance about the use of the grant which the Government requires, while avoiding excessive bureaucracy and enabling them to deploy the funding in ways which take account of the differing circumstances of individual homes
- Deciding, after rapid consultation with both care home and domiciliary care providers, how most effectively to use the 25% of the grant which is outside the requirement for allocation pro rata to the number of registered care home beds
- Reviewing the future of the block booked step-down beds, and considering what lessons have been learnt about future "discharge to assess" arrangements
- Reviewing the future of the 5% supplement currently being paid on top of care home fees. Longer term issues about the Council's contractual arrangements with care homes for older people, discussions about which were at an advanced stage in March but were then frozen because of the impact of the pandemic, will also need to be addressed.
- Continuing to take all available steps to ensure that care providers in Northumberland have adequate access to PPE
- Consolidating the more closely integrated approach to supporting care homes across health and social care which was already being developed prior to the pandemic, and has been accelerated as a result of it. This will include building on the arrangements that have been put in place for training, alignment of professional and clinical support, monitoring and communication. A programme of work which was already under way of more closely aligning adult social care with GP practices and primary care networks will be further progressed, and will support these wider aims.

6.2 A broader issue, which it will become increasingly pressing to resolve, is the growing level of vacancies in care homes, and uncertainty about how long this may continue. We hope for early Government clarification about what support will be available nationally. In our view, this will need to allow substantial scope for local flexibility, to take account of the differing situations of care home markets in each area.

Planning for winter

6.3 A crucial longer term issue, on which it will be important to make a start soon, is the need to prepare for the possibility of a very difficult winter for the health and social care system this year. There is a real possibility that a second wave of the pandemic may coincide with what is always a particularly challenging time of year. The measures taken by the Government in March were successful in avoiding a situation like that in Italy where hospitals were overwhelmed, though there are thought to have been some significant health costs arising from the large-scale avoidance of

admission to hospital. However it is not yet possible to be confident that a second wave might not have very serious consequences for health and social care services.

6.4 The key lesson of the experience of the past three months is that the risks arising from the pandemic need to be seen from the perspective of the health and adult social care system as a whole. We intend locally to ensure that winter planning begins soon and is approached as an issue for the whole system, rather than primarily as an issue about flow through acute hospitals. It is my view that local health and social care systems should be mandated to provide a jointly agreed community based winter plan.

6.5 Because of the scale of the potential risks, we will continue to need financial and other support from the Government to support us in preparing for the potential worst-case, in which Winter 2020/21 could be the most difficult in the history of the modern health and social care system.

Please let me know if you would like further information about any of the issues raised in this letter.

Yours sincerely

Daljit Lally