Covid-19

Lessons Learned Review

NW ADASS Programme Office

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Section 1: Executive Summary

In July 2020, the North West ADASS Regional Programme Office (NW ADASS) set out to conduct a "lessons learned" review across the 23 north west local authorities, exploring the health and care system response to Covid-19 and the implications for the future direction of social care in the region (as defined in the 'Care 2030 Strategy').

Covid-19 has turned normal life upside down for almost everyone and, for the health and care system, thrown into turmoil what we normally accept as the status quo. Whilst the human, social and economic cost of Covid-19 has been inexorably high, the pandemic has challenged our view on the way services are delivered, presented an opportunity to test new ways of working and provided a fundamental reset on both how the sector is perceived and the challenges which face the system.

The purpose of the review was not merely to recount *what happened* during the first phase of the pandemic, but also to understand *why* it happened and, fundamentally, the application of such lessons for the health and social care system in the future. In recognition that the situation with the pandemic is ever changing, it was also important to capture the lessons learned which could be incorporated into 'real time' responses to the current surge in cases.

As the health and care system continues to wrestle with the pandemic; providers, regulators and system partners must be able to maintain the appetite to work together and at pace. We must make sure that we learn from the response to the crisis, that we lock in positive changes, and that we drive a new way of working that is supported at a national, regional and local level by the whole health and care system. This report represents a concise analysis of this engagement.

Over a period of 5 months, the team commissioned by NW ADASS conducted:

- 167 individual and group interviews across a range of stakeholders, including Directors of Adult Social Services (DASS's), regional networks, commissioners, representatives from key partners (CQC, NHS England, Skills for Care, PHE), providers and wider stakeholders. In total, 250 hours of interviews were undertaken with over 300 stakeholders from across the system.

- Focussed engagement work undertaken with Wigan (Annex 1) and Lancashire (Annex 2) to help develop a whole system picture of the response to the pandemic – participants ranged from senior leaders (Chief Executive, DASS and Leader) to frontline staff (social workers) and residents in receipt of social services.

- A desktop review of over 50 recent publications relating to the impact of the pandemic on the health and social care system, from thought leaders within the sector. See Annex 3.

1.1 Methodology and scope of the review

A framework was developed to represent a high-level overview and structure of the adult social care system (figure 7). This framework was designed to develop key lines of enquiry (see annex 4) across the various components, thus ensuring that any lessons learned captured and reflected the complexity and richness of the system.

1.2 Top 10 lessons learned

Based on the analysis of the extensive engagement and review of pertinent literature, the below 'top ten' lessons learned have been identified. This list is by no means exhaustive; however it provides a basis for system reflection as and when we exit the phase of crisis response to the pandemic. The 10 lessons were:

1. For integration to succeed, systems need a common sense of purpose which extends beyond Covid-19
2. Strong, decisive leadership and moral courage inspires change
3. The market is responsive and resilient when given the right environment
4. Old ways won't open new doors
5. People powered change: the power of communities to deliver solutions
6. Demand and the concept of personalisation is fragile
7. Steer little and often: the value of data and intelligence in shaping operational and strategic approaches
8. The public needs a better understanding of social care
9. Social care workers are people too
10. Infection prevention and control is for life, not just for Covid

1.3 Key Findings

In addition to the lessons learned, throughout the course of the stakeholder engagement, a number of overarching themes (the system enablers) were common across individuals and organisations' ability to adapt in response to the pandemic. Alongside this, we have been able to derive a number of applications for the enablers in which the region may consider it beneficial to replicate or "continue to do" in support of the current surge in cases and beyond the pandemic.

The below describes these findings and our observations.

1.3.1 System enablers during the pandemic

The pace at which action was taken and the systems response to the pandemic has been unprecedented and whilst we have identified 10 key lessons learned which should be considered in relation to shaping the future strategy and transformation of social care, we cannot ignore the unique conditions that helped to give rise to these lessons learned (see figure 2) and how these may be replicated post pandemic.

Figure 1: system enablers

- Money: pre-pandemic budgets aligned to organisations and, in the context of financial pressures, acted as a significant barrier to delivering a change at pace; with debates focussing on 'who pays for what'. During the pandemic, guidance in relation to deferred charging, COVID discharges and additional monies removed these barriers.

- Focus: pre-pandemic there was a plethora of strategic objectives, transformation plans and national mandates across, which gave rise to only small areas of synergy which supported transformation (see figure 4). The pandemic simplified this and gave a singular focus; the phrase 'a common enemy' was cited on several occasions.

- **Urgency:** pre-pandemic decisions were not typically taken with great speed; this is in part attributable to shared objectives (see above), the maturity of integration and pooled budgets. There was also a sense from stakeholders that governance and risk aversion (requesting papers, justification of proposals and deferral to future meetings) throttled the pace of transformation and innovation. The pandemic gave all system partners a sense of urgency and permission to respond quickly and decisively.

- **Time:** pre-pandemic there was a sense that there was the day job and then the programme of transformation, with the latter often suffering due to staff time and capacity. Competing and mounting priorities often meant individuals working within the system did not have the quality time to make and deliver system changes. With the pandemic the *'what could we achieve if the world stopped for a day'* became a reality. A significant portion of 'normal' day-to-day activities were stopped and people were 'nudged' into reflecting on what they did, what was a priority based on the common sense of purpose and how things could be delivered in the new context.

- **Positive risk taking:** pre-pandemic some behaviours within the system were characterised as 'risk averse'; namely actions and decisions may have been driven by a fear of 'doing the wrong thing' and the potential repercussions for the system. A Community Care article in 2014[1] cited the House of Lords select committee inquiry into the Mental Capacity Act's implementation and the need to *"move from protection and paternalism to enablement and empowerment".* During the pandemic, staff, including social workers reported greater levels of empowerment to make decisions based on professional judgement and emergent need; a culture of 'doing the right thing' for residents was fostered.

1.3.2 Application of the lessons learned to support the system response now

Typically, winter pressure season brings an increase in hospital admissions, increased demand for primary care, increased stays in hospital, pressures around effective immunisation and increased demand for social care, residential nursing and home care in particular. This winter we face a unique challenge in the form of the pandemic and whilst increased infection control measures are likely to impact the transmission of typical colds and flu's we face a more complex challenge in the form of Covid-19. It was clear through the engagement that there was significant real time learning and adaptation during the first wave which will prove vitally important for the region in the coming months. However, the following areas are important considerations for the short term:

1. We need to be mindful of the **impact of our attempt at recovery**, especially on frontline staff. We should consider if we are at recovery stage and what the implications are of restarting things. The second spike in the virus has demonstrated how carefully we need to begin to phase elements of 'normal day-to-day' living. Whilst there is the promise of a vaccine in the coming months it is likely to take some time before a sufficient proportion of the population have been immunised in order to reduce the risk.

2. There may be a potential need to **restart some of the crisis/incident management** governance structures that were used to such good effect during the first wave, for example, daily 'sit reps'. Also, the invaluable support that local authorities put in place for providers, such as daily contact calls and what's app support groups.

3. In the event that we face another series of rapid discharges from hospital it is vitally important that we take the time to ensure that **checks and balances** are in place and that people going to the most appropriate setting based on care needs/trajectory. We cannot lose sight of the person and their voice, capacity, best interests and communication with family. There will be a continual need for **strong, individual and system leadership** throughout the winter period. This can be seen in fullest effect in the area of testing, without regular, rapid and easily accessible testing during winter the risk of insufficient workforce or high levels of transmission will be exacerbated. System leaders have to challenge and

[1] 'Risk-averse' social workers need fundamental attitude change to comply with Mental Capacity Act; Mithran Samuel, Community Care, March 13, 2014

advocate this cause. At time of writing this report some community service providers across the region, in particular supported living services, have still not established processes for regular access to testing.

4. Need to **ensure that the care workforce is not forgotten and devalued.** The steep rise in cases and hospital admissions being reported in the press as we enter into winter, coupled with the attention focussed on NHS roll out of a vaccine programme is likely to result in increased public focus and praise on NHS staff. Whilst this is completely justified this should not be at the absence of the role care staff will play over winter.

5. **Sharing of data at the right levels to inform decision making.** Considering what info would be useful for who and when? For example, access to community outbreak data for care providers could support workforce planning as staff absences due to isolation pose an increased risk to service continuity.

1.4 Recommendations

- **Recommendation 1: each area to reflect on their own lessons learned.** Whilst the insight from this report is intended to support local systems; it is not intended to replace areas own self-reflection.

- **Recommendation 2: staff teams to implement a "check and challenge" on what and how they do work.** Leaders and managers within public services have a key role in checking and challenging activities as they come back on board.

- **Recommendation 3: regional 'Care 2030' strategy and creation of a common focus/objective for the system.** The creation of the regional 2030 strategy provides a valuable opportunity to create and develop a common sense of purpose/objectives, which has been such a valuable enabler of transformation throughout the pandemic.

- **Recommendation 4: work with central government to tackle some systemic challenges,** such as understanding and awareness of social care and a clear ask of government regarding long term funding and strategic direction for social care.

- **Recommendation 5: regional development of the Markets Quality and Insight System (MQIS)** capitalising on the increased access to data and appetite for intelligence through the development of a sustainable platform for markets data.

- **Recommendation 6: harness the power of communities and the changing needs and expectations of populations.** Celebrate what people do for each other – tell stories of community, reciprocity and resilience to build social capital.

- **Recommendation 7: communicate the key takeaways for system leaders.** There are some key messages that leaders throughout the social care system should take away and promote post pandemic.

- **Recommendation 8: develop the way we commission.** Post-pandemic commissioning and market development strategies would benefit from a deep-dive review and refresh, taking into account some of the lessons learned and the appetite for change.

Section 2: Regional Context

2.1 Covid-19 and the North West population

As of 25th November, 300,071 cases had been reported across the 23 North West local authorities (22% of all cases reported across England), of which 10456 people passed away[2]. Office for National Statistics (ONS) data for 2018 identified that 18.6% of the region's population are over the age of 65 (the group most at risk of complications from Covid-19), with estimated increases up to 21.6% by 2030.

Other groups which have been disproportionately affected by the virus include people living with long-term health conditions, BAME groups (10% of the population) and individuals who are in temporary accommodation or homeless.

Based on the Indices of Multiple Deprivation (IMD), 10 North West LAs are within the top 20 most deprived areas in England. This measures the 'risk of premature death and the impairment of quality of life through poor physical or mental health'. National data shows that areas in the top half of deprivation deciles have had 8% more Covid-19 related deaths in May 2020 than the bottom half of deprivation deciles, indicating that deprivation could be linked to Covid-19 mortality. Given that several North West authorities are already 'deprived' in relation to health, the effect the virus has on the region will likely be more severe compared with less deprived areas.

2.2 Adult Social Care in the North West region

Adult social care (ASC) is a key contributor to the North West economy. The sector currently contributes £5.19 billion per annum to the economy and this will only increase as demand for services continues to rise. There are currently 215,000 jobs in the North West to care for people aged over 65 and it is estimated a further 110,000 jobs will be required over the next 15 years if demand continues. It is a major local employer, and any expansion of social care means new businesses, new job opportunities, increased tax contributions and a significant net contribution to the local and national economies. Adult social care provides an economic anchor for communities and has potential to play an even greater community wealth generating role[3].

Over the past 2 years, care home quality has improved throughout the North West. As a region, the % of care home beds are rated either 'Good' or 'Outstanding' by CQC (representing an increase from 65% to 78% of all beds), which reflects the extensive work local authorities have undertaken to support providers. 77% of community-based providers are also rated 'Good' or 'Outstanding' across the region.

Utilising the NW market's data, we estimate there are 63,800 individuals in receipt of care in the North West; 26,195 are in receipt of domiciliary care, 27,994 are in receipt of nursing / residential care, and 9,611 are in supported living settings. Presently, there are 3,113 active Adult Social Care organisations in the NW (*CQC registrations, October 2020*). A high-level composition of this market is provided in the below figure 2.

[2] Coronavirus (COVID-19) roundup: Deaths and health, Office of National Statistics
[3] Taken from NW ADASS Care 2030 Vision and Strategy Document.

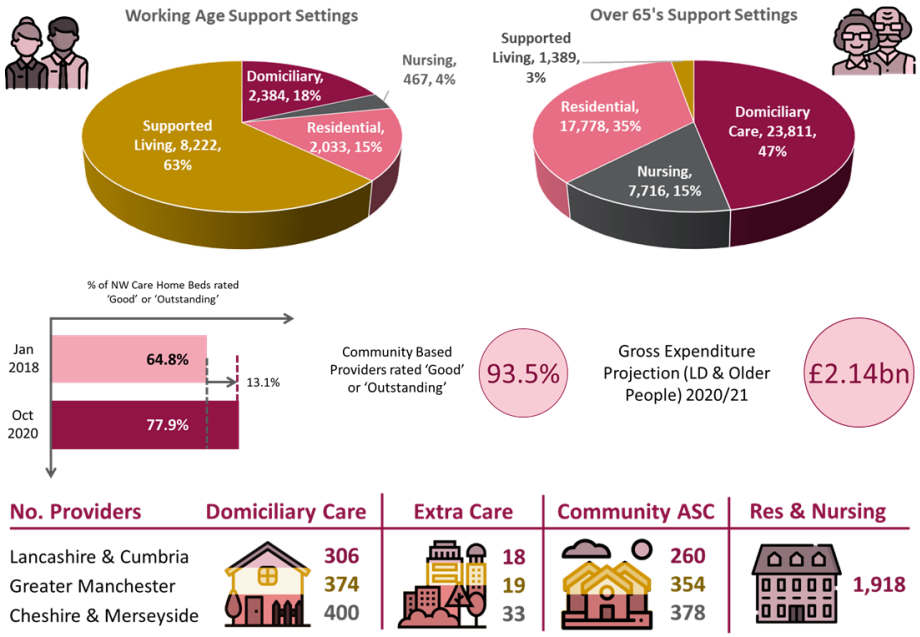


Figure 2: NW market overview

2.3 Impact of Covid-19 on North West Adult Social Care

Across the region, 29% of Covid related deaths occurred in care homes (11/08/20). Using NECS capacity tracker data for outbreaks in care home settings, and CQC registration information, the NW ADASS programme office were able to analyse Covid-19 cases by care home size. As of 19th October, 58% of outbreaks and individual cases occurred in medium sized homes and 32% in large homes[4]. A study by Burton, Bayne, Evans et al revealed that 'the number of beds was the only care-home characteristic significantly associated with the presence of an outbreak' with the likelihood of infection tripling every 20 additional beds. In comparison, as of the 20th October, there have been 705 confirmed or suspected cases of Covid-19 in domiciliary care settings (442 confirmed)[5].

Using local authority COVID-19 financial management reporting data (Financial Year 20-21), we can determine the expenditure across the country on adult social care (ASC) due to Covid-19. For the financial year 2020/21, additional ASC expenditure due to Covid-19 totalled £2.298 million nationally[6]. Based on NW gross current expenditure (GCE) as a proportion of England's GCE at 14%, we estimate that additional ASC expenditure due to Covid-19 in the NW is approximately £321.7 million[7].

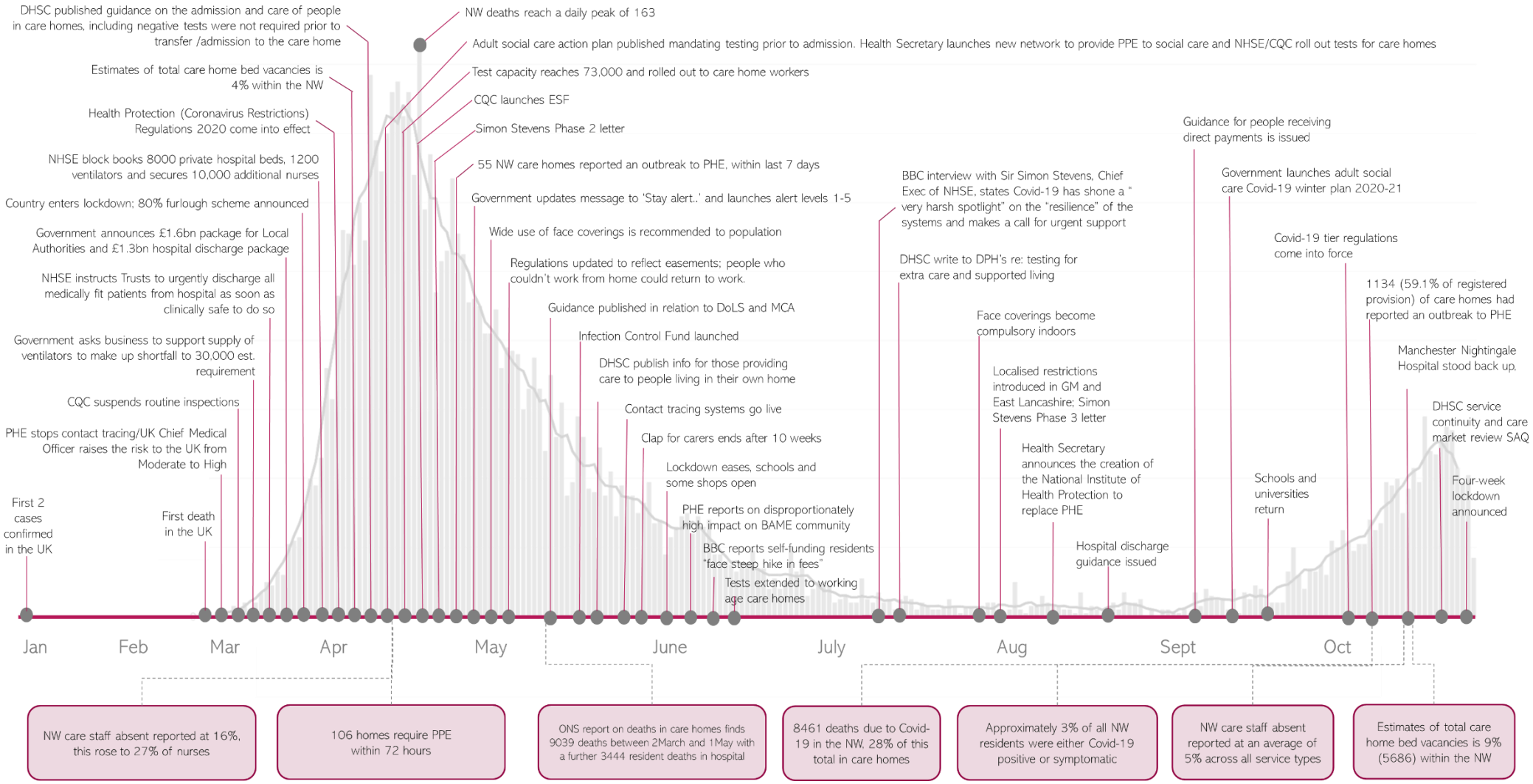
Since the start of the pandemic, CQC inspections have ceased in line with lockdown guidelines. These inspections restarted in June 2020, and early indications show the number of NW care homes rated 'Good' or has increased from 76% in October 2019 to 77% in October 2020, with homes rated 'Outstanding', increasing from 2% in October 2019 to 3% in October 2020.

Data collected by Skills for Care highlights a national picture of how the workforce has been affected during the pandemic. Pre-Covid (February 2020), the vacancy rate within the ASC workforce was at 8.6% compared to 7% in August, with the highest vacancy rates nationally being amongst Registered Managers at 10.3%. The current vacancy rate within the North West is 8.4%, the third highest nationally.

Figure 3 (below) provides a timeline of key national and regional events pertinent to the review of the north west lessons learned for the social care system.

[4] Less than or equal to 10 as 'small', between 11 and 49 as 'medium', and 50+ as 'large'.
[5] Cumbria has the highest number at 104 (only 6 confirmed cases). It is important to note that not all LAs complete these trackers, so this is to be taken with caution.
[6] Analysis from NW ADASS Programme Office up to October 2020
[7] Adult Social Care SALT return (2019-20)

Figure 3: timeline of key events during the first wave of Covid-19



Section 3: Top 10 Lessons Learned

Lesson 1: For integration to succeed, systems need a common sense of purpose which extends beyond Covid-19

Integration is an area that has received considerable focus throughout the pandemic. In March 2020, health and social care commentators noted the speed at which actions and longstanding issues were being overcome. Similarly, interviewers consistently identified that, from the outset of the pandemic, there was considerable effort to work together towards one common goal – a "common enemy" – as some stakeholders commented.

Pre-Covid, systems working towards integration were at varying levels of maturity and, whilst the level of integration was cited as an enabler to the speed of local response, challenges still existed in the form of "individual" versus "shared" objectives and purpose across organisations. Figure 4 is an illustrative example of how key system partners operated with their own strategic objectives, with the area of overlap being the point where organisations would come together with common aims.

During the pandemic, the urgency of the situation required systems to develop new approaches to crisis and incident management, converging on issues and sharing a clear purpose and function (see figure 4). Examples of this were "to keep people safe" and "prevent the care home system from collapsing" – it was soon discovered these issues were not merely the responsibility of one organisation, but requiring the combined effort of both the acute sector, local authority and care providers to work together. This also accelerated the introduction of new partners to having a seat at the 'integration table' (such as the Voluntary, Community and Social Enterprise (VCSE sector). Relationships were strengthened based on a mutual need and benefit and a clear focus.

Communities (including residents, local businesses, the voluntary sector and housing providers) also had an integral role to play in delivering the response to Covid-19, ensuring people were safe and stepping up to support lower level needs to reduce the demand on statutory services (see "People Helping People in lesson 5). The formation of Covid response 'hubs' and utilisation of volunteers was recognised by the system as a key component in protecting essential services. Examples of communities being an active (rather than passive) participant in the system is explored further in lesson 5.

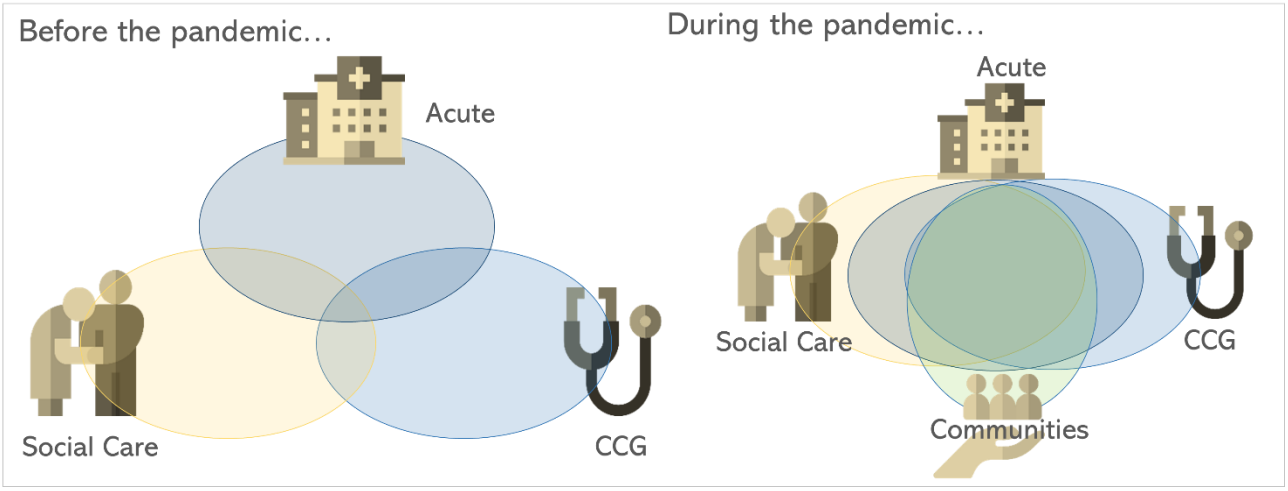


Figure 4: System alignment

Based on the extensive interviews it would appear that the complexity of the system, i.e. the number of system partners and existing architecture had an impact on how clear the 'golden thread' was, i.e. staff at all levels of the organisation had a clear sense of the objectives. This is not to say that in any way that it affected the outcome

or effectiveness of the response. To a certain extent, a common purpose, such as freeing up bed capacity levelled the playing field in relation to the maturity of integration. The concern is whether these complex organisations have the ability to maintain areas of progress post pandemic.

System partners could see how each other could be of benefit and thus supported closer working relationships across organisations, for example, the VCSE had a direct role is shielding essential services. The temporary erosion of organisational boundaries and convergence of a single purpose in the system has tested organisational identities in the last 6 months, to the benefit of both the population and the health and social care workforce.

The challenge will be whether this newfound focus and maturity of integration can stand the test of time, as the propensity to return back to old, predefined boundaries for the purpose of "organisational preservation" resurfaces. To counteract this, the introduction of new 'defaults' in the form of national policy and mandate should be taken into serious consideration.

"Inter-agency response put the population and staff ahead of organisational politics and boundaries"

Illustrative examples of **how the system worked together** include:

- The single focus on ensuring sufficient capacity on wards to treat the expected surge in hospitalisations meant that **historic delays and barriers to discharge disappeared almost overnight**. Whilst many practitioners had spent the last few years promoting the benefits of care assessments being carried out in communities, rather than hospital settings, the pandemic expedited the uptake of Discharge to Assess (D2A) policy at lightning speed. Partners had a clear commitment operationally to implement new hospital discharge guidance and to address the issues as a whole system rather that in organisational silos, and DToC shifted from a health and social care problem to being almost non-existent overnight, which may be reflective of the complete system sharing the same clear mandate (focus) and urgency.

- Suspending historic challenges of 'who pays for what' allowed several areas across the region to design and implement discharge hubs and adopt a discharge to assess approach that improved the flow through the hospital significantly, resulting in a high proportion of patients going home rather than to a community-based bed following the initial rush to discharge people from hospital. In several areas intermediate care became a concept or a steppingstone/pathway rather than a physical buildings based service.

- Unfortunately, this was not uniformly applied, meaning large numbers of people were subsequently discharged into residential and nursing care. As the situation evolved from an initial 'rush' to discharge patients in early March to a less crisis-driven mindset, one of the key areas of improvement and learning was adopting a 'home first' approach to all referrals. Equally, the pandemic accelerated transformation and innovation in other areas of service delivery: for example, one system brought forward the development of a 24/7 mental health crisis line by 12 months and took this online in just four days. This was achieved via devolution of decision-making (via the temporary suspension of governance structures and decisions no longer requiring ratification by local authority Cabinets), in addition to the immediate apparent need for better early intervention for mental health, as opposed to the consequence of placing unsustainable on scarce resources such as AMHPs.

Whilst closer working practice was broadly cited as a positive by-product of the pandemic, engagement with stakeholders identified the following areas of concern for further reflection:

- The nature of the NHS "command and control" model at times felt like system partners were not equal, even being described as 'assimilation' by some stakeholders. Concerns were raised that the 'local voice' of the residents and people the social care system serves was lost and (as a result) personalisation was affected (see lesson 6). Health and social care systems should be conscious of any unintended consequences of pursuing singular objectives, such as the loss of personalisation or independence in the case of rapid discharges.

- Whilst there was a consensus that strategically, integration had improved, some stakeholders experienced challenges within operational teams due to remote working due to the loss of spontaneous interaction between health and social care teams who were ordinarily co-located. Relationships that were being formed pre-Covid through co-location and the move to remote working has affected the formation of some of these teams. We need to try and safely restart this interaction to further multi-disciplinary team working/decision making.

- Deferred decision-making regarding funding was seen as a positive action at the start of the pandemic; however there is now considerable work to be undertaken to assess the appropriateness of settings for people including:
  - whether CHC is applicable,
  - full Care Act assessments,
  - best interest decisions, and
  - financial assessments where required.

  Returning back to this 'business as usual' was perceived as a return to some of the old behaviours and silo-based working.

Lesson 2: Strong, decisive leadership and moral courage inspires change

As statutory, regulatory and financial restraints were lifted across the system, the inherent administrative and political burdens within formal decision making were suspended, providing opportunities for leadership to come together in ways not realised before.

The accessibility of governance arrangements under a command and control structure meant that immediate and timely decisions were made which were not held up through time-intensive reporting requirements. This provided levels of assurance and accountability for decision making, whilst freeing up leaders to respond to demands, surges and changes in government guidance rapidly and effectively. Significantly, the system-wide and individual leadership in most cases created a culture of responsiveness, clear purpose, 'permission to act' and a trust in the expertise of staff and partners. Interviewees cited strong and visible leadership as a key enabler to support the pace of action, with staff across the sector swift to react, change and adapt to new ways of working. Key to this was the empowerment of staff to make decisions.

Illustrative examples of strong and visible leadership include:

- Several local authority resource panel processes were streamlined, temporarily suspended or the frequency was increased to support responsive decision making.

- Decisions taken early to refuse to accept admissions into care settings without a test were taken by senior leaders and providers across the region; despite this some providers reported pressure to accept referrals

early in the process and throughout the summer months. Strong and decisive leadership in this area protected vulnerable people.

- Use of simple messages: one stakeholder spoke about the introduction of 'obsessions' – simple, focussed measures that would drive team behaviours, such as '70% of people leaving intermediate care without needing additional support' – making it clear what staff should be working towards without being too prescriptive, allowing for creativity and innovation, whilst feeding back to the common purpose (the golden thread).

- The NW ADASS Programme Office, together with the regional Care and Health Improvement Advisor (CHIA) played an integral role in bringing together and representing system leaders, sharing and disseminating information. Throughout the pandemic, the Programme Office facilitated a range of networks, together with introducing new forums, such as the Care Homes Demand Working Group and the Day Services Group, with the aim of sharing approaches and providing peer support.

- Decisiveness, moral courage and positive risk taking have been the hallmarks of strong leadership during the pandemic and, whilst these characteristics are prominent across the sector, there were examples where this could have been improved. For example:

    - Following the launch of the Infection Prevention Control Fund (IPCF) in May, there was a great deal of ambiguity in relation to the conditions placed on funding, and the risk of costs being reclaimed from local authorities to the Treasury. This uncertainty caused considerable confusion amongst providers, which resulted in either a refusal to engage with the IPCF or a very prescriptive interpretation of how the money could be spent, based on cited examples in the guidance. Some system leaders were pragmatic about using the grant; however, this stance was not consistent across the region and led to uncertainty.

    - Coproduction was also cited as a key area of concern, on which progress had slowed down or ceased, with a lot being done TO service users and not WITH them. There was recognition that a balance needed to be struck between moving quickly whilst not losing people's involvement in decision making.

Lesson 3: The market is responsive and resilient when given the right environment

In 2017, NW ADASS conducted a detailed market review, which concluded: *"There is a high risk that fee levels will either become unsustainable for providers or the aggregate cost of paying them will become unaffordable for commissioners. There is a high risk that providers will fail or withdraw from the care and support market".* The current pandemic coupled with risks identified in the 2017 review and a decade of financial pressures within local authorities has exposed pre-existing and deep-rooted issues and led to unprecedented levels of risk within the social care market. Illustrative examples include:

- Bed-based care faces significant risk of market failure due to a number of factors:
    - High mortality rates in care homes due to the pandemic[8],
    - Uncertainty in future demand (due to public confidence[9] in care homes)
    - Longer-term strategic direction moving local authority commissioning away from traditional buildings-based care
    - Traditional reliance on self-funders to subsidise local authority fees[10], with the loss of a significant number of self-funders due to the above.

[8] Over 3,000 excess deaths in care homes registered up to 17th October compared with the previous 5 years average.
[9] Up to 20th October, 1,134 (59.1%) care homes had reported a Covid-19 outbreak to PHE-NW.
[10] Coronavirus: Care home residents face steep hike in fees, BBC 5 June 2020

The above instability has resulted in sustained low occupancy across the market. A number of homes have occupancy rates that could be considered to be significantly below their "break even" rate (as low as 63%).

It should be noted that historic and future demand trends are not the same for all buildings-based care. Whilst there has been a reduction in the demand for residential beds in most areas; the demand for nursing beds has been increasing in the recent past. It is therefore likely that any pandemic-driven drops in nursing occupancy is likely temporary, and sustained low occupancy is likely to have a negative impact on the market as there still remains a need for higher acuity beds.

Systems should also consider that there has been a historic underfunding in alternative housing-based support for a range of factors, which will have a bearing on how future needs will be met[11].

- The ability to provide respite and day services in a Covid-secure way has placed substantial pressures on individuals and families; creating a significant risk of carer breakdown as Covid restrictions continue. Continued isolation and lack of access to these services may also result in a significant increase in future care needs and complexity. Simultaneously, the reduced number of people accessing day services is resulting in increased unit costs for Covid-secure delivery. As local authorities are now preparing for day services to reopen, there is an opportunity to transition from a 9-to-5 buildings-based services to new, flexible models of outreach which are more person-centred.

- Safeguarding and quality issues are being exacerbated due to the limited access to services, as well as the temporary suspension of CQC's inspection regime. This is resulting in greater presentation of issues from a service user and providers perspective. The implementation of the Emergency Support Framework (ESF)[12] demonstrated a new way of connecting and supporting providers which has some valuable learning in relation to quality assurance and supportive continuous improvement. How commissioners, CQC and providers work together more closely needs to be explored further, as some silo working still remains between the agencies, resulting in duplication for providers and missed opportunities to streamline and support each other, though sharing data and intelligence..

Despite the above challenges, the pandemic has also provided the market with opportunities to develop, strengthen and reimagine service offerings, including:

- Additional homecare capacity has been sourced in some localities through the use of off-contract/framework providers, and identification of providers of last resort, with both block and flexible arrangements in place to support D2A protocols. The well-publicised issues of infection control within care homes has given a renewed focus on supporting people to live at home, with areas of good practice such as Greater Manchester Health and Social Care Partnerships Living Well at Home programme[13] offering valuable learning opportunities for the region. Equally, the use of home adaptations[14] and assistive technology[15] has been thrust into the spotlight.

- Programmes for trusted assessors have been accelerated out of necessity to support discharge, which offers an opportunity to build upon in the future.

[11] A useful discussion paper entitled 'Rightsizing: Reframing the housing offer for older people' has been produced by Manchester School of Architecture in 2018

[12] On the back of the ESF CQC has published 'innovation and inspiration: examples of how providers are responding to coronavirus (COVID-19)' which includes short examples of how care homes are adapting working practice to respond to challenges posed by the pandemic.

[13] Greater Manchester Health and Social Care Partnership

[14] Meeting the home adaptation needs of older people, LGA, ADASS, Care & Repair England and Age UK

[15] Digital innovation in adult social care: how we've been supporting communities during COVID-19, LGA, ADASS and Institute of Public Care (IPC)

- Nursing providers, arguably the most at-risk provision, are reporting concerns around additional demands placed on them for CHC packages and increasing administrative burdens on providers from the volume of data requests; highlighting how easily a return to silo based working can return.

Over the last 8 months, local authorities in conjunction with providers from across the market have worked to overcome some significant challenges in a collaborative manner. New dialogue and relationships formed with the provider market, greater frequency of contact and the offer of aid and support has made significant inroads in tackling a pervasive and historic culture of 'us and them'. Whilst this was present during the first wave of the pandemic, there is a risk that old behaviours could return. For example, one voluntary sector provider noted that throughout the pandemic their relationship with the acute sector was strong – however, the recent production of the Winter Plan made no reference to the voluntary sector. Despite the plethora of guidance that was issued to support the social care market, very little, if any, guidance was issued in relation to the voluntary sector – this would suggest that the system, at least nationally, does not recognise the vital role the Voluntary, Community and Social Enterprise (VCSE) sector plays in the social care market (see lesson 5).

Providers have been given increased freedoms and flexibilities in relation to how they discharge their duties, with a greater focus on "outcomes" as opposed to "processes". This has helped harness provider creativity and innovation, which indicates that the future shape of strategic commissioning needs to be simplified, to ensure the freedoms and flexibilities are retained and avoid a return to the market being over-governed and inflexible. The response to the pandemic suggests that the way we commission forces provider behaviours. Further work is needed to integrate assessment and care management professionals (i.e. micro-commissioners) into the process to ensure that individual voices are front and centre in the commissioning process.

The provider market cannot be commended enough in how they have stepped up to the challenge of responding to the pandemic. The number of vulnerable people supported by social care providers is significantly greater than the number of people who had both interacted with (or even required intensive support) from health services – thus demonstrating the impact providers have had on shielding frontline and emergency services.

Without a medium to long term plan for social care, local authorities will find it extremely difficult to put proactive and cost-effective solutions in place and, ultimately, the issues of underfunding, market stability and market development will continue to cause challenges to the system. The impact of Covid-19 is translating into discussions with providers about significant fee uplifts for the next financial year, significantly beyond the scope of CPI which is usually offered.

Lesson 4: Old ways won't open new doors

When strong patterns of behaviour are established, such as ways of working, we often need significant disruptors in order to break the most undesirable ones. Whilst we are creatures of habit, we simultaneously have the capacity for change and adaptation. The pandemic acted as a disruptor to the way we work and forced people over the last 8 months to 'do things differently'. Some illustrative **examples of positive changes that should be retained** includes:

- People being **empowered and trusted** to make decisions in order to act quickly, with more **streamlined governance** arrangements being developed. Pre-pandemic, proposed actions would need several sign-offs before being acted upon. As one interviewee stated: "we have been bold because we had to, and this has changed behaviours". Where meetings did take place, they were focussed and kept to time, with all the key decision makers present (see use of technology below) – the use of daily 'sit-reps' have been cited as an example of good practice. Similarly, experiences of using Local Resilience Forums (LRFs) was positive, as the

objectives were clear and action-focussed – reports were 2 pages rather than lengthy position statements or justifications.

- Systems need to evaluate how they oversee operations and *ensure that governance is as light touch as it absolutely needs to be* in addition to being careful not to have a *"we need to control everything"* mindset. However, this must be counterbalanced with the risks of returning to old behaviours which may stifle innovation and pace of change due to a fear of accountability and lack of ownership, which drives a culture of over-governance and control[16].

> *"...governance is important, but it was good to be able to act fast".*

- Procurement being simplified during the pandemic, which enabled commissioning to happen at pace. The government released a policy note setting out the use of procurement levers (such as exemptions) in responding to Covid-19[17]. Whilst this gave 'permission' to streamline procurement of goods and services, it is important to note these mechanisms already existed pre-pandemic which had not historically been utilised.

- Recognition from leadership teams that they attended too many meetings pre-pandemic. Upon return to Business as Usual (BAU), system leaders should review the necessity and purpose of these historic meetings and reflect on where leaders can empower Service Managers to 'step up' into a more strategic arena.

- A general agreement that there has been greater workforce flexibility with home working becoming commonplace and productivity still being maintained. More effective use of home working into the future should be considered. Figure 5 is taken from a recent Knight Frank publication[18] in which they explore the dynamics of a new 'working from home' culture and the potential mistake to "*...conclude that because we have worked from home for a while that we do not need to manage the change".*

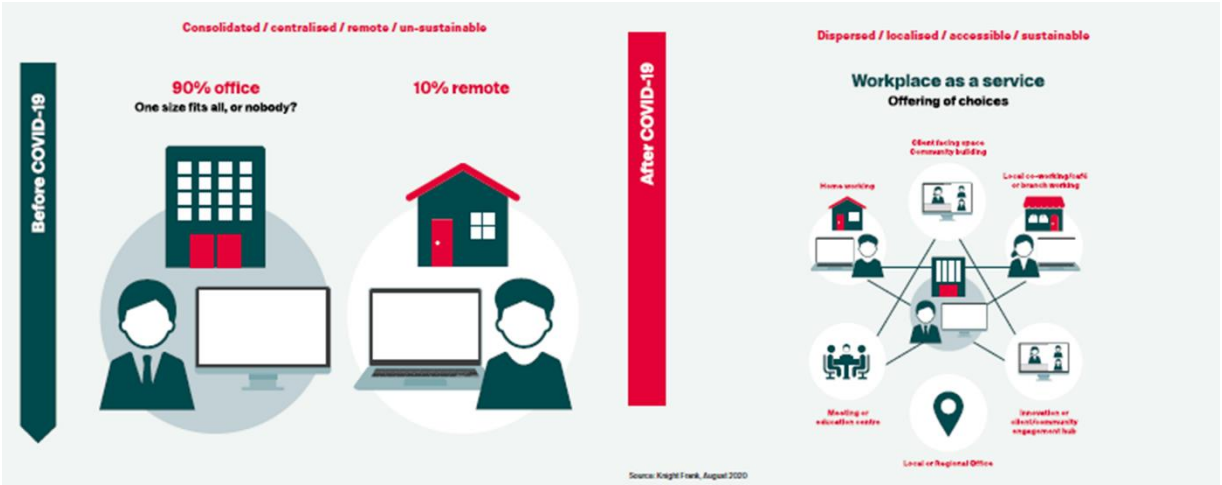


Figure 5: A new model for remote working [source: COVID-19 What we know, what we expect, what we question. Knight Frank]

- Rapid implementation of technological solutions such as Microsoft Teams, Skype and Zoom together with cloud-based services to enable agile working. This technology has been utilised to great effect internally (meetings, supervisions, interviews, inductions, training and workshops) and also externally (advice/guidance,

[16] In August 2020, the Department for Health and Social Care launched a consultation on 'reducing bureaucracy in the health and social care system'. The results are yet to be published but may present a useful platform for the region to retain some of the positive changes implemented during the pandemic.
[17] Procurement Policy Note - Responding to COVID-19, UK Cabinet Office, March 2020
[18] COVID-19 What we know, what we expect, what we question. Knight Frank, September 2020

welfare checks, reviews). There are some areas where staff reported less success, such as assessments of individuals, which may be due to the complexity of the task and the difficulty of building rapport remotely. As lockdown restrictions are lifted, the system needs to be cognisant of establishing the optimum balance between face to face and remote contact, to counterbalance the risk of isolation on individuals' mental health. At the very least, the default can be changed to offer a range of options, which also mitigates the potential risk of digital exclusion.

"Most of our communications have been through digital channels such as social media platforms and our web pages. This highlights opportunities for us to consider networks of communication with our most vulnerable adults in future, offering a blended approach rather than the default; the pandemic has demonstrated the art of the possible in relation to technology".

- The sector implemented new payment arrangements for social care providers and suppliers to help with cash flow challenges. For example, prior to the pandemic, local authorities typically implemented 30-day payment terms, which changed almost overnight to immediate payment upon receipt of invoice.

- Access to data improved, both from the perspective of provider returns and organisational data-sharing arrangements. Despite there being no material changes to GDPR, organisations began to use powers already available to support the sharing of data in the event of risk to human life. Post-pandemic, systems need to be clear on how legislation is interpreted and utilised to continue to benefit individuals.

- Much greater use of agile and modern working practices, for example, some areas introduced shortened assessment and review documents. Light touch triage of individual's care needs and welfare checks became common practice in some areas, demonstrating that care reviews can be carried out in alternative ways to a face-to-face client visit.

- Some existing policies and procedures have been adapted to reduce pressures on providers. For example, quality assurance monitoring has moved to a risk-assessed approach, operating virtually and based on intelligence gathering where appropriate. Some local authorities have also established "provider recovery teams" to work pre-emptively with the market to support with redesigning business models, rather than responding to crisis and market failure. The skill sets offered such as business planning are particularly pertinent for SME's who do not have access to central business operations ('back office' support).

There is however a real risk that the changes implemented during the pandemic will revert back to 'business as usual' – as suspended activities return, it is important that the system assesses the relative merit of each activity and how this is delivered.

Lesson 5: People powered change: the power of communities to deliver solutions

Since the outbreak of COVID-19, communities have sprung into action and there has been a huge societal response to the pandemic, with communities coming together to support people and a recognition of the importance of social connection. Informal support groups in local areas have organised to support people in need and, at the time of writing, there are over 2,000 groups listed on the mutual aid website established during

the pandemic[19]. Think Local Act Personal (TLAP) has also documented[20] how innovative, community-centred organisations are working differently during the pandemic and still offering good person-centred support.

Residents the length and breadth of the region have stepped forward as formal volunteers in the NHS, community hubs and with local VCSE organisations. Indeed, the Office of National Statistics (ONS) research into the social impacts of COVID-19 has also seen a steady increase in community spirit during the height of the first lockdown[21]; notably:

- nearly two thirds of adults (64.1%) saying other local community members would support them if they needed help during the pandemic
- three in four adults (77.9%) saying they thought people are doing more to help others since the pandemic
- nearly two in three adults (62.6%) had checked in on neighbours who might need help at least once in the last seven days, and
- almost half (48%) of people in the UK said that they provided help or support to someone outside of their household in the first month of lockdown in April 2020. This is a substantial increase since before the pandemic where just over 1 in 10 (11%) adults reported providing some regular service or help for a sick, disabled, or elderly person not living with them during 2017-18. Shopping was the most common activity that people undertook as part of their caring responsibilities (85%)[22].

> *"...demand on frontline services would have toppled had it not been for our carers and this is starting to be recognised".*

COVID-19 has also highlighted the need to build people's personal resilience and capability. It has shone a light on the need for connectiveness to a community, and the importance of placing social and non-medical needs alongside medical needs. We know that health is affected by a wide range of things, and access to food, housing and social connections have been brought sharply into focus over the past few months. Social prescribing has had to adapt during this period, switching the focus away from physical activities but continuing to work alongside people to find out what matters to them.

Social prescribers have also played an important role, providing practical support to people, organising shopping and prescription collections, as well as looking at innovative ways to connect individuals to online groups and community support in order to provide a variety of activities aimed at supporting mental and physical health. The pandemic has thus presented an opportunity to capture the societal response and to raise the profile and role of social prescribing and link workers in communities[23].

> *"Whilst there has been a welcome rise in the national profile of the vital work carried out by social care this does not feel that is has extended to the voluntary and community sectors in supporting the*

[19] Mutual Aid is a list of local support groups that have been established during the coronavirus (COVID-19) pandemic.
[20] See: Community-providers-response-to-Covid-19 - Covid-19 information - Think Local Act Personal
[21] Coronavirus and the social impacts on Great Britain: 23 April 2020, Office of National Statistics
[22] Coronavirus and the impact on caring, Office of National Statistics
[23] London South Bank University published a useful guide in 2019 entitled: 'The Asset-Based Health Enquiry: Howe Best to Develop Social Prescribing?'

health and social care sectors with the exception of NHS Volunteer Responders".

Local authorities, working with their partners in the VCSE sector, have taken a more active role in supporting vulnerable and shielding residents who may otherwise have not met Care Act eligibility criteria. Some illustrative examples include:

- Cheshire East's **'People Helping People':** a rapid response service to support residents out in the community that found themselves required to socially isolate and was launched on 20th March 2020. The service provides local residents with underlying health issues and/or who are above the age of 70 who do not have the available support networks, with the option to request help for tasks such as food shopping or prescription collection.

  To meet the needs of local residents, the service also allows local people to offer their availability and support (hence "People Helping People"). As of the end of April, overall numbers of people registered for support was 2,792, with 1,980 people supported/matched with a volunteer. Through People Helping People and the RVS NHS Volunteer Responding initiative, over 7,000 volunteers have been recruited.

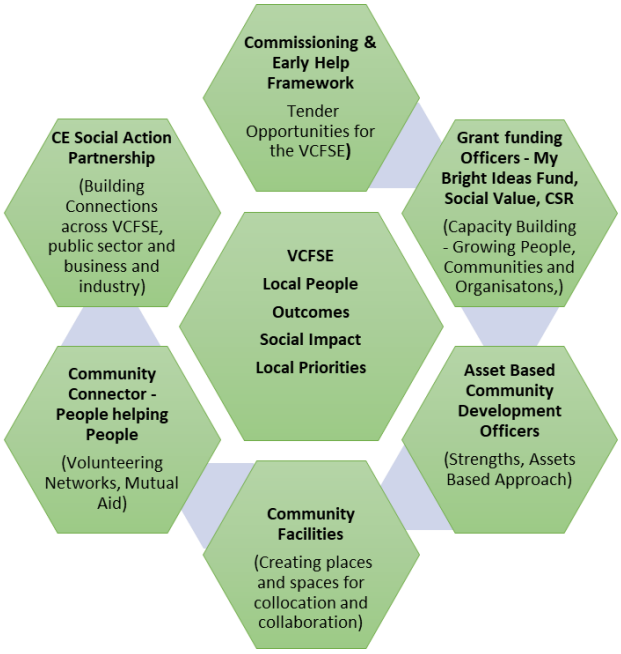


Figure 6: Cheshire East 'how it hangs together'

The local intelligence gathered from the service is being utilised to shape and develop a new prevention and early intervention offer.

- From the outset of lockdown, Age UK Wirral lost the majority of income from mainstream buildings-based services and retail and faced a position where they could furlough staff and suspend all services. However, the Trustees made a decision to deliver on their organisational mission and support vulnerable and isolated residents, resulting in the launch of the Covid-19 Emergency Support Service. Through a combination of reserves and fundraising, staff were redeployed to a practical and emotional support service. Since 16th March, the service has made 175,000 contacts (equating to 1 contact every 2 minutes). Some key outcomes include:

  - 16,455 wellbeing and befriending telephone calls made
  - 11,590 incoming calls answered
  - 7761 people supported through the website
  - 193 patients transported back home from hospital
  - 1573 bespoke shopping trips
  - 327 prescription collections

- A number of local areas (partnering with VCSE providers) have increased welfare checks on people with low needs, potentially helping to identify points of crisis before they occur. Similarly, the absence of professionals 'on the ground' has created an increased reliance on the community acting as the 'eyes and ears' of statutory services, as evidenced by the increased number of safeguarding concerns from the community.

To a certain extent, the introduction of Covid hubs have simplified what may often be a complicated system to navigate if individuals did not wish to engage with statutory services or were uncertain where to go to for support. The formation of response hubs in localities gave people one clear route in which they could make contact and access low level support.

Whilst there has been a plethora of positive stories, the system must be mindful of the considerable toll the pandemic has placed on carers – especially those who were used to accessing forms of support such as respite. To truly move towards a place-based approach to care, the region must consider how it best utilises 'touch points' (at which people come into contact with health and social care), be able to communicate key messages and make carers aware of the support that may be available. This is particularly pertinent considering the temporary closure of traditional carers centres.

"We should not re-direct our focus back to service first/service led, neighbourhoods and communities have shown great resilience and innovation and should be enabled to continue to support those in need within the community".

It quickly became apparent that the battle to 'protect the NHS and save lives' would be won or lost within communities. When we consider 'whole-system' responses, we often forget that people spend the vast majority of their time in their communities, in housing and engaging with local businesses – not statutory services. As this has been a key battleground for tackling the virus, there must be some consideration that this is equally true for wider health and social care challenges.

"Clap for the NHS", which was extended to acknowledge carers and key workers, needs to acknowledge the vital role people in their communities and community services play. The idea that professional services have come to our rescue in this time of need has been popularised and, whilst we cannot understate the invaluable role the system has played, we must equally remain cautious that we do not take a subconscious step back from the strengths-based approaches we are advocating. Simple gestures such as the recent letter distributed by Bolton Council's Public Health department, in which they made a 'heartfelt thank you' and acknowledged "all [residents] support and efforts so far in working with Bolton Council and our partners to control the Covid-19 virus".

The pandemic has demonstrated that when people collectively care enough about something and have something to offer and contribute, then they will act. The challenge is then to identify *what* people care enough about and foster the right conditions to support community action. The region should maintain the trust built with partner agencies, the community hubs and the residents within the community and enable the community to maintain its localised response with support, investing financially where required. The VCSE sector (which runs many of the activities prescribed above) have been financially affected by COVID-19 and may struggle to run the same types of activities in the future. The formation and development of Primary Care Networks (PCNs) working with local authorities presents an opportunity to capitalise and continue the social movement that has formed as a result of the pandemic.

The system also needs better partnerships with residents to understand people's lived experiences, including a better understanding of how behaviours and attitudes have changed and how services and programmes potentially need to realign to this, such as delivery of more healthcare services in community settings. Wigan are currently undertaking a consultation exercise to gauge the impact of Covid-19 on residents. This survey will

provide some insight into the social and mental health impacts of Covid-19 and could provide invaluable future learning for the system.

Lesson 6: Demand and the concept of personalisation is fragile

The impact of the pandemic will take some time to be fully understood. On the surface we can see the impact directly in areas such as A&E, which experienced a 21.2% decrease in admissions in the North West from September 2019 to September 2020[24]. In reality, the nature of the pandemic is likely to have suppressed some demand and enhanced other elements, e.g. physical frailty due to movement restrictions, mental ill health due to isolation and stress or support during a protracted period of recovery following the virus.

Broadly, referrals and demand at the front door reduced, including safeguarding concerns and DoLS referrals, at the height of the first wave (March through to May). Areas did however report a surge in demand over the summer months following the initial lockdown, along with a perception that needs, and acuity had increased.

The Care Act Easements legislation allowed for Councils to suspend the use of national eligibility criteria for adult social care services. Instead of determining whether a person was eligible under these criteria and providing care services to people who were, the easements permitted councils to stop determining eligibility, and instead to provide care and support services to people whose human rights would be breached without those services. As social care departments became responsible for co-ordinating their council's support for "clinically vulnerable" and "extremely clinically vulnerable" people, rough sleepers and the early release of prisoners; this meant that for those areas, the adult social care offer was effectively widened rather than narrowed, as support services were provided to people who would not normally have been eligible for care and support services under the Care Act (2014).

Considering these changes in patterns and the nature of demand, the system responded with changes to the way it assesses and understands urgent needs. Illustrative examples include:

- Flexibility and agility for staff within services increased, with most councils redeploying staff from reviewing teams and, in some cases, occupational therapy teams, to where the pressure or need was greater. This included hospital discharge and community assessment teams where it was deemed essential to prioritise the needs assessment for people who were not yet receiving care and support services.

- Most areas reported shifting a significant proportion of assessment and review activity to telephone and digital mediums and streamlined the content of assessment forms. Some clients, particularly those with Autistic Spectrum conditions found remote engagement more appropriate and beneficial to them. Interviewee reported that their teams are experiencing better engagements with some clients using this technology. As a region, work needs to be undertaken to consider what elements of these changes can be kept, whilst ensuring that key data is still captured, and people are not digitally excluded from services.

- As alluded to above, there was a new emphasis on lower level needs – for example, Trafford introduced a 'Well Being Review', which all LA statutory staff, CCG, carers centre & the VCSE sector adopted to ensure they were talking to as many people as possible to identify the need for care & support (including, food, fuel, caring needs, immediate needs). There is a need to review the effectiveness of continuing to

[24] NHS Digital A&E Attendances and Emergency Admissions.

screen low level needs in such a way in order to help shape the commissioning of prevention and early intervention services, which supports hospital avoidance and prevents crises escalating to the point where statutory interventions were required.

- Introduction of new streamlined hospital discharge guidance – promoting assessments in the community, resulting in people being discharged within a 3hr window, utilising revised discharge processes and pathways. It is widely accepted that long term planning should only take place prior to hospital discharge in exceptional circumstances. The current assessment pathways and associated forms will require review and amendment to ensure that new approaches are legally compliant post Covid-19. Specific focus will need to be given to ensuring adherence to Care Act, Mental Capacity Act and Mental Health Act duties. The need to apply a strengths-based approach to ensure an avoidance of 'fostered dependence' early on needs to be supported by the whole social care system.

- The region experienced an initial decline in demand (particularly for care and support services in the home) as many family members were furloughed or working from home and able to provide care and support for their loved ones. This capacity, both the practical and physical, but also emotional, has limits. Family solutions often worked well due to the lack of access by professionals, who found they had to trust family members or colleagues to provide information to prevent the need for more face-to-face contact. This enabled professionals to use their time more efficiently, with the experience and outcomes of people providing useful evidence to inform practice going forward.

- Renewed focus on pathways from a point of crisis to home with support and in areas such as Salford, Bury and Trafford, IMC has been seen as a principle and not necessarily a service, with discharge to assess clients being offered 6 weeks of reablement through an extended offer across the market in most instances. There was also evidence in some areas of moving away from electronic care management (i.e. time tracking) in homecare to temporary 'pay on plan' arrangements which had begun to foster a more holistic/wellbeing approach which is person-centred and has the ability to flex to meet a person's daily and weekly changes in need.

"Should the Hospital Discharge guidance be rescinded, this will impact significantly on the hospital discharge pathways and the way the assessment function is completed. If this was to return to the pre-Covid approach, where assessments were completed in hospital, due to the choice elements, the delayed discharges would increase significantly again".

- Some areas have reported the way in which people in receipt of a Direct Payment are supported (in particular, those with a Personal Assistant) has changed. The level and regularity of contact with individuals has increased significantly to ensure that people are supported in terms of PPE, testing, payment for provision, staffing arrangements, business continuity plans, and availability of provision. For example, in Trafford, the Direct Payments Team (brokerage and audit), who were previously centralised have all become home-based, with two enquiry lines transferred, and changes made to the duty rota to ensure that people can access the service 7 days a week as required. Staff have also offered a 'door to door' service in terms of PPE and other essential supplies, forging closer links with commissioning and community services. There is now a motivation to consider whether the Direct Payments Team should become de-centralised, home-based, aligned more closely to commissioning and community services, and available 7 days a week

- With the need to maintain social distancing and self-isolation, people have not been able to attend day services or undertake community activities to the same extent. Services, such as supported living, have had to become more 'relaxed' in their thinking about the types of support and activities they provide and have embraced the opportunities afforded by a home environment, recognising individual choice. How providers continue to support individuals when lockdown eases also requires consideration. Services such as day services may look very different as they reopen, not only to meet the requirements for infection control measures but also to reflect the new types of activities and choice that has been introduced to people's lives during the intervening period.

The debate concerning overprovision within the sector is not new, and is instead an area that has been well publicised[25] over recent years, with different areas taking focused approaches to reviewing and stepping down inappropriate packages of care that do not maximise independence. An inherent difficulty in addressing this challenge has been the skill levels and ability of some assessment and care management staff to have difficult conversations with people – ultimately saying 'no', despite their fundamental nature being one of caring and compassion. The psychological impact of the pandemic has provided a reason for staff to have these difficult conversations, providing an 'excuse' (where appropriate) rather than a feeling that (the social worker or the system) has to provide some form of care, simply out of duty.

Whilst this review has discovered several positive examples in relation to the system response to demand, concerns were raised through the engagement that limited ward contact and direct engagement with services has made judgements concerning hospital discharge more difficult. Some teams identified an increase in re-admissions which has been put down to a number of factors including hospitals wanting to discharge too early. In addition, it can be noted that less face-to-face contact with service users has the potential to minimise the impact of the individuals' voice in decision making.

Despite believing that integrated working had improved, there was still some concern, especially from providers, around the way in which decision making sometimes impacted negatively on vulnerable people (LD and OP in particular). This ultimately raises the challenge that all partners in the system should be able to demonstrate personalisation, the protection of individual human rights when determining the best care pathway and care destination, as well as training regarding mental capacity and best interests decisions.

Similarly, the pandemic has exposed that the system is set up in the wrong way: "single disease thinking along a single pathway" or, in the case of social care, a 'label' (OP, LD, MH and alike) alongside an almost predetermined and limited offer of support based on traditional models of care severely restricts personalisation. The case of day services is a prime example of this challenge. The system needs to think about the person and not the disease/condition/disability label, and – as we are in danger of starting to fall back into using the idioms of 'service land', e.g. service user, LD, cohorts, placements etc. – there is a real opportunity to review the language we use when talking about people. For example, in Cumbria, staff are using the language of "citizenship", talking about 'support' rather than 'services', avoiding the use of terms like LD, thinking about homes and 'where people live' rather than placements. Any future strategy should consider the power of language and how it impacts on culture.

Moving forwards, systems need to think differently about demand and how this is met. The impact the pandemic will have on mental health has been widely discussed, alongside the potential need for new services or expanded capacity of existing offers. However, if systems start with the 'person', 'communities' and 'mental well-being' rather than mental ill-health, we have the potential to reimagine such solutions. For example, housing providers are a key touch point for people more likely to be experiencing the impact of the pandemic on their mental

[25] Surviving the Pandemic: New challenges for Adult Social Care and the Social Care Market. Discussion Paper, Institute of Public Care

wellbeing and would be perfectly placed to support people with some of their needs much earlier, often before there may be a need for statutory social care services.

Some assessments such as OT, carers and financial assessments have temporarily been suspended or reduced in numbers, meaning there will be a considerable backlog in the coming months, when (coupled with increase in NHS Funded Placements during the emergency period) these individuals are appropriately followed up,. Without significant given thought to this process, the system runs the risk of moving 'super-stranded patients' in the acute sector to super-stranded residents in the care sector.

Some areas also noticed a reduction in joint / health funded packages which have been mainly attributable to eligibility under temporary hospital discharge funding. One particular concern has been the reinstatement of NHS CHC assessments, and the considerable toll this may take on social care assessment and care management staff. The system needs to be cognisant that demand for services will be partly driven by the actions and capacity of assessment teams *at the frontline*, who will need capacity to do the right thing at the right time. Whilst strengths-based assessments take longer, they provide the greatest opportunity for long-term positive impact to the system. To quote one regional DASS: *"staffing is the solution, not the efficiency [saving]".* Several publications have been released over recent months which explore the impact of the pandemic on vulnerable people within communities, see annex 3.

Lesson 7: Steer little and often: the value of data and intelligence in shaping operational and strategic approaches

A key question from the outset of this review was to understand whether demand for services changed due to Covid-19 and, if so, how this demand has changed – and which, if any, particular groups are affected. Whilst this is an extremely pertinent line of enquiry, the impact of this question is greater than the sum of its parts, as it exposes a fundamental challenge within social care, namely: how limited our data and intelligence is, particularly when it comes to real-time feedback.

Increased access to data during the pandemic has shone a spotlight on the limited visibility and intelligence the social care system has historically possessed. Whilst we have significantly improved access to information such as occupancy and workforce staffing within care homes, infection control procedures, service user risk profiles, including better visibility than ever before of those in the population with low level needs (via the development of community hubs), this has come at the considerable cost of staff time.

The rush towards (and reliance upon) Covid-19 related risk modelling was time consuming at the beginning, with many different partnerships locally and regionally attempting the task. In hindsight, the models that were developed have proven to be wildly inaccurate. This raises the issue of how much time and energy should be spent on such modelling exercises, rather than good, local intelligence and experience. Interviewees reported that they felt this was a symptom of NHSE&I driving lots of behaviours without fully understanding the systems at play.

Whilst the NW ADASS programme office has supported the development of regional data sets and analysis for some time, the current absence of a centralised data 'hub' with ready access to the plethora of datasets and 'real-time' markets data is a missed opportunity. In addition, improved access to data will be integral for future market and demand management programmes. Presently, local authorities do not have access to this and the programme office is not in principle set up to provide such a function. Whilst NW ADASS is a partnership of the region's local authorities, there is no social care infrastructure or mandate beyond the local authority itself to coordinate data and intelligence, despite the importance of taking regional approaches to areas such as market management.

Despite these challenges, there have been some good examples of improved data collection and analysis of intelligence emerging from the pandemic, including:

- LCR's project with the LGA to assess care home market viability, providing intuitive and innovative analysis and insight to a significant proportion of the market, with a focus on better understanding of provider sustainability and viability.

- Markets data (placement and spend) captured in 2017 and 2018, with agreement to now implement annually and explore reporting in greater frequency for the future. The programme office also produce dashboards covering national data sets (Quarterly Scorecard, SALT, and Monthly CQC reports) and during Covid-19, a Care Homes Dashboard reported twice a week (since the beginning of August has gone down to once a week), summarising: local authority information, NECS Capacity Tracker information as well as Public Health England North West data on cases, workforce absence and PPE supplies. A business case is also being drafted for the development of a Markets Quality and Insight System that will host markets data.

- Trafford have commenced a project in partnership with the CCG, Health Innovation Manchester & Safe Steps to digitally enable care homes, thus increasing clinical and commissioning oversight.

- Most local authorities also developed daily dashboards based on key data (the things that mattered and were actionable) to support decision making.

A key challenge to the system moving forwards is how important data is mapped to inform decision making, with the relevant access and sharing arrangements with other parts of the system where appropriate. For example, the richness of data CQC gathers and the likely duplication with what local authorities also collect needs to be addressed. During the pandemic, providers would benefit from outbreak data in their areas, e.g. schools, businesses etc. including what is happening in their neighbourhood – after all, if this is where local staff will be employed from, such data will give an early indication of workforce pressures and contingency planning to support auxiliary requirements. Whilst sensitivity is a barrier, the potential benefit should be considered against the impact of omission, recognising that providers are part of the system too and need to be considered as such. The pandemic has demonstrated the art of the possible and that with enough collectively will and accountability balanced with innovation, issues such as data sharing (with proportionality) can be overcome.

Lesson 8: The public needs a better understanding of social care

Despite the size of the social care market, there has been recognition that the profile and understanding of social care across politicians, central government and the wider public needs significant work. An Ipsos MORI poll of the British general public in May 2020[26] suggested that public views of standards remain more pessimistic around social care than the NHS; whereas a majority of the public think that hospitals (75%), ambulance services (69%) and GP surgeries (69%) are managing well at the moment. Fewer still think that NHS 111 is managing well (49%) although a large minority do not know (29%).

> *"The social care sector is a keystone of communities employing 1.5 million people in England and contributing £40.5 billion to the economy. Failures would have devastating consequences on individuals, their networks and beyond. Local authorities spent £22.2 billion on social care in 2018/19 supporting 841,850 adults. People privately purchasing*

[26] The Health Foundation COVID-19 Survey: A report of survey findings, Ipsos MORI, Public Affairs June 2020

their own care spend £11billion. There are an estimated 8 million unpaid carers with millions more during COVID-19. Around 18,500 provider organisations deliver services across 39,000 establishments and 70,000 individuals employ their own staff via a direct payment."[27].

The reported 'crisis in care homes' had also fed through to the public consciousness, with just under half (45%) thinking that they are managing badly. Illustrative examples of this lack of understanding include:

- The time taken for inclusion of carers within the national recognition of frontline staff: Public opinion may well be swayed by how the UK media has widely reported on events. Clap for the NHS began on the 26th March and was ultimately extended to carers and key workers, but public attention in relation to the social care only really began to gather traction as the media reported the number of care home deaths[28]. Adult Social Care needed a stronger voice regionally and nationally from an earlier stage.

- On 17th March, NHS England and Improvement (NHSE&I) instructed trusts to urgently discharge all medically fit patients from hospital as soon as it was clinically safe to do so. This rapid implementation of the 'discharge to assess' model aimed to free up 15,000 acute beds by the 27th March and maintain this model thereafter, so that hospitals would have capacity to care for the anticipated influx of patients who were seriously ill with COVID-19. NHSE&I made this decision having just witnessed the health and care system in northern Italy being overwhelmed by COVID-19 demand. The letter from NHSE&I directed trusts and clinical commissioning groups (CCGs) to work with local authorities to deliver this policy. These new rapid discharge arrangements were set out in detail two days later, when the Department of Health and Social Care (DHSC) and NHSE&I published the COVID-19 hospital discharge service requirements on 19th March. On the 2nd April, DHSC published guidance on the admission and care of people in care homes, which stated that some new admissions to care homes may have COVID-19 – whether symptomatic or asymptomatic – but all of these patients could be safely cared for in a care home setting if the appropriate guidance around infection prevention and control (IPC), isolation requirements and personal protective equipment (PPE) was followed. The guidance stated that negative tests were "not required prior to transfers/admissions into the care home", as at this time the national policy was for testing capacity to be limited to symptomatic patients. On 16th April[29], the government published its adult social care action plan which announced that trusts would need to test every single patient prior to discharge back to their care home or new admission to a care home (insofar as this wasn't already happening) – whether they had symptoms or not upon discharge from hospital. Trusts were already testing patients and care home residents with symptoms wherever testing capacity allowed, but this capacity was not reliably and consistently available across the country before mid-April. The actions and timeline of events demonstrated a lack of understanding of the bed-based care sector, the physical structures and the fact that the majority are not clinical spaces therefore reducing the efficacy of infection control measures.

- Linked to the above, the early redirection of PPE supplies towards the NHS severely hampered local authorities and providers' ability to ensure an adequate supply of PPE was available for frontline services.

- The early focus on discharge from hospital to bed-based care and the focus on the use of NECS' capacity tracking tool for the sector placed a disproportionate focus on one aspect of the care market, failing to acknowledge the wider support and the focus on 'home first, if not, why not'. Similarly, the recent DHSC

[27] Taken from Challenges and solutions: commissioning social care during COVID-19. Social Care Institute of Excellence (SCIE), published: July 2020
[28] For example: BBC- Coronavirus: Care home moves had 'tragic consequences' and Guardian- English care bosses say lack of resources cost thousands of lives
[29] COVID-19: our action plan for adult social care. Updated 16 April 2020; proceeded by support for care homes guidance on the 15 May and Homecare guidance released on the 22 May

Service Continuity and Care Market Review self-assessment missed key components of the market such as respite and day services, requiring local authorities to add these as 'other' services.

- Testing within social care services has been (and remains) an issue since the start of the pandemic. Frequent testing of residential and nursing care was only structurally introduced when the number of fatalities due to Covid-19 had become mainstream news. Testing within community services (such as home care and extra care) came much later, and providers of supported living services are still reporting issues in their service area across the region.

Attempts to raise the sector's profile through the launch of the CARE brand[30] has received a mixed reception, with some stakeholders feeling it offers some recognition, brand identity and some of the prestige associated with emergency services, whilst others feel that it is 'tokenistic'.

Lesson 9: Social care workers are people too

Alongside colleagues from the NHS, the 1.49 million[31] people working in social care in England have been central and critical to the country's response to the pandemic – supporting people in residential services and in their own homes and communities, by providing help with personal tasks, being a vital link with the outside world, and keeping people safe and well. The willingness of the social care workforce to respond flexibly, be redeployed into different teams and, at a time when they were facing challenges relating to their mental wellbeing, highlighted the positive commitment of the workforce to the health and social care sector.

Staff recruitment and retention has been an area of significant concern within the sector for some time. Parity with the NHS and attraction (pay, terms and conditions, career development etc.) is of particular concern within nursing. The way in which NHS staff were front and centre of the national praise and thanks for keeping people safe has demonstrated that, as a society, we value the technical skills over the relational.

Whilst the broader care workforce may have been bolstered by furlough and redundancies within other industries, as the economy bounces back, issues of attracting a pre-disposed care workforce are likely to resurface. We must also acknowledge that people taking employment due to circumstance may not reflect the values required for the workforce, which in turn could manifest in future pressures and challenges. Equally, as the workforce experiences further emotional and psychological strain, staff are increasingly suffering from fatigue. Discussions with one care home manager identified that whilst residents have really struggled with isolation due to suspensions on visiting, the impact has been equally felt by staff who derive a lot of the value from their positions by seeing residents interaction with family and receiving praise: *"there was a sense that the home feels more like a hospital than a 'home' and the reason why staff stay in the career had been stripped away to a certain extent"*. Similarly, whilst technology has enabled people to communicate more frequently, it should be noted that people in the profession are naturally 'people, people' and as such the absence of having direct contact in some instances will take its toll.

In a post-pandemic world, we need to consider how we address issues of parity and value attributed to a career in social care. This will require not only programmes relating to workforce attraction and retention[32] but also how we commission services to support personal development opportunities (such as delegated health tasks) and how we fund attractive employment packages in their entirety.

[30] For more information click here.
[31] Skills for Care
[32] Skills for care have produced a useful resource exploring best practice across providers with a staff turnover of less than 10% to understand what it is that they do that they feel contributes to their success in relation to recruitment and retention; entitled: Recruitment and retention in adult social care: secrets of success : Learning from employers what works well.

Lesson 10: Infection prevention and control is for life, not just for Covid

With increasing demand on health and social care services, the need to focus on "prevention" rather than "the cure" has never been greater. The principles of infection prevention and control has been thrust into the public conscience like never before. Unprecedented public messaging on the importance of hand hygiene and general infection control measures has been delivered both nationally and regionally. Similarly, extensive support is being offered to professionals through Infection Prevention Control (IPC) teams which includes training, provision of advice/guidance, reviews and audits of care settings. There is also a focussed effort on flu vaccination uptake, as described in the 2020 adult social care winter plan.

Logic would dictate, and is supported by preliminary reporting, that general infection control has improved, e.g. gastro outbreaks and other reportable diseases are lower than average. Analysis of data for statutory notifications of infectious diseases (NOIDS) in England and Wales in 2020[33] looking at the most recent report (week 46) shows that many notifiable diseases are much lower over the most recent 6 weeks and comparisons from 2018 and 2019.

More work is required to demonstrate the impact of increased prevention control measures on normal communicable diseases, and whether concentrated efforts similar to those applied this year would have a marked impact of future winter pressure cycles. Similarly, the considerable effort in supporting people with low level needs to avoid episodes of crisis should be explored further to ascertain whether there is an invest to save case in order to meet future social care demand pressures.

[33] NOIDS weekly report: week 46 (2020); see: https://www.gov.uk/government/publications/notifiable-diseases-weekly-reports-for-2020

Section 4: Recommendations

4.1 Application of the lessons learned for the system

The lessons learned identified above have application throughout the system framework (figure 7 below). The successful adoption of these lessons will be predicated on the regions' ability to replicate some of the system enablers described (in section 4.2) below.

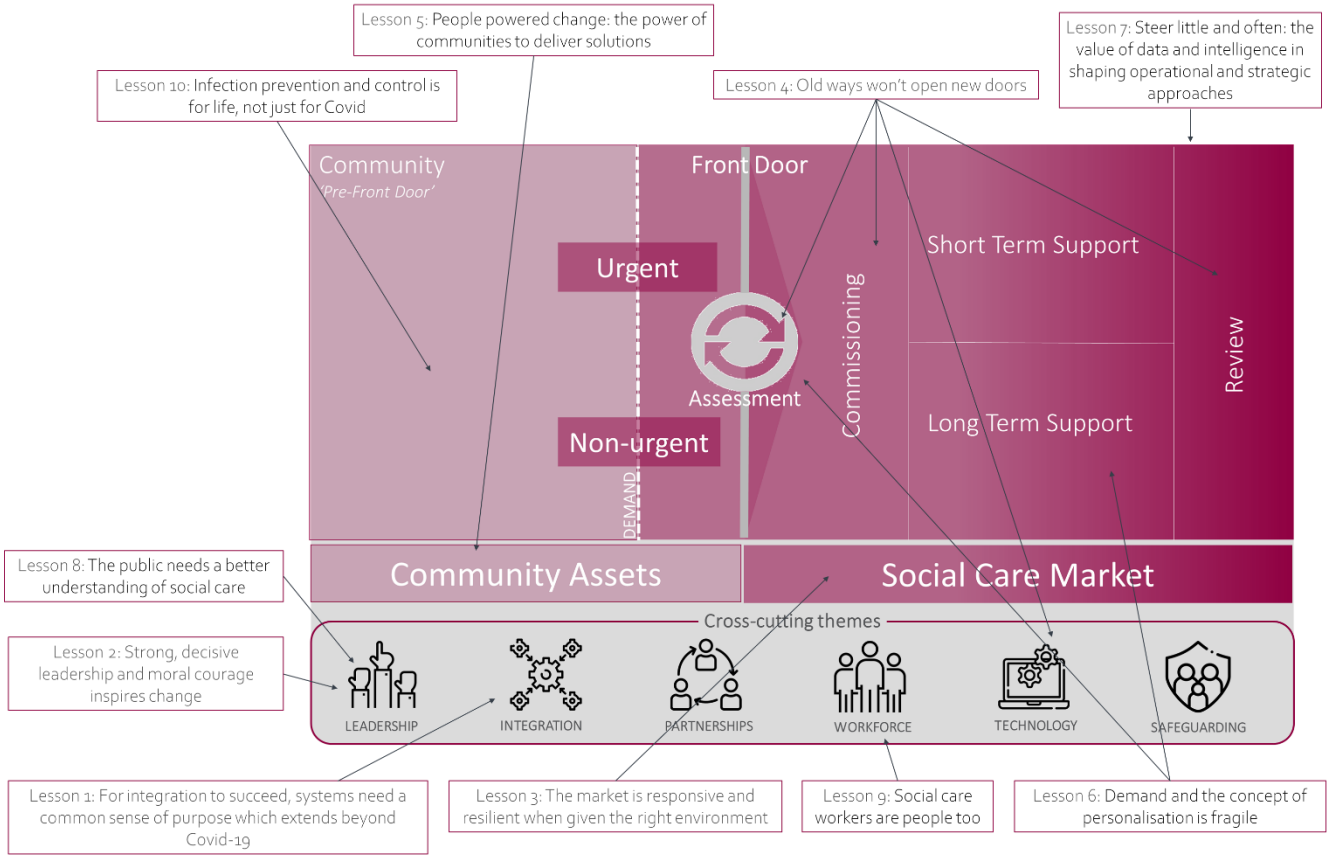


Figure 7: lessons learned mapped to the system framework

4.2 System enablers

As alluded to above, the successful actions taken during the pandemic have been predicated on 5 key enablers. In order to continue to embed the positive aspects of the system change we need to consider how these enablers can be replicated or embedded into a system post covid. Figure 8 identifies some of the examples.

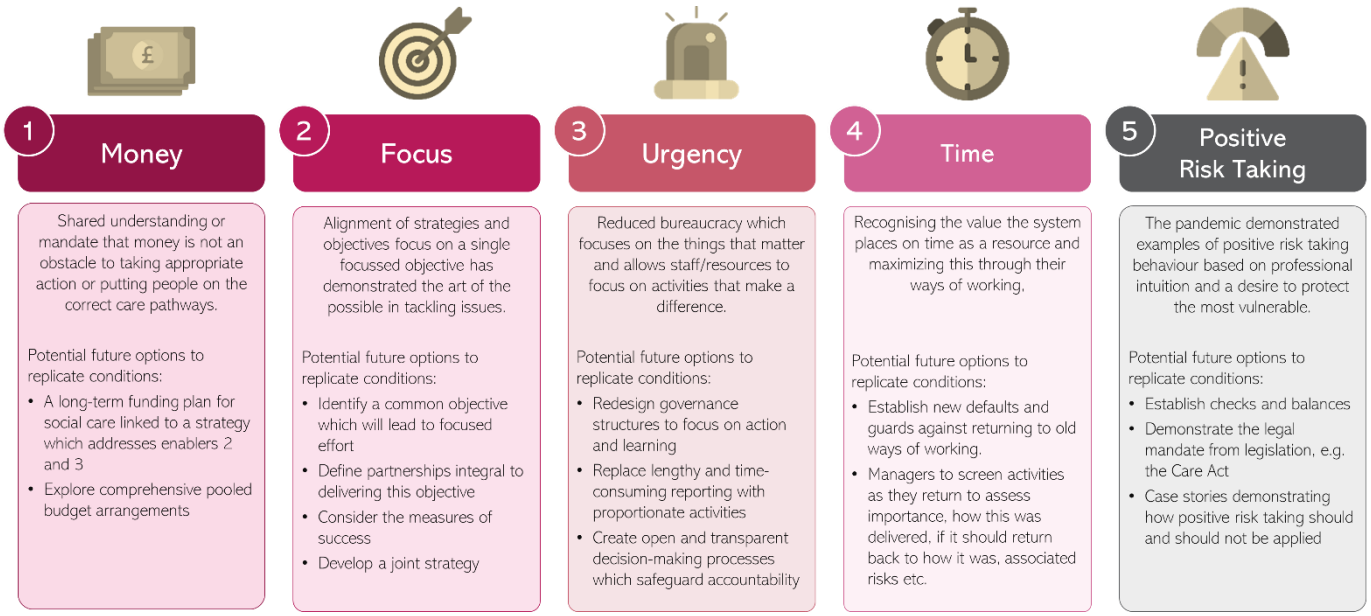


Figure 8: Creating the enabler environment post pandemic

The future will be driven by leadership, behaviours and replicating where possible those exceptional conditions. To embed the lessons learned and maximise the positive experiences as a result of the pandemic, we have identified the following 8 recommendations.

4.3 Recommendations

Recommendation 1: each area to reflect on their own lessons learned. Whilst the insight from this report is intended to support local systems; it is not intended to replace areas own self-reflection. To this end, we have provided key lines of enquiry in appendix 1 which areas can utilise. Figure 9 is also a useful tool produced by the RSA[34] to aid critical reflection. This has been utilised by Oldham in their review of lessons learned.

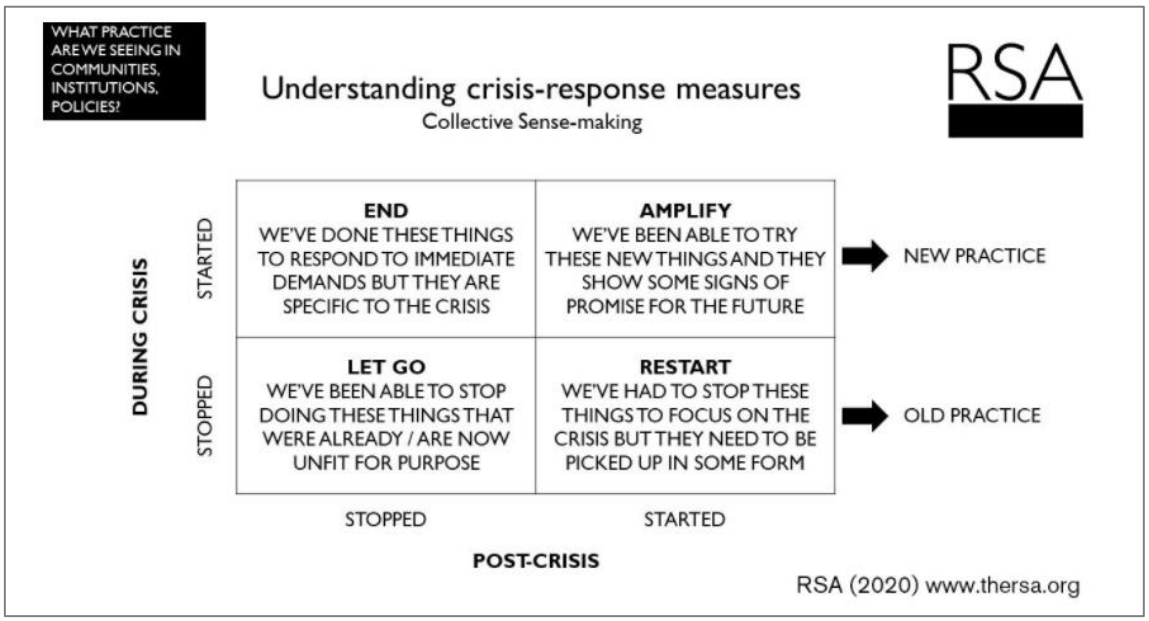


Figure 9: Critical reflection framework [source: RSA *How to Create Real, Lasting Change after COVID-19* by Ian Burbidge]

[34] *How to Create Real, Lasting Change after COVID-19* by Ian Burbidge

Recommendation 2: staff teams to implement a "check and challenge" on what and how they do work. National and local leadership has shown how quickly resource allocation, regulation and other system rules can be changed during the crisis. Necessity has driven some of the fastest innovations, such as rapid discharge from hospital and digital assessments and consultations. This willingness needs to continue, but the risk that we will return to business as usual without adopting new behaviours still exists. Leaders and managers within public services have a key role in checking and challenging activities as they come back on board. Key questions to consider are:

- Is it important and why do we do this?
- How did we do this during the pandemic, did this have any benefit?
- Would this be of benefit to the new 'norm'?
- What are the risks and can these be mitigated?

Residents need to be involved in conversations about what should be kept, as well as any large-scale changes to services.

Recommendation 3: regional 'Care 2030' strategy and creation of a common focus/objective for the system. The creation of the regional 2030 strategy provides a valuable opportunity to create and develop a common sense of purpose/objectives, which has been such a valuable enabler of transformation throughout the pandemic. This could take the form of simple propositions such as "Making a difference to people's lives" (as utilised within the Wigan Deal); "supporting people to live at home as independently as possible" or the current objectives identified within the draft strategy; namely:

- Live the life people want in their community
- A market for social care which is ethical, builds community wealth and offers greater choice
- People will be supported and cared for in the right way by brilliant and caring people

Whatever form the 'common purpose' takes, it will be important to engage with and garner shared ownership of the Care 2030 strategy from colleagues within the NHS; this will support the convergence of organisational priorities (see figure 4 on page 10).

Recommendation 4: work with central government to tackle some systemic challenges. The absence of the long awaited green paper on the future of adult social care, together with greater financial uncertainty, is hindering local authorities' ability to develop cost efficient and effective solutions to some of the deep rooted challenges the sector faces. such as:

- service transformation;
- raising the profile and understanding of social care; and
- integrated approaches to workforce planning and parity with the NHS.

In relation to the latter, there is an opportunity to utilise the lessons learned in this report, together with the findings from the NW ADASS Elected Member Commission, to work with regional NHS colleagues to disseminate findings. It would also be prudent to cascade the lessons learned through NHS Improvements existing Beneficial Changes Programme (NHS' review of lessons learned) and explore opportunities to integrate the findings into the NHS' Next Steps of Integrated Care Systems (ICS) review.

Recommendation 5: regional development of the Markets Quality and Insight System (MQIS). Capitalise on the increased access to data and appetite for intelligence through the development of a sustainable platform for markets data, linking key data sets to enable reporting and analysis which can inform commissioning strategy, market oversight, risk profiling, quality improvement and provider engagement.

Recommendation 6: harness the power of communities and also the changing needs and expectations of populations. Celebrate what people do for each other – tell stories of community, reciprocity and resilience, using the events of the last 9 months to bank and build social capital. Findings from the NW ADASS Elected Member Commission will support the communication of this finding and help to begin local discussions on how we integrate community resilience into our service offerings.

Recommendation 7: communicate the key takeaways for system leaders. There are some key messages that leaders throughout the social care system should take away and promote post pandemic; these are:

- Whilst we should always strive for perfection, this should not get in the way of progress. An illustrative example during the pandemic was the speed at which the regional recruitment campaign was quickly mobilised under the principle of 'don't wait for perfection'.

- Brave and selfless leadership, our services should not be defined by our organisational identity but what is the greatest good for the people that we serve, this requires the courage to say 'no'.

- Break and challenge the rules, be bold and decisive giving permission for the system to do things differently. A culture of informed and positive risk taking is instilled throughout the health and social care system and providers are encouraged and supported to think differently around services through the commissioning of outcomes as opposed to structured activity and outputs.

- Live and breathe personalisation, moving away from 'labels' to 'the person' and move away from co-production as a tool to a principle embedded in everything we do[35].

- Visible and engaged leadership "the top seemed in service to the work" e.g. "how can we help" rather than "I need a business case to demonstrate the work"

- Amplify what was working is better than constantly trying to fix what is broken.

Recommendation 8: develop the way we commission. Post-pandemic commissioning and market development strategies would benefit from a deep-dive review and refresh, taking into account some of the lessons learned and the appetite for change. The regional future models workstream offers a lever to support this recommendation. Examples of areas for consideration are:

- Bridging the gap between micro and macro commissioning to help stimulate market development and move from traditional models of care, shifting away from institutional care to support at home.

- Creating a flexible approach to services moving away from outputs (such as time and task) to outcomes. Homecare and making every contact count by supporting the creation of blended roles (delegated health tasks) is a prominent example. This is equally applicable to other areas of provision such as day services.

- Tackling the current structure and rigidity of frameworks which can stifle innovation and flexibility in provision.

- Build on the community assets that were developed and well used during the Covid-19 crisis (see recommendation 6).

[35] See TLAP's Making It Real

Annex 1: Wigan Case Study

The lessons learned have been developed following interviews with 34 stakeholders from across the Wigan health and social care system; this ranged from senior system leaders to operational staff, providers and local residents.

What was good about the system response?

- Integration and partnership working, such as the Healthy Wigan Partnership, was strengthened and evolved from an already strong footing. The pandemic has forced the system to scrutinise and challenge previous ways of working which may ordinarily act as barriers to the scale and pace of change. Rigid and extensive governance was replaced with rapid decision making.

> *"At the end of the day we all represent the same people whether it's me delivering council services or WWL delivering hospital services or whether it is CCG delivering practitioner services; we all want the same outcomes in terms of services, that part of it I think was already there".*

- Wigan was already quite advanced with their programme of transformation (the Wigan Deal, seven service delivery footprints (SDF's), joint senior appointments, enhanced health in care homes, well established primary care networks); and therefore was already significant headway in tackling organisational boundaries as can be seen by figure 10. Strong, collaborative and selfless leadership in Wigan, working for a common purpose of the best interests of the people of Wigan was a clear golden thread across the system and, provided a strong starting point for the response to the pandemic.

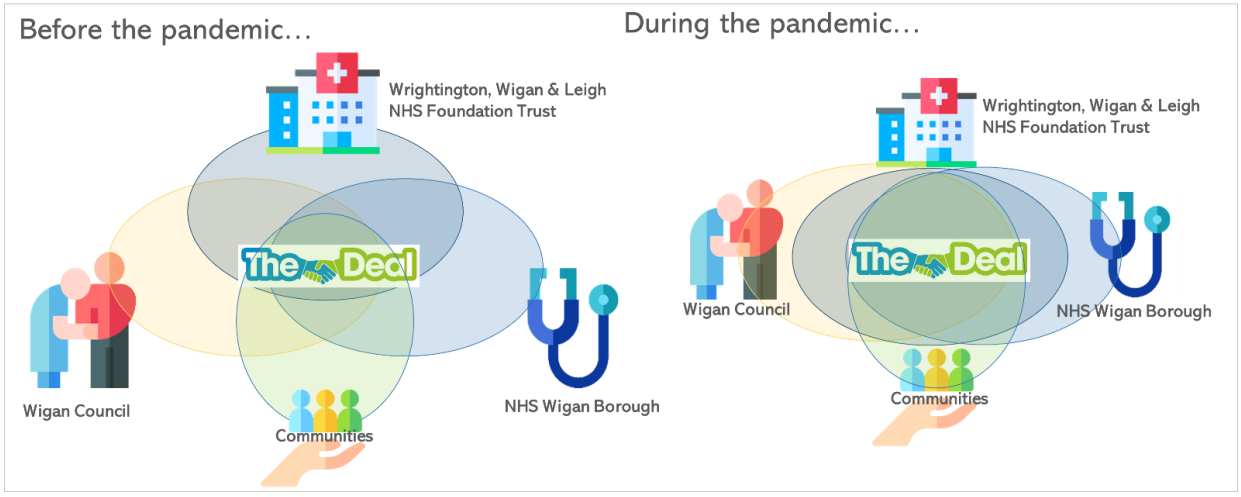


Figure 10:: Wigan system alignment

- The pandemic served to sharpen and provide a more urgent focus to all partners which resulted in a greater convergence (see figure 10) on the immediacy of saving lives. Interviewees identified the acute as one of the biggest relationship shifts.

"...people have had to be spontaneous, people haven't had to think how do I address this, what are the politics, basically we have to address things in 24 hours so it was a case of how do we do this and how do we do it quickly. I don't think we will ever go back to what we were doing previously".

- Innovative practice (see case studies); for example, a partnership with the Mercure hotel in the town centre in order to house rough sleepers, staffed by redeployed staff from the council and targeted support from mental health, GP, primary care and health promotion to provide wrap around care. Through targeted support from drug and alcohol services within the temporary accommodation there is now a number of individuals who are fully detoxed.

CASE STUDY: Album Covers

Wigan has always been well known for its love of music so as part of Care to Move programme we introduced a new creative way for people to connect with their favourite music - inspired by a care home in Edgware.

We asked Care Homes to lead activities for residents to listen to iconic albums and then recreate the album cover and send these into us. As you can see from the pictures residents came up with some amazing ideas.

- Despite issues accessing the NHS volunteer scheme, there was a significant growth in community capital with 700 volunteers, who were not known to the system coming forward to offer their help and support. This level of community commitment and engagement has never been seen on this scale before.

- During the height of the first wave of the pandemic 7000 people were supported through the community hub, giving out 32,000 meals or food packages across the borough.

- Financial and technological blockages that hindered the roll out of some remote working and use of technology, pre the pandemic, were overcome in a matter of weeks and staff have reported the benefits such as increased time (reduced commuting), flexibility and greater connectedness across organisations and within communities and the opportunity to work differently, for example, GP's (who were historically reluctant to) moved to digital appointments.

- Through integrated working and drawing on the strong relationship that existed between social care and the care home market; partners were able to channel support and build an effective intervention with the most vulnerable. This included the formation of deployment of 'care home squads'.

CASE STUDY: Care Home Squads

To support our providers in the most challenging times, we as an organisation deployed staff from our own teams to form Care Home Squads; teams of frontline staff with extensive experience of IPC, health improvement and care, to support provider staff where there were particular challenges.

Staff felt honoured and privileged to work in the care homes alongside the amazing staff and residents and shared many stories on the BeWigan Staff Facebook page throughout their deployment. They were all amazing and it was an emotional but rewarding experience for them. We would look to step this model back up as we respond to wave 2 of the pandemic as it worked so well.

- Arranged primary care through Service Delivery Footprints (SDF's) and pivoted from normal activity directly into health protection; embedding health protection into place based/asset based delivery, such as the SDF's. Whilst the epidemiological and bio-medical is incredibly important, too often health protection is over-professionalised making it difficult for other system partners and the public to fully engage.

- Development of hot and cold sites for covid management and hot and cold sites in secondary and primary care.

- Mutual aid across the system, for example the sharing of PPE in the early phases of the pandemic.

What would we do differently?

- Despite the legal mandate, work could have been undertaken earlier in the pandemic to ensure a more robust hospital discharge and minimise any difficulties post discharge. Some staff reported the consequences of rapid discharge such as packages of care not being put in place, medication not following patients. Richer community services providing follow up contact may have intervened and tackled some of these legacy impacts of rapid discharge. There is also a lessons learned around testing the risk assessment prior to discharge to a care home.

- The impact of rapid and sustained deployment of remote and agile working should have been considered from the perspective of mental health and wellbeing, whilst overall this has proven successful, staff need to be engaged on how they can be supported or functionally this can work in the future, e.g. a blended approach.

- Need to galvanise the full potential of our communities and local business, there is pockets of good practice and whilst there is a need to balance how we make it systematic versus organic from the bottom up, this development could and should be front and centre of planning.

- Loss of individual choice due to the urgency of the situation was a concern, for example rapid discharge into care facilities without sufficient checks and balances such as asking the individual and family. As a result of these lessons, during the second wave the system is doing a significant amount of work with Leigh Infirmary to stand that up as a step down provision, which includes quarantine floors to manage covid positive patients until they can be moved safely. Work is also being undertaken to replicate Covid designated care homes and to develop a 'Better at Home' approach between the Council, CCG and Acute Trust, to test the model between now and April 2021.

- The pace at which we push back when we feel that something is wrong such as the rapid hospital discharge or the pace at which testing is being rolled out to community care services such as supported living. This applies at a local, regional and national level.

- The was an understanding of the necessity during crisis of command and control to create capacity within hospital beds; however, there a common lesson was raised amongst interviewees; namely, the system should have been more challenging to ensure the individual voice was heard in the discharge process. As one interviewee stated: *"on a personal level wish we would have pushed back, we were petrified of people not having access to a ventilator but in hindsight there should have been pushback".*

> *"At our height we had 30 homes that had diagnosed positive Covid, residents and staff and over that period of time we have lost 200 residents and that is around 10% of our entire cohort of older people placed in that accommodation. Even though we have a lot to celebrate how we have managed to keep that number as low as possible and to support our homes to manage outbreaks it is still really sobering."*

- Redeploy the staff in a different manner to support system pressures based on skills and expertise, for example, deploy voluntary staff to support the hubs and Wigan Council staff to support care homes.

What helped our response?

- Willingness to accept change and adaptability both at an organisational and an individual level, for example, embracing technology for appointments and virtual meetings/'huddles' and the redeployment of over 800 staff into other roles helped the system respond to shifting priorities and areas of crisis.

- Delegation of decision making, empowerment and compassionate leadership with system leaders such as the Director of Social Care and CCG Chief Accountable Officer taking a more facilitating rather than dictatorial role. As one interviewee stated: *"Recognising that being daunted or sometimes fearful is okay as a leader and not transmitting it to staff in ways that are unnecessary. We have seen people shine in amazing ways and if we were doing staff awards for the year there would be a queue of many; people have been energised by what they can do in extraordinary times".*

- The commitment and positivity of staff together with good communication and visibility of the leadership helped morale across the system.

- The established SDF's and aligned teams of professionals (across the council and primary care) gave an architecture to deliver localised responses and mobilise the additional 700 volunteers that came forward. There is a recognition of how much the VCSE sector (and local businesses) contributes to the care of people within the borough – with examples of local businesses making visors and gifting hampers and survival kits for carers who weren't able to get to the shops.

CASE STUDY: Keeping in touch

Some of our residents in our Sheltered Accommodation schemes have been sending postcards to keep in touch with their loved ones. Our PR team designed the postcards using photographs from Wigan & Leigh archives. Betty was delighted to be sending a postcard to her son who lives in Germany.

We connected our schools to our care homes who sent cards & letters to each other throughout lockdown and some lovely new relationships have developed over the last few months. Pupils from Atherton Community School had written some brilliant letters; they talked about their experiences of lockdown as 7 and 8 year olds. The team shared these letters with our local care homes to use as conversation starters and reminiscence prompts to talk about childhood and related experiences of evacuation during the war and their own families. A lot of homes shared their gratitude for these letters and have let us know just how much joy they brought to people. Alice and Mavis have written some letters back to the pupils about their life as an 80/90 something during lockdown.

Our brilliant Homecare providers have continued to go above & beyond; from giving Mothers & Father's day cards to all their customers to taking a baby owl on visits to rase some smiles.

- Willingness of organisations across the system to share data and intelligence to inform decision making.

- Early in the first wave weekly market resilience meetings were established internally to look at support for providers, the CCG was actively engaged throughout which helped with decision making and distribution of resources.

- Mutual aid and the willingness to share staff and other resources such as PPE, this was incredibly important as the system supports 2000 people in care homes and 2000 in their own home through home care support. The collective power of Greater Manchester was effective in tackling the PPE issue

- Staff have been amazing in swapping jobs overnight without question and being redeployed to teams such as the Care Home Squads. Pre-covid that would not have happened at pace as time would have been taken with procedural matters.

- Existing strong relationships with the provider market, with examples such as the ethical procurement framework. Culturally, there is a shared sense of wanting to get the best for the people of Wigan and sharing what works and what doesn't work and how to collective drive up quality for the greatest good (outstanding providers sharing best practice to support outliers). During the first 2 or 3 months staff from the Council called providers registered managers to check in on them to see how they were, which was positively received.

CASE STUDY: Bringing the pub to you

There have been some heart-warming stories from one of our care homes in Leigh. Residents of Brideoak usually enjoyed a weekly trip to the pub. To make sure they still got to have fun during lock down they turned their outside space into a beer garden. Everyone has loved enjoying the sunshine and a few nice cold drinks.

What hindered our response?

- Focus on test and trace needs to be pro-active in terms of people being admitted to a care home and open communication would have been more beneficial. An example was provided of a situation that took place early on in the pandemic of a lady who had been discharged from hospital to a care home without having a COVID test and had to return to hospital as the care home refused to admit the lady in accordance with the guidance at that time. They were subsequently informed that the lady had tested positive so could have had consequences for the care had she been admitted.

- Sometimes balancing the time spent in GM against time spent locally provided challenges.

- Some learning has been observed by staff around court proceedings and the process around the time taken during the time of crisis and how this can be improved going forward the application to court process has slowed down which can affect the speed of some individual case decisions and add to bed pressures.

- Delays and accessibility of testing has led to un-necessary self-isolation which compounded workforce pressures.

- Issues about accessibility and supply chain disruption of PPE at the start of the pandemic.

- Clear and decisive messaging from central government; guidance was frequently changing and was not clear; equally the lack of understanding of social care by policy makers led to delays in guidance, especially in community service areas.

- Absence of one organisation to co-ordinate and provide a voice for the VCSE sector; this led to missed opportunities or duplication in support, such as assisted shopping which was a pre-pandemic offer but was replicated through the hubs.

- Information sharing / access to systems in some areas was problematic

What changes have happened and what has been the impact?

- 'Brighter Borough' monies now require the approval of the SDF locality manager which has fostered an increase in collaboration of community groups as opposed to competition for grants.

- Covid hubs were set up as part of the existing infrastructure with democratic services officers redeployed into the co-ordinating teams. This brought different experience and knowledge to the hub so for example all of the democratic services officers know all the councillors because they deal with them regularly so things like communication with the local councillors were vastly improved.

- Perception that utilisation of assessment processes improved, moving away from tick list approaches to probing what people can't do to having that different conversation about what people can do, what they would like to do, what they are interested in. Greater utilisation of the 50 to 60 social enterprises and community interest companies which provide a range of activities that could support people in the absence of traditional day services. Similarly, through new remote practice, the social work teams were able to address the backlog of annual reviews.

CASE STUDY: Innovating & finding new ways of working

Darryl, who lives in one of our supported living properties was missing his usual rugby training and wrestling. Staff could see he was starting to feel a bit down so they supported him to stay active at home. He invested his time in completing the Joe Wicks exercise programme as part of his daily routine and he carried out every single session.

- Changed how the Healthier Wigan Partnership (HWP) worked so the Alliance board went from monthly to 5 times a year and introduced a new activation board (decision making board) which was thematically led, not chaired by the partnership but by the subject matter experts. Reviewed the HWP leadership team, and other executive management team meetings between the Council and the CCG and created a new single smaller, action focused senior leadership team that oversees the actions of the activation board to make sure that they are progressing. This focussed governance has a smaller number of 'top priorities' and have made significant progress on stemming the flow of demand, which was at the projected rates, before the activation board, was showing almost a total closure of any admissions or referrals to services in mental health. Feedback from practitioners is that it has made a difference.

- It is felt that the value of social care input into the winter planning process has been acknowledged as a valuable contributor to assist the system.

- Aligned GP support to the 52 care homes in the borough, pre-pandemic there was several GP's supporting settings at any one time. knowing who the GP is when they are coming in and having that more personal relationship has been incredibly helpful but also for the resident experience.

- Pre-pandemic aspirations to review and remodel day services was given extra impetus. Services were suspended or operating with significantly reduced capacity which accelerated the system's ability to review and have honest conversations with users about what they have enjoyed; it has started to unpick some of the reasons why people go to day services and the overriding thing that the majority of people go to a day support services for is friends. Starting to see some incredibly creative ideas of how people have met these needs outside of the traditional model.

CASE STUDY: Tour De Wigan

We had 20 care homes taking part in our Tour de Wigan – The Big Pedal Challenge. Throughout the duration of the Tour De France residents were using the portable pedals we had provided to see how far they could travel in the 3 weeks of the competition.

Each home submitted their counts, encouraging residents to get on the pedals, each revolution is 80cm, so 1970 revolutions is a kilometre travelled – in total they travelled a whopping 650km! This took us from Wigan to Paris as the crow flies, if they had followed the roads we would have made it to Le Mans.

What should we keep?

- Communities have shown a level of self-reliance which the system needs to reflect upon and adapt place based working (where appropriate) to ensure independence continues to be maximised.

- Retain the option for virtual GP appointment and reviews/assessments. Need to be conscious of digital exclusion and how we address this to ensure equal opportunity.

- Keep elements of the redeployment of staff, i.e. the ability to share and develop skills and experience through more flexible job roles which allow staff to become multi-skilled and utilise their talents.

- Capacity assessments were being undertaken by the best placed professional; moving away from the current culture that a social worker has to conduct these.

- Providers reported empowerment and trust to assess new packages of care; need to look at a different model so it is not just about time and tasks.

- New governance structures such as the Activation Board alluded to above and a focus on people that has to be at the heart of everything the system does.

"I think we can integrate and sustain this because there is a higher degree of trust and communication, but do worry that the reason we have been able to have a different offer is that covid came with money – money will dry up and when we go back into local authority recession will we be able to maintain."

- Build on the programme of service transformation in areas such as day services, through recently launched community wealth building strategy and the creation of micro and social enterprises.

What should we stop?

- Emphasis from government during the first wave was to protect the NHS, and to make sure it wasn't overwhelmed but there was a failure to recognise that it is a health and care system are inextricably linked and it dangerous to make rules for one part of the system without understanding how that impacts on the rest of the system.

Summary of the local lessons learned

Whilst the pandemic is far from being over, we can begin to critically reflect on what needs to be retained, amplified and stopped as a result of the lessons learned, once the immediate threat of the pandemic. Figure 11 is a useful tool produced by the RSA[36] to aid critical reflection and provides a summary of the key observations from stakeholder interviews.

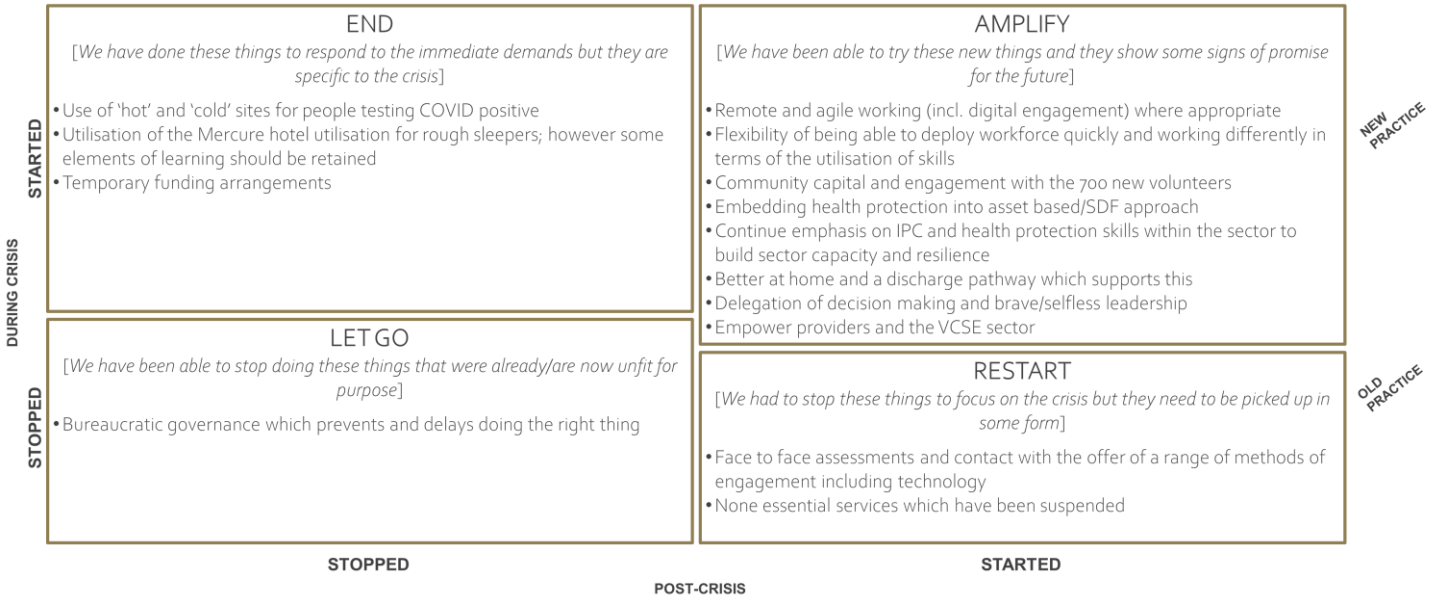


Figure 11: Understanding Wigan's crisis response measures: critical reflection framework RSA (2020)

[36] *How to Create Real, Lasting Change after COVID-19* by Ian Burbidge

Annex 2: Lancashire Case Study

The lessons learned have been developed following interviews with 77 stakeholders from across the Lancashire health and social care system; this ranged from senior system leaders to operational staff, providers and local residents.

System architecture

- Lancashire County Council operates within a unique and complex system architecture comprising of 12 district council's, 5 Acute Trusts, 8 CCG's, Lancashire Care Foundation Trust, 170 GP Practices and 2 unitary authorities. As figure 12 alludes to, pre-pandemic, the complexity of the structure and breadth of organisational priorities, processes and governance structures presented challenges to integrated working (convergence as identified by the Venn diagram). Significant work was underway with system transformation and stakeholders broadly felt that the last 6-9 months has helped improve the situation; for the following reasons: (1) historic financial barriers and tensions, (2) the formation of the social care cell brought all system leaders together and (3) there was a 'common purpose and a sense of urgency' (and severity if action wasn't taken).

> *"...for the first time all professional boundaries were put aside and people were a lot more honest and open, priority was discharge of people from hospital, funding arrangements were no longer an issue. We were making decisions then and there without having to go the CCG Board or cabinet approval. Some drawbacks to that on the spot decision making in terms of reflection time".*

- Whilst the perception of integration was broadly positive there was concerns that there still remains some barriers, cultural and structural differences, most notably, the 'top down' command and control approach of the NHS versus the 'bottom up' localised approach. Also, it was recognised that accountabilities and budgetary debates, are starting to, and will come back in some form which may slow down progress in relation to integrated working.

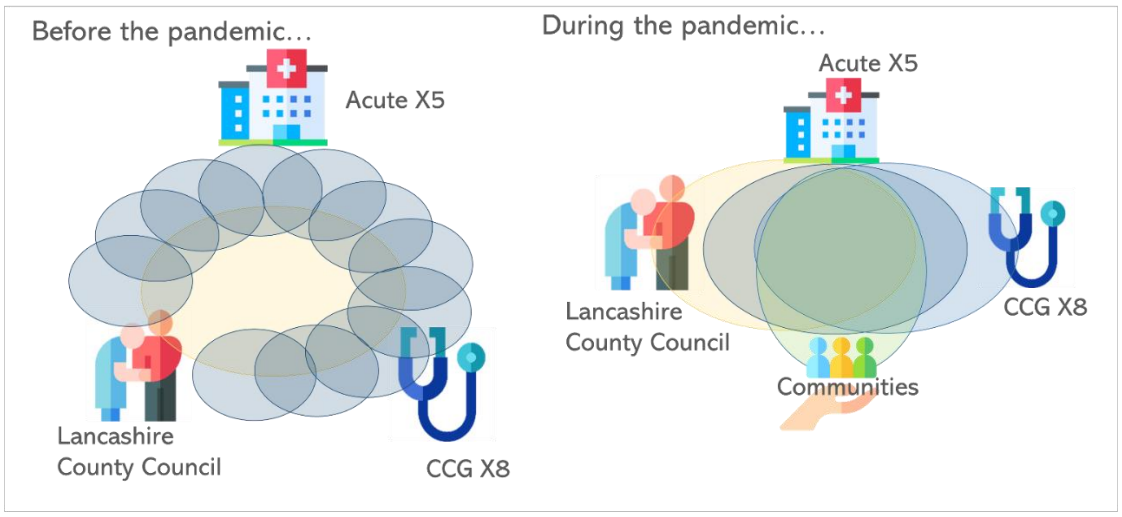


Figure 12: Lancashire system alignment

What was good about the system response?

- Relationships and engagement with providers has strengthened. Through daily sitrep reporting, during which care providers have a telephone conversation with a Local Authority colleague to check if any support or supplies are required. This has helped strengthen personal and organisational relationships.

> *"I think we have got to a good place that I hope we can build on and they understand that we see them as an equal partner. I think that has been a real positive".*

- Lancashire Resilience Forum (LRF) has provided structure and the opportunity to try and consolidate approaches ("do things once rather than fourteen times") given the complexity of the system alluded to in figure 12. Equally, the LRF brought partners (including the police and military) together to tackle issues such as mutual aid (particularly PPE sourcing and distribution).

- Reaction of the workforce to the pace of change has broadly been positive, with staff reporting positive empowerment and the emergence of new leadership traits coming to the fore.

- Rurality had caused a significant challenge to the system pre-covid; the pandemic gave extra impetus to implement technological solutions; enabling individuals and organisations to come together quickly or deliver services in new ways; for example, video consultations and 'virtual ward rounds' between care providers and primary/secondary care through the use of Microsoft Teams.

- Stakeholder perception that District Council's mobilised the voluntary sector really well, which will offer opportunities in the future in relation to the way the system supports and harnesses community capital. It is important to note that this view was not unanimously held, with several stakeholders expressing concerns that more could have been done to utilise the VCSE more effectively. This dichotomy of views is likely to be symptomatic of attempting to manage localised place-based approaches in such complex and sizeable system and geography.

> *"Local intelligence, presence and the work done with communities has been absolutely vital and that has to be our focus going forward".*

What would we do differently?

- Introduce safeguards to ensure that people's voice was still captured in the decision making; the drive and pace to create capacity within NHS acute beds resulted in a loss of individual choice and control in some cases (see below). Discharge process need to ensure these rights are protected. There could have been a stronger voice and push back from the social care system (locally and regionally) in relation to directives such as discharge.

> *"...guidance was naïve and poor in getting the person in the right place with the right care package; quality assurance checks were lost in the expedience in getting people out of hospital; think in the beginning the risks were probably justified the practice however from middle of May onwards the approach maintained even though the hospitals were operating at 60% and didn't need to discharge so quickly; should have been an integrated discharge process and less focus on 2hr decision and 12hr discharge".*

- Several stakeholders alluded to a 'hierarchy of importance' with hospitals at the top, then community health and social care below this. Greater publicity of the work of social care locally during the pandemic is needed to raise the profile of the sector, create parity with the NHS and raise public awareness of rights and responsibilities.

> *"...opinion of service users and their families were not taken into consideration; the aftermath is people discharged into care homes have just been left there, have had no rehab so have now lost window of opportunity".*

- One key area of concern mentioned by several operational staff related to coproduction; there was a sense that since the pandemic coproduction has slowed down or ceased, with individuals being 'done TO' and not 'WITH'.

> *" ...discharged to wherever there were beds and this may have been away from where family live or they weren't allowed to visit as the home was on lockdown; not enough awareness of DOLS/BIA in hospitals; - better training and support needed".*

- Ensure support was available for staff working from home sooner, the initial rush to move to remote working did not consider the stress and mental health implications from protracted isolation. Needed to consider how the system promoted resilience and supported staff who may have struggled with this rapid change to working practice. Any future application of agile working should consider a blended approach of remote and face to face working.

- Invested in additional support for IPC nurses earlier in the process given the size of market and the challenges experienced, need to consider how we build a sustainable knowledge base in the area to ensure future resilience.

- Identify earlier in the pandemic that there would be operational requirements which the system would need to support the 850+ care providers in accessing. For example: (1) testing & swabbing which is still under development and is currently the greatest source of confusion and concern for care providers; there is a lack of clarity and discrepancy between media/ national information and localised response. (2) Care providers were unable to receive timely access to PPE, this has been dissipated by the distribution from LRF.

- Need to look at how we can work better with our GP's and understand the community and place based offer, capitalising on the new emphasis on local response and the considerable work of communities to support themselves and each other. Despite some good local use of community assets within districts, there was a sense that some of the larger VCSE organisations and Healthwatch could have been utilised more effectively as community anchor organisations. Several stakeholders identify the need to the VCES sector to be more integrated, as a key resource, within the Integrated Care Partnership (ICP).

- Providers felt they were being contacted too much in some instances; there is a need to manage relationships and communication channels across the various public sector bodies to ensure that contact is streamlined, in some instances providers were getting the same information up to 3 times. One Provider reported the Local Authority Webinars were helpful but could have been improved with more opportunities for participation/Q&A.

- Future commissioning and market management arrangements for the care home market was an area for further consideration. At present there is three primary organisations who have an interest, the local authority, CCG and the Commissioning Support Unit.

What helped our response?

- Adaptation to pre-pandemic processes helped frontline staff to take swifter decisions in relation to care and support, examples of CHC assessments being put on hold so anyone who qualified for the budget could be put on it straight away and anyone identified as needing nursing could be placed swifter. Also, residential care panel changed to just 2 managers and was not restricted to a set day which has sped up the decision making process. Whilst there are process efficiencies and considerations there is a balance to be struck in relation to accountability and checks and balances.

- Virtual meetings helped ensure greater system representation and ability to call emergency meeting quickly, technology also utilised to form WhatsApp support groups.

- Covid has demonstrated a renewed sense of how place-based approaches can act as a vehicle to deliver transformational change within the system and communities. For example, a COVID Management service was set up with primary care to ensure that anyone discharged from hospital was followed up through primary care via an out-of-hours provider, who ensured that people connected with the Neighbourhood Hub.

- Covid funding, took out many layers of discussions about 'who paid for what'. There was a sense that this changed post 31st august with new hospital discharge guidance being introduced and a return to old organisational practices were creeping back in.

- Production of an easy read provider failure guide which was easy to pick up and use in a crisis so, not relying on people's knowledge but a document that anyone could utilise if required.

- Politicians delegated powers and devolved decision making which removed lengthy authorisation processes, enabling more responsive decision making.

- Workforce engaged with the changes that were required to respond to the pandemic; everyone pulled together and wanted to make a difference. However, we need to be conscious of the level of fatigue and isolation that staff may be experiencing as a result of this prolonged and uncertain change to practice.

- Increased market intelligence through the adoption of capacity tracking provided a much greater level of insight on the market which had not existed prior to the pandemic.

What hindered our response?

- The Government guidance is being continually updated which caused considerable uncertainty and confusion for the system and providers in particular (for example visiting guidance). Subsequently, oversight has been produced to clarify each change to Government guidance to enable swift processing of information for both key stakeholders and care providers, although there is always room for improvement in relation to streamlining communications.

- Intricately linked to the above, data intelligence sharing across the complex STP footprint (Lancashire and South Cumbria footprint) led to significant delays to providing one vision of reporting, which in turn led to frustrations and confusion from care providers in the initial stages who were having to manage the frontline

crisis whilst reporting, often the same information, to a number of sources. Clarity regarding one source of information and agreement from all the partnership needs to continue into business as usual to drive clear oversight of the sector.

- Nationally there was an emphasis on staffing in health with the 'bringing back staff' campaign, the unintended consequence of this is there was a reduction and pressures in nurses within social care; therefore, social care had to introduce separate recruitment initiatives.

- The 'restart' of NHS services over the summer period could have been undertaken in a more consultative manner both nationally and regionally, considering the impact upon the social care. This is important as the preceding months had shown how dependent both health and social care are on each other to tackle the pandemic. Despite this lesson, stakeholders felt consultation on the restart could have been improved, there was a sense of planning for the restart of services was taking away focus from preparation for the winter period.

- Concerns were raised by frontline and operational staff that there is a disparity between social care and NHS approaches to assessing individuals face-to-face (where required); social workers reported that their health colleagues were not mandated to carry out physical visits; therefore, assessments can become more complex presentations (mental health) or resource intensive. Whilst remote assessments have been positively received in some areas, such as Autism, this is not uniformly the case and has led to some distress and push back from residents. It is important that the drive for digital solutions does not widen the digital exclusion gap.

- Linked to the above there has been some operational disparities between general working practice (between those instructed to work from home (local authority) and those working in the office (predominately health colleagues); concerns were raised that this separation has set the joint working back.

- Loss of some service types, such as respite and day services which both offer essential support to carers, has resulted in increased pressures on assessment and care management staff to identify alternative support which is also Covid safe, the use of domiciliary care is one example but further work is required to consider what these alternatives may look like, not just in relation to long term service transformation but also for short term relief to carers.

- Access to and the speed of testing results returning is resulting in additional workforce pressures as staff are isolating where this may not be necessary.

- It was felt that during the pandemic there was disparity with regard to underrepresented groups (for example Learning Disability and Autism) with considerable focus being placed on older people.

> *"I would not feel safe going into hospital, I have a diagnosis of autism and also mild depression and if I was unfortunate enough to be admitted because I needed a ventilator because of Covid then I would be absolutely terrified that they would see my diagnosis and would put a do not attempt CPR on my notes. I have heard horror stories on the news of that happening to people....I am lucky to have a strong family around me so my parents would not allow a DNR to be put on my notes".*

What changes have happened and what has been the impact?

- Due to the need for quick employment of staff, recruitment processes have changed to reduce bureaucracy, this includes simplification of the application process, remote interviews, fast-track response to DBS and reference checks. Employer's induction training has been streamlined, allowing staff to complete e-learning training followed by shadowing in a similar home/provision and then in a provider's own service. Redundancies and furlough has seen a significant increase in applications for positions (500+ for recent care roles advertised) and the new processes are allowing more rapid and smooth deployment of staff where there are capacity issues.

- Focussed rollout of NHS mail / Microsoft Teams to support enhanced digital working within care providers has been achieved by suspending the requirement to complete the Data Security and Protection toolkit. This proves that care providers are keen to use digital but too many barriers were put in the way of accessing the digital requirements, moving forwards there needs to be a less onerous approach to delivery of 'one system' digital working.

- Emergency staffing response from the local authority through the facilitation of a 'bank' of care staff, targeted at homes in danger of closing. This has only been made possible through 'covid monies' but has helped to improve and enhance working relationships between the authority and care providers, and also provides additional oversight into private care services when issues arise.

- Whilst in the early stages of the pandemic the focus was on the NHS, there has been a subtle shift in recognising the important part that this sector plays in the overall support of the most vulnerable citizens within Lancashire; a sense of 'if we protect the care sector then we protect the NHS'. Enhancing the profile of social care must be taken forward regionally and nationally.

- Elected members introduced a delegation of decision making (through a temporary amendment to the constitution) to enable the senior leadership team to take decisions where urgency was required. Previously this may have taken considerable time through a formal governance process.

- Established a provider recovery team comprising of redeployed staff from social work and social care support officers to offer support in the event of an outbreak.

- Changes made to the assessment and review process, such as questionnaires received a mixed response from social work staff, whilst the review process was less time consuming there was concerns that there were areas that potentially could be missed in the absence of physically seeing individuals. For example, in substance misuse there was concerns that the remote method could lead to service users "telling you what you want to hear" equally the remote approach resulted in a "lot less useful and relevant information" the result of which was less detailed treatment support plans and a higher rate of early drop out. Similar concerns were raised by commissioning in relation to provider monitoring visits switching to virtual reviews. However, one benefit of the switch to virtual was an increase in attendance at provider forums as required less of a time commitment than the traditional physical meetings. It will be interesting if post pandemic this remains the case or whether the attendance was artificially high due to the context and events (alluded to above) which were occurring within the market.

"we spoke to our commissioner a few weeks before COVID hit, we said we wanted to draw up a list of the 35 most complex clients that we want to accelerate through for detox and rehab and get them into a place of safety now, we still haven't had official confirmation that Covid is going to cover that spend. The Commissioner agreed and we reduced the process time from months to 1 week so we could just get these people moving because they were the ones that we had looked at and we thought if we left it that these people would die".

- A detailed review of double handed care and the ability to augment packages with equipment, in order to free up system capacity, has yielded significant savings of £238,470 and reduced hours from 4649 to 2987 per week.

- Support groups have been essential in helping to keep people connected throughout the pandemic.

"An initiative that came from Covid is that I now attend an MDT on homeless to make sure that we are not missing those people who have been out on the street and were not getting access to services. I attend this once a week…there is social care, health, probation and the local council so we have managed to pick up people who might not necessarily have had a social care assessment. We managed to get one gentleman into supported accommodation who had been sleeping rough on the street, he hadn't been able to be placed anywhere else because of quite chaotic behaviour so this was a success story. Another gentleman who was quite risky he was in and out of prison and had not been offered a care act assessment before as he did not appear to be eligible but he was".

What should we keep?

- Overwhelmingly, stakeholders felt it would be beneficial to see less bureaucracy and pathways in the decision making process post pandemic, although there was recognition that the current position would not be replicable without some form of democratic accountability.

- Continue to build on the supportive engagement with the provider market.

- Agile working based on service needs as opposed to historic ways of delivery.

- The momentum of collaborative working as a system.

The recent appointment of a Transformation Manager will help the authority to review the changes implemented as a result of pandemic, such as digital, agile working, process changes (assessment and review), with a view to identify the areas that should be taken forward and embedded as transformation programmes. Key to the success of this work will be the consultation of stakeholders to ensure any changes are beneficial to the residents, staff and organisations.

What should we stop?

- Need to reflect and acknowledge that the events of the pandemic will have a long lasting impact on the traditional models of care. There is a need to widen the focus of attention to include the other areas of the provider market, such as home based care, as these are likely to be key support areas in the future.

- Move away from (as far as is practicable) different pots of money which will always act as drivers of organisational behaviours and silo working.

Summary of the local lessons learned

Whilst the pandemic is far from being over we can begin to critically reflect what needs to be retained, amplified and stopped as a result of the lessons learned, once the immediate threat of the pandemic has passed. Figure 13 is a useful tool produced by the RSA[37] to aid critical reflection and provides a summary of the key observations from stakeholder interviews.

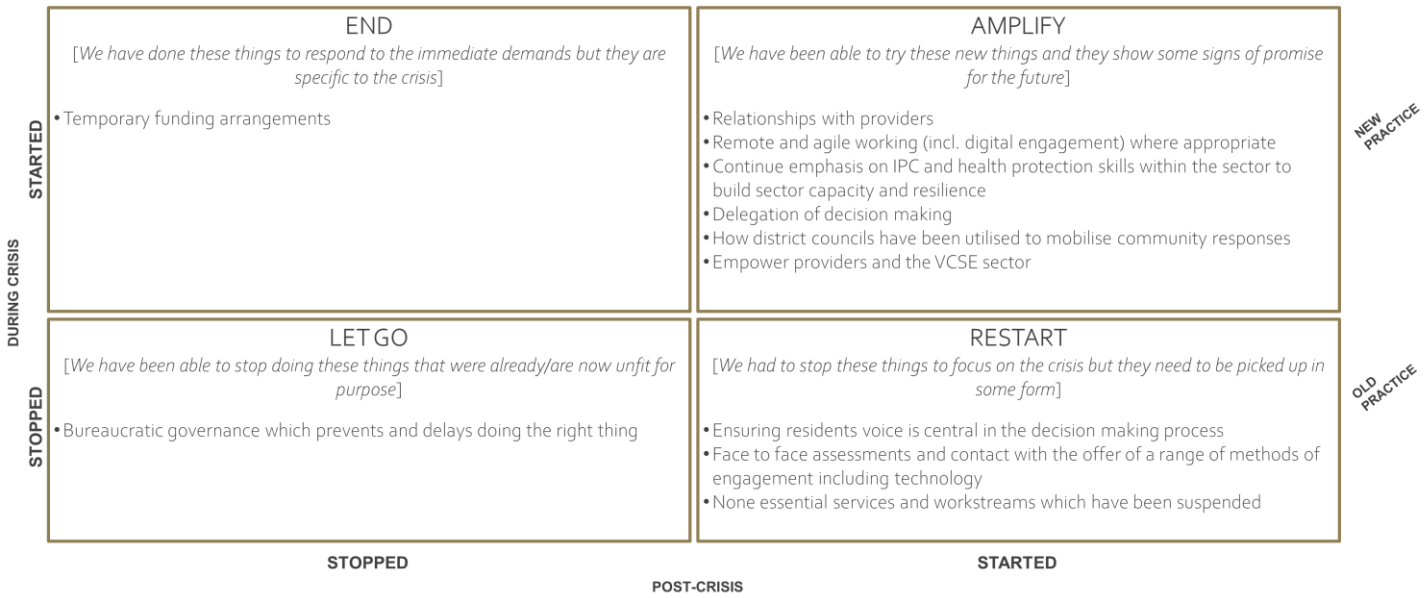


Figure13: understanding crisis response measures

[37] *How to Create Real, Lasting Change after COVID-19* by Ian Burbidge

Annex 3: Additional reference documents

Lessons learned and future transformation

[10 Leaps forward: innovation in the pandemic](#)
London South Bank University

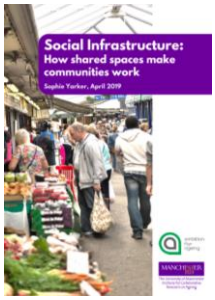
[Beyond COVID: New thinking on the future of adult social care](#)
Social Care Institute of Excellence

[Reimagining the future of health and social care](#)
RSA supported by Accenture

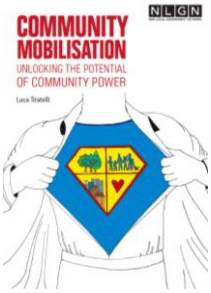
[NHS Reset: A New Direction for Health and Care](#)
NHS Confederation

Community resilience

[Developing social contact models in a time of social distancing](#)
Ambition for Ageing, GMCVO



[Social Infrastructure: How shared spaces make communities work](#)
Ambition for Ageing, GMCVO and University of Manchester



[Community Mobilisation: Unlocking the Potential of Community Power](#)
New Local Government Network (NLGN)

[Towards resilience: Redesigning our systems for a better future](#)
New Local Government Network (NLGN)

Impact on people's lives

[Caring behind closed doors: Forgotten families in the coronavirus outbreak](#)
Carers UK

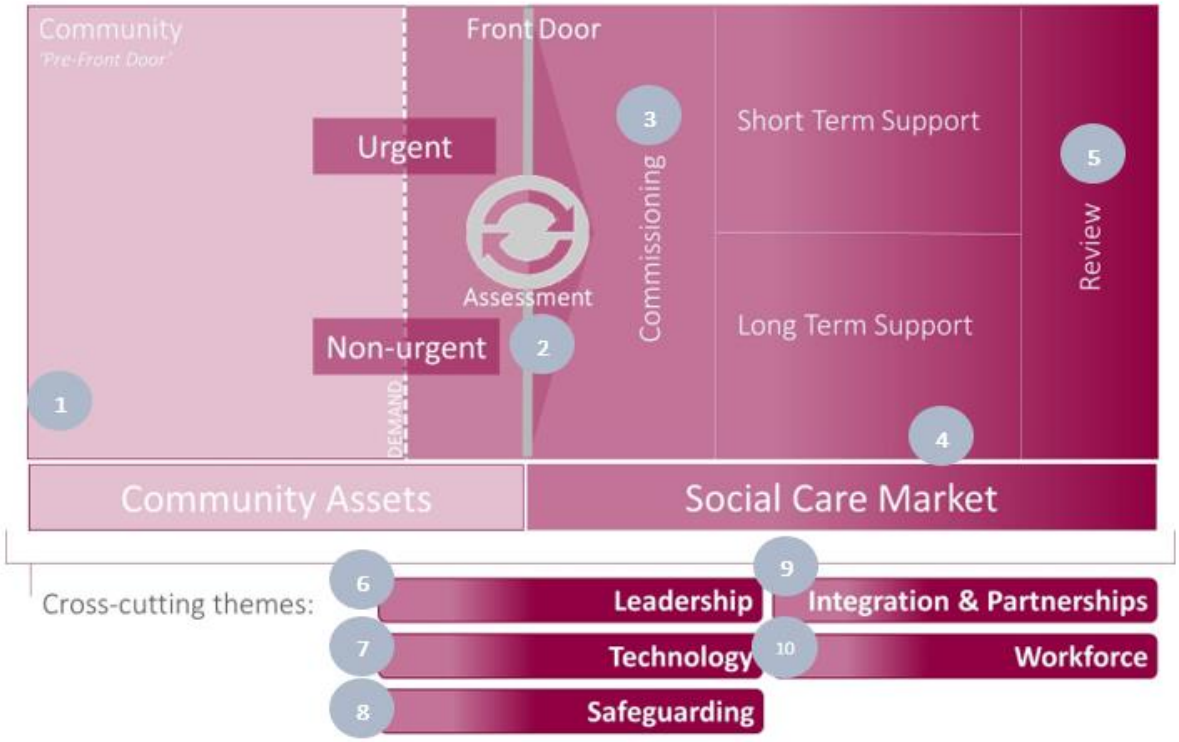
[A Telling Experience: Understanding the impact of Covid-19 on people who access care and support](#)
TLAP

[590 people's stories of leaving hospital during COVID-19](#)
Healthwatch and British Red Cross

Annex 4: Methodology and key lines of enquiry

Part A provides a detailed approach for engagement and a comprehensive set of key lines of enquiry, Part B is an abridged version of the questions which can be used to support local discussions should they wish.

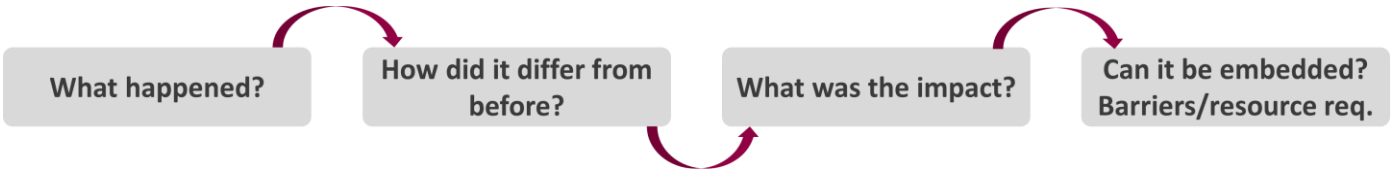
PART A: detailed stakeholder questions.



Key questions that should be asked of all interviewees are:

1. Has integrated working with health improved? If so, why has it taken a pandemic to overcome barriers and obstacles to integration?
2. How has your practice changed (activities, behaviours, with people/organisations? What has been the impact of these changes?
3. What one positive has come out of the recent pandemic that you wouldn't ordinarily have been able to do? (follow ups: why couldn't you have done this)
4. What challenges have you had to overcome and how was this achieved?

Each line of enquiry (question) should consider the following:



The questions overleaf should be used as a checklist and additional lines of questioning dependent upon who is being interviewed and the 'direction' of the conversation. *At the end of the interview ask if there is anything further they would like to add and make the offer to share the questions below for further consideration.*

(1) Community

Support in the community

- How are local businesses engaged during Covid 19 to develop service provision to maintain peoples' independence in their own home, e.g. cafes, shops and alike?
- Have you experienced a greater involvement from voluntary, faith and local community groups?
- Do you believe there has been an increase in the levels of unpaid care and support as a result of furlough and increased working from home?
- To what extent have community assets met traditional social care needs and what has been the enablers of this?
- How has mobility changed/been maintained to enable people to live independently?
- Based on the recent experiences is there anything potentially missing from the community?
- Are people accessing and using universal services differently?

Covid Hub

- How are hubs resourced? How are decisions made about where they are based? Do they redirect existing Council or other resource or is it new resource?
- How has the Covid Hub infrastructure and local response to supporting people shielding impacted on demand?
- What support did the hub offer?
- Where Hubs are integrated in a primary care infrastructure has joint working improved in relation to client assessment, reduce in demand, use of new technology in community hubs?
- Has the hub interface been beneficial for professionals working across the system and give examples, what was different, improved, needs to change?
- Has data on activity been collected, e.g. if known/un-known to services, types of support needs? Will this be analysed to inform future preventative/early intervention service offerings?

(2) and (5) Front-door / assessment / review

Demand

- Has demand increased, decreased or stayed the same?
- Are there any particular client groups where the trend has changed? If so why?
- Where has demand come from (urgent or non-urgent sources)
- How have people arrived at the front door? Has demand switched to different channels, i.e. from the 'physical' front door? Blue badge services? Town hall? Has e-mail, online referrals, ambulance, GP, referral routes changed?
- Has the time taken to initiate care changed? Has the wait time for support changed?
- Did you have an existing backlog? Has your backlog grown/reduced?

Assessment

- How have assessments been completed? Has the rate of assessments being completed changed? Have you done more/less/ the same?
- Have you changed your documentation or processes during the pandemic?
- If assessments were completed in a remote way how did you feel about that as a professional, what was different, what was your perception of that method of working and impact on the client?
- Has your perception of the clients' ability to promote their independence changed as a result of remote working?

- What has been the impact on people with dementia, MCI and clients with complex needs where capacity and the ability to process what is going on may be an issue?
- Did the solutions available to meet needs change (traditional models of care vs. a 'blank sheet of paper')
- What was customers perception of care services, for example residential care?
- Have step up and step-down pathways continued to be utilised? If not, what has been the impact upon client outcomes?

Review

- How did you continue the annual reviewing process?
- In cases of new assessments and placements was a 6-week review conducted?
- How has social work practice approached individual's ability to maintain their independence as part of their support planning during Covid?
- How were you able to identify those in need of support under different circumstances? How were individuals' resilience and their package of support 'stress-tested'?

(3) and (4) Commissioning, Social Care Market and Support Models

- Have any day-to-day commissioning, contracting, quality assurance or procurement processes been amended in response to Covid? What has been the impact?
- Have relationships with providers changed? If so, how and what are the reasons? To what extent will these changes in the relationship help or hinder future market shaping?
- What challenges have providers reported in delivering care? Has any care package or part of a care package had to ceased as a result of Covid?
- Have you seen innovation in service models and delivery? What are these?
- How responsive was the market to changing needs/demands?

(6) Leadership

- What was evident in the leaderships' behaviour during covid-19 within and across organisations?
- What were the component and skill sets of leadership that were positive and valued?
- How did it impact on the organisation infrastructure, staff, patients, users and carers?
- How visible have leaders been during the pandemic? More? Less? What form has this taken?
- What needs to change, kept, needs to be done differently in terms of leadership to promote a new society of person-centred and place-based working?
- How useful has national guidance and support from bodies such as SfC, PHE, NHSEI, CQC, LGA, SCI, SWE, HEE been?
- Has the voice of social care been strong? In what way have PSWs been utilised?
- What discussions were had with regards to Care Act easements? What rationales/scenarios had been played out? Under what conditions might easements have been placed and what new working conditions would have been in place?

(7) Technology

- What types of technology did you use in the remote engagement with the clients?
- What discussions have been had with regards to data protection?
- How have service users responded to the introduction of technology?

- Have any aspects of F2F care been replaced with remote technological solutions?

(8) Safeguarding

- Have safeguarding reports reduced or increased?
- How did you deal with safeguarding responses?
- Do you think there will be a potential impact from CQC's temporary suspension of the inspection regime?
- How have service users responded to the challenge of access to their home / personal space?

(9) Integration & Partnerships

- Has integrated working with health improved? If so, why has it taken a pandemic to overcome barriers and obstacles to integration?
- If the strategic intent before covid 19 was to work towards greater integration and partnerships with health during covid 19 would any of the lessons learned help to facilitate this moving forwards?
- Would any of those intentions or strategies be now rethought and why? i.e. hospital discharge procedures, the acute relationship with mental health organisations, how has the primary care integrated networks with social care worked during covid?
- Any evidence of good practice that would be kept and any areas that would be reviewed?
- Is there an opportunity to revisit the partnership relationship with the community as a whole and what has worked during this crisis that can be maintained forward to retain a new relationship one of equality, co-production and partnership?
- Has partnership working with housing improved as a result of the pandemic?

(10) Workforce

- What has the workforce's reaction to operating under more stringent general IPC measures been?
- How is the profile and value of the workforce being promoted differently as a result of Covid? If it isn't, why not?
- What opportunities has there been during Covid to achieve greater parity with health colleagues?
- Other than financial support, what have providers and commissioners done to support the workforce?
- Have retention issues been addressed? If so, how?

PART B: quick list of questions

1. What was good about the system's response?	5. What changes have happened?
2. What would we do differently?	6. What has been the impact?
3. What helped our response?	7. What should we keep?
4. What hindered our response?	8. What should stop?