directors of adass
adult social services
North West

North West Covid Lessons Learned

Highlight Report

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ARCC

1. Executive Summary

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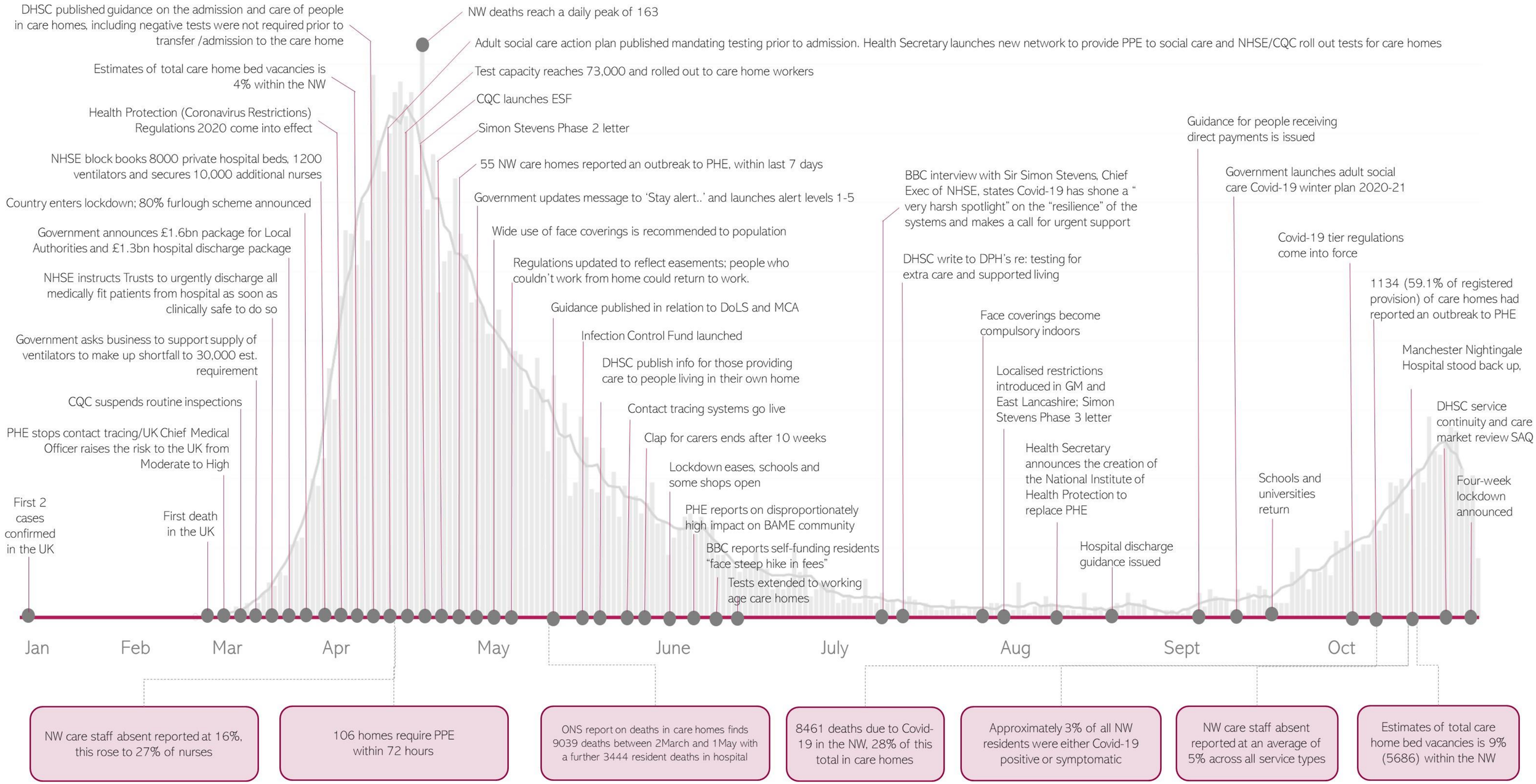
In July 2020, the North West ADASS Regional Programme Office (NW ADASS) set out to conduct a "lessons learned" review across the 23 north west local authorities, exploring the health and care system response to Covid-19 and the implications for the future direction of social care in the region (as defined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

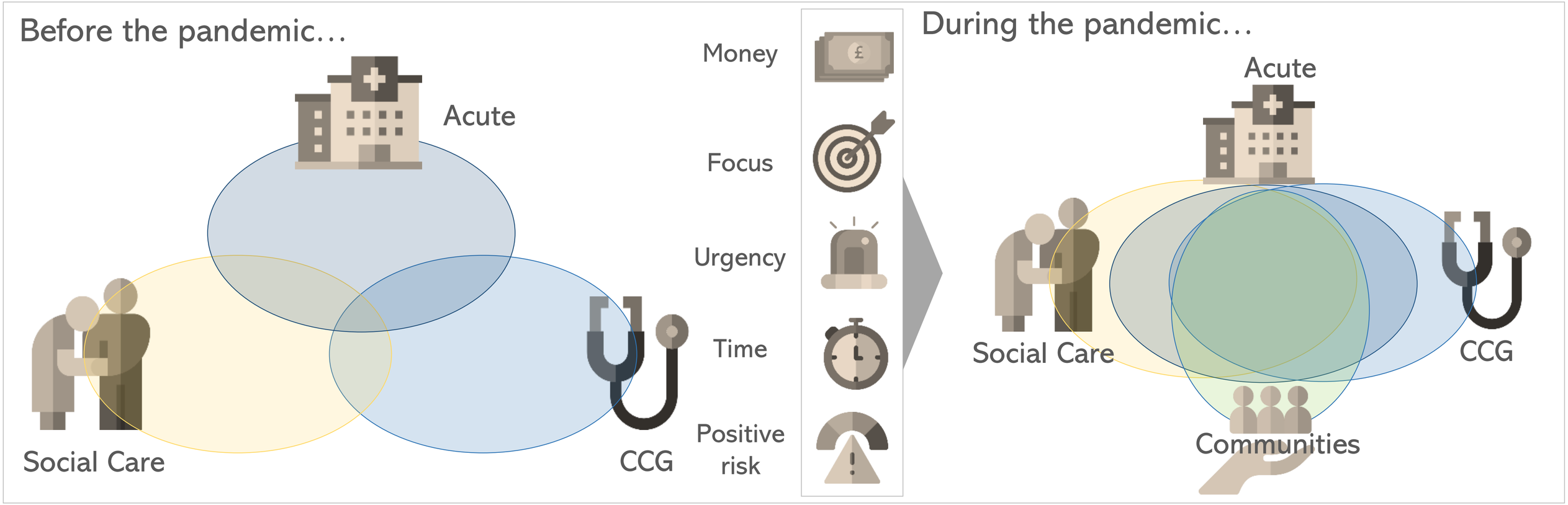
As the health and care system continues to wrestle with the pandemic; providers, regulators and system partners must be able to maintain the appetite to work together and at pace. We must make sure that we learn from the response to the crisis, that we lock in positive changes, and that we drive a new 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:

- In total, 250 hours of interviews were undertaken with over 300 stakeholders from across the system.
- 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.

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.


DHSC published guidance on the admission and care of people in care homes, including negative tests were not required prior to transfer /admission to the care home
Estimates of total care home bed vacancies is 4% within the NW
Health Protection (Coronavirus Restrictions) Regulations 2020 come into effect
NHSE block books 8000 private hospital beds, 1200 ventilators and secures 10,000 additional nurses
Country enters lockdown; 80% furlough scheme announced
Government announces £1.6bn package for Local Authorities and £1.3bn hospital discharge package
NHSE instructs Trusts to urgently discharge all medically fit patients from hospital as soon as clinically safe to do so
Government asks business to support supply of ventilators to make up shortfall to 30,000 est. requirement
CQC suspends routine inspections
PHE stops contact tracing/UK Chief Medical Officer raises the risk to the UK from Moderate to High
First 2 cases confirmed in the UK
First death in the UK
NW deaths reach a daily peak of 163
Adult social care action plan published mandating testing prior to admission. Health Secretary launches new network to provide PPE to social care and NHSE/CQC roll out tests for care homes
Test capacity reaches 73,000 and rolled out to care home workers
CQC launches ESF
Simon Stevens Phase 2 letter
55 NW care homes reported an outbreak to PHE, within last 7 days
Government updates message to 'Stay alert..' and launches alert levels 1-5
Wide use of face coverings is recommended to population
Regulations updated to reflect easements; people who couldn't work from home could return to work.
Guidance published in relation to DoLS and MCA
Infection Control Fund launched
DHSC publish info for those providing care to people living in their own home
Contact tracing systems go live
Clap for carers ends after 10 weeks
Lockdown eases, schools and some shops open
PHE reports on disproportionately high impact on BAME community
BBC reports self-funding residents "face steep hike in fees"
Tests extended to working age care homes
BBC interview with Sir Simon Stevens, Chief Exec of NHSE, states Covid-19 has shone a " very harsh spotlight" on the "resilience" of the systems and makes a call for urgent support
DHSC write to DPH's re: testing for extra care and supported living
Face coverings become compulsory indoors
Localised restrictions introduced in GM and East Lancashire; Simon Stevens Phase 3 letter
Health Secretary announces the creation of the National Institute of Health Protection to replace PHE
Hospital discharge guidance issued
Guidance for people receiving direct payments is issued
Government launches adult social care Covid-19 winter plan 2020-21
Schools and universities return
Covid-19 tier regulations come into force
1134 (59.1% of registered provision) of care homes had reported an outbreak to PHE
Manchester Nightingale Hospital stood back up.
DHSC service continuity and care market review SAQ
Four-week lockdown announced
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
NW care staff absent reported at 16%, this rose to 27% of nurses
106 homes require PPE within 72 hours
ONS report on deaths in care homes finds 9039 deaths between 2March and 1May with a further 3444 resident deaths in hospital
8461 deaths due to Covid-19 in the NW, 28% of this total in care homes
Approximately 3% of all NW residents were either Covid-19 positive or symptomatic
NW care staff absent reported at an average of 5% across all service types
Estimates of total care home bed vacancies is 9% (5686) within the NW



Unique conditions aligned systems, removed organisational barriers and enabled change.

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 the lessons learned and how these may be replicated post pandemic.

1 **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 focusing on 'who pays for what'. During the pandemic, guidance in relation to deferred charging, COVID discharges and additional monies removed these barriers.

2 **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. The pandemic simplified this and gave a singular focus; the phrase 'a common enemy' was cited on several occasions.

3 **Urgency**

Pre-pandemic decisions were not typically taken with great speed; this is in part attributable to shared objectives, the maturity of integration and pooled budgets. There was also a sense from stakeholders that governance and risk aversion throttled the pace of transformation and innovation. The pandemic gave all system partners a sense of urgency and permission to respond quickly and decisively.

4 **Time**

Pre-pandemic there was the day job and then the programme of transformation, with the latter often suffering due to capacity. With the pandemic 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.

5 **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. During the pandemic, staff 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.

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, 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

Application of the lessons learned to support the system response now

- We need to be mindful of the **impact of our attempt at recovery**, especially on frontline staff. The second spike in the virus has demonstrated how carefully we need to begin to phase elements of 'normal day-to-day' living.
- 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.
- 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. There will be a continual need for **strong, individual and system leadership** throughout the winter period.
- Ensure that the care workforce are not **forgotten and devalued.**
- 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.

2. Top 10 Lessons Learned

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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. 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) 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. The formation of Covid response 'hubs' and utilisation of volunteers was recognised by the system as a key component in protecting essential services.

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

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

- 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.

- Suspending historic challenges of **'who pays for what'** allowed the design and implementation of innovative services.

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

- Nature of the NHS "command and control" model at times felt like system partners were not equal and concerns were raised that the 'voice' of residents was lost and personalisation was affected.

- 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.

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.

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Illustrative examples of **strong and visible leadership** include:

- Several local authority **resource panel processes** were streamlined, 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**
- Use of **simple messages**: one stakeholder spoke about the introduction of 'obsessions' – simple, focused measures that would drive team behaviours, such as '70% of people leaving intermediate care without needing additional support'
- NW ADASS 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

Areas where there could have been **improvements**:

- Uncertainty around the distribution of the Infection Prevention Control Fund (IPCF)
- Loss of people's involvement in decision making

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. The provider market cannot be commended enough in how they have stepped up to the challenge of responding to the pandemic..

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'.

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

- 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 offering valuable learning opportunities for the region.
- Use of **home adaptations and assistive technology** 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.
- Forced the debate around some service offerings, such as the use of **residential care** and the form/function of **day services**

There remains a significant challenge post-pandemic, namely, without a medium to long term plan for social care, local authorities will find it extremely difficult to proactively develop the market. The impact of Covid-19 is translating into discussions with providers about significant fee uplifts for the next financial year.

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'.

"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".

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.

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.
- **Procurement being simplified** during the pandemic, which enabled commissioning to happen at pace
- General agreement that there has been greater **workforce flexibility** with home working becoming commonplace and productivity still being maintained.
- **Rapid implementation of technological solutions** such as Microsoft Teams, Skype and Zoom together with cloud-based services to enable agile working.
- The sector implemented **new payment arrangements** for social care providers and suppliers to help with cash flow challenges.
- **Access to data improved**, both from the perspective of provider returns and organisational data-sharing arrangements.

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 residents the length and breadth of the region have stepped forward as formal volunteers in the NHS, community hubs and with local VCSE organisations.

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.

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 most 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.

Some illustrative examples of **community responses** include:

- Cheshire East's **'People Helping People':** 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. The local intelligence gathered from the service is being utilised to shape and develop a new prevention and early intervention offer.

- **Age UK Wirral's Covid-19 Emergency Support Service**. Since 16th March, the service has made 175,000 contacts (equating to 1 contact every 2 minutes), including 16,455 wellbeing and befriending telephone calls, 1573 bespoke shopping trips and 327 prescription collections.

"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".

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 . The nature of the pandemic is likely to have suppressed some demand and enhanced other elements, e.g. physical frailty due to movement restrictions and mental ill health due to isolation and stress. Broadly, referrals and demand at the front door reduced 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 debate concerning overprovision within the sector is not new, issues of 'saying no' in order to maximise independence have been supported by the pandemic. There was a reason for staff to have these difficult conversations, providing an 'excuse' rather than a feeling that the system has to provide some form of care, simply out of duty.

Despite the sense 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).

Considering 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:

- Most areas reported **shifting a significant proportion of assessment and review activity to telephone and digital mediums** and streamlined the content of assessment forms
- There was a new **emphasis on lower level needs**
- Introduction of new streamlined hospital discharge guidance – **promoting assessments in the community**, resulting in people being discharged within a 3hr window, utilising revised processes and pathways. It is widely accepted that long term planning should only take place prior to hospital discharge in exceptional circumstances.
- Renewed focus on pathways from a point of crisis to home with support in which **intermediate care (IMC) has been seen as a principle and not necessarily a service**
- The level and regularity of **contact with individuals with direct payments** has increased significantly to ensure that people are supported

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.

A key challenge to the system moving forwards is how important data is mapped to inform decision making; the steering little and often concept, as opposed to sizeable and time limited analysis. There is also significant benefits in creating data sharing arrangements with other parts of the system to reduce un-necessary duplication.

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.
- 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). A business case is also being drafted for the development of a Markets Quality and Insight System that will host markets data.
- Most local authorities also developed daily dashboards based on key data (the things that mattered and were actionable) to support decision making.
- Pilots are being introduced to digitally enable care homes, thus increasing clinical and commissioning oversight.

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 suggested that public views of standards remain more pessimistic around social care than the NHS.

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

Attempts to raise the sector's profile through the launch of the CARE brand 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'.

Illustrative examples of this **lack of understanding include**:

- The time taken for **inclusion of carers** within the national recognition of frontline staff
- 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. The subsequent guidance stated that negative **tests were "not required prior to transfers/admissions into the care home".** On 16th April , the government updated this position so that trusts would need to test every single patient prior to discharge back to their care home or new admission to a care home (see chronology of events).
- 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.
- 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**
- **Testing** within social care services has been (and remains) an issue since the start of the pandemic.

* Taken from Challenges and solutions: commissioning social care during COVID-19. Social Care Institute of Excellence (SCIE), published: July 2020

Lesson 9: Social care workers are people too

Alongside colleagues from the NHS, the 1.49 million people working in social care in England have been central and critical to the country's response to the pandemic. 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.

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 focused 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 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.

3. Application for the System

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

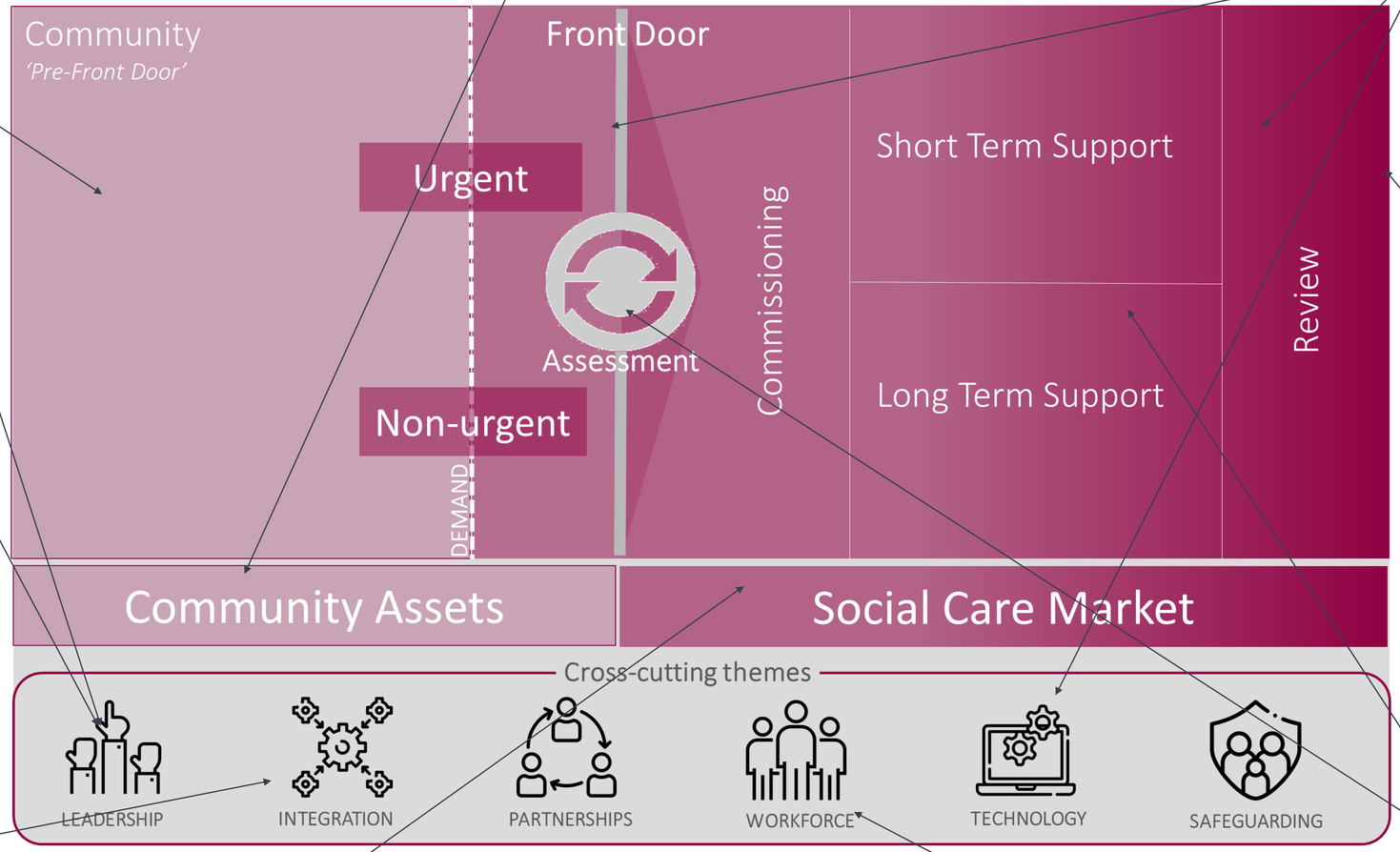
Lesson 5: People powered change: the power of communities to deliver solutions

Lesson 4: Old ways won't open new doors

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

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

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



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

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

Lesson 9: Social care workers are people too

Lesson 6: Demand and the concept of personalisation is fragile

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

1 Money

Shared understanding or mandate that money is not an obstacle to taking appropriate action or putting people on the correct care pathways.

Potential future options to replicate conditions:

- A long-term funding plan for social care linked to a strategy which addresses enablers 2 and 3
- Explore comprehensive pooled budget arrangements

2 Focus

Alignment of strategies and objectives focus on a single focussed objective has demonstrated the art of the possible in tackling issues.

Potential future options to replicate conditions:

- Identify a common objective which will lead to focused effort
- Define partnerships integral to delivering this objective
- Consider the measures of success
- Develop a joint strategy

3 Urgency

Reduced bureaucracy which focuses on the things that matter and allows staff/resources to focus on activities that make a difference.

Potential future options to replicate conditions:

- Redesign governance structures to focus on action and learning
- Replace lengthy and time-consuming reporting with proportionate activities
- Create open and transparent decision-making processes which safeguard accountability

4 Time

Recognising the value the system places on time as a resource and maximizing this through their ways of working,

Potential future options to replicate conditions:

- Establish new defaults and guards against returning to old ways of working.
- Managers to screen activities as they return to assess importance, how this was delivered, if it should return back to how it was, associated risks etc.

5 Positive Risk Taking

The pandemic demonstrated examples of positive risk taking behaviour based on professional intuition and a desire to protect the most vulnerable.

Potential future options to replicate conditions:

- Establish checks and balances
- Demonstrate the legal mandate from legislation, e.g. the Care Act
- Case stories demonstrating how positive risk taking should and should not be applied

- **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.** 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?
    - How would this impact stakeholders, e.g. what would residents say?

- **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.

  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

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

  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, linking to recommendation 8.

- **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:

    - 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.
    - 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 .
    - Visible and engaged leadership "the top seemed in service to the work" e.g. "how can we help"
    - 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.