Lessons Learned and Recovery Planning
Adult Social Care

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1. INTRODUCTION AND PURPOSE

On 23rd March 2020 the government announced that the UK would be sent into `lockdown' in an unprecedented step to attempt to limit the spread of Covid-19. The pandemic has impacted on over 190 countries; and in the UK it has presented us with the biggest challenge our health and care system has ever faced.

Across Cheshire East the majority of services were already overstretched with workforce challenges and increasing demand within significant financial constraints; and yet our health and care services and how we work collectively to deliver them, has been completely transformed in an extremely short space of time. We have attempted to capture the learning from this crisis and it feels right that we reflect on our response to the Covid-19 pandemic.

Adult Social Care has taken time to reflect on the changes in practice and service delivery in social care to understand the effect of those changes on the care sector and to assess the impact on service delivery post the current crisis. Reflections are informing the development of social care recovery plans and will contribute to wider whole system recovery to support the health and wellbeing of our local populations. The recovery plan will be used to inform longer term plans for the 'new normal' ensuring that the key principles of our Corporate Plan is taken into account.

Consideration will also need to be given to direction of travel pre Covid-19, in particular the focus on personalisation, prevention, an increased focus on the use of digital and technology and our Mid Term Financial Strategy; and the potential for further market change/disruption that may arise out of a 3rd wave. To inform our thinking moving forward it is therefore important that we understand:

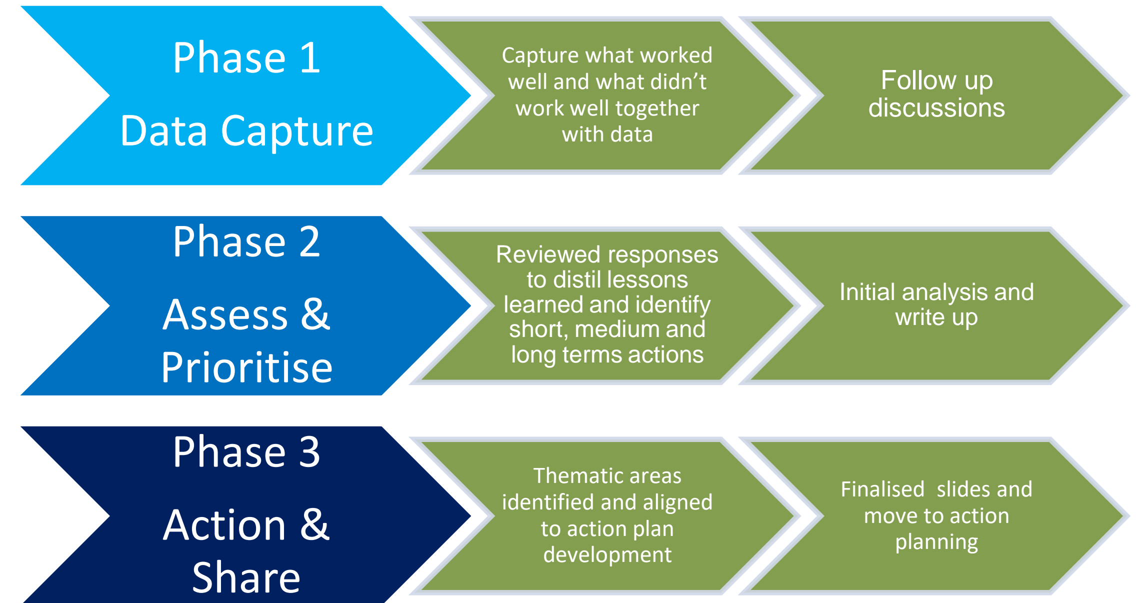
- The significant changes that have been made, the impact of these, and any unintended consequences
- We can retain the positive transformational changes that have come from this crisis
- We understand what the 'new normal' should look like and help shape the next phase of our strategic vision
- We need an evidence base to inform Recovery and Restoration planning
- The conditions that enabled our rapid response and use these to accelerate future service transformation.

2. DEVELOPING OUR APPROACH TO RECOVERY

- We have followed a phased-approach to recovery planning that will evolve as we move from phases of responding and managing the crisis through to service transformation

- The data capture included information from:
    - Operation and Commissioning Directors
    - Heads of Operational Services
    - Heads of Commissioning
    - Principal Social Worker
    - Performance and Data reports
    - Finance reports

- Further refinement of the report and action plan will be required as we move to further implementation.



3. CONSIDERATIONS

Initially few of the lessons learned and the resulting changes in practice are able to be evidenced. However, we will capture information as we continue this process on what has supported or enabled the change.

The Social Care aim is to work collectively to influence the reform and reset of social care within the wider context of population health and wellbeing .

The feedback in this report relates to the learning from the council and does not provide insight into the views of our populations in response to Covid-19. Understanding how the public's behaviours and attitudes have changed in response to this crisis will be collected over time and will be critical to 'lock-in' changes appropriately.

The impact of Covid-19 on our local communities and the changes in patterns of demand for health and social care services, will need to be understood and inform recovery planning.

Changes in legislation, decision making, governance, the financial context and leadership roles while the incident is ongoing have raised important questions about the future structure of the Health and Care system. This context provides a timely opportunity for partners to shape what a whole system approach to supporting population health and wellbeing needs to look like to best serve the population.

4. Lessons learned: ‘Top Ten’ lessons from feedback

1. Strong collaborative working and improved relationships with care providers has been positive and must be maintained and built upon moving forward.
2. There has been a strong focus on personalisation, with many imaginative service delivery methods identified. This should continue to be explored as an alternative to more traditional models of care.
3. The use of technology for both staff and individuals in receipt of services has been essential in supporting problem solving, delivering personalised care solutions and enabling effective service planning and delivery.
4. Decision making has been timely, through streamlined governance, changes to legislation and a different financial regime. Our governance processes have been agile and flexible and have enabled us to respond swiftly and safely, driven by the necessity to protect our communities and staff.
5. Many aspects of our future strategies have been accelerated and enabled; Integrated Discharge, work with Primary Care Networks and community health providers to deliver integrated health and social care in local communities and collaborative work with the community and voluntary sector and wider partners in the police, ambulance service and housing to ‘shield’ vulnerable groups within our population. This is an approach that we can build on as a foundation for a Population Health management.
6. This crisis has disproportionately impacted vulnerable groups within our population, most notably older people and people with a learning disability, which is worsening health and care inequalities, this needs attention.
7. Strong relationships with the Voluntary and Community Sector have been forged, they have become a real partners in the response to the pandemic and we need to ensure that they continue to be valued as equal partners as we move forward.
8. The pandemic has inevitably had a significant effect on the health and wellbeing of all of our staff. We must continue to support our staff through providing targeted health and wellbeing and mental health support.
9. We have seen positive changes in the behavior of our population during the crisis, for example, people working with their family and community to self care and not looking to more formal statutory support systems to keep themselves healthy and well; we should continue to work with our local populations and community services to retain this positive change.
10. There has been a real willingness to share information and learn from good practice which needs to continue, as we cant go back to silo working and silo thinking.

4. THEMES & OUR PRIORITIES

1	**System Leadership, Culture & Partnership Working** • Collaborative working and operating as a system • Quicker decision making and greater appetite for risk • Integrated services discharge planning • System level capacity management and working	• Strategic Recovery Planning • Integrated Commissioning • Hospital Discharge • Sustained and regular management meeting and leadership responsibilities • ICP development and implementation
2	**Market Shaping and Provider Sustainability** • Demand • Models of service provision • Safeguarding • Working with our local communities • VCS • Care homes • Testing and PPE	• Nursing Care • Residential Care • Hospital Discharge, Intermediate Care and Reablement • Home Care • Extra Care • Supported Living • Day Care • PAs (Direct Payments) • Preventative Low Level Support, Voluntary Sector and Universal Services
3	**Workforce** • Assessment & Review • Working virtually where possible • Flexible use of workforce	• Social Work • Carers • Provider Workforce • Volunteers • Generic Workforce and other LA Back Office Support Staff • Psychological Impact and Support
4	**Digital, AT & ICT**	• Understand changes driven through Covid response • Develop a short, medium and long term ICT / Digital Strategy
5	**Finance and Procurement**	• Identify and account for the financial impact of Covid • New cost landscape – projection/MTFS • Financial planning • PPE stocks & supply • Central Procurement Hub to support providers • Care market procurement and strategic planning
6	**Intelligence**	• Have live information on impact of virus • Flexible data flows to allow change reporting as circumstances and demand changes • Support the development of long term recover new landscape
7	**Premises and Estate**	• One public estate review • Care Provision Estate Strategy • Office requirements

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
1. System Leadership, Culture & Partnership Working	Built **great relationships** with partners during Covid which enabled us to "make things happen" at a greater speed and collectively.	All working together towards the same goal and common purpose Legislation Building on good relationships and systems working in existing local partnerships Streamlined decision making via CEMART/Operational Group
	Discharge guidance and discharge to assess model has worked well and removed barriers, want those barriers to stay removed.	Money has been available due to Covid and some of the relevant legislation has been suspended (e.g. Continuing Health Care and the Care Act). These changes have been beneficial so work on how we can keep the processes when the legislation is reinstated and use the learning to build on pre existing processes and arrangements e.g. Trusted Assessment, community follow up; and to redesign Hospital Discharge Services and pathways to ensure increased flow is maintained through winter.
	Speedy decision making - we have demonstrated that we have the ability to address and resolve issues as a system on same day	Clarity of purpose (i.e. now Covid but could be other agreed joint objectives) Collective decision making Legislation
	Enhanced neighbourhood working, linking Health and Social Care teams to Care Communities with better understanding of each organisation and their roles and responsibilities	IT infrastructure to enable remote consultation and assessment Doing the right thing has transcended organisations Previous focus on building base to host MDT teams was a block, this can now move forward at a much quicker pace through virtual teams. Barriers to information sharing removed.
	Public perception and expectation on our roles has improved, public appreciate our service.	Positive stories and national recognition of key workers Care workers in particular being valued alongside healthcare workers i.e. parity of esteem
	People **working collaboratively** to offer support for example, Council wide, mutual aid through partners, councils and agencies sharing good practice	Legally mandated command and control structures introduced to manage crisis System wide willingness to work across geographical and organisational boundaries in support of same goal and common purpose

5.What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
2. Market Shaping and Provider Sustainability	**Improved relationships** with community and voluntary sector,	3rd sector having a place at the table and parity with other sectors. VCS taking lead on and coordinating across sector Review the role of Communities Teams and their links to wider ASC
	We should continue to build upon the **excellent working relationships** and improved communications and engagement with the care sector which has been hugely important	Recognition of the importance of each others role National recognition of the valuable role care workers play in supporting vulnerable members of our community National recognition that the health service could not function without the support of social care
	Mutual Aid (across boundaries and across agencies) has been fantastic, particularly domiciliary care cross working arrangement	Legislation supporting temporary changes that haven't had to go through protracted HR or governance processes Barriers to information sharing removed (within bounds of GDPR)
	Further **integration / joint working with Health** – around operational issues / pathways / financial / commissioning / market engagement and doing joint messages to the market joint strategies and pathways and redesign projects	Giving people permission to just get on and work together IT supporting virtual working i.e. don't need to be sat together to work together.
	We have had the opportunity to **provide support in alternative ways** i.e. alternative options to traditional day care, for example linked groups for peer support and virtual day services pilot and greater use of voluntary sector and volunteers to support vulnerable adults, including the introduction of digital offer instead building based service, using technology to keep in touch, socialise and exercise, receiving support from community volunteers.	Legislation and in the absence of other services, peoples willingness to try alternative ways to be supported Need to take the opportunity to consider different more personalised services and models of care; and take an asset based approach to assessment We could remodel some services to ensure they are better able to 'flex' support as and when Service Users need it or in the event of a 3rd wave

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
2. Market Shaping and Provider Sustainability	Co-ordinating **training / education support** for providers	Necessity - needed to offer virtual training alternatives at scale and in pace with frequent changes to practice guidance Proved to be a good way to ensure that there is consistent good quality training across the market
	The importance of **infection control** now and as we move forward and our role in prioritising the rollout of Test, Trace and Vaccinations	Regular information from providers Evidence of the impact good IPC can have on managing and controlling spread of the virus. Good uptake of Vaccination within the borough. Test and Trace working well.
	Block purchase of care home beds at scale as a contingency to meet a surge in demand	Legislation and temporary government funding Consider potential annual commissioning of additional market capacity for winter use
	Recognition of the value in working with providers to develop robust **business continuity plans**	Learning from apparent lack of preparedness e.g. PPE, Testing, IPC. Take international, national and sub regional learning to inform joint work with provider to ensure that we are prepared for any further waves and have plans in place for other disruptive events

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
3. Workforce	We need to understand the positive change to people's lives from the **revised care offer** - assessment leads supported to understand the opportunity for alternative support and that the previous offer may no longer be a preferred option e.g. reduced demand for residential care and for home care. Changes to the trends in demand and service provision. Many want personalisation	Legislation and in the absence of other services, peoples willingness to try alternative ways to be supported Need to take the opportunity to consider different more personalised services and models of care; and take an asset based approach to assessment. Review SALT and ASOF data to inform trend analysis
	Make use of this opportunity of **heightened and changed public perceptions of the sector** to attract more people to work in care. We need to continue to celebrate and wave the flag for the care sector workforce and the importance of the role and give it the recognition it deserves and build upon the momentum	National, regional and local promotion of the work of key workers Public recognition of the valuable role care workers play in supporting vulnerable members of our community Public and government recognition that the health service could not function without the support of social care- parity of esteem.
	Changing the balance between utilisation of long-term and short-term / enabling services – i.e. changing the balance between the majority of people going straight into long-term services as opposed to firstly going through short-term enabling / rehab services	Individual and family choice not to go into care homes Limited choice of placement due to current restricted access to long term bed based provision Increased informal support networks from families/extended networks being furloughed and increased voluntary/community support Move away from care homes being the default offer
	7 day working arrangements in designated areas and undertake further review of requirements to expand to a full 8am to 8pm offer Staff have the trust of management to manage their working week	Flexible HR policies have been extremely useful and timely Legislation - reduced governance Increased flexibility / capacity over extended operating hours and weekend working has proved beneficial and should be reviewed to identify what should be retained as we move forward Staff more willing to work flexibly over 7 day period Mobile and agile policies to be based on Trust

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THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
3. Workforce	Greater use of **technology / virtual meetings** to support flexible working arrangements We should continue with the positive aspect of Agile working and working from home e.g. no time lost due to travel, no travel costs, no meeting room/conference hire costs, easier to work across larger footprints	Use of Microsoft teams / zoom to hold meetings. Virtual assessments and reviews (where appropriate) across both health and social care specialism including the use of digital platforms has been positive Changes to HR policies in support of this. Greater attendance at meetings virtually. We want to keep this as there are efficiencies in time and travel expenses.
	Corporate teams have responded in the crisis to provide a programme of **workforce learning**	Reduction in silo working, willingness to work together to meet the same goal, IT development support Good practice needs to be retained to support consistency of practice across Care Sector; welfare assistance; robustness of services during crises and greater professionalisation of the Care Sector
	Staffs have been willing to **work outside of their usual role** and do what was needed. Managers have place greater trust on staff to manage their working week.	Legislation/ mutual aid/flexible response from staffs, HR and unions. Flexible HR policies have been extremely useful and timely and we should work to see what can be retained Should consider having more generic job descriptions as this has allowed flexibility to respond in the crisis
	Previously some **practitioners over relied on managers to problem solve** for them, without actively seeking solutions themselves. This period has witnessed practitioners make decisions for themselves which have been appropriate, therefore, increased their confidence in their own practice.	Increased autonomy through remote working. Permission to 'get on and do'. This needs to continue to drive up autonomy in practice, producing a greater skilled workforce.
	Waiting lists for assessments (Social Worker and OTs) – doing today's work today model would be good moving forward. Processes have developed that do not promote lean working	The use of technology and acceptance of virtual assessment / reviews from both practitioners and service users Undertake peer Challenge/review of demand and lean processes

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
4. Digital, AT & ICT	Individuals, care homes staff and professions e.g. GPs, community nurses and social workers are willing to **carry out consultations and assess on a virtual basis**.	Change in public and professionals attitude borne out of necessity. A range of technology to support remote interaction between members of the public and health & care professionals e.g. skype, Microsoft teams, zoom etc. In addition, some areas have telecare/telemedicine systems in place. We have a fantastic opportunity to evaluate the most effective remote assessment and monitoring systems to support more personalised less intrusive interaction between the public and professionals; and the opportunity to establish virtual wards. Legal requirement for some assessments to be done face to face
	Staff having **greater autonomy to make decisions** has been good and has worked well.	Legislation, lean governance. Remote working. We need to look at processes and system permissions to build in this flexibility and Authority to make changes as we move forward
	We have seen an increase in the number of people opting to **use assistive technology** as an **alternative** to **or as part of their care package**	Legislation and in the absence of other services, peoples willingness to try alternative ways to be supported, We need to build and roll out AT pilots (proof of concepts) via AT consultation; and up the pace of deployment of technology for the care sector including to support remote staff working.
	The majority of the councils' workforce is **working remotely from home.**	National directive from government. Greater use of technology / virtual meetings to support flexible working arrangements e.g. Microsoft teams, zoom etc. Why does this need to change, what are the functions that require office based work

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
5. Finance and Procurement	LAs (and health) have received **temporary funding to support the care sector** and in particular care homes,	Government grants We need to understand the financial sustainability of the sector in the context of temporary funding being removed and changes in public demand for services. Public and government recognition that the health service could not function without the support of social care (parity of esteem) We need to review our HLBC and MTFS in the light of this funding
	Local authorities worked together and as individual LAs to use their buying power to secure PPE for the care sector, in particular for care homes.	All partners working together towards the same goal. Temp government funding to meet cost. We should use the learning to look at using our LA/Sub regional buying power to support external market with supplies e.g. consider potential for LAs to purchase goods to reduce cost of care, e.g. PPE, uniforms, food or to support the market to work together to increase buying power
6. Intelligence	There has been a recognition that we **need to share information across the system and originations to reduce risk**	Collaborative working arrangements, timely data sharing agreements We need to take the opportunity to fully embed shared care records e.g. care homes, work collectively to agree same data sets to provide system wide asks from a single data set; and maximise the use of **BI** to ensure wider focus on community requirements and impact e.g. third sector, statutory community services across health and social care
7. Premises and Estate	The majority of **council buildings** are now empty or are open for essential key workers only	National directive from government to work from home. Greater use of technology / virtual meetings to support flexible working arrangements e.g. Microsoft teams, zoom etc. Effective IT infrastructure and support We need to risk assess and plan for a safe return to work and understand the impact on LA, other Public Sector and provider owned estate.

5. What have we STOPPED DOING that we DON'T WANT TO RESTART?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE?
1. System Leadership, Culture & Partnership Working	**Can't go back to teams not sharing resources** / intelligence across boundaries.	Proved the extent to which information can be shared across geographies and organisations (in line with GDPR) Realising the benefits of systems wide views (intelligence) to support decision making and focus actions
	National bureaucracy is not always helpful - central directives regarding operational issues are better managed at a local level	Local Resilience Cells/forums have worked well. Arrangements have built on existing relationships and strategic forums and will therefore have potential to be sustained post Covid
	Strategic Planning - work on strategic/transformation plans has been on hold. Need to re set thinking/realign the vision.	Strategic Plans will need to be reviewed in light of Covid and to inform recovery planning. All plans/strategies will need to be reviewed to understand the impact and any potential change/redirection e.g. MTFS
2. Market Shaping and Provider Sustainability	A **lot of buildings based services** e.g. day services, respite have **been closed** in line with government directives around social distancing and IPC	Individuals, families and carers have worked with Social workers and commissioners to take up offers of alternative support . We need to continue to look at more **personalised alternatives** to traditional day care i.e. social care v personal care
	There has been a **reduction in the number of people accessing long term care**, in particular, we have seen a reduction in the number of people going into care homes	We have an opportunity to work with individuals, families, carers and system wide assessment leads to re imbed independence at home as the preferred model of care Redress balance between service users being committed to long term care against the use of reablement services and other bed based provision such as Extra Care Housing
3.Workforce	**There has been a change in commissioning of care, use of voluntary sector and PHP**	We need to ensure that when we **review any packages of care** we look for personalised care solutions and don't just automatically re-start what was in place before

5. What have we STARTED DOING that we will need to STOP DOING?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE?
1. System Leadership, Culture & Partnership Working	The **daily calls with partner agencies** and NHS will reduce as BAU starts to slowly be implemented. Internal regular calls across services has proved very successful	Regular contact with partners has been positive but contact needs to reduce to provide the capacity needed to move forward. Internal regular calls will continue on a reduced basis
2. Market Shaping & Provider Sustainability	Block purchase of care beds as a contingency measure in the event of a surge in demand	Requirement to have ‘capacity’ in all parts of the H&SC system Temporary government funding Capacity in the market is in excess of that predicted and public demand has reduced, discussions are required to determine the risk and sustainability of current arrangements
	We are have **provided support and supplies to services** that would ordinarily form part of their contract to deliver e.g. PPE, training, business continuity planning	We need to work with providers to agree what support is required and what both parties would like to see retained as we move forward- acknowledging the impact on the contractual relationship between commissioners and providers
	Commissioners have been holding **daily mutual aid calls with providers** which have been positive but these are reduced and now by exception	Positive working relationships with providers have been supported through daily mutual aid calls i.e. calls to discuss contingency plans, PPE usage and where daily concerns are addressed in partnership with providers and the LA. However, these are now reduced or ceased to create capacity for providers and commissioners to move forward.

5. What have we STARTED DOING that we will need to STOP DOING?

THEME	WHAT HAS CHANGED	WHAT HAS ENABLED THE CHANGE?
3. Workforce	To support the discharge to assess model we have implemented 7 day working, this has been on a voluntary basis. Further work is needed to understand the effectiveness and safety of the approach which will need to be evaluated.	Temporary HR policy changes / working arrangements have been established. If 7 day working is to continue formal HR policies / working arrangements will need to consulted upon prior to implementation.
	It was felt that when working from home was first introduced, the working day became longer as the distinction between travelling to/from work was removed. This has resulted in some **colleagues working very long days** with little time away from their screens. Whilst this practice is not supported corporately, practitioners need to recognise this is not an expectation and this needs to stop for their own wellbeing.	The changes to day to day working practice has blurred the lines for work life balance. HR have circulated policy to address provide clarity and concerns. If WFH continues at the current level this will need monitoring to support staff wellbeing.
	There is a project to review demand into ASC, together with review of processes, Going forward we will be looking at remodelling some of the process and staff deployment. Re-assessments will be taking place utilising strength based approach, and other options such as community solutions, telecare and personal budgets will be reconsidered.	The ability to identify and develop innovative solutions to provide care and support to our most vulnerable residents in response to Covid-19.
5. Finance & Procurement	**Additional temporary beds have been commissioned** to support and manage the impact of Covid-19 on the health and care system.	Flexibility of financial resources and the ability to commission additional beds at pace. We need to understand the new cost of care beds post Covid-19. (pathways 2,3)

5. What have we STOPPED DOING that we will need to RESTART?

THEME	WHAT HAS CHANGED	WHAT HAS/WILL ENABLED THE CHANGE?
2. Market Shaping & Provider Sustainability	The ongoing **quality assurance and monitoring of providers** ceased whilst responding to immediate needs in support of the Covid-19 response. We need to consider how will move forward with quality assurance and develop new ways of monitoring providers.	Recognition that access to services was limited to prevent infection (IPC). Consider alternative ways to gather QA information from providers e.g. self assessment and system wide intelligence to inform targeted interventions, with spot checks as an assurance mechanism.
	Business Continuity Planning, we need to look at how BCP's encompass both dealing with the emerging issues, whilst at the same time assessing/mapping what work needs to continue.	In action, response and delivery phase need to ensure lessons are built into plans for potential 3rd wave. Staff responded well to BCP together with 4 phase approach to managing pandemic.
	Carers support has been adversely impacted whilst informal care from carers has increased. - beginning to see increase in demand - need to understand pressure to carers and respond accordingly. Greater reliance on Carers Hub with fewer formal assessment and service offers. Reduction in direct payments.	Carers support has been impacted by both formal and informal carers becoming unwell, limiting capacity within a system that was already overstretched. Consideration should be given to the future commissioning of services to both formal and informal carers. Review DP strategy.
	Commissioning activity to support the development of **Future model of care (Emerging themes from the Newton Report and ADASS member engagement)** has been delayed.	Commissioners time was refocussed to responding to the crisis e.g. PPE, IPC, staffing, funding etc. and commissioning additional bed based provision. Previous developments and proposals for future models of care should be reviewed to ensure they will support the changed needs and expectations as we move forward.
	Scale and pace of **savings through the ASC demand management programme** has been impacted and includes: Payment on actuals / ECM for ASC, reassessment programme, AT in supported living project, Direct payments review, charging policy review, AT / Digital Strategy, Reablement, Single handed care. Review of demand into FPOC and processes has not taken place	Many services had significant savings to make and the financial impact of Covid-19 has exasperated this. All savings proposals should be reviewed in light of learning from crisis and in anticipation of a potential 3rd wave, prior to consultation / implementation. Demand management work to be reinstated

5. What have we STOPPED DOING that we will need to RESTART?

THEME	WHAT HAS CHANGED	WHAT HAS/WILL ENABLE THE CHANGE?
	Reduced demand at the **Front Door and for Early Intervention and Prevention** work during the initial months of the pandemic This has now increased beyond pre pandemic numbers.	In response to Covid-19 the demand initially on the front door reduced partly due to individuals supporting people at home for longer but also due to the significant role the voluntary and community sector have played within communities. This is now changing and there is an increase in referrals and demand. Consideration should be given to the role of the VCS and how they can enable people to remain within community services therefore reducing demand on statutory services.
	Reduction in the availability of **informal care evidenced by the large increase in referrals to Carers Hub, together with the employment of Carers Liaison Officer**	Analysis is needed to understand the how much informal care is provided and also level of support on offer to ensure that informal care provides to ensure this can be factored in to future business continuity planning.
	There has been a **loss in public confidence** in care homes and home care services which may impact on the demand for such services moving forward. **Review impact on publics loss of confidence in care homes and home** care.	Media briefings highlight the issues faced by care homes and home care services when dealing with Covid-19 in accommodation based services and entering into homes where residents / staff may be infected. Rebuild confidence in Care homes.
	Some provision of respite, day services, shared lives and alternative day services reduced	Government direction to stay at home, social distancing and IPC. Need to understand and assess the risk to vulnerable people and their carers and re introduce service provision based on risk via Day Care consultation.
3. Workforce	**Supervision** formal and informal has been impacted by limited staff / management capacity.	Supervision has been conducted remotely. Need to understand impact on staffs and managers and introduce/update supervision policies. Results of Pulse survey will feed this work
	It is felt that as soon as it is safe to do so, **some face to face individual** and team contact needs to commence. Not on an everyday occurrence, but for the purpose of moving forward into a new way of working.	Face to Face **assessments** (where appropriate) and full DST and CHC **assessments** recommenced alongside team contact. This will ensure residents and staff are supported appropriately. Recovery plans will include greater use of telehealth and assistive technologies. Reviewing attendance in the office on rota basis of 40/60% at home/in office

5.What have we STOPPED DOING that we will need to RESTART?

THEME	WHAT HAS CHANGED	WHAT HAS ENABLED THE CHANGE?
	Student social worker placements, AYSE, Student AMHP placements, recruitment and induction has all been limited during the pandemic	Capacity to support placements / recruitment and induction has been limited. Work needs to be taken forward to ensure placements are supported and appropriate recruitment and induction can take place. This will be particularly important if there is a 3rd wave.
	We continue to manage **DoLS** and advise as we have done pre pandemic. There has been an increase in DoLS applications from the managing authorities and this is being followed up by the DoLS/MCA lead. Also the transfer to LPS.	DoLS application and analysis is needed to understand if there are other factors that have contributed to the increase in applications to ensure residents are safe and processes and policies can be developed in the event of a 3rd wave.
	Staff have not been taking holidays during the past year as capacity has been limited	Agreement have been reached to enable people to carry over leave. Plans need to be developed to support staff to take leave in a timely manner ensuring appropriate service capacity whilst supporting staff to have a rest.
4. Digital, AT & ICT	B4B implementation was delayed System changes – such as Payment by Actuals (for all services) Restart work to merge Adult and Children's LiquidLogic systems	System implementations now proceeding and looking for other opportunities where systems can support practice

5. What have we STOPPED DOING that we will need to RESTART?

THEME	WHAT HAS CHANGED	WHAT HAS/WILL ENABLE THE CHANGE?
5. Finance & Procurement	A range of prevention contracts were temporarily ceased – these will be gradually commenced i.e. shared lives day care, Voluntary sector services changed to support pandemic effort.	Requirement to undertake essential duties relating to Covid. Refocus of priorities and a need to deliver statutory services has limited the delivery of preventative services. Work should be undertaken to understand the impact this has had plans developed to ensure service delivery can commence in a timely fashion.
	Full Financial Assessments were not undertaken/joint funding panels ceased temporarily. Some Families unable to make 3rd party top ups	Emergency guidance did not require financial assessments to be undertaken on discharge or where packages were jointly/wholly funded by health. Work should be prioritised so that capacity is available to undertake financial assessments moving forward. Joint funding panels should be re-established Review of 3rd party top ups required ASAP.
7. Premises & Estate	Majority of staff no longer working out of an office base.	Identify which staffs need to return in part/ or in full to an office base. Based on function not form Ensure office and environments are considered for return to work for some. Consideration to be given to social distancing and the need to be ‘on-site’. Identify the functions requiring Office base

7. Principles, Recovery Priorities

Principles

As we look to the next phase of our response, the re-establishment of full service, it is recognised that recovery will take place at different levels across local systems and the core purpose of this work is to ensure that, as we work towards a new normal, we are committed to working collectively towards the following principles:

- **Work with our communities to enable them to continue to support their own wellbeing; and where additional support is needed, offer personalised care that improves outcomes for individuals, families and carers.**
- **Minimise the inequalities exacerbated by the Covid-19 situation, particularly the impact on our older population and on people with a learning disability.**
- **Support the move towards a place based approach to population health and wellbeing and understand social cares role within this to deliver services which better meet the needs of individuals and local communities.**
- **Where appropriate, reduce variation in the delivery and quality of our services; and work with our provider partners to aspire to excellence.**
- **Make best use of our resources and understand financial sustainability within the new normal**

7. Recovery Priorities in PHASE 1: OVERLAP WITH RESPONSE

Maintaining the care market to deliver safe, effective care:

- **Work with PH and partners to ensure sufficiency of IPC support in care homes; and other community settings**
- Access to testing in all settings, particularly care homes and supported living
- Ensure adequate sources and supply of PPE/key supplies, to meet current demand and in the event of future outbreaks
- Work with health and other partners to enhance clinical in reach, medicines management and end of life support into care homes; and other community settings supporting people with high acuity
- **Continue temporary financial support and undertake modelling to understand the impact when funding ceases**
- **Reduce risk posed by Care Home sustainability: *over provision, lack of demand and resident isolation***

Safe re introduction of suspended services:

- **Work with community sector to re introduce suspended preventative support services**
- **Re opening of some building based day services and respite, supported by updated protocols and pathways for access to day services and respite**
- **Re opening of some building based intermediate care, supported by updated discharge protocols and pathways for access**

7. Recovery Priorities in PHASE 1: OVERLAP WITH RESPONSE

Workforce:

- **Ensure support is in place for carers as they return to work when furlough comes to an end**
- **Provide support to our shielded staffs to help them return to work**
- ***Ensure we have sufficient capacity in SW teams to complete strength based assessments/reviews as temporary Covid guidance is lifted***
- **Ensure mental health support is available for our workforce, in particular front line care workers and carers**

Supporting vulnerable people in our communities:

- Working with partners to meet the health, care and wellbeing needs of homeless people
- Working with partners to support people at home and in the community as shielding is lifted; and for those who are still shielded

Business Continuity and Winter Planning:

- Working with provider market to ensure plans are in place to meet winter pressures and that contingency plans are updated in anticipation of a further wave
- Work with health to imbed discharge to assess as the default discharge process
- **Development home closure protocol**

7. Recovery Priorities: Planning for the New/Normal

Understanding the impact and imbedding lessons learned:

- **Working with PH and other colleagues to understand and address the impact of Covid, particularly the impact on older people, people with a learning disability and BAME;**
- **Working together to understand current and future impact on demand for care; and the subsequent impact on the care market**
- **Developing a leadership/governance framework to replace the statutory Resilience Forums, that continues to support timely, effective system wide and sub regional decision making *(DASSs)***
- **Changing systems and processes to build the learning into practice going forward**

Building capacity to support people with high acuity in the community:

- Work with PCNs, community health and voluntary sector to develop *population health* approach to providing information, support, care services that are tailored to provide support to local communities
- **Work together to develop a model for Independence at Home that compliments a wider shift to a population health approach and imbeds recent good practice including D2A, use of technology, increased support from community and voluntary sector, mutual aid etc.**
- **Plan for expected increase in demand for care at home, including potential increased demand for assistive technology, adaptations and community equipment.**

7. Recovery Priorities: Planning for the New/Normal

Growing alternatives to traditional models of care:

- **Growth of Extra Care Housing**
- **Expanding the use of personalised budgets/Direct Payments**
- **Use learning from LeDeR reviews and MRF impact assessments to progress a new model of care for people with a learning disability: Shared Lives, a move away from shared to individual supported living, equal access to affordable housing and extra care housing, meaningful activity and employment**

Supporting our Residential and Nursing Care Sector to aspire to excellence:

- **Professional support for Care Home Managers**
- **publication of a quality assurance framework**
- **Continue and expand Audit of quality, local value and risk to care home stock, to support Market Diversification**
- **Capital programme required to consolidate position of future stock that is fit for purpose**
- **Programme of digital support in Care Homes- initially focussed on Electronic Care Records**

Supporting individuals, families and local communities to stay healthy and well:

- **Engage with customers over the support and services they would like to have moving forward**
- Work with voluntary and community sector to scale preventative support/social prescribing
- **Use learning from increased application of technology to support assessment for personalised, less intrusive care**

7. Recovery Priorities: Planning for the New/Normal

Workforce:

- **Work with providers to understand vacancy rates and skills gaps**
- ***Work with providers to address financial sustainability***
- **Work with providers and wider partners to develop our workforce through the introduction of blended roles and trusted assessment and growth in the number of Personal Assistants**
- **Increase the number of staff working in home care settings– 'Grow your own' approach, apprenticeships**
- **Work in primary and secondary schools highlighting career pathways in social care**

Guiding Principles

Our focus will be on improving life opportunities for individuals, their family and the community and place in which they live.
Our work will be guided by the following principles:

- *We will make use of our collective strengths to reduce inequality and improve health and wellbeing by working closer with public health and partners*
- *We will share good practice, learn from each other , reduce unnecessary variation and make best use of our resources*
- *We will look to provide the support and mutual aid our partners may need in times of crisis*
- *We will jointly support our shared provider market and workforce*

Next Steps

- Integrate Workplace recovery plans into this report
- Develop Formal Action Plan
- Share across partners and LA
- Engage with Stakeholders
- Co produce future Social Care priorities
- Identify opportunities to integrate with partners.
- Identify review of the plans