Unprecedented Pressure: Learning from complaints about council and care provider actions during the Covid-19 pandemic	
LGSCO Key Questions (February 2022)	**Service area / response**
Is there the opportunity for your organisation to run a 'lessons learnt' exercise related to its response to Covid-19?	Adults Social Care management team were involved with a GM exercise to review their response to Covid-19. (copy of final position to follow) Additionally we are planning workshops with managers and staff to reflect on learning from the pandemic which will inform the surge plan and business continuity plans for the future.
Is there any learning from the pandemic about rapid development of new policies, for example: a. How are they promoted externally and to frontline staff? b. How is their development documented – are there reasons for key decisions, for example about prioritisation? c. How are they consulted on proportionately and effectively, particularly considering the needs of people with protected characteristics?	It was important that new guidance was available for all, however it was also crucial that this was delivered in ways that was accessible to the people charged with dealing with the guidance. Development of policies and the more efficient methods of governance to support implementation was effective and efficient. An example is how working with Human Resources we were able to implement fast track recruitment processes and ensure they were processed through key decision and governance quickly to support increases in staffing capacity. All changes to policies and guidance were reviewed and communicated to internal and external agencies using a staff briefing system. An internal and external briefing document was sent out weekly to ensure that agencies and partners were updated on any changes. Plans were put in place to implement policy change quickly if prioritisation through Care Act Easements was required. This was supported by the more efficient methods of governance. However there was no need to progress this and implement policy changes. The PSW worked closely with legal to develop guidance to support proportionate decision making based on the Ethical Framework for decision making. This was aimed at senior leaders in terms of strategic decision making and frontline staff making day to day decisions. The Guidance was shared with our partners such as the CCG, ICFT and providers.

What lessons could be learnt around prioritising workloads – are staff appropriately empowered to make decisions about this in crisis working conditions?	It was important that staff were able to make "on the spot" decisions, most particular the ability of front lime managers to deploy resources effectively with immediate effect**.** We did not implement easements during the pandemic although we did make decisions around prioritisation based on government guidance at the time. An example would be that we did not close day services but asked managers to prioritise access and outreach to those individuals who had complex needs and or who were potentially at risk of carer breakdown. This was supported on a more senior level via the daily Silver Command meetings that involved senior managers who would be able to conduct daily appraisals of the situation and make informed decisions in a timely manner. As the pandemic evolved and risk-mitigating measures increased such as PPE, we reviewed and updated guidance regularly for staff in the social work teams in terms of making proportionate decisions regarding assessing risk re: visiting people at home or make virtual contact**.**
Did the organisation get the balance right between the need for rapid, often blanket, application of new rules, and making decisions that reflect personal circumstances?	New guidance was a continual feature of the ongoing pandemic. It was crucial to ensure that personal circumstances were considered in particular cases, for example ensuring those at end of life were supported appropriately with their families and friends. Additionally we chose not to close day services but to reduce activity to manage infection control whilst ensuring individuals and their carers needs were met. This reduced the risk of carer breakdown but also offered support to the most complex individuals either in the day service facility or via outreach in the community. In some circumstances this could not be facilitated for example in the lockdown of care homes where we needed to apply new rules to protect the most vulnerable, and there was little scope for flexibility. Hospital discharge was also a challenging area to offer choice and control to all. There were rapidly changing policies and procedures in this area as well as pressure in terms of increased demand. Discharges to care homes increased and choice was not always facilitated this was due to the pressures placed to discharge promptly and also availability of placements due to outbreak management in the care homes. Additionally it was important to ensure vulnerable groups were supported to receive the vaccine, ie individual clinics for those with learning disabilities.

Did the organisation give appropriate weight to key safeguards, such as the public sector equality duty, in emergency decision-making?	Safeguarding and ensuring inequalities were addressed as part of the response. This in particular included those who were at risk due to complex health issues relating to disabilities and mental health issues due to extended periods of isolation and shielding. Silver command did consider equality duties in decision making as this was often challenged during the pandemic particularly around care home guidance. Managers kept written logs of key decisions made at daily meetings.
Did the organisation (where appropriate) have the right levers and ability to influence the work of key contractors and others delivering services on its behalf during the crisis? Were contracts sufficiently robust and flexible to accommodate crisis working?	ASC worked closely to support the providers of care homes and home care. Daily check calls and twice weekly whole system meetings to pick up key issues, including management of outbreaks and continual updating of guidance. This is included the use of digital technology to ensure clinical oversight. Our relationships with key contractors are robust and very much based on collaborative working which helps in terms of flexibly responding to a rapidly changing operating environment. Communications were open with those organisations that were delivering services on our behalf and information and guidance was provided on via briefings as necessary. Commissioners were available, and any key decisions were supported by daily silver command meetings. We worked collaboratively with service providers to assist in flexing capacity to meet demand in terms of staffing and support.
Was the organisation able to effectively redeploy staff to ensure service delivery was maintained as far as possible? What impact did this have on the services staff where taken from and how was this managed?	Workforce pressures were very acute during the pandemic response. High levels of staff isolating. Daily decisions were needed to ensure priority services were delivered and staff were redeployed where necessary. Staff were redeployed from non-essential / non-urgent areas of operations to support front line services. A coordinated response to staffing support, the provision of PPE and testing were just some examples of this. Another example was the redeployment of social workers and assessors to support hospital discharge at peak times during the pandemic. The impact was that some non- essential functions were stopped to facilitate redeployment. There were no detrimental effects reported although some non-essential strategic plans were delayed / paused during lockdown periods. There have been recent concerns about staff wellbeing connected with the extended length of the pandemic. These staff welfare issues are part of our HR/OD response for the future.