HEALTH AND SOCIAL CARE SCOTLAND
Integration | Collaboration | Transformation

Community HEALTH AND SOCIAL CARE SCOTTISH GOVERNMENT

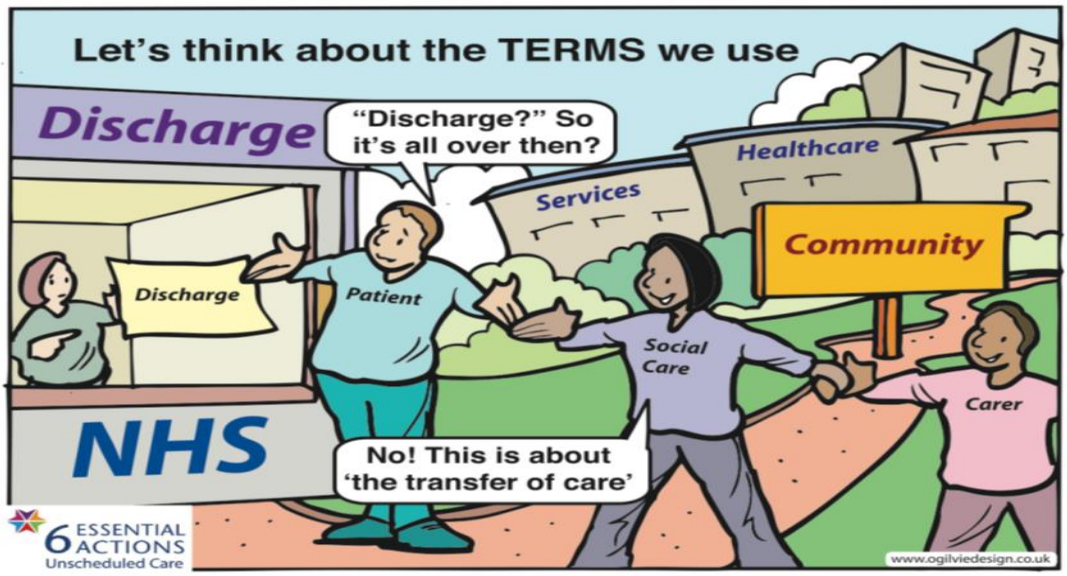
LESSONS LEARNED FROM REDUCING DELAYED DISCHARGES AND HOSPITAL ADMISSIONS

INTRODUCTION

The Cabinet Secretary agreed with COSLA that we undertake a short piece of work with Health & Social Care Partnerships to look at how delayed discharges, A&E attendances and hospital admissions all reduced significantly during March and April as the COVID-19 outbreak hit. We looked to establish what had worked well, what hadn't and what could have, and could be, done differently. Officials from Scottish Government Integration Division and Health and Social Care Scotland sought the views of managers and practitioners involved in hospital discharge, unscheduled care and social care provision.

This is the report of those conversations.

We are indebted to colleagues across all 31 partnerships for their time and contributions. See Annex A for a list of interviews held.



"People talk about delayed discharges but we think about it as a transfer of the care of our residents between different parts of the system".

Contents

FOREWORD

Health and Social Care Scotland has very much welcomed the opportunity to work jointly with Scottish Government colleagues on this Lessons Learned exercise around the Delayed Discharge / Unscheduled Care – or "Transfer of Care" agenda. For us this has been about hearing the voices of the wide range of our health and social care staff including those from third and independent sectors who work with these pathways every day.

This has been an important and focussed piece of work. We also recognise that this work sits within a wider context of interdependencies and determinants across the whole system.

This report highlights that throughout the pandemic our whole system was working within a different context – a context with different drivers, a common purpose that has never quite been experienced before, backed by funding and supported by different permissions.

The report very comprehensively outlines the conversations across the 31 Integration Authorities, the activity and impact, the experiences and observations of staff, and ably demonstrates excellent integrated work – across the statutory bodies but also real collaboration with our third and independent partners and indeed, importantly, our communities. It describes very well "what" we do – it also reflects some of the "how". We now need to build on the "how" – specifically leadership, behaviours and relationships, which will in turn positively influence the "how", where relevant, of our systems and processes.

As we go forward, we are keen that this work does not standalone, but links in to other lessons learned and reflective pieces particularly in relation to health and social care leadership and ultimately how this benefits the communities we serve. Chief Officers have commissioned a Reflective Appreciative Inquiry exercise, that may contribute positively to future conversations.

More specifically we see three areas of potential opportunity in guiding some next steps:

- To build on the "Framework for Integration" – focussing on the key success factors for the "Transfer of Care"
- To explore the possibility of putting in place a national workforce development framework & programme – that draws out and consolidates the deeper and very positive collaborative practice experienced by our Teams throughout the pandemic
- To engage with our Council and NHS Chief Executives on these reflections, and their reflections on this period, and those wider dependencies that draw our work even closer together.

EXECUTIVE SUMMARY

Existing processes have been proven to remain effective, but work was done at a greater pace with various impediments removed. Better partnership working, with shared goals and improved lines of communication, coupled with a clear focus on ensuring people were cared for in a more appropriate setting than a hospital, has undoubtedly contributed to reducing delayed discharges.

Those processes have been advocated for many years but have become more embedded. So we have seen a Home First approach being adopted in some form in all partnerships and discharge to assess being implemented in various guises. Seven day working is more widespread but discharge decisions are still focussed on consultant ward rounds, mainly occur on weekdays and are still prone to bundling on certain days. Intermediate care has been increased with additional AHP capacity temporarily being redeployed from hospital to the community while hospital services were scaled back or suspended. Some partnerships have deliberately moved away from a bed based step-down model to a more home based reablement model, while others have used suspended respite service beds to enhance their local bed based intermediate care provision.

The key factors that have seen delayed discharges and hospital admissions reduce by unprecedented levels are reported as:

- A “fear of hospital”, abiding by national messaging to stay at home and protect the NHS.
- Availability of families at home to support relatives, while furloughed or working from home.
- Changed attitudes to risk, with the risk of remaining in hospital or being admitted to hospital seen as greater, by the public and health and care professionals, than being supported in the community.

These have been underpinned by:

- **Shared goals and joint commitment**. There was a common sense of purpose and greater collaboration between teams and professionals.
- **The appetite of staff to embrace change,** coupled with a better understanding and acknowledgement of each other’s roles and responsibilities.
- **The promise of additional funding**. Partnerships were emboldened to do the right thing without being constrained by budget controls.
- **Strong leadership,** showing integration in action as partnerships were at the forefront of the response.
- **Permissions to act**. Long planned work has been accelerated as partnerships were given the power and freedom to act, with urgency.
- **Delegation of responsibility**, as local teams were empowered to do the right thing.
- **An increase in digital technology**, with remote working and virtual meeting technology seeming to have helped togetherness and joint working rather than hinder it.
- **Better lines of communication** between professionals, including access to expert consultant advice for GPs, other primary care professionals and care home staff.

- **Greater trust** in what social and community care could provide, led to seeing some long-held prejudices reconsidered.
- **Public perceptions and expectations changed**. Hospitals were no longer regarded as "safe" and families did not want their relatives to be there (or to a large extent in care homes as well) and were more willing (and able) to care for them at home.
- **Realistic conversations** were had with families as to the level of formal support that could be available.
- **Family members** being able to support relatives due to being furloughed or working from home.
- **The mobilisation of the third sector and volunteers** to support the delivery of food and medicines, carry out shopping and conduct a check-in service remotely using technology to combat loneliness and social isolation, particularly for those shielding.
- **Close contact** with isolated families has enabled continual review of support needs.
- **Staff redeployed** from the closure of day care services supplemented care at home with other duties also being carried out by those redeployed from other services, such as leisure.
- **Fewer admission** were seen for social reasons, socially isolated, deconditioned or people generally unable to cope, with alternative support mechanisms in place in the community.
- **Reduced flow** through hospitals allowed partnerships the time to focus on the more entrenched delays without having to move on to the next crisis from normally relentless activity coming along behind them.
- **Discharge to assess** has been implemented, partly due to the speed with which people wanted to get home, coupled with difficulties in social care staff accessing the hospital to carry out an assessment. It is more widely acknowledged that someone's home is a far more appropriate setting in which to assess long term needs than an acute hospital.

Barriers

The consistency of national messaging "stay at home, protect the NHS, save lives" was lost with the advertising campaign that "the NHS is open", which invited people back to A&E who probably did not need to be there. This also coincided with improvements in the weather and the lessening of lockdown in England, all of which may have contributed to the increase in A&E attendances.

The distribution problems with PPE and confusion over changing guidance on testing were also highlighted, with the early difficulties of getting PPE to front line staff a serious concern. One of the biggest challenges was the media coverage of care home deaths, with the alarmist reporting of care homes as "COVID rife" turning families against co-operating in the placement of their relatives. This was coupled with the care home providers' fear of taking people from hospital to possibly infect the home. This was exacerbated with the announcement of police investigations in to deaths, leading to fear of negligence claims, litigation or prosecution. There are long term concerns over the sustainability of, and reputational damage to, the care home sector.

The return to work of people following the easing of lockdown restrictions is likely to cause some difficulties in care at home provision, with services needing to pick up packages that had

been suspended. Partnerships have been in constant contact with families over the last three months to regularly review their needs and are planning for phased returns. The continued short-term redeployment of some staff will help alleviate some of the difficulties.

Two of the major barriers to further reductions in delays remains the adults with incapacity legislative framework and the entrenched complex delays (code 9).

NATIONAL SUPPORT

Partnerships were unanimous that the progress made would not have been possible without the promise of additional funding. They also felt that while the DG Health letters seeking specific levels of reductions in delayed discharge helped focus minds, they did not materially affect performance and progress would have been made regardless. Some partnerships felt the letters were an unnecessary additional pressure and left staff open to criticism if perceived "targets" were not achieved. Indeed, some partnerships expressed concern over how the emphasis on delayed discharge performance had left their staff exposed to criticism at a time when everyone was working relentlessly.

Treatment of social care staff was a regular theme in the conversations. The constant praise and goodwill in the early stages of the pandemic towards NHS staff was somewhat galling to social care staff who were finding themselves very much in the front line, feeling unappreciated. It was acknowledged that recognition of their efforts did belatedly arrive. It was also expressed that staff at all levels were suffering from fatigue due to the efforts put in.

BACKGROUND

The Expert Group report on delayed discharge[1], issued in October 2011, remains the blueprint for tackling delayed discharges. It found that the cause of delays could be split in to five broad categories, which have a degree of interdependency:

- **Pathways** – too many people are admitted to hospital when there could be safe and effective viable alternatives; too many people are moved inappropriately around the hospital system; too many people remain in hospital because there is a perceived 'risk' in discharging them.
- **Process** - which might include all delays in assessment as well as issues such as Adults with Incapacity. Process delays are compounded by system problems.
- **Systemic** – the patient who is in hospital is considered to be "safe" and ceases to be a cause for concern and focus for community staff who move on to the next crisis, reducing the priority of patient discharge.
- **Capacity** – which would include patients delayed awaiting care home availability (although data suggests this may in some areas be driven by flawed process rather than a local lack of provision), care at home capacity or access to specialist services, such as younger adults with brain injuries.
- **Resources** – There has been a growing number of patients delayed awaiting funding. However, this has the effect of transferring cost to the NHS where the cost of inpatient care is far greater. This is not a good use of scarce public resources.

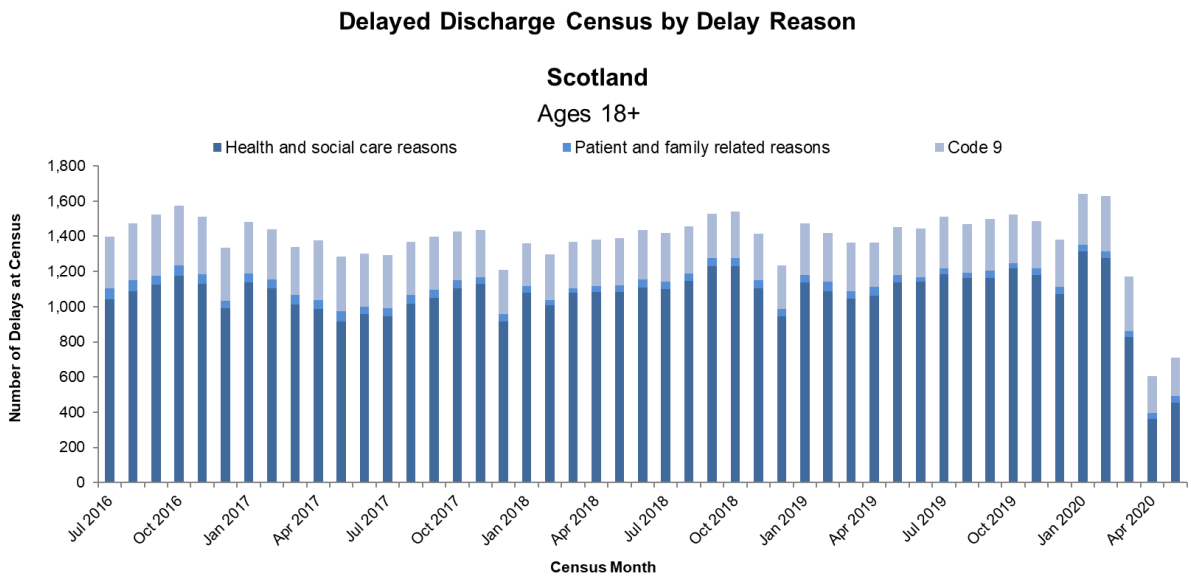
These have been found over the years to be compounded by deep rooted behavioural issues, different organisational and professional cultures leading to a lack of trust in which the default position has become staying in hospital. With hospitals being increasingly busy, staff tended, by necessity, to move on to the next crisis and the delayed patient could be forgotten, with all the known harmful consequences of deterioration and deconditioning. This has led to a blame culture creeping back in; where people don't trust each other there is a tendency to blame each other when things go wrong. As the delayed discharge numbers kept getting higher and higher, there was an acceptance of failure, fed by a perception of futility. Bad became the norm and nothing changed because everyone reverted to the "aye bin" way of working – we never change because it has "always been done that way".

Until COVID-19. When everything changed.

With the onset of the COVID-19 outbreak it was clear that delayed discharges needed to reduce, both in order to free up hospital capacity and create a better outcome for individuals at risk of acquiring infection in hospital.

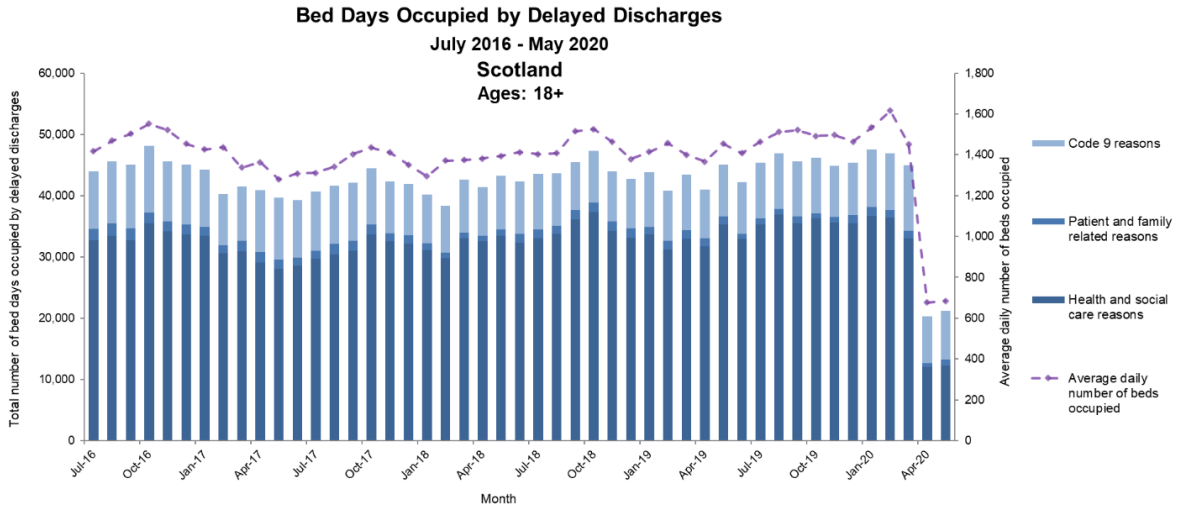
With a total of 1,627 delayed discharges at the February census, DG Health & Social Care wrote to all partnerships asking for a reduction in that total of 400. When this was achieved, he wrote again to partnerships on 27 March seeking a further reduction of 500 by the end of April.

[1] Delayed Discharge Expert Group report, October 2011



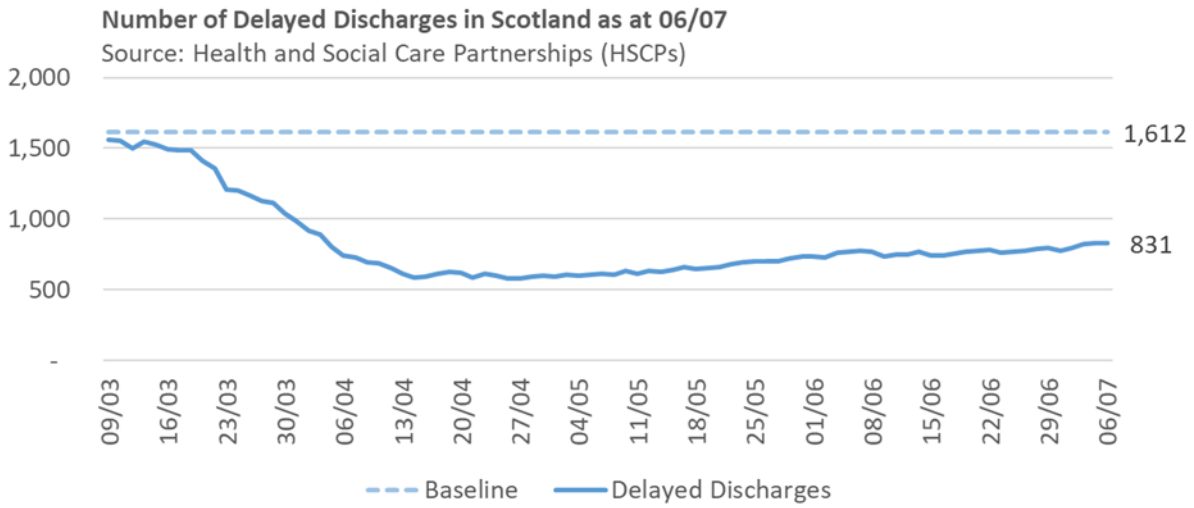
By the end of March delayed discharges, of any reason or duration had reduced to 1,171 and at the end of April to 604. These then rose at the May census to 711, but were still 51% below the level at May 2019.

COVID-19 has undoubtedly proved to be the stimulus needed to make significant reductions. The response to the outbreak has removed some of the historic barriers as well as providing the enablers and incentive for progress. It has in a perverse way created the necessary conditions to make the sort of significant progress that had long proved difficult to achieve. This progress has come at a speed that has never before been possible.

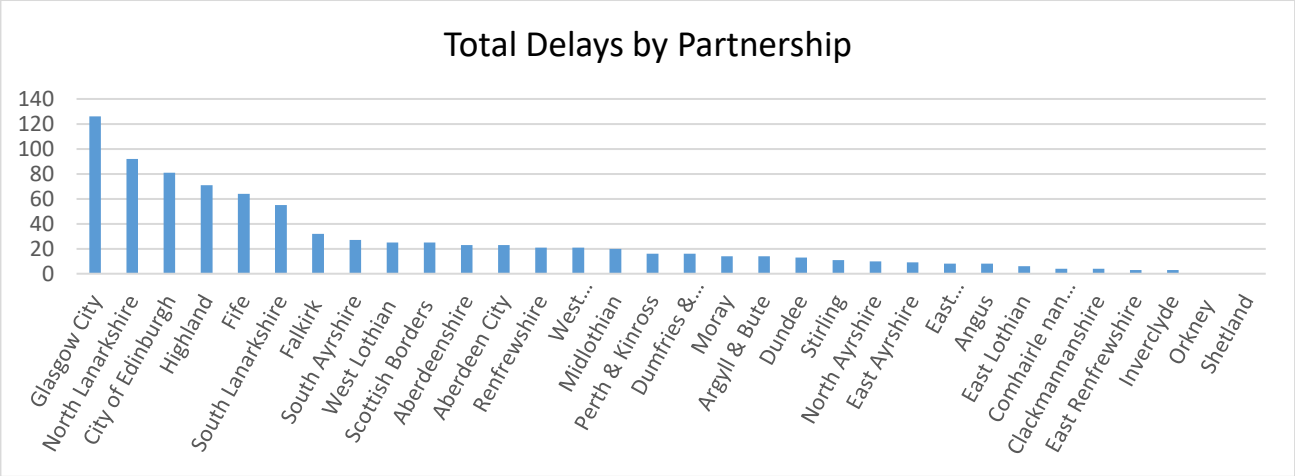


Bed days associated with delayed discharge, noted in the Expert Group report as a more appropriate measure of the effect on the whole system, were down from 45,061 in May 2019 to 21,225.

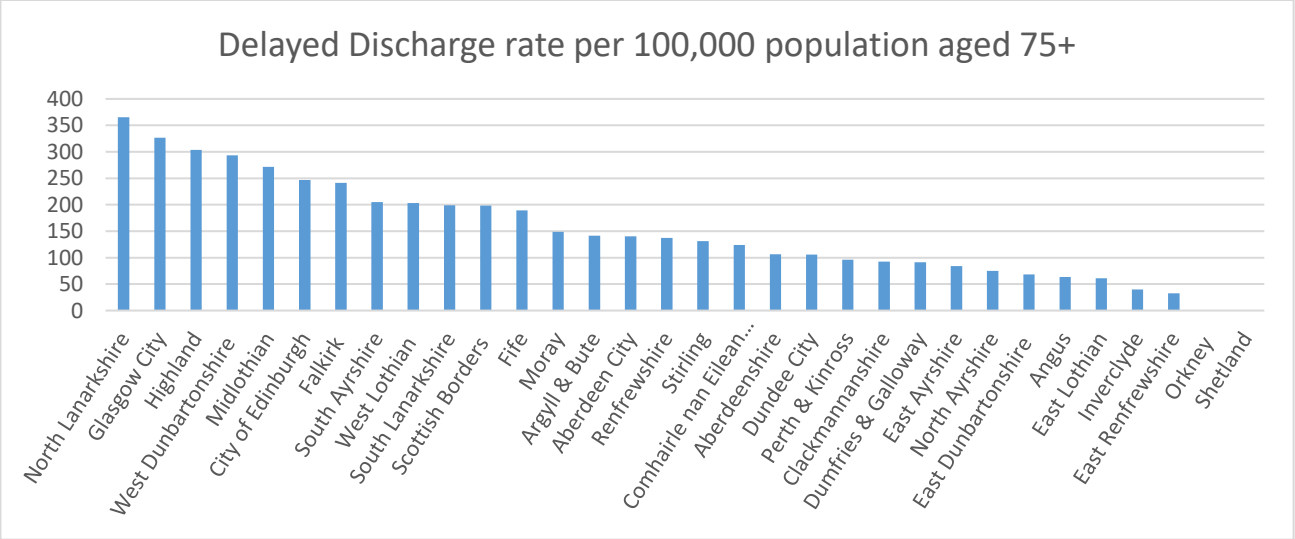
Since the start of March, partnerships have been providing the Scottish Government with their total delayed discharges on a daily basis.



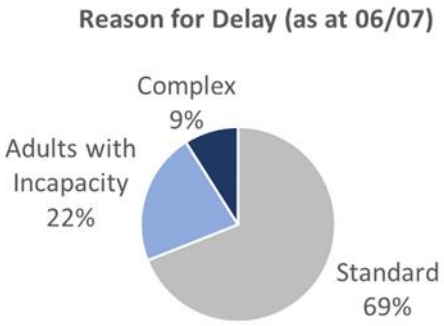
Performance has been variable across partnerships but not unexpectedly the biggest partnerships have the highest numbers.

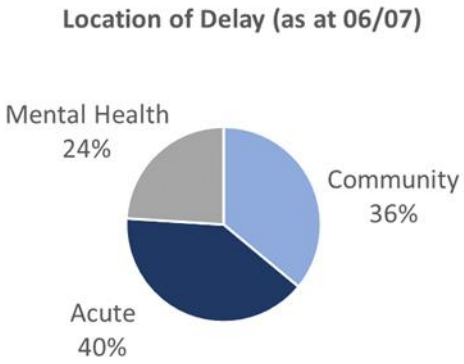


This can be seen as a rate per older population.



The daily management information also shows the location of delays and type of delay. At 6 July, 31% of all delays were coded as complex – outwith the immediate control of partnerships. 40% of delays were in acute hospitals, with 36% in community hospitals and 24% in mental health facilities.





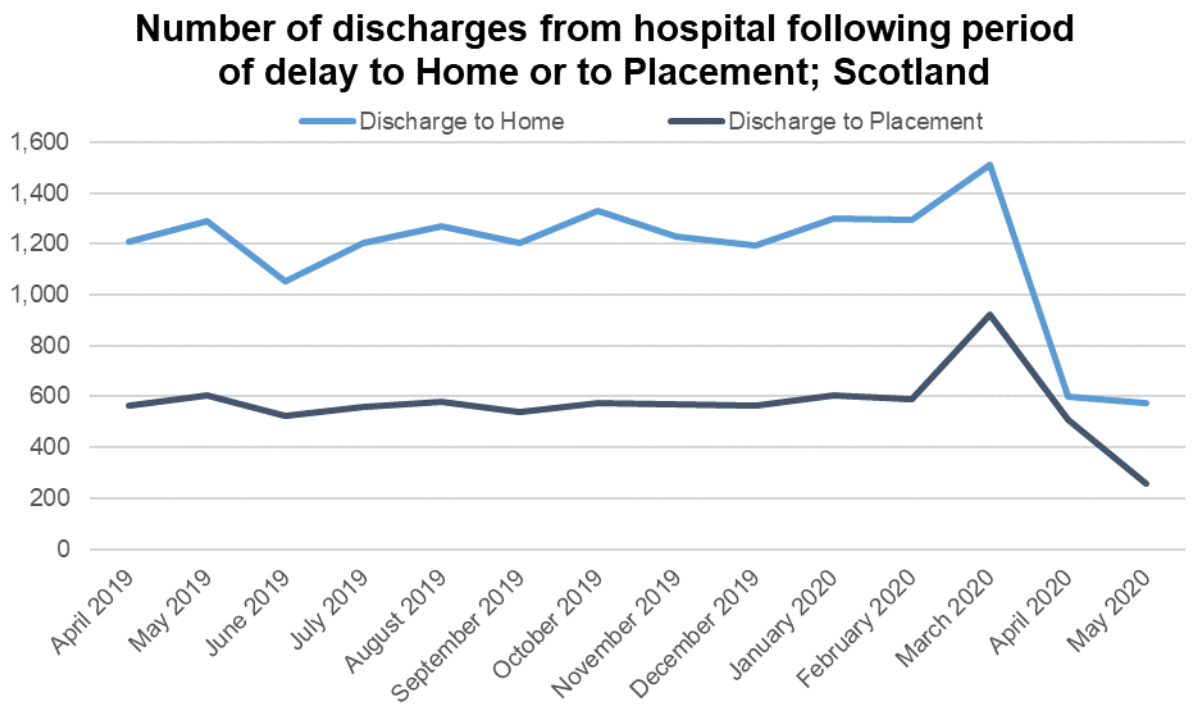
The following table shows the destination of patients who had encountered some delay in their discharge.

	Discharged to Home[1]		Discharged to Placement[2]		
Month of Discharge	Number	%	Number	%	Total Discharged
April 2019	1,207	68%	566	32%	1,773
May 2019	1,290	68%	607	32%	1,897
June 2019	1,053	67%	526	33%	1,579
July 2019	1,206	68%	559	32%	1,765
August 2019	1,267	69%	581	31%	1,848
September 2019	1,204	69%	541	31%	1,745
October 2019	1,330	70%	574	30%	1,904
November 2019	1,227	68%	570	32%	1,797
December 2019	1,194	68%	566	32%	1,760
January 2020	1,300	68%	607	32%	1,907
February 2020	1,296	69%	589	31%	1,885
March 2020	1,513	62%	921	38%	2,434
April 2020	600	54%	510	46%	1,110
May 2020	573	69%	257	31%	830

Source: Public Health Scotland

As can be seen, March saw a far greater number of delayed patients being discharged, with a significantly higher number of people discharged to care homes (it also saw a higher number going home) and April, with fewer than normal discharges, saw a significantly higher proportion of discharges going to a care home (although it should be noted that “placements” can include short-term interim or intermediate care).

After a spike in discharge activity in March, this has slowed down in April and May.



The following table shows the numbers and proportion of delayed discharges, who were discharged home or to a care home or intermediate care facility.

	Discharged to Home[1]		Discharged to Placement[2]		
NHS Board area of treatment	**Number**	**%**	**Number**	**%**	**Total Discharged**
Scotland	**573**	**69%**	**257**	**31%**	**830**
NHS Ayrshire & Arran	65	78%	18	22%	83
NHS Borders	14	61%	9	39%	23
NHS Dumfries & Galloway	-	-	-	-	-
NHS Fife	19	59%	13	41%	32
NHS Forth Valley	23	70%	10	30%	33
NHS Grampian	19	68%	9	32%	28
NHS Greater Glasgow & Clyde	38	32%	80	68%	118
NHS Highland	25	52%	23	48%	48
NHS Lanarkshire	237	85%	41	15%	278
NHS Lothian	98	72%	38	28%	136
NHS Orkney	-	-	-	-	-
NHS Shetland	-	-	-	-	-
NHS Tayside	30	70%	13	30%	43
NHS Western Isles	5	63%	3	38%	8

Source: Public Health Scotland

Notes:

1. Home includes discharges home, and discharges home with support.
2. Placement includes discharges to care home, and other placements including Intermediate Care.
3. These figures are a subset of the total number of discharges from hospital and include only those people who experienced a period of delay prior to their discharge and were discharged home or to a placement (delays in hospital that ended due to death are not included).

NHS Lanarkshire has a very high proportion of people going home but also an out of proportion number of delay episodes. It accounts for 18% of delays at the May census, 17% of all bed days associated with delays in May, but 33% of all episodes of delay.

Everyone agrees that delayed discharge is a bad thing. Everyone agrees that being in hospital when you don't need to be there is a bad thing. There is no 'upside' to this problem. It uses up valuable NHS resources, denies a bed to others that need it and, most importantly, it is a very poor outcome for the individual concerned.

Some partnerships have historically performed better than others. Almost all partnerships have achieved record low numbers at some point since March. This paper reflects the 31 conversations with key health and social care officials, some of which also included independent and third sector providers.

We will work with Chief Officers to ensure the lessons learned over the last few months are used to create the circumstances that will allow the incredible progress over such a short period of time to continue as a longer-term legacy of the pandemic.

SECTION ONE: HOME FIRST / DISCHARGE TO ASSESS

Almost all partnerships have adopted a Home First approach with many at varying stages of adopting Discharge to Assess. Home First is particularly well established in Inverclyde and has undergone a successful trial in Edinburgh. Some are taking pan-Health Board approaches. The three Grampian partnerships had already embarked on "Operation Home First". There was a local flavour to the models with Home First called different things in different parts of the country. One partnership described their approach as "Enhanced Community Support" as a form of *"hospital at home but prevention earlier in the journey".*

There is broad agreement to the principles – that an acute hospital is not the optimum place to assess people's long-term needs; that home is best when surrounded by familiarity; and that people should not ideally move directly to a care home from an acute setting. However, that is not a position that is yet firmly established.

One partnership succinctly summed up the Home First philosophy as *"get it right first time",* while another described *"own bed is the best bed"* ethos as underpinning their approach.

To an extent, discharge to assess has been implemented by default lately with the difficulties inherent in assessments within hospital due to access restrictions. In the main, initial assessment discussions took place remotely via telephone or Microsoft Teams (MS Teams), with fuller, longer-term assessments being completed when people had returned home.

The involvement of relevant practitioners in discharge decisions was felt to be better over recent months as technology has been adopted and virtual meetings become more commonplace. Several partnerships reported this way of working has improved communication between professionals and with the public. It was felt easier to bring people together remotely, when large travelling distances were involved or when booking a room could be problematic. It was also highlighted that this method created a better standard of discussion and could be less like an interrogation. "Virtual" morning huddles in the hospitals and Discharge Hubs have become the norm.

The use of Discharge Hubs is now commonplace but several partnerships highlighted their added value over the last few months. There is particular merit in involving the Hub early in the patient's journey and certainly prior to the ready for discharge date. The Hub works least well when it is seen solely as a problem solver, only involved when difficulties arise. For example, one partnership has a multi-disciplinary approach with all involved in planning for discharge from the point of admission, with everyone working towards an agreed planned date of discharge. This was not the case for everyone with one partnership reporting that 70% of referrals were received on the ready for discharge date.

One partnership is establishing sub-sets of the team for different specialties and has successfully moved away from a clinical bias to a position where there is mutual respect and each partner having an equal voice. An Integrated Discharge Manager is in place, with a social work background although an individual's background will perhaps become irrelevant as integration grows. Another partnership has delegated authority to team leaders within the hospital Hub to place people accordingly. There are conflicting views on this delegation to one

person or one team. While there is the worry of responsibility sitting with one individual rather than collectively, having named individuals, empowered with relevant financial and decision making authority, has been proven to work in facilitating timely discharge, helping to provide necessary challenge when obstacles are in the way.

One partnership described their approach as *"an assertive early in-reach model"* which utilises a dashboard to make staff aware of any resident that becomes admitted to an acute hospital. They can then track the length of stay and start conversations with family very early on in the process.

Other partnerships are building on the Home First approach, ensuring home becomes the default option for people being discharged and that the "why not home, why not today?" question is embraced by all staff. Some partnerships have established dedicated Hospital to Home (H2H) Teams to support this approach. In one partnership this team operates with a reablement ethos, supporting people home 7am - 10pm, with nursing staff working with individuals to establish personal goals for the near future in order to maximise their independence. The team also scan the daily admissions data to "pull" people back out, a similar approach to long established practice in another area where social work teams are in constant touch with ward staff about the on-going care of their residents. Many partnerships were supported in this general approach, particularly in regard to H2H, by their third sector partners. Two national organisations were referenced a few times, British Red Cross and Royal Voluntary Service.

Generally, partnerships reported decision making and discharge arrangements had been eased at the start of the pandemic. There was an accepted need to create hospital capacity, therefore discharging people who had no clinical need to be in hospital was deemed an urgent necessity. Coupled with a fear of remaining in hospital for individuals and their families, many of the historic behavioural barriers were removed. Prolonged delays over choice, for instance, were now dealt with speedily with a desire to be moved out of hospital quickly and family resistance dissipated. These factors returned as deaths in care homes became more widespread and this is examined further in section four. Managers also spoke of enhanced capacity in the system due to redeployment of staff from services such as respite and day care into teams which required additional resource.

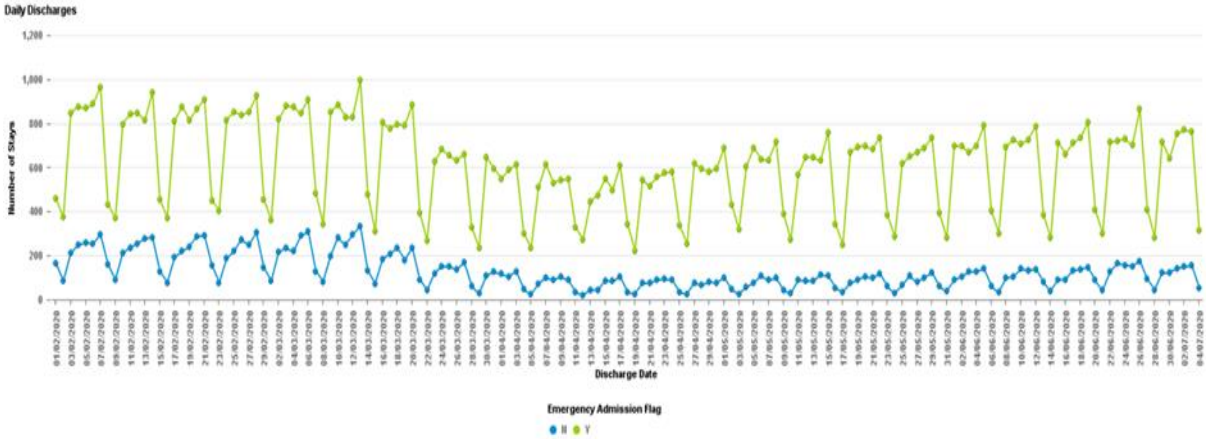
There was also more realism in conversations with people about their perceptions and expectations. The previous Chief Medical Officer, in her first Realistic Medicine report, said that doctors often prescribe more care for their patients than they would for themselves. So to a large extent does social work – social care needs tend to be overprescribed when done in an acute hospital. One of the positives over the last few months has been the constant dialogue with individuals and their carers to discuss their on-going needs. This has created some form of review and it may well be the case that full care packages will not have to be reinstated. Indeed, some people might not need any formal support going forward. There does appear to be more of a feeling that people are better able to care for themselves. One partnership has adopted the Three Conversations Model, which some other partnerships are also looking at. Another has a long established "Good Conversation" process based around "*what matters to you*".

Risk was mentioned throughout the discussions. Older people may have many things wrong with them but will likely have coped with them in their own way for a number of years. Hospitals are not there to "fix" all these things, nor necessarily to even identify some of them. An example given was of an elderly man essentially admitted because he was lonely. Leaving aside that he shouldn't have been admitted, there was then discussions in the ward about a move to a rehabilitation ward (for what?) and worse, discussion about a permanent move to a care home. These sort of discussions should not take place in an acute hospital. He needed to get home quickly, before deconditioning started with some support for the first few day while the third sector was engaged to deal with the social isolation/loneliness aspect.

We heard that such things had improved during March to May, that people were far more respectful of other's roles and responsibilities, while there was a "real camaraderie" with everyone working to a common goal, with a "just get on with it" attitude. One partnership described this as "*needing to get people to the right place, efficiently*" adding that "*medical staff were leaving social decisions to social care teams*". Worryingly though, there were reports of behaviours reverting back to pre-COVID as pressure on hospital beds changed. This was seeing people slipping back to their work silos and self-interests.

Several partnerships referred to the need for strong leadership within the hospital setting so that people did not interfere in the role of others. Ward staff suggesting a patient will not be able to go home or will not go home without a package of support has long been a problem, and very difficult sentiments to overturn once embedded in people's minds. Hospitals at the outset were doing "*just enough to move the patient on*" but have reverted to "*trying to fix everything in hospital*". Some areas saw geriatricians and other hospital based staff working in the community, which had borne the brunt of the crisis, in trying to support admission avoidance and had their eyes opened to what could be done outwith the hospital. Much of this activity was spread across seven days but there was talk that this too had started to revert back to old practices.

Discharge activity in particular is still not happening across seven days, despite most partnerships ensuring teams were available at weekends. Bundling of referrals and clinical readiness decisions is still commonplace and can be seen in the sudden fluctuation in the delay totals being reported to the Scottish Government on a daily basis. The following chart from SystemWatch shows discharge activity and graphically highlights the lack of discharge activity over the weekends. Partnerships also told us that there is a flurry of activity in the mornings through the week but very little later in the day.



These clinical behaviours require clinical leadership to resolve them. Many partnerships suggested the responsible clinicians, particularly in medicine of the Elderly wards, should be under the structures of the Integration Authority. This works particularly well in Tayside where unscheduled care was seen as a joint venture with the programme board joint shared by a senior social work manager and a clinical lead.

One partnership which described itself as having a "*two tiered discharge system*" described a visit to Tayside which revealed differences in recording process and a sense there was a *"whole system change in mindset"* they were keen to learn from. This was a good example of shared learning between partnerships and further visits between the two areas are planned. The demographic of a particular area was also considered to have an impact on the length of delays. For example, one partnership with a largely affluent health literate older population described them as *"not people who are to be hurried about care home choice or persuaded to deviate once they have made a choice".*

There did not appear to be any insurmountable barriers to fully adopting a Home First approach and a Discharge to Assess policy. Long standing behaviours and attitudes to risk seemed to be the main obstacles. There should be some simple rules, such as desisting ward staff from referring to long-term care needs during an acute episode; not carrying out a full assessment of need in an acute hospital; and not transferring anyone directly from acute to a long-term placement in a care home unless unavoidable.

Early engagement with social work, multi-disciplinary working and engaging with the third sector to provide short-term support on discharge are also key.

Adopting the principles of the "end PJ paralysis" campaign, with its key messages to "get up, get dressed, get moving", would be helpful in avoiding the deconditioning of patients, with the subsequent loss of independence and life skills that a prolonged stay in hospital can provoke.

> *"Nothing regarding COVID was revolutionary – but it enabled faster and deeper business as usual".*

SECTION TWO: CARE AT HOME

The vast majority of partnerships interviewed indicated their care at home service remained fairly stable and resilient throughout the pandemic. Partnerships described the key areas which helped sustain the delivery of care at home as:

- The use of redeployed staff from closed services or use of fast track recruitment to provide additional capacity on both the front line and administrative support. Some partnerships undertook initial modelling at the start of the crisis in an attempt to predict levels of sickness absence.

"We anticipated 25% of staff to be off…so we put jobs out to advert and redeployed staff. The Learning team developed 3 days of hot training and around 50/60 people were trained".

- The suspension or reduction of existing care packages by clients. There were two key reasons for this:
  i. Increased availability of family due to staff furlough and people working from home.
  ii. A reluctance to have care workers in the home due to risk of infection.
- Reduction in admissions and flow through hospital resulting in a reduction in requests for care packages. This reduced flow also helped partnerships address the backlog in delays.

One partnership, which described itself pre COVID-19 as having real challenges and complexities in relation to their care at home service reduced their service level to critical and proactively negotiated on each individual case with family. They described often a fundamental lack of understanding by other partners in the system on the *"critical importance of care at home in terms of shifting the balance of care to home".*

It was also clear that joint working both between partnership colleagues and external providers had strengthened during the crisis, with increased open communication, through virtual meetings and huddles.

"We have recognised that we are all one big team. The relationship important before COVID have become even more so and have grown during this period with our providers."

Taking a Home First: Discharge to Assess approach has also proved beneficial; providing a more realistic assessment of people's long-term needs, rather than quickly over-assessing. Some areas developed or scaled up their hospital to home services to provide a bridge home, before long-term care was put in place.

Clients who had chosen to reduce or suspend packages due to family support were contacted regularly; as one manager described *"so we have assurance that nobody was left at risk".* Some partnerships were not expecting a huge surge in demand for services as lockdown restrictions start to ease and people returned to work. In fact, some had used the opportunity to review and reapply eligibility criteria in order to maximise any reablement gains and opportunities for independence.

TECHNOLOGY

Where care packages were reduced or suspended partnerships put systems in place to support clients, families and carers and ensure they were safe and well. This was done in a number of ways using technology such as Near Me, Ms Teams, telephone calls and "signposting" websites. One area also developed a series of YouTube exercise videos to support people with their rehab at home. However, some concerns around the ability of all service users to access technology need to be looked into and addressed.

Local teams also benefited from the use of technology to carry out assessments, and hold virtual team meetings, with many areas reporting that teams were working better virtually. Technology also proved vital in supporting staff wellbeing, particularly with a large number of care staff working from home. The use of MS Teams proved popular with many areas, which allowed staff to keep in touch with each other virtually.

> *"Staff feel more connected all round with the introduction of MS Teams, despite working remotely."*

However, some areas did report issues in accessing suitable technology such as smart phones and council email addresses to enable home working.

Many areas are now thinking about how they can continue to make use of technology to support clients and engage with colleagues and stakeholders over the longer term.

WORKFORCE

Staff absences were an issue for many areas. Indeed, in some areas the care at home staff were described as an ageing workforce, which resulted in a number of staff shielding. In general, once regular testing of staff commenced areas saw absences reduce significantly as people had the confidence to return to work knowing they had tested negative. In fact, interestingly, one partnership remarked *"sickness absence levels if you take COVID out of the mix have never been better".*

The Chief Officer in a partnership which experienced the early death of a social care worker described staff as being *"hit really hard by this".*

All areas reported the use of redeployed staff to support care at home. This included staff from closed care services such as day centres, respite and clinics to provide homecare. Library and leisure centre staff were also used to provide back room support, and with appropriate training, home care services.

The increased volunteer workforce also provided vital lower level support to local communities, this has included the delivery of groceries and prescriptions to shielding patients. This has been particularly noticeable in the smaller remote and rural areas, where small communities are 'used to looking after their own'. A manager noted how helpful the use of community volunteers was, particularly in relation to the prevention and social isolation agenda. Most partnerships described the support for those shielding being led by the local authority, often in partnership with the third sector. One partnership described setting up a Persons At Risk (PAR database) who they contacted and, if needed, referred to the humanitarian arm of the response.

One partnership did express a potential worry around an unintended consequence of COVID-19 that *"people who could previously independently access resources in the community have fallen back on people helping them during the lockdown period….so they might now have increased dependency"*.

Many areas felt there was a real opportunity to promote the care sector as a long-term employment opportunity. Seeing it as "*a chance to recalibrate our caring industry*".

Access to PPE

Many areas reported issues with accessing PPE at the start of the crisis, with concerns over quality and the ability of independent providers to access it. All areas set up local PPE hubs to help distribute PPE across partnership services, with some areas also bulk buying and distributing to all sectors.

Going forward, the development of a national or regional PPE purchasing consortium would help address issues of quality and help share PPE fairly across whole sector.

A number of areas reported that the support of Public Health consultants during the crisis had proved extremely helpful in terms of addressing staff and union concerns around PPE, and providing advice and guidance on appropriate infection control procedures etc.

However, different guidelines and support for health and social work around infection control and safeguarding led to some confusion initially. The continually changing guidelines around the use of PPE were also challenging.

To conclude one partnership summed up how important care at home had been:

> *"Care at home staff have been the real unsung heroes of this pandemic. They are the people who really deserve the nationwide applause."*

SECTION THREE: INTERMEDIATE CARE

"Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland"[2] describes intermediate care as a continuum of integrated community services for assessment, treatment, rehabilitation and support for older people and adults with long term conditions at times of transition in their health and support needs. These services offer alternatives to emergency inpatient care, support timely discharge from hospital, promote recovery and return to independence, and prevent premature admission to long-term residential care.

Intermediate care can be provided in:

- Individuals' own homes, sheltered and very sheltered housing complexes
- Designated beds in local authority or independent provider care homes
- Designated beds in community hospitals

Partnerships took a measured approach to reducing delayed discharges by maximising capacity levels of intermediate care prior to the start of the COVID-19 pandemic in Scotland. Some partnerships placed a focus on the "person centred patient care" approach, especially around discharge planning. They also looked to reduce the length of stay in hospital for patients and incorporate a whole system approach to balance the correct level of care and facilitate discharge to the appropriate setting.

One area already had five housing with care flats with a voluntary provider, voids in those buildings were quickly adapted to provide an additional 10 flats to support the discharge of patients. Thirteen Supported Hospital Discharge Rooms in sheltered housing developments across the City were also available.

"Overall it's much simpler if you have an existing model and then need to do things quicker, than if you have to do something from scratch."

In addition to the above, the voluntary sector provided additional surge beds and interim beds across its housing with care settings which made a significant contribution to improving delayed discharge during this period.

"This was possible because of a "fantastic" collaboration between the provider and the partnership and discussions are ongoing about the possibility/desirability of sustaining this capacity."

[2] Maximising Recovery, promoting Independence: An Intermediate Care Framework for Scotland July 2012

Partnerships which had no intermediate care accessed additional care home places to support patients who either required a care at home service or who required longer rehabilitation. This work was supported with additional AHP capacity temporarily redeployed from hospital to the community while hospital services were scaled back or suspended. AHPs ensured care planning, risk assessments and appropriate supports were put in place to support patients.

Some partnerships commented that they did not need to (fully) utilise the additional care home capacity they acquired for intermediate care because the expected volume of patients they had modelled out in COVID pre-planning discussions, did not materialise. One area's care model ensured they did not need to utilise their intermediate bed capacity and noted that they had scope to use this for respite.

A few partnerships suspended their respite services to enhance their local intermediate care provision. Whilst this approach gave the partnerships additional capacity to manage the potential increase in demand, one partnership, assessed the increased risk for unpaid carers, noting that they should have maintained some form of respite for people with dementia to alleviate increasing carer stress. Another area also commented that they would like to see a return to planned respite for carer stress which was always beneficial but could be more important after extended periods of families providing 24 hour support.

Although not widespread, where utilised, seven day working proved beneficial and worked well.

Working Practices

Over the last three months, several partnerships identified effective in house working practises that benefited both staff and patients that they would look to maintain or enhance post COVID. For example:

One partnership introduced a "Pharmacy Perspective" where staff working within Intermediate Care settings requested medication support and advice for individuals who were planned to return to their own homes and had complex medication support needs which would be supported within a Care at Home service. This allowed the two Care at Home Specialist Pharmacists to provide detailed support to Intermediate Care teams, along with community mental health teams, hospital pharmacy and social work, in order to facilitate patients returning home. Support was provided around issues including covert medication, clozapine, and Adult Support and Protection issues around medication.

Another partnership are looking at how best they can utilise their step down beds more efficiently and how they can use it for both step up and step down.

One partnership wants to review the community hospital and care home capacity and delivery model which will be key to strengthening available options to improve outcomes. This will include consideration of the bed based requirements for intermediate care as step up/down capacity and a proposal has been developed to test this through repurposing of some community beds and alignment of key AHP and ANP to support this initiative as part of the winter plan.

Another is keen to review the number of different discharge pathways and give some thought to moving to a more blended approach to discharge. Previously, there could be a bit more "to me, to you" in the process and they are working to take a more "person-centred approach".

One partnership has continued to utilise their community team approach by seeking to prevent admissions to hospital in particular, but also to take strain off existing beds where possible and used phone and video calls as well as "attend anywhere" to make contact with patients.

Another moved to an entirely community based strategy so they can continue to push the home first approach. This shift in the balance of care enabled the closure of a 28 bedded intermediate care unit during COVID. An eight bedded unit for people with Mental Health difficulties remains available. The partnership has linked its rehab services more closely with social care, and refreshed links with the third sector, to build a more holistic view people's needs. Previously the partnership was perhaps overusing social care and under-using the third sector. Different pathways are now in place, and social care staff are used for the fundamental social care needs, but others such as Red Cross are vital in supporting people's other needs.

"The Red Cross Hospital to Home service is invaluable in terms of helping rapid access to a social care service."

One partnership described intermediate beds as something they would like to drop, precisely because they are only ever going to be interim. Some other partnerships expressed a similar sentiment. For some intermediate care is at odds with the *"get it right first time"* approach; therefore, rather than two moves, people would be in their placement of choice first time.

Moving interventions upstream to enable less deterioration in people. It's not about 'rest of life' but promoting someone's independence in relation to their current circumstances.

"The message to the public is that the social care package is an assessment and based on what you need rather than something that we have prescribed"

SECTION FOUR: CARE HOMES

The impact COVID-19 has had on care homes is well known. Unfortunately, our elderly population has been hardest hit by the virus and for all residents in care homes (including those unaffected) partnerships acknowledged it had been a particularly difficult time for them and their families. Partnerships described the emotional impact on staff in the sector as huge and there are likely to be real issues going forward in terms of sustainability particularly for smaller providers. Interestingly, one partnership commented that *"there was no way of foreseeing where the outbreaks were going to be….that's the nature of a pandemic".* This partnership, which was particularly affected at the beginning described three large outbreaks in very different care homes, *"one where there had been a large scale investigation last year so not entirely surprising, one in a large care home not on our radar and another in one of our own care homes, the jewel in our crown which had very high inspection ratings".* This comment perhaps suggests that the disparate nature of the virus meant that the usual indicators associated with predicting where it may "hit hardest" in terms of care home settings is largely irrelevant. The magnitude and unprecedented nature of the situation that partnerships and care homes were working through cannot be underestimated.

CHANGE ENABLERS &FEATURES OF CHANGE

However, repeatedly, we heard that the COVID-19 pandemic itself was a catalyst for change, within and between services and supports, and in conversations with service users and their families. One partnership described setting up a "care home task force" co-chaired by a care home manager which really helped engender a partnership approach. The close working with public health was also welcomed by partnerships. One Chief Officer described *"public health being right down the middle of what we have been doing since the outset"* and although not delegated, during the pandemic *"it behaved as though it was".* It was highlighted that at the next review of their Integration Scheme, one of the key conversations will be where public health fits going forward.

There has never been a more important time to be integrated.

During the initial mobilisation period, the additional funding promised from Scottish Government was used in many areas to make over 1,000 additional care home beds available to Integration Authorities, as part of contingency planning should they need them during the pandemic (either to support discharge from hospital, or in the event that care at home or other social care capacity became insufficient). Additional availability came in a variety of ways, such as opening new wings within existing facilities, or block purchase of beds with external providers. Some areas noted that increased care home bed capacity had been helpful in allowing them to reduce existing delays, or avoid new delays, by discharging people into a care home (where this was the assessed need, and agreed with the person/their family).

Many areas reported that they had developed much closer, more mutually supportive relationships with their care home providers during this period, even where those relationships were already established and working well.

For us it's about partnership working whether you are public or private.

Many areas noted they have been having regular virtual meetings with all of their care home providers. Often these have built on existing provider forum arrangements, but during the pandemic have been more frequent and with a wider range of colleagues and specialisms present. The move from physical meetings to virtual ones was a crucial positive step forward for many. It was often reported that the virtual meetings have been better attended and working better than the previous physical meetings, which would require travel. These virtual meetings have been really important to involve everyone - for care providers to connect with each other as well as colleagues in other parts of the partnership, to share experiences, raise queries, and solve problems. There was emphasis on treating all providers – whether in-house or external – with parity and this was really crucial to those relationships.

Our relationship with our local care homes, whilst good before, has got hugely better in the past 6 weeks or so.

The degree of impact on care home staffing levels (due to the staff shielding, self-isolating, sickness etc.) seemed to be fairly variable. However, partnerships noted that they were generally able to counterbalance absences of the regular staff. Often this was through redeployment of staff from other services that had necessarily been reduced or suspended, particularly day services. Also commonly reported was additional support from nurses, Allied Health Professionals, or other council employees (with training where required). Sometimes Agency staff were needed. Some partnerships noted the concern about residents with dementia and self-isolation and whether additional staffing resource would be required to manage this.

Partnerships mobilised to provide additional clinical support to care homes (often in advance of the SG requirements to do so, and in addition to support already available). Commonly this came from primary care and community clinical colleagues, but in some cases also from hospital consultants.

- For care home residents. With remote consultations (via Attend Anywhere or Near Me) to triage and identify where more support for a care home resident might be needed. This was done remotely as much as possible, recognising that asymptomatic staff going in and out of care homes could potentially be vectors for the virus. In some areas this is already fairly well rolled out, in others it is being piloted and expected to be adopted more widely.
- For care home staff and providers. In particular around infection control procedures, the use of PPE, and translation of the many iterations of guidance. Some areas made reference to testing being established locally in advance of national guidance. Also in many cases to provide financial assurance e.g. that they would not be financially disadvantaged if their staff had to stay off work whilst self-isolating.

- Some partnerships did allude to difficulties presented by the new oversight arrangements, meaning accountabilities and governance was being muddied. There were challenges inherent in involving parts of the system in an assurance role that are not normally familiar with the care home sector.

We have had more involvement than we have ever had before with external partners. Huge task.

We want to emphasise how hard we have worked with our care homes, we have built up a lot of goodwill, this is the soft side but it's really, really important. We have worked hard to keep them supplied with the PPE they need. We gave them a commitment that they would not be financially disadvantaged which was appreciated and I think stabilised things, also that feeling of working in partnership to support everybody in working through this period. This feeling of we are in this together.

When people were discharged from hospitals into long stay care home beds, this was because they had been assessed as needing a care home place and went with their agreement and that of their families. As much as possible this was directly to their first choice of home. A few areas reported moving some people to interim care home beds in advance of a bed in their choice of care home becoming available, but noted that this could result in other problems, so over time they did this less. More commonly people were only being moved once, when their care home of choice became available.

More broadly in terms of technology, there was a general sense that COVID-19 has moved the debate much quicker than would have happened. Things that would not previously have been a priority in people's normal busy day jobs have been accelerated, e.g. practical matters such as getting internet connections into care homes established or improved.

- Helping care home residents to stay in touch with their families during lockdown has been a concern. Some areas noted that they had provided iPads/tablets to Care Homes so that family members could see and speak with their loved ones by video call. Other areas have expressed an interest or intention to do this. The main challenge reported through the June conversations was around care home residents not being able to see their families/loved ones in person. Although there is a lot of virtual contact through video calls, this remains a point of difficulty, especially for residents with dementia and associated challenging behaviour.
- Technology has helped people to make their care home choices. During the lockdown, homes in some areas have been able to provide virtual tours, to help people and their families choose their preferred care home, once a place becomes available for an appropriate move.

There was some reluctance from families and care homes to admit people into them before testing became available. There was a lot of time spent working through and addressing these concerns. Testing has been helpful as it has given some reassurance about allowing people to be admitted. In some areas, testing was introduced locally ahead of national roll out. With the benefit of hindsight, it would have been helpful to have been able to introduce testing earlier.

There was recognition that guidance for care homes was iterative as the pandemic progressed and knowledge about COVID-19 developed. However, all areas noted that it has been really difficult to keep up with, understand, and apply the many different iterations of guidance. This took an enormous amount of time, caused a substantial amount of stress and frustration, and in some areas strained relationships with care home providers. Many areas have used existing, or developed, single routes of communications for their care home providers to help work through a lot of the issues. Issues around guidance and engagement with national bodies is covered in more detail in section seven. It was also noted that a lot of the matters applicable to care homes are also applicable to supported living arrangements.

Partnerships described the level of scrutiny being placed on the care home sector, and at times it leading to an uncomfortable relationship between the partnership and provider. It was felt, at times, there was a lack of recognition that many providers are independent, private businesses and some of the oversight requirements ran contrary to this

Many areas reported that they had spent a substantial amount of time responding to demands from the media, local and national politicians. Whilst they understood the reasons for the intense interest, at times it felt that they were having to spend so much time responding to information requests and demands for assurance about what organisations were doing, that they had less time to focus on the people (staff, residents, families) that they were working hard to support. Negative media reporting has also contributed to anxiety among the public that care homes are no longer a safe place for their loved one to be. Partnerships spoke of difficult discussions with family members in discharge planning conversations in relation to this.

Many care home managers have experienced scrutiny and demands that they have never experienced to that level in their careers. They have provided information that has been vital to help monitor supply of PPE, outbreaks, testing and so on. But this has been a relentless demand from a variety of different national organisations and has caused substantial amounts of stress and frustration.

WHAT CAN PARTNERSHIPS KEEP DOING?

- Maintain and build on the enhanced sense of partnership with all care home providers, with appropriate quality assurance frameworks.
- Remote triage and consultations with care home residents: Many areas are working to retain and further embed the use of Attend Anywhere/Near Me.
- Support for communications between care home residents and their families: Retain and look for ways to assist this – e.g provision of iPads/tablets. Also virtual tours of care homes – some areas have done this, others are looking to.
- Clinical oversight of entire care home (as opposed to individual residents) to ensure joined up and safe care for all residents.

WHERE IS FURTHER WORK REQUIRED (THIS MAY INVOLVE NATIONAL ORGANISATIONS)

Many areas noted that they had suspended their use of care home beds for emergency placements, or for short respite stays. They are planning to, or in the process of, restarting this use of beds as they know they have some families struggling and in need of a break.

Often it was noted that additional purchased care home bed capacity had not been fully needed as the impact of the pandemic on hospitals had not been as substantial as initially anticipated, and/or because areas had managed to sustain their care at home services and did not need to resort to using care home beds. Although there was sometimes the observation that in March it felt like the right thing to do. Many areas noted that it would not be desirable, nor a financially sustainable model for them to continue to have as many care home beds, and that alternative ways of supporting people were preferable and would be further explored. Examples of further work on this include:-

- Rationalising care home estate
- Use of very sheltered housing
- Supporting more people at home on larger care packages
- More broadly, reference to appetite with the public for considering "the art of the possible" options for alternatives to care homes

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People have supported and put up with a lot but we don't know if it's sustainable. Also a challenge to articulate what we mean by the recovery message – it's harder than the initial message, which was so clear and unequivocal.

There is a very real opportunity to change the local and national narrative around where is the best place to be. Often there has been a perception that hospital is the safest place to be, or a care home. But there has been a renewed sense of appreciation that home, with appropriate support where needed, is the safest place for many people. Some areas noted that they have had a higher number of care home vacancies than usual.

It always comes down to what and why you are doing something. Politically we got into a bit of a debacle, for example with politicians if we wanted to close a care home because it wasn't the kind of facility or environment that we felt was most helpful for people to be in. We need to stick to what the narrative needs to be, around looking after people in their own homes until they really do need a higher level of support.

The fact that people know now that you are safer in your own home, this is something we need to push now. The pandemic has highlighted that hospitals are not the safest place to be and neither are care homes. If you get the supports right in the community and make that the new norm, that would be good, that is something we have tried to do for decades.

Information shared by care home providers has been vital, but processes need to be substantially improved to keep the demands on them to a sustainable level. Care homes are not always well linked in electronically in terms of email, IT skills, etc. Having real time data on vacancies would be helpful.

There is thinking and work to be done locally and nationally about how to achieve the right balance of medical and social support for care homes, to make sure that people are safe but can also live without being over medicalised. Many partnerships expressed concern that the focus on infection control, while clearly important had turned care homes into *"mini-hospitals"* and there was a desire for a return to what care homes really are – *"people's homes".* However, appropriate links with clinical teams, health protection etc. are recognised as being helpful, in addition to existing good links with the Care Inspectorate and Scottish Care.

Section Five: Adults with Incapacity (AWI)

All partnerships already had operational processes in place. Some partnerships did not make any significant changes to the AWI processes as the relevant emergency legislation was not initiated but others made the following enhancements to their processes –

Mental Health Officer (MHO)

- Employment of a small group of experienced, sessional MHOs intervening at an early stage with applicants and solicitors to continue to move forward with AWI applications.
- Introduction of the MHO Team Manager to the daily management discussion, as well as relevant manager from mental health services to ensure discussions reflected patients across hospital services.
- Forward planning crucial and MHO more involved/explaining to families about process/legality and social workers then able to focus beyond on care options.
- Recruitment and retention of Mental Health Officers remains an ongoing challenge. Some managed with existing MHO capacity but others enhanced capacity by moving MHOs into hospital teams
- A need to have a MHO in the discharge team or align some additional MHO resource to the Integrated Discharge Hubs this helped to focus relationships with doctors on wards
- Edinburgh has dedicated AWI MHOs who respond to all hospital AWI referrals. This ensures the least restrictive option is pursued, private guardians are supported to make an application for a welfare guardianship order, and the dedicated MHOs process all local authority applications for a welfare guardianship.
- Training staff to “master level in AWI” including advocacy workers

Guardianship and interim orders

Challenges faced by partnerships are that guardianship application procedures at the Sheriff Court had been suspended. It has also been difficult to access private solicitors as they have less capacity due to furloughed staff.

Some partnerships did increase the number of interim guardianship orders to authorise discharges due to courts being open for emergency orders. This was done on a risk/opportunity/human rights basis and only done with relatively non-contentious cases. However this is not something that would be regarded as business as usual and the preference would be not to move people on an interim basis as that causes distress for the individuals.

At the moment most AWI delays are people waiting for welfare guardianship applications and waiting on the courts reopening. Partnerships anticipated a surge in applications to the Sheriff Court for welfare/financial guardianship when the Courts eased the restrictions on 1 June.

Powers of Attorney and Anticipatory Care Plans/DNACPR

Individuals admitted to hospital with existing cognitive impairment and difficulties with decision making were identified early by health and social work staff, who then engaged with individuals and families to promote power of attorney and anticipatory care plans.

Partnerships have a good working relationship with the Office of the Public Guardian and reported that any power of attorney queries were answered within 48 hours.

Further work required into DNACPR and ensuring the right processes are in place and are being followed nationwide. One partnership had some issues around 'Do Not Resuscitate' as the Chief Social Work Officer (CSWO) is the named Guardian. There is a need for a clear protocol about who is involved in the consultation and decision making.

Partnerships had run local campaigns around Power of Attorney and had agreed before the pandemic to continue these.

Section 13ZA

Partnerships have not seen an increase in the use of 13ZA and processes were already in place prior to the pandemic, including MDT meetings and family discussions. Various options available were looked at and going into the pandemic social workers triangulated all the information about the individual in terms of assessments and discussions that had taken place and the least restrictive option available. Some partnerships tried to appropriately limit the use of guardianships. 13ZA has not been applicable for the majority of AWI cases but the majority are awaiting guardianship, court processes, solicitors being available to families.

Early introduction of AWI easements contained in Coronavirus (Scotland) Act 2020 could have been helpful in enabling a number of AWI delays to be addressed. However, this had required Ministerial Direction to activate the measures which had not been forthcoming. It was recognised that these powers were very controversial with human rights implications and there could potentially have been subsequent legal challenges.

The use of 13ZA is done in a controlled manner and includes full participation of independent advocacy support and family discussion, in situations where this matches the needs of the adult and the circumstances'. Early referral to advocacy ensures rapport and a relationship is established. The pandemic has enabled social workers to be more confident in how to have conversations with families about guardianship, power of attorney and 13ZA. This has led to ethical implications and human rights being better understood. Staff have open discussions with family but wouldn't use 13ZA if there was an extreme issue or the patient did not comply.

Partnerships have found family members have been keen to get their loved ones out of hospital and settled somewhere else, with Home First the underlying principle. For examples some partnerships have found the benefit of having a dedicated MHO in the Integrated Discharge Hub.

Court Proceedings

The Scottish Courts and Tribunal Service ceased AWI Welfare and Financial Guardianships hearings which resulted in not being able to move some individuals who were ready to leave hospital but were not able to give their consent to this.

Partnerships have some concerns that demand may outweigh supply of staff available to complete reports for court within the 21 day timescale. Some easement of these timescales would assist to ease this pressure and would also serve to maintain the role of the MHO with respect to the protection of legal safeguards and supporting families in this area of work, and at a time of high anxiety for adults and applicants alike.

Some courts have a reduced service but continued to hear cases remotely and this has involved the use of MS Teams and involving a psychiatrist in the process but some courts didn't consider people in hospital as priority as the hospital was seen as a safe place.

Some barriers were experienced with respect to individual legal practices, where offices had closed down creating delay in applications for legal aid. There have been some challenges more generally around individual Sheriff's view as to whether a care home is a suitable final destination versus what the professional assessment was.

During the COVID-19 crisis some partnerships worked together to give all MHOs access to Near Me, which enabled the assessment process and applications for Court to be completed. Edinburgh were able to submit documents to court electronically although serving papers to people in hospital who are subject to a welfare guardianship application would be the exception.

This is an ideal time to take the opportunity locally and nationally to liaise with courts on how the courts can meet their priority of offering protection and streamlining traditional responses without negatively impacting on their role. Given the technological solutions across the workplaces and home lives, consideration could be given for these hearings to proceed on a virtual basis without compromising anyone's rights, leading to a positive benefit for the individual and local system.

TECHNOLOGY

Using MS Teams has proved to be advantageous to facilitate AWI discussions with all parties present and helped with timelines. This has been much quicker than looking for meeting rooms and trying to get everyone into the same place. It has also been crucial to staff in the integrated Discharge Hubs being able to provide accurate information. Giving MHO's access to Near Me can assist the assessment process and applications for Court to be completed electronically.

Some partnership are now holding AWI case conferences remotely and every effort is made to include and convey the views of the family and carers. This is a change which could be carried forward and would be a better use of resources.

Even though MS Teams is good it doesn't work for everyone. There would have to be allowances made for family members who cannot use this means of communication. We also have to be mindful that contact with families under stress can be challenging and unhelpful and technology can only be taken so far. MHOs have been using PPE to interview people where face to face assessment is required.

SUMMARY

The pandemic response still requires to have moral and legal authority and all decisions must be person centred rather than system and sector centred. The desirability of reducing delayed discharges was acknowledged but conversations in respect of this, seemed at times to be acute-led rather than the multi-agency, multi-disciplinary collaborations.

Partnerships feel the AWI reform should be brought forward as a matter of urgency and not left beyond 2021

Partnerships would like staff back in hospitals to make assessments, as it is felt face to face contact provides a better level of understanding.

There is a requirement to ensure that key professionals understand the legislation and the role of MHOs in the process. Edinburgh is going to host a conference on 8 October as part of their mental health strategy "Thrive – Rights Based Care" workstream.

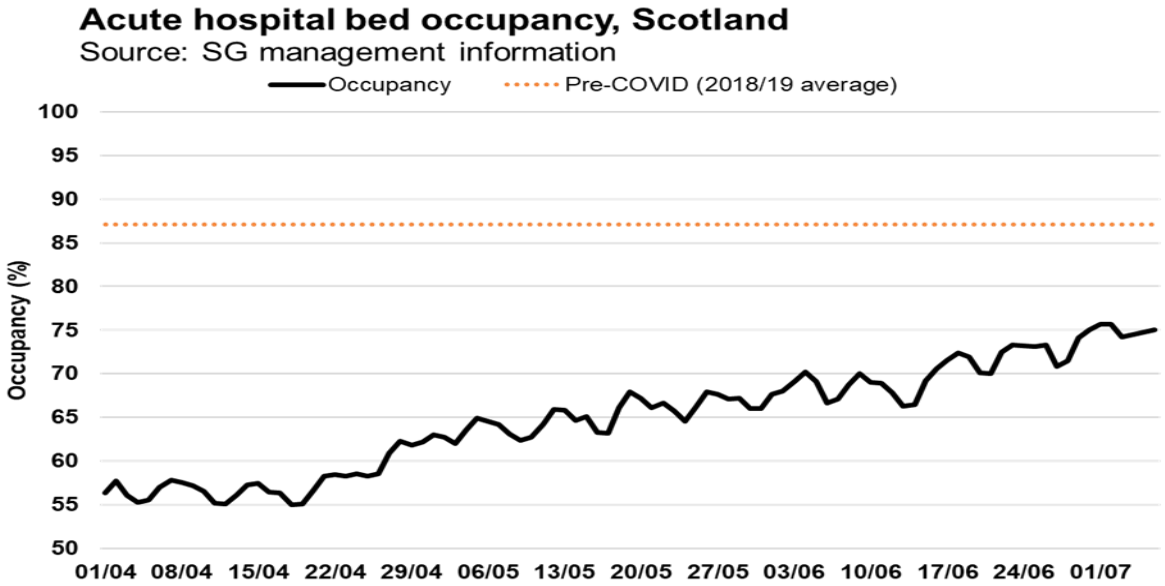
Also need to ensure that

- reliable technology is readily available and is consistent across all organisations.
- need further support and training for staff – particularly social work staff working on the delayed discharge – so they understand clearly their roles and responsibilities.

And finally "*although we support streamlining of processes, you can't streamline it completely, this is about complex needs*"

SECTION SIX: HOSPITAL ACTIVITY

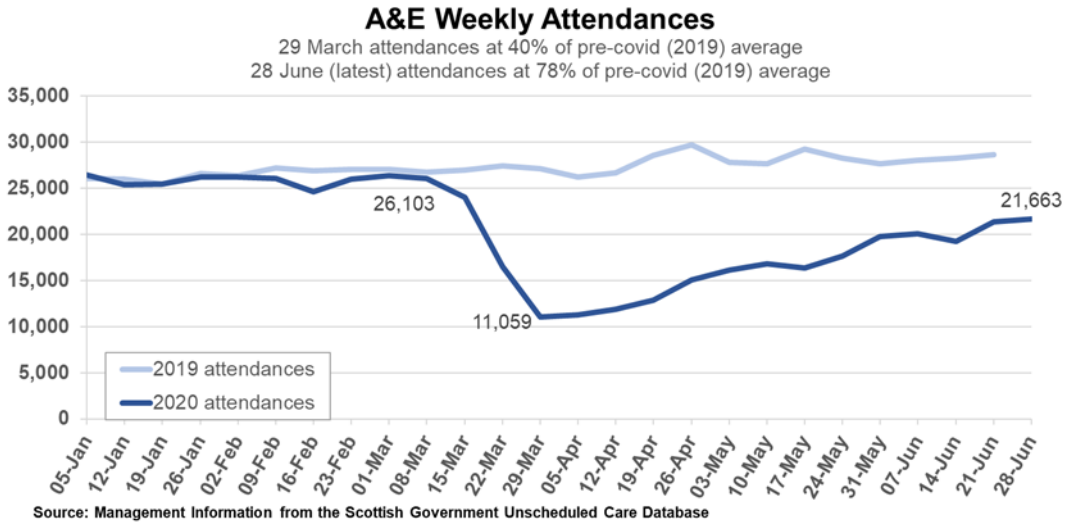
Prior to COVID-19, Scotland's A&E performance against the 4 hour target had slipped, in line with the rest of the UK. The Royal College of Emergency Medicine had blamed this deteriorating performance on "exit block" and claimed there was a shortage of beds. Events during the last three months have seen hospitals empty as elective procedures were cancelled and the level of delayed discharge halved. At one stage occupancy levels in acute hospitals were down at 55%.



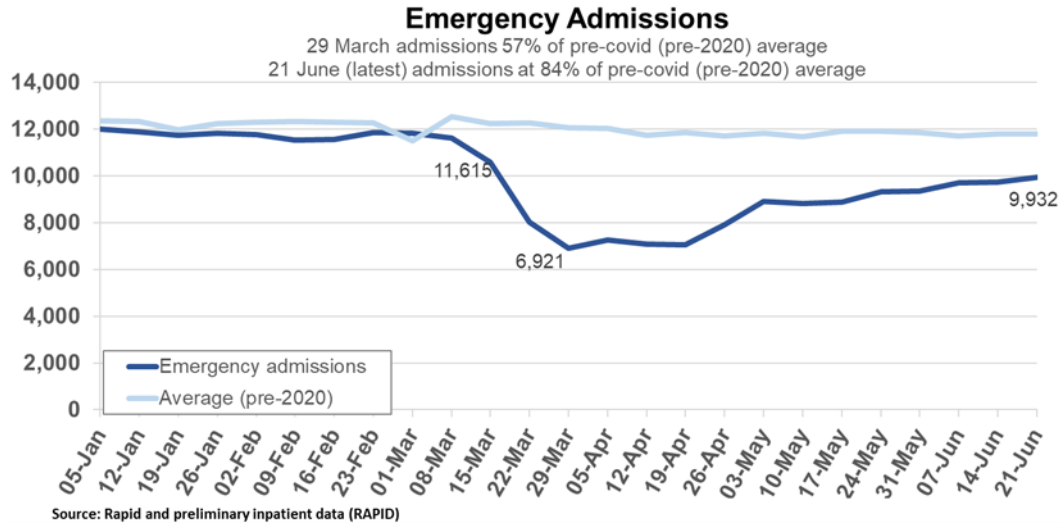
Hospitals emptied and the focus was on creating additional ICU and other acute capacity. This reduced the level of, sometimes inappropriate, movement around the hospital, including boarding, allowed for a simpler flow through hospital.

Far fewer people presented at A&E and we discussed why that might have been with partnerships.

We were at risk of not having enough capacity depending on what support people needed. But community co-operation at this extraordinary time was vital. The message around Stay Home, Protect the NHS, was really clear and people were really behind this.



This also saw a huge reduction in admissions which allowed discharges to outnumber admissions nearly every day in March and early April, resulting in the downward trend in delayed discharge numbers.



Partnerships reported reduced activity at all levels – fewer 999 calls, reduced attendances at A&E, primary care being quieter. There were various suggestions as to why A&E attendances and hospital admissions had fallen, with many partnerships largely attributing it to *"the way our population behaved"* rather than any specific action that they undertook

On reduced attendances, we think this was around government communications around responsible use of services. We think this has demonstrated the effectiveness of an honest transparent dialogue between government and populations. We would be interested in what we can do to drive this agenda forward.

In terms of the public's response to the pandemic, these included:

- Fear of exposure to COVID-19 in the hospital setting;
- Media messages asking the public to stay away from hospital if possible. Repeated messages of Save our NHS. Pulling together and not putting others at risk;
- The public self-managing aspects of their own care or that of loved ones;
- Improved self-management could be as simple as improved hygiene with the consistent messaging about washing your hands, but had also generally seen people take more responsibility for their own health.
- With more people staying at home during lockdown, fewer slips and falls, sporting injuries, road traffic accidents and work-related injuries. Although conversely it was noted that there may be rebound issues e.g. muscular de-conditioning, cardio de-conditioning as people have not been doing their usual activities. The extent to which this may happen is as yet unknown.
- Bars being closed had reduced drunkenness and drink related violence.
- The weather had been generally good (although the public holiday weekend combined with improved weather had seen some increased activity).
- One partnership reported that, with less traffic and air pollution, non-COVID related respiratory illness presentations were down.

People are more adept at listening to medical advice now, maybe it's more likely that people would receive a message around places they can go for help and support

This should be a national campaign around not going to hospital unless you really need to, and emphasising other services (e.g. we have had Pharmacy First).

In terms of the health and social care system's response to the pandemic that would have contributed to the reduction in A&E attendances and hospital admissions, factors cited included:

- Substantially increased use of triage and assessment (often remotely, to minimise physical attendances) to ensure people were directed to the appropriate support or pathway. These took various forms, particularly NHS24/111 and COVID Assessment Hubs, but also others with a more specific focus such as Mental Health.
- Increased signposting to other supports and services, such as community pharmacists. Community pharmacies may have helped screen out inappropriate demand. Additionally, in many areas pharmacy deliveries to those in shielded and vulnerable

groups using redeployed staff and volunteers will also have diverted emergency admissions.

- Changed attitudes to risk, such as GPs seeking alternatives to hospital referrals and paramedics providing more treatment in situ rather than transporting people to hospital. Some areas noted GPs had more direct access to hospital consultants to enable more informed decisions around decisions to admit (or not).
- Increased availability of social and community care, such as care at home packages and step-up supports from Multi-Disciplinary Teams.
- Also family supports to prevent admissions (although this may fall away as more people return to work). Realistic and often difficult conversations were being had with people to discuss options and allow people not to be admitted if avoidable. Whole families were often involved in these conversations to agree how they could look after their relatives at home, and with appropriate information in place such as Anticipatory Care Plans and Key Information Summaries.

The gatekeeping function of the various assessment and triage Hubs was significant in helping to reduce demand that would otherwise go to GP practices or A&E. Some of the features and benefits of these are listed below. There is further thinking and work to be done about the desirability and sustainability of maintaining aspects of these as services move forward into the "new normal".

- COVID assessment hubs were staffed 24/7 by senior clinical decision makers (GPs, geriatricians or other senior hospital doctors, ANPs). This was vital to ensure that access to the most appropriate pathways or supports was enabled. Many of these clinicians were off their normal work plans (with their services reduced or suspended).
- GPs often had more direct access to hospital consultants or senior registrars, to facilitate more rapid, mutual decision making.

GPs had, through the community hub, a means of communicating directly with consultants, and they felt this was really helpful and built good relationships. How do we sustain that as volume goes up again, this is really tricky. But there is an ambition to work collaboratively and strategically in terms of community/hospital interface

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- Many areas made reference to setting up, or making increased use of, Mental Health assessment Hubs. These Hubs, making use of Near Me or phone consultations as much as possible, were able to divert potentially complex mental health presentations away from A&E and subsequent admission.

Community Mental Health Teams continue to manage 'difficult' cases in the community, however all patients requiring assessments for admission to hospital have been seen via the Kildrummy Hub. Created in response to the pandemic to be single points of access for all critical and unscheduled care referrals as well as Place of Safety requests at Royal Cornhill Hospital. The hub operates 24/7 and is staffed by experienced doctors and senior nurses. Although fewer people have been assessed, compared to pre COVID 40% of patients presenting were admitted

- However, whilst there were reflections on the success of these Hubs and feedback that service users often found their experience of obtaining help and support much improved, there were also observations from some areas around the high cost of these services relative to the numbers of people helped in this way, and the need to look into models for these kinds of hub-driven supports as regards long term financial sustainability.

There is a conversation we have been having with the police, A&E, inpatients around Mental Health. There has been a lot of work in the community around MH from the Inverclyde Citizen's Advice Bureau (ICAB) group who have done a few thousand contacts with people over this time. We have seen a reduction in the numbers of people turning up in hospitals in distress

While all partnerships had seen fewer "walk-ins" at A&E, most partnerships agreed that they had seen a particular reduction in "frequent attenders". One partnership estimated that their regular attenders (attending over 9 times a year) were down by two thirds. Others had seen regular weekly attenders at GP clinics also falling as technology was embraced, including staff telephoning these regulars in a weekly or monthly check-in. Partnerships reported far greater take-up of alternatives to physical visiting, such as telephone consultations, on-line physiotherapy guidance and prescription collection. The telephone triage system implemented by many GP surgeries had worked well and partnerships were considering how this could be replicated going forward when surgeries are fully open.

National messaging was important - "Stay at Home, Protect the NHS, Save Lives" was clear and supported by the public. Whereas the more recent "our NHS is open" should have been better targeted at people returning to primary care services, emphasising use of A&E for emergencies only. Some people felt the messaging needed to be "more nuanced going forward".

A mixed picture around returns to A&E and hospitals emerged during this series of conversations.

- Some reported that patients who have been presenting to A&E and other unscheduled care in recent weeks have been considerably more unwell, which had meant a higher percentage have been admitted, and have greater care needs than they might have done.
- Others agreed with the sentiment that the people not going to A&E during the pandemic were the people who should not have been going anyway and that the second national campaign message had been taken as inviting them back. Suggestions included "it's accident and emergency, not anything and everything" and something suggesting that if people have "chosen" to go to A&E then they probably should have chosen somewhere else, that A&E is not somewhere you would choose to go to.

How the SG communicates will also be vital going forward, we are hearing more anxiety from our service users and their families, MSPs, MPs, asking about a return to routine/going back to what it was before. But we can't have it back to what it was before, we can't have over-crowded GP surgeries or over-crowded Emergency Departments. People need to have the right access to information and support that they need

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Generally partnerships were considering how to turn more unplanned care in to planned care, and there were many references to local and national work around scheduling unscheduled care. One partnership wondered if A&E attendance could be better scheduled in future to manage the flow better between urgent and non-urgent care. Others were considering adapting the red and green flows for that purpose.

Many partnerships did express concern about several potential legacies from COVID-19

- An emerging theme around the considerable rehabilitation task for some COVID-19 patients
- Hidden pathologies and potentially worse health and social care outcomes for those who did not access services during lockdown when they needed too
- People who have experienced worsening mental health during the pandemic

Section Seven: Overarching Reflections And Looking To The Future

Partnerships were given the opportunity to feedback more generally on how the experience of working through a pandemic had been for them; reflect on key lessons learned and intentions for the future. In particular, common themes emerged around relationships and decision making; finance; targets; engagement with national bodies; staff wellbeing; community resilience and future models of care. Overwhelmingly, partnerships agreed that the pandemic's impact was not as great as initially feared and capacity in the system was maintained throughout. However, as one partnership stated *"it has been a long sustained pressure unlike anything previously experienced and will take time for the HSCP to recover and return to previous levels of service".*

Despite challenges, many partnerships seemed hopeful for the future and commented on seizing the opportunities the COVID-19 response has brought. One partnership highlighted that *"the pandemic necessitated a change in behaviours and provided a catalyst for change in our approach and processes which we would want to sustain….there will be no presumption of a return to old business as usual".* Building on the success of innovation and the acceleration of transformational change was a common thread described throughout the sessions.

Relationships and Decision Making

Relationships

Many partnerships described having watched the situation in Europe unfold during February and early March it absolutely focused the minds of staff that hospitals were not a safe place to be and to prepare for the potential impact of COVID-19. There was a real sense of *"all in this together"* with a joint commitment and sense of shared purpose driving the planning response. Relationships were strengthened across the whole system, particularly with the third sector and commissioned services. Indeed, one partnership acknowledged that *"partners have flexed and adapted their service provision and this has in turn ensured we have been able to support the most vulnerable".*

Collaboration and the pivotal importance of an integrated approach was clear in all partnership discussions. Teams spoke of *"everyone being equal partners to try and solve problems whether in acute or the community".* One area, which has previously had issues around the pace of integration, commented that *"COVID has helped the whole system mobilise and work together in an unprecedented way".* One partnership spoke about the entrenched cultural and organisational behaviours which for some areas has hindered progress with integration. It was remarked that these *"have been disrupted with a change to the power dynamic previously in play, namely, we (the HSCP) are now directing discharges, where before this was led by acute".* Positively, a common theme from the discussions was that there had been true adoption of whole system thinking and that this *"arguably is what the integration of health and social care was meant to achieve in the first place".* A key lesson to take forward is for areas to build on this progress to foster an even greater understanding of the complexities of the health and social care system in Scotland.

However, not all partnerships were as positive on the impact of the COVID-19 response on furthering integration. In some areas it was felt that much of the communication and directions were channelled through Health Boards, not taking cognisance of IJB and Council responsibilities. There was a desire to go back to proper governance arrangements. Indeed one staff member described *"at times it has felt like we have been colonised by the health service".* One partnership spoke of *"the old arguments that have dogged integration since the beginning – whose data, whose staff, whose budget"* rearing their head again. In fact, it was suggested that *"the ongoing barriers are still the same problems they always were….COVID response has not made it go away, it has just meant people stopped looking at them for a period of time. I suspect it will be back to old arguments by start of the next financial year".*

Decision Making

Partnerships spoke of the speed of change being rapid. There was an autonomy related to decision making where there was *"permission just to get on with it".* There was a strong sense that teams felt empowered to make change. Partnerships spoke about the unusual circumstances of the pandemic allowing them to progress things very quickly which usually would not be possible e.g. the quick internal redeployment of staff. This was summed up well by one person who described the *"relaxation of red tape….what we have been able to do in very short timescales is remarkable. If we were going through the normal bureaucratic channels it would have taken a year. We can't go back to that".* Many partnerships described being able to progress with things that had been spoken about previously but never implemented. In some instances, thresholds for sharing information were lowered which contributed to access and speed of making change. This was complemented well by an increased appetite of staff to embrace change, coupled with a better understanding of each other's roles and responsibilities.

Most sessions touched on the command centres which were established to lead the pandemic response. Experiences of these were varied and some tension in the system was reported with different areas involved at different levels of gold, silver and bronze. One partnership described the NHS and Local Authority as having very distinct processes. This meant the partnership took part twice in parallel command structures which took up a lot of additional time. A streamlined approach would have been more beneficial. Another partnership insightfully commented *"it is easy in crisis to fall back on command and control but the solutions are always to be found in partnership".*

Leadership

Leadership within partnerships was described in sessions as being compassionate and strong, with one team member describing it as *"a supportive backbone for people to feel confident about change".* Chief Officers used a range of methods to keep in regular communication with staff to overcome the obvious challenges to visible leadership in these circumstances e.g. vlogs. Technology was consistently described as a key enabler, allowing agile and remote working. Relationships between teams grew and was aptly described by one individual as *"we might have been apart but have never been more together".* One Chief Officer spoke of *"the hard position to be in as a leader when the science constantly changes"* as decisions were made based on the science at that time.

FINANCE

The promise of additional funding was described by partnerships as *"providing comfort"* and for most it assisted in providing the freedom to develop services quickly that needed to be delivered as part of the COVID-19 response. One partnership stated that without the additional funds *"our interventions would have been much more limited in scope and ambition".* It allowed partnerships to make timely decisions on an effective operational response *"without being constrained by funding".* The situation was pertinently described by one as *"unprecedented circumstances require unprecedented funding solutions".*

However, the initial feeling of comfort and freedom has overwhelmingly been replaced among partnership staff with feelings of *"uncertainty", "anxiety"* and *"disappointment".* One partnership described the situation as one of *"risk – where we are committing to levels of expenditure without really knowing definitively what funding will be met".* There is a real concern that the money available will not come close to meeting the additional costs occurred, which will undoubtedly have an impact on balancing budgets and the continued provision of services.

One partnership raised a real concern around the *"ongoing lack of clarity around funding for provider sustainability where providers are being advised that HSCPs will fund their costs before we have had confirmation that we will receive this funding".* A particular issue was raised around the methodology whereby all claims are paid for by the HSCP the provider operates from rather than the HSCP using the service. This could potentially lead to a partnership paying substantial costs to a provider with whom they have few service users. Until full funding for provider payments is confirmed this remains a particular worry.

Many partnerships expressed a general concern on the impact of COVID-19 on the economy as a whole and what that will mean for the financial outlook in public services going forward.

TARGETS

The sessions discussed the targets that were issued nationally to reduce delayed discharge by 400, then by another 500. Interestingly, partnerships were varied in their response as to whether these targets were helpful and contributed to focusing attention locally. A few partnerships described the targets as being *"irrelevant"* if they were already a high performing area. Indeed, most partnerships surmised that a focus on reducing delayed discharge is an intrinsic element of day-to-day practice, so what was being asked for in the letters in light of the potential infection risk in hospitals, would have happened anyway. Several partnerships however, despite having a long standing commitment to reducing delayed discharge did find *"a national focus on the importance of resolving this issue helpful"*…however moderated this by saying *"the target, in and of itself was not".* The tone of the letter was raised on several occasions. However, one partnership suggested that *"people had maybe become normalised to the high number of delays within the system and felt there were no workable or sustainable solutions. This has demonstrated there are".*

There were strong views among some partnerships that target setting was an unnecessary, additional pressure. One Chief Officer highlighted that *"the complexity of managing someone's discharge from hospital is not properly understood"* and that staff can feel demoralised by criticism of performance where they are working relentlessly to address underlying issues

(e.g. around choice, availability, risk) best they can. Indeed, all partnerships agreed that a further target (e.g. 200 or zero) would have been *"meaningless"* and indeed often *"impossible"* as most of the remaining delays were due to complex cases or AWI issues which legally could not be progressed during the pandemic. One partnership expressed concern that additional targets could have *"forced us to make decisions on discharges that we would not have otherwise had made, which could have put patients and community care services at risk of harm".* The language around delayed discharge often felt uncomfortable as it is people's lives that are being discussed and their transfer of care from one setting to another. Many partnerships were quite clear that they did not want to move people to any place with speed, irrespective of circumstances. In spite of the unusual circumstances, a home first approach was advocated where possible with choice and inclusivity of families still at the forefront.

Rather than the targets making the difference, some partnerships described other factors as being key enablers:

"What was arguably more relevant to our combined endeavours was the pandemic modelling scenarios and the experience of other countries showing the likely scale and impact we could expect".

"The focus was on getting our citizens into the right place and out of a hospital setting that no longer met their needs. The availability of money and the whole system being focused on one goal of creating hospital capacity was the critical success factor".

"Further pressure on delayed discharge targets will not transform the behaviours in acute settings, nor promote a Home First approach. However, a focus on reducing hospital and community beds would better serve this end".

"The driver was around supporting and protecting our population rather than any set delayed discharge target".

Engagement with National Bodies

The partnership sessions were an opportunity for staff to reflect on how engagement with the various national bodies had been and feedback on what could have been done better. There was acknowledgement that overall Scottish Government had done well in their response, however there were aspects (mainly in relation to PPE, testing and care homes) which led to an additional strain on partnerships who were already under pressure. Two partnerships also specifically stated that *"we should have locked down more quickly".*

Guidance and Communications

Every partnership interviewed highlighted the *"constant changing guidance"* as problematic. There was a plea in future to include a summary or a page at the front highlighting the changes as it was a struggle at times for managers and staff to find their way through it. In terms of the national guidance, several partnerships stressed that *"one size doesn't fit all, proportionality has been the most difficult thing to grapple with throughout this". "Island proofing*" of guidance was suggested by one manager as a lesson for the future. Many partnerships commented on the timing of announcements as being unhelpful e.g. the release of guidance on a Friday which often required significant changes to be made by the Monday.

This led to partnerships having to *"continually flex and respond within extremely short timescales"* leaving little time to plan, often with already depleted staffing resource due to shielding/caring responsibilities or sickness absence. Discussing the huge volume of information asks, one manager stated *"there is a real risk of the system burning itself out and individuals being burned out too. I can run a marathon but not three in one go".*

The disjointed nature of correspondence coming from different parts of Government, Health Boards and Councils was commented upon *"which did not reflect nor capture the spirit of integration and focused too much on individual functions rather than taking an integrated approach".* One manager posed the question *"could Scottish Government not have thought whole system from the beginning?"* Correspondence was addressed to a variety of senior leaders, with occasions where issues related to delegated functions were addressed to NHS and Local Authority leaders and not to Chief Officers of Integration Authorities. In relation to the guidance and letters, many partnerships felt that a small forum where iterations could have been consulted on would have made the process feel more engaging and supportive.

Personal Protective Equipment (PPE)

It is not surprising that many partnerships described the early days in relation to distribution of PPE particularly challenging. Some partnerships felt that the guidance at this stage was perhaps being influenced by availability; and in some areas there was real anxiety felt amongst staff and service users. The continually changing advice which involved negotiations each time with trade unions etc. was far from ideal. However, after overcoming the initial issues several partnerships praised NSS for the supply process that was established via community based hubs and triage support line and felt that it had worked well.

Care Homes

In relation to care homes, partnerships consistently described the increased scrutiny of care homes as difficult for them to manage. Negative and alarmist media reporting of the situation contributed to managers feeling blamed. One partnership described *"the speed and pace at which some of the advice and guidance came out was frightening"* and this combined with the plethora of requests for information and data asks was burdensome particularly on small providers. One partnership pointed out that in their area the *"local narrative was very different to the national level and collaboration was very good".* There was a desire to get the positive messages out, rather the negative stories always being the focal point. In addition, many partnerships commented on the need to change the conversation on care homes. The narrative from Government has contributed to a medicalised approach, focused on infection control when in fact these are people's homes.

Testing

In relation to testing it was felt that UK and Scottish Government guidance at times felt contradictory. Weekly testing in care homes was commented by many as being a huge pressure. One partnership commented that *"we needed a national testing strategy*". More generally, one Chief Officer stated that the *"uniqueness in partnerships was not recognised….we are all tarred with the same brush if one area not doing well".* This approach was felt to be demoralising for staff.

Other National Bodies

The majority of the feedback related to engagement with Scottish Government. However, several noted the *"lack of communication from some of the regulatory bodies"* and the lack of a co-ordinated approach e.g. guidance coming out from SSSC, the Care Inspectorate and Scottish Government which was sometimes contradictory. One manager asked *"who are we supposed to be following?"* There was a common plea for a more joined up approach to communication from agencies in the future, if Scotland was to experience a second wave. One partnership went as far too ask *"where have the Care Inspectorate been?"* throughout the pandemic. Particularly in relation to care home oversight, some confusion was highlighted in relation to roles and responsibilities. Specifically, the issue of nurse directors having responsibilities that are normally part of the Care Inspectorate's was flagged by one partnership as being confusing.

The Chief Officer teleconferences with Government were felt to be a helpful route in and to feel connected. The network in general was felt to be beneficial for peer support and discussion around common issues; however the daily meetings were felt by some to be too much.

Staff Wellbeing

Chief Officers unanimously expressed gratitude for the *"real can do attitude from staff – keep calm and carry on"* which was demonstrated throughout the COVID-19 response. One partnership described frontline staff feeling at first *"scared",* while others said the experience was *"frantic, busy and confusing"*. However, as the system response became more co-ordinated and managed staff have reported a *"real sense of pride"* in their contribution.

Partnerships commented that Government could have been quicker to place NHS and social care staff on equal footing from the beginning. This disparity, with focus initially on NHS heroes and social care being overlooked in a number of areas including public campaigns and access to testing was disheartening for staff. A clear positive from the crisis has been the renewed focus on the importance and the value of social care. A real admiration for care home staff and managers was evident in many of the partnership sessions and the very difficult job they had and continue to do. Many partnerships set up wellbeing hubs for staff which were positively received. One manager described the additional society wide appreciation for health and social care staff as being greatly felt and has helped re-enthuse staff.

However, all partnerships described a level of fatigue setting in among staff across all levels. "*People are tired"* was reflected in all discussions and an anxiety in relation to whether staff can do it again if there is a second wave. One Chief Officer described human behaviour and response in relation to a crisis…. *"but if crisis becomes a permanent situation…there is a sense that people can't keep doing this".* Some partnerships also described the focus on recovery as challenging as their area was still in *"response mode".* There was an acknowledgement in several partnership conversations about the transition to a "new normal" in a context sometimes where staff want to go back to the "old normal" which will not necessarily be possible. In relation to care homes, one manager reflected on whether *"we should have done something different in relation to care homes…it's been an ethical dilemma and very difficult for staff to deal with".* This comment perhaps hinting at a level of trauma which has been experienced by staff working within these settings.

Some of the well-known issues with integration pre-COVID in relation to different organisational policies were described as being problematic. For example, in some areas Council staff were to work from home, whilst NHS staff were to come in to work.

Community Resilience

The mobilisation of the third sector and volunteers particularly in relation to support for those shielding was commended by partnership staff. Many partnerships described the *"benefit of massive grassroots mobilisation"* which benefited locally and helped provide additional resilience in the community. Rural partnerships in particular described having already very active communities who mobilised with minimal statutory support. A key question posed by most partnerships in relation to the enormous role of volunteers in providing lower level support was *"how do we sustain this going forward?"* particularly when people start to return to work as lockdown restrictions ease.

Future Models of Care

Partnerships reflected on the *"real window of opportunity that COVID-19 has given us to transform our models of care".* It was strongly felt that integrated working is what made the pandemic response a success and hoped there would be a *"commitment by all stakeholders not to re-trench".* There was a sense across the country that public perception had changed on the role of families in caring for loved ones and this was the opportunity to *"rewrite the narrative about hospitals being the best place to be".*

In summing up some of the key learning points realised by the pandemic and what would be needed to sustain progress, partnerships described the following.

- Greater emphasis on supporting people at home, real investment in care at home and early intervention and prevention
- A renewed focus on integration with effective leadership needed across the whole system
- Less focus on acute re-mobilisation
- The need for a redefined relationship with the public which clearly defines the roles played by statutory services, communities and individuals in achieving better outcomes
- A belief system that prevention of admission works
- Further investment and support on the use of technology
- A national conversation on adult social care in particular services for older people
- A focus on the widening health inequalities and mental health issues which have been exposed and exacerbated by the pandemic

CONCLUSION

Health and social care partnerships have been at the forefront of dealing with the pandemic. It has been services in the community that have borne the brunt of it and the way the partnerships have managed this has proved the value of integration.

Within these partnerships, independent and third sector providers, scores of volunteers, families and carers have all stepped up to the plate. It has created a real focus on "home", with a common feeling that the best place to care for people is within their own home. While this welcome adoption of home being best was continually referred to in the interviews, much of the time was taken up discussing hospitals, with learning specific lessons around the reductions in delayed discharge particularly, and hospital admissions and activity generally, being the primary focus of the exercise.

Delayed discharges dropped from over 1600 delays to under 600 in only 6 weeks, A&E attendances from around 23,000 a week to about 11,000, admissions by over 60%.

It is therefore vital that we do learn the lessons from the last few months, keeping the many good things that have been highlighted; the common, shared purpose; the improved behaviours that have replaced historic cultural differences; the strong leadership and empowered decision making; closer relationships that have been fostered across the whole system. The uptake of digital technologies, mentioned in each section of the interviews.

Fatigue was mentioned in many of the discussions. Realising how busy everyone continues to be, we thank again the hundreds of senior managers and practitioners who took part in nearly 50 hours of discussion, across all 31 health and social care partnerships.

NEXT STEPS

- We will share the report widely to inform other local and national lessons learned exercises.
- We will work with health and social care partnerships to create a record of good practice, both long established and that developed during the pandemic.
- The findings of this report will help the refresh of the Framework for Community Health and Social Care.
- Drawing on the findings in this report, along with examples of local initiatives and established good practice, we will form a small expert group, comprising Chief Officers, providers, health and social care practitioners to chart key activities by August to ensure progress is sustainable in the longer-term.
- We will use the findings to inform parallel national work on social care, primary care and unscheduled care.
- We will link this work to the Short-Life Working Group on complex delays, chaired by David Williams and Jane O'Donnell, also reporting in August.
- We will work with Chief Officers, along with local authorities and NHS Boards, to establish methods for ensuring learning is spread at all levels across health and social care.

ANNEX A: Interview Schedule

June 9	Argyll & Bute
June 12	Inverclyde
June 15	East Renfrewshire
June 16	Moray
June 17	South Lanarkshire
June 18	Aberdeenshire
June 18	Fife
June 18	North Ayrshire
June 18	South Ayrshire
June 19	Edinburgh
June 19	East Lothian
June 22	North Lanarkshire
June 22	Angus
June 22	Borders
June 22	East Ayrshire
June 23	Western Isles
June 23	East Dunbartonshire
June 24	Glasgow
June 24	Midlothian
June 24	Aberdeen
June 25	Falkirk
June 25	West Lothian
June 26	Clackmannanshire & Stirling
June 29	Renfrewshire
June 29	Highland
June 30	Dundee
June 30	West Dunbartonshire
June 30	Orkney
July 2	Shetland
July 3	Dumfries & Galloway
July 3	Perth & Kinross