INVERCLYDE
HSCP
Health and Social Care Partnership

AGENDA ITEM NO: 2

Report To:	**Inverclyde Integration Joint Board**	**Date: 24 August 2020**
Report By:	**Louise Long** **Corporate Director (Chief Officer)** **Inverclyde Health & Social Care Partnership**	**Report No: IJB/55/2020/LL**
Contact Officer:		**Contact No: 01475 712722**
Subject:	**HSCP COVID-19 RECOVERY PLANNING UPDATE**	

1.0 PURPOSE

1.1 The purpose of this report is to provide the IJB with an update on Covid-19 recovery planning as we move towards Phase 3.

2.0 SUMMARY

2.1 The unprecedented response from our staff and local citizens to the unprecedented challenge that came with Covid-19 has been both innovative and compassionate. Despite the terrible impact the virus has had, the responses across Inverclyde community and services has been and continues to be phenomenal and provides a solid foundation upon which to build towards a new future.

2.2 The HSCP Recovery Plan has been developed to enable us to navigate our way through the uncertainties that the virus has created and rebuilding our public services and the local economy. We need to plan in a way that allows for flexibility to enable preparation and response to resurgence of waves of Covid-19 activity with little notice.

2.3 Some lockdown restrictions are still in place across Scotland. We are all familiar with the Scottish Government Road Map out of recovery which sets out a ‘phased’ planned approach to how we collectively recover across Scotland. The HSCP Recovery Plan was developed by the Strategic Management Team (SMT), further developed by the HSCP Recovery Group which is responsible for overseeing the implementation of the plan and monitoring progress.

2.4 The HSCP Recovery Plan has been based on a set of principles and is one where we learn and understand what the impact of our response to Covid-19 will, or perhaps should, have on how we deliver services in the future, and follows a phased approach to restarting services.

At the end of each phase there is reflection and learning before moving to the next phase.

2.5 The HSCP is now preparing to enter into Phase 3 of the Recovery Plan and will run from August until February 2021.

2.6 The HSCP is working closely with NHS Greater Glasgow & Clyde to ensure our plans are aligned. The Chief Officers are represented on the Health Boards Recovery Tactical Group and Inverclyde has a representative on the Board-wide Planning Group.

3.0 RECOMMENDATIONS

3.1 That the IJB notes the progress made to stepping up local services and plans to make further strides as we enter Phase 3 as outlined in the HSCP Recovery Plan.

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 Over the next few months, the HSCP needs to develop new ways of working that include an element of catching up with activity that has been scaled down or ceased as part of the response to Covid-19.

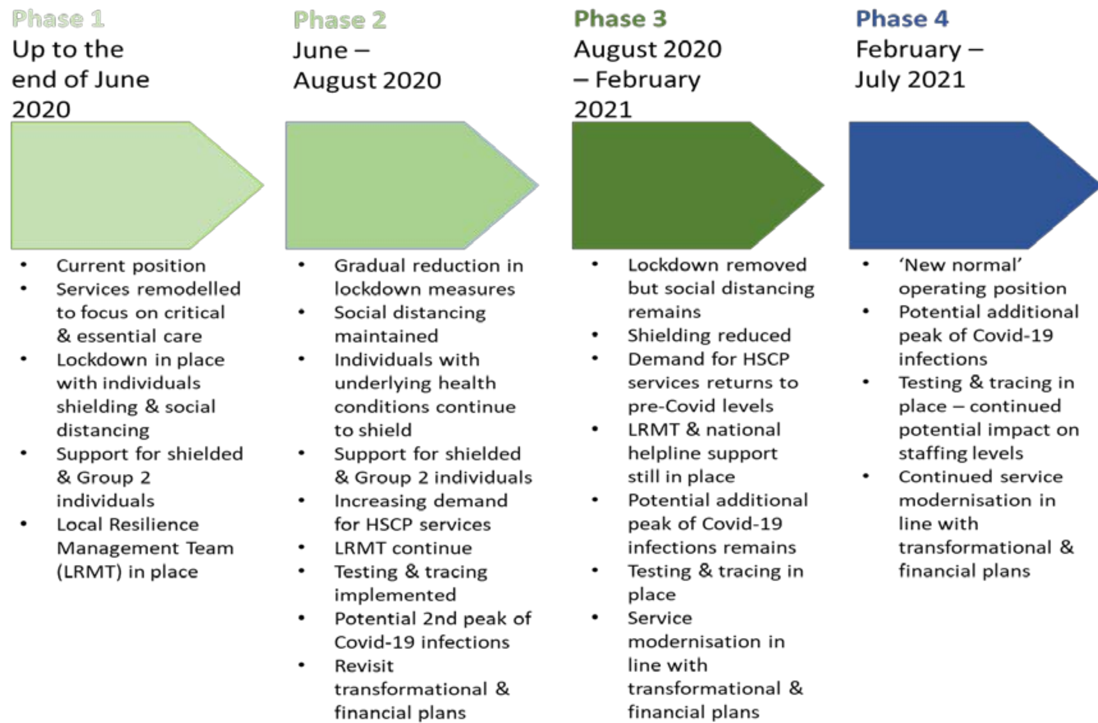
4.2 The unprecedented response from our staff and local citizens to the unprecedented challenge that came with Covid-19 has been both innovative and compassionate. Despite the terrible impact the virus has had, the responses across Inverclyde community and services has been and continues to be phenomenal and provides a solid foundation upon which to build towards a new future.

4.3 The HSCP Recovery Plan has been developed to enable us to navigate our way through the uncertainties that the virus has created and rebuilding our public services and the local economy. We need to plan in a way that allows for flexibility to enable preparation and response to resurgence of waves of Covid-19 activity with little notice.

4.4 Some lockdown restrictions are still in place across Scotland. We are all familiar with the Scottish Government Road Map out of recovery which sets out a 'phased' planned approach to how we collectively recover across Scotland. The HSCP Recovery Plan was developed by the Strategic Management Team (SMT), further developed by the HSCP Recovery Group who is responsible for overseeing the implementation of the plan and monitoring progress

4.5 The HSCP Recovery Plan has been based on a set of principles and these are:

4.6 Our overall anticipated planned approach to recovery is one where we learn and understand what the impact of our response to Covid-19 will, or perhaps should, have on how we deliver services in the future, and follows a phased approach to restarting services. The phases are:



4.7 Phase 1 is complete, Phase 2 is being implemented and we are now planning our transition to Phase 3 during which we aim to have all services reinstated and develop a 'new normal' to service provision. At the end of each phase there is reflective session with extended management team to understand the learning for the next phase. Phase 3 will run from August until February 2021. Details outlined for Phases 1 -3 are provided at Appendix 1, with particular note of Phase 3 where we will increase face to face contact with more people.

4.8 Service areas have developed initial, phased recovery action plans which detail step up and step down arrangements over the coming months. These are reviewed by the HSCP Recovery Group and overseen by the Strategic Planning Group (SPG).

4.9 Engaging and ensuring that people receive services is important to their health and wellbeing so the planned phased approach sees more face to face contact as we move from the hub to service model.

4.10 Ensuring we focus on safety and wellbeing, the positive response from staff throughout this has been incredible and it is vital we continue to support each other through the phased recovery. Risk assessments have been carried out in preparation for the safe return of staff to buildings, and measures put in place to ensure social distancing is observed – desks have been taped off with no hot desking but weekly rotas being established to keep the numbers in offices to a minimum. Ultimately, where staff can work from home they will continue to be encouraged and supported to do so.

4.11 Our plans allow for flexibility to enable preparation and response to resurgence of waves of Covid-19 activity with little notice; this includes policy / processes in place to manage a further outbreak. There is active resilient management around this issue.

4.12 The HSCP is working closely with NHS Greater Glasgow & Clyde to ensure our plans are aligned. The Chief Officers are represented on the Health Boards Recovery Tactical Group and Inverclyde has a representative on the Board-wide Planning Group. The HSCP has been involved in Health Board remobilisation plan.

5.0 IMPLICATIONS

FINANCE

5.1

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

LEGAL

5.2 There are no legal implications from this report.

HUMAN RESOURCES

5.3 There are no human resources implications arising from this report.

EQUALITIES

5.4 Has an Equality Impact Assessment been carried out?

	YES
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

5.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None

People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender-based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no clinical or care governance implications arising from this report.

5.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
People, including those with disabilities or long-term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	None
Health and social care services contribute to reducing health inequalities.	None
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None
People using health and social care services are safe from harm.	None
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	None
Resources are used effectively in the provision of health and social care services.	None

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

8.0 BACKGROUND PAPERS

8.1 Inverclyde HSCP Covid-19 Recovery Plan.

APPENDIX

INVERCLYDE HSCP Health and Social Care Partnership

COVID-19 Inverclyde HSCP Transition Plan

1 CONTEXT

1.1 Across Scotland we are currently in the first wave of the COVID-19 outbreak. Novel coronavirus (COVID-19) is a strain of coronavirus first identified in Wuhan, China in 2019. Clinical presentation may range from mild-to-moderate illness to pneumonia or severe acute respiratory infection. COVID-19 was declared a pandemic by the World Health Organisation on 12 March 2020. We now have spread of COVID-19 within communities in the UK.

1.2 COVID-19 is expected to be an ongoing threat requiring continued social distancing until we, as a country, have built up overall immunity (approximately 60-80% population immunity) through vaccination or natural infection. In the meantime, we will have to deal with waves of COVID activity (infected individuals and public health measures), and also deliver other health and care services. In this first wave, we stopped a wide range of activity to allow us to prepare for COVID activity, comply with social distancing requirements and address high levels of staff absence in the first few weeks within the HSCP and the wider provider network. We have also put in abeyance many of our existing planning and governance structures.

1.3 Extensive measures have been implemented across the UK. Current recommendations for Scotland are for people to stay at home as much as possible and severely restrict their interactions with others outside the household.
Current government advice is that people only leave the house for very limited purposes, for example:

- for basic necessities, such as food and medicine. Trips must be as infrequent as possible
- daily exercise, for example a run, walk, or cycle - alone or with members of your household
- to ensure basic animal welfare needs are met, including taking dogs out when necessary
- any medical need, including to donate blood, avoid or escape risk of injury or harm, or to provide care or to help a vulnerable person
- travelling for work purposes, but only where you cannot work from home

1.4 The above measures have obviously had an impact on staff, our service users, key workers in other areas and the whole community and have required all organisations to adapt their normal operating models. The HSCP did this by moving to a hub model and pulling back on non-essential face to face contact.

1.5 Moving Forward

Over the course of the coming months, the HSCP will require to develop a new way of working including an element of catching up with activity that may have been scaled down or ceased as part of the pandemic response.

This will require to be planned in a way which allows for flexibility to enable sufficient preparation and response to resurgence of waves of COVID activity.

1.6 We will need to consider services that will see an increased demand as a result of COVID-19 mitigation measures. To do this effectively, we cannot simply return to previous ways of working. We need to understand the changes we have made to services, assess the risks and opportunities in continuing with these changes and apply learning from the COVID response to our recovery planning. We also need to plan our recovery with the other Health Boards in the West of Scotland.

1.7 Measures initially designed to prevent the spread of Covid 19 are dynamic and subject to change at short notice. The main business consequence and continuity risks for the HSCP are:

(i) Increased community-based demand due to:

- Reduced acute hospital capacity, as a result of Covid 19 emergency admissions;
- Reduced informal carer capacity, as a result of carers becoming ill with Covid and/or of being unable to provide support due to self-isolation or lock-down;
- Reduced day and respite services due to service closures;
- Reduced wellbeing of vulnerable people, post-infection;
- Mental health impact of self-isolation and community lock-down;
- Potential for increase in harm to children and vulnerable adults, and domestic violence due to self-isolation and lockdown;
- Increased levels of end-of-life care at home;
- The deferred impact of reduced health and social care referral rates for non-Covid related concerns.
- Increase in demand for CJSW Court Reports and Social Work Community Sentences due to most summary Court business as of 10th April 2020 being deferred for 12 weeks.

(ii) Reduced service capacity due to:

- HSCP staff illness due to Covid-19 infection;
- HSCP staff illness due to work-related stress as a result of the significant extra demands of Covid-related work;
- Equivalent staff pressures in the commissioned social care sector, with voluntary and independent sector provision under significant pressure;
- Primary care impact with GPs providing additional Health Board-wide support to assessment centres and NHS24;
- Diversion of community-based resources (especially nursing) to acute hospitals.

1.8 The anticipated infection trajectory across the country means that the impact of these business continuity risks is highly significant and potentially critical.

2 INVERCLYDE HSCP BUSINESS CONTINUITY PLANNING

2.1 The HSCP has updated all of its departmental and service Business Continuity Plans (BCPs) to reflect the particular challenges of Covid-19 emergency planning

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requirements. The HSCP's overarching BCP has also been updated and new Standard Operating Procedures (SOPs) developed. These documents cover:

- The new HUB model, including team consolidation and merging
- Essential service continuity and prioritisation
- Public protection
- Commissioned services
- Staffing
- Staff and public communications

2.2 A Local Response Management Team (LRMT) has been established that meets twice each week. These meetings are supported by ongoing Senior Management Team (SMT) meetings. The Chief Officer updates the Chair and Vice Chair and two other voting members of the Integration Joint Board (IJB) weekly and a virtual IJB will be held monthly from mid-May. On a wider level, THE HSCP is part of robust and routine Council, Health Board and national emergency planning activity.

3 PREPARING FOR TRANSITION

3.1 It is clear that the process of transition through emergency planning and business continuity for Covid-19 will be neither linear nor guaranteed.

3.2 Scotland in common with all parts of the UK entered lockdown on 23rd March 2020. These constraints were implemented then strengthened through legislation (the Coronavirus (Scotland) Act 2020) and through the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020. Under law, the UK and Scottish Governments must review this lockdown at least every three weeks. This ensures the impact of restrictions remains proportionate to the threat posed to wider societal and economic aspects.

3.3 In common with nations across the world, Scotland is planning for a managed **transition** away from current restrictions in a way that enables the suppression of transmission to continue. This will include ongoing physical distancing, the continued need for good hand hygiene and public hygiene, and enhanced public health surveillance - while seeking to very carefully open up parts of our economy and society.

3.4 As and when restrictions are lifted, the Scottish Government has indicated in its report *COVID-19 – A Framework for Decision Making (April 2020)* that it will need to put in place public health measures to stop cases becoming clusters, clusters becoming outbreaks, and outbreaks becoming an uncontrolled peak that would require a return to lockdown to avoid enormous loss of life and the overwhelming of our health and care system. This is a clear indication that the lifting of restrictions will be carefully phased and measured.

3.5 The lifting of restrictions may also be reversed if the “reproduction number” or “R” rises above 1, i.e. the number of cases each infected person passes the virus on to.

3.6 A framework of assessments will be undertaken by the Scottish Government to inform its decision in how it manages its response to the epidemic:

Scottish Government Assessment Framework

1. Options for physical distancing measures – easing, maintaining, (re)introducing – are technically assessed using the best available evidence and analysis of their potential benefits and harms to health, the economy, and broader society so as to minimise overall harm and ensure that transmission of the virus is suppressed.
2. Potential options – individual and combinations of measures – are assessed for their viability, for example taking account of how easy they are to communicate and understand, likelihood of public compliance, the proportionality of any impact on human rights and other legal considerations.
3. Broader considerations also include equality impacts and consideration of tailoring measures, for example to specific geographies and sectors.
4. Assessments will inform the required reviews of the Coronavirus regulations and collective assessment and decision-making with the UK Government and other Devolved Administrations as appropriate.

3.7 The Scottish Government’s policy approach to transition provides a clear context within which the HSCP should prepare for its own transition, through its business contingency and continuity planning processes. It is essential that a plan is in place that allows the HSCP to take account of the path of the epidemic and the national response, while constantly re-orientating its continuity planning in line with presenting demand, shifting trends and trajectories and the impact of organisational capacity issues. In this respect, having clarity and perspective on our emergency arrangements is essential in order that we can act both reactively and proactively in response to the challenges we face.

3.8 The key principle which must guide recovery planning is the need to provide safe and effective services for people which maximise the health benefit for our population, promotes independence and protects the most vulnerable. Principles also include the need to minimise risk to staff and patients, to maximise the use of remote consultations where appropriate, and to ensure equality of access based on need.

3.9 The long term impact of Covid-19 will be significant so it is crucial that we learn from the pandemic and our response locally and nationally, use this knowledge and insight to guide and improve how we work now and how we plan ahead.

3.10 It is proposed that the successful aspects of rapid implementation across the health and care system, which were driven by the strategic and tactical COVID response groups are replicated in the recovery phase. Potential detrimental impacts should also be identified and addressed. Implementation of COVID responses has been supported

by public buy in, political and media support, finance/budget and a high degree of staff goodwill.

4 HSCP PRINCIPLES AND STRATEGIC PRIORITIES

The HSCP Recovery Plan has been based on a set of principles and these are:-

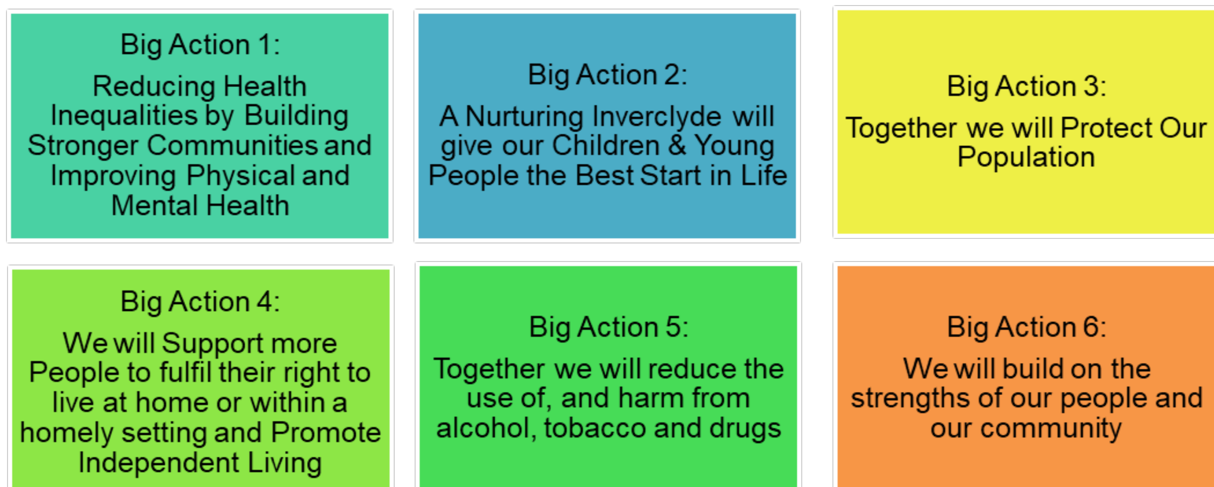
These principles are set alongside the continuing need for social distancing, and the likelihood that future waves of COVID will drive the need for us to be able to flex our system to respond to this.

4.1 Where possible, it is proposed that existing structures are used to develop the recovery plan, and the Senior Management Team will support these structures and processes. By working within a hub and spoke model, aligned to each of the key areas of recovery until phase 3 when services will move back to service operational model.

4.2 In order to provide governance and leadership, a local HSCP Recovery Group will be set up and chaired by Chief Officer with membership from across HSCP, 3rd Sector, Human Resources and Staff side representatives. The Recovery Group will report through the Recovery Tactical Group in the Health Board and the Council Recovery Group respectively through their reporting structures. This will enable a system-wide overview of component plans to inform recommendations presented to the IJB. Terms of Reference for the Group are enclosed at Appendix 1. All plan will link with NHS remobilisation plan and will be fully costed.

4.3 It is important not to lose sight of the wider strategic priorities that guide the work of the HSCP and the principles and values that underpin what we collectively and individually do in support of these priorities. Covid-19 emergency planning and

response arrangements do not operate in isolation, although right now it can feel that they dominate matters almost to the exclusion of all else. Inverclyde HSCP continues to be guided by its principles and values and a commitment to delivery of our overarching vision and Strategic Plan and 6 big actions:



5 CLINICAL AND CARE GOVERNANCE

5.1 Given the ongoing pressures presented in managing the challenge of Covid-19, it has not been possible to maintain the normal range of clinical and care governance and functions. The NHS Strategic Executive Group approved adaptations to the arrangements for governance of healthcare quality. This includes suspension of the strategically supported Quality Improvement programmes, revisions to processes for clinical guidelines, audit and clinical incident management. NHS Acute, Partnership and Board Clinical Governance Forums are currently suspended.

5.2 Within Inverclyde HSCP there was a temporary suspension of our clinical and care governance meetings. However it is important to note that the legal duty of quality and the requirement to maintain health and care quality continue to be standing obligations, therefore where local arrangements cannot be sustained, operational oversight of healthcare quality and clinical governance has been maintained by embedding the following essential functions in the local management arrangements:

- Responding to any significant patient feedback
- Responding to any significant clinical incident
- The approval and monitoring of any clinical guidelines or decision aids that are required for the Covid-19 pandemic emergency
- Responding to any significant concerns about clinical quality

5.3 Examples of the mechanisms currently in place to support the operational oversight at service level include: Corporate Management Team meetings with Inverclyde Council;

participation in NHS Board COVID-19 governance; three times weekly HSCP Senior Management Team (SMT) meetings; daily SMT communication re Covid – 19 risk issues; development of dynamic risk assessments for all services with an overarching HSCP Covid -19 risk register which is reviewed weekly and is submitted to the Local Resilience Management Team (LRMT) and SMT and maintenance of communication with individual staff and teams. The latter has been an essential element in the provision of operational and professional supervision and caseload management to identify areas of exception with escalation as appropriate to the LRMT and the SMT.

5.4 Plans are now in place to re-establish our governance arrangements. Inverclyde HSCP Clinical and Care Governance Group is scheduled to take place on 26 May. The primary focus of discussion will be clinical and care governance arrangements to support our Recovery Plan.

6 PROCESS

6.1 Detailed plans will be developed for the following areas:

1. Reflection and review with staff groups (see Appendix 2) within each hub in HSCP services, mental health, drugs and addictions, Children and Families ,Criminal Justice, Homelessness key processes and key priorities, longer term look at links to strategic plan 6 big action
2. Reflection within primary care, mental health inpatients, children and adults residential services
3. Review with 3rd sector, CVS and communities about how we continue to engage and harness support while maintaining social distancing
4. Assessment and Testing Centre and plans developed for step up and step down for assessment and testing as required
5. Emotional and operational recovery in the longer term will require managers and leaders to ensure there are regular opportunities for feedback and support for their teams and staff members.
6. The reflection has led to learning which has informed the phase 1, 2 and 3 action plans and the wellbeing plan. (Appendix A)

6.2 Phase 1 plans will focus on key issues to be addressed, timescales and the following areas:

- governance, leadership and assurance
- sustainable improvement (aligning capacity and demand, standard operating procedures and training)
- managing clinical risk
- performance management
- communications
- risks and mitigations

The Plan on a page is outlined in Appendix B, each plan has a detailed action below undertaken, so that all actions, monitor, assessed to ensure it is safe to move to the next phase of planning.

6.2 Phase 2 plans focus on priorities, resource, people ensuring we keep safe and communication. The model of working during a pandemic, system/process building and ensuring the most venerable are care for in Appendix C.

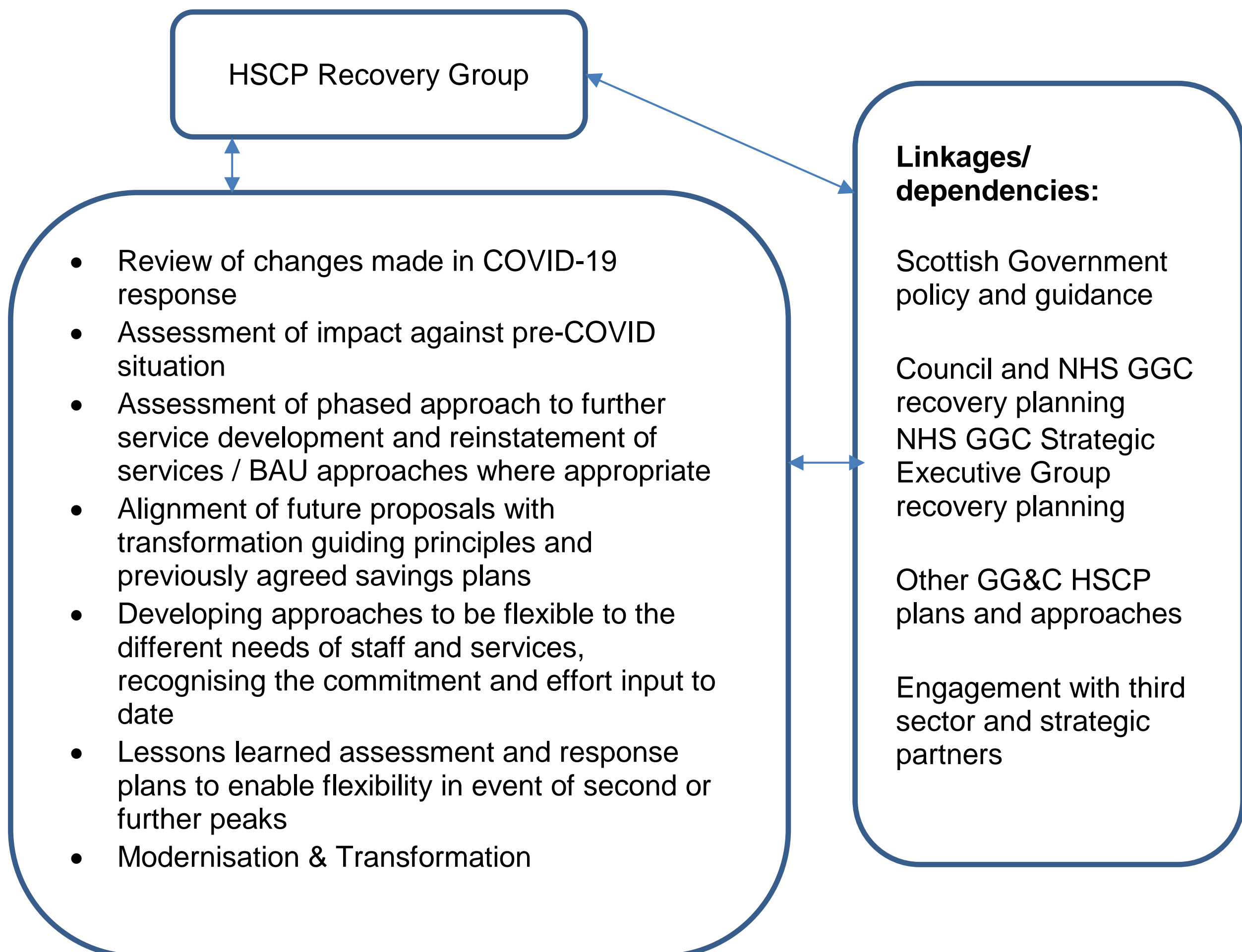
6.3 Phase 3 focus on moving back to new normal as the lockdown restrictions are reduced and levels of infection reduce allowing more face to face contact. The phase 3 plan outline in Appendix D.

6.4 Phase 4 will focus on the new way of working including modernisation, transformation of services.

6.5 Recovery action plan was agreed by with the HSCP Covid-19 Recovery Group and the IJB. This is a live document and is updated regularly and reported through the Recovery Group and Strategic Planning Group. Each phase of recovery was a plan.

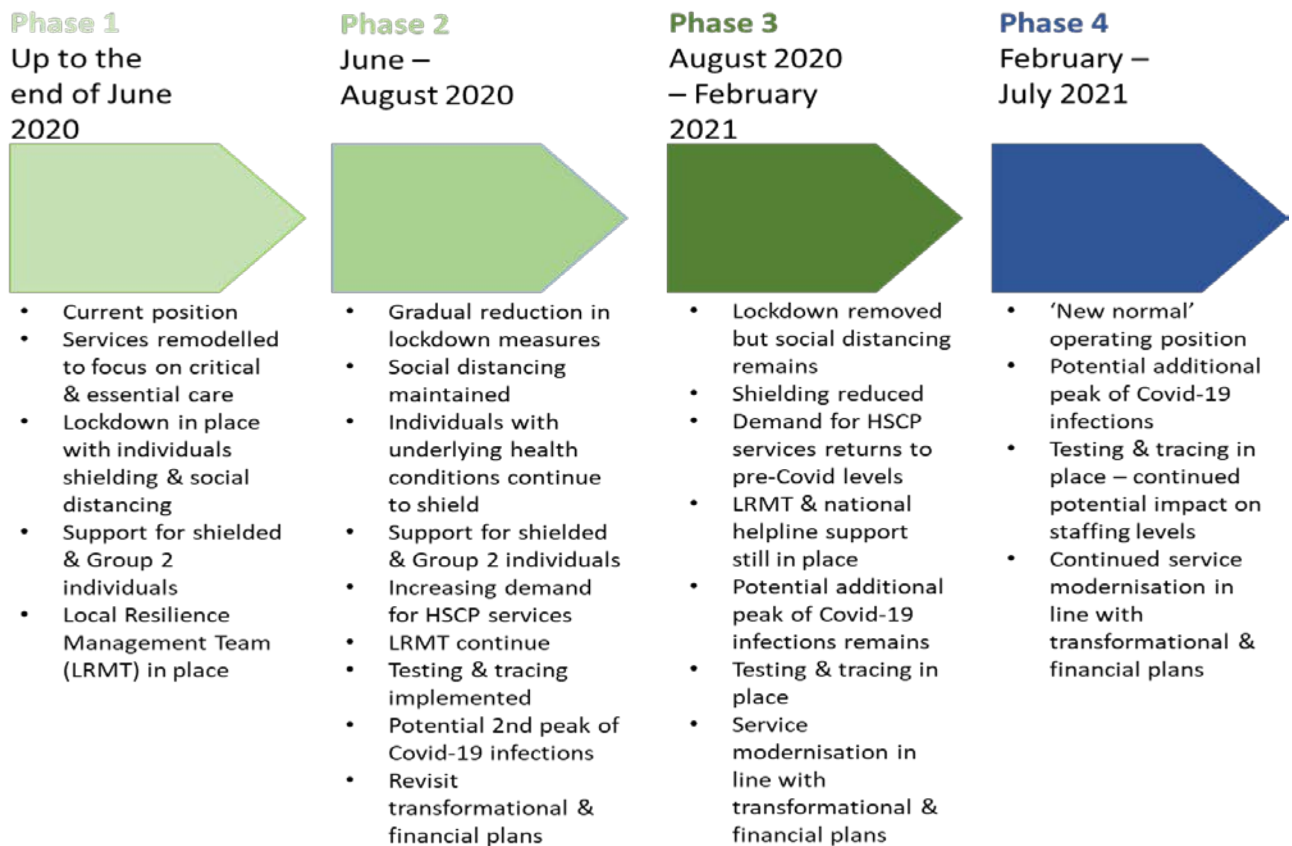
6.6 HSCP recovery plan links to the council recovery, Alliance Partnership Recovery Plan and the NHS Remobilisation Plan.

6.7 Planning Approach Overview



6.8 Anticipated Recovery Phases

Our overall anticipated planned approach to recovery is one where we learn and understand what the impact of our response to Covid-19 will or perhaps should have on how we deliver services in the future, and follows a phased approach to restarting services. The phases are:



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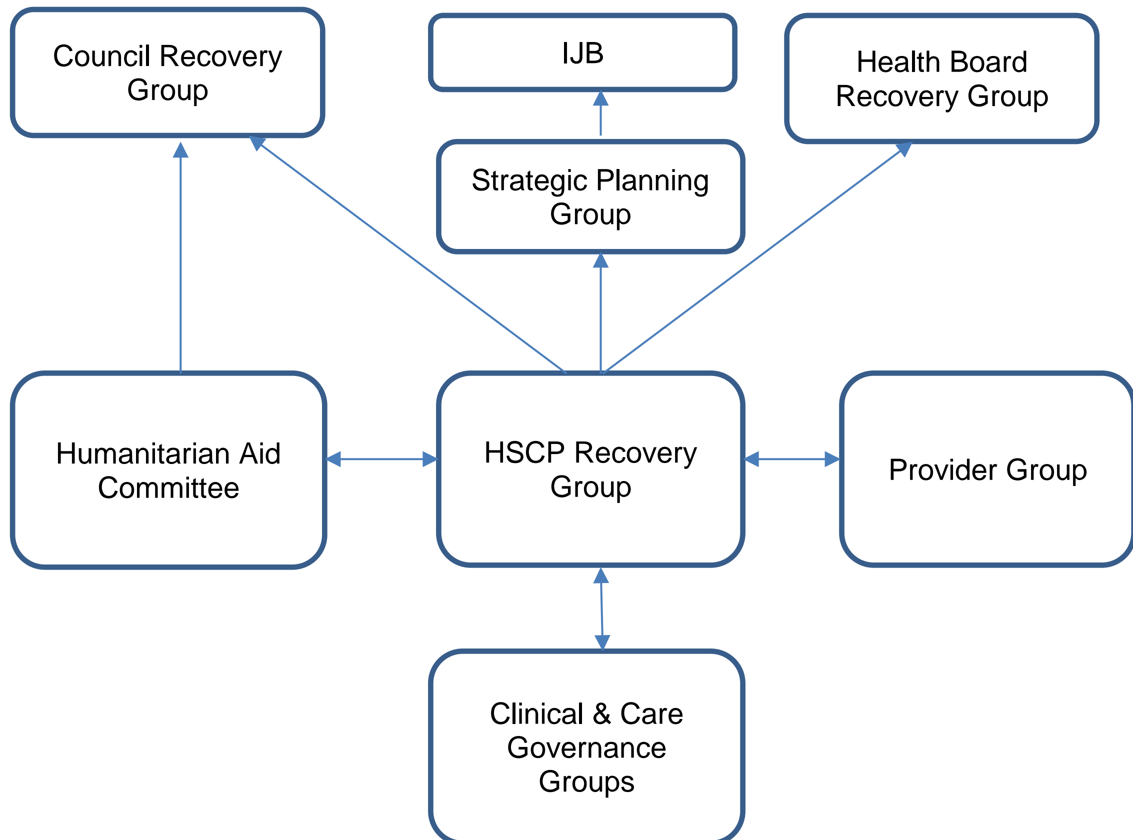
6.9 The governance and reporting structures around this work are as follows:

Recovery Planning Governance and Reporting Overview



7. ALIGNMENT WITH COUNCIL AND HEALTH BOARD RECOVERY AND TRANSITION PROCESSES

7.1 It is important that the HSCP recovery and transition plan aligns strategically with Council and NHS processes. Inverclyde's Councils Strategic Recovery Plan and NHS Greater Glasgow and Clyde's NHSGGC COVID-19 Recovery Plan both set out common objectives and broadly similar approaches. NHSGGC remobilisation plans sets out priorities and timeline for moving forward.

7.2 The unique governance and accountability frameworks that establish the HSCP Board and its strategic planning responsibilities place it central to the process of linking operational recovery and transition to longer-term strategic priorities, including integrated effectiveness, efficiency and economy. The HSCP Board's directions to the Council and Health Board to deliver operational services in line with these strategic priorities ensure that the Council and Health Board will wish to have confidence that operational recovery and transition processes are well planned and executed. Furthermore, for reasons of consistency, the Council and Health Board separately may wish to align their approaches across whole systems and cross-cutting corporate issues that may include or affect aspects of delegated services. This may create a potential overlap of recovery and transition planning activity. The HSCP will therefore work in partnership to harmonise recovery and transition planning in pursuit of outcomes that are mutually supportive and meet the needs of all parties.

8 CROSS-CUTTING AND COMMON THEMES

8.1 The Council has, in its recovery and transition planning arrangements, identified aspects and considerations which are common and are corporate in nature, including implications for shared space in buildings; health & safety and PPE; workforce; technology & digital; travel and transport; contracts & procurement, etc. As such, corporate considerations and implications will be collated and assessed by lead Corporate Director of the Council. To support this work and in anticipation of similar requirements by the Health Board, the Chief Officer will identify HSCP Heads of Service to act as HSCP points of contact for these issues.

8.2 In addition, the Chief Officer will identify cross cutting operational issues as they emerge from service-level recovery and transitional planning work and will identify an HSCP strategic lead for each of these, to minimise duplication of work at a service level and to consider strategic solutions in conjunction with Council and Health Board officers and colleagues in other HSCP areas. These cross-cutting issues may include but not be limited to: public protection, congregate models of care, HSCP governance, clinical and care governance, financial impact and planning.

9 CHANGE MANAGEMENT AND DUE DILIGENCE

9.1 With social distancing likely to be a feature of public health, social and economic life for the foreseeable future, concepts of "normality" and "recovery" become relative rather than absolute concepts. More accurately, the processes of recovery and transition are steps through continued business continuity and contingency planning. At each stage, changes to operating systems, processes and service models may be

necessary to safeguard the health, safety and wellbeing of staff, our patients and service users, our communities, businesses, jobs and our partnerships.

However tempting it may be to consider the value of permanent shifts to some of these contingency arrangements (particularly as the people we support have experienced unexpected benefits in some of these), long term change should be by design and not by default.

9.2 The process of longer term service change requires careful consideration, consultation, evaluation and impact assessment. These elements of due diligence will be essential as we work through the transition process, so that the HSCP emerges stronger by design.

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Appendix A

<u>HSCP Recovery Group Terms of Reference</u>

Name of Group:	**Inverclyde HSCP Recovery Group**	Version 1.0
Constitution:	This Recovery Group has been established to coordinate and monitor the recovery planning of the Inverclyde HSCP and support the recovery planning work of NHSGG&C and Inverclyde Council. The role of the Group is to oversee the Inverclyde HSCP Covid 19 Recovery Planning process through initial development to implementation and close. Meetings will be held virtually through conference calls to allow for appropriate social distancing and other current safety measures to be accommodated. Initial focus will be on internal HSCP services, longer term this will be widened to include externally provided services and the group membership expanded accordingly.	
Composition/ Substantive Membership:	The Recovery Group membership will be constituted as follows: • Chief Officer (Chair) • Interim Head of Strategy & Support Services (Vice Chair) • Heads of Service • Chief Nurse • Clinical Director • 6 x Hub Managers • Service Manager Business Support • Service Manager Commissioning • Action Note taker • Staff side x 2 • HSCP Rep on Health Board Recovery Group	
Responsibilities:	The Group will plan, prepare, organise, monitor and communicate the transition from current model to normal activities to Council, NHS and community. This will include: • The development of overall principles in line with NHS Board and Council • A review of current arrangements • Preparation of a plan and phasing of implementation • Ensuring staff and members of the community are protected • Effective support for staff • Monitor the implementation including assessing risks • Communicate to staff, provider each step in the transition process through LMRT and NHS Tactical Group and Chief Officer brief • Report to Council, CMT, NHS and Strategic Planning Group ultimately to Health and Social Care Committee and IJB	

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Frequency of Meetings:	Meetings shall be held weekly at the same set time or as directed by the Chair.
Quorum:	To be quorate at least 30% of the agreed membership including at least one member of the HSCP SMT must be at the meeting
Reporting Procedures:	One page hub summary report as per the enclosed template will be circulated to Group members at least 24 hours before the meeting. Following each meeting an updated action note will be distributed within two working days.
Action Note to be circulated to:	Action note from each meeting to be circulated to: • Recovery Group Members • HSCP SMT and Extended Management Team • Inverclyde Council Recovery Group • GG&C Recovery Group
Review Date:	These terms of reference will be reviewed every 3 months to ensure the Recovery Group is operating at maximum effectiveness.
Date Terms of Reference Approved:	31/08/2020 by the Recovery Group

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Appendix B

LEARNING FROM LOCKDOWN

The approach can be described as consisting of three steps

1. Phased approach to restarting services

The Heads of Service and Service Managers would be required to use the Business Continuity plans in each of the Care areas as the framework for phasing a return to full provision of HSCP services, bearing in mind that the sequencing of this could be different to the retraction of the services. Areas to consider would be how in the immediate situation we utilise the experiences of staff (and ultimately service users/patients) to assist us to re-introduce services and identify.

- What has proven to be effective?
- What has been unhelpful and/or of little value?
- What processes/procedures/ways of working should be adopted and which should we consider discontinuing?
- What have we been doing that we need additional capacity and resource for?

2. Learning and understanding

The shift in ways of working will also have a long term impact and we need to review:

- Benefits of increased digital approaches to working from home, connecting with each other , running meetings formally and informally
- Early feedback suggests there are a number of skills to be developed to support this and this will need an ongoing programme
- The change in relationships with clients through the use of technology will also need to be considered for future ways of working
- Collecting this feedback and reviewing it should form a main strand of recovery and planning for the future

3. Staff wellbeing

The positive response from the workforce has been incredible and a number of supports have been put in place to sustain staff in the current time. Collect and report on the narrative around staff experience of support and resilience:

- Teams have continued to meet and support each other either in person, while adhering to social distancing protocols or through virtual meetings
- Managers have been connecting with individuals and teams
- Good questions for teams include:
  - What types of supports helped you through this?
  - What other things would have helped?
  - What did not help?

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REFLECTION FROM PHASE 1

Recognising the need to consider and programme our renewal and recovery.

Whilst we have all been affected by the COVID19 pandemic, we know that for some groups, the social economic and health caused by both the virus and associated lockdown measures, will be greater and that this could have a profound and long lasting impact, exacerbating already existing inequalities in our communities. The pandemic is also likely to drive more individuals and families into poverty and we have already seen significant increases in the unemployment rate and in the number of people applying for Universal Credit. Each service area (hub) completed debrief record at the end of phase 1 to record the learning and consider how learning could inform the next steps.

EXECUTIVE SUMMARY

General services during pandemic:-

- HSCP adapted rapidly and universally in response to the COVID19, it also used technology, triage, remote consultation, keeping in in touch with people and establishing duty services
- Strong team work was key
- Usual activities have reduced, some significantly (home visits) while others have stopped (moved to virtual)
- Remote consulting, by phone or video (clinics)
- Group staff galvanised to undertake other roles mental primary care, health visitor to move testing/assessment centre. Community link workers help supported the most vulnerable
- PPE supplies established quickly despite concerns the system worked effectively

Concerns

To protect people services has put work on hold, staff are concerned about the impact this is having on people. The increased demands is a challenge to come:-

- Face to face is still essential much of the behaviour work is based on relationships. Those with complex problems who cannot access/use technology need an alternative
- Poverty IT
- Vulnerable children and families who have had their support network withdrawn

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- Mental health problems are increasing and impact in socio-economic deprivation
- Concerns that economic consequences of the pandemic will impact mostly on the disadvantage groups, who live in precarious financial circumstances and will wider the health inequality gap.
- Homelessness ongoing targeted support

What Come Next?

- Make building/system safe
- New challenges to meet backlog, with increased demands with reduced staffing
- Psychological support for distress to the community and staff needs to meet the needs. A well-developed Well-Being Plan
- Redesign services so that web, technology can be used more readily, however the need to address inequality of access of IT, health literacy
- Face to face contact is still important
- Speed and agility are required to ensure planning is paced at suitable rate to meet the needs of the public, meet government guidance and keep staff safe
- Understand how to step up and step back services so we are prepared for second a wave

New Challenges

The backlog of work resulting from services having been put on hold during the COVID19 pandemic. Each service will need a common approach plan.

Expected increase in child protection, mental health illness and domestic abuse.

New issues of social access and equity as a result of the expansion of remote consulting, involving the use of phone and video technology.

Continued Challenges

There are gross longstanding inequalities in health and social care with large differences on healthy life expectancy and life expectancy between most affluent and most deprived.

Addressing inequalities in a structured way, structured solution to structural issues. Influencing wider system.

Multi morbidity is the 'new norm' including both the multi-morbidity of old age and the multi morbidity of socio-economic disadvantage. High prevalence alcohol and drugs, impact on drug deaths/excess deaths.

Learning in the Aftermath of COVID19

The key ingredients was:

- Leadership, visible, clear communication, team working
- Agility
- Ability to plan, monitor and asses
- Open/transparent, listening
- Developing remote/blended practise
- Bolster universal service primary care by increasing link worker, financial advisors, mental health and alcohol and drug practitioners to reduce stigma
- Evidence, data, measure, analysis evaluated
- Maintaining pace and focus
- Partnership working with unions, key stakeholders

Summary

It is not a race back to normal. This is a time for change, a time re-evaluate what is important, what we need to do less of and a timing of re-introducing services will need to match the Scottish Government agreed progress future phases.

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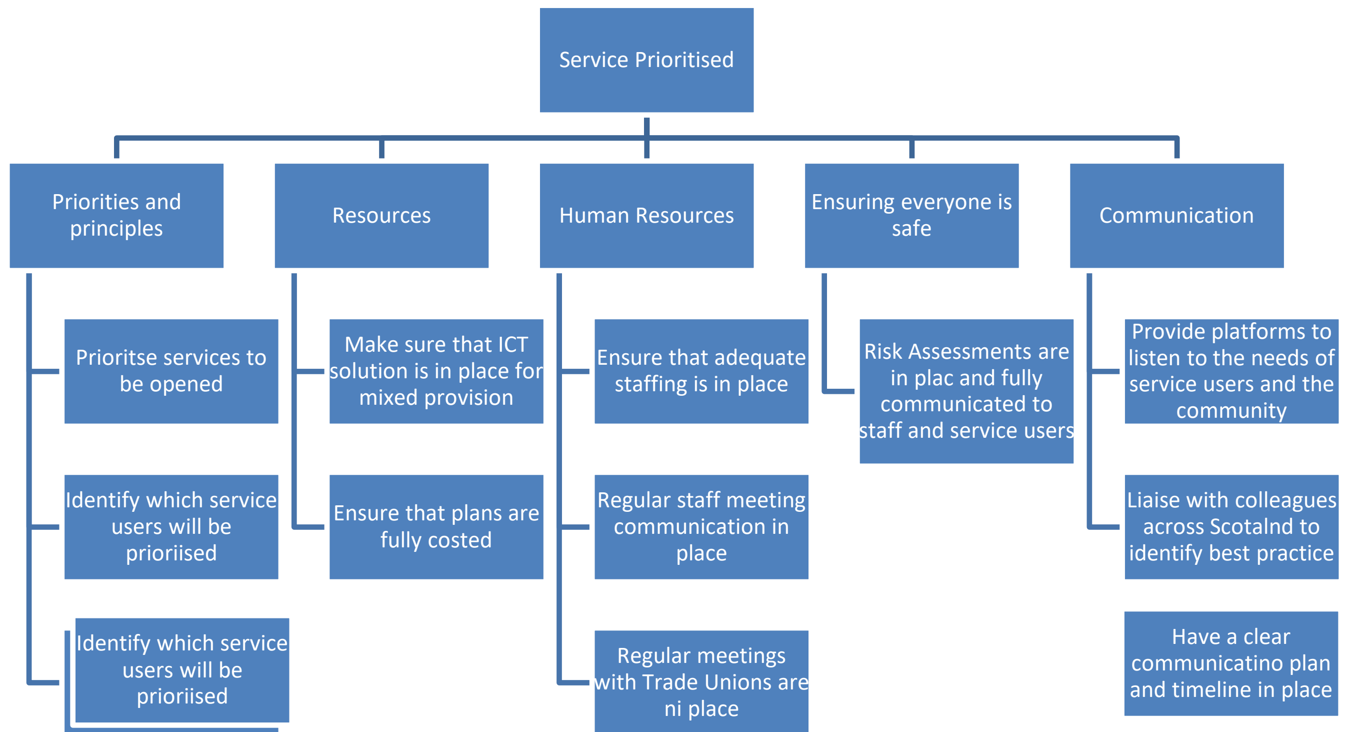
Appendix C

HEALTH AND SOCIAL CARE - PHASE 1



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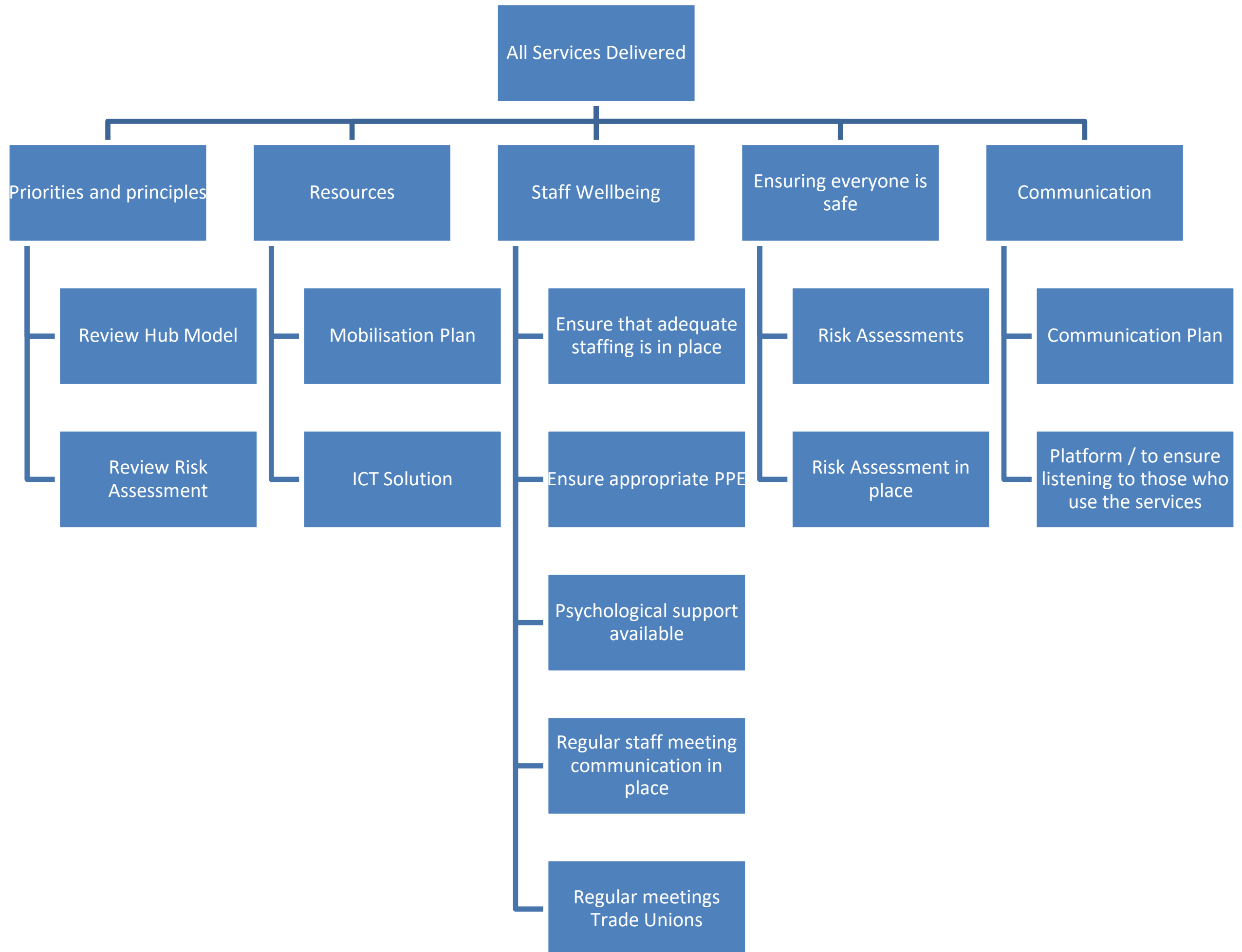
Appendix D

HEALTH AND SOCIAL CARE - PHASE 2



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Appendix E

Health and Social Care Phase 3