care inspectorate

Delivering care at home and housing support services during the COVID-19 pandemic

Care Inspectorate inquiry into decision making and partnership working

September 2020

HAPPY TO TRANSLATE

Contents

Foreword

The primary focus in social care during the first months of the COVID-19 pandemic was understandably on issues relating to care homes for older people. Yet most people in need of care and support, including people with complex health and social care needs are supported in their own homes. COVID-19 had a significant impact on care at home and housing support services providing this support.

At the start of the COVID-19 pandemic, there was widespread uncertainty and a lack of information and knowledge about the potential impact of the virus. There was also uncertainty about how best to protect people and how to contain the spread of the infection.

Health and social care partnerships and service providers addressed the unknown and unprecedented experience of the pandemic and resulting restrictions in different ways. The evidence from this inquiry indicated that most partnerships and service providers worked well together during this time and with available information and resources made every effort to act in the best interests of people in need of support.

We may yet face a second wave of this virus that takes us back into the lockdown we experienced early in the pandemic. Even if this is not the case, we know there are ongoing challenges in the care at home and housing support sector that mean we need to continue to work together to drive improvement in it.

This report draws together the views of health and social care partnerships and service providers about their experience of care at home and housing support services during the first phase of this pandemic. It is intended that it helps to inform future planning for, and improvement in, these services.

Peter Macleod

Chief Executive

Key messages

This inquiry looked at responses to the pandemic in relation to care at home and housing support services across all health and social care partnerships (HSCPs) in Scotland. Through this, we identified common themes and challenges which we have set our here as key messages from the inquiry.

We found that:

- despite uncertainty and fear about health risks to themselves, their families and people who experience care, housing support and care at home staff worked hard and flexibly to ensure there was capacity to meet needs and keep people safe throughout this pandemic.

- people who experience care and their carers declining their usual supports, to reduce the risk of infection, contributed significantly to maintaining services during the pandemic, but carers needed more support to sustain the effort of providing care.

- social isolation, disruption to daily activities, limitations on physical activity and the suspension of reablement adversely impacted on the health and wellbeing of people who experience care and carers.

- the increased use of technology and creative alternative approaches to support had positive outcomes for some people who experience care and these developments should help inform new service responses.

- HSCPs effectively prioritised support for people with critical needs, but how this was managed in terms of the impact of this prioritisation on packages for other people using services was very variable across the partnerships.

- HSCPs and service providers worked collaboratively in almost all partnership areas to find creative and effective solutions to key challenges such as maintaining staff capacity and shortages of PPE, with the most robust responses to the challenges involving fully integrated, responsive approaches between all partners.

- the requirements for care at home and housing support providers to provide similar data and information to a range of agencies was time-consuming and onerous for providers.

- the challenge of responding to COVID-19 further exposed the complexity of and weaknesses in funding for care at home and housing support services. HSCPs and service providers were concerned about future funding for these critical services.

Recommendations

As we move through remobilisation and recovery phases of the COVID-19 pandemic there are key issues from this inquiry that warrant further consideration or follow-up action. We recognise that across Scotland's health and social care partnerships (HSCPs) and service providers are at different stages in relation to addressing the issues behind these recommendations.

1) All partners, at national and local HSCP levels, should ensure new or emerging guidance on infection prevention and control measures address the unique challenges of providing care at home and support in people's homes.

2) HSCPs should work with care at home and housing support service providers to ensure there is adequate contingency planning for PPE supply, access and distribution in the event of a future peak in infections.

3) HSCPs should prioritise rehabilitation and reablement in their recovery plans. This should seek to limit the potential for adverse impact on health and wellbeing from extended periods of lockdown or other restrictions for people who experience care.

4) HSCPs should seek to better understand the experience of healthcare for people who used services and their carers, during the pandemic, to inform how care at home and housing support services could work more effectively with primary care in the future.

5) HSCPs should update their workforce plans for the care at home and housing support labour force. These plans should be set in the context of health and social care integration, be cross-sectoral and reflect the pivotal role of care at home and housing support staff in meeting critical needs

6) HSCP's should prioritise the assessment and review of people's needs, taking into account their wishes and preferences. People who experience care should be fully involved in their assessments and reviews which should be person-centred and focused on individual outcomes.

7) HSCPs and service providers should research, reflect on and learn lessons from the positive experiences of people who used services and carers during the pandemic, of the increased use of technology and alternative approaches to support. These lessons should inform new service responses that can deliver equally successful or improved outcomes for people who experience care.

8) Service providers should engage with their staff, people who experience care, carers and HSCPs to explore opportunities to deliver more person-centred approaches building on the creativity and flexibility shown during the pandemic.

9) HSCPs should update their eligibility criteria for accessing services, to ensure that they are equitable and transparent and clearly explain the prioritisation of services during this pandemic.

10) HSCPs should consider incorporating into their eligibility and priority frameworks, the emerging lessons about the impact of social isolation and restricted movement on the physical and mental health and wellbeing of people who experience care.

11) The Scottish Government, HSCPs and service providers should review the processes for accessing Scottish Government sustainability funds for current or future COVID-19 related costs, to facilitate access for service providers, where relevant, to such funding.

12) Partners at national and local levels should acknowledge that routine use of PPE is an ongoing necessity and ensure the associated costs are reflected in the cost of care at home and housing support.

13) HSCPs and service providers should consistently engage with people who experience care and carers to understand the impact of actions they took in response to the first peak of infections, to inform future practice and improve outcomes for individuals.

14) HSCPs should further engage with carer centres and carers representative groups by routinely including them in planning for care at home and housing support services to ensure carers receive the support they need.

15) All partners, at national and local HSCP levels should work together to streamline data collection and monitoring systems for care at home and housing support to minimise the administrative burden on service providers.

16) Nationally and locally, health and social care partners should build on the findings of this inquiry and bring these together with other emerging information about care at home and housing support services to inform planning for the ongoing pandemic response, but also more widely to inform the agenda for adult social care reform.

1. Introduction

This report sets out the findings of the Care Inspectorate's inquiry into care at home and housing support services, carried out with the support of the Cabinet Secretary for Health and Sport. The inquiry relates to the period between March 2020 and August 2020, during the COVID-19 pandemic.

The inquiry focused on five key questions:

- How were services prioritised during the COVID-19 pandemic to help ensure service delivery continuity?
- What were the known impacts on people who experience care?
- What were the risk management arrangements in place to mitigate the risks to service delivery?
- How effective were the partnership working arrangements?
- What were the recovery plans for services?

This inquiry covered services registered with the Care Inspectorate as providing care at home and services with a dual registration for care at home and housing support. These are services, delivered to adults across a range of care groups and for children and young people.

The content of this report is informed by HSCPs senior managers and managers from service providers, reflecting their experiences during the period of the inquiry.

Ascertaining the views of people who experience care or their carers[1], or other stakeholders, including frontline staff, was outwith the scope of this inquiry and are not reflected directly in this report.

The focus of this inquiry has been on approaches and processes, how well partners worked together and what we can learn from this. It has not focussed on outcomes for people who experience care. It is essential that the views and experiences of people using services and their carers, during the pandemic are understood to inform the overall learning for care at home and housing support services from the pandemic.

Our inquiry process

Phase 1 – Planning and information gathering

The inquiry team comprised of inspectors from the Care Inspectorate. The team collated and analysed publicly available data (for instance, the Scottish Government and Information Services Division), information held by the Care Inspectorate and evidence provided by HSCPs and service providers.

[1] In this report when we refer to carers this means unpaid carers.

Phase 2 - Surveys, meetings and analysis

This included direct contact with HSCPs and service providers. It involved:

- all 31 HSCPs across Scotland providing a written response to a set of key questions in an electronic survey
- meetings with over 100 senior officers across 30 HSCPs. Meetings were undertaken using video conferencing
- an electronic survey and supportive discussions, using telephone or video conferencing, with over 300 identified care at home and housing support service providers including those in the public, third[2] and independent sectors.

Phase 3 – The inquiry report

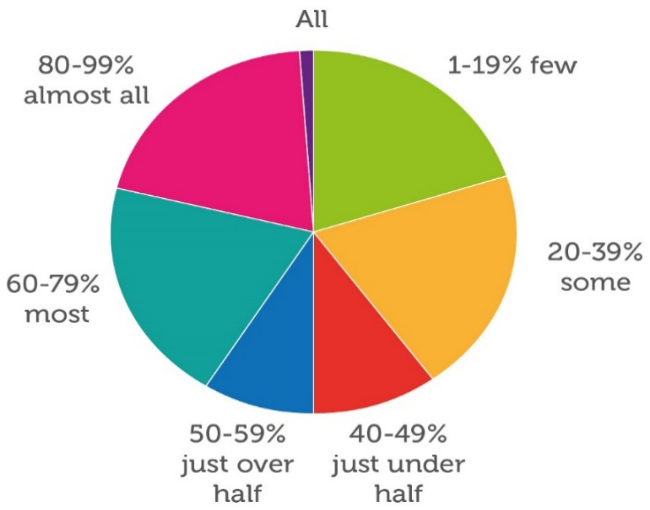
The report sets out above the key messages from this inquiry along with recommendations from our findings. The main body of the report which follows on from here is structured around the five key questions of the inquiry.

Numerical analysis of both HSCP and service provider survey findings are available on our website.

- Appendix 1 - Health and social care partnership survey results
- Appendix 2 - Service provider survey results

Note: Throughout this report we refer to the proportion of HSCPs or service providers who reported on a particular issue. For example, 'almost all (between 80% -99%) of HSCPs developed contingency plans'. How we describe these proportions is shown in figure one below.

Figure 1: Data descriptors for percentage



[2] The third sector comprises community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers.

2. How were services prioritised during the COVID-19 pandemic to help ensure service delivery continuity?

In this section we consider how HSCPs prioritised care at home and housing support services and how these decisions were informed by changing circumstances.

Summary

- While some staff needed to shield or self-isolate, many of their colleagues worked hard and flexibly to maintain services.
- Many people experiencing care chose to reduce the support they received to reduce their risk of infection. This reduced demand on social care services and made a key contribution to balancing the impacts of reduced staffing capacity.
- The duration of the lockdown period left many carers exhausted and anxious about the future.
- HSCPs and service providers mostly worked well together to find creative and responsive solutions to key challenges, like maintaining care at home and housing support staff capacity, shortages of PPE, rapidly changing guidance and access to testing.
- All HSCPs prioritised support for people with critical needs, almost all made changes to packages of care to do this, but the number of people affected by this reprioritisation across HSCPs was very variable.

The challenges of the pandemic

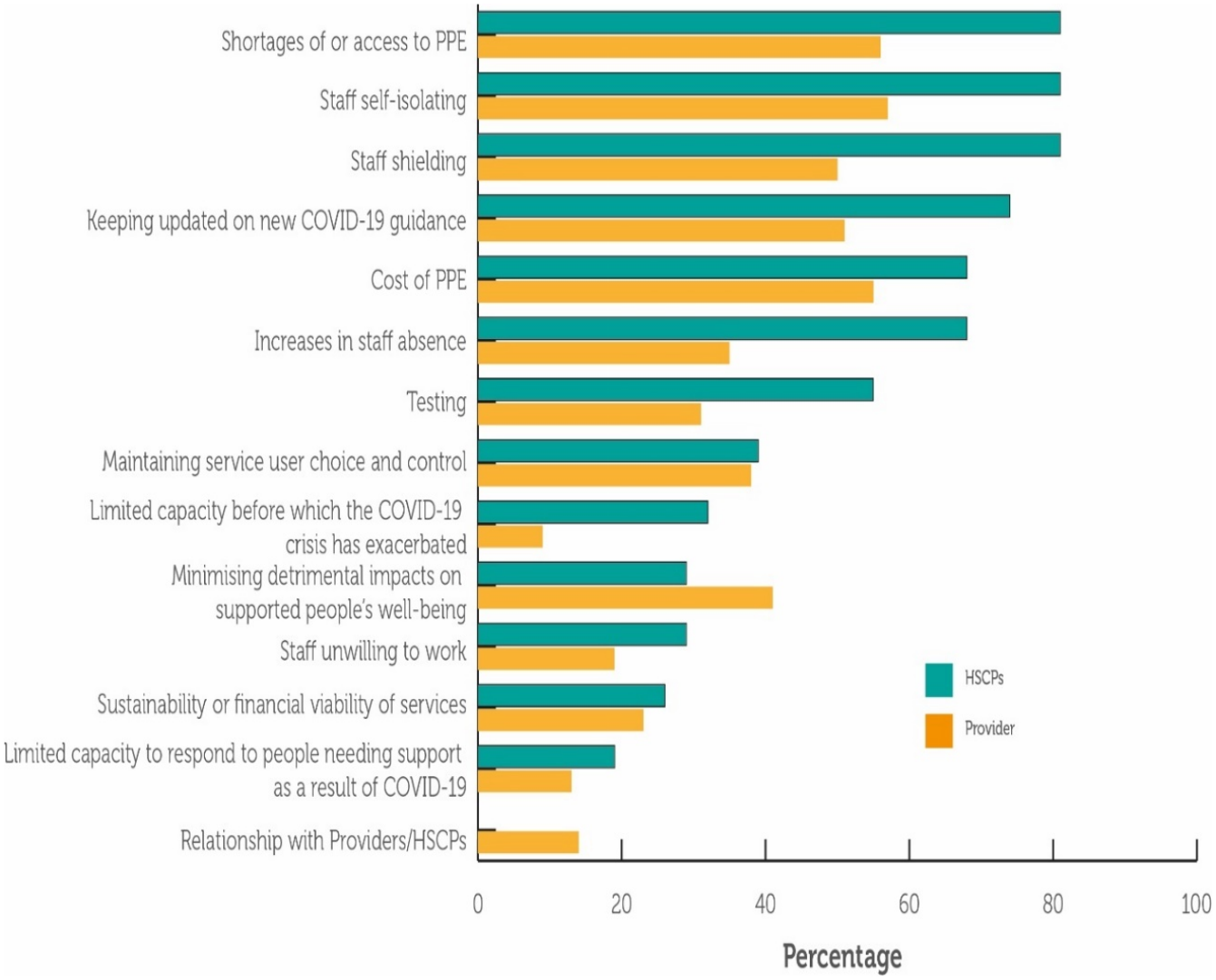
The size and impact of challenges and the actions taken to respond were different in each HSCP area. This reflected the different levels of COVID-19 infection in different parts of Scotland. It was also influenced by the socio-economic profile of local populations in terms such as age and levels of deprivation. Existing strengths and weaknesses of each local health and social care system prior to the pandemic also had an effect on both the challenges experienced and the actions taken to respond. The main challenges experienced by HSCPs and service providers are shown in figure two below.

The commitment of care at home and housing support staff and the decision of some people who experience care, their families and carers, to reduce or cancel their care packages, to reduce their risk of infection, was critical. This helped to release service capacity for those in greatest need.

It took some time for HSCPs and service providers to adjust to managing the risks, for example, to ensure routine access to PPE and testing. The overwhelming majority of care at home and housing support staff remained committed to maintaining service delivery despite the challenges they faced.

In the early weeks of the pandemic this meant continuing work through uncertainty, increased anxiety and fear about the risks to themselves their families and the people they supported. Many staff worked hard and more flexibly to maintain the service while some colleagues needed to shield or self-isolate.

Figure 2: Main challenges reported by HSCPs and service providers (% of respondents)



Source: Care Inspectorate

The challenge of staffing capacity

At the beginning of the pandemic there was a lack of clarity in guidance for care at home and housing support staff on the risks for themselves and their families. There was a lack of understanding of who needed to shield or self-isolate or who could be furloughed. Staff were concerned about the risk of spreading infection to their own family members who were shielding. This lack of clarity exacerbated problems with staffing capacity.

In almost all HSCP areas, many people who experienced care and their families chose to reduce the support they received from the HSCP or service providers. This reduced demand on social care services and made a key contribution to balancing the impacts of reduced staffing capacity. In two HSCP areas, services did not change. This was due, in part, to the comparatively low numbers of COVID-19 infections in these respective areas.

Almost all local authority service providers reported frequent and substantial problems in maintaining sufficient staff capacity, particularly in the early stages of the pandemic, due to staff self-isolating or shielding. Nearly a third had problems with some staff being unwilling to work. There were similar issues for third and independent service providers with over half having issues with staff self-isolating or shielding but fewer had problems with staff unwilling to work.

As the pandemic timeline progressed staff absence rates declined. This reflected a growing confidence in staff as advice, guidance, systems and protocols for identifying and managing risk were developed, consolidated and rolled out.

The scale of care at home and housing support staff capacity problems varied considerably. Some HSCPs had capacity reductions in excess of 30% whilst other HSCPs found the significant reductions in staff capacity they had planned for did not materialise or were only experienced in the early days of the pandemic.

In a few HSCP's, externally commissioned service providers supporting children stepped down their operations significantly. This was often in response to parents, whose children had disabilities, wishing to shield their children.

HSCPs implemented a range of measures to maintain their capacity to meet the critical needs of vulnerable people. This included seeking to recruit more staff on a temporary or permanent basis. The success of these efforts was mixed with highlighted barriers such as recruiting and delivering training in a socially distanced way.

Most HSCPs offered overtime and increased contracted hours to their existing staff, which helped to meet reductions in capacity but risked exhausting the existing staff group in the longer term. Staff from other local authority services, that had ceased to operate, were redeployed to social care roles. Experienced social care staff from day services and other services that had suspended operations were retrained and also redeployed. Staff from non-essential services and those shielding helped, for example, to provide telephone follow-up for people who experience care, who were themselves shielding or with reduced support.

A few HSCPs sought to expand the number and capacity, of externally commissioned service providers to deliver services. The success of this approach depended on whether externally commissioned service providers had any additional capacity available.

Some HSCPs reported that externally commissioned provision experienced lower levels of staff absence. This was due to a different workforce age profile or perhaps, less positively, because of less generous terms and conditions of employment. Some third and independent sector service providers found it easier to recruit additional staff because of the numbers of people displaced from other sectors such as the hospitality sector.

The challenge of accessing personal protective equipment (PPE)

HSCPs and service providers identified that shortages of, and access to, sufficient supplies of PPE were significant issues. This was especially so in the third and independent sectors in the early part of the pandemic. PPE costs remained an ongoing pressure for some service providers.

Some HSCPs reported that they had difficult discussions with trade unions, particularly on issues such access to, and availability of, PPE. These were improved through better communication, gradual improvement in PPE availability, and the improved clarity of associated guidance. The early difficulties with PPE supply and changing guidance contributed to higher levels of fear and anxiety among staff, people who experience care and their families. This also contributed to difficulties in maintaining sufficient staff capacity. Fears were amplified by some media reports.

Third and independent sector service providers had additional challenges in accessing PPE. A small percentage of service providers were able to secure and maintain their own required PPE supply. Others rapidly encountered problems with suppliers prioritising supplies for the NHS and significantly increasing prices. There was a range of problems with the initial system of national PPE hubs but the establishment of local hubs in each HSCP ultimately satisfactorily addressed PPE supply.

There were good examples of HSCPs adopting an integrated approach to PPE supply, which ensured that all staff could access and use PPE in a consistent way, according to the risks associated with their job, regardless of which organisation they worked for. Where NHS boards sought to increase the level of PPE to higher levels than national guidance required, this created challenges for social care providers.

Guidance about PPE was plentiful but at times confusing and presented challenges to staff, people who experience care and their families. Service providers wished for one authoritative source of guidance with clear, timely and specific updates, as required, with realistic lead in times for implementation.

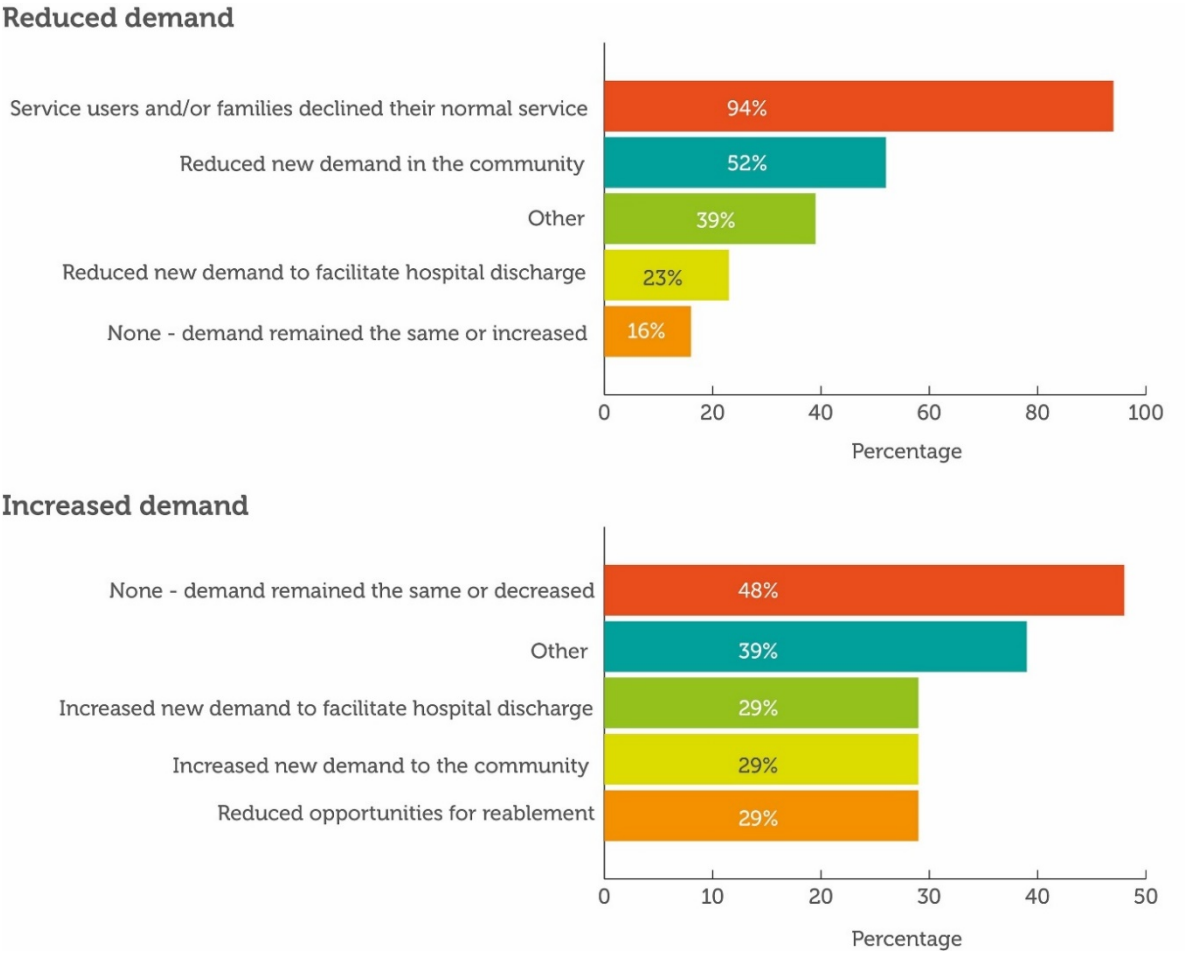
The challenge of testing for COVID-19

Over half of HSCPs and around a third of service providers identified the testing of people who experience care and staff as a challenge. Initially, the absence of clear processes for testing care at home staff, raised anxieties among staff and people using services. These were, mostly, overcome by HSCPs providing updated advice and guidance. Improved testing regimes, prior to hospital discharge, significantly helped to ensure necessary processes were followed. The establishment of 'Test and Protect' processes brought a potential risk of numbers of staff members being required to self-isolate. While critical in preventing the spread of infection, it created short-term challenges in staff capacity in particular localities.

The challenge of changing service demand

Almost all HSCPs experienced a reduction in overall demand for care at home and housing support services during the pandemic. People who experience care and their families reducing or cancelling their support was the most common reason for this. The main reasons for changes in demand are shown in figure three below.

Figure 3: Reasons for reduced and increased demand (% of respondents)



Source: Care Inspectorate

This was combined with reductions in demand in the community or for hospital discharges. One HSCP experienced an overall increase in demand, and for a few HSCPs after an initial decrease, demand began to grow gradually returning towards approximately pre-pandemic levels.

Some HSCPs and service providers identified increased demand as a risk to recovery, as health and social care services returned to 'normal' levels of activity. This risk would increase if combined with a rise in infections and significant numbers of staff needed to self-isolate.

There was a distinctive impact of COVID-19 on demand in each HSCP. This reflected factors such as the direct effects of the spread of infection and how staff and people who experience care reacted to actual and perceived risks. There were also the long-term local trends in service delivery patterns, levels of delayed hospital discharges, policy decisions such as providing alternatives to day services and respite combined with local socio-economic population profiles.

The challenge of reprioritising services

Almost all HSCPs developed contingency plans to re-prioritise services. These plans aimed to maintain support for those with critical needs, in instances where staffing capacity reduced below 'normal' levels. The plans were partly based on the experiences of contingency planning to meet winter demand pressures. In some HSCP areas reprioritisation was not required due to the reduced demand from people experiencing care who reduced their care packages. Service providers adapted existing plans designed for other contingencies.

HSCPs and service providers looked for alternative ways to meet lower-level needs including relying on more support from families, making fewer visits and introducing new services to provide meals and shopping, in conjunction with third sector organisations.

The degree to which these plans were implemented varied considerably with around one third of HSCPs needing to make little or no change. For the most part, these HSCP areas did not have the highest levels of recorded infection. The other two thirds of HSCPs reprioritised services to a greater or lesser extent, with the aim of ensuring that those with the highest assessed needs continued have these met. Just under half of the HSCPs reviewed care packages themselves, some delegated the responsibility for reviews and amendments to service providers.

Estimating the scale of the impact that COVID-19 had on the amount of care delivered across Scotland was difficult to gauge. The situation was dynamic, and many changes were short lived or agreed directly between people who experienced care and service providers or not recorded adequately on HSCP business systems.

We asked HSCPs to provide us with numbers of care packages that had been subject to changes during the pandemic up to end of June 2020. In addition, we asked about the number of packages that decreased or increased. As figure four shows, there were significant variations, between HSCPs, in the proportion of people's care packages that were changed.

Of the 23 HSCPs that provided information, 21 had changed care packages and 19 indicated that changes had involved reductions in provision. The proportion of people experiencing care affected by these reductions ranged from as low as 0.3% to as high as 71%. Nearly two-thirds increased a small number of packages. The proportion of people experiencing care who received increases in support ranged between 0.2% to 15%.

Figure 4: Proportion of people's care packages that were changed

Source: Care Inspectorate

The primary aim of reprioritisation was to protect people with critical needs from possible reductions to their care package. In some instances, some low-level elements of care and support were reduced for people who had other than critical needs. The most robust approaches included good joint working between the HSCP, operational social work teams, commissioning teams, service providers and community nursing to ensure that those with the most critical needs where effectively identified.

Despite the large numbers of people who experience care facing changes in their support in some HSCP areas, the number of hours of care released, by these changes was small. Of those HSCPs who could provide information, half had released less than 4% of the total number of care at home and housing support they had delivered before the start of the pandemic. The remaining percentage of hours released varied between 5-20%. This was consistent with the re-provision of capacity towards low intensity support and non-critical activities.

Almost all HSCPs communicated changes with people individually, but some combined this with large-scale communication strategies involving writing to everyone and publicising the need to prioritise in social media.

Almost all HSCPs undertook some form of review or risk assessment to determine if support could be reduced safely. Most HSCPs maintained contact with people who experienced care to check if their needs or situation had changed. Where partial assessments were undertaken under emergency legislation, many people received services. Most HSCPs commented that it was their intention that partial assessments would be revisited and reviewed in line with emergency legislation.

The challenge of enabling successful hospital discharges

In most HSCPs there was a drive early in the pandemic timeline, to release capacity in acute hospital services. Subsequent reduced admissions and flow through hospitals meant that the transfer of care became less of an issue. Some HSCPs temporarily purchased additional capacity of additional care home placements and two HSCPs re-opened previously closed care homes as part of the co-ordinated effort to reduce the numbers of people in hospital. A few HSCPs purchased additional dedicated bed-based intermediate care places. These HSCPs found that these measures were mostly not needed as the anticipated levels of demand did not materialise.

Overall, delayed discharges reduced during the pandemic with care at home and housing support services making an invaluable contribution to reducing these delayed discharges.

Service providers had some concerns about people being discharged own home without a test, in the early stages of the pandemic, or with incomplete information about their COVID-19 status or their health and/or social care needs. The lack of testing of people discharged from hospital and the limited availability of PPE were the main challenges for providers in supporting hospital discharges in the first weeks of the pandemic. HSCPs addressed this by introducing enhanced advice and guidance, better testing protocols and practice alongside improved PPE supply.

Rising to the challenges

Almost all HSCPs and service providers emphasised that their care at home and housing support staff had more than stepped up to the challenges of responding to this pandemic and had ‘gone the extra mile’. This included working through the uncertainty in the early stages of the pandemic and the fear and anxiety it produced.

Greater recognition of their care at home and housing support staff by the general public was a clear positive for most service providers, although some reflected that they had felt partially forgotten in the very early days, where public appreciation appeared to be focused more on the NHS.

‘Staff showed an amazing level of commitment to the people they were supporting, taking care to adhere to all guidelines, at work and at home, to prevent transmission of COVID-19. Staff created opportunities for people to keep fit and active and this led to supported people taking a lead role in organising activities, building on new skills as well as confidence.’

(HSCP)

Most service providers experienced stronger working relationships with families and carers. Some had improved their working relationship with their local HSCP. However, a few service providers continued to experience difficulties in their relationships with their HSCPs.

The response of care at home and housing support staff was identified across all sectors as an overwhelming and major achievement. No other single issue had a greater degree of unanimity. A main feature of our discussions with both service providers and HSCPs was that they identified improved working relationships and developing sense of trust during the pandemic to have been a key benefit for all. There was agreement across all HSCPs and service providers that the key support provided was the provision of PPE, advice and information.

Decision making and governance

At the beginning of the pandemic, most Integration Joint Boards (IJB) decided to amend many of their direct governance activities. HSCP chief officers and their senior management teams acted under delegated authority from the IJB. HSCPs were represented in local authority and NHS board ‘pandemic response’ groups.

HSCPs had in place, or quickly developed, escalation protocols for joint and robust decision-making in response to the unknown and unprecedented circumstances they faced. Strategic decisions to reprioritise care were most commonly made by HSCP chief officers or through emergency planning decision-making structures. Key factors influencing decisions to reprioritise included staffing capacity reductions and whether HSCPs anticipated significant and ongoing reductions in such capacity. Decisions at the operational and individual level were mainly made by local HSCP managers in co-operation with service providers and in consultation with people who experience care and their families.

Several service providers had been impressed by the strong directional leadership, shown by HSCP senior managers, particularly in the early pandemic timeline. Leadership and management had been responsive, assertive and decisive to ensure services were adaptable and staff resilient in a fast-changing environment.

This gave staff confidence and certainty about their approach and resulted in more active teamwork and a sense of shared purpose. This was not always the case and a few service providers commented that they were disappointed in their local HSCP leadership's performance.

Externally commissioned service providers implemented their own business continuity plans, undertaking risk assessments to identify whether service changes were necessary either due to individuals' circumstances or other pressures. This information was shared with HSCPs to support further risk assessment and to help ensure shared decision making.

Most HSCPs advised us that the pandemic had paradoxically enabled the development of a more open environment where there was space for more autonomous decision making. Projects and programmes that had been 'on the back burner' for some time had been accelerated as HSCPs were enabled to act quickly. This had been helped with the delegation of responsibility to lower levels of management and operational localities.

3. What were the known impacts on people who experience care?

In this section we consider how the pandemic impacted on people who experience care, and their carers, how HSCPs monitored this impact and the outcomes of any changes to care and support for vulnerable people.

Summary

- Some people who experience care, their families and carers chose to reduce or suspend their support to reduce the risk of infection. HSCPs needed to respond rapidly when carers were unable to sustain support needed over time.
- Social isolation, disruption to daily activities, limitations on physical activity and the suspension of reablement adversely impacted on the health and wellbeing of people who experience care, their families and carers..
- Care at home and housing support staff worked creatively and flexibly to find alternative ways of delivering support to minimise negative impacts on people experiencing care.
- Across all sectors, there was a consensus about the commitment and dedication of staff.
- People who experience care faced more detrimental impacts if they were unable to understand the need for infection control measures, such as social distancing or why staff were wearing PPE.
- Digital inclusion was important to reduce negative impacts, such as social isolation.

Impact on people who experience care, and carers

We acknowledge the limitations of this inquiry in relation to people who experience care, carers and staff experiences and outcomes. This section provides insights into the impact of the pandemic, on people who experienced care through the lens of the HSCPs and service providers.

Across all sectors, there was a consensus about the commitment and dedication of staff. Care at home and housing support staff had gone above and beyond the requirements of their role. The outcomes for people who experienced care directly benefitted from the actions of staff and families.

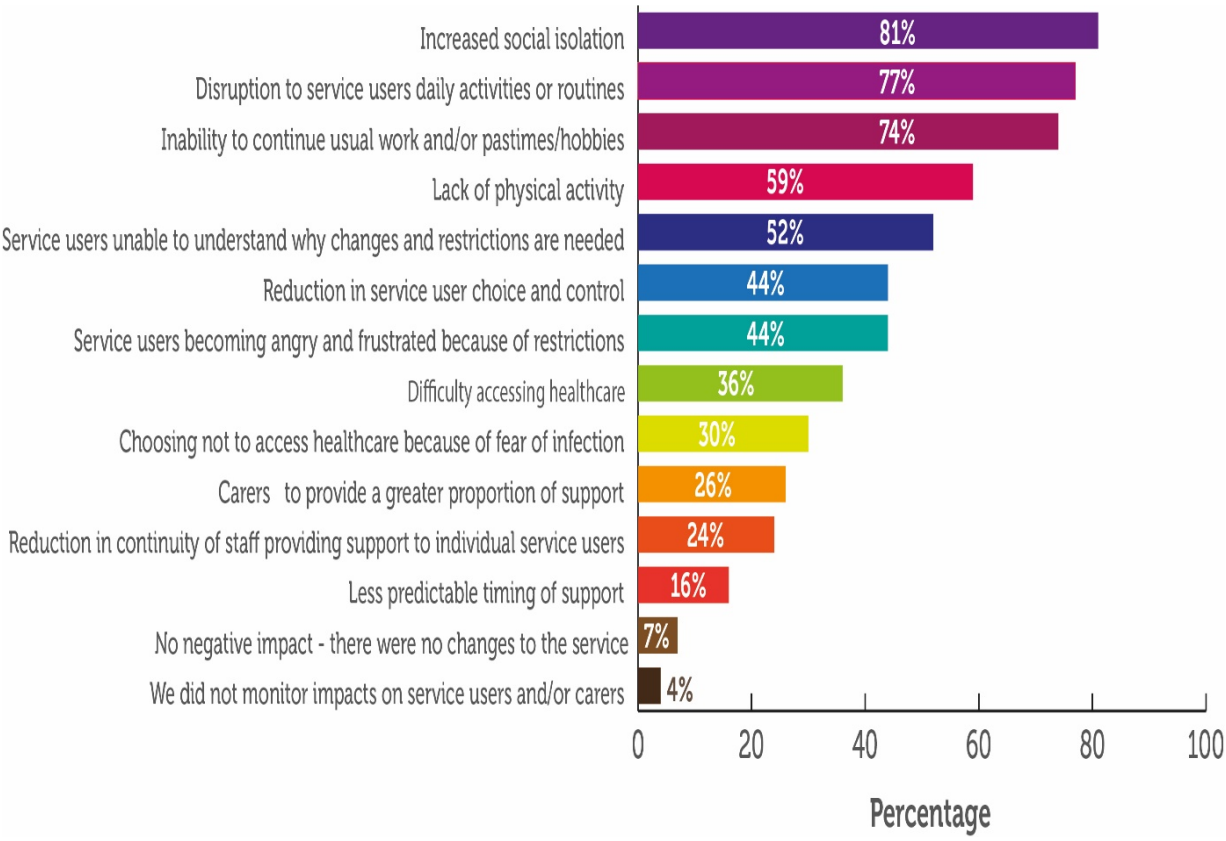
> ‘I have never been prouder of the staff … they were amazing and because of this, the people we supported were safe and well throughout.’
>
> (Local authority service provider)

This was crucial in supporting and sustaining people who experience care and protecting both statutory social work services and NHS healthcare services. The word 'willingness' frequently featured in HSCP responses when describing the co-operation of families taking on more of the caring role.

In almost all HSCP areas, some people who used services or their families, declined their normal service to reduce footfall in the home. Where respite or day services ceased to operate, the pressure on a carer's ability to continue to support was at times intense. Where families were not able to sustain additional support or contact, HSCPs and service providers had to step back in, to varying degrees. The duration of the lockdown period left many carers exhausted and anxious about the future.

Over four-fifths of service providers noted problems with people who used their service experiencing increased social isolation. This was the case across Scotland. Social isolation was closely connected to disruption with people's daily activities or routines and their inability to continue with their usual work, pastimes or hobbies. Increased levels of anxiety and stress were common. Figure five below illustrates the most noted adverse impacts reported by HSCPs and service providers.

Figure 5: Negative impacts on people who experience care
(% of respondents)



Source: Care Inspectorate

Lockdown restrictions had adversely impacted on people's choice and control. The health and wellbeing of people who experienced care was also adversely affected by the lack of physical activity.

A third of service providers reported that people who experienced care faced difficulty accessing healthcare or chose not to access health services during the pandemic. There were the difficulties with people not having routine health appointments, access to medical interventions or advice from healthcare professionals. Many service providers reported that they had no or very limited access to the NHS 'Near Me' online video consulting service. Service providers believed that the difficulties in accessing healthcare had adversely impacted on the health and wellbeing of people who experienced care.

Differences between care groups' experiences

Just over half of HSCPs identified that there were significant differences between care groups in terms of the challenges they experienced from COVID-19, the response to these challenges and how they planned to recover.

HSCPs' responses highlighted that people experienced more detrimental impacts if they were unable to understand the need for infection control measures such as social distancing or why staff were wearing PPE. Staff often used creative ways to engage with people, such as 'easy read' paperwork, social stories and pictorial cues to encourage a better understanding of the virus and the necessary restrictions.

The potential impacts on the mental health of people who experienced care, as family members returned to work were not wholly known. Both mental and physical health needed to be closely monitored and services planned to monitor potential future rise in the incidence of illness in those using care at home and housing support services. It would be important for HSCPs to understand the impact of social isolation and reduced mobility on health and wellbeing to inform responses to future spikes in infection rates or further outbreaks.

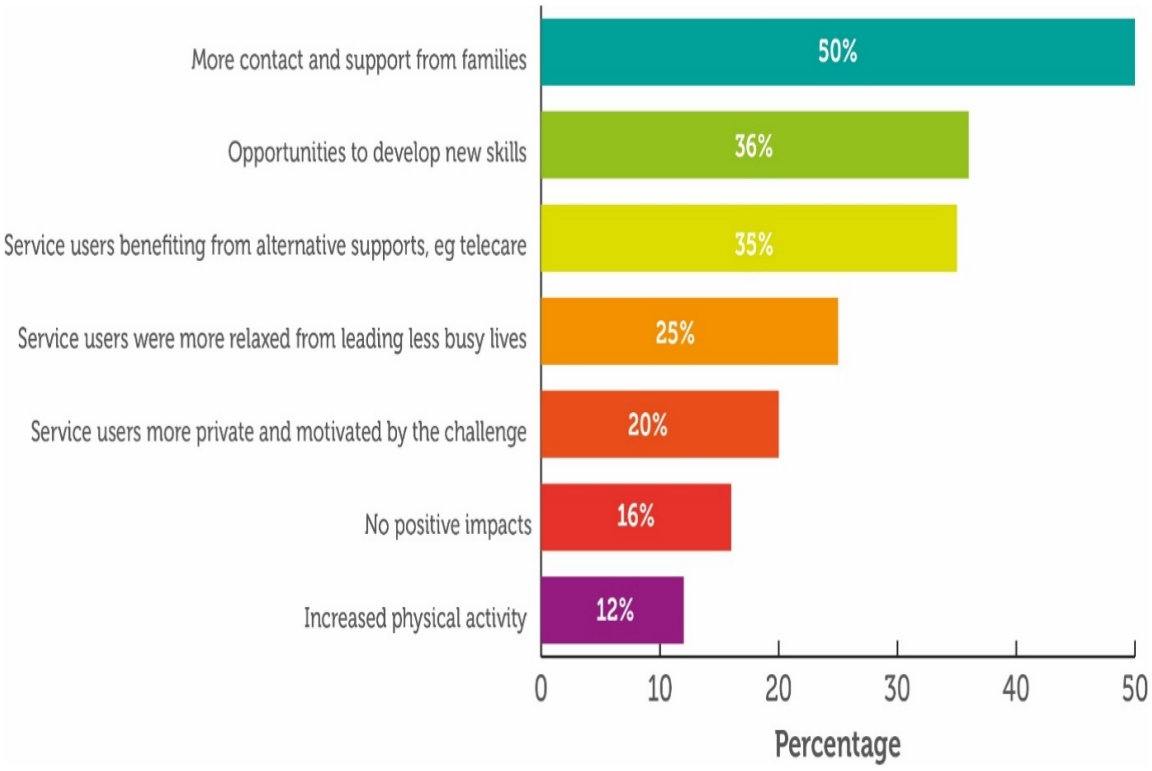
When combined with the cessation of respite and planned breaks from caring, people with a learning disability and their carers experienced a particularly significant loss of service. It was more difficult for those people who had less capacity to understand the enforced changes. There was increased care at home activity by some learning disability care providers to compensate for the loss of community service provision.

Regarding the impact on people with autism, reduced community access, due to lockdown, resulted in a loss of daily routines and predictability. Service providers described higher levels of stress for those who used their service.

While there was a reduction in activity out with the household, this was not all negative. Some people who experienced care seemed to achieve a better life balance with less busy routines. For others, this was an opportunity to develop new skills and maintain or develop higher levels of independence and benefitting from alternative supports such as assistive technology and digital inclusion.

There were some positive examples of how people were supported by technology to see families and staff via online platforms. This online presence facilitated creative and practical supports including telecare, online shopping and engagement with physical exercise regimes. This promoted stimulation, activity and entertainment, positive outcomes consistent with the Scottish Government's promotion of technology enabled care. Figure six below illustrates the most commonly noted positive impacts on people experiencing care, and their carers, reported by HSCPs and service providers.

Figure 6: Positive impacts on people experiencing care and their carers (% of respondents)



Source: Care Inspectorate

There were increased risks of social isolation for people who experience care, who had neither the resources, skills nor capacity to engage with online solutions. Remote support through telecare and video communication required careful assessment, supplementing rather than replacing face-to-face interactions. There was a 'digital divide', where some older people were less likely to be confident with technologically supported means of social contact.

Carer organisations and carer centres provided critical support to carers. HSCPs acknowledged the need to recognise the important work of these organisations and to include them in future strategic planning around critical services of support for people who experience care in emergency responses.

> 'The Carer Centre continued to provide a range of services via digital or phone. Visits were prioritised for those most vulnerable in the critical category.This provided contact for those shielding or carers who were shielding.'
>
> (HSCP)

Particular issues for children and young people

There was a mixed picture across Scotland in terms of maintaining or amending services for children and young people. The experiences of children and young people were broadly in line with other care groups but there were some distinct issues.

Children with disabilities were particularly reliant on care at home service providers and personal assistants (PAs). Some of these services ceased during lockdown. As some families were shielding, this reduced the level of care at home support that was needed.

The impact of the suspension of day services and respite had a particular impact on children and young people with additional support needs, learning disabilities or behaviours that were challenging. Children and young people, whose school education and building-based social activities had been suspended, were particularly adversely affected as were their parents who, in some situations, became quickly exhausted. The level of understanding of children and young people regarding the lack of these services' availability put additional strain on families.

It was evident that demands of children and young people with challenging behaviour and or particular care requirements were often considerable for those families coping in these circumstances.

Communities, friends, neighbours, volunteer groups, input from social work and education, were all significant in supporting families and providing practical and emotional support. While the resilience of supported individuals and families was apparent, the longer-term impact, potential burnout and shift in goodwill needed to be considered going forward. Regular family contact, arms-length practical and emotional support was mobilised to prevent families entering crisis. This included shopping, food parcels, medicine collection and technology equipment. Increased access to direct payments alleviated the costs associated with PAs shielding or this service being replaced by care at home.

Education hubs offered support for some of the children at highest risk. Local authority children's services staff and service providers worked effectively to resume limited support to those most in need whenever possible.

The risk of hidden harm for children during the pandemic was a concern. Recovery planning needed to focus on the educational and social deficits that the pandemic had created for children and young people.

Prevention, early intervention and reablement

Responses from HSCPs highlighted very differing views about how essential it was to carry on with prevention, early intervention and reablement during the pandemic in the context of immediately competing demands. For some, actively continuing with this work was a priority. However, most HSCPs deemed early prevention and reablement work as 'non-essential' with service delivery prioritised for critical care and support during the pandemic.

This approach had led to unintended consequences such as increased numbers of falls and reduced mobility for people who experience care, and an increase in waiting times for 'non-essential' services including preventative and reablement services. The critical role of prevention, early intervention, rehabilitation and reablement needed to be reviewed in the context of defining 'essential' and 'non-essential' services in the future.

HSCPs recognised, as they progressed their recovery planning, the need for a greater emphasis on actions to support an individual's capacity for self-care and self-management to manage long term conditions.

Promoting choice and control

Maintaining the usual levels of choice and control for people who experience care was a challenge during the pandemic. Even when the impact of reductions in staffing capacity required unavoidable changes, the best approaches included personalised contingency plans for each person. Self-directed support (SDS) provided an opportunity to achieve meaningful choice and control but meeting desired outcomes through SDS sometimes became problematic. Public Health guidelines impacted significantly on the way that social care services could be delivered.

Choices became limited, and agreed budgets were at times not in keeping with the demands resulting from lockdown restrictions. When staffing capacity reduced, changes to SDS care packages were often unavoidable. Only one HSCP made clear that they were able to maintain all SDS options, in full, during the pandemic.

HSCPs worked hard to maintain available SDS options with the most successful solutions achieved by taking a more flexible approach. For example, the blending of SDS options with HSCP's available capacity not only resulted in benefits for the people experiencing care but also for working relationships between HSCPs and service providers. Another effective approach was to allow more discretion on how direct payments could be used, by providing funding to cover for shielding personal assistants (PAs), procuring PPE for PAs or where PAs left their employment and recruitment was difficult, HSCPs freeing up additional support from in-house care at home staff.

Monitoring the impact on the care and support experienced by people.

HSCPs used a range of methods to monitor the pandemic's impact on people's care and support. Formal reviews and needs assessments by care managers played an important part. Monitoring information was received from service providers. Nearly three-quarters of HSCPs had undertaken surveys of people who experience services or who had direct contact with those that do. Over half had contact with or surveyed carers. However, this means that there were still large numbers of people who experienced care, or their carers, in some HSCP areas, that had not received any direct contact.

The changes to care packages did not generate a substantial number of complaints to HSCPs or the Care Inspectorate. Between mid-March and 30 June 2020, a few HSCPs received a very small number of formal complaints about service reductions Most received no complaints at all. The Care Inspectorate received 156 complaints, from April until the end of August 2020, regarding care at home and housing support services, that were potentially linked to COVID-19 issues. This was a small proportion of the overall numbers (approximately 60,000) of people who experience care at home services across Scotland.

4. What were the risk management arrangements in place to mitigate the risks to service delivery?

In this section we consider how the decisions to change the care and support provided were informed by the wider risk assessment processes applied.

Summary

- HSCPs implemented their resilience plans to manage the strategic and operational risks.
- The most robust approaches to identifying and managing individual risk involved a person-centred approach that was supported by service providers, social work and community health teams working together.
- Keeping in regular contact with people who experienced care was essential to responding appropriately to changing needs and risks.

Strategic and operational risk management

At a strategic level, HSCP senior management teams were responsible for assessing, gauging and addressing the strategic risks. Some HSCPs, local authorities and NHS boards had dedicated 'resilience' or 'pandemic' groups which had HSCP senior officer representation. These bodies oversaw the pandemic strategic risk registers and reported to the Integration Joint Boards and NHS boards through the HSCP's chief officer or other senior officers. With hindsight, some partnerships acknowledged it would have been beneficial for these 'resilience' or 'pandemic' groups to have had a wider membership, including the third and independent sectors, as well as local authority housing representation.

The strategic risks for HSCPs included consideration of public protection, governance arrangements, staffing capacity, technology and communication and the financial sustainability of services. Almost all HSCPs had identified, assessed and managed the risks relating to care at home and housing support services as part of their wider assessment of the impact of COVID-19 across all its activities.

Just over half the HSCPs had undertaken risk assessments when individual care packages were changed as a result of its response to the pandemic. Over a third had specifically assessed risk in relation to care at home and housing support provision. Just over a quarter had risk assessed the impact of the changes it planned to make to care at home and housing support services. For future planning a more detailed focus on the exact nature of the risks, including those at a local and individual level, involving care at home and housing support would be beneficial rather than as part of a generic high-level framework. Detailed assessments on the impact of the changes would be essential.

Some of identified risks were mitigated by, for example, developing improved protocols between agencies, training on PPE, delivering staff engagement sessions and developing staff wellbeing hubs. Most HSCPs had accelerated the availability of a range of digital communication platforms (for instance, online training materials). Increasing investment in information technology had made a major contribution to improving how local services worked. It helped to increase the potential for staff to have more agile working and improved their communication and risk assessments between staff, families and people who experienced care. A few HSCPs were at a very early stage of taking this forward.

Risk management for people experiencing care

Needs, risk assessments and reviews identified people at high, medium and low risk. These assessments considered known adult support and protection concerns, high levels of unpaid carer stress, complexity of condition or complexity of existing care arrangements. The aim was to undertake these through discussions with service users and their families.

Most, but not all cases, were kept under review, to help monitor changing circumstances. Regular (for instance, telephone contact) was maintained in many instances with individuals identified as higher risk, with additional face to face contact provided where necessary. Some HSCPs had completed these reviews of care packages themselves. Some delegated this to their externally commissioned providers. Enhanced risk assessment tools helped to assess risks for people living alone or with no family support and people whose family supports would be unable to undertake tasks due to self-isolation or COVID-19 symptoms.

There were potential ‘unseen risks’ in telephone reviews during COVID-19 rather than with face to face equivalents. These risks were higher for those who lacked capacity or exhibited challenging behaviours. Risks could be mitigated, in part, by regular staff contact with families and reporting to care managers. Some HSCPs had reduced the frequency of contact with people who experienced care, their carers and care mangers, as risk assessment practices became more established.

HSCP senior managers were confident that, where relevant, they had assessed and reviewed packages and that appropriate tools and processes to assess and manage risks were in place. However, some service providers reported that, in some HSCPs areas, people who experienced care had not always received the level of risk assessment and review suitable for their needs.

5. How effective were the partnership working arrangements?

In this section we consider whether engagement with service providers demonstrated a true partnership approach.

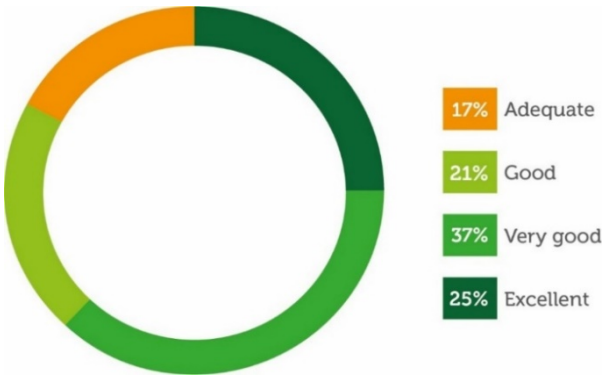
Summary

- Most HCSPs and service providers considered their working relationships had improved during the pandemic crisis.
- Most service providers considered the HSCP gave them good support with key challenges, however, one in ten service providers said that they had received no or little support.
- Service providers were concerned about the impact of the pandemic on their financial viability.
- Service providers highlighted the requirement to provide similar information to a range of agencies and the need for this to be streamlined.
- HSCPs that generally worked well with their in-house and externally commissioned service providers to deliver well-functioning and well-balanced social care markets, suitable for their respective areas, were more readily able to respond swiftly to the sharp changes in the market demands.

The experience of service providers

The pattern of local service delivery influenced each individual HSCP and their externally commissioned service providers' contribution to delivering services during the pandemic. Where the HSCP had almost all the local care at home provision, it was less usual for them to have frequent dialogue with service providers. Supported living services were less likely to keep close and very regular communication with HSCPs. Care at home provision service providers were more likely to have more regular communication. Overall, service providers, as shown in figure seven, rated the quality of support or partnership working with their HSCP during the pandemic positively with most saying support was very good or excellent.

Figure 7: Service provider rating of HSCP support or partnership working (%)

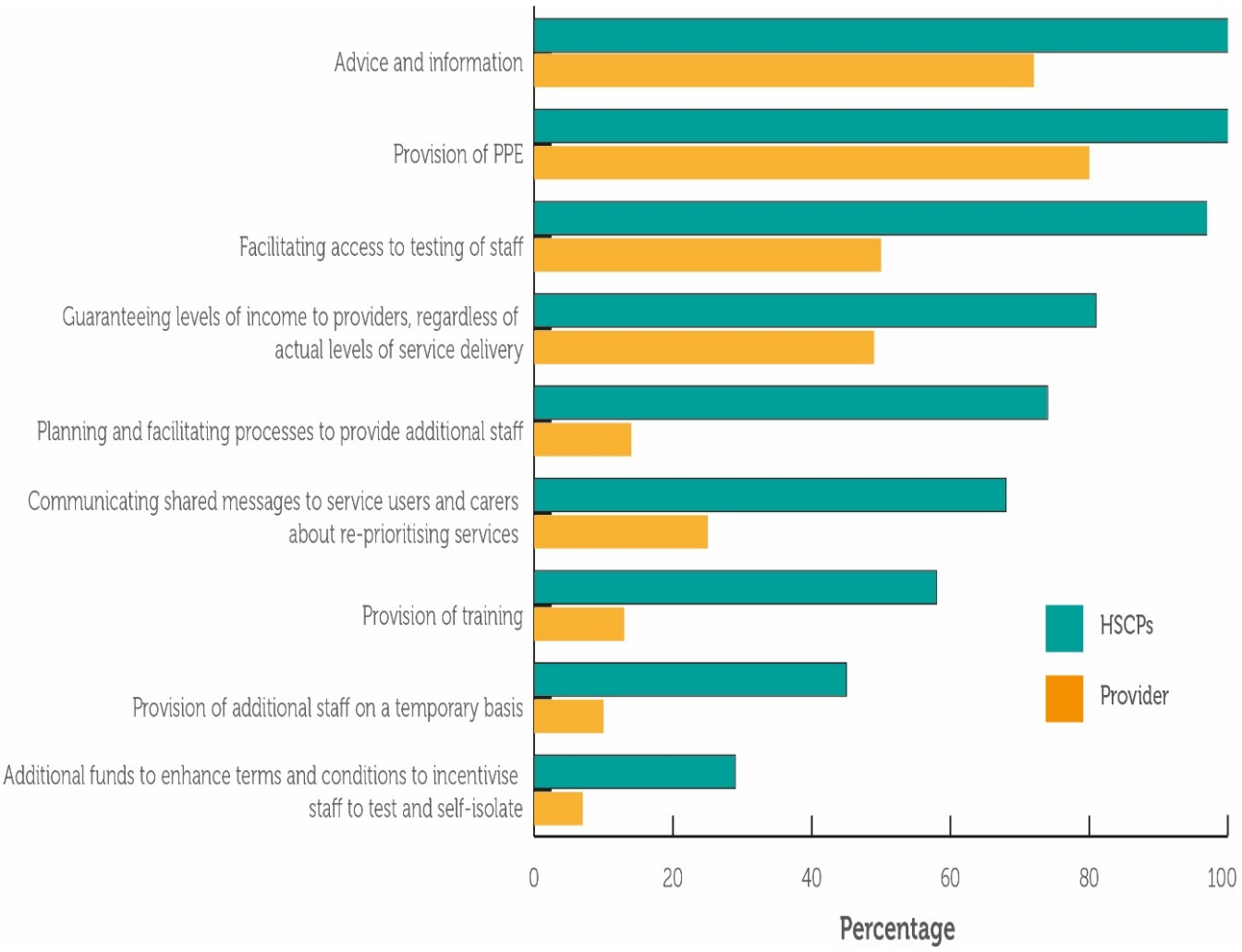


Source: Care Inspectorate

A mix of practical support and regular communication reinforced or improved relationships between HSCPs and local service providers. These are shown in figure eight below.

The most valued support included, advice and information, provision of PPE, facilitating access to testing of staff, guaranteeing levels of income to service providers regardless of actual levels of service delivery and enabling the provision of additional staff. However, one in ten service providers said that had received little or no support and were frustrated with what they saw as poor communication from HSCPs. A number of HSCPs were positive about the role of Scottish Care in supporting engagement and a few had provided additional funding to extend the availability of Scottish Care representatives.

Figure 8: Main areas of HSCP support for service providers (% of respondents)



Source: Care Inspectorate

HSCPs were mostly responsive to individual queries with just over half of service providers able to access forums using video or teleconferencing. Most service providers highlighted that there were several competing requests to provide information and data to a range of agencies, often the same information requested in different formats. This put service providers under stress and could be time consuming. This indicates a need to streamline information gathering and collection in relation to care at home and housing support services.

The quickly developing COVID-19 crisis meant that speed and communication of decisions were prioritised by HSCPs over consultative processes. HSCPs were clear that service provider involvement in the pandemic response was essential, welcomed and that all parties benefitted from collaborative working. Nearly two-thirds of HSCPs highlighted good communication and strong relationships with service providers during the pandemic. The remaining HSCPs felt working relationships had improved as a result of coming together to solve problems.

Some service providers felt their respective partnerships were very slow to adapt to changing circumstances and that forward planning had been at times cumbersome. While there were mixed experiences of how HSCPs had communicated and worked with service providers, on balance this was positive with the majority of service providers complimentary about the support that they had received.

Different sector's experience

Over a third of HSCPs identified that there were significant differences between in-house and external provision in relation to the challenges posed by the pandemic.

Differences tended to focus on matters, such as access to PPE and financial sustainability. In-house provision could draw on substantially greater resources in relation to accessing or procuring PPE, and staffing. HSCPs used their leverage to better access PPE and staffing to support service providers across all sectors. In-house services' staff generally had better terms and conditions, compared to third and independent sector employees, where statutory sick pay and zero-hour contracts issues featured more regularly. The Scottish Government's intervention to provide financial assurance in relation to topping up statutory sick pay was a welcome support.

HSCPs with a significant in-house share of the local market commented that this model conferred benefits around the speed and directness of their response in terms of decision-making and allocation of resources. Moving to a 'command and control' structure meant that these partnerships felt they were able to respond more dynamically and quickly to allocate resources than the third or independent sectors. On the other hand, those with a more diverse mixed local market expressed their views that their market profile enabled them to respond more flexibly.

For third and independent sector service providers, there was a more even spread of challenges. Staffing issues, self-isolating or shielding were less significant than for local authority in-house provision. The reasons for this were likely to include different staffing age profiles and less preferential terms and conditions of service in the third and independent sectors.

Commissioning

HSCPs that generally worked well with their in-house and externally commissioned service providers to deliver well-functioning and well-balanced social care markets, suitable for their respective areas, were more readily able to respond swiftly to the sharp changes in the market demands.

HSCPs that had capacity and quality issues with care at home and housing support prior to the pandemic found these exacerbated by COVID-19 and faced greater challenges during the pandemic.

Financial viability was a concern for a quarter of third sector service providers, nearly a third of independent service providers, and over one on ten of in-house service providers. This reflected an uncertainty created by the pandemic and a wider acknowledgement of the substantial public expenditure committed so far to support the response and whether this commitment was fully sustainable in the future.

Financial support to address additional costs for many service providers was appreciated but some thought the funding was inadequate. There were fears of possible future reductions in financial contributions from HSCPs. Some service providers saw a commitment to future funding as essential to protect services. Additional costs from routinely using PPE remained.

Sustaining the viability of the right blend of service providers would be essential for winter planning and beyond. Building on the positive collaborative approach established during the pandemic in most HSCPs would be important.

While almost all HSCPs had committed to continue to pay service providers on planned levels of service delivery, regardless of volumes actually delivered during the pandemic, service providers faced a very anxious time until this was delivered. Some services said that these agreements took too long to establish and that not all HSCPs had delivered on their promises. This placed service providers at substantial risk and compromised their sustainability. As activity reduced, some service providers experienced relatively higher reductions in demand for their services with care packages reallocated to in-house service providers.

Service providers welcomed the additional financial support from Scottish Government sustainability funds during the pandemic but had found the process for accessing them cumbersome and slow in some HSCP areas. Service providers were also concerned about the ability to meet the ongoing costs of additional PPE once dedicated funding came to an end.

Service providers reported, in some instances, short-sighted decision making of some HSCPs on items such as contract values, tendering arrangements during the pandemic. These were not well received by service providers in these respective areas.

The pandemic encouraged HSCPs to begin to review and, in due course, revise their strategic commissioning plans with updated HSCP priorities and related resource contributions that improved peoples' health and wellbeing outcomes. This work was at a very early stage in some HSCPs. If solely resource-driven decisions dominated commissioning decisions during recovery, the reserve of goodwill shared through the joint endeavour during the pandemic would wither, with adverse impacts for integrated and co-operative joint working. Forthcoming strategic commissioning and locality plans, alongside their implementation, required to be informed by the successful ongoing engagement with people who experience care, carers, the wider public, staff and service providers.

6. What were the recovery plans for services?

In this section we consider HSCPs recovery planning for care at home and support services.

Summary

- It was important that all stakeholders were included in discussions about recovery and that decisions were based on what was right for service users and carers.
- The impact of the pandemic and the response to it had been different for different people experiencing care, and their carers. Individual reviews were important to establishing needs and the best way to address them.
- In planning for recovery, HSCPs were concerned about the combination of pre-existing financial pressures and additional costs arising from this pandemic.

Moving towards recovery

In May 2020, the Scottish Government requested that health and social care services begin to remobilise[3], in the context of the pandemic. Each HSCP assessed the impact of changes that had taken place over the pandemic period and identified proposals for the recovery stage in service provision.

Regarding recovery planning for the care at home sector, just over half of HSCPs planned to review and revise care packages in line with individual needs. Four HSCPs did not intend to make any changes to care at home and housing support packages and one planned to restore care packages to previous levels but did not anticipate making any substantial changes to their immediate future service delivery.

Reviewing people's individual circumstances

There were substantial differences between HSCPs on how they intended to review and or reinstate care packages. Some planned to fully review all care packages. Some others intended to reinstate reviews as part of an ongoing programme that was suspended during the pandemic. A few HSCPs reported that that they intended to return suspended care packages to pre-pandemic levels as a starting point.

The impact of the pandemic and the response to it had been different for different people who experienced care, their families and carers. Individual reviews were important to establishing needs and the best way to address them. Returning care packages, automatically, to previous levels of support might not be suitable in every individual circumstance. Reductions in family support as furlough schemes ended meant that reviews needed to be undertaken promptly.

[3] Re-mobilise, Recover, Re-design: the framework for NHS Scotland, Scottish Government

HSCPs stated that these planned approaches to recovery would include a reablement approach. Few HSCPs reported, in any detail, how far they had gone in support of their recovery intentions. There were organisational capacity issues that had limited the progress in taking these matters forward.

HSCPs were sensitive to possible perceptions that the pandemic might provide an opportunity to arbitrarily reduce care and support hours on a substantial basis as a cost saving measure. All HSCPs were keen to stress that any reductions in care package hours would be with the involvement of the people who experience care, and carers, in accordance with an assessment of needs. Individual care packages would be reviewed in line with established policies and processes and not as a by-product of the pandemic. Service providers informed us, that there had been some instances, where this seemed to have happened in a number of HSCP areas.

It was important that all stakeholders were included in discussions about recovery and that decisions were based on what was right for people who experience care and their carers. Eligibility criteria for services needed to ensure that a person-centred approach continued to be the guiding principle seeking to promote improved outcomes.

Identifying the areas for future improvement

The main themes identified by HSCPs as areas for improvements arising from the pandemic included improved access to PPE supplies, testing programmes and investment in technology to help widen accessibility. For service providers the most prominent issue was improvement in relation to infection prevention and control. Shared priorities were promoting independence, increasing flexibility in how support was delivered, improving partnership working, delivering more efficient services and the recruitment of staff.

There were challenges to make sure that recovery planning had a whole-systems approach, aligned with strategic plans and supported by performance management and quality assurance systems. This would be important as HSCPs moved on from a pandemic response mode.

Most HSCPs intended to reflect on their current assessment, review and risk management policies and procedures including eligibility criteria. They were concerned about the significant financial implications and future Scottish Government financial support and their ability to meet the volume and the nature of the demand that might lie ahead.

Most HSCPs had an increasing focus on workforce planning. They were trying to ensure that employees received appropriate and relevant training (for instance, infection prevention and control) and, in some areas, making it available for other service providers.

There was a growing focus on developing flexible working patterns and deploying interactive technology. They were aiming to make sure that staff felt well supported and their workloads were appropriately managed to enable them to deliver positive outcomes.

Service providers' main issues were to return their services to more sustainable levels. Their key concern was in relation to additional costs, particularly that of PPE. Just under half were concerned about spikes in infection rates and the potential impact of testing programmes on staffing capacity.

Recovery planning

The pandemic acted as a catalyst to escalate and drive approaches to reflect on the care at home service as part of the wider local health and social care system. Recovery planning, for care home at home sector, was heavily influenced by the interdependencies with other elements of the health and social care system.

Recovery planning has been complex, with an emerging landscape and the development of recovery plans aligning with their respective council and NHS board recovery plans.

Recovery planning was at varying stages in HSCP areas and in some, there had been limited progress. A few HSCPs had established specific care at home plans with associated remobilisation groups. A quarter had consulted service providers in relation to the recovery plans and a third indicated that recovery planning was underway, in consultation with service providers. Three noted that recovery planning was not required for them because they had made limited changes to the level of service provision during the pandemic.

HSCPs had restarted their medium to long term integrated financial planning alongside updating their operational budgeting and control arrangements. They advised us that COVID-19 mobilisation funding was insufficient to address the additional costs of recovery. This, in combination with pre-existing financial pressures, would be central in HSCPs recovery plans.

7. Conclusions and next steps

Health and social care partnerships and service providers worked hard to maintain care at home and housing support services, particularly for people with complex health and social care needs, during the COVID-19 pandemic. All HSCPs prioritised support for people with critical needs, almost all made changes to packages of care to do this, but the number of people affected across HSCPs was very variable.

Frontline staff and families played a major role in supporting the efforts of the HSCPs. Their dedication and commitment were critical to maintaining care at home and housing support services during the pandemic.

Although not without significant tensions, relationships between service providers and HSCPs improved during this time from pre-COVID-19 through working together with a shared commitment to find solutions. The most robust responses to the challenges and uncertainties of the pandemic involved an integrated approach and included:

- targeting resources to meet gaps and pressures as they occurred and reviewing and refining approaches as new information came to light
- maintaining a focus on how staff remained confident, safe and secure by addressing the challenges of PPE, guidance and testing
- responding quickly with additional financial support and guarantees to ensure services remained viable and that the commitment was not undermined by unpredictable reductions in income and additional costs
- investing in staff terms and conditions to reduce disincentives to testing and self-isolating when required
- working together across health and social care, service providers and the community to:
    - deliver responses in a way which allowed priority to be given to those in greatest need.
    - provide less critical support in different ways.
    - make decisions together with people who experienced care, their carers and families based on assessments, views and risk assessments.
    - maintain contact with people who experienced care, and their carers to identify and respond when circumstances change.

Looking to the future there is still considerable uncertainty about COVID-19. There are substantial risks from COVID-19 to the ongoing resilience of the care at home and housing support sector and the people it supports. This is in the context of services that were already stretched before the onset of this pandemic. Staff are by now tired and may be less able or willing to continue to go the extra mile on an ongoing basis.

The social isolation, anxiety and disruption experienced in lockdown has had an impact on the mental and physical wellbeing of people experiencing care and their carers and many may need more support to regain independence and remain resilient. There are increasing financial pressures on HSCPs and concerns that future funding may impact on the sustainability of some services.

The COVID-19 pandemic exacerbated the significant challenges that already existed in the delivery of care at home and housing support in Scotland. There is now perhaps a greater awareness of the unique challenges in the delivery of these services and also of the critical role they play. There is a need to do everything we can to build on lessons learned from the pandemic to develop resilience in the system to meet the anticipated further challenges of this pandemic and beyond.

Next steps

We have set out our recommendations based on the findings of this inquiry. We recognise that HSCPs are at different stages in relation to addressing the issues behind these recommendations, but these are key areas for consideration by all partners as we continue to respond to the current pandemic and plan for the future.

Nationally and locally, partners need to ensure the findings of this inquiry are linked to feedback from people who experience care, and their carers, about their experiences during the pandemic. Listening to people who experience care will be essential to gaining a fuller understanding of the impact of COVID-19 and what we can learn from this.

The findings of this inquiry will help shape the Care Inspectorate's agenda for the future scrutiny, assurance and improvement of care at home and housing support services. We hope it will also inform deliberations on the reform of adult social care.

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