NEL adult social care winter plan 2021-22

Background

What is winter planning?

The winter creates unique situations that can impact directly on business as usual, service delivery. In their singular format, most of these impacts can easily be managed, however, the very nature of winter often triggers a domino effect, producing multiple problems that then require complex solutions.

An ageing population combined with increasing numbers of people with a long-term health condition means that demand for both health and social care is increasing, and we know that these pressures increase during winter months, particularly across the urgent care system. As we head into winter with an already pressured position due to COVID 19, this winter will prove challenging for all partner organisations.

North East Lincolnshire council will ensure everyone who needs care or support will get high-quality, timely and safe care throughout this period.

In our reasonable worst-case scenario, four additional challenges would exacerbate

- pressures on the health and social care system in winter 2021/22, by increasing demand on usual care as well as limiting surge capacity.
- A large resurgence of people becoming seriously ill with COVID-19 nationally, with local or regional epidemics, leading to pressure on hospital capacity or workforce availability.
- Disruption of the health and social care systems due to reconfigurations to respond and reduce transmission of COVID-19.
- A possible influenza epidemic that will add to the challenges above.

Our plan will aim to mitigate the impacts of winter pressures through coordinated action via the integrated care partnership arrangements, as well as through the joint leadership team within North East Lincolnshire.

This plan will provide the foundation for a joint approach across adult services, commissioned services for adults and relevant partner organisations to consider and manage known winter pressures.

Management arrangements

This plan will be managed using a strategic, tactical and operational approach. Clear roles and responsibilities are required to ensure the effectiveness, success and maintenance of this plan.

This plan and the winter response will be reviewed using weekly meetings.

Roles and Responsibilities

Adult services strategic lead – Bev Compton, director of adult services

The responsibilities include:

- Accountability for the plan aim and objectives, including their sign off
- Providing strategic direction to achieve plan aim and objectives
- Ensuring tactical requirements are met by identifying a suitable content owner
- Ensuring plan effectiveness is measured using SMART objectives
- Providing progress, effectiveness and escalation to the integrated health care partnership and joint leadership team, Integrated Care system and resilience forum
- Inputting to sub-regional and regional professional networks.

Winter plan content owners (tactical)

Tactical content owners will be experts in their respective service area fields. They will be responsible for delivering objectives in this plan. They will also be responsible for ensuring this plan is shared as appropriate across their service area, ensuring any relevant training is delivered and that staff fully understand when this plan will be used, how and what their operational responsibilities are. Confirmation of responsibilities under this plan will be provided to the strategic lead as appropriate.

Winter plan delivery (operational)

Operational delivery under this plan will consist mainly of business-as-usual service delivery. Employees delivering their day-to-day services will have a clear understanding of how this plan works, what their role is and complete training as applicable. It is key that employee's knowledge and understanding of the four objectives in this plan is clear, this will enable them to deliver not only efficient day to day services but also identify and act when winter pressures are experienced.

Compiling this plan

Councils received national direction in 2020 in relation to the creation of their winter plans and our local plan was based on DHSC guidance issued for adult social care: coronavirus (COVID-19) winter plan 2020 to 2021, which builds on advice issued to councils earlier this year including adult social care action plan, published on 15 April 2020 and the care home support package, published on 15 May 2020. We have based this year's plan on a review and re-assessment of the previous one, in the light of new and emerging issues in the health and care system. In compiling our winter plan response, we have reviewed our previous year's "gap" analysis and reflected on practice that is now in place for our care businesses operating in an on-going pandemic environment. Our winter plan will continue to operate to local outbreak control measures and our well-established mechanisms for preventing and controlling the spread of infection in care homes. During the past year, we have focused on meeting the requirements of the national hospital discharge policy and care pathways which have been developing throughout the course of the pandemic.

This year, national government made its announcement on winter planning in mid-September 2021, with the key emphasis being on:

- Roll out of flu and covid booster vaccinations
- Access to health and wellbeing support for workers in the care sector, to mirror those for existing health workers

We await further details of the winter plan. However the announcement of the continuation of infection control and testing funding is welcome.

We will continue to work hard to maximise the support to the care sector, using well established systems and protocols for managing the impacts of COVID on the most vulnerable people in our community.

Actions have also been developed to ensure that care providers feel equipped to support their workforce in preventing the spread of infection and protecting the people they care for.

Winter pressures

The following have been identified as having the ability to disrupt service delivery during the winter season, from October 2021 to March 2022:

- COVID 19 Pandemic
- Seasonal flu
- Winter vomiting sickness
- Access to supplies, and higher than expected inflationary costs of goods and services
- Heavy prolonged snow
- Heavy rain / flooding

Impact:

- Loss of staff within the council and within the care provider community leading to inability to deliver services effectively
- Increase hospital discharges, over and above ‘usual’ numbers and inability to meet this excess demand via home care or care home support
- Increased referrals across a number of, or all services
- Business viability due to changes in demand for services

National plan for adult social care 2020

The national plan set out three key aims for adult social care:

- ensuring everyone who needs care or support can get high-quality, timely and safe care throughout the autumn and winter period
- protecting people who need care, support or safeguards, the social care workforce, and carers from infections including COVID-19
- making sure that people who need care, support or safeguards remain connected to essential services and their loved ones whilst protecting individuals from infections including COVID-19.

This year plan encapsulates the following themes:

- Protecting service users and staff
- Maintain good quality care & high quality of life for service users
- Sustaining the service

In our gap analysis in 2020, we were able to provide significant assurance with regard to around 80 per cent of the actions required by national government and worked to ensure that the remaining actions were delivered.

This means that we are already operating with significantly better infrastructure in place to prevent and control the spread of infection, to support care settings to manage illnesses, avoid hospital admissions and access better community-based support.

For this winter period, we will seek assurance from our provider community and wider health and care partners regarding the maturity and sustainability of the measures established over the past twelve months by conducting a “winter readiness” appraisal. We will therefore continue to ensure that ways of working, systems and processes that we have already established continue to be delivered throughout the winter period.

We have recently received confirmation of the continuance of infection control and testing funding for the period October 2021 to end March 2022. This will support providers to maintain the measures imposed by the pandemic. However, there may be some further relaxation of COVID measures which will facilitate more flexibility to manage the workforce in particular. We are already engaging with providers regarding current costs of care to inform our winter plans as well as our budget setting for the period beyond March 2022.

We have identified the following issues as areas where we need further action and focus to ensure our winter plans are robust:

1) Additional reablement capacity (step up/step down) to bolster bed availability at Cambridge Park and intermediate care at home provision. Both services have lacked staff capacity for a prolonged period.
2) Reablement, asset-based approaches and positive risk-taking principles, culture and practice are embedded in our health and care bed based and community provision.
3) Ensuring that there is adequate workforce capacity across the social care sector, and working with partners, across the health sector to create a system of mutual aid.

4) Delivering an effective COVID booster and flu vaccination programme within care settings and across the care workforce.
5) Sustaining the care market in the face of critical workforce shortages and escalating costs due to COVID measures, pandemic recovery and inflationary increases.

Protecting service users and staff

Application of guidance on infection control and outbreak management (Levi Clements-Pearce/Brett Brown/Bruce Bradshaw)

We have well established mechanisms for the distribution of guidance to our care providers and within our wider workforce. Regular direct contact with care homes enables us to ensure that all care providers are confident in understanding, disseminating and applying any new guidance in practice

Managing staff movement (Bruce Bradshaw)

We have worked with care home providers to ensure that staff movement between settings is limited unless absolutely necessary to help reduce the spread of infection, including by reviewing exclusivity arrangements with recruitment agencies, and considering the recruitment of additional staff over the winter period. Some providers have used infection control funding (ICF) to meet additional costs associated with restricting workforce movement for infection control purposes, in accordance with the conditions on which it is given by local authorities. We will review new guidelines emerging as COVID restrictions begin to ease and ensure that if practicable, providers can collaborate to ensure adequate workforce is in place to meet need.

PPE (Brett Brown)

Processes are established for regular review and assurance regarding access to and guidance in relation to PPE use. The capacity tracker and adult social care dashboard provides up to date monitoring information and webinars provide a discussion forum to clarify practice issues. All guidance is issued via the on-call system within the CCG. Weekly and sometimes daily contact is made with providers regarding on going assurance and advice via the contracts team; ICF has been used to support improvements in infection control practice. We have supported providers to access the national portal and have provided further stocks of PPE should it be required. We will review provider contingency plans in relation to PPE and ensure our stocks are adequate.

COVID19 testing in care homes (Brett Brown/Bruce Bradshaw)

We have well established mechanisms in place for testing and reporting on COVID testing in care homes, supplemented by follow up support from the contracts team and infection control team. We also have and established outbreak control plan in place and outbreak management standard operating procedure with senior strategic and operational oversight; exceptions can be reported at weekly meetings with escalation to joint leadership team or the integrated care partnership as required.

Seasonal flu vaccination (Geoff Barnes)

We will continue to promote and support people to access vaccination, including booster vaccination and flu vaccination and delivering covid vaccinations in school settings for 12-15 year olds and flu vaccinations for children. We are also offering flu vaccination free of charge to NELC/CCG staff.

Access to vaccination for provider workforce needs to be supported by options which include in-reach into care homes/care settings or locality based working/targeted sessions to make it easy for staff to take up the offer. A service has been commissioned to increase flu vaccination uptake in care homes. Additional information about uptake rates is gathered via the contracts team.

Care home support plans (Bruce Bradshaw)

Processes are established for regular review and assurance regarding all elements of support. The capacity tracker and adult social care dashboard provides up to date monitoring information and weekly webinars provide a discussion forum to clarify practice issues. All guidance is issued via on-call system within the CCG. Weekly and sometimes daily contact is made with providers regarding on going assurance and advice via the contracts team.

We will ensure that time is allocated to enable care workers to access flu and COVID vaccination boosters.

A working group has been established to re-invigorate support to care homes, specifically to ensure that multi-disciplinary support teams are engaging, via linked primary care networks and GPs to ensure the best quality health and care delivery within the settings.

Safe discharges from NHS settings and preventing avoidable admissions (Nicola McVeigh)

Arrangements are in place for the commissioning of packages of care for all individuals being discharged from hospital. Wendy Lawtey (NLCC) is the identified executive lead for discharge across Northern Lincolnshire, Nicola McVeigh (NELCCG) is the deputy. All individuals are being tested prior to hospital discharge. The COVID test date and result are included in all discharge documentation. Where an individual is COVID-19 positive and they requires bed based care they will be supported to discharge to an appropriate service. The community urgent care team provides therapy support to prevent avoidable admissions to hospital and also supports with any shortfall placements in care homes where the individual would otherwise have gone to Cambridge Park. However, further investment is needed to ensure therapy support is covered throughout the day, early evening and seven days a week. Intermediate care at home services also offer rehabilitative support but this service will need to be extended/supported by enhanced support at home to meet peak demand if we are aiming to maximise the home first pathway.

Work has been established to ensure that health and care providers understand the appropriate application of the Mental Capacity and Mental Health acts and the interfaces between them via an MoU. Currently we are implementing RESPECT to replace DNACPR, and EPaCCS which will support improved personalisation and the sharing of information. The Ward staff (pathway 0) or our Hospital Discharge Team (pathway 2) work with care homes when repatriating or supporting a new admission into a care home, to ensure the home have all the necessary information to meet people's needs.

Enhanced health in care homes and winter resilience (Bruce Bradshaw)

We are establishing a Northern Lincolnshire working group to develop services and build our resilience over winter. The focus will be on strengthening our support to care homes work with representation from the clinical lead, nursing lead, public health direct and primary care commissioning lead. Part of this work will help homes to support people with more complex needs that are discharged and some of the work will aim to prevent hospital admissions.

Arrangements are in place for infection control advice and support in the event of an outbreak; working with public health, we are providing a system for earlier alerts to care homes when levels of infection are rising in ward areas.

The primary care networks are working with other providers (e.g. community nursing) and their aligned care homes to develop requirements and support. Plans to support patient registration have been agreed. However, further work is required to ensure consistent support to care homes and earlier intervention through better planning and support to more vulnerable residents; Further work also required on community nursing and community therapies to ensure that rehabilitation following hospital discharge is

optimised and that we are maximising proactive support to prevent hospital admissions.

As described previously we provide an enhanced nursing support offer to care homes, as well as providing each care home with training in IPC and use of PPE, followed up by regular contacts to maintain those skills. We are also training care home staff to recognise deterioration in residents' health and a clear process for raising these concerns with the GP. The CCG director of nursing leads on an area of the public health outbreak plan which focuses on the enhanced nursing offer to care homes and on nursing leadership in and out of hospital, as well as leading for the health and care executive across the whole system on workforce response during escalated COVID19 cases and how we support the system including care homes.

Technology and digital support (Bruce Bradshaw)

We have undertaken significant work with providers to ensure that they have access to NHS mail and other technologies to reduce the need for face-to-face contact. Additionally, care homes have been provided with equipment and training to undertake basic observations. We have had a good response to the requirements to input data on the capacity tracker which enables the contracting team to identify any issues within the care home setting.

Work has been established to ensure that health and care providers understand the appropriate application of the Mental Capacity and Mental Health acts and the interfaces between them via an MoU. Currently implementing RESPECT in replacement of DNACPR, and EPACCS which will support improved personalisation and sharing of information.

Acute hospital admissions (Nicola McVeigh)

Practice in relation to hospital discharge has traditionally relied on a multi-disciplinary hospital discharge team. Practice has recently developed to ensure adherence to new discharge guidelines. Additional capacity has been developed at Cambridge Park through the renovation and upgrading of a former residential care setting designed to offer 52 intermediate tier beds. A specification for the service is in place but at the present time this is not operating at full capacity, presenting a risk to the system.

We will deliver an enhanced care at home service and additional capacity in our care at home service to ensure a home first approach, reduce the reliance on short stay residential placements and to protect and preserve the more limited re-ablement bed-based capacity that we will have access to.

Additionally, NHS commissioners need to strengthen the community primary care support to vulnerable people and those recovering from illness throughout the winter period. This should include better resourced community therapies to ensure we maximise independence and mitigate the risk of re-admissions.

Our care homes and care providers are fully conversant with the requirements to isolate residents following discharge and where practicable have invested ICF money in arrangements to ensure the physical separation of recovering residents and to cohort their staff to minimise infection risk.

Social prescribing (Sarah Dawson)

The three primary care networks (PCNs) are currently recruiting to the social prescribing link worker roles. Two PCNs are working with the existing Thrive NEL social prescribing service and one is recruiting directly.

Candidates are due to be appointed imminently for those roles where the PCNs are working with Thrive NEL.
The newly appointed link workers will focus on the individuals identified by the PCN as most at need, which may be different to the individuals currently managed within the existing social prescribing service. The existing Thrive NEL service has continued to operate remotely during COVID19, providing support to the vulnerable clients.

Maintain good quality of care and high quality of life for service users

In the past year we have launched the Livewell site, which includes a comprehensive online information and advice offer to support people to access services in their communities and access appropriate information to help them.

We have delivered substantial support to care homes over the past year to ensure that the quality of care experience for vulnerable residents is improved, with more direct support and oversight be community teams and general practice. As far as possible we are working to ensure that health and care needs can be managed without a hospital admission.

Care home residents can now receive visitors. Should the position change through the winter period, we are confident that visiting can be maintained due to the adaptations made to homes during the pandemic. Additionally, homes have technologies to support residents contact with their families digitally.

To sustain the market, we will not commission services from any new care homes through the winter period.

Workforce initiatives

We are conscious that care workers have been placed under significant strain during the past 18 months and we have therefore maintained information and advice to enable access to local wellbeing support, access to mental health support and occupational health services.

Balance between IPC, Wellbeing, and Rights

The winter plan needs to work for everyone. Protecting people needing ASC involves protecting our wellbeing and rights as well as freedom from infection.

Quality of Life

Planning for winter needs to consider how to make sure QoL is prioritised in policy thinking and the hidden harm of isolation & inability to have active community involvement in care settings remains front & centre.

Day centres and respite services

Support will be in place to support the provision of these essential services or alternatives.

Supporting independence and quality of life/visiting guidance (Bruce Bradshaw)

A policy for limited visits (if appropriate) has been developed and regular contact with care providers ensures that up-to-date guidance from the director of public health can be given. It is based on dynamic risk assessments which consider the vulnerability of residents. This includes whether their residents' needs make them particularly clinically vulnerable to COVID-19 and whether their residents' needs make visits particularly important. Social workers can assist with individual risk assessments, for visits, and can advise on decision-making where the person in question lacks capacity to make the decision themselves

Direct payments (Ros Davey)

Our relatively small cohort of direct payment recipients (approx. 360 individuals) has allowed us to manage and respond flexibly since 23rd March 2020 and we continue to do so. At the start of lockdown all individuals were contacted by focus CIC Our principal social worker, Christine Jackson gives assurance that we are working flexibly in NEL across the board. Social workers are aware they need to work flexibly and if they have any issues/risks they need to raise they can attend the multi-agency risk and quality

Panel. Staff can also attend to gain advice and guidance (to meet needs in a flexible manner). focus CIC has facilitated service users to use their payments differently to meet their needs.

We will disseminate flu jab information to all personal assistants (PAs) and ensure continued access to free PPE for PAs.

Support for carers (Nicola McVeigh)

The multi-agency single point of access operates 24/7. Carers and those they care for can contact the SPA at any time if they have new or enhanced needs. SPA offers a triage and referral service for assessments, reviews or reassessments as required. Focus CIC, CPG, Navigo and all of our carers' support services have actively kept in touch with their clients and/ or their carers to ensure they are appropriately supported throughout the COVID-19 pandemic, this will continue into winter 2021/22.

All clients and their carers have been involved and included in decision making where facilities have not been available to support their needs during the pandemic (i.e. day centres, respite placements) and alternative arrangements to meet need have been sourced. Respite and the ability for carers to take a break from caring has been a problem during COVID19. The carers partnership is working to explore options. In addition to formal commissioned support for carers, the NEL carers' support service along with our wider carers support services have kept in regular contact with known carers to keep abreast of "real time" carer need throughout the pandemic and ensure they have advice, support and services. Notes and needs are recorded/updated as required. Where needs have changed that are beyond the support of the carers support services the carer has been referred with consent to the single Point of Access (SPA). In addition, these organisations have been trying to continue to raise awareness of carers and the carers support available to hidden/ new carers, as our residents find themselves new to caring or their caring roles increasing.

The carers' operational lead has been in close contact with all carer organisations throughout the pandemic and supporting (via information and LA expectations for the area) organisations to develop plans. Carers' organisations are independent, commissioned providers of carers' services, and as such have their own universal COVID plans, which the operational carers' lead has ensured are consistent with local government requirements. Note: no direct carer services closed fully, but many were required to reduce their offer.

End of life care (Bruce Bradshaw)

System wide work is taking place to ensure consistent application of guidance and support around end of life planning including roll out of the EPACCS system. However, anticipatory care planning is not yet consistently in place.

Supporting the workforce (Brett Brown)

Regular communication with providers enables the dissemination of guidance and advice. All providers have access to free induction training which is promoted on an ongoing basis via our routine communications mechanisms.

Supporting the wellbeing of the workforce (Vicky Leach)

Council and CCG employees have access to an employee assistance programme. For wider providers, weekly check-ins and business continuity updates are an opportunity to review and remind employers about workers' wellbeing.

Workforce capacity (Jan Haxby)

Processes are established for regular review and assurance regarding business continuity planning in adult social care services with the capacity tracker and adult social care dashboard providing up to date monitoring information and there are well established intelligence systems to highlight potential problems. We have arrangements in place to deploy additional capacity from the local infection control team to advise on practice in the event of an outbreak. To strengthen our local health care system, we are developing plans with the health care executive with regard to further recruitment of health care staff, health care assistants and care workers. To minimise demand on the health and care system we are strengthening our support at home model further to enable people to be discharged to their own home where possible and with enhanced support.

We are working with our voluntary sector partners regarding additional support, should it be needed, for lower-level support. We are also linking in with the DWP regarding the supply of new workers.

We are looking at incentives to maintain capacity during the winter months.

Shielding and people who are clinically extremely vulnerable (Helen Isaacs)

The council and its local partners in the voluntary and community sector mobilised an extremely effective support mechanism during the first wave of the pandemic to support those who were vulnerable. The council is ready to mobilise voluntary support should it be needed.

Social work and other professional leadership (Christine Jackson)

North East Lincolnshire has been working towards the development of an asset based approach to social work practice. However due to the dispersed nature of social work in the area, only partial assurance can be given about the effectiveness of this approach

as it varies across the three agencies (Navigo, focus and Care Plus Group) undertaking this work. All social work and continuing health care partners are expected to work under the local ethical and pragmatic decision making framework, which is a micro-commissioning framework and reflective of the national ethical framework. All providers are bound by the same co-produced local Mental Capacity Act 2005 (MCA) policy.

focus CIC, our largest social work practice provider, has extensively trained staff and has embedded a strength based approach particularly within the single point of access (SPA) though this needs to be an ongoing process to refresh those who went through the training and for new staff. focus CIC SPA work closely with and deliver multi-disciplinary decision making with both health and therapy staff. There are also good operational links with mental health services.

Links are well developed with the CHC nurses but links could be improved with community nursing. A triumvirate meeting is in place on a weekly basis to resolve issues from community nursing teams to social work issues, in particular around hospital discharge.

Contingency plans are in place to ensure that staffing levels are maintained to respond to safeguarding concerns in a proportionate way depending upon the presenting risks. It is acknowledged that due to the reduction in face to face contact with service users over the pandemic period – some safeguarding concerns may have gone unrecognised, and unreported. The use of technology is being promoted to facilitate contact with service users, however, where face to face contacts are essential, these are still being undertaken. At the moment, there are sufficient staff to respond to safeguarding concerns within locally agreed timescales, and the team work flexibly to prioritise concerns using a risk-based approach. Partner agencies are engaged with the local safeguarding arrangements and contribute to enquiries as required. An escalation process is in place to alert senior management and the safeguarding adult board (SAB) should there be any systemic failures within the safeguarding response resulting from winter pressures or due to the pandemic.

We are working with the social work practice to ensure that we can robustly and flexibly review packages of support, to ensure that we optimise provider capacity in the winter period. This may mean agreeing to de-prioritise other areas of work.

Sustaining the service (occupancy, funding etc)

Market and provider sustainability (Beverley Compton)

Our care home occupancy is at historically low levels and we are conscious of the impact that this will have on our care home providers.

Well established market intelligence systems are in place, supported by further actions developed during the COVID pandemic to enhance support and communication with the care provider community. This is extended to all care providers in North East Lincolnshire and should enable the early identification of potential provider sustainability issues. We will engage early with providers whom we believe to be at risk of service failure, using our winter readiness assessment tool and other information.

Our market intelligence and provider sustainability risk assessment identified that we need to understand more about those providers offering support to people with direct payments and ensure that an appropriate mechanism is in place to ensure that they are accessing support and guidance.

Occupancy guarantees - given current depressed occupancy levels we are considering other market sustainability measures such as occupancy guarantees. Any identified measures will be included in the action plan section.

Numbers of people waiting for a care needs assessment

We will put in place timely information to monitor the number of people needing social care assessments so that we can prioritise our resources. We will also implement a situation report so that we can anticipate pressures on care services.

Funding and insurance

We implemented an infection control fund steering group to oversee the planning and distribution of infection control fund (ICF), testing funding and workforce capacity monies, including the gathering of reports so that we can see that the funding is being used as planned. We will continue to administer the new funding announced a the end of September. We are engaging with our care provider community as to the cost implications of continuing to work in a pandemic environment and gathering information ready for the council's budget planning in the autumn 2021.

On-going funding may be required to sustain staffing levels, support testing or workforce recruitment and retention issues. ADASS nationally has made representations to government departments about the funding needs in social care if we are to effectively support the hospital system.

Move away from short-term support – we must look at sustainable solutions to the challenges faced. Serious consideration needs to be given to a sustainable funding model which will take staffing issues into consideration, which would work across departments.

Winter plan contingency and escalation plans

We are working with colleagues in ADASS to agree a winter escalation approach for adult social care to mirror that used for health settings.

Action plan

The action plan sets out work required to deliver against identified gaps:

Protecting service users and staff				
Gap	Action	Milestones	Action owner	Update
Assess provider readiness for winter	Create winter readiness assessment tool, distribute to providers for completion	End Sept 2021	Tanya Burnay	S@H providers monitoring tool distributed, weekly & daily report completed & returned on ongoing basis
Approaches to reduce risk and improve independence	Ensure community/ voluntary sector wrap around offer to support individuals to remain at home and facilitate discharge from acute or bed-based care	Engagement with sector partners to explore possible offers of help	Caroline Barley	
	Ensure BRC and Carelink work together to support individuals at temporary increased risk.	Formalise additional capacity needed for winter months	Nic McVeigh	
Vaccination uptake	Promote access to COVID booster vaccinations		Geoff Barnes; Julie Wilson	
	Releasing staff to attend vaccination appointments	Use of/administer infection control and	Julie Jobling	

		testing fund to support the sector		
	Ensure all residential care workers required to do so have had 2 doses of the COVID vaccination	Ensure providers are ready for the 11th November cut off date and contingencies in place for any gaps in staffing	Bruce Bradshaw	Monitoring tool in place and providers regularly contacted for updates and CCG assurance re business continuity (TB)
	Uptake of flu vaccination amongst vulnerable population and care worker populations	Winter vaccination campaign launched	Geoff Barnes	
Maintain good quality of care and high quality of life for service users				
Gap	Action	Milestone	Action owner	Update
Intermediate bed based care capacity and enhanced delivery	Work to increase CP to fully capacity		Nic McVeigh	
	Deliver against the CCQ improvement plan for Cambridge Park		Lisa Revell	
	Establish the enhanced service offer (?)		John Berry	
	20 additional beds commissioned	Spec out for providers end Oct 2021	Nicola McVeigh/Bruce Bradshw	
Home first capacity	Embed the enhanced support at home offer	Costed case needed following pilot; pilot extended	Bruce Bradshaw	
	Work to ensure therapy resources is targeted to those most in need	Agreed priorities for support including suspending housing assessments for DFG	Karen Grimsby	
	Ensure the support at home winter pressures teams are on standby and can be operationalised.	Agree trigger points for further capacity; Can Navigo Extra support?	Bruce Bradshaw	
Enhanced bed-based offer for those with delirium	Work to amend the enhanced dementia beds specification to accommodate		Bruce Bradshaw	

	1. Those without a formal diagnosis who have a similar presentation 2. Short stay placements			
Day support	Ensure continued engagement with those people requiring day support to ensure that wellbeing needs can continue to be met should pandemic conditions reduce the opportunities for social contact	Monthly contact starting October 2021	Ros Davey (direct payment users Amy Clarke (supported living users)	
Direct payment users	Ensure continued engagement and continuity of access to PPE	Monthly contact starting October 2021	Ros Davey	
Enhanced support to care homes	Establish Northern Lincolnshire development and winter resilience working group	Mid Sept 2021	Bev Compton	Established
	Create plan to refresh essential training for care home staff	Quality team leads to deliver	Bruce Bradshaw	
	Formalise support from community teams to support residents with complex needs post discharge		Jan Haxby?	
Sustain the service				
Gap	Action	Milestone	Action owner	Update
Realtime understanding of pressure in the system	Develop a system pressures dashboard	Initial contact with providers to create RAG rating tool	Bruce Bradshaw and Martin Rabbetts	Tool in place and providers routinely contacted
	Develop a discharge and onward care dashboard		Nicola McVeigh	
Workforce capacity	Create workforce capacity improvement plan	End October 2021	Bev Compton	
	Establish geographical map to link support at home contractors with care homes in their localities	End September 2021	Bruce Bradshaw	
	Facilitate webinar discussion between providers to facilitate mutual aid agreements	Early October 2021	Bruce Bradshaw	

	Re-launch care workforce recruitment campaign	Throughout October 2021-March 2022	Bev Compton/Anneline Wilson	
	Explore the development of protocols to enable flexible deployment of care workers to meet needs	End October 2021	Bruce Bradshaw	
	Develop escalation plans to relieve pressure in the light of prospective workforce shortages	End October 2021	Bruce Bradshaw/Nic McVeigh	
	Complete winter readiness assessment of providers	Early October 2021	Tanya Burnay	Is this the same as the entry above 'Assess provider readiness for winter'?
	Identify and target support conversations with providers who may be at risk of instability	Early October 2021	Nic McVeigh/Brett Brown	
	Create care contracting committee report advising of sustainability measures for the care market	End October 2021	Bruce Bradshaw	
Efficient and effective use of capacity in care at home teams	Providers to alert focus as soon as possible if a care package can be ended; Focus to review all packages in a timely fashion	Starting end October 2021	Denise Hopper	
	Care at home providers to take part in daily HDT meetings	Immediate effect and ongoing from Oct 2021	Nic McVeigh	
	Review of care packages to see if some of the support package can be supported by VCSE or alternative provision e.g. cleaning calls	Starting early Nov 2021	Bruce Bradshaw, supported by care at home providers	
	Investigate the availability of alternative providers for clearing calls	Mid Nov 2021	Nic McVegh	

Proposal	Unit costs	For how many weeks?	Total cost	Approved
Additional recovery beds (NM) will have cost implication into 2022/3				