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CABINET
Agenda

Date Tuesday 7 July 2020

Time 6.00 pm

Venue https://www.oldham.gov.uk/livemeetings The meeting will be streamed live as a virtual meeting

Notes 1. DECLARATIONS OF INTEREST- If a Member requires any advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Liz Drogan in advance of the meeting.

2. CONTACT OFFICER for this Agenda is Liz Drogan Tel. 0161 770 5151 or email elizabeth.drogan@oldham.gov.uk

3. PUBLIC QUESTIONS – Any member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the Contact officer by 12 Noon on Thursday, 2 July 2020.

MEMBERSHIP OF THE CABINET IS AS FOLLOWS:
Councillors Brownridge, Chadderton, Chauhan, Fielding (Chair), Jabbar, Moores, Mushtaq, Roberts and Shah

Item No

5 Additional expenditure in support of health and social care in response to Covid-19 emergency (Pages 1 - 56)

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Report to CABINET

Additional expenditure in support of health and social care in response to Covid-19 emergency

Portfolio Holder: Councillor Chauhan, Cabinet Member for Health and Social Care

Officer Contact: Mark Warren, Managing Director Community Health and Social Care Service and DASS

Report Author: Helen Ramsden, Interim Assistant Director of Joint Commissioning
Ext. 07971 396833

7th July 2020

Reason for Decision
To support the care sector with the impact of Covid-19 from 1st July 2020 and for the remainder of the financial year.

Executive Summary
The report seeks to provide an update on the support provided thus far to the care sector through the Covid-19 pandemic, and agreement to extend some support measures until there is further clarity on the national position, particularly with regard to market sustainability.

The purpose of seeking to extend the period of time over which support is offered reflects the ongoing requirements around the use of personal protective equipment, the impact of regular testing on the workforce, the vacant care home beds in the market and the resultant financial implications.

Recommendations

It is recommended to extend a number of the proposals from 1st July 2020 until such time as any national guidance or funding is announced, namely:

- extend the 90% bed occupancy guarantee until the end of July, and delegate authority to the DASS to adjust this support from that point onwards up until the end of October, to respond to the prevailing market conditions, in order to meet Care Act duties to meet eligible care and support needs, and ensure sufficiency, sustainability and quality of supply of care services to meet those needs.
- that the Financial Support Panel continues until the end of October 2020 in line with Procurement Policy Note (PPN 04-2020), or until such time as there is further national guidance or funding in relation to the financial impact of covid-19 on the operational running costs of care services. It is further proposed that information and outcomes of the panel are reported to the Procurement Bronze Group and the Financial Assistance Board ensure oversight, connectivity and Governance.
- to continue to pay for commissioned rather than actual care delivered in the care at home sector until the end of October 2020 in line with Procurement Policy Note (PPN 04-2020), or until such time as there is further national guidance or funding in relation to the financial impact of covid-19 on the operational running costs of care services.

- that the 5% uplift continues to apply for the remainder of 2020/21, and by default becomes Oldham's uplift in social care fees for the current financial year. Consultation has already taken place with the care sector and feedback indicates that a 5% uplift would be accepted by providers. Ongoing dialogue with providers throughout the year will enable an assessment to take place of the extent to which this, along with the other measures proposed, is ensuring sufficiency, sustainability, quality and choice of provision.

- acknowledge that in relation to adaptations to properties being undertaken by framework contractors through the Disabled Facilities Grant, there are additional costs now associated with Covid-19 such as PPE, additional cleaning and the impact of social distancing that were not originally priced for as part of the tender undertaken in 2018, and to offer a uniform amount, as all other costs within the framework are set. This is suggested as £30.00 for PPE plus £120 for additional labour/cleaning costs per job.

- acknowledge that for more major construction requirements which are tendered on an individual basis through use of the Disabled Facilities Grant, (typically extensions) we will ask for additional costs associated with C-19 to be priced for within each individual tender.

- It is proposed to make provision by applying a 5% uplift on current activity that recognizes increased demand for carer respite and carer breakdown.

1 **Background**

1.1 The report seeks agreement to extend a range of initiatives implemented early on in the Covid-19 pandemic, to support the care sector deal with the impact and in the absence of further central government guidance or directives at this time. The situation in the care sector has changed as a result of the impact of Covid-19 and short term sustainability of the sector is now the primary concern. The previous report is attached as Appendix 1.

2 **Current Position**

Care homes and vacancy rates

2.1 There are currently 42 independent sector care homes in Oldham with 1,746 registered beds, of which 265 were vacant as at 15th June 2020, a 15% vacancy rate which has been rising throughout the Covid-19 pandemic. In total, as at 15th June 2020, 106 deaths of care home residents since week ending 22nd March have had Covid-19 recorded on the death certificate, with 25 of these residents having died in hospital with Covid-19. The largest number of deaths believed to be Covid-19 related in a single home is 21.

2.2 The vacancy rate prior to Covid-19 was on average 4%, and had been at this position for some time. During the Covid-19 pandemic, the success of the "home first" approach of the hospital discharge team, the (assumed) lack of appetite amongst the self paying market to move into care homes, and the number of excess deaths have combined to increase the vacancy factor almost four fold. Attempts have been made to address short term risks to provider viability through supplements to fees, the block booking of available capacity, and more recently a 90% bed occupancy guarantee, paying "on plan" for commissioned care rather than care delivered in the care at home market, support with exceptional costs, and the continuation of funding to services, particularly day services, which have had to suspend operation during the lockdown. The table below sets out current occupancy levels across the Oldham care home market:

Occupancy levels	Total reg beds	Comments
<75%	576	10 homes with occupancy below 75%, this includes four nursing homes.
75-79%	237	4 homes in this category including 2 nursing homes.
80-89%	404	12 homes, including a number usually full with waiting lists, and who target the self funding market.
90-94%	202	5 homes
95-99%	107	3 homes
100%	219	8 homes
Total	1745	42 excludes MC and BG)

2.3 If, as currently seems likely, the effect of the pandemic is to leave many care homes for older people with a large number of vacancies, and possibly a reduced level of demand for an extended period, if older people and their families continue to see them as undesirable

places to live, and are not reassured by the early development of an effective vaccine, the Council may have a number of options (unless the issue is taken out of our hands by national directions). The main options are as follows:

a) Do nothing, beyond meeting our statutory duty to ensure that residents in care homes which close are supported to find alternative accommodation. Whilst this might minimise spend on care homes, and contribute to our longer term objective of home first or care closer to home, it would potentially expose a large number of vulnerable older people to the anxiety and disruption caused by unexpected moves between care homes. It might also lead to an unpredictable geographical pattern of services, or gaps in key areas of strategic importance such as nursing and dementia nursing provision; and in the medium term, if confidence in care homes does recover, or if it proves to be impossible or unaffordable to meet additional demand for support at home, there might be too little capacity in the surviving care homes to meet needs.

b) Extend paying subsidies to care homes while they have a high level of vacancies. In the short term, this may become a necessary step, to avoid premature closures before the overall picture becomes clearer. In the long run, it would clearly be necessary to avoid propping up indefinitely any care homes which did not appear to have a long-term future. Individual discussions would need to take place with all providers below pre-Covid 19 occupancy levels, to support the development of a longer term commissioning strategy and allow time for NW ADASS and LGA initiatives to mature, and for demand to adjust to the new operating environment to support a more informed assessment of the longer term impact.

c) Seek to increase its influence over the pattern of services by becoming more directly involved via Miocare to operate care homes, or to purchase care premises and lease them to other operators while exercising some control over the model of care.

2.4 In the short to medium term it now seems almost inevitable that the council will need to consider extending some form of financial support for care homes with a financially unsustainable level of vacancies. Without support, this would be likely to trigger a wave of closures, without the opportunity to influence where those closures occur, or the type of provision for which there is over/under capacity under “normal” circumstances.

2.5 Even if the medium to long-term objective is to move to a system which makes less use of care homes, it would be obviously undesirable for there to be a series of care home closures during the period when Covid-19 is widespread. Moving residents between care homes would be logistically very difficult, and would create a serious risk of spreading infection.

2.6 However any sustained programme of subsidising vacancies in care homes would potentially have high and unpredictable costs. While there is currently encouraging evidence that the number of deaths in care homes is falling, the number of vacancies is continuing to rise, and we cannot yet be confident about when and at what level it will peak, or how quickly (if at all) demand will recover.

2.7 One option might be to introduce an arrangement which reduced the level of protection over time – perhaps gradually, so that there was no point at which a large number of care homes were simultaneously faced with a financial cliff edge. For instance, the level of funding for

each vacancy could gradually reduce, or the occupancy level below which no subsidies are paid could reduce.

2.8 Given the scale of the financial problems which care home operators are likely to have, and the fact that some providers are large national corporates, there is likely to be pressure for a national solution (which may or may not then turn out to influence wider decisions about the future funding of adult social care). However providers are already approaching us about the financial consequences of increasing vacancy levels beyond the end of June.

The workforce

2.9 There have been significant workforce issues for many care providers because of the impact of self isolation, shielding and Covid-19 itself on rates of staff absence. These have recovered with 91% of staff reported as being available to work and 3.1% self-isolating as of 15th June 2020. However, further outbreaks or the impact of test, track and trace may see a repeat of the staff absence witnessed at the peak of the crisis.

2.10 Efforts to recruit additional staff and volunteers to work in the independent sector have proved largely unsuccessful, despite high profile regional and local campaigns and significant levels of interest. In the longer term, a joint piece of work with the Get Oldham Working team is proposed.

2.11 In the medium to long term, there is considerable uncertainty about what the impact of the experience of the pandemic will be on the care workforce. On the one hand, it has been suggested that people currently working in the care sector will remember this as a time when they were required to carry out dangerous and distressing work while getting little of the same recognition as NHS staff, being a lower priority for PPE, and getting little of the additional financial recompense that staff in supermarkets and other key services have received. On the other hand, it is possible that care work could become more attractive as a reliable source of employment during what may be an extended period of national economic difficulty.

Support to the care sector

2.12 The support extended to the care sector has been wide ranging, and the detail is attached as Appendix 2.

Carers

2.13 The Carers Team have carried out 495 carers assessments and reassessments since 23rd March and have made welfare calls to over 1200 carers. Feedback from the team is that almost all of the carers have said that although they are doing extra caring they are coping and managing. Over 95% of the carers have, however, reported that they are really looking forward to having a break from caring as soon as they possibly can. Concern from the team is that a lot of the carers may feel the impact of the extra caring once the situation starts to ease and resilience shown by the carers cannot continue indefinitely. This will have an impact on the need for additional respite.

Financial Support

2.14 To support the local authority to respond to the Covid-19 pandemic, funding of £7.6 million and £6.5 million has been received, plus access through the NHS to the £1.3 billion nationally where spend meets certain criteria. It is understood that the NHS route is available for eligible expenditure until at least 31st July 2020, pending further guidance which may extend this date.

2.15 In addition, Oldham's allocation of the Infection Control Fund is £2.3 million, of which 75% is allocated to care homes and 25% to other adult social care services, and has to be spent in line with very prescriptive conditions to implement particular infection control measures.

2.16 In relation to the Government's un-ringfenced grant support received by the Council of a total of £14.2m that was to address all pressures faced by the Council there was an early expectation that the majority of this funding would be used to support the provision of adult social care. Based on the Councils last financial data return to the Ministry of Health Communities and Local Government the Council anticipates that expenditure and loss of income will exceed the funding available by in excess of £20.7m, to this extent any allocation of funding is arbitrary.

2.17 In line with the report presented on 1st April 2020, and attached as Appendix 1, the following support has been provided to the sector so far:

- The provision of Personal Protective Equipment, both through the PPE Hub and via assistance with costs in excess of those which provides would ordinarily expect to meet
- Financial Assistance Panel – this weekly panel considers requests from social care providers for support with Covid-19 related costs, including the need to backfill staff who are self-isolating, PPE costs, enhanced cleaning, increased staffing levels due to dependency of those with or recovering from Covid-19, transport for staff and additional uniforms to improve infection control and prevent transmission.
- Securing 24 beds in the care home sector on block contract arrangements to ensure supply to support hospital discharge.
- Supporting providers whose occupancy has fallen below 90%, through additional payments equivalent to 90% occupancy.
- Paying on commissioned rather than actual care delivered
- 5% uplift on all commissioned care rates. This reflected that the usual annual fee negotiation process could not be concluded in March 2020. The uplift percentage is in line with Local Government Association and ADASS guidance, and reflects feedback received by providers during the paused consultation process. This guidance is attached as Appendix 3.

In addition to the above the Council has been charging the cost of packages directly linked to hospital discharges as a result of COVID, including step up and step down care to the £1.3bn NHSI and E funding accessible through Oldham CCG., To date £0.458m has been submitted on claims. This arrangement will continue to 31 July 2020 at the very least as outlined at 2.14 above.

2.18 A new financial pressure is now emerging in relation to construction companies undertaking adaptations to properties, such as low level access showers and extensions, funded through the Disabled Facilities Grant with the purpose of enabling people to remain

in their own homes for as long as they are able. As these adaptations start to recommence, the need for enhanced levels of infection control measures, including the use of PPE and the need to clean down sites each day are adding to the costs of these adaptations.

Annual Adult Social Care Budget Survey

2.19 The results of the annual adult social care budget survey, conducted by ADASS have just been published. The report included specific questions related to Covid-19 as well as more generally in relation to the financial position associated with the delivery of adult social care services. North West ADASS have compiled a summary of the picture across the 23 localities, which provides useful context when considering the issues raised in this report:

- Recent investment in the form of the council tax precept, winter pressures funding and social care grants has been temporary in nature and has largely failed to address any previous underfunding. This has offered limited scope for investment in transformation towards sustainability, or the ability to address fragile care markets.
- 70% of NW Councils reporting an overspend against their adult social care budgets in 2019/20. Some positions being supported by reserves or offset against underspends in other council services.
- Over 2/3rds of demand growth budgeted in 2020/21 relating to adults of a working age.
- Use of resources work highlighting an increasing issue regarding adult care debt, alongside poor resident experience of the charging system. Average debt represents c30% of annual charging.

2.20 Key in-year pressures within adult social care, compounded by the impact of the Covid-19 pandemic include:

- Care market support – increased care fees, cost reimbursement, support for under occupancy (including self funders), payments on planned support and PPE purchase.
- Workforce investment – income protection for staff self isolating, increased pay and recognition.
- Increased support and intervention – direct payments, additional 1-1 support etc
- Reduced charging income i.e. within day support, home care etc. Increased bad debt risk.
- Impact on savings and transformation delivery.
- Significant in-year impact on council budgets without additional funding means reduced resilience to support existing pressures in adult social care or fund transformation investment from reserves.
- Unprecedented uncertainty making it difficult to plan forward - duration of the pandemic, extent of economic impact on 21/22 council budgets, the Government's response etc
- Ongoing requirement for PPE, market support etc unknown – with funding sources due to end.
- Uncertainty that is exacerbated by the short-term nature of funding that already underpins a significant proportion of recurrent adult social care investment.

2.21 There was a lack of clarity as to what future demand will look like. It was recognised that there is some potential for temporary underspends in some budget areas due to a temporary reduction in demand and utilisation of interim funding i.e. the NHS hospital discharge £1.3bn (national resource), but caution about assuming the continuation of that funding stream into the future.

2.22 The survey highlighted an evident requirement for additional Government funding – including consideration of the wider impact on NHS budgets. Adult Social Care is a pre-requisite to acute sustainability, both in terms of admission avoidance as well as discharge.

Recovery

2.23 A significant amount of work is underway across all aspects of the Community Health and Social Care service, and the wider health system, to work through what recovery and the "new normal" look like, understanding the short, medium and longer term implications on resources, staffing, service delivery and most importantly, the impact on individuals, their families and carers. The report attached as Appendix 4, Surviving the Pandemic: New Challenges for Adult Social Care and the Social Care Market, published by the Institute of Public Care, and written by Professor John Bolton, explores some of these issues, and a number of the proposals in this report reflect Professor Bolton's recommendations.

3 Options/Alternatives

3.1 There are three options:

Option 1

Do nothing. Allow the support implemented up to the 30th June 2020 to end. This is not considered to be a viable option for the reasons set out in the current position above. In order to ensure that Care Act eligible care and support needs can be met, there needs to be sufficiency, sustainability, quality and choice of provision in the local care market (Care Act section 5 and Care Act Statutory Guidance section 4 relate). Whilst there may be a need to revise the commissioning plans in relation to care and support services to reflect a shift in future demand, any contraction or other changes in the market need to be undertaken in an informed and managed way.

Option 2

Do nothing and respond to national directives when these are published. Discussions are continuing at a national level between the Association of Directors of Adult Social Services, Department of Health and Social Care, the Ministry for Housing, Communities and Local Government and the Local Government Association, however there is no indication as to when any guidance might be published.

Option 3

Extend a number of the proposals now until such time as any national guidance or funding is announced, namely:

1. Extend the 90% bed occupancy guarantee until the end of July, and delegate authority to the DASS to adjust this support from that point onwards up until the end of October (subject to interim reviews), to respond to the prevailing market conditions, in order to meet Care Act duties to meet eligible care and support needs, and ensure sufficiency, sustainability and quality of supply of care services to meet those needs. Whilst it is difficult to predict the financial implications of this proposal in an ever changing picture, a worst case scenario of continuing to guarantee 90% bed occupancy to the end of October, based on the current vacant bed position would be £1.6m.

2. That the Financial Support Panel continues until the end of October 2020 (subject to interim reviews) in line with Procurement Policy Note (PPN 04-2020), or until such time as there is further national guidance or funding in relation to the financial

impact of covid-19 on the operational running costs of care services. It is further proposed that information and outcomes of the panel are shared with the Financial Assistance Board and Procurement Bronze Group to ensure oversight and connectivity. The number of claims that directly relate to measures within the infection control fund, should reduce. However, for care homes there may be ongoing or incidental costs that fall outside of the scope of the grant, and for other providers who will not benefit from a share of the non-care home element of the grant, there needs to be recognition of the increased costs. Using the past three months activity through the panel, and not factoring in the favourable impact of the infection control fund, an estimate until the end of October is £0.582m.

3. To continue to pay for commissioned rather than actual care delivered in the care at home sector until the end of October 2020 (subject to interim reviews) in line with Procurement Policy Note (PPN 04-2020), or until such time as there is further national guidance or funding in relation to the financial impact of covid-19 on the operational running costs of care services. This recognises the need for flexibility within the sector to be able to respond to fluctuating and irregular demand, the need to respond differently as lockdown easements are implemented, and the unknown impact on the workforce of test, track and trace, or further Covid-19 outbreaks in the community. Based on the last three months, and assuming no change in volume of activity, an estimate until the end of October is £0.4m.

4. That the 5% uplift continues to apply for the remainder of 2020/21, and by default becomes Oldham's uplift in social care fees for the current financial year. Prior to the Covid-19 pandemic, and in line with usual process, consultation commenced with the commissioned providers in the care sector regarding fee levels for the financial year 2020/21. The uplifts proposed to the market averaged at 3.5%. Feedback received (but not progressed through to decision) referenced, amongst other factors, the increase in the National Living Wage of 6.2%, and a view that commissioned rates should be increased accordingly. Ongoing dialogue with providers throughout the year will enable an assessment to take place of the extent to which this, along with the other measures proposed, is ensuring sufficiency, sustainability, quality and choice of provision.

   During the pandemic, the Local Government Association and ADASS issued guidance for commissioners, which included a recommendation that fee increases should be uplifted by around 5% to take account of the National Living Wage, and that when taking account of additional Covid-19 related costs, increases of up to 10% in costs were being experienced by the sector. Individual discussions between LGA finance leads and council officers recognised that the 5% uplift, along with the wider financial support available, was in line with the published guidance.

   Given the current circumstances and the volatile operating environment, which now makes it difficult to establish what typical cost pressures across the sector are, and how these might fluctuate over time, it is proposed that the 5% uplift continues to apply for the remainder of 2020/21, and by default becomes Oldham's uplift in social care fees for the current financial year. Dialogue will continue with providers during the course of the year with regard to cost pressures and financial viability.

   Based on the current volume of activity, it is anticipated that the cost of the uplift for the remainder of the financial year is £2.37m.

   It is worth noting that the CCG has agreement from Governing Body to extend the 5% uplift for care services until 31st July 2020, in line with NHS guidance, with a view to reviewing the position once further guidance is received.

5. Acknowledge that in relation to adaptations to properties being undertaken by framework contractors through the Disabled Facilities Grant, there are additional costs now associated with Covid-19 such as PPE, additional cleaning and the impact of social distancing that were not originally priced for as part of the tender undertaken in 2018, and to offer a uniform amount, as all other costs within the framework are set. This is suggested as £30.00 for PPE plus £120 for additional labour/cleaning costs per job.

6. Acknowledge that for more major construction requirements which are tendered on an individual basis through use of the Disabled Facilities Grant, (typically extensions) we will ask for additional costs associated with C-19 to be priced for within each individual tender.

7. It is proposed to make provision by applying a 5% uplift on current activity that recognises the potential for increased demand for carer respite and carer breakdown.

4 Preferred Option

4.1 The preferred option is option 3 in the absence of any national guidance or directives regarding the impact of Covid-19 on the immediate and future sustainability of the care sector.

4.2 As reported at 2.6 above the Council is currently predicting a £20.7m combined overspend and loss of income over and above the specific COVID funding received to date. An announcement regarding a further round of funding is believed to be imminent, the amount of funding and the extent to which it will mitigate the Councils shortfall is not yet known. To this extent the allocation of the grant received (and due to be received) is an arbitrary exercise. It is more important that the Council takes whatever measures it feels necessary and appropriate to support the care sector as set out in option 3 (effective from 1 July 2020) and records them in such a way they can be identified as relating to the pandemic. In addition, the Council will continue to reclaim relevant costs from NHSE and I via the CCG, again the time period for this arrangement is uncertain and upon cessation it is anticipated there will be residual costs that will then fall to the Council.

4.3 The risks of not acting to extend the support proposed include the potential for multiple, unplanned exists from the care market, resulting in risks to the health and wellbeing of residents associated with moves to other provision, should that provision be available.

4.4 There are also risks in relation to continuing higher costs associated with care delivery as a consequence of increased operating costs and more stringent infection control measures, and whilst some of these can be mitigated by the Infection Control Fund, the restrictive nature of the grant conditions mean that some costs cannot be covered through this route.

4.4 There is risk of carer breakdown and the need to plan for this both financially and in terms of having respite options available either within people's own homes or in care settings.

5 Consultation

5.1 Consultation with the care sector has been ongoing throughout the Covid-19 pandemic. This has taken a number of forms, including daily situation reports, video calls both

individually and collectively and daily newsletters containing key information, guidance and updates.

5.2 In relation to fee negotiations prior to the outbreak of Covid-19, formal consultation commenced on 10th March 2020 until 31st March 2020, and proposed on average, a 3.5% uplift to care providers. Feedback was received from 15 providers, and overwhelmingly suggested that the proposed uplift was not sufficient to enable providers to meet their increased costs, and in particular, meet the cost of the uplift in the National Living Wage of 6.2%. The formal consultation process was paused on 1st April 2020.

6 Financial Implications

6.1 Extending the 90% bed occupancy guarantee based on current capacity levels until July 2020 will cost approximately £0.400m. The expectation is that the NHS funding route will be utilised as this is an extension to the market capacity strategy in response to supporting hospital discharge, and this has been agreed with the CCG. Were this not to be the allowed by NHS E the cost would revert to the Council and be a call against the resources received to fund the pandemic. It should be noted that this initiative largely, but not exclusively replaces the previously approved block booking of spare capacity within the market referred to in section 2.17.

6.2 There is a fair degree of complexity and uncertainty involved when attempting to quantify the cost implication of extending the Financial Support Panel until the end of October 2020. Many unknown impacts will likely be felt within the market over the next year including potential virus outbreaks, PPE supply chain issues, testing and changes to the discharge pathway (discharge to assess). The total sum the Council has approved responding to financial assistance requests from providers, from 1 April to 19 June is £0.437m. On this basis the Council could incur a further £0.582m up until October 2020.

6.3 At this stage, NHS England have not announced the funding regime or figures for CCGs. It is expected that this will come as separate “BAU” and “COVID” funding streams. The CCG will seek to obtain funding for this measure through one of these funding streams, but this is currently uncertain.

6.4 The allocation of the Infection Control Fund in addition to potentially reducing provider claims should also reduce the financial ask of the Council in terms of paying staff wages in full to those care workers who are isolating, additional staffing and recruitment costs and for steps to limit the use of public transport. The Council will continue to incur costs relating to PPE for care homes. To date PPE requests specifically approved by the finance panel has cost £0.198m with an expected cost of £0.264m to 31 October 2020. This has been agreed as a recharge to NHS E via the CCG until the end of July, but as noted above, CCG COVID funding post-July has not been confirmed, so the latter amount is subject to confirmation.

6.4 Opting to pay for commissioned activity rather than actual care delivered within the care at home sector until October 2020 will cost approximately £0.400m. Invoices will continue to be monitored on a monthly basis with an overall reconciliation at the end of the crisis period.

6.5 Adopting the 5% uplift within the base costs across all care sectors for the remainder of the year will cost circa £2.37m. From July, for every month the Council is able to continue accessing NHSE funding via the CCG, £0.264m can be offset against the NHS resources.

6.6 Taking into account the growing requests from contractors delivering DFG schemes, and basing an estimate on what has been approved so far at panel by applying a cost

premium for PPE and additional labour within future tender applications, the cost to support contractors will be around £0.065m up until 31 October 20.

6.7 Based on the 2019/20 cost of providing respite care and assuming a 5% increase is to be expected in the latter part of the year for increased demand and potential carer breakdown, the projected cost is £0.209m.

6.8 The total estimated cost from 1 July 20 until 31 October 20 should all recommendations be accepted/ retained is £3.642m as summarised in the table below. This does not include all of the costs and losses of income that the Portfolio expects to incur as a result of COVID19. This will be financed through a combination of Council resources (supported by Government grant subject to availability) and NHS resources. It is important to note that an announcement on further Government resources to support Councils is expected imminently. Any costs that cannot be financed via NHS funding, grants and contributions will have to be addressed by the Council.

	To Date £000	to 31 Jul 20 £000	to 31 Oct 20 £000	Total £000
90% Capacity	309	400	1,200	**1,909**
Panel Awards	437	145	582	**1,164**
General PPE	311	103	415	**829**
Commissioned Activity	300	100	400	**800**
5% Fee Uplift	731	264	995	**1,990**
DFG - Works	25	15	50	**90**
Total	**2,113**	**1,027**	**3,642**	**6,782**

(Andy Cooper Senior Finance Manager Oldham Council & Ben Galbraith Chief Finance Officer NHS Oldham CCG)

7 Legal Services Comments

7.1 Legal Services has worked with Adult Care Service to ensure that the government guidance in PPN02-2020 has been followed and to ensure compliance with the guidance notes surrounding State Aid issues. To date the Council has provided assistance and support to subsidise service providers under State Aid block exemptions, namely the Temporary Framework issued in respect of the COVID-19 emergency and Services of General Economic Interest. Recipients of funding have been invited to self-declare receipt of support from public bodies so that the Council can regularly inform the Department for Business, Energy & Industrial Strategy.

7.2 On 9th June 2020 the government issued a further Procurement Policy Note (PPN 04-2020) which sets out information and guidance for public bodies in relation to the recovery and transition from the COVID-19, outbreak. The guidance note is effective from 1 July to 31 October 2020. It updates and builds on the provisions contained in PPN02/20.

"Action
All contracting authorities should:
● Review their contract portfolio, including where they are providing any contractual relief due to COVID-19 and, if appropriate to maintain delivery of critical services, continue or commence measures in line with PPN 02/20.
● Work in partnership with their suppliers and develop transition plans to exit from any relief as soon as reasonably possible. This should include agreeing contract variations if operational requirements have changed significantly.

● Work in partnership with their suppliers, openly and pragmatically, during this transition to ensure contracts are still relevant and sustainable and deliver value for money over the medium to long term.
● Continue to pay suppliers as quickly as possible, on receipt of invoices or in accordance with pre-agreed milestone dates, to maintain cash flow and protect jobs.

7.3 The Council should be using the next four months to re-assess the interim relief provided to contracted suppliers with a view to assessing the market conditions, in the light of its statutory duty under the Care Act 2014, to ensure the sustainability of the market. In the circumstances, it would be advisable to align any interim relief measures to the time limit of 31st October 2020 imposed by the effective date of the guidance.

7.4 The report outlines the requirement to reconsider the uplift to the annual social care fees approved by Full Council at its budget setting meeting in March 2020 and the need for additional support for carers.

7.5 When setting the fees, the authority should address the effect of its decision in terms of the quality of the service provided and the sustainability of the providers.

7.6 The courts have provided some guidance with regard to the appropriate considerations of a Local Authority when setting fees in relation to the actual costs of providing care. A Local Authority has a statutory duty to provide residential accommodation to categories of adults in its area in need of care and attention which is not otherwise available to them. The duty can be discharged by contracting with a private care home provider. Local authorities are responsible for achieving a responsive, diverse and sustainable market of service providers that can provide high quality, personalised care and support that best meets the needs of people. Local authorities must have regard to the sustainability of the market as a whole including, for example, taking care not to set fee levels below an amount which is not sustainable for providers in the long-term.

7.7 Local authorities have to act under the general guidance of the secretary of state who has issued formal statutory guidance in Local Authority Circular LAC (2004) 20 which stated at para.2.5.4 that councils should have due regard to the actual costs of providing care and other local factors. Councils should also have due regard to Best Value requirements under the Local Government Act 1999 to “make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness”. It was held by the Court of Appeal that the circular did not prescribe any methodology which local authorities had to adopt in order to have due regard to the actual cost of providing care. An arithmetical calculation was one way of carrying out the exercise but it was not the only way. Provided some inquiry was made by the decision maker, it was for the decision maker to decide how much attention to pay to it. In one case the fact that the Local Authority had considered the rates and compared them to others in the region and had sought information from one of the providers and carefully considered its accounts, which was sufficient for the decision of the Authority for it to be robust. In paragraph 3.3 of the statutory guidance “a council should be able to demonstrate that this cost is sufficient to allow it to meet assessed care needs and to provide residents with the level of care services that they could reasonable expect to receive if the possibility of resident and third-party contributions did not exist.” Non statutory guidance “Building Capacity and Partnership in Care” points out that local authorities must not use their dominant position to drive down fees. “Fee setting must take into account the legitimate current and future costs faced by providers as well as the factors that affect those costs, and the potential for improved performance and more cost-effective ways of working.”

7.8 Consultation is necessary for this type of decision. As stated above, the statutory guidance states that “local authorities are to have due regard to the actual costs of providing care and other local factors” and to take account of the legitimate current and future costs.”

7.9 When making financial decisions the authority must ensure that it takes account of all relevant circumstances and is able to carry out its statutory functions. The council is able to take into account its limited financial resources but must draw a reasonable balance between such limitations and its other duties, including an obligation to make decisions with an awareness of responsibilities under the Equality Act 2010. The public sector equality duties under the Equality Act 2010 extends to cover various protected characteristics, including age and disability, and therefore the Act is relevant here in that there is a potential effect on such people. Under the Act, public authorities have legal duties to have due regard in the exercise of their functions to the need to eliminate discrimination; advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.10 Case law also suggests that it is good practice to document how decisions were reached. Equality Impact Assessments are not a prescribed requirement but they provide a structured framework which enables the Council to ensure that it considers the equality impact of its decisions, and to demonstrate to others that it has done so.

7.11 It is essential that consultation with providers and stakeholders should address the issues raised above to ensure that the Council has the evidence necessary to defend its position when making a decision with regards to the uplift of adult social care fees.

7.12 Similarly, it is important that any decisions around the level of support provided to carers is evidence based with appropriate consultation in light of the current circumstances surrounding the COVID -19 pandemic. (Elizabeth Cunningham-Doyle)

7.13 Timeframes for consultation should be proportionate and realistic to allow stakeholders sufficient time to provide a considered response and where the consultation spans all or part of a holiday period. Policy makers should consider what if any impact there may be and take appropriate mitigating action. The amount of time required will depend on the nature and impact of the proposal (for example, the diversity of interested parties or the complexity of the issue, or even external events), and might typically vary. The timing and length of a consultation should be decided on a case-by-case basis; there is no set formula for establishing the right length. For a new and contentious policy, 12 weeks or more may still be appropriate. When deciding on the timescale for a given consultation the capacity of the groups being consulted to respond should be taken into consideration. (Salma Yasmeen)

8. Co-operative Agenda

8.1 This decision relates to the Council supporting the independent care sector and the wider healthcare system to respond to the challenge of Covid-19, by taking all reasonable and practical steps to enable the health and care sector to support some of the most vulnerable members of our community

9 Human Resources Comments

9.1 There are no direct staffing implications for the Council.
(Emma Gilmartin, HR Business Partner)

10 **Risk Assessments**

10.1 The risks of not acting to extend the support proposed include the potential for multiple, unplanned exists from the care market, resulting in risks to the health and wellbeing of residents associated with moves to other provision, should that provision be available.

10.2 There are also risks in relation to continuing higher costs associated with care delivery as a consequence of increased operating costs and more stringent infection control measures, and whilst some of these can be mitigated by the Infection Control Fund, the restrictive nature of the grant conditions mean that some costs cannot be covered through this route.

10.3 There is risk of carer breakdown and the need to plan for this both financially and in terms of having respite options available either within people's own homes or in care settings.

10.4 Given the level of financial support to Care Homes by Councils since the pandemic there is a risk at a point in time that the total amount of financial support provided both nationally and locally to larger providers could breach State Aid limits.

10.5 This report gives authority to ensure continuity of provision until the end of October 2020. There is a risk the occupancy levels will not return to pre-pandemic levels by this date and the option of further financial support to preserve long term capacity may need to be considered.

11 **IT Implications**

11.1 None

12 **Property Implications**

12.1 None

13 **Procurement Implications**

13.1 The Commercial Team agrees to extend the support measures as recommended in the report to support the care sector through the COVID19 pandemic. However, as referred by the Legal Team the current Procurement Policy Note (PPN04-2020) which provides guidance to the contracting authorities to continue supporting their contracted providers where required until 31st October 2020 ensuring delivery of critical services.

13.2 The commercial team also recommends the following:

a. Assess the care market until such time i.e. by end of Oct 2020, with a view to fully understand the additional or further support they may require ensuring their sustainability.

b. Assess all available support to the care market from various sources and ensure it is applied proportionately to all providers avoiding any duplication.

(Raj Ahuja, Senior Category Manager)

14 **Environmental and Health & Safety Implications**

14.1 The environmental and health and safety implications relate to the impact of Covid-19 and the increased risk of the spread of infection, which a number of these measures is seeking to address.

15 **Equality, community cohesion and crime implications**

15.1 The proposals relate to actions required which will contribute to the ability to meet the health, care and support needs of the entire Oldham population.

16 **Equality Impact Assessment Completed?**

16.1 No

17 **Key Decision**

17.1 Yes

18 **Key Decision Reference**

18.1 Under Rule 14 an agreement has been made by the Chair of the Overview and Scrutiny Board to authorise the decision in respect of additional expenditure in response to the Covid-19 Emergency.

18.2 The Chair of the Overview and Scrutiny Board has agreed that the decision cannot be reasonably deferred in order to authorise the support to Covid-19 response. The support is in line with the Council's Budget and Policy Framework. The decision is exempt from call-in.

19 **Background Papers**

N/A

20 **Appendices**

Appendix number or letter	**Description**
1	Emergency Decision 01/04/20
2	Support to Adult Social Care Providers During Covid-19
3	LGA Statement – summary of the approach proposed by local government – ASC final
4	Institute of Public Care - Surviving the Pandemic: New challenges for Adult Social Care and the Social Care Market

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Emergency Decision
Chief Executive in consultation with the Leader of the Council

NOT FOR PUBLICATION by virtue of Paragraph(s) 3 of Part 1 of Schedule 12A of the Local Government Act 1972 and it is not in the public interest to disclose the information because it includes iinformation relating to the financial or business affairs of any particular person including the Council

Decision Maker	**Chief Executive in consultation with the Leader of the Council**
Date of Decision:	**01/04/20**
Subject:	**Additional expenditure in support of health and social care in response to Covid-19 emergency**
Report Author:	**Helen Ramsden – Interim Assistant Director of Joint Commissioning**
Ward (s):	All

Reason for the decision:	To support the care sector to respond to the Covid-19 challenge, and facilitate rapid hospital discharge.
Summary:	The report seeks agreement to implement an initial set of provisions, and also seeks approval to subsequent steps potentially being implemented as required over the next 12 weeks as the challenges for the care sector, arising as a result of Covid-19 materialise. Reports to provide updates will be submitted as the situation develops. The purpose of implementing a range of short term initiatives is to support the care sector to respond to the Covid-19 challenge, following national directions around hospital discharge, and guidance to commissioners. This includes ensuring that the care sector is adequately able

	to accept hospital discharges within 3 hours, manage the care and support of those Oldham residents with health and support needs who are suspected or confirmed Covid-19 positive, and those who would otherwise have remained in hospital. This will assist in the system wide efforts to ensure as far as possible, sufficient capacity in the hospital to provide hospital based care to those in greatest need.
What are the alternative option(s) to be considered? Please give the reason(s) for recommendation(s):	All options considered are included in the attached appendix, including those that are not considered for implementation at this time. In terms of the point at which to make this decision, there are two options: Option 1 Wait for more detailed national guidance to be published. Discussions are continuing at a national level between the Association of Directors of Adult Social Services, Department of Health and Social Care, the Ministry for Housing, Communities and Local Government and the Treasury, however there is no indication as to when any guidance might be published. Option 2 Implement a number of the proposals now and approve subsequent steps being implemented as required. Engagement with the care sector has established that we need to act as soon as possible to provide the support required. It is anticipated that any further national guidance may well go further in some aspects than this report recommends. In these circumstances, a further report will be submitted.
Recommendation(s):	The preferred option is option 2, to implement a number of the proposals immediately and approve other measures for implementation as the situation develops. The range of proposals and the intentions around timing of implementation is set out in the Proposals section below.
Implications:	
*What are the **financial** implications?*	The provisional cost to the Oldham Health economy should all market support measures be

implemented for a 12-week period, is currently estimated to be approximately £9.983m as illustrated at appendix 1. It should be noted that not all elements have been costed, the costings provided are at best indicative and will vary with demand and the emerging market conditions. The split between the Council and the CCG, based on activity (not who will ultimately carry the cost) is £8.845m and £1.138m respectively.

Both organisations have received funding to assist with the costs of the COVID 19 outbreak.

- The Councils share of a £1.6bn national support package is £7.6m (received in 2019/20 and rolled forward into 2020/21). This will be used to support the Council (and its partners) in its response to the virus including, but not limited to Adult Social Care (predominantly focussing on supporting the provider market), the wider social care market (including Children's Services), homelessness and loss of income. Provisional modelling reveals the additional costs will far exceed the initial allocation that has been received, indications being that further releases of funding will be made available.

- The CCG have access to a £1.3bn national fund to support accelerated discharges from hospital, costs are claimed in arrears and includes relevant costs borne by the Council. In line with National NHS Guidance Oldham CCG will be reclaiming actual costs incurred from NHSE. The Oldham CCG finance team are working closely with OMBC colleagues to ensure that all costs that should be funded by the NHS (for the duration of emergency) are captured accurately to enable them to be submitted to NHSE for payment.

It is not proposed that all the options are implemented in the first instance. The immediate options that will be applied, as per the proposed draft communication to the market at appendix 2, aim to provide reassurance and cashflow support to care providers enabling them to become more financially resilient to economic hardship and the measures of which will also

	prove valuable in establishing a discharge pathway. Based on current best estimates the likely cost to the Oldham healthcare economy will be in the region of £2m, with an expectation that this will be funded by a combination of the grants referred to above. It is felt that this integrated, staged approach will both satisfy care providers apprehensions and allow both the Council and CCG to flexibly consider further investment in what is a highly volatile market.(Danny Jackson)
What are the ***procurement*** implications?	The Commercial Team supports the decision to commission the services in response to Covid19 pandemic. An award of a direct contract under these circumstances without prior publication of a notice has arisen as a result the extreme urgency of the situation arising from the COVID-19 Pandemic. (Rajnish Ahuja)
*What are the **legal** implications?*	Legal Services will do what it can to support Adult Care Commissioning Services to put the proposals in the accompanying spreadsheet into action. There will need to be approval for a modification of the Nightingales Contract and a Deed of Variation will have to be sealed to pay for the additional placements required. The Council will follow the requirements of the Government Guidance issued in PPNs 01-02 March 2020 to avail itself of the exemption provisions in the Public Contracts Regulations 2015 and the advice given to support service providers and suppliers during the current state of emergency. The Council must be mindful of the implications of paying the top up fees for some of the care home placements. The report indicates that this proposal would be for a period of twelve weeks and subject to review. However, the Council would be entering into a contract for a care placement and such placement would become the individual's home and the implications of Article 14 of the Human Rights Act 1989 apply. Furthermore, at this stage it is not clear how long the government guidance to waive its former guidance on top up fees will continue and the longer the waiver continues the stronger the individual's right to call the placement his/her home. In the event that the Council makes a

	future decision not to continue to pay the top up fees a decision would have to be made as to whether or not a third party top up payment would be available. Under existing guidance an individual is not entitled to pay his or her own top up fee after the initial twelve-week period of a placement. Therefore, the Council with the individual's agreement, may have to find suitable alternative accommodation to meet the individual's need. It would also have to meet the individual's right of choice under the provisions of the Care Act 2014. This means that the Council would have to have find vacancies in at least more than one care home which could meet the individual's need. The likelihood of being able to meet its statutory obligation to provide choice may be impaired by the consequences of COVID-19 Pandemic and as such, the risk to the Council in continuing its contractual obligation to pay the full cost of a care home placement including the top up fees has to be considered.(Elizabeth Cunningham Doyle)
*What are the **Human Resources** implications?*	There are no direct staffing implications for the Council. (Emma Gilmartin, HR Business Partner)
***Equality and Diversity Impact Assessment** attached or not required because (please give reason)*	An Equality Impact Assessment has not been completed due to the fact that the proposals relate to actions required which will contribute to the health care and support required for the entire Oldham population.
*What are the **property** implications*	*None*
Risks:	The risks of implementing the proposals relate largely to legacy issues that may arise. Communications with the care sector will be clear that any arrangements made are initially for a 12 week period only and will be reviewed. The risks of not putting in place the measures described, will be that the health and care sector is unable to adequately respond to the challenges presented by Covid-19. Examples include the government guidance to temporarily waive the former guidance on care home top ups and 1:1 payments. There is a potential impact during this period on the income social care receives from charging. Whilst difficult to quantify at this time, robust

	monitoring arrangements have been implemented and regular liaison with finance leads is taking place to gauge any additional cost pressures.
Co-operative agenda	This decision relates to the Council supporting the independent care sector and the wider healthcare system to respond to the challenge of Covid-19, by taking all reasonable and practical steps to enable the health and care sector to support some of the most vulnerable members of our community.

Has the relevant Legal Officer confirmed that the recommendations within this report are lawful and comply with the Council's Constitution?	Yes
Has the relevant Finance Officer confirmed that any expenditure referred to within this report is consistent with the Council's budget?	Yes
Are any of the recommendations within this report contrary to the Policy Framework of the Council?	No

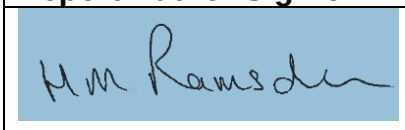
Reason(s) for exemption from publication:	Information relating to the financial or business affairs of any particular person including the Council.
Reason for emergency report	To support the care sector to respond to the Covid-19 challenge,and facilitate rapid hospital discharge in the absence of a Cabinet decision.
Reason for exemption from call in	The Chairman of the Overview and Scrutiny has agreed to this item being exempt from call in because of the urgent nature of the item.

Reason why this Is a Key Decision	(1)	to result in the local authority incurring expenditure or the making of savings which are, significant (over £250k) having regard to the local authority's budget for the service or function to which the decision relates; or
	(2)	to be significant in terms of its effects on communities living or working in an area comprising two or more Wards or electoral divisions in the area of the

local authority.

Agreement has been sought from the Chair of Overview and Scrutiny and this report is exempt from Call-in.

There are no background papers for this report

Report Author Sign-off:	
	Helen Ramsden – Interim Assistant Director of Joint Commissioning
Date:	01/04/20

Please list any appendices:-

Appendix number or letter	**Description**
1	Supporting hospital discharge and supporting the market (excel spreadsheet)
2	Draft communication to providers
3	COVID-19: guidance for residential care, supported living and home care https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance
4	Coronavirus (COVID-19): hospital discharge service requirements https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements
5	ADASS/LGA/Care Provider Alliance https://www.local.gov.uk/coronavirus-information-councils/social-care-provider-resilience-during-covid-19-guidance-commissioners
6	Department of Health and Social Care – What the Coronavirus Bill will do https://www.gov.uk/government/publications/coronavirus-bill-what-it-will-do/what-the-coronavirus-bill-will-do
7	Department of Health and Social Care – Care Act Easement Guidance https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities

Background:
The report seeks agreement to implement and/or make provision to implement a range of initiatives to support the care sector to respond to the Covid-19 challenge, following national directions around hospital discharge, and guidance to commissioners. All guidance and directions have been referenced as appendices to this report.

Proposals:

The short term initiatives (initially for up to 12 weeks) include elements aimed at ensuring that the care sector is adequately able to accept hospital discharges within 3 hours, manage the care and support of those Oldham residents with health and support needs who are suspected or confirmed Covid-19 positive, and those who would otherwise have remained in hospital, including those at the end of their lives. This will assist in the system wide efforts to ensure as far as possible, sufficient capacity in the hospital to provide hospital based care to those in greatest need. In addition the aim is to ensure that care providers operating in neighbourhoods are able to continue to support often vulnerable people and prevent presentation to hospital. Many providers are seeing significant reductions in staffing levels whilst at the same time demand increases.

The proposals are set out below and those for immediate implementation are reflected in the draft letter to providers:

For immediate implementation	To make provision for implementation if required as the situation develops
Suspending consultation on fees for 2020/21 and will recommence at a later date, with decisions backdated to 1st April 2020.	Where providers have challenges around cashflow or are facing significant costs through the need to backfill staff absences as a direct result of Covid-19, consideration of financial support that be required.
Increasing current fee rates by 5% across all commissioned adult social care services. The only exception to this is rates for PA's.	To support care homes with specialist nursing advice and support in relation to people whose physical health may be more complex than care homes would normally provide for, or for people at the end of life, who would have otherwise died in hospital.
Block purchasing of all vacant beds in the Oldham care home market at a weekly fee rate which recognises the loss of income to providers that would, if not for the hospital discharge directions, have been achieved via private payers and top ups	Making provision for the need to purchase an additional 100 care home placements/packages of care
Paying on commissioned rather than actual care provided and reconcile at a later date. Providers will be asked to continue to record where there is a difference between the care commissioned and the care provided. This also relates to people being admitted to hospital who are in receipt of care at home or in a care home, or other accommodation	Making provision to cover care provided by personal assistants, should they be unable to work as a result of Covid-19.

based service.	
Expansion of the home from hospital service	Making provision to support providers with IT equipment if required to enable them to access health support digitally.
Paying for additional 1:1 support where complexity of need determines that this is necessary to deliver safe care.	Provision for additional funding to support providers to care for people at the end of life, rather than convey to hospital.
Enabling care at home providers to reduce call durations where appropriate and safe to do so to increase capacity. Establishing a central procurement, storage and distribution centre for PPE.	
Launching a recruitment process for temporary staff, which will be via the Greater Jobs website. This will be centrally overseen and applicants directed to providers who have identified key risks and gaps. Providers may want to consider whether they could utilise catering and cleaning staff in caring roles (with training) and backfill catering and cleaning roles which may be less challenging to fill. The advert on Greater Jobs will continue to run and we can expand the roles it will target as we become aware of key staffing challenges.	
Recognising that the hospital discharge directives mean that financial contributions cannot be levied for the care arrangements put in place to facilitate discharge, which will result in loss of income for the local authority.	
Stopping intermediate care and reablement and utilising bed and home care capacity to support hospital discharge.	
Assistive Technology – rapid implementation of assistive technology to support discharge and reduction in carers.	
Equipment – making provision for increases in unit price and volume of equipment to faciitiate hospital discharge and support reduction in carers.	

Given the unprecedented nature of the current circumstances, and the difficulty to predict nature and volume of demand, the financial impacts of some elements proposed are difficult to quantify at this stage, but methods have been developed to track and reconcile

across Broadcare (the CCG's case management system for Continuing Health Care and Complex Care) and Mosaic (the Council's social care client database) on a weekly basis. In addition, separate cost centres have been established to capture Covid-19 related expenditure.

With regard to appendix 1, the OMBC/CCG columns do not relate to how these costs might be shared across the organisations, but reflect how each organisations current activity relates. Where it is impossible to split until we know actual activity, or it is a general cost (for example, staffing) this is stated, and is just listed in one column.

Within the next few days, the hospital discharge function will be mobilised, and there is therefore an urgent need to clarify with the market our intentions around financial support, and make the necessary changes to contractual and payment mechanisms.

Conclusions:

In order to support the care sector and the hospital to respond to the challenges that Covid-19 is presenting, approval is sought to implement and make provision to implement a range of measures as detailed in appendix 1.

All Covid-19 related expenditure will be captured separately from business as usual expenditure, monitored and reported on a daily basis across both the Council and the CCG. Any expenditure that directly relates to hospital discharge will be reclaimed by the CCG from central government and refunded to the local authority.

Further reports will be provided as the situation develops.

Signed: Chief Executive 

Date: 02 April 2020

Signed : Leader of the Council 

Date: 02 April 2020

Support to Adult Social Care Providers during Covid-19

The information below sets out the support that Oldham Council and it's partners have provided and continue to provide to organisations that deliver adult social care services in Oldham, during the Covid-19 pandemic.

This information is correct as at 29th May 2020, and will be updated on a regular basis.

Support being offered to ALL adult social care providers (contracted and non-contracted):

- COVID Financial support panel for additional COVID incurred expenditure, including enabling providers to pay their staff a full wage if absent from work as a result of Covid-19
- PPE support and supply through dedicated PPE hub
- Infection Prevention & Control and outbreak advice, support and training
- Swabbing and testing
- Daily Sit Rep Calls with support and signposting as required
- Key Worker support letter
- Recruitment and Volunteer programme
- Frequent (initially daily) provider newsletters
- Frequent (usually weekly) teams calls with providers chaired by DASS with clinical representation such as GP's
- COVID Centre for primary care support
- Provider support videos on a range of topics
- Prescribing & Pharmacy support
- Silvercloud online CBT for anxiety and stress
- Staff support help line

Support being offered to ALL care homes, in addition to the support listed above:

- GP Support to Care Homes - Clinical Digital Hub, provision of equipment such as BP monitors, pulse oximeters, thermometers and urinalysis dipsticks and smartphones to access GP support.
- Care home support group consisting of senior clinical, social care, commissioning and quality representatives from across the system to identify priority areas requiring rapid intervention and support
- Multi-disciplinary STICH (Supporting Treatment In Care Homes) team visits to homes to support practically and on a range of topics. Support includes Covid testing for staff and residents, prescribing support, advice on non-pharmacological treatment options as per best practice guidance, provision of pressure area care and prevention including SSKIN bundles and equipment reviews, reinforcing and role modelling infection prevention measures and appropriate use of PPE put in place by the Infection Prevention Team, mobility and functional assessment, bladder/bowel advice and support, nutrition and hydration advice and support, swallowing and communication

assessment and management, provision of a resource pack with information and key contacts for ongoing support and advice.

- Cygnets are being deployed to provide additional capacity to support EOLC for staff and residents
- Frailty app for additional support, information and advice
- GP led webinars on range of key topics such as COVID and dementia, frailty, Digital hub, EoL support, DN support etc.
- Primary care are conducting daily virtual ward rounds. Primary care support to adult social care and community health services to enable an integrated approach to care home support.
- Care Home Liaison service for specialist mental health support

Support being offered to contracted adult social care providers in addition to the support listed above:

- Increased fee rates (+5%) for all social care providers
- Block purchasing of vacant care home beds
- Payments to guarantee care home occupancy rates at 90%
- Payment of care commissioned not care delivered (paying on plan)
- Enabling care at home providers to reduce call durations where appropriate and safe to do so to increase capacity
- Payments in advance to improve cash flow
- Continuation of contractual payments to providers not operating services during this period, enabling them to focus resources on wider community support (these amounts are not included in the figures below)

Support to providers that the local authority has contracts with			
	Domiciliary care	Residential care	Other provision
Support being offered	Please see detail above		
Total spent to date on supporting providers the local authority has contracts with in response to COVID-19.		£1,389,198.13	
Support to providers that the local authority **does not** have contracts with			
	Domiciliary care	Residential care	Other provision
Support being offered	Please see detail above		
Total spent to date on supporting providers the local authority does not have contracts with in response to COVID-19.		£8,325.58	

Fees for 2020/21

At the point at which the outbreak of Covid-19 occurred, formal consultation on fee rates for 2020/21 was under way. This was paused and a 5% uplift applied to the base rate for residential care, and to all other care fees in line with the tables below:

Care home fees 2020/21	2019/20 rate	2020/21 rate
Base rate	£500	£525
PQuIP engagement	£10	£10
CQC Good	£25	£25
CQC Outstanding	£45	£45
Dementia premium	£45	£45
Mental disorder premium	£84	£84
12 month bridging payment for homes currently rated as "excellent" under the Oldham scheme and Requires Improvement with CQC*	£10	£10
12 month bridging payment for homes currently rated as "excellent" under the Oldham scheme and Good with CQC*	£20	£20
Nursing premium – payable for all nursing placements	£30	£30

	Care at Home	CHC Care at Home	Extra Care Housing	Supported living non-complex p/hour	Supported living complex p/hour	SL Sleep ins Per night	PAs
2019/20 rates	£15.22 £17.22 OL3 area	NA	£14.26	£14.26	£15.70	£80	£10/hr £62.64/night sleep-ins
2020/21 rates	£15.56 £17.56 OL3 area	RGN/RMN £21.72 Enhanced £16.56	£14.57	£14.57	£16.05	£80	£10/hr £65/night sleep-ins

Introduction

This statement has been produced to give a framework for the consideration of the locally determined temporary funding of social care providers in the light of the current national emergency.

Its focus is on stabilising the adult social care market during the crisis. It is not intended to impede local successful relationships with providers, but to recognise that nationally there are critical concerns about sustainability and price.

Providers have several concerns which reflect their anxieties about being able to survive in the short term. Some of those concerns are operational such as the need to ensure that care workers have the right personal protective equipment and appropriate testing. However, there are also immediate and very pressing concerns about the increased costs they are facing and the impact this will have on their cash flow.

Councils also have concerns about the range of calls on the Covid-19 funding which has been made available to them by Government and need to carefully monitor the additional costs being incurred to support adult social care providers.

Many authorities have already taken action to support providers in meeting the additional costs that they face locally and in managing cash flow challenges. We hope that the information about the scale and nature of pressures set out in this statement will help councils who have not yet been able to agree what level of temporary additional support providers in their local area will need. We would welcome a local open book dialogue to build trust between commissioners and providers.

Objectives

Adult social care faces three major challenges over the next four weeks and beyond in response to Covid-19:

a) To ensure that the adult social care sector continues to provide care to those who need it at a time when providers will need to recruit additional employees to replace those who are off sick or to respond to increased demand. This will be a cost pressure for providers which must be recognised. Other sectors have reported staffing absences of over 20% at any point in time.

   All the evidence is that adult social care is facing similar challenges. This will be a significant challenge especially given the high level of vacancies in the sector

and the significant turnover of employees and will mean that providers incur additional costs. Providers are likely to face other increased costs especially Personal Protective Equipment (PPE) and the extra time required to deliver care safely whilst following infection control guidance.

It is important to acknowledge the existing fragility of the care market before it had to contend with the challenges arising from Covid-19. It is not intended that the additional £1.6 billion of Government funds are used to make up previous shortcomings.

b) To support the immediate discharge of hospital patients who are medically fit to leave. Adult social care packages will be required for many of those people. Home care packages and care home placements will need to be sourced locally and fees agreed locally with providers along with the NHS and Government organising appropriate testing.

Given the need for immediate discharge from hospital within two hours, for additional reablement capacity to maximise independence and the implications of Covid-19, we need to invest in safe and sustainable approaches that will in themselves help people recover and free up resources. All organisations should be following the guidance on discharge that has been issued.[1] Local authorities are the lead commissioners of discharge care packages working closely with colleagues from the NHS.

c) To increase capacity to enable the social care system to meet additional need and demand in relation to hospital discharge the NHS is seeking to achieve. This is through a combination of a 5% increase in care home capacity utilising half of the existing vacancies – 20,000 beds and increasing capacity for care at home by 10% including home care, personal assistants and other community and voluntary services.

In some instances where homes have inadequate quality, this will require additional staffing and oversight from health and social care. Capacity cannot be judged simply by the number of hours but also needs to take account of how the services in the community help people to recover and rehabilitate.

Funding Providers

There are 3 areas where councils can take action to support providers as they manage through this crisis; in many cases some or all these actions will have been taken or be under consideration:

1. It is important that underlying fee increases for 2020/21 consider the impact of the 6.2% increase in the National Living Wage with effect from 1st April 2020. We estimate that the impact of this on provider costs is approximately 5%. Our

[1] https://www.local.gov.uk/our-support/coronavirus-information-councils/covid-19-adult-social-care-and-support

calculation recognises that all providers will face an increase in their labour costs of 6.2%. However, labour related costs only make up a proportion of the costs of providing care. We have assumed that those other costs (accommodation, equipment, overheads and profits) make up 30% of costs.

We have assumed that inflation is 2.5% on those other costs. Councils will have already budgeted for revised fee levels in 2020/21 so this is not a call on the £1.6bn Covid-19 resources.

Providers have given positive feedback about the approach taken by some councils but are also critical about the lack of information provided by other local authorities about the level of fees payable from 1 April. We would refer all local authorities to the commissioning guidance note published by the LGA, ADASS and the Care Provider Alliance[2]. Local government will be working with the Care Provider Alliance to share best practice to help with the implementation of that guidance note.

2. Additional temporary funding to recognise the cost pressures caused by Covid-19: higher dependency levels, higher staff sickness absence rates, higher administration costs due to greater volatility of support packages, and PPE costs. It is suggested that any temporary increase could be initially for 1 month with effect from 1st April 2020 with the expectation that it would be extended further if significant staffing issues persist. It is also suggested that the default position is that this extra temporary funding will end when the Covid-19 emergency finishes or is scaled down significantly.

   Councils will want to monitor the actual impact on provider costs, and this will also be reviewed nationally in conjunction with the Care Providers Alliance (CPA) during April and each month thereafter. It could also be affected by the different impact of the pandemic in each area on provider costs.

   Local authorities will need to consider the most efficient and effective way of making these additional payments which could include by agreement to directly meet additional costs, by uplifts to fees or through support in kind e.g. staffing. We suggest that any temporary increase is conditional on providers continuing to accept new service users (where it is safe to do so and committing to work collaboratively locally).

   An initial review of the information from providers suggests that nationally costs are likely to increase by in the region of 10% in April. However, we want to understand this issue better. It may be the case that costs in learning disability services may be differently affected and may need a differing local solution. There are many calls on the Government grant of £1.6 billion and whilst it was expected that a substantial part of would be needed for adult social care, it would not be possible to sustain substantial temporary increases in funding to providers over a number of months without additional Government resources.

[2] https://local.gov.uk/coronavirus-information-councils/social-care-provider-resilience-during-covid-19-guidance-commissioners

If temporary costs are increasing by significantly more than is affordable from the £1.6 billion funding, then we will join with providers in requesting more resources from the Government to help fund this additional burden. Consideration of the long term impact on the sector must be taken into account once the additional Government funds cease.

3. To help providers with their cash flow especially in the current month. Many authorities are already taking action to do this, for example, paying on plan in advance, for anticipated care delivery rather than in arrears, with retrospective adjustment as required and appropriate. This would mean payment at the beginning of every month for the work planned for that month. It is important that the first payment is made as early as possible in April.

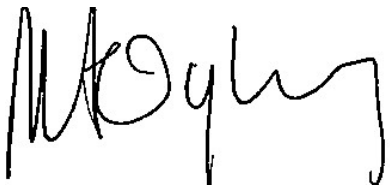
   For providers, this would mean that they would receive two payments in April: the payment for March in arrears and the payment for April in advance. We believe that this will help with the challenges of managing their cash flow.

Funding Services to Support Discharge from Hospital

On 19th March 2020 the Secretary of State for Health and Social Care wrote to local authority Chief Executives and Directors of Adult Social Services about the coronavirus pandemic. As well as commenting on the additional pressures on adult social care which are considered above in this note, he also referred to the £1.3 billion funding to the NHS to support enhanced discharge arrangements.

"This will include providing free out-of-hospital care and support to people discharged from hospital or who would otherwise be admitted into it, for a limited time. This will remove barriers to discharge and transfer between health and social care, and get people out of hospital quicker and back into their homes, community settings or care settings."

We have been working with the NHS and central Government to provide some advice about those resources. We expect to issue further advice on this in due course.



Cllr Ian Hudspeth
LGA Community Wellbeing Board Chairman

Julie Ogley
ADASS President

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Surviving the Pandemic: New challenges for Adult Social Care and the Social Care Market

Discussion Paper

Professor John Bolton

May 2020

OXFORD BROOKES UNIVERSITY

http://ipc.brookes.ac.uk

Institute of Public Care

Surviving the Pandemic: New challenges for Adult Social Care and the Social Care Market

Discussion Paper

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1 Introduction

For the past decade there has been a constant cry from the Adult Social Care Sector that it is underfunded and that it is on the brink of collapse. This discussion paper by Professor John Bolton at the Institute of Public Care (IPC) looks at how councils have avoided the predicted collapse over the period of austerity (2010-2020) and highlights new problems that have emerged during the Covid 19 pandemic and how these might be the issues that pushes social care over the edge. Drawing on several previous papers developed by Professor Bolton, this paper explores these new challenges and how can the care provider sector survive after the pandemic?

2 Background

At time of writing this paper in early May 2020, providers of care homes (both residential and nursing care) and domiciliary care are facing unprecedented challenges to maintain the provision of services. Not only has Covid-19 resulted in a significant death rate amongst those who receive adult social care in care homes and from those people receiving support in the community, but perhaps more significantly, there has been a real challenge for the valuable staff who work in these services. They have found that they were unprotected; being placed at risk and certainly many felt undervalued compared to their equals (in financial terms) in other services, particularly those working in supermarkets. The skills these workers had were not really recognised and the response for their services came across as very much an afterthought by those making decisions. An article in a national newspaper suggested that 25% of carers would leave after this crisis was over is on top of the 120,000 vacancies that existed in the care sector prior to the pandemic. It is good to see that the Welsh Government is offering all front-line care workers (domiciliary and care homes) a £500 bonus for working “on the front line” during the pandemic. It will be interesting to note the impact of that action on retention of care workers in Wales. It might also be noted that little attention has appeared in the media on the role of personal assistants and as they deliver a significant proportion of the services particularly to younger adults the impact of the pandemic on them should also be understood.

There are many issues and challenges being raised by the pandemic which puts a number of uncertainties on the capacity of those who provide services that requires a significant change of mindset from commissioners, providers and other stakeholders if there is going to be an effective and timely recovery from the pandemic. However, resolving these issues are complex and in order to give the sector a better chance of identifying possible solutions we need to fully understand the demand and supply factors that over the past 20 years have contributed to the current position and state of our care home and domiciliary care markets.

One further observation is that they way in which the results of the impact of the pandemic will hit a particular area will vary significantly. Each council will need to take its own view on the opportunities and threats that now are there for them. Looking at one’s neighbouring council might give some clues, but it won’t give the local answers.

3 Managing demand: demographic pressures

The main argument for much of the last twenty years put forward to demonstrate their need for additional resources by local authorities and others has been the clear evidence that in the UK (as in most of the western world) we have an ageing population who are living longer with increasing levels of care needs. This is undoubtedly true, as well as clear evidence that many younger adults with complex needs are also living longer with some having very high levels of care needs. All the simple evidence suggests that there would continue to be a great pressure put on the care sector to meet these higher levels of growing need.

Councils have developed strategies that assist them in managing demand over the last 20 years:

- Applying tighter eligibility criteria.
- Helping people to recover, recuperate or rehabilitate from the conditions they find themselves with at the time they are assessed for their care needs. Helping people to maximise their own independence.
- Helping people to make progress in better living with their long-term conditions.
- Helping people to use aids and adaptations to assist them with daily living, including assistive technology.
- Reducing the use of care homes and only using them as a place of last resort. Supporting more people in the community or in alternative provision, shared lives, assisted living, extra-care housing etc.
- Using community-based support mechanisms such as building social enterprises to help build networks (circles) of support around people.
- Working with experts by experience to add capacity to individuals and groups with care needs.
- Using asset-based (or strengths-based) assessment tools and helping link people with their own families, neighbourhoods and community organisations.
- Looking to get the right level of care to people at the right time by improving decision making e.g. not over prescribing care at the point of hospital discharge.
- Developing models where providers of care can be trusted to deliver better outcomes for their customers.
- Using personal budgets to help people find their own solutions.
- Offering better support for carers.
- Using volunteers in a constructive way e.g. to help older people who have been discharged from hospital.

These strategies, when applied in a constructive and positive way, have reduced demand (or costs) for adult social care whilst improving outcomes for many citizens. These have contributed significantly to enabling most councils to survive the period of austerity (2010-2020). The work of IPC has shown that councils have operated the above policies at various levels of success. In our paper (Institute of Public Care, 2017) a set of measures were put forward to help councils understand the progress they were making in attaining best practice in these areas. Some councils have either adopted these measures or adapted them to suit their local circumstances so that they can constantly seek to improve how their arrangements are working.

There has been a counter-pressure to managing demand that has built up in adult care over the last decade. It has had two different angles first the strong emergence of adult protection and second the development of Deprivation of Liberty Safeguards.

Safeguarding has been the single biggest area where demand on adult social care has placed pressure on staff. There has been a widening of the definitions of safeguarding and the requirement for a protection plan for an increasing number of people. The issue for safeguarding is to ensure that those people who are placed at risk and require some support to take back control in their lives are distinguished from those people where an error or omission occurred, and they didn't get the care they were expecting. The Deprivation of Liberty Safeguard (DOLS) assessments were established to ensure that those people who were not able to always make decisions in their own best interests had a process around them that offered support and a clear way of making those decisions without unnecessarily depriving them of their liberty. Both of these policy developments have added new pressures and demands on adult social care over the last decade. Most of this pressure has fallen on social workers and care managers though often the people who are being assessed are already placed within existing services.

The one area where financial pressures have been experienced by most councils is in the care and support for adults with learning disabilities. This has been an area where many councils have found it hard to manage within their budgets according to the annual budget surveys conducted by the Association of Directors of Adult Social Services in England. There has been work in some councils to reduce these pressures e.g. helping people to move from care homes to community-based provision; helping people to progress to greater independence and supporting people through their local community networks[1].

Overall fewer people get longer term commissioned help and those who do receive assistance often have complex needs and receive higher levels of service. However, in many ways councils have been managing demand and reducing the impact of demographic pressures on their communities. This has led to significant savings being made. In one study (Institute of Public Care, 2016) about 25% of the monies saved by councils in adult social care between 2010 and 2015 were found to come from managing demand. It has also allowed many adult social care services to remain within their budgets whilst the pressure has been on them from their local council (because of the significantly reduced monies from central government). It was always known that this was only sustainable up to a point. Though there are still councils who may have been slow to start their journey who are currently making significant savings through strategies to manage demand.

4 The supply of care

Whilst the programmes for managing demand always had a focus on better practices and on achieving better outcomes, the same attention was not always paid by councils to the supply of care. Care homes have not really been a commissioned service as many were already in place within local communities and were being used to serve the local population. Decisions about where care homes were located and how many places were required were generally left to the local providers to determine (there were

[1] See Local Government Association Care and Health Improvement Programme – Efficiency Work

exceptions, but these were quite rare). In order to determine what they paid for the cost of care home placements, councils followed the method that had previously been adopted by central government in the 1980s. Councils would annually set a price they were willing to pay for care. During many years in the period of austerity councils considered that it was fair as they were getting reduced amounts of money from central government that they would not offer any increase in their fees to providers when in the past as a minimum they would have paid an inflationary increase.

In 2016 it was reported (Institute of Public Care, 2016) that 20% of the savings that has been made by councils in England had been achieved in this way. This led to a strangulation of the care market. Many investors had assumed that there would be a constant supply of older people requiring accommodation in a care home with the ageing population (resulting in a healthy profit). This did not quite prove to be the gravy train that many expected and those investing in care homes were not getting the return for their investment that they had expected or been promised. Councils paying a lower rate than was probably fair only made this situation worse. Some providers who had invested heavily and maybe unwisely found themselves in financial difficulties and some care homes were closed as a result.

However, across the United Kingdom there was actually an oversupply of care homes – mainly because councils were purchasing fewer places (as covered above). So, if a few places closed this may have had an impact on individuals in the homes but it often didn't overall affect the required supply – there were often vacancies in other care homes that could be filled. From 1990 to 2010 most councils had reduced their own provision of in-house care homes (also making significant savings) but they had become reliant on the care market to make the right provision for them.

At the same time councils had put large parts of their domiciliary care services out to tender. They started to procure most of the day to day care of people in their own homes from the private and the not-for-profit care sector. This has led to very low prices being paid by many councils for their domiciliary care services. In turn this has led to low pay and poor conditions (e.g. zero hours contracts, minimum wages and limited travel allowances or travel time) for the staff who work in domiciliary care. Companies report a one third annual turnover of staff in this sector.

For both care homes and for domiciliary care councils focused on low cost care. Providers of care were able in some parts of the UK to subsidise their costs with people buying their own care and for some this ensured their businesses had long term viability. For those who relied mainly on council contracts there was much more risk.

This approach to procuring care by councils has had the following lasting consequences:

1. Many councils (commissioners) did not understand the makeup of the costs of running a care home and many refused to engage in a process or be open with providers about this. This led to the Pembrokeshire Judgement in 2010 (High Court Judgement on 21 December 2010 that ruled that councils must have in place a proper process to come to a view on the rates they were willing to pay care homes). Some places have developed an open and transparent approach where providers and commissioners come together to negotiate the costs of care and the fess that might be paid but this is not as widespread as the judgement indicated.

2. Councils have not understood the costs of delivering domiciliary care (even though their own services that they still run costs over twice as much as that they pay to the private sector).
3. Many care homes operated with a vacancy rate that made it difficult for them to sustain their bottom line.
4. Despite some attempts to better train and promote the work force in both care homes and in domiciliary care, staff are still paid at a low rate (something close to the minimum wage). This has led to a significant challenge for both retention and recruitment of staff across the board.
5. Many providers of care were running their operations with a very low profit margin and often day to day contracts with councils led to a loss.
6. Older people entering care homes were often asked to pay top-ups to breach the gap between what the council declared as the rate at which it would pay and the set fees for a care home.
7. The recent government migration policy combined with Britain leaving the European Union has led to a significant reduction in the people who had previously come to the UK to work in the front-line care sector.
8. Over the last couple of years some councils have started the process of bringing back these important services in-house, but at a significantly higher cost than they were willing to pay previous providers.

There is much rhetoric within the adult social care world about the value and the skills of this workforce but very few councils have looked to find ways to ensure that this is demonstrated by ensuring higher wages for these staff.

There has been excellent work undertaken by some in the sector to help understand what might make up the cost of care, e.g. Laing and Buisson for care homes and the UK Home Care Association for domiciliary care, which has not had the full traction with commissioners that providers might have hoped for or even expected. IPC produced with commissioners and providers in Wales a toolkit (Institute of Public Care, 2018) to assist them in coming to an agreement on the costs of care for any part of Wales. But even in Wales there was limited take-up of the model. It is suspected that if commissioners acknowledge that they did understand the cost of care that they would need to start paying additional amounts that they could not afford.

So, by March 2020 when the Covid-19 pandemic began to hit the UK the provider market for adult social care was already in quite a precarious situation.

5 Future opportunities for managing demand

There is a strong chance that degrees of financial austerity will be reapplied in the public sector when the Covid-19 pandemic is better under control. It is unlikely that a government that will be trying to look at how it repays the large sums of money that it has borrowed to get through the pandemic will be investing more money into public services. Councils may still have to look at how they can sustain themselves and their local services. This paper suggests that some of the shorter-term challenges will make this really hard.

What are the opportunities in the future for councils to continue to manage demand after 2020 or has this opportunity now been taken? There are still areas which councils continue to explore that may allow further reductions in demand. There are a number listed here but there will surely be other initiatives that will emerge in the coming months and years that will see further opportunity.

There are thought to be real opportunities to further explore the **use of assistive technology in social care**. This is a field that is hardly tapped in the UK but the emergence of robot technology, tracking technology, better use of data and better ways of communicating through video links all offer potential areas to see efficiency savings in care.

There are a number of studies that show that **social care can be overprescribed – most notably at the point of discharge from hospital** where one study (Better Care Support Programme, 2017) showed that two out of every five people discharged with a care package was on the wrong care pathway. This was partly shown when prior to the lockdown in the UK in preparation for Covid 19 a number of older people were discharged from hospital and suddenly they were found not to require the care that had previously been considered essential. Though for some of these older people they were rushed into safe places (many into care homes) in order to create the capacity in hospital to take the expected demands from Covid-19. These people will need a review of the placements made at the earliest opportunity and especially before they settle into an inappropriate way of life. One of the key messages from the last decade is that when people stop doing things for themselves they are likely to deteriorate.

In addition (prior to Covid-19) there was some evidence from providers of domiciliary care that many older people were not offered the 'right' type or level of care when they are assessed by councils for support (Institute of Public Care, 2019). A simple example is the numbers of people who were assessed as requiring four half hour visits a day for seven days a week where it soon emerged for providers that was not the best solution for these people. Care providers were reluctant to advise care managers because they reported that it takes so long for them to respond. There is a slow move towards outcome-based commissioning for domiciliary care where at least the older person and the care agency can sort out between them the best way of delivering the help that is needed (often found to require less help than that originally assessed). A continued focus on the evidence that allows people to recover from some of the conditions that led them to needing social care is also likely to assist in reducing longer term demands.

For those people being discharged from hospital following an admission for a Covid-19 related problem it is important that the health and care commissioners ensure that the right facilities and support are available to encourage and to help people to rebuild their strength and capacity. This may take longer than the traditional six week reablement programme that many places currently offer. However, this should not allow people to drift into needing longer term care where that can be avoided through good therapeutic interventions. There was important guidance (Royal College of Occupational Therapists, 2020) issued specifically to support the best care pathways for recovery of Covid-19 patients.

At the start of the Covid-19 outbreak there was a significant reduction in people coming forward to seek help. This was fuelled by a combination of fear of people coming into their homes and a surge in response from communities to help those people who had

been declared as vulnerable and requiring special attention to ensure they were protected from the virus. This **volunteer and community effort** enabled a number of people to carry on living independently without having to seek formal help. This was the very essence of what many thought could happen if communities and neighbourhoods were enabled by councils to build networks or circles of mutual support. Our study (Institute of Public Care, 2019) on Local Area Co-ordination in Thurrock points to this. Can councils further build on this community capacity that has been created or will it dissipate when people get back to work and to wider family commitments? There will be a double challenge for local councils – will neighbours step aside when the lockdown restrictions are over and expect the state to take over the caring roles that they performed during the pandemic? One council reported that it was not the traditional social care voluntary sector that always came up trumps to help out in the crisis, it was often the wider community sector, including the cultural and leisure sectors that were also present to help people. This gives further ideas for building future community capacity.

Alongside this evolving approach to community co-ordination there has also been the evolution of community enterprises. The work pioneered by Community Catalysts has enabled a number of places to tap into their communities to find people who are very willing and able to add additional capacity to the care market. Places such as Somerset have worked alongside communities to build on earlier work on Village Agents, develop community networks (of volunteers) and from both of these to develop groups of local people or individuals who want to run social enterprises that can offer care to people. It is reported by Somerset Council that without this capacity their local care market would not have coped in delivering the required services prior to the pandemic. It is further reported that these services have further developed their reach during the pandemic. For some councils there are real alternatives to the traditional care markets. This has raised the question about the regulation of these services particularly from those providers who do have to pay and to meet the requirements of the regulators in order to deliver similar services (Institute of Public Care, 2020a). It is understood that there is some work being undertaken by the Care Quality Commission to rectify this. For those councils that wish to explore the wider opportunities for commissioning future care services the work of Chris Watson at IPC should be considered.

There are some who think that there are greater opportunities than many places have so far developed to help adults with learning difficulties or in the autistic spectrum to make more progress towards independent living. The work shown in the Local Government Association Efficiency Programme for adults with a learning disability demonstrated a wider range of help could be offered that both assisted people to greater self-determination and wider independence. There is potential scope for more of this type of development including better management and support for those with challenging behaviours.

There are stories that some people have built up a reliance on services that they would not normally receive and have become dependent on the effort of local people. They may not all wish or be able to continue carrying out their current level of support when people are back with work and wider family commitments. Councils will need to ensure that local services have not created a dependency on services that has led to some people deteriorating because they stopped doing things for themselves during the pandemic. Some people may need a period of reablement to assist in rebuilding both their confidence and their muscle strengths after the pandemic.

There was a cohort of older people and others with a range of serious underlying medical conditions that the NHS identified as needing shielding during the pandemic. These people were all very vulnerable to the virus and were likely to have serious difficulty in surviving if they actually caught the virus. These people were required to remain socially isolated during the pandemic. They received letters instructing them to stay at home. An infrastructure of support was also put in place for them. They were regularly contacted by their GPs to ensure they were medically managing their conditions and they were contacted by community and council agents to ensure that their overall needs were being met. They received food parcels and offers of good to help them. Many of these people had not required formal social care support prior to the pandemic. In fact, it is being reported by some councils that these are not the most vulnerable people when it comes to their social care needs. Many of them already had in place excellent support networks and would have never considered requiring social care support. It will be interesting to see what these people will require in the way of additional help once the lockdown has been lifted for them (though this could still take quite a while). In some places there is a fear that these people have started to become dependent on these services. As they have had less exercise and been doing less for themselves has the very action that was intended to protect them hastened their decline?

There may be a significant new increase in demand for services as people's confidence in the care arrangements returns. One group who will be known to have found the disruption of the past few weeks really challenging are those who have conditions within the autism spectrum. People for whom routine and regular patterns are important to help manage their anxieties are likely to have found the lock down very stressful. This may also have impacted on their carers. It is expected that new demands may come for respite and other support from this group.

People awaiting elective surgery to restart after the crisis will require some support for their recovery, but there are also risks that the delays for their surgery might mean that their condition has worsened. There are likely to be further demands from this group of people. In addition, there are a range of people who may be described as vulnerable for whom their experience of isolation may require reassessment of their needs including more best interest assessments. Demand for social care will start to rise again.

Earlier in the paper a cohort of older people were identified who had been discharged from hospital in haste right at the beginning of the pandemic in order to create capacity in UK hospitals for the possible demands from patients with Covid-19. Some of these people may have been put in inappropriate placements in the haste to create the capacity in hospitals. These people will all need reviewing at an appropriate point and before they get too settled in the wrong place for them.

It is not just by managing demand that councils can reduce their costs. There is some evidence that the experience of remote working for assessment and care management staff and some managers; the better use of technology including using it to communicate with people with needs; the better use of data to understand what is happening; the reduction of some of the bureaucracy that was removed during the pandemic; and some improved relationships between partners could all improve the efficiency and effectiveness of local authority staff. There might be learning and future efficiencies in how councils have operated due to social distancing. Most assessment

and support planning have been done remotely. It will be interesting to test if this has had any negative impact - doing things in a more summary way might save money but might also empower the individual to have more control on how things are organised for them.

6 Considerations for outcome focused management of demand

Councils that are looking to continue to focus on the delivery of outcomes and the management of demand might consider the following actions for the future:

1. Be prepared for a surge of new referrals as the pandemic eases and ensure you have a strategy for dealing with these.
2. Focus on better care pathways for older people at the point of discharge from hospital (Institute of Public Care, 2020b).
3. Focus on outcome-based commissioning with domiciliary care providers and trust providers to make adjustments to packages of care with their customers (Institute of Public Care 2018, 2019).
4. Build on the community assets that were developed and well used during the Covid-19 Crisis. (Institute of Public Care, 2019).
5. Use a performance management framework such as the one suggested by IPC (Institute of Public Care, 2017).
6. Focus on helping people with long term conditions to better manage those conditions in order to help them to progress to greater independence.

So, will demand increase significantly as normal services begin to resume? Has latent demand been hidden as people have been frightened to come forward during the pandemic? How will councils manage this and will they have the supply of services to meet the needs?

Of course, the very sad impact of the pandemic will mean that there are less short-term demands on adult social care. Many of the people who have died during the pandemic are older people who already had a number of long-term conditions. These are likely to be people who were already receiving care and support from councils (e.g. the high numbers of deaths from older people in care homes) or were people who were at high risk of needing care in the future. The high death rate resulting from the pandemic will have had an impact on demand for adult care.

7 The future of adult care homes and domiciliary care provision

This paper has set a context into which providers of both care homes and domiciliary care entered the crisis of Covid-19. Those providers who were dependent on local authority placements to help with their occupancy were running their operations on low profit margins, with challenges in recruiting staff and often higher vacancy rates than was financially sound for them.

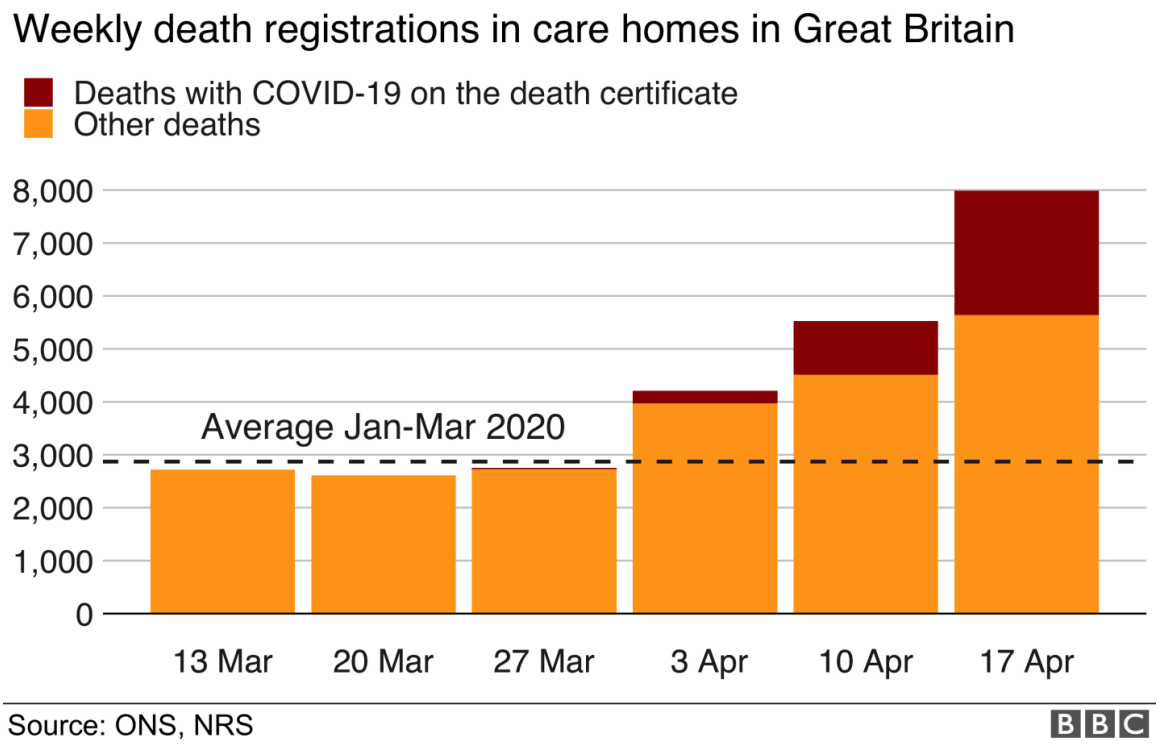
The devastation that Covid-19 has cast on the most at risk older people living in care homes and some in the community has meant that there has been a significantly higher death rate than one would expect even for this population. This will lead to a big gap in both vacancy rates with a shortage of residents and a bigger challenge to recruit staff to

work in such a vulnerable sector. The costs of meeting this shortfall will mostly fall on local councils – if they choose to respond to what has happened. There are also reports in the media that where the provision is mostly for self-funders that the increased costs of the pandemic are already being passed on to their residents.

In addition, whilst they have been looking to protect their residents and their staff from the virus care homes and domiciliary care providers have been experiencing much higher costs than they would normally expect. This includes the purchasing of protective equipment and the maintenance of staffing levels (paying either overtime or using agency staff at extra cost). Staff have had to take time off to socially isolate themselves when they are at risk and at the earlier stages this appears (from reports in the media) to be up to one third of the staff not available for work at any one time. For domiciliary care this has been slightly off set by the decrease in demand on the services (mentioned above) but for care homes they have had to continue to meet statutory requirements without additional resources. The government gave monies (£3.2 billion) to local authorities to cover a wide range of functions that they have including adult social care but also for grants to individuals, businesses, to support other key staff e.g. refuse collectors, children's social workers etc. Care homes and domiciliary care agencies are reporting in the media that in many places this money is not being shared with them. This means that before the pandemic is easing there are already real financial strains on many care providers both in the community and in care homes.

The diagram below comes from data provided by the BBC using the Office for National Statistics. It shows the death rates in care homes. The death rate in care homes during the first weeks of April 2020 were more than double the previous levels (and rising)[2]. This rate will make a significant impact on the population of care homes. In addition, the death rate in the community also showed a sign of a significant increase from a similar base 2,000-3,000 deaths per week rising to 4,000 deaths in April 2020. These deaths are likely to include many more vulnerable people who are also in receipt of social care help and support. This data shows that there will be in the short run a significant fall in demand for social care as previous recipients will have died during this period. There has been a lower level of demand for new people coming forward requesting help since the lockdown. For both care homes and for some domiciliary care agencies this will absolutely challenge their viability to survive (Vic Raynor, 2020).

[2] The official figures appear to suggest that 28% of deaths in care homes have Covid-19 as the cause on the death certificate. However, given that at the time these figures were produced there was minimum testing in care homes this figure is thought to be a gross underestimation of the impact of Covid-19 on care homes. (ONS 28 April 2020).



There will be a very difficult period for providers of care homes and domiciliary care after the worst of the first wave of Covid-19 has hit the UK. There will be a lot of providers of care whose businesses are unsustainable without a serious injection of cash. Those businesses with a higher death-rate would be at greatest risk. Councils are going to have to consider how they want to respond.

In the work that IPC has undertaken in Wales (Institute of Public Care, 2018) on the cost of care homes it was shown that the following features make up those costs:

Land: the land on which a home is built, whether owned by the operator or a third party.

Labour: the carers, kitchen staff, cleaners, maintenance, managers and head office staff (where relevant).

Capital: anything fixed that is needed to provide the service, such as vehicle costs, uniforms, food and buildings. This either needs to be bought and paid for by the operator or leased from the owner. Either way, there is an annual cost. If the operator owns it, it will be the annual cost of depreciation to replace this fixed item at the end of its useful life (e.g. staff uniforms 1-3 years, the building 20-30 years). If the operator rents it, then there will be the cost of annual renting it (rent to the landlord).

Enterprise: the operators return for organising the above three. It is worth noting that even the not for profit organisations are seeking to generate a 'surplus'.

During the pandemic the capital costs of equipment have risen as well as in some cases have the staffing costs. For care homes in normal times much of these costs are stable and do not vary according to the number of residents in a care home. The way in which

fees are determined is to divide the total costs (from above) by the number of expected residents living in the home at any one time. Most care homes will calculate these costs based on 90% occupancy (this is the reported occupancy levels of care homes in Wales in 2018 as reported by the Care Inspectorate for Wales). If homes are running at lower occupancy levels, then their costs must go up or they will not survive. If the death rate in care homes is double the usual rate, then one can expect to see a significant increase in the costs for that home even if this is short term whilst the care home gets back to its predicted level of occupancy.

Councils are going to have to agree with their local providers how the shortfall in their funds are going to have to be met in the short term or to risk losing a significant part of the market. As is indicated above a risk factor that councils might use is if there has been a higher death rate in a care home by more than 20% of their usual levels the provider is likely to experience some serious financial challenges if the previously agreed rate is the one that is continued to be paid.

For domiciliary care they could be some similar challenges if providers have lost part of their customer base. The provider will have to make a choice to lay off staff in order to bring down their costs or to increase the price whilst they wait for new demands to replace the people that they have lost. In order to sustain and build the capacity for domiciliary care (which was a challenge for this market in many places before Covid-19) then they might need to again agree a short-term price increase to allow a business to be successful. The United Kingdom Home Care Association costing model calculates that about 73% of the costs of delivering care are the staffing costs for front line workers.

Both before and during the crisis of the pandemic there have been positive attempts to recruit new staff to the sector. There were a number of initiatives already in place. During the pandemic the Department of Health and Social Care launched a national recruitment campaign to help attract a new range of people to work in the sector. There have been some reports that both before and during the crisis there have been a number of people making inquiries to join local care workforces. This of course will vary, and each place will need to consider if the new or potential recruits will balance the risks of those who will have left during the pandemic. One council reported that actually it was these front-line care workers who really showed their full value during the pandemic. This value now needs to be captured and nurtured for the future. However, for many front-line staff there has been an emotional strain both in relation to protecting themselves and their families as well as the grief and sadness experienced as some of the customers with whom they have built ongoing relationships have died during the pandemic. Councils must both ensure these staff get the support they need as well as supporting the local recruitment programmes, offering to help train new staff and building locally a stronger culture to value these staff for the longer run. There may be an opportunity as others unfortunately lose their jobs for some more good people to join the sector.

No doubt councils will make pleas for central government to help them to mitigate the higher costs that will hit them, particularly where:

- There is an increase in costs for those requiring social care
- An increase in the vacancy rate will require additional funding
- The recruitment and retention of care staff will require additional funding

- Sustaining the supply in the care market will require additional funding
- There is surge in demand for care at the point at which the current rules relax

It is possible that for some citizens their experience of the services they received during the pandemic may have worried them. They may now be thinking about different arrangements and new ways of being helped. It is possible that the growth of social enterprises might flourish more, building on the community capacity created during the crisis. There may be a stronger move towards the use of personal assistants. Councils will want to consider if a part of the local solution is to offer a wider range of options for people to help them find ways of meeting their needs (Institute of Public Care, 2020a).

8 Considerations to ensure and support sufficient market capacity

As a result of these scenarios, it is recommended that commissioners prepare accordingly for their local circumstances by:

- Moving to open book accounting with providers and agree to meet additional (unfunded) costs that had had to be met during the pandemic.
- Agreeing a process on how to calculate the cost of care in the market in the future.
- Working with providers to rebuild the workforce and to support the workforce that supported the sector through the pandemic.
- Considering if further payments are required to both retain staff and/or to recruit new staff.
- Ensuring that personal assistants are not forgotten in the strategic way forward. This may require a more formal strategy that includes helping to recruit (or commissioning an organisation to recruit) more personal assistants (Institute of Public Care, 2020a).

9 Structural changes and partnerships

During the pandemic there have been a number of journalists, politicians, national bodies and others who have said that the failure of parts of the system to work collaboratively now requires a structural solution to better address the longer-term needs of social care. The most common suggested solution is for a full integration to take place between health and social care.

During the pandemic there have been some excellent examples of partnership working between NHS managers (particularly in the acute sector) and some council managers. There are examples of better use of combined data to help in day to day planning and decision making; of the sharing of voluntary and community effort; the speedy discharge of patients at the outset; and a cementing of good collaborative relationships. On the other hand the focus on the bedded facilities in the NHS at the expense of front line care; the inappropriate placing of older people in hotels and other establishments; and the general directives from NHS headquarters that some report as omitting to recognise the importance of social care also led to the breakup of good relationships and the sense that if the NHS ran social care it might be a disaster loomed in other places. On

the ground the jury is still out as to whether bringing all these fragmented services together would necessarily be a good thing.

When faced with a challenge politicians like to offer a structural solution. There are some merits to looking at models of integration, but it could be a massive distraction from the tasks facing both health and social care in managing their recovery from this pandemic if such proposals dominated the agenda post the pandemic. That is not to say that partnerships between the various parts of the NHS and with local government aren't really critically important both in facing the pandemic and in any future arrangements. There is some anecdotal evidence that the partnerships have worked well where they were already well established. For example, some evidence from parts of Wales that their Partnership Board Structure that has led to much joint working prior to the virus has served partners well as they have collaborated to meet the challenges of the pandemic. Maybe a simple structural solution is to look at the governance models in both Scotland and Wales to assess which of these arrangements might best apply for England!

10 Leadership

The Kings Fund (2020) has been very active in setting out support options for leaders and they have taken a very similar view to IPC:

- Remember we are all just human and you are doing your best.
- Your imperfections make you valuable as a leader – people can relate to you and trust you with their own uncertainties if they know you have some too.
- In moments of stress, draw a breath; keep in touch with your humanity, emotions and intuition.
- Ask others for their views – they will have ideas you haven't thought of.
- There is no need to constantly be the superhero. Keep hold of your courage for those moments when you do need to speak up or out.
- Stay in touch with those who use the services that are commissioned and provided: their experience is always invaluable in helping to plan for the future (Institute of Public Care, 2020c).

These are messages that continue to be important to those leading the care sector both now and when the worst of the crisis is over.

11 Conclusions and next steps

There are both new threats as well as opportunities that will be there for those working in adult social care. The threats absolutely outnumber the opportunities. There are going to be a number of pressures arising from new demands. Most notably to ensure the survival of the care provider market, which will include both a close examination of the financial viability of many care providing companies and a renewed focus on staff recruitment and retention**. This requires action now.**

There will also be **pressures arising from new people seeking help** who may have put off their requests whilst everyone was in lockdown and the plight of a range of

previous customers and others who may have found the experience of the previous months both stressful and challenging to their mental well-being.

Councils will have to **continue to develop their strategies for managing demand** in particular looking at either those areas where care has traditionally been over prescribed and/or through building on the capacity that has been further built in communities whilst they have collectively supported each other to get through the pandemic.

Councils should consider the following actions:

1. Acknowledge the need to **formulate a short-term strategy** to address the local issues arising from the issues described above. The need to attend to this crisis as a priority should be agreed corporately by the council, adult social care, health partners and care providers.
2. Engage in **conversations with their providers** of care to understand: *What are the additional costs they experienced during the Covid-19 outbreak and how can they account for those costs in a transparent way?* Councils have then got to consider if they can meet all of part of these costs from the monies passed to them from central government.
3. **Consider the death rate in care homes in their area** and look at the impact this will have on their occupancy levels in the short-term and then consider what financial assistance they will need to become sustainable again in the longer run. Failure to do this will lead to a significant set of market failures.
4. **Undertake conversations with domiciliary care providers** to ensure they can continue in a sustainable way both now and after the Covid-19 pandemic is seen to be reduced.
5. **Undertake conversations with their customers** and in particular with those who use **personal assistants** to help them to manage their care and support needs. There needs to be an assurance that the capacity is still there to support the growing number of people who may (partly as a result of the pandemic) be looking for new forms of care to help them in the future. The emotional impact of the virus on a range of customers should not be underestimated.
6. **Review their approaches to commissioning care** and to learn from those places that have successfully developed local social enterprises or built on local community capacity to contribute to meeting people's needs in the future.
7. **Undertake a review of workforce strategies** with a particular view of front-line carers – this must include all care homes, domiciliary care providers and personal assistants (including where they are available social enterprises, shared lives schemes and other providers of care). There is likely to be a real challenge in the numbers of staff available in a number of settings that will require a serious challenge.
8. **Commence a review all the placements and care** provided to those older people who were discharged from hospital (in haste) in March 2020. This needs to ensure that people had some support with their recovery from hospital and that their longer-term interests are still best served by the placements that were found for them at that time.
9. **Consider the needs of carers** who have offered more support than they might usually be expected to do whilst the lockdown was on. They should consider for

each carer if any remedial or current action is required in relation to the care and support of the person for whom they care and for their own mental well-being.

10. Have continued dialogue with the **voluntary and community organisations** who supported the community effort during Covid-19 in order to **determine what can be continued and built for the future.**
11. Councils should with their partners **review the simpler processes** that many introduced during the pandemic to take a view on which processes might continue to simplify arrangements after the pandemic.
12. **Refresh and review their strategies for managing demand** and consider what they might further do in the current situation including rethinking their relationship with domiciliary care providers (outcomes based or trusted assessor models) as well as building on the community effort identified above. Councils should also look to understand what the fall out in demand might be as a result of the deaths in their areas.
13. **Collecting the data together from all of the above actions in order to collect real, hard evidence** to put the case to the Treasury and Department of Health and Social Care to meet the real costs of the pandemic on adult social care. This needs to be tempered by recognition that some of the demands on social care may fall as a result of the large number of deaths of those who received care or who might have needed care in the future.

This paper has only been possible to write because of the generosity of time and of thinking from a number of colleagues with whom I work and share ideas regularly. This includes the teams at Somerset Council and Coventry Council as well as colleagues at Newton (Europe) and at the Institute of Public Care.

John Bolton
4 May 2020

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