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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.

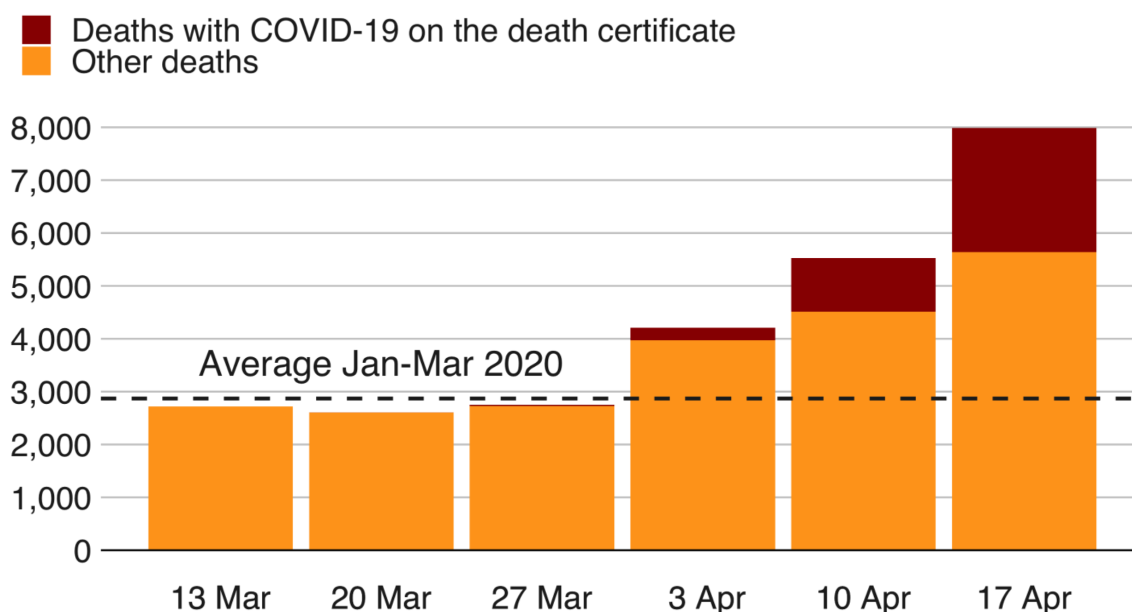
The devastation that Covid-19 has cast on the most at risk older people living in care homes and some in the community has meant that there has been a significantly higher death rate than one would expect even for this population. This will lead to a big gap in both vacancy rates with a shortage of residents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