Written evidence submitted by Essex County Council [ASC 042]

Essex County Council (ECC) welcomes the Committee's inquiry. The pandemic has exposed the fragility of the existing adult social care system. More positively, it has also demonstrated the strong inter-relationship between social care, health and public health and showed the progress that can be made when debates about funding between the NHS and social care are set aside.

While there is much that we still do not know about the long-term impact that COVID-19 will have on our residents or what "recovery" will look like for health and care services, there is agreement across the NHS and local government in Essex that we do not want to simply return to a pre-COVID "business as usual".

ECC welcomes the financial support that the Government has provided for local government and for care providers during the pandemic. Without it, councils and care providers would have suffered severe financial consequences and failure.

However, COVID-19 has increased the level of funding uncertainty against a background of already existing issues. The need for a sustainable funding solution that will enable adult social care to plan for the longer term, invest in the workforce and give financial assurance to the care market is therefore all the greater and more urgent.

1. How has COVID-19 changed the landscape for long-term funding of the adult social care sector?

COVID-19 has increased the level of uncertainty, but the underlying issues have not changed.

The pandemic has increased levels of need. Those who have had COVID, sometimes on top of existing conditions, or are suffering long term health effects as a result, require rehabilitation and are sometimes left with higher health and care needs. The needs of some vulnerable and disabled people have undoubtedly deteriorated in the face of changes and restrictions to access health and care services. Delays to routine operations may increase physical decline, particularly among older people. The extent and challenge of Long Covid is still being understood.

It is hard to predict new patterns of demand that may emerge but the underlying demand pressures have not changed. In addition to increased levels of need there are signs that more people may need mental health support. For instance, the Centre for Mental Health estimates that up to 20% of the population will need new or additional mental health support as a consequence of the pandemic.

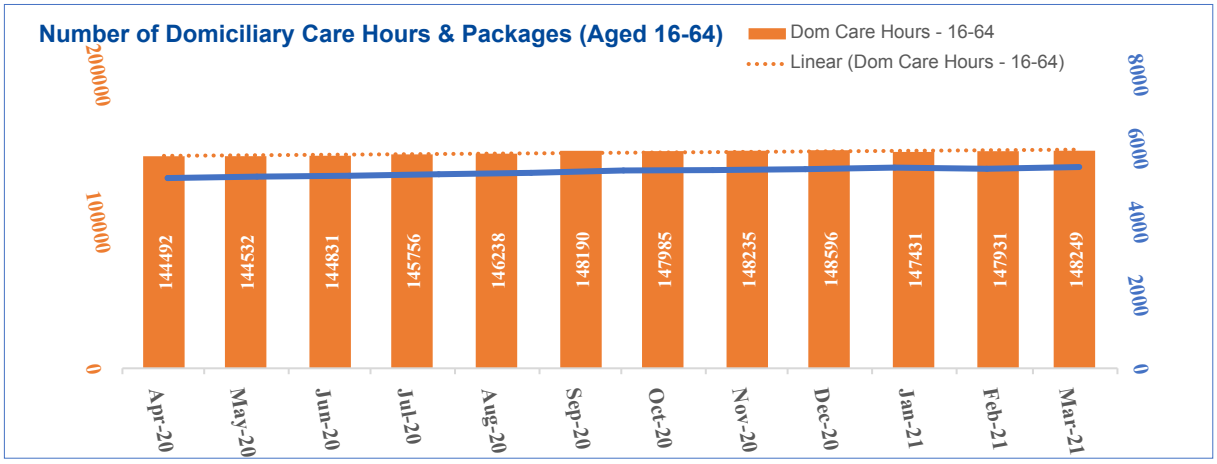
Demand for adult social care services was increasing before the pandemic, particularly for learning disabilities and older people. We are also seeing more complex cases as longevity and improved health care mean that people are living longer but with more health conditions. Age UK estimate that around 1 in 7 older people already live with some level of unmet need while the population of people with learning disabilities is forecast to grow 30% over the next decade. It is worth noting that we have also been seeing increasingly complex care packages in Children's social care, which we would expect to feed through into adult services in future.

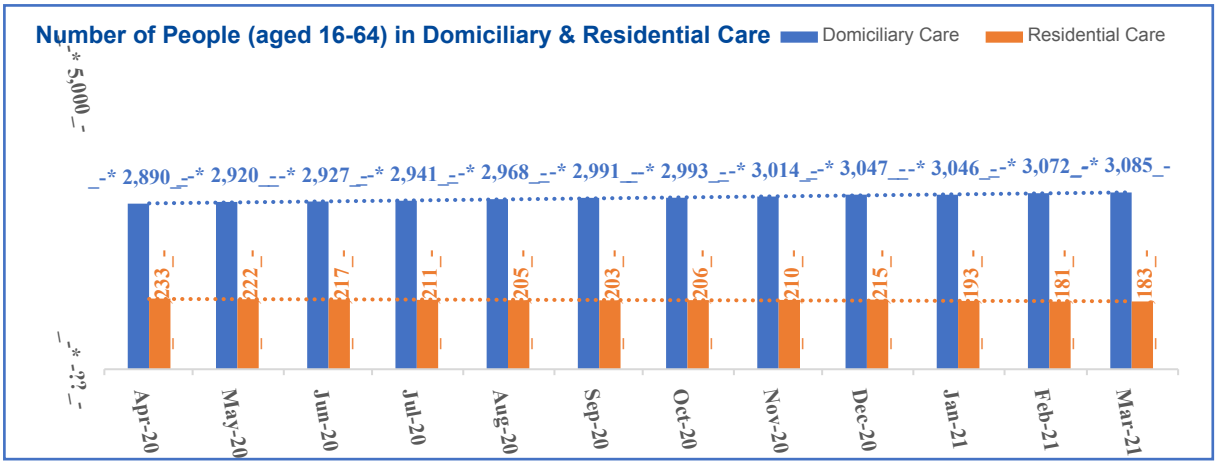
People's support systems have been disrupted. Shielding arrangements and restrictions limited the role that families, informal carers and professionals could play in supporting vulnerable people, forcing care and support organisations to change the way they operate. While most residents adapted readily to (and often welcomed) changes in the way services were delivered, some vulnerable people undoubtedly struggled and in consequence may lose confidence or experience a loss of independence. ECC has conducted research into the experience of vulnerable and disabled people during the pandemic and some of the results are included in the attached Appendix.

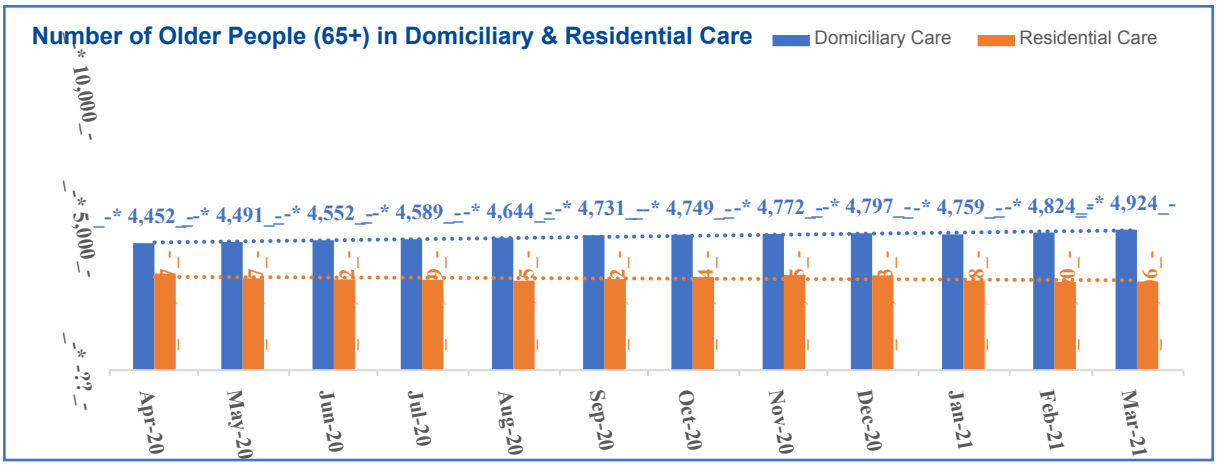
The pandemic is likely to accelerate a trend away from residential care. there has been a gradual decline in demand for care home placements for several years as more individuals choose to stay at home as long as possible but COVID has significantly accelerated this decline. COVID outbreaks in care homes and the impact of restrictions on families' ability to stay in contact with their relatives during the pandemic are likely to exacerbate this trend. Demand for extra care housing has been growing among older people and for supported living among younger adults with disabilities and the Council is actively encouraging development of these housing models. Access to suitable housing and accommodation is a particular challenge for people with learning disabilities and in the absence of supply, we incur higher costs on care packages and residential provision. Even before the pandemic, ECC's market shaping strategy was to shift the market towards a model of care that is focused more on prevention, personalisation and supporting people to live independently.

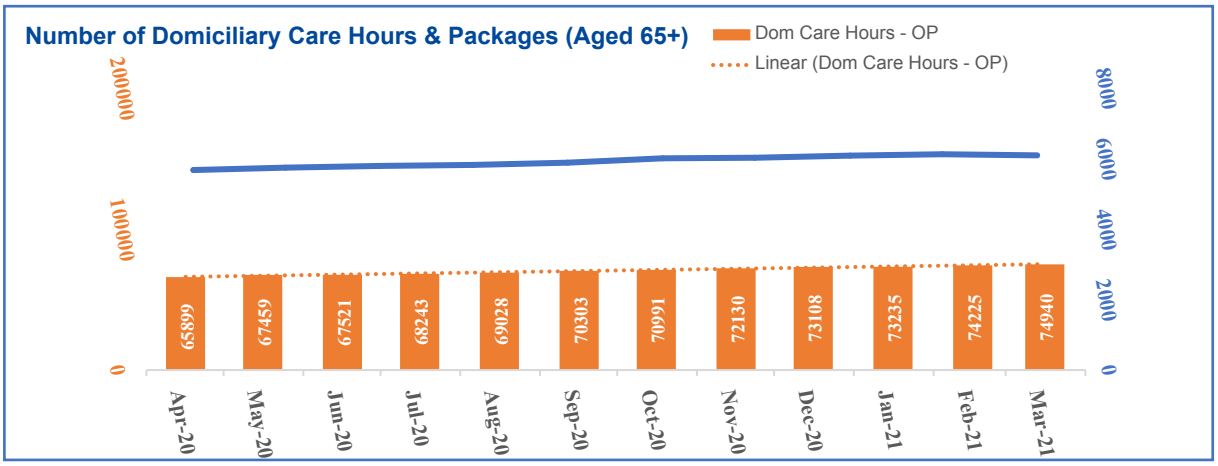
The pandemic has left the care market strained and fragile. Providers have faced significant additional costs as well as reduced income. The Government's emergency funding has been invaluable in sustaining many providers through the crisis but there are risks as that funding is scaled back. Before the pandemic, occupancy rates in Essex were c. 91%, which is just sustainable. However, this fell to c.81% in the initial stage of the pandemic and some care homes are reporting occupancy as low as 50%. The NAO has estimated that it could take at least 18 months for occupancy rates to return to former levels, but in Essex we suspect that occupancy levels may never recover in the light of the long term trend away from residential care leaving many providers vulnerable. We anticipate a period of instability in the care market as a result.

Demand for domiciliary care exceeded supply before the pandemic and was growing, particularly for end-of-life care; mental health needs and dementia care. The charts below show the changes in the number of people in residential care and the number of domiciliary care hours and packages In Essex over the past year. Residential care saw falls through to August, slight increases in October and November and then a return to month on month decreases. A total fall of 7.2% from April 2020 to March 2021. In domiciliary care, there has been a 6.1% increase over the same period which now appears to be levelling off.









The pandemic is likely to exacerbate workforce pressures. Recruitment and retention of care workers has been a problem in Essex for some time, especially in rural areas. In 2019/20, vacancy rates were over 8% in the Essex care market (Skills for Care). During the pandemic workforce availability has been critical to the ability of providers to continue providing care and effective COVID testing has been vital to ensuring that as many of the workforce as possible remain available. A shortage of care workers is a major constraint on growth in the home care market.

ECC has incurred additional financial pressures on top of an existing budget gap. The emergency funding provided by the Government has been critical to enabling the Council to meet additional commitments and

balance its budget and we are grateful for that support. The main risk now is the uncertainty of future funding. The key thing that both the Council and the care market need now is a permanent funding settlement that gives us funding certainty over the next 3-4 years to enable us to make longer term plans.

The pandemic generated exceptional patterns of spend and activity and the Council incurred significant additional commitments on top of an *existing* budget gap. Our budgets and activity levels are also not operating according to usual patterns so that we are operating with greater uncertainty. We expect to have incurred additional exceptional expenditure and lost income of c.£160m against our 2020/21 budget. This is a 16% increase against our original budget. In 2021/22 there has been a net increase of £19m in the Health and Social Care original base budget, rising from £423m in 2020/21 to £442m. The adult social care precept was applied at 1.5% to raise £10.6m in 2021/22, which will partially contribute towards the financial pressures.

In terms of projected 2020/21 outturn, we have utilised government funding streams to underwrite substantial costs incurred due to Covid, without which we would be reporting an overspend position. We are forecast to have spent some £39m during 2020/21 on additional Covid related expenditure. In terms of the long term impact, we are not yet sure of the ongoing market implications as a result of the pandemic, but we do expect there to be ramifications related to cost and market stability, as well as changing needs within the community.

We are concerned about the emergence of as yet unknown demand or cost pressures that arise as the pandemic recedes and as a result of the impact of EU exit. This includes if there is not a full economic recovery and the local tax base is hit through unemployment or loss of business rates. This could hit our 2022/23 budgets more severely as the full impact of unemployment is now not expected to be seen until the Coronavirus Job Retention Scheme finishes. Council tax and business rates are 84% of our total funding, with a 1% fall in council tax reducing funding by £7m. Currently we are projecting an overall council funding gap of £25m by 2022/23.

2. How should additional funds for the adult social care sector be raised?

Adult social care needs a sustainable, long term funding solution more than ever. The principles for any settlement to be effective remain the same.

In our submission to the Committee's joint inquiry with the Health and Social Care Committee in 2018, we argued that the key principles for any solution to be effective is that it must:

- Address all the pressures facing social care, not just the ageing population. In Essex the pressures are dementia, long term conditions, learning disabilities and mental health, not just frail older people.
- Clarify the expectations on individuals, families and communities. It is important that there are clear rights and obligations. Where there are alternatives to state-funded support it is right that they are used but also important to acknowledge the genuine limitations on communities, carers and individuals to contribute more.
- Strike a balance between local and national accountability. The Care Act 2014 defines a *national* offer for care and support but the pressure to finance that national offer falls largely on local councils. Accountability for the sustainability of social care should not rest on local authorities alone. Central government has a clear role to ensure there is adequate funding. Key partners such as the NHS and Public Health have an interest in supporting sustainability.

- Think in decades, not years. A long-term solution that looks at the system as a whole would have the scope to explore the option of a phased approach with different funding options for different generations. It should also maximise the opportunities for new technologies and emerging models of care, not tie in traditional models. A long-term solution would also allow Councils and the care market to plan for the long term and develop more innovative care options.

We do not think these principles have changed. If anything the pandemic has highlighted the fact that there needs to be a fairer balance between individual and state contributions; and between local and national funding. Essex County Council has argued before for financial products that encourage people to save for their care, but these will take time. We see value in a phased approach with different solutions for different generations. At individual level, funding should be linked to ability to pay but in ways that are fair. If proposals are linked to property assets, there needs to be some provision for the huge regional variation in property values.

Some form of cap on individual contributions may be a necessary element, but it is important that lessons are learned from the Care Act proposal, which was deemed unaffordable and unworkable. Financial incentives need to be realigned to ensure people receive care and support in the most appropriate setting.

Whatever the solution, there is an overriding need to improve clarity about what level of care people can expect, the likely cost, and therefore why they might want to invest in financial products, such as a Care ISA or insurance, to enhance that offer.

Some specific proposals that could be considered:

a) A community version of funded nursing care could be paid to people with eligible care needs in cases where dementia is identified as the primary need. Dementia, although a medical condition, does not receive NHS support for costs of treatment. This would address the perceived unfairness and would also reduce disparities between councils.

b) A portable tariff or bond when moving into supported living / shared care. This would allow people to place some of the revenue from the sale of their home into a supported living scheme on a leasehold or bond type arrangement. The bond would be redeemable to the family / estate when the person dies.

c) Council Tax reform, as proposed by the Committee, should be part of the solution, particularly increased freedom for councils to raise funding and removal of council tax increase thresholds.

The issue of free personal care also needs to be resolved. If offered without adequate funding, or funding that fails to keep pace with demand, this is potentially a disastrous burden on local authorities.

The distribution of funding also needs to be addressed. Counties typically have larger populations of older people but county councils receive 44% less per head than the national average. Given that social care accounts for such a high proportion of local authority budgets (typically around 45%), we need a funding distribution formula that accurately reflects the level of need in each area. The County Councils Network also found that the average private self-funder pays £243 more than the council in county areas, a 43% difference, with the council unable to pay higher rates due to chronic funding shortfalls.

The approach to ring-fenced funds and transfer payments also needs to be reviewed before the new inspection regime proposed for adult social care is put in place. There is considerable variation between local authorities in spending on adult social care and no centralised process of equalisation or transfer payments, which causes significant variation between authorities. We would advocate a system that clarifies expected levels of statutory funding and what is discretionary within health and care systems.

Charging is a key component of local authority funding and an area increasingly subject to judicial challenge. Lack of clarity in national guidelines is fraying the boundaries of what is allowable and is leading to increasing variation in approach between local authorities, which cannot be acceptable. Particular areas for review are the definitions of allowable benefits, minimum income guarantees and allowable disability-related expenditure.

Funding is not the only issue. We think it is equally important to look at the drivers of care costs. As well as growing demand for care and reductions in local government funding, increases in care costs are a significant issue. Workforce costs, particularly the national living wage, are a key element of this. The pandemic has only added to this with new requirements for PPE, infection prevention and control and the challenge of maintaining safe staffing levels.

The issue is not only about funding and the care market. We also need more emphasis on supporting people to access meaningful employment opportunities and incentivising the supply of housing and accommodation for disabled people. People with learning disabilities and autism in particular struggle to access suitable opportunities. Addressing this will improve outcomes for the individuals while reducing care costs.

We also need an honest conversation with the public about what they want from social care. The pandemic has demonstrated the interdependence of social care, health and the wider community in supporting vulnerable people. If people want to see greater integration of care services with health, this suggests that in the long term we need greater parity between the relative skills, status and pay of health and care workers, which would raise broader implications for funding and workforce strategy.

3. How can the adult social care market be stabilised?

Financial stability is critical but it is inevitable that we will see significant change in the market and some of this change may be helpful.

Financial stability is crucial to stabilising the market. In the short term we need clarity on COVID support for adult social care during 2021/22 as the pandemic continues to have an impact. Uncertainty over continuing financial support is a significant risk, particularly for providers facing continuing outbreaks, high cost pressures and reduced occupancy rates.

ECC used COVID funding to create a £12m COVID-19 Response Fund to help Essex providers cover the exceptional costs of additional staffing, PPE, etc that they faced to keep people safe. We also established Care Home Hubs with health, Public Health and other partners to provide advice, guidance and practical support to over 400 residential care homes across Essex. We will be keeping, and building on, this model of collaboration beyond the pandemic.

Following the crisis ECC plans to reinvigorate its market shaping activity; increase the pace of transformation activity and work with providers and partners to shape models of care and support. We are also investing in recruitment to attract people into the care sector, targeting those displaced from hospitality or retail; and we are increasing capacity in our own Essex Social Care Academy to support recruitment and training.

It is important to recognise that it is natural for there to be change in the market. We want the market to move away from a traditional model focused on time and tasks to one that is more responsive to individuals. Likewise, although there will always be some people for whom residential care or 24 hour support is the only option, as a rule we do not want to put people in residential care. In particular we need more alternatives to residential care for people with learning disabilities or autism. A shift away from care homes towards more community-based services or care products that provide high quality support to people in their own homes would be positive.

The pandemic has provided a brutal demonstration of the inter-dependence of the different parts of the health and care system. To make the market more sustainable, it is essential that recovery and transformation plans work across the whole system to develop a more integrated approach and build resilience.

One step the Government could take would be to align the procurement frameworks that apply to health and social care. Under the proposals in the Integration White Paper the NHS and Public Health will no longer need to comply with the Public Contracts Regulations 2015. But Adult Social Care will continue to be subject to those procurement rules. This has the potential to change the dynamics between NHS and local authority commissioners and inhibit our ability to work across the system. Greater freedom to direct award contracts could also distort the market if the NHS chooses to work with care homes in ways that conflict with wider objectives for adult social care. On a more positive note, we are interested in potential opportunities for the NHS and Councils to have more joint market strategies and align incentives.

4. How can the adult social care market be incentivised to compete on quality and / or innovation?

A sustainable funding settlement would enable longer term planning and give both councils and providers the assurance to innovate and build capacity.

While there is no doubt that the care market has been stretched to the limit and faces some major challenges, the response to the crisis has also driven changes to models of delivery and use of technology. The pandemic forced care services to test alternatives to traditional hands-on care, including technology solutions such as the use of digital platforms to connect people and virtual alternatives to face-to-face care. Some of these changes are likely to lead to longer term changes in provision of services. Our research with service users showed that many people embraced and benefitted from these technology innovations.

ECC has just completed a Care Technology procurement so that we can deliver more care technology solutions across Essex and embed these in care practice. People who use care and support services have themselves shifted to digital solutions during the crisis and there is an opportunity to build upon this as we think about future services.

Continuing uncertainty about long term funding drives a focus on savings and short-term commitments. Over years this has forced providers to focus on costs and outputs rather than outcomes. A sustainable funding solution for adult social care would enable councils to plan for the long term and look at different ways to

incentivise providers. This would give both councils and providers the assurance to build capacity over several years rather than the short-term horizon of one-off grant settlements.

ECC is looking at ways to commission differently and to structure models of care in ways that encourage innovation and more responsive person-centred care. We are engaging with health partners and providers to build on existing programmes to shape the future care market.

A key objective of our approach to adult social care is to maximise people's independence and support them in the community. We have launched a major programme with NHS partners (called the *Connect* programme) which is focused on improving outcomes for people when they leave hospital and promoting more independent outcomes. Yet we know that once someone begins receiving a care service or enters residential care, there is no inherent commercial incentive to the provider to reduce that person's dependence upon that service or enable them to leave the care home. Rewarding providers according to outcomes is one way to align commercial and strategic incentives to rehabilitate more people to return to the community.

Smaller providers are key to developing a strong community-based care market that is responsive to individuals' needs. However, many small providers struggle with technology through lack of knowledge, skills and resources. They also don't benefit from the economies of scale that maximise the benefits of investment in technology. This is one area where Government might fruitfully provide more infrastructure or assistance to make it easier for providers to test technological solutions or gain access to cost-effective supplies or equipment.

Conclusions

The primary need is for a multi-year funding settlement that provides funding certainty, preferably over the next three to four years. We have previously argued that the multi-year funding settlement foradult social care should mirror the time period of the funding settlement for the NHS. That is the fundamental requirement to stabilise adult social care and enable us to make long term plans, aligned and in step with our NHS partners. This also needs to consider the relationship between adult social care, the NHS and Public Health and make it possible for all of us to work together without being encumbered by funding barriers or unnecessary differences in regulatory treatment. This needs cross-party consensus.

We need a wider debate about the future role of the market and how its offer can support a focus on recovery and independence.

We need a fully funded workforce strategy for social care and the NHS to address the recruitment and training challenges that face the whole sector.

In the long term we need people and families to take more responsibility for their health and wellbeing in order to achieve a more sustainable health and care system. All parts of the system are prioritising early intervention and prevention but this requires the kind of long term investment that is not possible through short term grants to individual parts of the system in isolation.

Appendix : Lived Experience of service users and those requiring support during the COVID-19 pandemic: Case studies

Essex County Council has carried out research into the experiences of vulnerable and disabled adults during the pandemic. These are some of the stories we have been told.

Practical help for peace of mind

Sarah's Story – "Maybe I'm getting the best I can expect"

Sarah is over 85, lives alone, and is fully independent. She has a progressive illness and knows that if she gets Covid-19 she will not survive. She needs information to be simple and explained to her in person or on the phone. She's had a **significant decline in her mental health**. She's **petrified** about catching Covid-19 and is having panic attacks for the first time ever. She is **frightened, lonely and isolated** despite the **community support she gets** and, frequent calls from family members; **it's not quite enough**.

CVS provide her with support, arranged shopping deliveries, and befriending service. Her neighbour helps her with small things that mean a lot. Her son lives in out of county, she talks to him on the phone and he's tried to reassure her. Her GP referred her to the Mental Health team, but she agreed to be 'taken off the list' as she isn't suicidal. All of this is **not the same as quality contact**, a cup of tea and a hug.

She wants to know if her son can come into her home or she go to his, but she is **terrified of the risk** to her health. She needs **help to make this decision** or for her support to come around her in a different way. She called her GP to ask but was 33 on a call waiting list; she doesn't have the stamina to wait. **She is miserable** and it's affecting her physical and mental health.

"I'm lonely and alone…there's no advice out there. I feel let down"

Cancelled appointments led to increased anxiety

Jody's Story – "Becoming more isolated without realising"

Jody is in her 20s. She was then given an emergency residential placement in North about a year ago as her mum could no longer look after her. She has a planned move to supported housing closer to her mum by December.

For the last year she has been living with people who are over 55 years old, which makes her feel **"out of place".** Jody has many conditions affecting how she thinks, her vision and mobility and, she has a serious mental health condition.

Jody is waiting for a new **referral to Mental Health services.** She also has not been able to access her health specialist services. The **cancellation** of some regular of these check-ups have led to her having regular panic/anxiety attacks and often presenting at **A&E**. As a result, she paid privately for a telephone consultation which added to her worsening financial spend.

Jody is in regular contact with the RNIB who check in with her by phone. Her care has remained the same during Covid-19, but relationships with her carers have changed and she feels less connected.

She wants to move into supported living; closer to family, with people who are more her age and gain some independence. She hopes to move in December ***"Where we are able to shop, eat, cook and do day-to-day things"***

Jody 20s, not able to access health specialists

Jody feels less connected with staff since Covid-19 *"Distance restrictions, they [the care staff] wear masks all the time... can't have a chat with them…you can't judge what mood we [all] are in, now all on face value, less interaction"*

Cancelled appointments made Jody feel *"less heard, but not desperate"*

Feeling Frightened

Affects **everyone**, but higher levels of anxiety are seen in people with a vulnerability or condition.

People feel very anxious, scared and angry about other people's behaviours and the fear of infection. It's impacting people's confidence in going out and having people into their home. This was brought about by:

Fear of infection	From the public, care staff and residential care setting including concerns about Covid-19 testing and PPE
People's behaviour	People's behaviour not following the guidance, lack of disability awareness, some aggression (visually impaired, older people, physical impairment, autism)
Trusting others	Concerns about accepting support from 'untrusted sources', such as neighbours or online security (carers; visually impaired, older people, LD&A)

"I asked the carers about their procedures but they told me they didn't have any. I asked them to wear a mask." **[Christina, 50s, Physical Impairments, Interview]**

"I did have a note put through my door from a neighbour saying if I needed anything to call them, but I am so unsure of peoples intentions I wouldn't ask for help even if I needed it, I have to know I can trust them." **[Carer, 80s, Interview]**

"No one keeping to the rules…It's making me angry. I'm avoiding going out" **[M, Autism]**

Feeling unsupported and forgotten

Potentially impacting **everyone with a support need** and **Carers.**

Some participants feel they have been let down and abandoned. This is due to a number of challenges that have impacted people's care, support and emotional health needs. Caused by:

Lack of usual care and support	Loss of usual support networks and/or infrequent information (everyone with a support need and Carers)
Mental Health demand	Community groups **struggling with the demand** for those with **mental health** concerns
Being treated differently	People being treated differently from their peers and non-vulnerable residents and feeling forgotten, frustrated and anxious

"The biggest challenge was not having the support, not understanding what was going on in the outside world. I haven't been in a shop since February." **[Deaf Blind Focus Group, Aug 2020]**

"I have never felt so alone in my life and I have never felt so low… I was saying things that really scared her [my girlfriend]. I can't remember but she said I was talking gobbledegook" **[Mike, 50s, Mental Health, Interview]**

"Some people here have the same conditions as me and they have received shielding letters and I haven't. So the disparity over that. I have stuck myself in 'clinically vulnerable'. My GP signed me off." **[Long-term Conditions Focus Group, Aug 2020]**

We spoke to participants about their care now and in the future

- Some participants are content with how things are and it forms their future wishes:
  - Level of care hours to remain
  - Remain where they are (at home, supported housing or residential care)
  - For some where they are now will be their last home.
- For others they are looking for a change:
  - Accommodation and support that enable more or continued independence is key
- There was an understanding among carers and older people that residential care provides a safe environment where they or their family member can be cared for, when they are unable to continue to live where they are.

James, 70s uses a wheelchair. Carers visit twice a day. He has kidney failure so anticipates this is his last home. Some of his carers are friendly, anticipate his needs and do extra tasks like getting his clothes from the dyer. **A bidet** would make his life better for now, but he was told he wasn't entitled to one as he didn't have bed sores.

"I really do not want him to go back there [residential care]. His health suffered so much under them…We know one day that he's got to have a home away from us because we're not going to be here"
[Older Carer, Chelmsford]

"I would be happy to have support in my home when I am older. I do not want to go into a residential home. I spent many occasions in hospitals and home settings when I was sectioned, and I don't want to go back to that type of place again."
[Maggie, 40s, Supported housing]

April 2021