Scrutiny Briefing Note

The **Health & Adult Social Care Scrutiny Panel** has asked for an update on the impact of Covid-19 on adult social care. This briefing contains the latest position as at August 2020

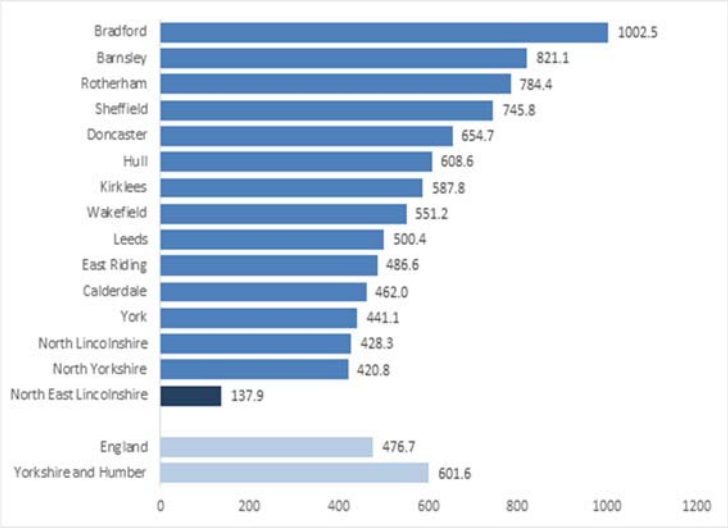
Introduction

A total of 220 residents of North East Lincolnshire (9th August 2020) have had a confirmed diagnosis of Covid-19. This is a rate of 137.9 per 100,000 and is by far the lowest in the Yorkshire and Humber region (rate 601.6 per 100,000) and the lowest of all upper tier councils in England.

Care homes across England have been one of the main centres of the Covid-19 pandemic with almost half nationally having experienced cases and a large proportion of deaths have occurred in these settings.

Deaths across the UK associated with Covid-19 are now well down on the peak in April and are continuing to fall each week. In North East Lincolnshire we have had a much smaller proportion of deaths associated with Covid-19 than other parts of the country. Only one death has been registered in North East Lincolnshire since the beginning of June with Covid-19 identified as a cause of death.

Laboratory confirmed cases of Covid-19 at 9th August 2020:



North East Lincolnshire care homes have fared much better than is the case nationally. Public Health England reports that 9 out of 53 care homes in North East Lincolnshire have reported a suspected or confirmed Covid-19 outbreak[1]. This represents 17 per cent of all care homes in the borough and is the lowest (best) in England.

Currently (August 2020) the CCG care home tracker reports that one care home has an active case of Covid-19 amongst its residents. All homes are currently open to admissions, 6.9 per cent of nurses, 3.2 per cent of care workers and 5.2 per cent of non-care workers in care homes are currently absent.

[1] https://www.gov.uk/government/statistical-data-sets/covid-19-number-of-outbreaks-in-care-homes-management-information

National issues with social care

The most significant issues faced by care settings, as a result of the Covid-19 response have been set out by ADASS (the national professional body for directors of adult social services) as below:

- Occupancy levels – with a significant decline in residential and nursing occupancy in many areas. This issue is particularly a risk for nursing homes which have higher fixed staffing costs and yet is also the part of the sector where stable capacity is most likely to be needed longer term. Sudden home closures represent a risk to the individuals living there and to the broader local health and social care system given the capacity needed to safely manage a home closure. They also present an additional cost to the taxpayer: when people move home, the costs of care often increase.
- Providers facing significant increases in insurance premia and/or refusal of coverage for Covid-19 related activity
- Continuing high costs of PPE, which are not necessarily funded via commissioners or the £600m Infection Control Fund
- Potential issues and variation around revised NHS discharge pathways, funding commitments and support for the sector, with good practice not always being universal
- Turnaround times for testing within care settings
- Balancing human rights issues – including early concerns about Do Not Resuscitate policies, and, more recently, visiting and easing of shielding

ADASS has also commented that at this stage, it may be too early to draw evidence-based lessons from the last 6 months. However, some emerging *national* patterns appear to be as follows:

- Extra care seems to have been a safer model of care than residential and nursing care. In part, this may be explained by a different customer group but, increasingly, extra care is supporting people with more complex needs and it would seem that the design and staffing models within schemes may have added extra protection
- Regional and national PPE supply chains have been problematic, particularly during the peak of the pandemic
- Hospital discharges have been of varying quality and safety
- Multi-agency working has generally been strong and effective
- National trackers, policies and distribution systems have taken insufficient account of people who use direct payments, family carers and non-regulated services, all of which are out with the national regulator and national portals radar. Councils and the NHS have had to step in to ensure that people have been supported, including with PPE, testing and other practical help such as keyworker entitlements
- The national “capacity tracker” has served some purpose but it relies very much on the person completing it and does not necessarily provide an accurate picture of each care setting and/or the interventions and help offered by councils and the NHS
- Different areas have varying levels of infection control capacity
- An ad-hoc approach to the national roll-out of whole home testing: whilst paused, homes still continue to receive testing kits via the national portal and some areas are experiencing

problems with anomalous results, with significant implications for care providers and residents in terms of quality of life and financial costs
- NHS enhanced care in care homes is being accelerated but there are practical issues that need to be resolved e.g. 1) most effective arrangements for care home multi-disciplinary teams so that these do not completely over-take other urgent primary care, community health and social care workloads and 2) the operational staffing capacity in homes
- Social care staff do not generally feel that they have had the same public and "official" recognition and support as NHS and other emergency services staff – and care settings residents and care workers have, sadly, suffered a disproportionate share of Covid-19 deaths
- The level of digital capacity and capability in care homes was/is significantly under-developed in terms of connectivity, hardware and staff skills
- The confusing and rapidly changing national guidance has created difficulties around interpretation and dissemination to care homes in a timely fashion
- Movement of people out of hospital/home to care homes in the early phase of the pandemic and problems with testing significantly impacted on perceptions of safety
- The NHS hospital discharge pathway has worked, in general, and has helped to embed discharge to assess. However, it now needs to fine-tuned if it is to provide a basis for future joint working

Local adult social care response

At the beginning of the government's lockdown in March 2020 the care and independence team developed a robust action plan to prepare the adult social care system to manage the likely effects of Covid-19. Key objectives included:
- the need to ensure safe and effective service delivery,
- reduction in face to face contact where possible
- establishment of communications systems and intelligence, enabling care providers to respond rapidly to changing government guidelines
- maintaining flow through the health and care system to ensure intensive care and acute bed availability for Covid-19 patients
- creation of additional health services bed capacity
- protecting and shielding the vulnerable

A plan was created with key themes allocated to service leads within the CCG.
These themes covered:
- Communications and intelligence
- PPE
- Support at home
- Direct payments
- Residential care
- Learning disability and extra care housing
- Mental health
- Workforce supply
- Finance

- Social work practice
- Hospital discharge
- Community response
- Operating within a legal framework

This report is intended to provide scrutiny members with key information about the local management of adult social care during the early stages of the pandemic and some of the impacts experienced, which have included many positive benefits to the health and care system.

Key areas of impact:

Infection control
Following the government's initial focus of the pandemic on hospital (acute) provision, attention soon turned to care homes. The CCG contracts with 44 care homes and has good relations with them through the contracting officers. As care homes "locked down" and reduced foot fall to protect vulnerable residents contact with health and social care staff needed to be carried out differently.

The CCG has previously issued contracted care homes with NHS N3 internet connectivity and NHS laptops. Work was carried out to allow these laptops to connect to the primary care video consultation allowing GPs and community nurses to video call care homes and where possible talk to or see residents. 4G Tablet devices were provided to all care homes in our area including 10 that the CCG didn't contract with.
The care and independence team set up weekly webinar calls with providers using the new devices and Microsoft teams (MS teams) software. This has proved to be an effective and efficient way to engage with large numbers of providers in a relatively informal way via webinars.
This allows care homes to access senior clinical advice and support which has been key to working with primary care networks (PCNs) and community nurses to support their enhanced Covid-19 support service.
Community nurses and PCNs are now aligned to care homes and are offering a weekly multi-disciplinary team meeting via MS Teams. This has been an initiative that the CCG has been trying to embed for some considerable time. Part of the purpose of these meetings is to support the care homes in meeting the needs of residents. Pre Covid-19 we envisaged that working in this way would help the homes to feel more confident in caring for residents and would avoid the need for hospitalisation. During the peak of the epidemic, clinical support from nurses and GPs helped homes to deal competently with outbreaks, maintaining high quality care, best practice in relation to infection control and preventing wider community spread. This something care homes have found beneficial.
Unfortunately, with the advent of Covid-19, residents found it harder to contact relatives and social isolation has become a subject of national attention. Whilst technology has supported this it hasn't been a total replacement. There is anecdotal evidence that this has resulted in more challenging resident behaviour in some cases with an increase in prescribing medication to control these symptoms as well as referrals to mental health services.

On the positive side though, some of our local looked after children initiated a series of postcards to residents as a means of supporting people in homes and making new

relationships. Some of the young people have met the residents at a safe social distance. The initiative was featured on the local television and radio news.

We have had three care homes where there have been outbreaks of Covid-19. Our first outbreak highlighted weaknesses in the homes' emergency planning leaving the home unable to staff to appropriate levels. Staff struggled to cope with the stress and pressure of the pandemic as well as the constantly changing and confusing guidelines. Extra support was provided by the infection prevention and control (IPC) team within Care Plus group who provided in-home support and assurance which staff greatly appreciated. This was a model that was repeated for subsequent outbreaks.

Medical equipment is being issued to care homes to allow for basic health "observations" to be carried out, including blood pressure, oxygen saturation and temperature. This will allow for communication to GPs on a person's symptoms and hopefully assist in providing better care.

The CCG has supported the delivery of money from the government to support the implementation of infection control measures. The infection control fund has been paid to the council in two instalments of around £1.1m in each round. The grant has stringent conditions attached to the mandated elements of the fund, which included requirements that all care homes use the NHSE Capacity Tracker tool. We have supported all our care homes to now use the capacity tracker which has become a key tool in monitoring the pandemic. Initially designed to monitor bed capacity, this now monitors outbreaks and suspected cases in care homes as well as business continuity plans for PPE, workforce and testing. This is usually updated daily by care homes about 80 per cent of the time.

We have used MS Teams surveys and polls to provide a way of interacting with care homes to gain assurance.
To support staff, a portfolio of online training resources has been circulated including dietetic training. To also support the Northern Lincolnshire end of life programme the use of EPaCCs (electronic palliative care co-ordination system) will make end of life care plans available to all care givers at the point of care delivery an allow for care plans to be updated and shared.

Hospital discharge

What the challenges were:

At the outset of the emergency response we had to remodel the hospital discharge function to meet the Covid-19 hospital discharge guidance. This included the following changes:
Development of a trusted assessment for all discharges from hospital
Change the funding mechanism for all patients discharging with a new or increased package to Covid-19 funding
Ensuring the hospital discharge function became health led (this moved the ASC function from the hospital into the community).
Redesigning the discharge pathway to ensure discharge occurred within 3 hours of the patient becoming medically fit
Working to ensure either the home first model or all bed based service could receive patients within the 3 hour window
Ensuring there was an 8am-8pm 7 days a week discharge response
Ensuring that the voluntary sector supported with discharge (extended and re-designed the British Red Cross winter discharge programme)

Ensuring those discharged from hospital with a need for health or care intervention were followed up within 24 hours with a full comprehensive needs assessment
Retaining oversight of all individuals leaving hospital on Covid-19 funding to ensure when required a full financial review was undertaken to determine funding stream (health/ care) moving forward and any client contribution.
All of this was successfully achieved and enabled acute and critical bed space to be made available in the hospital. We achieved a significant improvement in discharge performance.

What the challenges are now and going forward

New discharge guidance is imminently due for release. Work will be required to understand the changes need from the current Covid-19 hospital discharge guidance and a plan developed to ensure these requirements are adopted in NEL. A discharge steering group is well established who meet weekly, it is this group who will be leading this work. What we know already is that:
All individuals on Covid-19 funded packages of care will have to be reviewed. This will be a huge task. Over 400 reviews will need to be delivered alongside all other health and care assessments and reviews, at a time where we are approaching winter pressures.
Discharge to assess models will need to be fully in place and implemented which will require a significant amount of work to design, agree and implement.
The work around discharge needs to be fully embedded into the wider health and care system and aligned to ensure pathways flow smoothly for individuals requiring care and support.
There will be an implementation of new finance systems and the restarting of continuing health care (CHC) related work which will pace further pressure on the CHC team.
Moving into winter, increased volume of work through flu, Covid-19 and other winter related illnesses will be a challenge especially with the next timescales for discharges.

The impact this has had on residents and services
Patients being discharged from hospital have seen a much speedier and efficient discharge process, hopefully ensuring they were able to return home much quicker.
Patients have been Covid-19 tested at point of discharge which will have helped to reduce the risk of transmission.
The development of the discharge trusted assessment will have ensured that more is shared about the person (with consent) at point of discharge supported improvements in care planning and ensuring the needs of the individual are met.
The discharge steering group has brought services together to design and coproduce pathways and improve practice. This has improved professional relationships and joint working.
The delay in transfers of care (DToC) have reduced significantly with the new ways of working.

Protecting and shielding vulnerable people
What the challenges were:
There were 5,313 residents in the borough identified as having a clinical condition that required them to be ‘shielded’. These individuals have been in receipt of food parcels from the national distribution hub which ceased on 31.07.20.

We had data about the individuals on our lists and we had to cross-reference with records to establish whether contact had been made. We undertook welfare checks on this cohort (via

the Council's contact centre) who were not known to the Council or our partner organisations. We received several data sets in relation to the shielded groups on a regular basis. As there was a gap in our local information we worked at speed to pull together a community factsheet which signposts our community and professionals to all the local food, shopping, befriending and advice services that were and still are working to support our communities - this was managed by Sector Support NEL
A wide range of local organisations have been providing support to people isolated. NELC telephone contact with vulnerable people, identified from health and adult social care data, identified several isolated residents, who have requested and are now benefitting from regular "check in" telephone calls. People are having access to regular wellbeing call via the Council's wellbeing team, our local Councillors or the Contact Centre - this is also being supported by our local befriending organisations.
The volunteering approach included the creation of a central register - administered by Blue Lights Brigade (BLB), (a local emergency response voluntary organisation) to:

- support local groups which were setting up via social media
- Be a key contact point for volunteer registrations
- set up a referral process (complements NELC's TakePartNEL process)

Some of these roles included supporting homeless people and rough sleepers, prescription collections, wellbeing checks and telephone befriending, food parcel packing and delivery, making face masks, shopping and delivering, kitchen and general duties at a supported living organisation, making and delivering hot meals to the vulnerable and the elderly

What the challenges are now and going forward
We are now working to providing digital support to those who are digitally socially isolated as there is a reliance on greater use of digital access for health and care services and information, advice and guidance. This requires the use of digital technology, affordable access to it and broadband. Many of these approaches were used in order to reduce the amount of face to face contact with people to ensure adherence to social distancing guidelines
We found that the collation of data was time consuming and highlighted inconsistencies and inaccuracies. In databases and recording practice/
Contacting some identified vulnerable people has been difficult due to telephone number records being out of date or to vulnerable people having blocked numbers for their own safety
Joint work between analysts from CCG performance team and the public health team has worked well so we can have central data and business intelligence and is something to work on going forward
Voluntary sector organisations and volunteers were exemplary in their response and critical to the effort. We need to think longer term about how we support the sustainability of the sector as well as supporting the recruitment and deployment of volunteering in the future and for the recovery phase.
Overall, staff have demonstrated skills, expertise and knowledge in working at pace
The community recovery meetings (lead by Helen Isaacs) are focusing on how we address a further outbreak

The impact this has had on residents and services:
NELC, CCG, partners and Sector Support NEL have provided considerable support to the sector during the pandemic. The LiveWell platform has been launched to provide wellbeing

information so information is in one place and creation of dementia portal to give a better overview of services that can be accessed locally.
Positive feedback from the public through the hub, NELC contact centre and calls to shielded people and families has been received.

The regular and ongoing contact between CCG's care and independence team, the NELC contact centre, SPA and Sector Support NEL has worked well and been beneficial to residents and services. As part of this relationship a new way of working with carers support centre has started where NELC contact centre staff will help identify carers and signpost them to the support available

Key costs and financial impacts
Nationally, £3.2bn of funding was made available to local areas to support the emergency response. NEL received around £11.2m. Councils were directed to use some of this money, which was not ringfenced, to support and sustain the local care market. A range of sustainability proposals were put in place to ensure that any significant drops in service demand would not destabilise the local care market, especially since bed capacity would be needed to facilitate hospital discharge. These measures included in quarter 1 of 2020/21:
In summary our support offer included:

- Signposting to advice and support regarding government grants and loans to businesses
- Improving the pace and efficiency of invoice payments through the implementation of an electronic invoicing system
- The payment of a 5 per cent lump sum (in 2 instalments) to enable providers flexibility to meet additional costs
- The provision of an income guarantee based on known activity levels in the months prior to the epidemic
- Enhanced budget available to the "just checking" fund to enable providers to flex support upwards should additional care at home be required

The application of these measures has resulted in estimated £954k of additional expenditure as at the end of June 2020, against an approval limit of £1.0m referenced against ODR ASC021. To date, this expenditure is being met from the adult services budgets.
The ASC budget position is highly complex at the current time due to the impact of fee changes, significant demand fluctuations and greater uncertainty in relation to future impacts of COVID.
It is clear from recent government guidance and policy initiatives that there remains an imperative to sustain the adult social care market and to support the sector in protecting older, vulnerable care home residents from the spread of Covid-19 infection. Accordingly, the council has now submitted its infection prevention and control plan and has distributed the infection control fund to providers to help with specific infection control measures. Of the £2.2m allocation for ICF 75% of this is being used to support care homes. Vulnerable adults supported at home are also at risk from the spread of infection. It is likely that further government advice and guidance will follow with recommendations linked to all community-based settings in an effort to prevent and reduce the infection risk from COVID. For this reason, the 25% residual amount from the ICF funding was allocated for infection control measures to care at home providers and to supplement personal protective equipment (PPE) reserves.

Further provider sustainability proposals were agreed by cabinet in August 2020. These proposals included consideration of the infection control funding. For ease a copy of the relevant cabinet report is appended. This also sets out some key considerations in respect of the infection control fund.

Adult Social Care financial implications for the introduction of these further proposals estimated to be £441k for payment periods 4 to 6, ending 13th September 20. In addition, £100k contingency funding for targeted support to providers in significant financial difficulty, making a total of £541k.

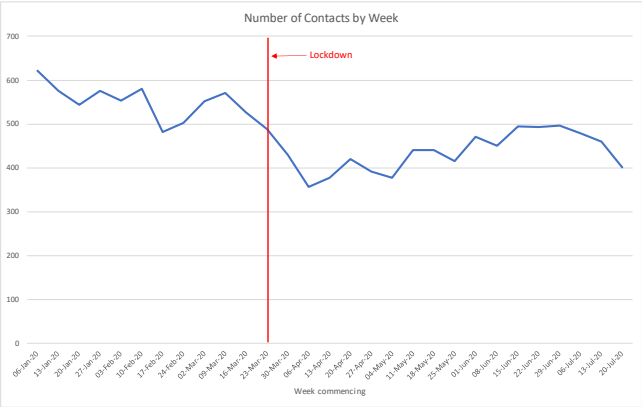
Financial impact

As indicated, there is a higher degree of uncertainty and unpredictability in the ASC budget as a result of the pandemic. Financial monitoring has shown that the indicative year end position could be as high as a £3.5m overspend for ASC services alone. This is partly due to the provider sustainability costs but also due to undelivered savings which have not been realised due to demands on the system during the pandemic.

Performance and delivery

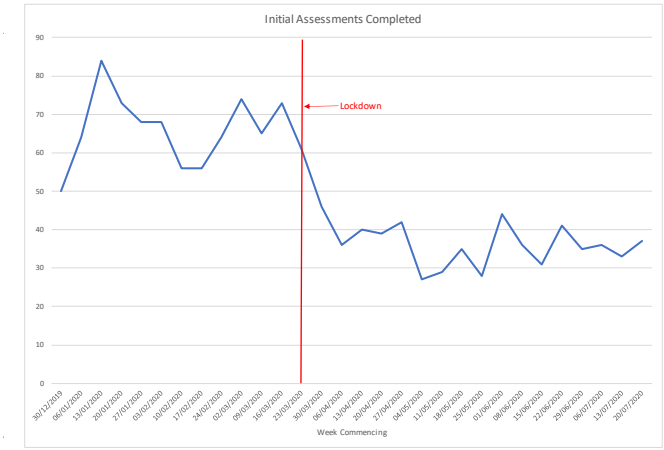
The actual ASC performance measures monitored by the focus/CCG performance group haven't seen much of an impact with most measures maintaining levels seen before COVID-19. The following areas of activity however have seen an impact.

ASC Contacts



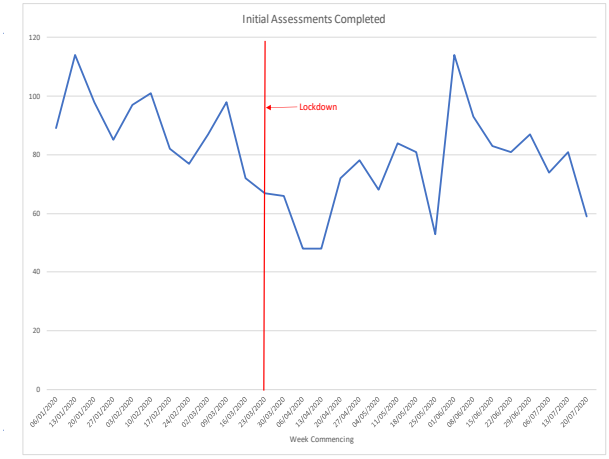
Number of contacts into the adult social work team reduced significantly post lockdown from an average of 556 contacts per week pre 23rd March 2020 to 435 post (22 per cent reduction). The numbers started to climb from early April 2020 onwards but in recent weeks the numbers have seen a slight drop again.

Initial Assessments:



No doubt affected by the drop in number of contacts, the number of initial assessments dropped from a weekly average of 66 pre lockdown to 36 post. A drop of 45 per cent. To July 2020 this has not seen any further increases.

Reviews:



After an initial drop towards the end of March 2020 and beginning of April 2020 the number of review assessments bounced back quite quickly to near normal levels which has been evident in the measure of the proportion of services users receiving their annual review which has remained stable and meeting target during this time.

Concluding remarks

The operation of adult social services during the early phases of the pandemic required an unprecedented amount of change and adaptation to local practice to ensure the safety and effective care of our most vulnerable people in NEL. We have been very fortunate in being able to implement the required changes in a timely manner, as the lower infection rate in NEL has meant that we were able to prevent some of the worst impacts of the disease on our vulnerable population. We now have systems in place that can assist in the on-going management and prevention of infection. As DASS for NEL, I would like to formally thank our local providers for the way in which they have worked closely and in genuine partnership with the council and NHS to maintain safe care in the borough. I would also like to thank staff in the CCG and council for their dedication, teamwork and for going above and beyond their usual

high standards to ensure that we have robust systems in place for the on-going management of Covid-19.
#

Contact Officers:

Beverley Compton
Director of adult services

Tel: 01472313131
e-mail: Beverley.compton@nhs.net

If you require any further information please contact the named officer(s) or alternatively,

Scrutiny Adviser – Zoe Campbell
Tel: 01472 323838
e-mail: zoe.campbell@nelincs.gov.uk#

If you would like to find out more about scrutiny you can contact us:

By email or by post
NELC Scrutiny Team,
Municipal Offices,
Town Hall Square,
GRIMSBY DN31 1HU.

CABINET

DATE	15th July 2020
REPORT OF	Councillor Margaret Cracknell Portfolio Holder for Health, Wellbeing and Adult Social Care
RESPONSIBLE OFFICER	Beverley Compton Director of Adult Services
SUBJECT	COVID 19 response – adult social care provider sustainability proposals phase 2
STATUS	**Open**
FORWARD PLAN REF NO.	SPECIAL URGENCY Not included on the Forward Plan therefore to be considered as an urgent item under the Special Urgency provisions of the Constitution and with the permission of the Health and Adult Social Care Scrutiny Chair.
CONTRIBUTION TO OUR AIMS	This report has been written in the context of the on-going impact of COVID 19 in relation to adult social care provision, recognising that providers' costs have increased in response to the need to protect social care clients from infection and the spread of infection. In addition, there is a need to ensure continuity of quality care for the most vulnerable members of the adult community in NEL by ensuring provided services can maintain their businesses beyond the immediate response phase. This is part of the council's overall emergency response and fulfils in part the council's duties to ensure the health and wellbeing of its communities

EXECUTIVE SUMMARY

In responding to the COVID 19 pandemic, the government was keen to ensure that health and care providers were able to continue to maintain services and patient flow through the health and care system by providing non-ring fenced funding to support both the health and care sectors. The council is responsible for ensuring that adult social care providers can continue to meet the cost of care provided to those with eligible social care needs, as care costs escalated to meet PPE and staffing requirements. An initial round of funding was allocated to adult social care providers under the emergency ODR provisions. This report provides an update on the use of the phase 1 funding and proposes new support arrangements which are recommended to be reviewed monthly by the DASS in conjunction with the director of finance.

RECOMMENDATIONS

It is recommended that Cabinet:

1) Adopts the proposals in relation to phase 2 of provider sustainability for the second quarter of 2020/21 (to 13th September 2020), to be implemented by the director of adult services on a payment period by payment period basis and commencing from payment period 4 (22nd June 2020).
2) Delegates authority to the DASS and director of finance to review and adjust such arrangements on a monthly basis subject to a financial limit of £600,000 to the end of payment period 6 (13th September 2020)
3) Makes a formal recommendation to the North East Lincolnshire Clinical Commissioning Group to adopt an equivalent approach in respect of NHS funded residential, nursing, continuing health care (CHC) and supported living placements

REASONS FOR DECISION

At the height of the COVID epidemic, councils were urged by the government to ensure that social care businesses were supported to continue to operate safely throughout the pandemic. This was to ensure safe and effective care to residents within the care system as well as to ensure that availability of services did not adversely impact on the health system. Efficient flow through the hospital enabled treatment beds to remain available for COVID patients. Financial assistance was provided to sustain social care providers, enabling them to meet the additional costs of COVID and associated business risks. Following an initial offer of support during quarter 1 2020/21, a further decision is now required to consider future and on going financial support to the social care sector.

1. BACKGROUND AND ISSUES

Phase 2 of financial support to care providers

1.1 On 19 March 2020, the government announced £1.6 billion of additional funding for local government to help them respond to coronavirus (COVID-19) pressures across all the services they deliver. An additional £1.6 billion was announced on 18 April 2020. This extra £1.6 billion takes the total given to councils to help their communities through this crisis to over £3.2 billion. The government further announced on the 14th May 2020 a further £600 million was available through the Infection Control Fund (ICF) which has been ring fenced for adult social care, and is given to local authorities to ensure care homes can cover costs and any measures to reduce outbreaks and transmission.

1.2 In response to the Covid-19 pandemic, this funding is available to councils to support adult services' local care markets. This was in part to ensure the sustainability of care providers, to enable the continuance of care and support to vulnerable people as well as assist the health service in meeting health demand at the peak of the outbreak. North East Lincolnshire council agreed a package of support across residential, nursing and care at home provision. This support was available to providers up to the end of payment period 3 (June 2020). It did not include a contribution from NHS commissioning towards NHS funded placements.

1.3 Guidance from NHS England & NHS Improvement (NHSE/I) has identified that there are inflationary pressures across the NHS and social care stating "NHS England & NHS Improvement recommends that CCG commissioners should locally, and in conjunction with local authority partners consider the sustainability of the local social care market, the challenges faced by providers and the level of financial support required. This should also take account of other support packages announced by Department of Health and Social Care in recent weeks".

1.4 In summary the councils initial support offer included:

- Signposting to advice and support regarding government grants and loans to businesses
- Improving the pace and efficiency of invoice payments through the implementation of an electronic invoicing system
- The payment of a 5 per cent lump sum (in 2 instalments) to enable providers flexibility to meet additional costs
- The provision of an income guarantee based on known activity levels in the months prior to the epidemic
- Enhanced budget available to the "just checking" fund to enable providers to flex support upwards should additional care at home be required

1.5 The application of these measures has resulted in estimated £954k of additional expenditure as at the end of payment period 3 (June 2020), against an approval limit of £1.0m referenced against ODR ASC021. The government made provision for adult social care sustainability measures in its subsequent funding allocations to support the COVID emergency response. Provider sustainability measures represent a significant additional pressure on the adult

social care budget from that anticipated at the commencement of the year.

1.6 The ASC budget position is highly complex at the current time due to the impact of fee changes, significant demand fluctuations and greater uncertainty in relation to future impacts of COVID. Further details of the budget implications will be provided as part of routine budget monitoring and review of budget planning over the coming weeks and months.

1.7 Provider engagement has continued throughout the emergency response and a short survey conducted to ascertain how provider sustainability funding has been used. Against a context of relatively low levels of community infection to date in NEL, the most significant additional area of cost appears to be the increased use of personal protective equipment to comply with government requirements. This is exacerbated by rising prices due to high demand. Provider vacancies appear to have been less of an issue locally suggesting that the minimum income guarantee is not required for the next phase of support.

1.8 It is clear from recent government guidance and policy initiatives that there remains an imperative to sustain the adult social care market and to support the sector in protecting older, vulnerable care home residents from the spread of COVID infection. Accordingly, the council has now submitted its infection prevention and control plan and has distributed the infection control fund (round 1) to providers during June 2020 to help with specific infection control measures. Of the £2.2m allocation for ICF, 75% of this is being used to support care homes. Vulnerable adults supported at home are also at risk from the spread of infection. It is likely that further government advice and guidance will follow with recommendations linked to all community-based settings in an effort to prevent and reduce the infection risk from COVID. For this reason, the 25% residual amount from the ICF funding is being allocated for infection control measures to care at home providers and to supplement personal protective equipment (PPE) reserves.

Phase two proposals (payment period 4 onwards, 2020/21)

1.9 In the first phase of funding, providers received a lump sum payment designed to be used flexibly to meet the following costs:

- increased costs due to use of temporary or backfill staff e.g. agency costs.
- increased costs due to staff recruitment and DBS checks
- Increased overtime pay costs due to higher staff sickness absences.
- Increased travel time due to disruption to planned care delivery
- Increased costs associated with enhanced infection control e.g. cleaning or additional equipment or PPE costs.
- Other related costs e.g. administration / management.

In addition to this, providers received a minimum income guarantee for payment periods 1 to 3.

1.10 Residential care providers will now receive a share of the ICF monies to help with the following areas of support:

- Ensuring that staff who are isolating in line with government guidance receive their normal wages while doing so. At the time of issuing this grant determination this included staff with suspected symptoms of Covid 19 awaiting a test, or any staff member for a period following a positive test.
- Ensuring, so far as possible, that members of staff work in only one care home. This includes staff who work for one provider across several homes or staff that work on a part time basis for multiple employers and includes agency staff (the principle being that the fewer locations that members of staff work the better;
- Limiting or cohorting staff to individual groups of residents or floors/wings, including segregation of COVID-19 positive residents;
- Supporting active recruitment of additional staff if they are needed to enable staff to work in only one care home or to work only with an assigned group of residents or only in specified areas of a care home, including by using and paying for staff who have chosen to temporarily return to practice, including those returning through the NHS returners programme. These staff can provide vital additional support to homes and underpin effective infection control while permanent staff are isolating or recovering from Covid-19.
- Limiting the use of public transport by members of staff. Where they do not have their own private vehicles this could include encouraging walking and cycling to and from work and supporting this with the provision of changing facilities and rooms and secure bike storage or use of local taxi firms.
- Providing accommodation for staff who proactively choose to stay separately from their families, in order to limit social interaction outside work. This may be provision on site or in partnership with local hotels.

1.11 All local residential care providers, irrespective of whether being commissioned by the council/CCG or not, will have access to this funding. ICF funds are paid in two instalments and there are grant conditions, which must be complied with. The council must disperse these funds in June and July 2020, and providers must spend their allocations by the end of September 2020. The council is required to make formal returns to verify that the money is used as intended by the government.

1.12 Locally we have decided to allocate the residual 25% of ICF funding across the following areas:

1) Replenishment of PPE contingency supplies for distribution to providers in extremis. It is likely that these costs will be recharged to those providers requiring additional, emergency supplies to ensure equity in the system and to ensure that contingent stocks can be replenished.
2) Care at home provision
3) Supported living.

1.13 As the pandemic has progressed, North East Lincolnshire has seen one of the lowest rates of community infection and therefore changes in demand have not been as significant as anticipated. This has not been the case in other areas, and the council does have a number of adult service users placed out of area. If all areas have supported their local markets in their entirety, then our out of area contractors may have already received provider sustainability funding from their host local authority. In any event, all out of area residential providers will

receive IPC funding from their host local authority. We will not therefore offer a lump sum payment to out of area providers.

1.14 **Further proposals:**

1) **In area contracted and commissioned support:**
   a. **Residential care** in addition to the ICF funding outlined above we will offer a monthly payment up to an equivalent of a 5% fee uplift on delivered activity for commissioned placements reflecting the additional costs to support through the next phase of the pandemic.
   b. **Support at home** - each lead provider will receive a share of the discretionary element of the ICF money based on activity levels as outlined earlier. In addition, we may offer a monthly payment up to an equivalent of 5% uplift on the hourly rate for delivered activity on contracted and commissioned provision
   c. **Supported living** - each provider will receive a share of the discretionary element of the ICF money based on the number of clients supported and we may offer a monthly payment up to an equivalent of 5% uplift on the hourly rate for delivered commissioned activity.
   d. **Commissioned services (other)** -each provider may receive a monthly supplementary payment up to an equivalent of 5% uplift on the hourly rate for delivered commissioned activity

2) **In area, non-contracted, non-commissioned residential care** – Providers will receive advice and guidance as well as the ICF support. All providers have access to emergency supplies of PPE and can access additional advice and guidance if they run into difficulties.

3) **In area, non-contracted but commissioned residential care providers** will receive advice and guidance, ICF funding and we may offer a monthly payment up to an equivalent of a 5% fee uplift on delivered activity on commissioned placements

4) **Out of area placements**
   These providers will receive a share of the ICF allocation from their host local authority. As these fee levels are generally either based on the prevailing local rate or are bespoke packages of care any fee uplift will be considered on a case by case basis. (This will be a maximum payment up to an equivalent of a 5% fee uplift on delivered activity on commissioned placements any further increase by exception)

5) **In area, non-contracted, non-commissioned, community providers including direct payment support**
   These providers do not have a direct relationship with the council/CCG, as they receive funding through individual direct payment arrangements. Typically, these are micro-businesses or voluntary and community organisations. Not all are registered care businesses.
   a) Personal assistants have access to free PPE
   b) A tiered support arrangement will be offered comprising:
   a. Signposting and advice regarding business grants and loans via sector support or usual business advice offered by e-factor

b. The opportunity to provide alternative, chargeable services which must meet the same users' needs defined in their care plan
c. Access to emergency PPE

6) Block contract arrangements to continue on current terms.

7) Contingency funding of £100k to be held for targeted support to critical service providers experiencing significant financial difficulty.

Publication of Local Offer

1.15 In line with the latest guidance published on the 14th May 2020 North East Lincolnshire has published the offer being made to residential care homes.

1.16 To date, all sustainability funding for the independent care market in NEL has been provided by social care funds. This has created a disjointed approach in respect of those providers who receive commissions for NHS and local authority funded clients and services. It will be recommended to the CCG's care contracting committee that the same approach be adopted to all NHS funded residential, nursing, CHC and supported living placements.

Considerations in relation to clients paying towards their cost of care

1.17 Adult social care services are means tested and some clients receiving care will be charged the full cost of their care. It is not proposed to charge clients for these supplementary costs as government funding has been allocated to the council to meet the additional costs of COVID.

2. RISKS AND OPPORTUNITIES

2.1 The proposal has been prepared in line with national guidance which has been developed to ensure that during the pandemic, local care providers can sustain their business operations during a period of uncertainty and change. Care businesses will face instability in terms of peaks and troughs in demand for services as a result of the epidemic and it can be anticipated that there will be staff shortages as a result of staff members self-isolating. The measures proposed in this report acknowledge that providers may face higher than usual staff costs due to the need to source additional capacity from agencies, or due to the need to fund overtime to ensure that safe care can continue to be delivered. Providers will also have other unforeseen business costs, for example additional food costs if usual supplies are interrupted, sourcing additional PPE etc. The proposed measures aim to mitigate the risk of business failures. Phase 2 proposals have been developed in the light of experience as the pandemic effects have developed over the past few months. The council has also since the previous response received and dispersed infection control monies to local providers which helps to supplement the overall offer to the sector and provide further support with staff costs, cohorting and other infection prevention measures for the next phase of the pandemic.

2.2 It continues to be important to maintain safe and effective adult social care services to enable the flow of patients into and out of the hospital system, so

that those requiring critical and intensive care can access the treatment required should there be a resurgence of cases in the area. However, at current levels of infection, the impact on occupancy and activity levels has not been as marked as was predicted therefore this proposal removed the minimum income guarantee. Should any provider get into difficulty, commissioners still have the option to response with a more targeted offer of support to prevent provider failure. It is recommended that ongoing dialogue with the care sector continues to ensure that changes within the local care market can be responded to quickly. The support offer should be reviewed monthly to ensure that it remains fit for purpose. There is a risk that post COVID there will be an expectation of higher levels of care activity than is currently the norm and that these will represent an on-going cost to ASC budgets. To reduce this risk, social workers will have to ensure that placements into adult social care as a result of the epidemic are managed as short term placements and moved on quickly to usual residence.

3. OTHER OPTIONS CONSIDERED

3.1 In developing these proposals, consideration has been given to national advice and to the practice which has been shared by other councils operating within the region.

4. REPUTATION AND COMMUNICATIONS CONSIDERATIONS

4.1 The council need to demonstrably follow government guidelines in its consideration of measures needed to sustain local and out of area care provisions and must be seen to be acting reasonably and fairly in allocating resource to sustain the care market. In developing these proposals, providers' views have been taken into account as well as the approach taken by other local authorities. The consequence of a provider failure would be damaging to the health and wellbeing of adult clients who need adult social services as well as being a significant cause for adverse media attention.

5. FINANCIAL CONSIDERATIONS

5.1 Adult Social Care financial implications for the introduction of these proposals is estimated to be £441k for payment periods 4 to 6, ending 13th September 20. In addition, £100k contingency funding for targeted support to providers in significant financial difficulty, making a total of £541k.

5.2 Estimated costs are based on current activity levels as at 31st May 20, the overall cost of the proposals may vary if changes in activity occur.

6. CLIMATE CHANGE AND ENVIRONMENTAL IMPLICATIONS

6.1 These proposals have a neutral impact on climate change/environment.

7. CONSULTATION WITH SCRUTINY

7.1 N/A

8. FINANCIAL IMPLICATIONS

8.1 Since the last Emergency ODR the Council has received further funding in

respect of the COVID pandemic as outlined in the report. One pot was a further S31 of £4.4m which added to the £5.2m received at the time of the last report brought the total to £9.6m. Whilst this amount was not solely for social care, and was to assist in meeting financial challenges across the financial spectrum, the government made explicit reference to the need to sustain social care provision. In addition to this an allocation of £1.1m was received in respect Infection Control Funding (ICF) which has been distributed as detailed above. At present it is our understanding that there will be no further funding given to Local Authorities and any costs over and above the funding received will need to be met from within the Council's resources.

8.2 As per the comments on the last ODR it is essential that during this period strict controls and principles are maintained and followed to prevent and mitigate significant financial pressures on the Council in future. Costs should be charged to the appropriate funding area. All recipients of this additional financial assistance from the Council must agree to an open book approach and the should be no situation where providers have profited from this pandemic.

8.3 As per the last report to avoid costs increasing and to ensure effective governance of decisions it is recommended that this report approves the additional costs capped at a £0.6m.

LEGAL IMPLICATIONS

All directors have the power to determine and exercise, having regard to prevailing Council policy, the operational requirements of their functions and to manage the human and material resources available for their functions. Cabinet is asked to support the Director for Adult Services' recommendations in the ongoing support of providers in the adult social care sector.

The Council is still in a state of declared emergency and the decision sought goes to the response to that emergency and is in line with the statutory enablement provisions (s138 Local Government Act 1972).

9. HUMAN RESOURCES IMPLICATIONS

10.1 There are no direct HR implications contained within this report.

10. WARD IMPLICATIONS

11.1 The report affects all wards within borough.

11. BACKGROUND PAPERS

12.1 None.

12. CONTACT OFFICER(S)

13.1 Beverley Compton, Director of Adult Services

COUNCILLOR MARGARET CRACKNELL

PORTFOLIO HOLDER FOR HEALTH, WELLBEING AND ADULT SOCIAL CARE