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COUNTY COUNCILS NETWORK

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Ideas

The Other Side Of The Coin:

Adult social care reform in a post-COVID world

September 2020

INTRODUCTION

The COVID-19 emergency has affected every facet of England's public services in a manner unseen in the post-war period. But nowhere has the impact of the pandemic been felt more greatly than within the Adult Social Care (ASC) sector. Whilst the plight of care homes affected by Coronavirus in particular has been tragic, the welcome legacy of this period is that the Government is now fully committed to finally tackling an issue that has gone unresolved for decades – the need for root and branch reform of our ASC system.

Despite the haste to stabilise and improve the vulnerabilities that have been so cruelly exposed by the virus, the Government must ensure that any reform brought forward is focused on people and place, delivers genuine transformation and is sustainable in the long-term. The temptation towards knee-jerk reform will be strong, but it is vital that changes to the system are fully 'future-proofed' to address not just the immediate management of the present emergency, but also the many challenges, stresses – and opportunities – which have been identified as likely to emerge in the decades ahead.

This might feel like a gargantuan task if one were starting from scratch. But luckily this thinking has been ongoing for some years now – and no sector is better placed to surmise the full scale of the reform needed than local government, which currently delivers social care to communities, day-in and day-out.

This short paper draws on this experience of local authorities up and down the country, identifying the key issues which need to be addressed so that the reform that emerges builds on the ASC system's present strengths, addresses its weaknesses, and creates a person-centred approach which meets the needs of all those who come into contact with the social care system – which is most of us, at some point or other in our lives.

In recent years there have been impressive efforts to better integrate health and social care which are beginning to show progress. But there is still an understandable tendency for policy-makers to view what social care should deliver through the prism of what is needed to best support people's *health* care. This doesn't appreciate that most people only need acute health care for a limited period of time, whilst it is the social care they receive which, although less intense, is much more extensive and has a far larger impact on quality of life on a day-to-day basis.

Crucially this report inverses traditional thinking on this issue. Rather than seeing how social care can be used to cushion a health-centric system, it asks the reader to instead see the other side of the coin – how can social care ideally reduce the need for contact with acute health services as far as possible and be seamlessly integrated into wider place-based communities as the central service which ensures every citizen is able to live their best life?

EXECUTIVE SUMMARY

CCN acknowledges that whatever reform of the social care system is proposed the intent will be to provide the highest quality and most efficient provision of Adult Social Care (ASC) that it is feasible to deliver. To get this right will involve considering the views of a number of stakeholders from large institutions such as the NHS to the individual stories and experiences of service users and their families.

As the present responsible agency for ASC, local authorities are perhaps the best placed to identify not only the strengths, but the weaknesses of the present delivery mechanism, as well as the potential of a place-based integrated health and social care system. County authorities have particular expertise, with their unique perspective of delivering social care across large, complex, and diverse geographies – usually incorporating urban, rural, and coastal communities, and often working across multiple or overlapping boundaries with health agencies. The purpose of this think piece is to distil this experience and identify some key principles which CCN's member authorities believe should be taken on board by policy makers in determining the direction of future reform.

Our principles have been collated under four broad themes specifically designed to support policy-makers focused on getting the big picture right. These are summarised below and explored in more detail through the chapters of the report. More detailed explorations of specific issues covered in the paper – such as the provision of retirement housing; the recent history of adult social care funding; or the management of social care markets – can be found in other CCN publications available from the CCN website. **[1]**

1) SCOPE: What is care?

Key principles:

- ASC is more than just services for older people. Reform needs to take account of the full gamut of social care including services for working-age adults with chronic conditions, disabilities, and mental health issues.

- People are citizens first and patients second. Although health care naturally preoccupies policy thought as it is costly and intensive, social care is a more important factor in the quality of people's lives and wellbeing on a day-to-day basis. ASC reform should be predicated on the philosophy of helping all people to 'live their best lives' rather than solely in terms of supporting their acute health outcomes.

- Due consideration should be given to whether the real conceptual divide for policy makers should not be between 'health' and 'care', but instead 'acute' and 'community-based' services – and whether reform should be undertaken on this basis.

[1] https://www.countycouncilsnetwork.org.uk/advocacy/publications-and-research/

2) INFRASTRUCTURE: Delivering integrated holistic place-based care

Key principles:

- ASC is fundamentally a 'place-based' service dictated by local demographics and geography. Reform must fully acknowledge that regardless of whether infrastructure is centrally or locally-led, most decisions around delivery will ultimately need to be taken locally.

- When considering reform local authorities are the easily accessible means by which ASC can be kept locally accountable within democratic structures.

- As a community-based service ASC is intrinsically interwoven within a much wider menu of local services including housing, children's services, public health and the voluntary and community sector (VCS) amongst others. Local authorities as the hub of communities are best placed to facilitate joined-up working across these different services.

- Reform must take into account the risks of disrupting the progress already made towards integration between health and social care in recent years, and also the potential overlap of substantive change of structural reform to local government expected in the coming years.

3) RESOURCING: Ensuring properly funded, well commissioned care markets

Key principles:

- Reform needs to take into account that ASC markets over recent years have become increasingly unsustainable. In the wake of the pandemic there is an opportunity to reshape markets so they are fit for the future, but this will require central and local government working in partnership to best utilise national regulation and guidance in conjunction with local knowledge and intelligence.

- Whilst funding, in itself, is no guarantee of a high quality ASC system it cannot be ignored. Reform must ensure ASC receives a sufficient, sustainable, long-term funding package that enables ambition to be matched with reasonable expectation.

- Reform must address the urgent problem of recruitment and retention in the ASC workforce. This includes issues related not just to pay and conditions, but recognition of the professionalism of the service, as well as requisite access to training, development and progression. It also must ensure the system is capable of adjusting to the potential impact of immigration changes post-Brexit.

4) IMPROVEMENT: Maintaining modern, innovative and preventative care models

Key principles:

- Reform must not just consider inspection and regulation of ASC provision, but how to foster a culture of continuous improvement.

- Any reformed ASC system should have prevention at its heart – the aim should be to stop people's health and wellbeing deteriorating in the first place.

- A thriving system of ASC must be underpinned by a culture to innovate and try new approaches. This is as true of systems as of technology. Reform should take into account how such innovation can be encouraged within the system.

- Reform must consider how the ASC system can be 'future proofed' to enable it to adapt to fast-changing trends in demographics and technology over the coming decades.

THEME 1: SCOPE

Whilst there is practically universal agreement that the present system for Adult Social Care (ASC) needs reform, often less determined among professionals and policy makers alike is what the purpose of reform is. This section explores some of the key principles identified by CCN members to provide some perspective of what they perceive ASC to encompass and how it should be described, so that reform fully appreciates the parameters of change it needs to work within.

Understanding the full range of Adult Social Care provision

The COVID-19 health emergency has exposed weaknesses in the present model and this is rightly accelerating calls for systemic change. But it is important to realise that the impact of the coronavirus has not fallen equally on all parts of the existing ASC system – with particular pressure on the process of discharging patients from hospital into the community, and the market for residential care for the elderly and infirm.

But the ASC system familiar to local authorities is far more extensive, encompassing a wide and diverse range of services that have not been as subject to media scrutiny or directly affected by the pandemic (in part because councils have done a good job of shielding vulnerable people in their community). These services include:

- care for working-age adults with chronic conditions (such as early-onset dementia);
- welfare and care for adults with mental health conditions and disabilities;
- domiciliary care to help people stay in their own homes;
- support for those suffering with substance-abuse addiction and related issues;
- respite and assistance for those being looked after by unpaid carers/family members.

Knee-jerk reform of the ASC system based on a deficit-led analysis of the effects of the pandemic without fully considering this wider menu of services would be a mistake. It would be akin to the Government deciding to radically alter the health system by upturning the fundamental way that hospital care is delivered without even acknowledging the existence of GPs or community health and the way they interact with hospitals.

Helping people to live their best lives

One of the reasons it is important to appreciate this full gamut of ASC provision is to understand how care is inextricably interwoven with people's day-to-day existence in a way that health is not. For most (lucky) people interaction with health services is piecemeal and usually time-limited such as a course of treatment or a hospital visit. But even those with chronic conditions have periods when they need either more or less direct contact with acute services.

But receiving care has much more pervasive influence on people's lives and overall potential. It can be needed intensively, for long periods (often life-long), and affect every aspect and decision-making of that

person's life choices. High quality care can transform lives and enhance wellbeing. Conversely, without good care facilities it can be impossible for many of our most vulnerable citizens to live their best lives.

There is a paradox here, though. Because health services are acute, expensive, and more visible as public services (not least in the public imagination) they have tended to dominate policy making. Social care can too often be ignored or misunderstood, partly because services are usually of lower intensity, delivered in a variety of different ways, and provided comparatively inexpensively or often for free by family members and unpaid carers.

This has created a perverse narrative where a functioning ASC system is seen as a smaller provisional appendage to the wider concern of protecting people's health. In actual fact social care might be better conceived as the overarching default where most of us receive some sort of care from time to time, usually unpaid within family structures, while only occasionally needing more intensive health treatment. After all – how many of us have not at some point relied on a relative, friend or neighbour to help us through a low-level period of illness or convalescence by providing a meal or looking after our children? The ASC system more than anything else is designed to ensure those who do not have this resource are protected by this safety net.

However, in reality more often than not ASC is viewed as a supporting partner to the health service. Decisions on its resourcing and organisation are often made as a means to maximise the impact of supporting health care rather than viewing high quality social care as an end in itself. This has been exposed perhaps most viscerally in the early stages of the pandemic, such as when social care providers found themselves very much second in the queue for PPE to the NHS, or where key workers in ASC were not initially offered the same public acclamation or fringe benefits like specific supermarket shopping hours as colleagues working in health.

One of the principles upon which reform needs to be predicated is to shift this narrative further towards parity of esteem between health care and social care. There have been laudable efforts in recent years to shift this tide – not least by creating a newly retitled Department of Health *and Social Care* in 2018 and by attempting to better integrate the two systems at local level. But England is still some way from parity between the two services and reform must take this into account.

Heath and care services... or acute and community services?

Perhaps, though, whether health and care should be viewed equally is the wrong question to be asking. Maybe instead reform should consider whether the existing divisions we have drawn between health services and ASC services are correct in the first place. After all, one of the most commonly levelled critiques of the present system is why someone suffering from cancer should have their care funded by the NHS, whereas someone suffering from dementia should not?

Maybe a clearer compartmentalisation in the present day would be between acute services and community

services. As technical advances have ensured acute health care has grown exponentially more sophisticated than in the past, it has become increasingly distinct from community health services which are more readily interlinked to ASC and a wider range of community services, including housing.

Given the benefits of integrated systems (discussed in theme 2) any reform of ASC should look very closely at how any reorganisation might best facilitate both acute and community services to thrive at high quality – and to what degree the existing constructs determining what 'is' health and what 'is' care need to be re-evaluated?

Additionally the importance of distinguishing acute and community services may better serve to embed the key principle of prevention when devising the best means of ASC reform. Ultimately the most effective and lowest cost form of social care is where it is delivered at a lower level or even not required in the first place. Any consideration of the scope of ASC reform should have as its central aim facilitating effective lower-level social care in the community which minimises the need for acute health and social care as far as possible.

THEME 2: INFRASTRUCTURE

Local authorities would be first to admit that they don't always get it right. Like every other agency of public service there are strengths delivering high quality services – often unsung and more prevalent than publicly acknowledged. But there are also pockets of poor performance and systemic failure, one of the central reasons why regular rounds of reform are so vital to system and service improvement.

However, in the immediate wake of the COVID-19 emergency some commentators have already begun suggesting that the issues highlighted by the unprecedented circumstances we are living through means that the entire social care system is broken. Their solution is that it ought to be centralised and reconfigured wholesale either within the NHS or as some sort of equivalent National Care Service.

Notwithstanding the fact that many of these commentators appear to have the same narrow health-centric view of what the social care system actually provides (as outlined in the previous section) CCN believes this would be an over-reaction and a mistake. There are weaknesses in the current system, some of which have become more publicly exposed due to COVID-19, and many of which local authorities have been extremely vocal in raising over recent years. Central reform of the social care system will, rightly, wish to strength-test whether different or new models may deliver higher efficiency or better outcomes. However, it must also ensure it fully appreciates what may be lost in moving from the status quo.

Tempting as the nuclear option of centralisation may appear to policy makers at national level, it is likely to create more problems than it solves. Good ASC is fundamentally a place-based service received in and delivered by communities rather than the national state. This section assesses some of the key aspects of local authority infrastructure which the process of reforming ASC must recognise and weigh accordingly.

Accountability, Democracy, and User Voice

One of the key strengths of local authorities delivering ASC as opposed to other agencies is the direct relation to local democratic structures. ASC is fundamentally a 'place-based' service with its parameters dictated by local factors such demographics and geography. Given how strongly social care markets are shaped by local need in the community, commissioning decisions will inevitably need to be taken on a localised basis regardless of whether political responsibility sits centrally or not. Councils are confident in being accountable and to stand and fall on their own record in this regard.

More deeply though one of the most important advantages of local politicians making decisions is they have deep links with, and an instinctive understanding of, their constituencies. A high quality ASC system must necessarily take account of local need - not just through an abstract understanding of 'demand' in the market sense, but also through a more nuanced grasp of what constituents want and need ideally.

For instance should projections of an ageing demographic be catered for by more private retirement flats, an increase in residential care home places, or greater investment in housing adaptations to keep people in their own homes? Local councillors with their strong connections into their communities are in a better

position to understand the local dynamics and balance required in such decision-making than a central bureaucrat.

Links to other community stakeholders and services

Aligned to this is the fact that the local authority sits at the hub of its community – with links to all key stakeholders. In the previous section it was pointed out that social care is intrinsically a community service and that this is probably a better distinction from acute health provision than a blunt health/care split.

Reform of ASC needs to take into account that as a place-based service the system does not operate in a vacuum – it is intrinsically interlinked with a range of other services in the local community. This notably includes health, obviously, but more widely there is also overlap with housing; children's social care; the voluntary and community sector (VCS); and employment & benefits, among others.

Given the local authority has deep links with all of these services, even where it does not provide them directly, the present situating of social care within councils provides a number of 'hidden' benefits – the value of which may only be fully appreciated after centralisation renders them more difficult to access.

Impact on health and social care integration, and local government reform

Finally, in terms of establishing infrastructure it is important to recognise that reform to ASC at this time will not be operating in a vacuum but in tandem with other extensive shifts in the machinery of government around social care, both ongoing and about to take place.

As indicated earlier in this paper, the process of integration of health and social care has already made extensive progress over the past decade. In particular, new mechanisms such as Health and Wellbeing Boards and Sustainability and Transformation Partnerships are just beginning to bear fruit in many areas, with the requisite links and trust having now built up on the ground between local partners from different stakeholder organisations after several years of working together.

Indeed in some places it seems these links appear to have been strengthened further by the need to work together to address the impact of the COVID-19 pandemic. **[2]** There must be a recognition that more radical reform of ASC involving more centralisation may mean jeopardising this progress which has already been made towards a more joined-up approach at local level.

More remains to be done. But more fundamentally the Government has also been planning a process of structural reform to local government and devolution which is likely to cut across any moves to reform ASC. This is expected to involve a further move towards the creation of more unitary councils. To provide better evidence around the potential impact of this move, CCN recently commissioned a report from PwC exploring the potential benefits and savings which such a step could achieve. **[3]**

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[2] There will no doubt be deeper analysis of this hypothesis in the future, but the early signs are good: https://www.kingsfund.org.uk/blog/2020/04/health-social-care-covid-19-coronavirus

[3] *Evaluating the importance of scale in local government reorganisation* (2020) http://www.countycouncilsnetwork.org.uk/download/3148/

It is also likely that a streamlined county unitary model could assist further local health and social integration – for instance by reducing the number of local authorities needing involvement in Health and Wellbeing Boards.

But the report also highlights the risks to ASC if local government reorganisation ended up disaggregating existing county ASC departments across smaller unitary authorities. Two very real possibilities of such disaggregation it point outs are as follows:

(i) *Market realignment – "disaggregation could create a scenario where multiple authorities in the same area could result in a competitive environment for providers, potentially creating issues in both capacity and quality."* **[4]**

(ii) *Loss of Economies of Scale – "commissioning the right level of services in terms of quality and specialism is a continuing challenge in social care and that there is greater buying power across a larger place which would be a risk if it were to be disaggregated across several smaller economies."* **[5]**

Even perceived solutions to these problems such as maintaining a combined county-wide delivery mechanism across new unitaries (such as a trust) would only create additional problems of extra costs, lower accountability and additional challenges to achieving clear governance.

As such any proposals for ASC reform will need to fully take into account what changes are feasible to achieve locally in conjunction with the wider improvements to local governance which are being planned at this time. If both projects contain radical change and are undertaken simultaneously then there could be serious concern about the risk of disruption to service in some places as local areas – including agencies beyond just local government – would need struggle to simultaneously adjust to not just one but two huge shifts in the local machinery of government and the knock-on impact on local care markets.

[4] ibid

[5] ibid

THEME 3: RESOURCING

The first two sections in this report have explored what issues reform of ASC should be seeking to address, and what considerations should be made for adjusting the machinery of government to deliver it. Ensuring that the right infrastructure is in place, though, will not in itself deliver high quality ASC unless it is properly resourced. This third section draws on the experience of CCN members to consider what is needed in terms of funding, commissioning and workforce to ensure that reform is able to achieve the intention behind it – namely a high performing, well-functioning ASC system.

Restructuring Care Markets

Fundamentally the central function of the state in delivering social care has evolved over recent decades from a direct provider of services to increasingly one of market manager across an extremely diverse network of delivery partners. Local authorities understand this better than most, being the agency holding responsibility for this market management role.

Over the last five years CCN has published extensively on the topic of restructuring and reforming Social Care markets. **[6]** At the heart of the concerns raised in these reports has been the impact of the limiting of fees paid for publicly funded care home places which has been compensated for by providers largely through raising fees for those who pay privately. Ultimately this has gradually distorted and begun to destabilise local care markets:

> "...public/private fee polarisation has become more deeply embedded as a structural feature of the care home market, with private fees more than 40% higher than publicly paid fees for the same level of amenity, and in all probability the same level of care. This brings with it risks of disinvestment by care providers serving public markets, falling capacity and 'crowding out' of public payers by private payers." **[7]**

Government has been made aware of and accepts the validity of this issue of the 'fee gap'. But the longer it has been allowed to persist it has created not only "*the largest financial risk that councils' social care departments face*" **[8]** but also:

> *"A second potential financial risk... that central government funding may be inadequate to pay for the full costs of any long term care funding reforms that are implemented. This is inextricably bound up with the 'care home fee gap' risk because funding reforms may force councils to raise the fees they*

[6] Literature CCN has produced includes two reports specifically looking specifically at the issue of ASC markets commissioned from analysts LaingBuisson - *County Care Markets: Market Sustainability & the Care Act* (2015) and a subsequent update paper (2017) (http://www.countycouncilsnetwork.org.uk/download/122/) and (http://www.countycouncilsnetwork.org.uk/download/1179/)
It also includes specific reports which feature assessments of the functioning of the market within the context of the wider ASC system and its associated integration with health:
A New Deal for Counties:Adult Social Care & Health Integration (2017) (http://www.countycouncilsnetwork.org.uk/download/1012/)
Sustainable Social Care – A Green Paper That Delivers A New Deal for Counties (2018) (http://www.countycouncilsnetwork.org.uk/download/1663/)
[7] http://www.countycouncilsnetwork.org.uk/download/1179/
[8] ibid

pay to fend off market destabilisation from payor shift and market equalisation." **[9]**

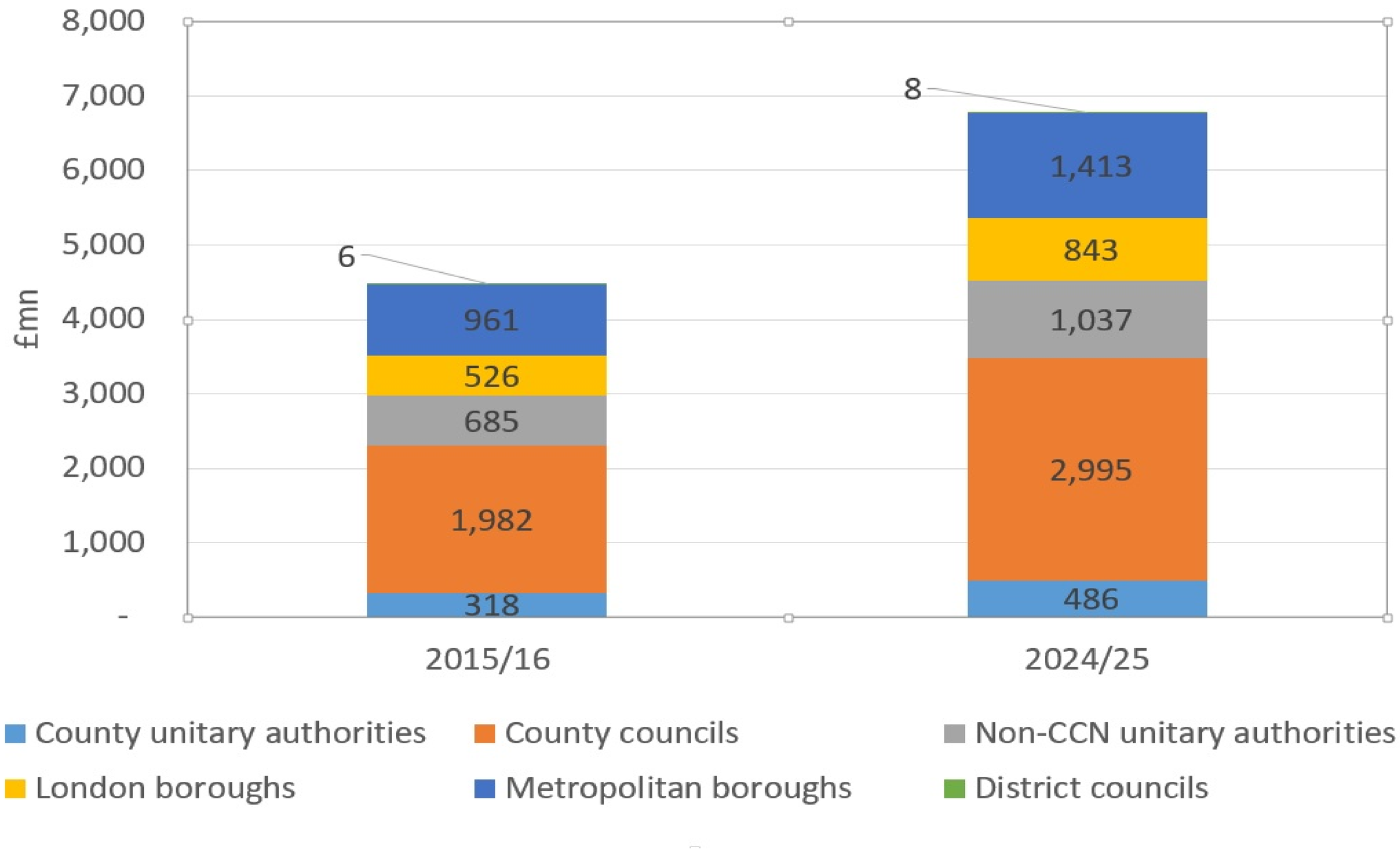
In simple terms what this means is that presently much of the public stake in the market has been increasingly cross-subsidised by private payers. Any attempt to reform social care will need to fully take account of this fact. But in doing so this also means accepting that extending the reach of state-funded provision to offset catastrophic care costs for the most unfortunate will also entail raising the rates that the state presently pays for places in the residential care market. This will be vital in order to compensate for the decline in cross-subsidy the sector achieves through sales on the open market for private payers, otherwise the market may collapse.

Similarly, it is well acknowledged that England is going to need to expand its care market over the coming decades as demographics mean the numbers of elderly continue to increase. Between 2009 and 2019 the number of over 65s increased by nearly 2% across England and by 3% in CCN member authorities. This trend of an ageing society is anticipated to continue across the coming years which will require increased expenditure.

Last year CCN commissioned PwC to conduct large-scale analysis which estimated spending need across the full range of local authority services between 2015/16 and 2024/25. Graphs 1 and 2 show these projections for adult social care for both working age and older adults.

GRAPH 1:

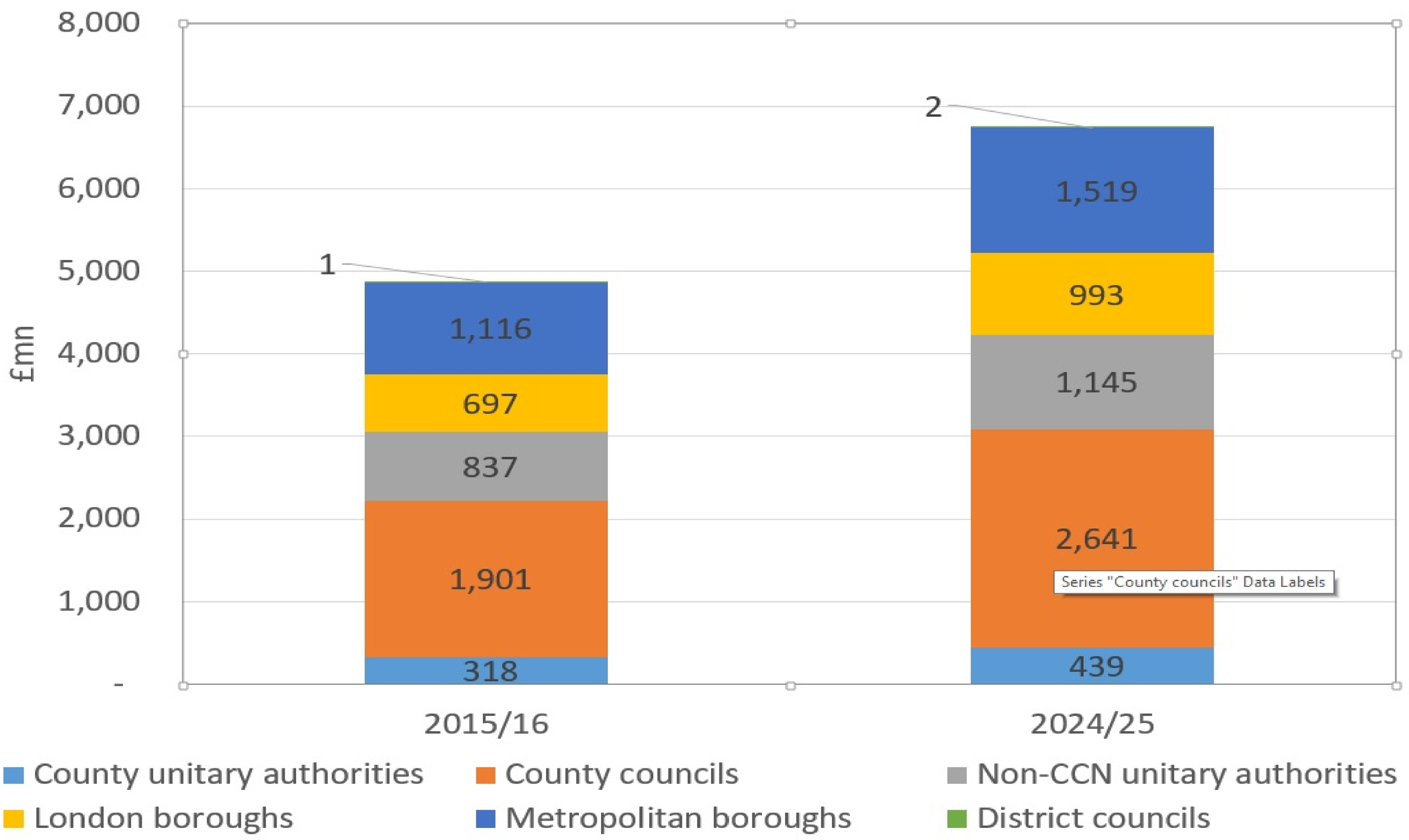
Estimated spending need on adults 65 or over in poor health by local authority tier (£m 2015/16- 2024/25)



[9] ibid

GRAPH 2:

Estimated spending need on adults 18 or over with learning disabilities by local authority tier (£m 2015/16- 2024/25)



There are other issues too. One is the distinctly localised flavour which characterises ASC markets. For instance, a principal issue for some of CCN member councils might be a dearth of domiciliary carers to serve remote communities – whilst another will have a surfeit of home care providers but is having tremendous difficulty recruiting and retaining staff in a high-wage labour market nearer a metropolitan area. Some struggle to compete with higher paying external authorities for places in, say, specialist mental health provision within their own boundaries, whilst others in a two-tier system have to manage the concerns of lower tier councils that offering social provision to ostensibly meet the needs of the whole county may encourage a shift in their own demographics.

Of course, though, the COVID-19 pandemic has now dramatically disrupted the market for ASC well beyond these existing structural problems. Residential care homes for the elderly in particular are facing a range of threats including reduced capacity (to cope with isolation for COVID-affected residents) which may last indefinitely; significant extra costs, such as through using more PPE and enhancing cleaning routines; as well as facing a dramatic dip in demand as relatives become increasingly concerned about placing their loved ones in an environment which they see as a health risk and instead opting for alternatives.

It is impossible at present to determine for how long and how far these trends are likely to reshape the market. Additionally there may be other medium- to long-term trends which may occur as a result of the pandemic – such as an upturn in mental health issues and/or substance abuse affecting vulnerable adults; other long term conditions which emerge as a result of suffering COVID-19 even after recovery; or even

just a shift in demographics as more people seek less risk by moving from cities to smaller urban or rural areas.

One potential solution will be for policy-makers to shift thinking from 'buildings-centric' to 'person-centred' care – the notion of a person staying largely unassisted in their own home until an accident or injury leads them to fall off a 'cliff edge' and into hospital and then residential or nursing care is no longer the only, or the most acceptable, option. As a recent CCN report noted:

> *"Historically the UK has focused on a binary strategy of developing retirement housing for independent living alongside the provision of designated care and nursing homes to cater for people when they become more infirm."* **[10]**

However, the report goes on to outline the increase in more sophisticated models situated in-between these two extremes – Retirement Communities in particular offer people the opportunity to move into housing which offers additional care facilities on-site, allowing people the freedom of owning (or renting) their own home still with the assurance of being able to access care in it easily as they become more infirm in the future. This model already makes up around 5-6% of retirement housing provision in comparable countries like the US, New Zealand and Australia but in the UK is only 0.5%, leaving extensive scope for growth.

The most immediate and urgent need in ASC arising from the pandemic has been to stabilise care markets. Welcome injections of funding from central government have helped local authorities to achieve this in the short term, but in the longer term it is not clear how much of this additional support can – or indeed should – be propping up the market. As the picture presented in this section has demonstrated, reform of the care system will need to take account of these more far reaching trends in supply and demand for social care – some of which were in evidence before the pandemic took hold, and others which are likely to emerge as a consequence of it.

Appropriate Funding

Care markets, though, will only function properly if they are adequately funded. CCN has long argued publicly that more money will not in itself solve the pressures in social care alone and must be one factor considered alongside wider reform of the ASC system. However, the issue of funding also cannot be ignored.

The pressure on funding is likely to be even greater in the immediate future. COVID-19 has created extensive additional costs for the ASC system - the latest projections for which are detailed further in this section. Whilst local authorities have received additional funding from central government to meet immediate pressures faced by ASC, at this point it is uncertain how long these are likely to remain in the system - particularly in the event of a second wave and the pandemic lagging into the next financial year. As well as increased costs, council finances will also be impacted by the loss of fees/income which would

[10] *Planning for Retirement* (2020) http://www.countycouncilsnetwork.org.uk/download/3074/

normally be generated by services unable to operate in the present circumstances.

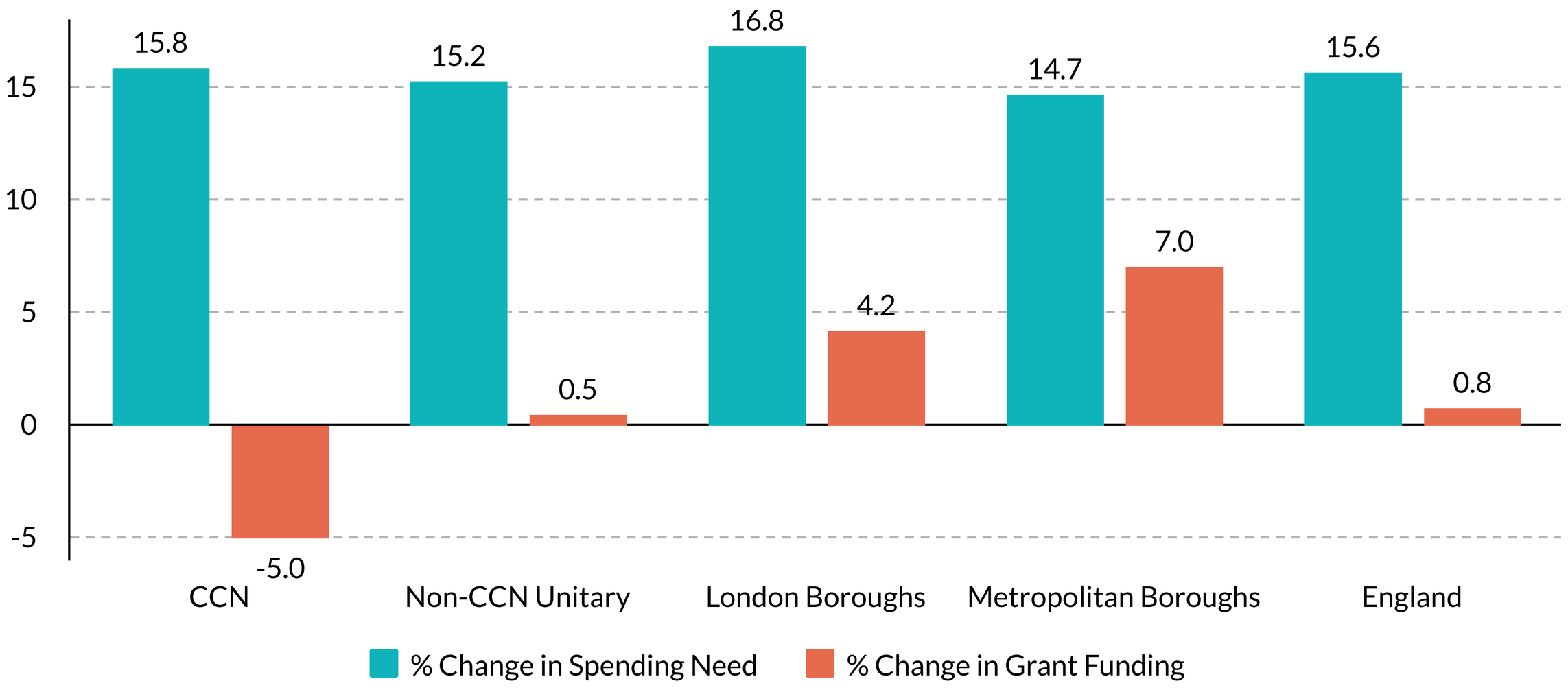
This is particularly pertinent given that the ASC system was already under extensive pressure even before COVID-19 emerged. Over the past year CCN has commissioned extensive analysis of social care funding from LG Futures which has shown how funding for ASC has declined since 2015. One key finding from this work (summarised in the analysis section on pages 17 and 18) demonstrated how funding for ASC has increasingly shifted from core allocations to temporary and in-year pots. The full analysis can be found in two published reports from CCN. **[11]**

ASC reform needs to address the instability this shift of so much funding from fixed grants into temporary funding has created in the sector. It has meant local authorities have been less able to plan local ASC services more strategically for the medium to long term during this period given the uncertainty of what income they are likely to receive in the years ahead.

This is going to become an increasingly difficult issue given the ASC sector knows it needs to plan for the rises in estimated spending need which it is predicted an ageing society will bring. Increasing investment is needed just to maintain services at present levels even before services can be improved, but this has not been the trend over the past five years. Graph 3 below shows how the growth in estimated spending need for ASC has already diverged dramatically from the amount of grant funding received between 2015/16 and 2019/20 for different types of council – a value CCN refers to as the 'divergence'.

GRAPH 3:

'Divergence' of Estimated Spending Need and Grant Funding for *Adult Social Care* 2015-2020



[11] The full report on ASC funding also contains the explanation of the methodology LG Futures used to conduct the analysis and how the figures have been calculated: *Adult Social Care funding and the Spending Review* (2019) http://www.countycouncilsnetwork.org.uk/download/2397/
Further comparative analysis between ASC funding and Children's Social Care funding was published by CCN earlier this year in *Children's Services Funding and Early Intevention* (2020) http://www.countycouncilsnetwork.org.uk/download/3003/

ANALYSIS: How adult social care funding has become more temporary

Table 1a shows how over the five years from 2015/16-2019/20 Total Core Grant Funding from Government (comprising formula funding and various other core grant funding) has declined by over a third across England as a whole – and by substantially more in CCN member authorities (42%).

TABLE 1a:

Change in Total Core Grant Funding for Adult Social Care (*without* Temporary Grant Funding) 2015/16 - 2019/20

	2015-16 (£/m)	2019-20 (£/m)	(£m) +/-	% +/-
CCN Member Councils	2,511.01	1,449.62	-1,061.40	*-42.27%*
Non-CCN Unitary	1,217.52	527.17	-385.62	*-31.67%*
Metropolitan Districts	1,968.54	1,417.25	-551.29	*-28.01%*
Inner London Boroughs	580.89	446.06	-134.83	*-23.21%*
Outer London Boroughs	617.22	416.71	-200.51	*-32.49%*
ENGLAND*	6,895.17	2,926.63	-2,333.65	*-33.84%*

Much of this decrease, though, has subsequently been offset since 2017 by a number of temporary and 'one off' streams of grant funding - such as the Winter Pressures Grant or the improved Better Care Fund. Table 2a shows the overall grant funding envelope for ASC initially steeply declined after 2015/6 before subsequently climbing back to roughly the same levels by 2019/20, disregarding inflation – rising 0.5% across England and only declining 5% in CCN Member authorities.

TABLE 2a:

Change in Total Core Grant Funding for Adult Social Care (*with* Temporary Grant Funding) 2015/16-2019/20

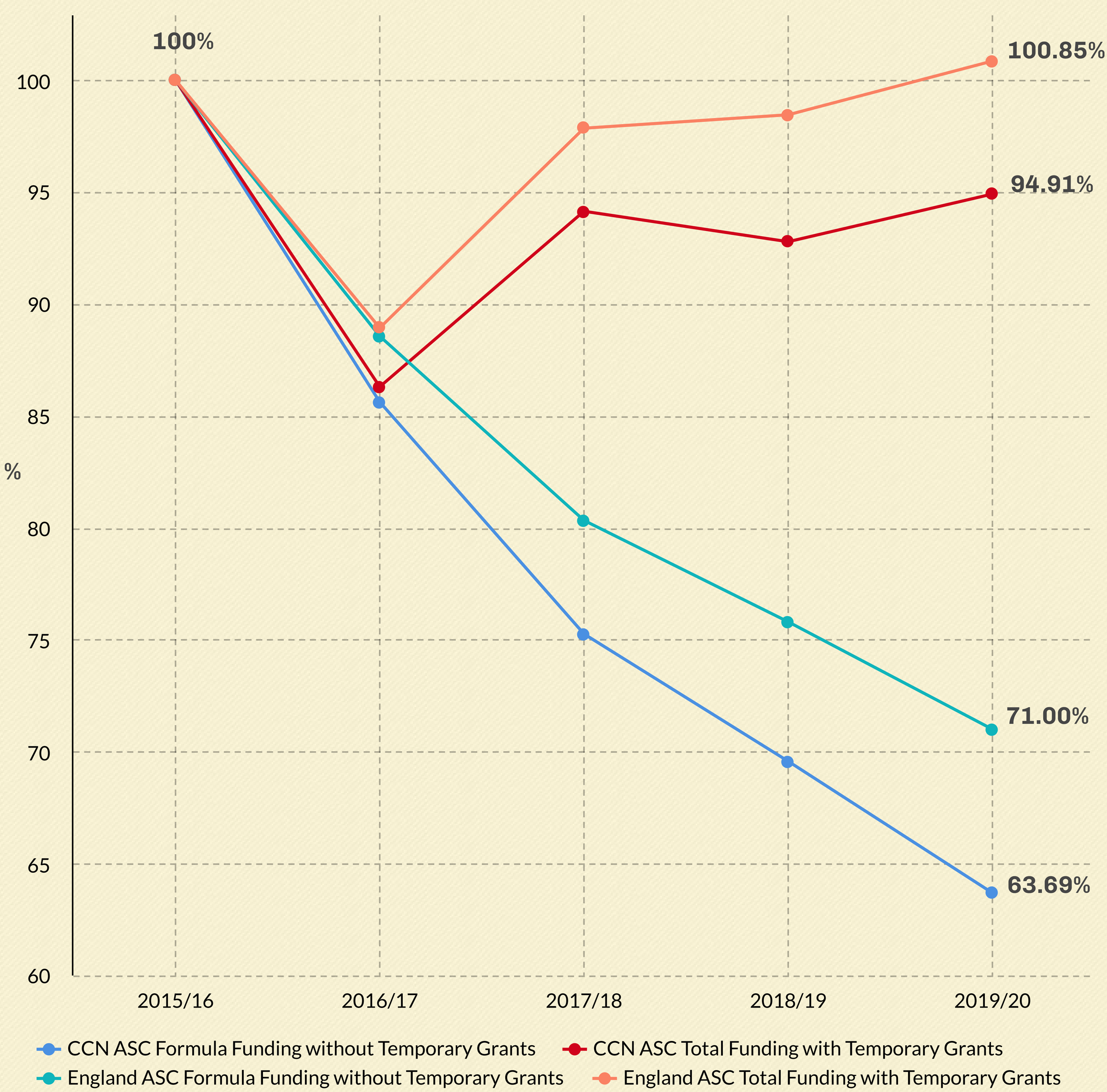
	2015-16 (£/m)	2019-20 (£/m)	(£m) +/-	% +/-
CCN Member Councils	2,511.01	2,383.19	-127.83	*-5.09%*
Non-CCN Unitary	1,217.52	1,223.95	6.44	*0.53%*
Metropolitan Districts	1,968.54	2,106.73	138.20	*7.02%*
Inner London Boroughs	580.89	635.29	54.40	*9.36%*
Outer London Boroughs	617.22	604.43	-12.79	*-2.07%*
ENGLAND*	6,895.17	6,953.58	58.41	*0.85%*

* NB - this analysis excluded City of London and Isles of Scilly. It also excluded Richmond-upon-Thames which was found to have negative upper-tier Formula Funding in 2013-4.

These trends are shown visually in Graph 1a which compares the trajectory of Formula Funding for Adult Social Care over the past five years with and without the addition of the Temporary Grant Funding – shown for both CCN member authorities and the whole of England.

GRAPH 1a:

Formula Funding for Adult Social Care without Temporary Grants vs Total Funding for Adult Social Care with Temporary Grants [12]



[12] nb- for technical reasons - in order to show year-by-year progression - this graph plots just formula funding as the baseline rather than total core grant funding (including other grant funding) explaining the slight discrepancy with the figures in Table 1. Total funding remains unchanged. The trajectory is broadly the same for the illustrative purposes needed here, but slightly mitigated as the proportional decline in total core grant funding is even steeper than the decline in formula funding alone.

County authorities in particular have faced the biggest divergence between estimated spending need and grant funding. Although part of this divergence has been offset by the ability for councils to opt to add a precept to council tax to help specifically pay for ASC, this cannot wholly compensate for changes to grant funding. Local authorities have still needed to balance their budgets through making service reductions, introducing higher thresholds for access to care, and keeping down provider fees (thus further exacerbating the gap between fees charged to state and private payers identified earlier).

These figures also do not reflect the substantial increased costs which the COVID-19 pandemic has now placed on the sector – many of which, such as the recommended 10% uplift in provider fees, will now raise costs for the foreseeable future even after the most intensive phase of pandemic has subsided. The most recent DELTA returns for July suggest the following additional costs have been accrued by COVID-19 so far:

TABLE 1:

Additional costs for Adult Social Care from COVID-19 2020/21 (Projected at July 2020)

Additional Demand	£359,959,808
Supporting The Market	£413,860,929
Workforce Pressures	£73,200,731
Personal Protective Equipment	£115,623,910
Other	£61,382,618
TOTAL PROJECTED COSTS FOR ADULT SOCIAL CARE	£1,024,027,995

When deciding on how to proceed with reform policy-makers need to consider that even though local authorities accept that there have been challenges in the system, how much more effectively might LAs have been able to deliver ASC in recent years with more resources and greater stability of funding?

Workforce Issues

One of the fundamental issues which will underpin the success or failure of ASC reform will be the prominence given to promoting recruitment and retention of the care workforce. Just as austerity has impacted the fees received by providers from councils, this has also had the effect of limiting the remuneration of the care workforce – most of whom are paid at or around the minimum wage.

One of the issues that reform needs to get to grips with are misapprehensions about care work is that it is an ‘unskilled’ job. In actual fact good care requires an enormous amount of expertise, just as nursing does – too often, though, little training or support is provided meaning that those suited to the role often find themselves frustrated, whilst others less suitable are not weeded out as quickly as they might be.

Yet greater investment in ASC and its workforce could be an important part of the economic recovery from COVID-19. Care already employs 1.5m people, whilst much of the content of this paper suggests there is scope for this sector to grow over the coming decades. ASC needs to be seen as a vital part of England's social infrastructure and a means to create jobs at a time when unemployment is predicted to soar.

Reform for the ASC system needs to address these structural issues around staffing. Without the prospects for progression in salary or status too often staff – particularly those most competent or capable – will seek out other career opportunities, regardless of how much they enjoy the job or the self-satisfaction they obtain from the value they can add to other people's lives. In particular many will use the skills they obtain through care work to seek better pay, conditions, training and status within a similar role within the NHS or even a local supermarket.

It is also vital that ASC reform looks to ensure that there is quality leadership at all levels of the social care system – practical, operational, and strategic. This is one of the single most crucial factors in achieving high performance and optimal quality in the ASC system. This may involve considering what investments may help to embed and maintain such leadership – perhaps through a Social Care Leadership Academy or more defined forms of graduate programme.

THEME 4: IMPROVEMENT

The first three sections have considered principles for reform based on the present circumstances. However, the most effective reform takes account not only of existing concerns but seeks to create flexible and responsive systems capable of reacting to future trends and creating a culture which welcomes change and actively seeks to improve.

It is already widely anticipated that the ASC system will face extensive demands in the coming years from a number of policy drivers. These include projected trends in demographics and an ageing population; changes in the expectations of service users and older people about what care they receive and how it is delivered; and advances in technology – particularly bio-technology – which may radically alter what is available to support those with care needs.

This final section therefore considers some of the key principles which should be embedded in reform to ensure that a new ASC system remains fit for purpose and responsive to these trends as they develop in different ways in the years and decades ahead.

Continuous Improvement

It will be expected that part of the process of ASC reform will be to identify appropriate outcomes and performance measures by which success can be benchmarked. Inspection and monitoring is a necessary part of ensuring a base level of standards in any public service. By itself, though, this risks creating a deficit model whereby services are judged by whether they do or do not meet minimal standards rather than an asset-based approach concentrating on celebrating aspiration and success. Reform, therefore should also consider how the ASC system can best be incentivised to create a culture of continuous improvement through peer support mechanisms allowing learning to flow effectively across the country.

Local government already has extensive experience in this regard. Councils regularly engage in practice-sharing and peer-monitoring activity supported by organisations like CCN, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). It also has a wider network of links to obtain direct representation from service users about their aspirations for ASC going forward to set local strategies within such a framework. CCN and its sister organisations across the local government family stand ready and willing to draw on this experience to help shape a quality and improvement framework for ASC in partnership with Government which helps spur aspiration.

Innovation and Future Proofing

Some of this experience has also demonstrated to local government that the process of improvement in part means creating the space to innovate. This has been particularly evident over the last few months where the constraints placed by the COVID-19 pandemic have led councils to develop new ways of delivering services digitally – some of which will now stay permanently.

A culture of innovation requires commitment, though – both in terms of funding and also an acceptance

that failure will sometimes occur as part of the learning process. For too long local authorities feel that the ASC system has been 'just about managing' with little scope for looking beyond anything other than coping with immediate pressures. The issues highlighted in this paper have shown many of these pressures have been caused by under-investment and lack of reform. However, despite this many authorities have continued to demonstrate innovative new ways to improve efficiency. Reform should be predicated on notion that innovation is a vital part of the system and incentivised at all levels – possibly through central government investment.

This may be even more important as advances in technology emerge over the coming decades. Given the impact this is likely to have in delivering health and ASC, reform must look forward and do its best to create a 'future-proofed' system which is adaptable to rapid change and has the ability to incorporate new technology quickly and effectively.

Prevention

Whilst this paper is predicated on the self-evident need for an ASC system to exist, one of the key principles that it should be built on is that ideally everyone values self-autonomy and no-one would actively want to be cared for if it can be avoided. As such the prevention of the need for health care or social care should be a central tenet of any ASC reform which is proposed.

By prevention this paper means two things. Firstly, stopping people requiring care in the first place as far as possible. Secondly, minimising the level of care people require, stopping them from escalating to more intensive and expensive services.

In terms of the first measure, there are four key drivers which push people into care:

- health
- housing
- carer breakdown
- societal pressures

Reform of the ASC system should encourage preventative strategies for all of these factors. The blueprint is provided by the first of these drivers in which the public health system already attempts to promote healthy living and supports people to take steps to improve their health – through smoking cessation programmes or anti-obesity drives.

Part of a new deal for social care should be to look at the other three factors too. For instance, how can more appropriate retirement housing be built and how can the Disabled Facilities Grant be used to more easily convert existing residences so that people don't always have to leave their home as they become more infirm. Can carer breakdown be mitigated by better provision of respite care services? How can initiatives to tackle, say, poverty or substance abuse, be fully targeted to prevent people requiring social care?

Such strategies will inevitably need extensive inter-agency working and local co-operation will need to be prioritised. Just as in public health the local authority is well-placed to play a pivotal role.

The second measure, though, is just as important. Reform must assess what provision is put in place to help intervene at an earlier stage. Advances in technology may play a part in helping people to manage their own lives without as much direct care. But in some cases more investment needs to be made in lower level services which help prevent people's problems exacerbating. A good example might be the Tiers of mental health support, whereby lower-level non-specific interventions at Tier 1, such as within GP surgeries or in institutions like schools or colleges, can prevent escalation of a problem up to more serious services at Tier 5 or 6.

The Government has made a welcome shift in this direction with the Prevention Green Paper published in 2019. Reform needs to embed these principles at the very heart of the ASC system.

CCN

COUNTY COUNCILS NETWORK

Founded in 1997, the County Councils Network is the voice of England's counties. A cross-party organisation, CCN develops policy, commissions research, and presents evidence-based solutions nationally on behalf of the largest grouping of local authorities in England.

In total, the 25 county councils and 11 unitary councils that make up the CCN represent 26 million residents, account for 39% of England's GVA, and deliver high-quality services that matter the most to local communities

The network is a cross party organisation, expressing the views of member councils to the government and within the Local Government Association.

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