IMPACT OF THE PROPOSED IMPLEMENTATION OF SECTION 18(3) OF THE CARE ACT 2014 FOR RESIDENTIAL CARE

BRIEFING NOTE FOR RESIDENTIAL CARE SERVICES

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1. INTRODUCTION

This note has been developed in the context of the government's proposals to implement section 18(3) of the Care Act 2014 as a means of addressing the adverse impact of differential fee rates for residential care between those paid by councils and those paid by private individuals.

The purpose of this note is not to provide specific legal advice but to set out the legal context of the proposed change to section 18(3) and the interaction between section 18(3) and other relevant legislation and regulations.

The changes proposed to section 18(3) cannot be seen in isolation so the consequential changes which may occur as a result, are also highlighted in this note. Specifically, the note covers the potential changes to:

- the cost that local authorities ought to pay for care, the so called "fair cost of care";
- the extension of "First -party" top-ups for all residential care arrangements;
- the approach taken to a fixed tariff for "daily living costs" and how that might impact the market;
- the potential introduction of an appeals mechanism; and
- personal budgets and the creation of payments records showing the movement of each individual towards the care fee cap.

This note focuses on residential care because that is where the change to section 18(3) will be effective but much of the analysis will apply also to home care where the provisions already apply but with less obvious levels of cross subsidy in evidence.

We will be publishing further briefings on the recently published draft operational guidance on Implementing the cap on care costs, in due course.

2. CURRENT POSITION

2.1 The Care Act

The current position is that several provisions in the Care Act 2014 were not put into force in 2015 and have never been applied. This was as a result of the delay and then abandonment of the Dilnot reforms of 2014. These provisions include not only section 18(3) but also the following (the purpose of which are briefly described):

section 24(3); this section provided that even if the local authority is not paying for care, it must still provide an independent personal budget for the resident;

section 26(2)(b)(ii); this provision would have allowed a note to be kept of the amount each person had spent (excluding daily living costs) towards the care cap;

section 28; established the method for creating the independent personal budget, which was to be a statement which specified what was being paid by an individual towards the care cap; the phrase used for the relevant costs in the section is interesting; it refers to a statement which "*specifies what the cost would be to the local authority concerned (see section 24(3))", (our emphasis)*; the rationale was that, if an individual did not have a personal budget under section 26, because the local authority was not under a duty to prepare a care and support plan for them, a separate mechanism was needed to record their care costs for the purposes of measuring progress towards the costs cap; it was not made clear what was meant by the phrase "*what the costs would be to the local authority"* but it could imply the rate would be the council's standard rate or the usual private pay rate available locally;

section 29; this created the mechanism by which local authorities are required to keep an account for each adult whose care costs were counted towards the cost cap; in the original policy paper issued by the Department of Health in 2013, *Caring for our future: consultation on reforming what and how people pay for their care and support*, the government likened the annual care account statement to an annual mortgage or pension statement; and

section 72; an extensive appeals mechanism to support the Care Act was envisaged and section 72 gave the Secretary of State the power to make regulations providing for an appeals process; the section is in force but the relevant power to create an appeals mechanism has not been exercised; in 2014 the appeals mechanism as it related to the care costs cap was seen by the government to be a fundamental requirement to make the system work. In their recent communications the government have indicated that they have no intention of introducing the appeals mechanism but are keeping it under review.

2.2 Care Fees

The costs which a local authority must pay for residential care services are generally open to market forces. The government's policy paper *"Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023"* (**the Fair Cost Paper**) published on 16th December 2021 gave some indications of how the government expected to see local authorities adopting a different approach. The changes are explained below.

Currently local authorities are generally free to procure care services in any way they chose, with only very limited rules being applied by public procurement law, but there have been a series of cases in which care providers have sought to challenge how residential care services have been commissioned and the basis on which reasonable costs have been calculated. The majority of the relevant cases were in relation to the pre-Care Act 2014 provisions, but they are, nevertheless, relevant to the current debate

regarding a fair cost of care. This is because the significant purchasing power of local authorities does not create a normally functioning market, which has had a number of effects alluded to in the Fair Cost Paper:

- a concern on the part of government and the provider community that local authorities should not use their purchasing position to drive down fees to a level which will not sustain a variety of care homes delivering good quality services;
- the development of numerous different fee-calculation mechanisms (including some which have been bespoke to a single local authority), leaving a wide area of disagreement about what should make up the calculation of a fair cost (particularly in areas such as void risk and return on capital);
- the creation of procurement methods such as dynamic purchasing systems which undermine the choice of individuals (a concept at the heart of the Care Act and Build Back Better) and discourages innovation, investment and continuous improvement; and
- the increase in legal disputes, in both public and a private law, which is an expensive distraction from dealing with the care needs for which local authorities are responsible and which providers want to deliver.

2.3 **Care Market Oversight**

The Care Act includes various "target" duties around promoting an efficient and effective market for services, and the standard set out in the Care Act Statutory Guidance, Annex A paragraph (11) states: "*In all cases the local authority must have regard to the actual cost of good quality care in deciding the personal budget to ensure that the amount is one that reflects local market conditions*" (*our emphasis*). However, there is no clarity about what this means; case law has indicated that it is legitimate for local authorities to take into account the cross-subsidy available from private payers, thus entrenching the cross-subsidy that exists and which the government now hopes to see removed, to the advantage of all consumers. The extension of section 18(3) to residential care is a major element of the government's plan to bring this about.

The extent to which any new legislation or regulations will simply replicate the planned implementation of the legislation made in 2014 is not yet known. The impact of the changes proposed to section 18(3) will be influenced significantly by the extent to which other changes are made by reference to the sections listed at 2.1 above and the outcome of the actions taken to determine the fair price for care in accordance with the Fair Cost Paper.

An important change is the enhanced role CQC will have to review the performance of local authorities and suggest interventions where the local authority is failing to abide by its obligations. This will give providers a lever to counter some of the worst excesses of poor commissioning practice.

3. THE PROPOSED CHANGE TO SECTION 18(3) AND ITS IMPACT

There are various sources of information available which indicate how the imminent changes in the landscape for care fees which have been based on the Care Act 2014 and the associated regulations since 1st April 2015 will occur:

- The Health and Social Care Bill (the Bill) refers to a cap on care costs of £86,000 and changes to the capital limits for public assistance with care costs, which will take effect from October 2023;
- Build Back Better (**BBB**) references the new cap and also the proposed removal of the restriction in section 18(3) which currently means local authorities are under no obligation to arrange residential care for someone whose capital exceeds the current cap, they only have the power to do so.
- the Charging Reform Finance Paper produced by DHSC, as updated on 5th January 2022 (the **Charging Reform Paper**), states that the statutory operational guidance on the extension of section 18(3) to residential care is to be published in "early 2022"; it also proposes that the proportion of costs to which the cap will apply will only be the care costs, with a standard allowance (irrespective of actual costs) being given for "daily living costs" (often previously referred to as "hotel costs") which has provisionally been set at £200 per week;
- the Fair Cost Paper (see 4.3 below); and
- Implementing the cap on care costs: draft operational guidance, consultation published 4th March 2022 ("the **Operational Guidance**").

The fundamental change if s 18(3) is enacted is that, simply stated, it will be possible for individuals to rely on an enforceable duty which will require their local authority to arrange their residential care. This will apply notwithstanding that the care will be fully funded by the individual because of their financial position. Whether this will have the effect of driving care home fees down is, of course, the key question.

Local authorities will have a choice to make regarding this change: will they only meet such needs where specifically requested by the individual with the minimum of intervention in the relationship with the provider or will they take a proactive role in promoting their role and the opportunity it might offer to secure for individuals residential care at the rates the local authority can secure through their stronger purchasing power?

The Operational Guidance covers such things as the revised approach to deferred payment arrangements, first party top-up arrangements (not currently allowed for most residential care), and the process by which individuals asking local authorities to arrange their care will engage with the local authority. All these changes will be overlaid by the potential impact of the Fair Cost Paper.

Taken in isolation, the changes to section 18(3) seem unlikely to be a catalyst for major change in commissioning practice, so any assessment of what the future holds must

involve an analysis of all of the moving parts and their implications for the market. We set out in the next section our thoughts on the 4 elements that seem most likely to influence this.

4. THE OTHER CONSEQUENCES OF THE PROPOSED CHANGE

4.1 Personal Budgets

It appears that the role of personal budgets will take on a much more prominent position in the setting of care fees when section 18(3) is in force. Various consequences arise from this issue, as set out below.

The current Statutory Guidance is clear; for example, clause 11.4 states:

"*It is vital that the process used to establish the personal budget is transparent so that people are clear how their budget was calculated, and the method used is robust so that people have confidence that the personal budget allocation is correct and therefore sufficient to meet their care and support needs. The allocation of a clear upfront indicative (or 'ball-park') allocation at the start of the planning process will help people to develop the plan and make appropriate choices over how their needs are met*."

It is a specific requirement of section 25(1)(e) of the Care Act that the resident's written care and support plan (which must be prepared by the local authority) includes a personal budget. This process will become a key issue for individuals to engage with as they will want to ensure that the personal budget covers all of their needs and gives them enough money to pay someone to meet those needs.

The Statutory Guidance (paragraphs 8.57-8.59) make it clear that local authorities can charge for making arrangements for people that can afford their own care, and this may lead to some local authorities seeing an opportunity to create "brokerage" services as part of their response to the proposed changes.

A question will arise in connection with the extent to which the care fee cap will apply only to eligible care needs, not the cost of meeting needs which fall below the eligibility criteria (as set out in the Care and Support (Eligibility Criteria) Regulations 2015). Once again, this is likely to be a fruitful area for dispute and is further justification for an effective appeal mechanism to avoid unnecessary costs and unnecessary judicial reviews.

4.2 Top ups

The current regime for top-ups applies where an individual wishes to choose more expensive accommodation than the local authority is prepared to pay for. Top-ups are only generally allowed if there is a third party available to make the additional payments and various other rules are often imposed by local authorities. This is because the local authority remains liable for the full fee, including the top-up, so has to have ways of mitigating the risks associated with the top-up not being paid. The proposal is that individuals will be able to make top-up payments themselves to secure a place in a home which is only available at a higher cost than the local authority is prepared to

pay. Crucially, the current arrangements for third party top-ups, which are found in the Choice of Accommodation Regulations, are meant to protect residents in circumstances where there is no other possible alternative, so that a top-up is only a legitimate option if the local authority can show that there is suitable accommodation available at a lower price. If the local authority cannot do so, it must pay the full price and cannot require a top-up.

It can be seen that, as a result of the new requirement, there will be further pressure on local authorities to be transparent about what alternative accommodation might be available and the price of such accommodation. The impact of first party top-ups, taken with the changes to section 18(3), are clearly intended to put more power in the hands of individuals and providers must expect, at the very least, that the system will be transparent and fair in its application.

There is the potential for circumstances to arise similar to those for NHS Continuing Healthcare funding ("**CHC**") where care is funded by CCGs. That system allows providers to charge for additional services through a separate contract for goods and services which are beyond the basic assessed needs of the individual, for which CHC pays. The creation of a system in which a 'basic' care package is available at a set price with additional or enhanced services being available at an additional cost seems a likely outcome from these changes.

4.3 **Fair Cost of Care**

The stated objective of the policy paper Market Sustainability and Fair Cost of Care Fund: Purpose and Conditions 2022 to 2023 (**Fair Cost of Care Paper**) is that more people who fund their own care in residential care will be enabled to

"*ask their local authority to arrange care on their behalf to secure better value*."

This objective is tied specifically to bringing into effect section 18(3). It is claimed that

"*This will help to address the current differential in fee rates charged to some self-funders*".

It also asserts that

"*The market effect of this change will be that some providers will, over time, need to reduce reliance on subsidising state funded care from self-funders.*"

This is a rather peculiar way of addressing a subsidy which is forced on providers by local authorities and central government underfunding of social care, rather than something which providers volunteer for.

The Fair Cost of Care Paper also references the low fees paid by local authorities giving rise to under-investment and poorer quality outcomes. The same message that was given in the Department of Health's paper "Building Capacity and Partnership in Care" as long ago as October 2001, which resulted in guidance issued in 2004 which first gave rise to the obligation on the part of local authorities "*In setting and reviewing their usual costs, councils should have due regard to the actual costs of providing care",* something which was repeated in the Care Act guidance.

There is, of course, little in the way of guidance as to what constitutes under-investment or poorer quality outcomes, and the government is clearly intent on making local authorities do the necessary work to establish benchmarks for what a fair cost of care might look like. It is doing so by each local authority being required to undertake its own exercise to determine what sustainable rates are locally and assesses how close their own rates are to that sustainable rate. The initial exercise is to be undertaken during the period to October 2022, when formal returns will need to be submitted by each local authority using standard templates and guidance. Local authorities are threatened with further funding being withheld until they have carried out the exercise. Similar surveys will have to be undertaken in successive years.

The Fair Cost of Care Paper indicated that the government would be "inviting sector partners" to support the development of the guidance, templates and wider support needed", but exactly who this will include and how much the government will drive a standardised approach in which a shared understanding is reached regarding what elements must be included in a fair cost of care, will need to be judged when it is seen.

One apparently glaring omission from the analysis being undertaken is that of capacity and investment, with the focus being almost entirely on annual costs. There are already significant discrepancies in what private payers will pay for different standards of physical environment, and over time the ability of investors to justify building care homes which have a lower capital cost and deliver a lower specification for accommodation must be decreasing. Unless local authorities are willing to underwrite such investment by agreeing to purchase bed places at an acceptable price, there may come a time when local authorities will be obliged to promote such investment directly, if they are to create sufficient capacity.

It has been seen in other aspects of the care sector (such as children's secure accommodation) that an obligation to make accommodation available does not easily translate into the necessary investment being made to make sure that that accommodation is made available. The Fair Cost of Care paper seems to significantly under-estimate the impact of that dynamic on the market. The voice of investors probably needs to be heard more strongly in the debate.

4.4 Hotel costs

The £200 per week hotel or daily living costs amounts to £10,400 per annum compared with the figure which was tabled in 2014/15 of £12,000 per annum. This also compares with typical "hotel costs" assessed in care calculator models. For example, Birmingham City Council's current approach indicates a rate of £232.50 per week (£12,010 per annum) which was established from 1st April 2018 in the Council's draft Community Strategy Pricing Proposals. Clearly, the lower sum is potentially more generous to residents who will, as a result, use up more of the "care cap" on care services than they would have done. It will be interesting to see whether local authorities seek to drive down fee rates by reference to the £200 per week tariff, although it is explicitly a "notional" figure.

A residential care service is for both accommodation and personal care, and generally different elements of the costs are not separated out in fee calculations (although in most fee calculation models they are). The government's expectation seems to be that the £200 allowance will be treated only as a notional sum rather than the true cost.

It is uncertain what incentives will be created by the cap; on the one hand it is the resident's own money so they will want to get value for money but may feel that the £200 per week is still something they want to reduce so they reach the cap sooner so they can get assistance for all of their costs.

£86,000 at £500 per week covers 3 years and 4 months of care; at £700 per week it covers 2 years and 4 months of care. Both of those periods are significantly in excess of the average stay in a residential care setting and therefore only likely to benefit people with certain conditions demanding long-term residential care where they have mental incapacity rather than physical issues which are likely to cause their death within a limited period of time.

If similar calculations re applied to home care, then at £17.50 for a 3 hour per day package, that amounts to £19,000 per annum or 4 years and 5 months' worth of care. This seems to indicate there will be pressure on people to remain at home, receiving less care per week, and that the assessment of care needs will be adjusted to suit local authority budgets, rather than being based on care needs.

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