Caring for our future

A response from the English Community Care Association

1 Introduction

1.1 The English Community Care Association (ECCA) is the leading representative body for community care in England. Our members provide a wide range of services for adults with care and support needs including residential and nursing settings, homecare, housing and community-based support. Our members also deliver specialist care home services such as rehabilitation, respite, palliative care and mental health services.

1.2 We welcome the opportunity to comment on Department of Health proposals on Caring for Our Future and would firstly want to make some general observations on issues raised in the consultation document, which are of particular importance to providers of care. We feel that the consultation concentrates on the way the new system will work very much from the point of view of Local Authorities and the individual receiving care to the detriment of the providers, who will of course be responsible for the delivery of the actual care and support once these proposals are implemented.

1.3 ECCA is pleased to be a member of the DH Paying for Care Advisory Group and we trust that this consultation will be the start of an on going formal engagement with independent providers to work through the practical implications of these proposals for the care market. In addition by way of introduction we hope that this consultation and the communication plan that results ensures that people with assets will be quite clear of their continuing responsibilities to pay for their care and the fact that they will, in all probability, pay more than £72,000 in care costs before they receive help from the state. The use of the word 'cap' is a misnomer.

2 The role of LAs in advising and contracting on behalf of self funders

2.1 This is, without doubt, the development with the most far-reaching consequences for providers. Raising the asset threshold will bring more current self funders into the LA control. More importantly, if the self funder wants to, they can request the LA to arrange their care with the provider at a rate that the LA would normally pay. The consequence of this is simple. If care providers are to remain sustainable, local authority rates will have to increase in order to meet the true costs of care, or there will have to a fundamental change in attitude to enabling relatives, and indeed residents, to pay 'Top Ups' to care. Currently many social workers are ideologically opposed to 'Top Ups'. The fact that LAs do not currently meet the real evidenced costs of care means that these proposals are being built on sand. The recent concern over 15 minute homecare visits is just a symptom of a deeper malaise facing commissioning where downward pressure on price results in poorer services for individuals.

2.2 This will also impact areas to very different degrees. For example, although nationally, it is estimated that around 45% of people pay for their own care, in many SE authorities the percentage is much higher. For example, Surrey – due to its relative wealth – estimates that closer to 80% of people fund their own care, whilst Hampshire estimates that around 60% is self-funders

2.3 Independent sector commentators have noted;

> *"… moving the upper limit of the asset threshold from £23,250 to £100,000 would mean that large numbers of care home residents who are presently private payers would be drawn within*

the ambit of local authority payment, meaning that a significant proportion of the premium fee rates which are presently needed to cross subsidise inadequate local authority fee rates may gravitate towards the low fee regime of councils … Without these subsidies, large numbers of care homes would be literally bust. It is understandable that cash-strapped councils are seeking to pay care homes as little as they can, since this is now the biggest single cost that councils have to bear, but it needs to be recognised that this amounts to a 'hidden tax' on private payers, who are in effect bearing the brunt of austerity measures." [Laing & Buisson, January 2013]

2.4 It is important to note that all these comments were made before the thinking underlying the new right for self-funders to ask local authorities to make the necessary arrangements on their behalf had been made explicit. As in:

> *"The introduction of the cap on care costs will mean that a person who chooses to meet their own needs will be able to compare what they might pay to meet their needs with what the local authority pays. If a person wants to, they will be able to ask the local authority to arrange to meet their eligible care needs so that what they pay to the local authority to meet their needs would be the same as the figure that counts towards the cap."* [Health Minister, Lord Howe, 9 July 2013]

It must be pointed out that like-with-like comparisons of "care costs" would not be possible unless the provider's fee is also broken down into its component parts.

2.5 The consultation (published on 18 July 2013) repeats the minister's theme, and goes on to describe the consequences in rather bland terms:

> *This could present both local authority commissioners and care and support providers with new challenges and opportunities. It is likely this greater transparency in the prices paid by the local authority will change the care and support market, although it is not clear whether pressure may fall on commissioners, care and support providers or both."* [Paragraph 300]

We would argue that the evidence on costs of care and the gap between what councils generally pay and what are the true costs of care is already there and has been for many years. In the spirit of transparency this information needs to be publicized.

If self-funders contract at LA current rates then providers will not be sustainable and will close. There is no question that this should be known to the DH and playing down the possible consequences is misleading in the extreme. It is no one's best interests, least of all residents of care homes, to ignore this issue. In addition to talking to providers the DH may wish to contact the main bank lenders to the sector to get a further understanding of the sustainability of the current market.

2.6 LA commissioning remains a slave to council budgets, regardless of movements in providers' costs, and the notion of top-ups for "special" facilities has long been an anachronism. Over many years, providers have struggled to maintain a quality service in the face of uneconomic prices from local authorities by seeking third party top-ups – where they are available – and by charging self-funders premiums in an attempt to balance their books.

2.7 As to the probity of budget-determined commissioning, the Government's initial response to the findings of the report into the Mid Staffs Inquiry contained a statement of common purpose signed, among others, by the Permanent Secretary at the DH and the chair of the Local Government Association. That statement was explicit on the preferred order of priorities:

> *"Blind adherence to targets or finance must never again be allowed to come before the quality of care. We need to use public money well and we need to be efficient and productive but these are a means to an end – safe, effective and respectful care, compassionately given."*

We would strongly suggest that this statement should become a touchstone for local authority commissioning.

2.8 Encouraging self-funders to believe that they need only pay the local authority rate – when, in fact, providers will undoubtedly ask them to top-up to bridge the gap between the authority price and the home's fee (in which case what is the point of going via the LA?) – will damage relations between home operators and their residents (and prospective residents), who may also see in it a breach of trust by LAs and the Government; second, it will place an unnecessary burden on providers; and third, it will destabilise the market, reducing investment and reducing supply. Indeed, there is the very real risk that by allowing an all-encompassing local authority monopsony to undermine competition "the open market" might cease to exist. All of which will of course has serious implications for the NHS as discharge from hospital will be severely delayed. If there is to be economic oversight of providers then there needs to be a similar oversight of commissioners and an understanding of the links between financial sustainability of providers and commissioning practices of LAs and CCGs. The implementation of these proposals without the safeguards of ensuring LAs pay the true costs of care will put the financial health of all providers in even more jeopardy, by removing self-funder income and disincentivising investment.

2.9 We do not believe that "making arrangements" for self-funders – for the avoidance of doubt, a group that should include individuals who, but for the increase in the upper asset threshold, would have remained private payers – should not involve setting the price.

3 Choice and top-ups

3.1 The Bill gives people the ability to spend their own money to purchase more expensive care and support through the provision – in Section 30(2) – for the "additional cost" to be met not only by third parties but also, where appropriate, by the adult resident, subject to regulations. This is long overdue. However, the concern that some local authorities might seek to use top-ups as a way to keep down costs [Paragraph 265] is well made.

3.2 This is another opportunity, therefore, to reinforce the need for the previous guidance on the National Assistance Act 1948 (Choice of Accommodation) Directions 1992 National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Amendment) (England) Regulations 2001, suitably amended, to be continued under the new legislation in order to ensure that local authorities meet their statutory obligations. Paragraphs 2.5.4 to 2.5.8, under (b) "Cost" are particularly relevant.

3.3 ECCA recently collaborated with Independent Age, on a report which revealed, inter alia, that a number of authorities still believe they have discretion, perhaps under the terms of placement agreements, to refuse to countenance setting up top-ups. The original guidance was produced 20 years ago and updated 12 years ago.

4 Determining the individual budgets and the right of the individual to challenge the rate set by the LA

4.1 As the local authority will decide the amounts that are allocated in personal and independent personal budgets to "care costs" and "daily living costs", there needs to be absolute clarity about what constitutes care for the purposes of calculating "care costs" and, equally, about the components of "daily living".

4.2 The desired clarity might be provided through the medium of regulations – Section 15(8) provides for the amount attributable to an adult's daily living costs to be specified or determined in accordance with regulations – and/or guidance. We welcome proposed guidance on a set of "common principles" on which all Resource Allocations Systems should be based [Paragraph 218] and to develop statutory guidance on the formation of personal and independent budgets [Paragraph 212].

4.3 It should be emphasised that transparency is essential, not least where RAS systems are concerned.

4.4 The Bill refers to "care costs" as what it costs – or for self-funders what it would cost – the LA to meet eligible needs. The Government accepted the Joint Scrutiny Committee's recommendation that the amount of a personal budget should be equivalent to the reasonable cost of securing the provision of the service concerned in the local area. However, the concern is that, as the Bill is currently drafted, the expression will be open to interpretation, being in practice less what the actual cost to the provider is (or would be) than what the LA is (or would be) prepared to pay.

4.5 The consultation proposes a personal contribution to living costs set at a standard rate of £12,000 a year as proposed by Dilnot. It will apply, among others, to people with assets between £27,000 and £118,000, many of whom will be swept into the catchment of LA commissioning by the increase in the upper threshold from £23,250. There must be a concern, therefore, that when authorities specify the amounts in personal and independent personal budgets that are attributable to daily living costs, this national figure will be applied rigidly, regardless, for example, of geographical variations in accommodation costs. These costs should therefore be calculated with the same flexibility as the care costs that count towards the cap.

4.6 Laing & Buisson's breakdown of average weekly fees has "Accommodation Costs" at between £151 and £153 and "Ancillary Costs" at £205, giving totals of between £356 and £358, annualised at between £18,512 and £18,616 – for "Operator's Profit" ie more than the £12,000 being put forward in these proposals.

4.7 The recognition that individuals should have a right to challenge authority decisions [Paragraphs 238-250] is welcome.

4.8 The model for hearing school admission appeals, mooted in the consultation document as a possible mechanism for resolving disputes between service users and councils, could also be attractive to providers as a means of settling their disputes over costs with councils. We supported the scrutiny committee's recommendation for an independent adjudicator, which was however rejected by the Government. Unfortunately this consultation does not ask for comments on this as in fact the consultation deals only with dispute resolution for service users. This is omission and needs to be remedied.

4.9 Providers will expect a resolution mechanism to be both credible and effective: It must be independent, members must have relevant expertise and the panel's decision must be binding – criteria met by the admission appeals procedure. However, for this purpose its decisions must be quantified – as opposed to being narrative commentaries on the disputed amounts.

4.10 Important though this appeal procedure might be, it must be emphasised that it is no substitute for commissioning that consistently recognises the true costs of providing care services and ensures they are reflected in the prices paid for care services.

5 Consistently effective and equitable commissioning

5.1 ECCA has consistently argued that nothing short of effective independent oversight of local authority commissioning will bring the present unacceptable situation to an end. Based on the experience of ECCA members, without the effective regulatory oversight of commissioning behaviour, the association has little confidence that the DCMQC programme will succeed where so many previous initiatives and guidance issued by the DH have been largely ignored by commissioners – most notably Building Capacity and Partnership in Care, published in 2001, which in many respects reads like an early draft of DCMQC.

5.2 ECCA is particularly concerned about commissioners' reluctance to take a strategic approach to price setting, engaging constructively with their local providers to ensure care prices reflect providers' costs.

This despite the existence of independent, authoritative figures published by analysts Laing & Buisson – a source quoted extensively in publications from the DH. In consequence, independent oversight is an imperative. At a time when it is essential that there is more joined-up commissioning of services, this oversight should extend to considering commissioners' overall best value judgements which, rather than perpetuating a "silo" approach, should consider how a service can deliver Best Value to taxpayers as a whole rather than just the commissioner in isolation.

5.3 It should be noted that, as well as promoting and protecting the interests of service users, local authorities' commissioning activity can also damage these interests, specifically by a reluctance to see beyond budget management to take a joined-up, forward-looking view of the various factors at play in their local health and social care markets. On pricing, for example, many authorities have resisted the idea of an agreed formula for determining fair, economic rates for care homes – taking account of sector costs and allowing for a reasonable return on capital invested – preferring instead to exploit their monopsony power by imposing on providers the lowest possible prices, regardless of the quality of care provided or the prevailing economic conditions. These prices contrast sharply with the unit costs of local authority provision, where it exists. Of the authorities that have at some stage co-operated in such schemes, most, if not all, have since abandoned the agreed model, citing financial pressures from reduced revenues.

5.4 LAs faced by severe budgetary pressures are being challenged by judicial reviews launched by provider associations to seek a means of addressing the funding gap; litigation thus becoming negotiation by other means. That is not a sign of a healthy market. Providers who might otherwise have invested in their service will be forced to instead cut back. Quality and viability may be casualties of this approach. As far as the duty of local authorities to shape their local markets is concerned, an NAO study, *Oversight of user choice and provider competition in care markets* (2011), found that:

> *"… only one of the six authorities visited had carried out its own market analysis to see what type of care services users would like to see provided in future, the amount they would be willing to pay and the likely level of demand."*

The report also makes reference to OFT research that revealed that:

> *"social care providers felt there was a lack of clear strategic direction from local authorities, and a lack of commissioning and procurement skills – which was leading to market inefficiencies and difficulties in planning."*

5.5 Since the community care reforms were implemented twenty years ago, the DH has issued countless documents offering local authorities guidance – some of which have statutory status – on working with providers to achieve better commissioning. Few have had any practical effect. In view of the ability of local authority policies and practices to impact on providers' financial viability, with the concomitant consequences for the wellbeing of the health and social care market and, not least, the care of people using services themselves, we question whether the Government can reasonably continue its present laissez-faire stance – authorities' democratic mandate notwithstanding.

5.6 CQC (under its original remit) and its predecessor body, CSCI, both had responsibility for assessing the quality of local authority commissioning of adult social care services. Within that ambit, they had the ability to examine the relationship between levels of public prices for care home services and the quality of care provided – indeed, ECCA urged both to do so. In the event, this did not happen. The recent Judicial Review decision regarding the decision-making of Sefton Council clearly shows that this council did not assess the impact of its fees policy on providers and people using services. Subsequent Judicial Review decisions regarding the respective decision-making processes undertaken by Newcastle City Council and Devon County Council have highlighted issues concerning the irrationality of price-setting and breaches of obligations under the Equality Act 2010.

5.7 It must be stressed that the problems and inadequacies referred to above are not a direct consequence of the current squeeze on public spending, although they have undoubtedly been exacerbated by it;

they are endemic to the system. Since CQC was relieved of the responsibility for monitoring local authority commissioning, there has been no effective oversight of this area of council activity, a deficiency that has been noted in the NAO report:

> *"Despite having policy responsibility for social care, the Department has few formal mechanisms to influence the way care is delivered locally. For example, in evaluating progress of local authorities against the milestones, the Department had to rely on self-assessment reporting by local authorities and regional information from the Department's Deputy Regional Directors."*

5.8 Is the "democratic mandate" of local authorities sufficient reason for central government to permit a situation that would not be tolerated in the NHS? The reformed health service will benefit from the establishment of an independent commissioning board to provide leadership on quality improvement, design financial incentives that reflect quality standards and provide commissioners with detailed guidance on how to meet pre-defined national outcomes. When ministers have been at pains to emphasise the "critical interdependence" between the NHS and adult social care in securing better outcomes for people and the need for consistency of approach across the sectors, ECCA feels bound to ask why comparable arrangements cannot be made to bring some coherence to adult social care.

5.9 We are concerned that recent developments imply that hoped for regulations to allow CQC, to review and assess the performance of the provision and commissioning of adult social services by English local authorities and which we hoped would provide that the performances of all authorities are reviewed routinely, seem to be in the process of being watered down. Instead CQC will be able to review local authorities but not as a regular programme, and in essence it would be pretty exceptional that CQC would actually do so at all.

5.10 The disparity between the costs of in-house provision and the prices paid to independent providers has long been a source of discontent. For a useful, authoritative comparison of unit costs between local authorities' own provision and purchased services, see the Audit Commission's publication, *Social care for older people: using data from the VFM Profiles*, dated July 2013: www.audit-commission.gov.uk/8283-2/ at Para 32.

5.11 We would argue therefore that, in setting prices for independent providers – and, by extension, for the calculation of "care costs" counting towards the cap – LAs should use the costs of their own provision which meets quality standards, to benchmark the reasonableness of their prices. In cases where they do not have equivalent in-house services, the data gathered by the Audit Commission and PSSRU should be able to help produce the necessary figures.

6 Treatment of the provider's profit

6.1 The provider's profit element has not been dealt with explicitly by either Dilnot or the DH. On the one hand, the consultation has recognised that:

> *"Care costs can vary to reflect complexities of individual needs and other factors such as the local care market and commercial negotiation"* [Paragraph 131]

implying that profit will be counted in "care costs". On no level can it be described as the type of costs individuals would have to meet if they were living in their own home. On the other hand, there is a widespread assumption that profit will be excluded from "care costs" for residential care – see, for example, the Laing & Buisson report, *Care of Elderly People UK Market Survey 2012-13* in which care home fees have been broken down into their component parts, one of which is "Operator's Profit". If it is not counted as "care costs", will it be subsumed within "daily living costs" for the purpose of the standard annual contribution of £12,000, subject to review?

6.2 The status of the provider's profit in homecare rates is also uncertain. Will authorities be expected to

disentangle it from the prices they pay for these services (which obviously include profits)? How will they do so? Or is it to be regarded as integral to "care costs" and therefore counted towards the cap? Should the latter be the case, people receiving residential care must be treated in the same way, otherwise they would be at a significant disadvantage. Clarification would be appreciated.

6.3 Provider profit is critical and explicitly linked to capital investment and financing costs. The sector needs capital investment for replenishment of stock, and that has to be accounted for in the breakdown of costs which the proposals seem to demand. Protecting the profit margins and investments are critical to both current stability, and future improvements in the sector. Indeed independent assessments of the market believe that there is a need for significant investment in new care homes to manage the demographic shifts in the coming years.

7 Direct payments for residential care

7.1 We welcome the move to confirm that DPs will be available for use in care homes and ECCA is a member of the DH Advisory on this issue. The 'trailblazer' sites will be very useful in looking at the practicalities of implementing direct payments for this purpose and we will facilitate provider involvement going forward.

Consultation Questions
Paying for Care
Fairer and more consistent charging – the charging framework

Consultation Question 01
Do you agree that the future charging framework should be based on the following principles? The principles are to be:

- Comprehensive
- To reduce variation in the way people are financially assessed; be transparent, so people know what they will be charged
- Promote wellbeing and support the vision of personalisation, independence, choice and control and enables delivery of funding reform
- Be user-focused reflecting the variety of care journeys and the richness of options available to meet their needs
- Encourage and enable those who wish to take up employment, or plan for the future costs of meeting their needs to do so; support carers and not place additional burdens on them, in recognition of the invaluable contribution they make to society
- Minimise anomalies and perverse incentives in choices between care settings
- And be sustainable in the long term.

These are eminently sensible aspirations for the charging system. Indeed they could be the touchstone for the way the whole system works. Personalisation and choice need innovative, high quality and sustainably funded providers; transparency on how personal budgets are arrived at; and clarity on what care costs and the types of services available and the quality of those services.

In reality however, few people will receive any financial support via the proposed scheme as a result of much shorter lengths of stay(from about 600 days to nearer 200 days – Care of Elderly People UK Market Survey 2012/13 Laing and Buisson) and support based only on council fees rather than actual true costs of care. Many will be making substantial care and daily living costs for many years. These points are explored in the recent report – A Cap that Fits – Strategic Society Centre August 2013 which should be required reading in relation to this consultation.

Fairer cap for working age adults – varying the levels of cap
Consultation Question 02

Do you agree that the decision on the level of the cap on care costs set for working age adults between the ages of 18 and state pension age should be based on the following principles? The principles are:

- People in similar circumstances should make a similar contribution
- Reflect people's ability to plan, prepare and build up savings
- Be simple for people to understand and feasible to implement
- Support integrated care and effective transitions between services
- Help people to live independent lives.

These are helpful principles and we would want ECCA members of such services and the people receiving these member services to have direct discussions with the DH on these matters.

Consultation Question 03

Do you agree in order to support transitions from children to adult care and support we should extend free care for eligible needs to young people up to age 25? Or are their alternatives we should consider such as through integration between child and adult care and support and the guidance provided on how to set the level of the cap?

We are not in a position to answer this question.

Aligning contributions in different care settings – daily living costs

Consultation Question 04

Do you agree the contribution a person makes to daily living costs should be calculated on the same basis as financial assistance with care costs, taking into account both income and assets?

In the interests of simplicity we would agree but this is not an area on which we, as provider representatives, are fully qualified to comment on.

Who will qualify for a deferred payment?

Consultation Question 05

Do you agree our criteria for determining who qualifies for a deferred payment should be? The criteria include people who would benefit from residential care and people with less than £23,250 in assets excluding their home.

Are there any examples of where greater flexibility might be necessary to ensure people do not have to sell their homes in their lifetime to pay for care?

Yes this seems sensible and ensures people who have other assets and income are not loaned money for fees that they could afford to pay from these other sources of income. There may be a need however for flexibility to allow councils discretion for exceptional circumstances and allow people with assets over the lower limit to make a deferred payment.

What fees can someone defer?

Consultation Question 06

Do you agree with the principle that local authorities should have the discretion to introduce reasonable safeguards to ensure deferred payment agreements can be repaid? If so how can this be done in a way to support people's choice of care home?

If the council has any reasonable grounds for concern that the debt might not be repaid then the council should not offer the deferred payment. Once an offer has been made there should be an assumption of trust and one that allows the deferred payment to enable the choice of home that the person makes and which they would have been able to pay for if the house had been sold. We would be interested to know if there are any figures which show the extent to which current deferred payments are not repaid and the reasons for this.

We would expect that the LAs have systems that deal with deferred payment requests quickly and which ensure the place a persons wants can be taken up without delay. In addition, on going payments

to the home should be prompt and payable within the expected standard time for invoice payment. We are finding that providers are suffering more and more from late payments of invoices by councils and CCGs currently. Finally any debts to providers for top ups for example need to be protected within the scheme.

How long can the deferred payment last?
Consultation Question 07
Do you agree local authorities should normally wait at least 3 months after someone has died before actively seeking repayment? Are there circumstances in which the Local Authority should wait longer?

This is a question for LAs to answer.

Wider flexibility to offer deferred payments
Consultation Question 08
Do you agree that local authorities should have additional flexibility to go beyond what they would normally cover and allow people to defer care charges to help them get the care they want in wider circumstances such as domiciliary care?

On the basis of equity and choice then yes.

Calculating what counts towards the cap
Consultation Question 09
Do you agree with the proposed principles for calculating the independent personal budget and personal budget? The principles are:

- To support the overall outcome of promoting a person's wellbeing
- Be equitable to everyone who accesses local authority support, no matter whether they pay for their own care, or where they live
- Ensure consistency in the outcome of the calculation of the costs of meeting a person's needs according to their individual circumstances as if the local authority was under a duty to meet them
- Be transparent over the calculation and the basis for it
- Where needs are being met by a carer, reflect the carer's ability and willingness to care
- And the impact of continuing to provide this support, and reflect what it may reasonably cost a local authority to meet a person's needs according to their particular circumstances.

Yes with the addition of a principle that a personal budget reflects the costs of local good quality provision and that this is assessed through a national respected costing tool such as the Laing and Buisson model. Choice will be restricted if there is not an understanding of what the budget can actually purchase locally. It would be open to challenge from the individual if such an assessment has not been made we would suggest.

The transparency over the calculation and the basis for it is essential and the lack of transparency has been open to legal challenge in the past and rightly so.

Recording progress towards the cap – the care account
Consultation Question 10
Do you agree that local authorities should have flexibility on providing annual updates where a person has not had care needs for many years, or they have already reached the cap? In what other circumstances should discretion be given?

Yes as this is an unnecessary burden on LAs however the LA should be responsive to a request for an update from an individual.

Providing redress and resolving complaints
Consultation Question 11
Do you agree that the following principles should underpin dispute resolution mechanisms? The principles are:
• To be clear and easy to understand, be locally accountable
• Be fair and effective and should therefore have public confidence
• Resolve issues in a timely, effective and cost-effective way
• Have an independent element; and promote local resolution, minimising the need for more formal challenge mechanisms which could be costly and time-consuming.

We support these principles and believe that they should apply to both individuals/families and any local care providers who wish to challenge how the system is operating locally. LAs have responsibilities to support the development of a local market that supports choice and where providers feel this requirement of the Act is not being met to have the means of challenging that. This is an extremely important point that needs to be addressed.

Call for Evidence
Staying independent for longer – planning and preventatives

Raising awareness - information and advice
Evidence Question 1
How can we raise awareness of how care and support works to help people financially plan for their care needs? What should this cover and who should be involved? What are the key points in a person's life where we should seek to provide this information?

Admission to a care home is clearly key and there should be a centrally agreed set of materials for individuals on how the system works that care homes, other local care providers, charities, GPs etc can distribute to people.

There should also be local third party brokers who can provide more detailed advice and assistance that builds on the central material produced. Advice and further discussion on options would be best provided independently of LAs and providers to ensure people get truly impartial evidence based advice.

There needs to be very clear central messages that inform the public of the facts that they will need to continue to pay for long term care unless their assets are below the lower cap and how they can obtain impartial independent advice.

Advice on financial planning and decisions
Evidence Question 2
In what circumstances is support required to help people with their financial decisions on how to pay for care? What information and support is needed to help them? How should local authorities work with other organisations to facilitate access to this information?

See answer to question above.

Encouraging people to plan to pay for their care and support
Evidence Question 3
We welcome views on how, through implementation of funding reform, we can encourage people to take responsibility for planning and preparing for future care and support. What could prevent people from taking responsibility for paying their contribution towards care costs? What can Government, local authorities or others do to address these?

The message on funding reform must be absolutely clear and honest. The actual use of the word 'cap' in relation to £72,000 of care costs is, we believe, misleading. The well documented gap between the fees paid by many LAs and the true cost of care in care homes (evidenced through national well researched costs of care tools) means that, to be sustainable, self funders will be charged fees that reflect true costs and as such will be forced to pay well in excess of £72,000 in care cost fee, as well as £12,000 annually in living costs, before they are eligible to a contribution to these care costs from the LA. Even at this stage the person will still have to pay a top up to the LA contribution.

There may be some people who do not wish to have a LA assessment and people should have the right to refuse an assessment. A national agreement framework on how such cases might be managed should be drawn up for LAs to use.

As average lengths of stay in care homes continue to shorten then many people might never reach the stage where the LA steps in with a contribution to their care costs. This message needs to given now and people must understand that they will be required, even with these reforms, to continue to pay for their care or towards their care, unless they have assets of less than the lower rate £27,000 for the purposes of charging. As we have mentioned people may not wish to be assessed and there is an argument to be made that people should be told in some circumstances it will not be worth them having an assessment – eg palliative care stays may be only weeks or months – and whilst some of these are CHC funded not all are.

A greater understanding of what good quality care costs and how that quality is independently determined in future by CQC, and what local councils generally pay for care, is necessary to set the context for better planning but also individual challenge within the system.

Information needs to be centrally prepared to ensure a consistent and clear message is given on the reforms and subsequent advice and support should be provided independently by local charities or brokers whose aim is solely to ensure people have an understanding of the local market, how they can seek good quality care and their right to challenge the allocation of an inadequate personal budget.

Assessment of the Care and Support you need

Accessing the cap on care costs – managing demand for assessments
Evidence Question 4
What flexibility should be given to local authorities in how they provide assessments of a person's needs to accommodate the introduction of the cap and meet demands on local authority resources? How can we ensure assessments still support wider aims to signpost people to types of care and support, reflect each person's preferences, and ensure safeguarding concerns are dealt with appropriately?

We suggest that in order to deal with the number of assessments there should be serious consideration to outsourcing to relevant organisations. This could include local providers following an agreed assessment tool. This would have particular relevance for existing residents of homes who would have staff undertaking the assessment who would be known to them and who would know their history and specific needs. Providers would need to be funded to undertake the assessments but the advantages of the ready and able capacity within providers and the reduction of stress for residents in dealing with familiar people should not be disregarded as an option. This would be carried out within a national framework of eligibility.

The ability of people to self-assess should also be explored. The use of web based self assessment with a checking of say 10% with a face to face assessment could be a way forward.

Removing barriers to integration of services – joint assessments
Evidence Question 5:

How through the implementation of the cap, deferred payments and the new charging regime can we support integrated health and care planning for both the person receiving care and carers? What potential barriers to integration could implementation of the cap or the charging framework create, and how might we reduce or overcome them?

The main barrier to integration is the lack of joint health and social care budgets. We set out our vision for integration in our Social Care Vision document last year. There are innovative approaches from care providers who of course already essentially effectively manage the care of people with long term conditions in integrated care settings.

We would seek reassurance as to how continuing care funding is integrated into these proposals particularly where people move in and out of CHC funding.

Ensuring individuals are able to access and benefit from these reforms
Evidence Question 6
Do you have any evidence on how we can best ensure everyone can access and benefit from these reforms? In particular, we would like to gather evidence on the protected characteristics of:

- Disability
- Age
- Sex
- Race
- Religion or belief
- Gender reassignment
- Sexual orientation and marriage and civil partnership
- Pregnancy and maternity.

In order to benefit from the reforms you must have the necessary independent information and advice and a range of good quality care and support services from which to choose.

Accessing support towards your care cost – the financial assessment
Evidence Question 7
What flexibility should be given to Local Authorities in how they provide financial assessments to accommodate the introduction of the cap, extended access to financial support and meet demands on Local Authority resources? How can we ensure financial assessments are proportionate yet still provide an accurate valuation of a person's assets?

This is in essence for LAs to answer but we would say that financial assessments be based on the principles of

Transparency
Equity
Be open to challenge and that any further financial advice be given by bodies better qualified and independent of LAs.

Paying for Care

Fairer and more consistent charging – the charging framework
Evidence Question 8
We welcome views on the potential advantages and disadvantages from a common approach to charging. In what areas could a common approach be taken in the charging rules across all care settings? In what areas would different approaches be needed to reflect the different circumstances of people who are receiving care and support in the range of care settings? Please explain your answer illustrating with evidence on the number of people who could be affected where possible.

Any charging system should be as fair as possible and not provide incentives for receipt of care in one setting as opposed to another but allow decisions on care settings to be made on the basis of personal choice and ability to meet need and wishes of the individual.

Requesting the local authority to arrange your care – the arrangement fee
Evidence Question 9
What are the administration costs associated with arrangement of care by a local authority, and which of these costs is it appropriate to pass on to the person requesting the arrangement of their care? We intend these charges should not apply where a person lacks capacity and has no one to act for them. Are there any other circumstances where local authorities should not charge an arrangement fee?

This is a question for LAs to answer in respect of their expected costs in arranging care for self funders. The LA should be able to provide evidence to back up their decision and for this to be made transparent to the self funder asking the LA to arrange their care at the very beginning of the process.

Evidence Question 10
What incentives could charging of an arrangement fee have on people receiving care and carers, Local Authorities or providers?

As a provider and any other local taxpayer the interest would be that the arrangement fee properly reflects the cost of the administration involved to the LA. Clarity is needed on whether this is a one-off or annual charge.

Fairer cap for working age adults – varying the level of cap for different ages
Evidence Question 11
What additional evidence can you provide on the ability of people of different ages to plan prepare and build up assets both before and after they develop eligible care needs?

We feel charities representing users of services would be best placed to answer this question.

Evidence Question 12
How could new charging rules work together with options for a lower cap to address problems faced by working age adults? Please explain how this would deliver the following principles:

- Ensure that people in similar circumstances (age, care needs, and financial assets) should make a similar contribution to their care costs. For example people who develop care needs at 44 and 46 years old should have a similar cap;
- Reflect the ability of people of different ages' to plan, prepare and build up savings to meet their care needs;
- Be simple for people to understand and feasible for local authorities to implement;
- Support integrated care and effective transitions between services helping people to have their needs met in the most appropriate care setting;
- Help people to live independent lives meeting their goals and aspirations;
- Ensure any reforms are sustainable in the long term
- And ensure that the overall costs of the reforms are unchanged.

See above Question 11

Evidence Question 13
What factors should determine the age it is appropriate for people to begin to contribute towards the cost of meeting their eligible needs? What factors should determine how the cap on care costs should rise after this point?

We have no comment to make.

Evidence Question 14
How should the cap on care costs be set for people whose eligible needs are initially met by services other than adult care and support? Please explain your answer.

We have no comment to make.

Universal deferred payment agreements – 12 week property disregard
Evidence Question 15
How could the 12 week disregard be used to better support people to make decisions and practical arrangements about their care and finances?

This can give time for independent advice to be arranged for individuals.

Who will qualify for a deferred payment?
Evidence Question 16
What situations may make it more challenging to offer a deferred payment? How can we address such situations to ensure people have consistent access to deferred payments without putting the local authority at unfair financial risk?

Clearly there may be concerns that an individual or their family will not for whatever reason maintain the house in good repair and the value falls below that which would be necessary, upon sale, to clear the deferred payment debt with interest.

Any economic situation that means house prices are falling which could have the same effect as above.

This is in essence an issue for LAs to address with government. The issues for providers are as mentioned previously that the scheme allows people choice in accordance with the known value of their house; arrangements are made speedily to ensure any placement of the persons choice is secured; and that individuals seek independent financial advice.

Use of disposable income
Evidence Question 17
Should people be free to decide the proportion of their care costs met by their income and how much is deferred? Or should they be required to pay their care costs from income (leaving only an allowance to cover personal and household costs) and defer the remaining balance?

Should people who are essentially still self- funders not be able to use their assets as they wish and use any combination of house value and other asset/income as they wish? Would setting too many rules around this not create more administration and cost to the LA?

Evidence Question 18
If you think people with significant disposable income should contribute some of their income towards their care fees, then what types of personal and household expense should be taken into account before determining the income contribution?

See above

Support for homeowners
Evidence Question 19
How could local areas develop support for homeowners to maintain, sell or rent their home? Are there examples of good practice that already exist? How could support innovation in this area in the future? What is the likely impact of deferred payments on housing more generally?

We are not in a position to offer any evidence on this.

Information and advice
Evidence Question 20
What information do people need when they take out a deferred payment?

- *Any maximum amount that will be loaned*
- *The interest rate on the deferred payment*
- *Where they can seek independent financial advice*
- *What action they need to take with respect to maintaining the value of their home*
- *Will there be a length limit on the payment*
- *What happens if they want to move care home during the period of the payment*
- *How quickly can the payment be arranged and what information do they need to supply*

Ensuring deferred payments are financially sustainable
Evidence Question 21
What are the administration costs associated with offering a deferred payment, and which of these costs is it appropriate to pass on to the resident?

This is a question for LAs to answer.

Alternative approaches to recovering local authority costs
Evidence Question 22
What alternative approaches would still allow authorities to recover their costs, for example based upon approaches from Islamic finance?

This is a question for LAs to answer.

Local Authority processes for setting up deferred payments
Evidence Question 23
How well do current Local Authority processes for deferred payments currently work and what could improve?

This is a question for LAs to answer but it is an important question and the new scheme should be set up using the experience gained by LAs operating the scheme currently.

Wider flexibility to defer payment

Evidence Question 24
If you agree that local authorities should have additional flexibility to defer care charges, what situations would these powers help with? Are there any factors local authorities would need to take into account to ensure fairness and to avoid excessive costs? Please provide detail of how the deferred payment would work in practice.

This is for LAs to answer but we would be pleased to comment on any proposals for additional flexibility.

Improved options for those who pay for their care
Evidence Question 25
What financial solutions will be important in helping different groups pay for their care? What are the priorities in terms of supporting the market to develop?

Financial solutions must recognise the real cost of providing good quality care and ensure choice between service types and settings.

Meeting your eligible needs

Measuring what counts towards the cap – the personal budget
Evidence Question 26
What additional information should be included in a personal budget or independent personal budget to accommodate these reforms, provide greater transparency and support planning?

The personal budget should take account of a person's preference and be clear whether the individual will have the ability to top up should they wish. The rules around Choice and topping up as currently set out in the Choice Directive which should be preserved as far as possible and the DH should ensure this guidance is implemented.

Calculating what counts towards the cap
Evidence Question 27
What sort of information does a local authority need to calculate an independent personal budget that they might not get through an assessment?

Costs of local good quality services.

Evidence Question 28
How should we build on the common principles for resource allocation systems (covering five areas: equity, people with high support needs, future-proofing, unpaid care and support, needs of carers), existing good practice and guidance to ensure consistency, equity and transparency in the setting of independent personal budgets? How should this be reflected in the requirements for local authority information systems?

The current principles omit knowledge of cost of good quality local services so that budgets are based in reality.

We would be interested to see what current good practice exist on RASs and what criteria has determined they are examples of good practice

LAs will be open to legal challenge if they do not set out clearly how the budget has been determined and the rationale for the decisions.

LA information systems should reflect customer feedback on PBs and how the PB has helped to meet a person's choice, care needs and life aspirations.

Reviewing needs and budgets as circumstances change
Evidence Question 29
How can we ensure a proportionate approach to reviews so personal budgets and independent personal budgets record the costs of meeting a person's needs as circumstances change?

There will be a role for providers here but it must be a role that is agreed between the LA and the provider and funded as appropriate. We would expect the lead responsibility to be that of the council but would like clarity as to the expectations and liabilities on providers in the process of providers prompting and undertaking reviews.

Recording progress towards the cap – the care account
Evidence Question 30
We welcome views on whether the annual care account statement should also include projections of when a person may reach a cap, or qualify for financial support, and how this can be provided without putting Local Authorities at risk of unfair challenge.
How would this support a person's planning? What impact would this have on the complexity of Local

Authority systems needed to operate the care account? How can Local Authorities reduce the risk of challenge?

Many financial products give forward projections and the basis for these assumptions and there should be no reason why such projections could not be built into a care account.

Who is responsible for your cap or deferred payment – ordinary residence
Evidence Question 31
We welcome views on what incentives the cap on care costs and deferred payment arrangements in combination with ordinary residence rules may create for individuals, or local authorities, and how the number of transfers between local authorities may change as a result.

We feel LAs would be best able to answer this question.

Evidence Question 32
We welcome views on how we can support Local Authorities understand who is responsible for the person's care account and deferred payment agreements.

We have no comment to make.

Providing redress and resolving complaints
Evidence Question 33
Given the reforms to the care and support funding system do you consider that existing processes to provide redress and resolve complaints are appropriate and accessible? Please explain your answer.

Yes but there needs to be the ability for individuals and providers to complain and the latter seems to have resorted to Judicial Reviews to resolve disputes and there must be other ways of ensuring the cost and time spent in such exercises is better spent. We believe more central direction is needed alongside a strong role for CQC oversight of council commissioning.

Evidence Question 34
Do you agree that a tribunal system would be likely to slow down the process of resolving complaints and add significant costs, introducing a further burden on the system? Please give evidence to support your answer.

A tribunal system can bring in an important third party perspective to resolving complaints. In a House of Lords debate conducted on Monday 14 October 2013, reference was made to the advantages of a tribunal model.

*"**Lord Warner**: The whole point about a tribunal system is that you build up case law, so you spread consistency across the country through the case law that individual tribunals have made. Without that structure of a tribunal system I suggest that it is very difficult to achieve the objective that the noble and learned Lord is seeking.*

Evidence Question 35
Are there any lessons that can usefully be drawn from complaints processes in other sectors or local areas? Please provide evidence of approaches in other sectors that you believe would be more effective.

We would be happy to share experience of provider complaints procedures but this would need to be organised as separate exercise as we do not have the time or capacity to organise to fit in with the timetable of this consultation.

Evidence Question 36
Do you have a view on the strengths and weaknesses of applying a similar mechanism to the schools admissions code appeals process to adult care and support?

See our comment at 4.8 above.

Transition to local support
Evidence Question 37
How should the transition for people who have been arranging their own care and support be managed most effectively? How should the key requirements placed on local authorities - care and support plans, personal budgets, direct payments, right to a choice of accommodation - be used proportionately to support this process?

Once a self-funder reaches the cap and the LA meets a core component of the care cost, we would expect that the self-funder to remain as the paying customer, with the LA making a payment directly to the resident. We believe this would be the most straightforward and efficient way for the transition to be undertaken.

The additional responsibility of organising top ups is also likely to feature here for reasons already mentioned. If there is any possibility of a person having to move to new accommodation we expect, as now, that this is based on a proper assessment of need including the risk and distress that any move might cause.

When the cap on care costs is reached

Personal choice and control over care – additional payments ("top-ups")
Evidence Question 38
The provision of financial advice on paying for care will help manage some of the risks to local authorities, care and support providers and the adult from greater flexibility over the use of top ups to pay for types of care and support. What more could be done to support people and LAs to help ensure top ups are used appropriately and to manage these risks in a way that is consistent with allowing people choice over their care and support?

The wording of the question is a bit confusing implying greater flexibility is a risk?
The fact is that top ups are now an essential part of ensuring care is viably funded in many care homes. Recent reports have shown the growing role of top ups and this reality needs to be faced and addressed through sustainable funding for providers. There needs to be a continuation of the current rules around top ups which are very clearly spelt out for LAs, providers and individuals in the Choice Directive. Ensuring top ups are properly implemented in line with the current Choice Directive should be the starting point.

The Independent Age reports shows disturbingly that councils are still not following the requirements of the directive making this whole issue more of a problem and more risky than it should be. However if LAs paid the appropriate amount for care homes then top ups would just be necessary for extras as clearly set out by the provider and there would not be a need to ask this question at all.

Transition to the introduction of the cap
Evidence Question 39
We welcome examples of needs assessment practice from elsewhere and what we can learn from them to help manage the demands on local authorities from the introduction of the cap on care costs.

Providers undertake assessments and if there is more information from providers that would be helpful then we can request that from members.

Evidence Question 40
We welcome views on how the Government, working in collaboration with local and national partners, can best encourage people who arrange their own care and support to come forward for an assessment prior to April 2016.

National advertising and a clear set of publication materials that can be used in care homes, GP practices and many other care settings will be helpful.

We would be happy to comment on any communication plan in due course.

Implementation Questions

Transition to the introduction of the cap
Implementation Question 1
Do you agree local authorities should conduct assessments of people who are funding their own care and support up to 6 months before the introduction of the cap on care costs?

This makes sense if LAs think it is possible. But as previously suggested outsourcing the undertaking of assessments could make sense and reduce the need to do them quite as far in advance which is risky should needs change and an assessment has to be undertaken twice.

Implementation Question 2
How could local authorities use reviews they have planned with individuals throughout 2015 to prepare for introduction of the cap on care costs in 2016?

Through the provision of centrally prepared information on the changes and informing people how they can get independent advice.

Workforce development
Implementation Question 3
We welcome views on the implications for commissioners and workforce leads from the potential use of partners' resources to help manage the demands on local authorities from the introduction of the cap on care costs and how this should be addressed within the workforce development strand of the implementation programme.

Providers could take a role in the undertaking of assessments and will certainly be key in giving information materials to residents and prospective residents.

Market shaping and oversight
Implementation Question 4
We welcome views on how local authority commissioning and care and support provider provision should adapt to take advantage of the opportunities provided by the introduction of funding reform and respond to the challenges it may present.

The points have been raised in the introduction and in answering the above questions. We would only add that this is an iterative process and we believe the engagement with providers must be genuine and on-going leading up to and beyond 2016. We will of course be happy to facilitate this process. Just as the DH has set up national working groups there will be a need for similar dialogue locally. The Social Care Partnership in Lancashire is a model for such a discussion.

Implementation Question 5
We welcome views on how funding reform and increased transparency will affect the shape of local markets for types of care and support, and evidence to understand how the demands on local authorities to arrange care on behalf of people who arrange their own care and support may change.

The evidence is in the current documents/report detailing the difference in current LA fee rates paid to care homes and the actual costs of care. If that gap cannot be made up by top ups or self funders meeting the true costs of care then homes will no longer be viable. If councils do not, through these reforms, better understand and pay the actual costs of care as evidenced by national respected costing tools such as Laing and Buisson, then homes will have no choice but to close or to refuse admissions on LA contract rates and people will have reduced choice unless they contract with the care home directly.

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ECCA

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