London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date: **Thursday 16th October 2014**

Report Title: **CARE ACT IMPACT**

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1. SUMMARY

1.1 The Care Act received Royal Assent in May 2014. Its provisions commence on 1 April 2015 and 1 April 2016 (for charging reforms). The law modernises the statutory framework for adult social care, updating and replacing many preceding statutes and bringing into primary legislation much of existing best practice. This report presents an initial financial model of the impact of the Care Act alongside the key assumptions underpinning this model.

1.2 This report has been scrutinised by the Care Services Policy Development and Scrutiny Committee (October 2014, Item 8c).

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1 It is important for the Health and Wellbeing Board to have full awareness of the impact of the Care Act and the changes it brings to adult social care.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1 The Board is requested to note and comment on the initial financial model.

3.2 The Council's Care Act Programme is leading on implementing the changes required by the Care Act.

3.3 The proposed schemes for the Better Care Fund have been designed in a way to complement delivery of the principles and the duties of the Care Act.

Health & Wellbeing Strategy

1. Related priority: Not applicable

Financial

1. Cost of proposal: £192k net cost projected in 2015/16

2. Ongoing costs: £4-5m gross costs 2016/17 to 2018/19; up to £12m gross cost in 2020/21

3. Total savings (if applicable):

4. Budget host organisation:

5. Source of funding: Central government revenue grant to the Council; the Better Care Fund

6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicator(s)

n/a

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4. COMMENTARY

4.1 The Care Act was passed in May 2014. The law modernises the statutory framework for adult social care, updating and replacing most preceding statutes and bringing into primary legislation much of existing best practice. This modernised adult social care system focuses on the principle of well-being for individuals with care needs and also for carers, and emphasises the prevention and delay of needs for support. Alongside these practice elements, the Act introduces a number of financial and charging reforms including the Cap on Care Costs, 'care cap'. The key changes introduced by the Care Act were outlined in the report to the Council Executive in November 2013.

4.2 Draft Regulations and Statutory Guidance were published on 6 June, with a consultation period lasting until 15 August. The Regulations and Guidance are due to be released in final form in October 2014. Consultation on regulations and guidance for the financial reforms including the care cap is due in December 2014.

4.3 The non-financial provisions will commence on 1 April 2015 and most of the financial reforms commence on 1 April 2016.

4.4 The Care Act imposes a number of changes required for compliance that have financial implications for local authorities; these form the focus of this report. But, more broadly, it also incorporates many important principles that align with Building a Better Bromley and the Health and Wellbeing Strategy, such as prevention, enabling individuals to retain as much responsibility as possible and prioritising support by an individual's family, friends and local community. These are highlighted in the general duties on local authorities, Clauses 1 to 7 in the Care Act. Officers will explore opportunities to access funding to further embed these principles in order to enhance the social care offer care locally, including, where appropriate, working jointly with Bromley Clinical Commissioning Group partners through the Better Care Fund. Doing so offers the prospect of transformational change - aligned with the Care Act - delivering demand management from long-term state-funded care to short term interventions and low-level support in the community. This report focuses on the anticipated costs arising from delivering compliance; comprehensive delivery of these principles may entail higher costs than are outlined within this paper which takes a 'de minimis' standpoint as a starting point for the Board's understanding of the financial situation.

4.5 **Funding**

4.5.1 Central Government in Spending Round 2013 pledged to fund all new costs arising from the Care Act. In 2014/15 £125k of funding was received in order to establish a programme to deliver the Care Act. Central Government has allocated funding for 2015/16 of £1.885m from formula grant and a nominal £750k has been provisionally agreed locally from Better Care Funding, subject to confirmation by NHS England. The Government, as part of the spending review 2013, announced additional national funding of £1bn from 2016/17 towards the cost of the Care Act but the Department of Health is working together with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) and the sector to establish an accurate projection of the ongoing costs arising in order to provide sufficient funding.

4.5.2 The Council Executive has authorised £266k to fund pre- 1 April 2015 implementation costs.

4.6 **Care Act Programme**

The Council's ECHS (Education, Care and Health Services) Department set up a Care Act Programme to make the preparations required for implementation of the Act. Work has been completed over the past months to review the requirements of the Act and to understand the changes required in order for adult social services to be at least compliant. This Programme has improved the Council's understanding of the Act and previous best projections of costs that were based on preliminary national and London Councils estimations.

Financial Model

4.7 **Financial Model: Introduction**

4.7.1 As part of this Programme of work a detailed financial model of the estimated costs which are identifiable at this stage has been created by London Borough of Bromley officers and this is presented in this report.

4.7.2 As stated in 4.4, the model reflects a 'de minimis' reading of the impacts of the Care Act and comprehensive delivery of the principles enshrined in the general duties may require additional resources.

4.7.3 It is important to note that projecting the financial impact of the Care Act is a difficult task. A number of models have been produced over the summer by Surrey, Lincolnshire, Birmingham, Barnet and other councils. The number of variant models reflects the complexity of the number of elements involved. In the Bromley model there are approximately 50 assumptions made, and some of which have to be projected several years ahead. Where the Bromley model estimates volumes and behaviours this has been based on the experience of officers and on national and local data where this is available. Therefore whilst this is an informed model, it is complicated and small variances in estimations have the potential to compound to create significant variations in the overall financial projections. The assumptions will need to be tested and refined as the various elements of the Act are implemented.

4.7.4 The Bromley model identifies cost pressures arising from four main areas:

- **The Care Cap and Cared-for Assessments:** The financial reforms create a significant incentive, beginning in October 2015, for people with care needs to request and receive a care assessment.

- **Carer Assessments:** Under current legislation a carer only has a right to an assessment if they carry out a substantial caring role regularly; under the Care Act there is an unqualified right for carers to request and receive an assessment.

- **Carer Support/Services:** Carers have a right under the Care Act to receive sufficient support to offset identified unmet significant risks to well-being. Currently councils have discretion about meeting carer needs.

- **The Care Cap:** Individuals assessed by the Local Authority as having eligible needs will have a 'care account' that meters the amount that it would cost the local authority to meet those eligible care needs, excluding 'hotel costs' and 'top-ups'. An individual will no longer be required to contribute towards their eligible care and support costs once the care account reaches the 'cap', initially set at £72,000 and

rising with inflation. All accounts will start at £0 on 1 April 2016. A 'tiered cap' will be introduced for adults of working age (when an eligible care need is first identified); it is expected that a cap of £0 will exist for under 40s. Details on all these matters are due to be made public in December 2014 draft regulations and guidance.

The care cap will result in an immediate loss of client contribution income from working age adults and will, in time, create significant lost income from older adults who stay in care long enough to reach the cap.

4.7.5 The main results of the four areas above are that the Council will require additional assessment workforce, an improved service offer will be needed for an expanded number of carers, and income will be foregone as a result of the change to charging rules.

4.7.6 In addition, there are a number of smaller scale service changes that are required to deliver the modernised system of care, which include: improved access to advocacy, an IT system for care accounts, improved information (web-based) for individuals, and improved processes around support planning and personal budgets. A number of projects are in place under the Care Act Programme in order to make progress in all these areas. This also includes training provision for the Care Services workforce alongside significant revision to practice guidance, policies and procedure since it is vital to delivering compliance that adult social services staff understand the provisions of the legislation and the underlying principles.

4.7.7 Detailed projections in all areas have been made for four years, 2015/16 to 2018/19 inclusive. The Care Cap impact has been projected beyond this.

4.8 Financial Model: Key Assumptions

The Care Cap and Cared-for Assessments

4.8.1 There are estimated to be 858 self-funders in care homes in the borough (239 in residential and 619 in nursing). It has been assumed that 25% of these will not request an assessment despite the care cap. It is assumed that there are 1,795 self-funders in domiciliary care and other care-related support in the community, and it has been assumed that 20% of these will not request an assessment despite the care cap. The planning assumption is that ECHS will need to undertake 40% of the one-off cap assessment burden between October 2015 and March 2016, and the remaining 60% between April 2016 and September 2016. The total number of additional care assessments for self-funder service users is 719 in 2015/16 rising to slightly over 2,000 thereafter. There is no long-term services cost pressure for self-funders but it has been assumed that some of these self-funders will benefit from reablement and minor equipment which are prohibited by law from being charged for.

Carer Assessments

4.8.2 It has been assumed that the number of carers receiving assessment will rise as a ratio to the number of service users known to the Council. The model uses a figure derived from a local sample as a starting point, applying this also to carers of self-funders. Several assumptions have been made to refine this further. Firstly, it is assumed that only 75% of the effect will take place in 2015/16 following the change in the law on 1 April 2015, with 100% thereafter as culture and communication take effect. Secondly, with knowledge of the past decade, the model assumes that carer requests for assessment will depend on the charging regime, and that carers are unlikely to want to be assessed if the result is that they have to pay the full cost of any support regardless. For the reasons above it is assumed that there will be an extra 1,722 carer assessments in 2015/16 increasing to 2,159 extra in 2018/19, over current levels (1,130 per year).

Carer Support/Services

4.8.3 Estimations are made about the form that carer support might take following assessment, including discounting a small number for being ineligible or best suited to a support that has no cost to the Council. The current ratio between low-level telephone support / group access and higher level respite-equivalent support is expected to move slightly towards the higher level, recognising that the Act introduces a duty on a local authority to offset unmet risks to carer well-being and this is likely to require a higher level of intervention in a higher proportion of cases. For the same reason, it is assumed that additional funding for lower level support is required.

The Care Cap

4.8.4 Based on current Bromley rates the average time spent in a Bromley residential care home before reaching the cap (£72,000) is 4.2 years and for a Bromley nursing home is 3.5 years. Unless someone in domiciliary care is receiving a package costing more than £138 per week it will take at least 10 years to reach the care cap. The model projects the numbers reaching the cap in both care homes and the community, for those already known and those unknown.

Potential Other Costs

4.8.5 A number of service changes are referred to under 4.7.6 as being required for compliance with the Act. These elements and others have been provisionally costed as part of the model, however, further work will be required to set out rigorous cost-effective proposals in these areas. As set out under 4.4, the Board should also be mindful that delivery of the wider principles of the Act may require further improvements outside of the elements identified in this report.

4.9 **Financial Model: Net Cost Pressure**

4.9.1 The table below summarises the net financial implications to the Council in 2015/16 and the estimated impact from 2016/17. A detailed summary page of the financial model is included as Appendix 1.

		2015/16 (£'000s)	2016/17 (£'000s)	2017/18 (£'000s)	2018/19 (£'000s)
Total estimated cost		2,826	4,579	4,176	4,505
Funding	Grant	-1,885	-3,500	-3500	-3500
	Better Care Fund	-750	-750	-750	-750
NET COST*		192	329	-74	255

* Officers have identified scenarios where the actual costs could be lower but the costings identified represent the most realistic assumptions at this stage.

4.9.2 As can be seen from the summary, the model suggests that funding will not be sufficient to cover the cost impact of the Care Act in 2015/16 and that there will be a loss implication estimated at £192k. The gross costs for impacts of the Care Act are estimated to be less than £5m per year over the next four years. From 2019/20 older people in care homes reaching the cap adds a significant additional cost. This extra cost is £8m in the peak year of 2020/21, falling to slightly over £6m in years thereafter. Therefore the maximum total gross cost pressure from the Care Act is projected to be £12m in 2020/21.

4.9.3 For 2015/16 the Council will receive £1.885m in specific grant; local nominal agreement for £750k funding from the Better Care Fund is still subject to confirmation from NHS England.

4.9.4 The above model assumes continuation of funding of £750k from the Better Care Fund. In addition the model includes estimated annual funding of £3.5m in Government Grant from 2016/17 because the Government, as part of the spending review 2013, announced additional national funding of £1bn from 2016/17 towards the cost of the Care Act.

4.9.5 There is expected to be a consultation paper in the Autumn providing details of the allocation of funding for 2016/17 (the current social care formulas used to apply funding are expected to change). No allocations, even provisional, have been provided to local authorities at this stage (but £3.5m has been assumed for the purposes of the model and this report) which provides a degree of uncertainty and inherent risks. Any estimates of funding must be treated with extreme caution until final allocations are confirmed in December 2015; the report highlights broad costings and funding which must be treated with caution at this stage (see para 4.7.3.)

4.9.6 To highlight the uncertainty of costs the Care Act Regulations and Guidance are not yet finalised and both London Councils and the LGA have identified a lack of adequate Government funding which could jeopardise reforms.

4.9.7 Officers will continue to update the projections when more information is available.

4.10 **Risks**

4.10.1 The Care Act has been modelled as not having any effect on the cost of service provision to service users (except for the Cap), however, as noted in London ADASS' response to

the draft regulations and guidance consultation, testing of new eligibility wording has suggested that 15-25% more people may be found eligible. This presents initially as a major risk, although due to the low level of service cost it seems likely that the main component of cost would be from an assessment burden, and local interim estimations assess this total risk to be no more than £200k annually. However, it has not been included within the modelling and within the balance because it is a recognised issue under review by the Department of Health and ADASS and the Government have indicated that the final wording issued in October 2014 will be set at the equivalent of Fairer Access to Care Services 'Substantial' banding, meaning a zero cost impact. ECHS will monitor this risk.

4.10.2 The procedure for care accounts gives greater visibility of the price for care paid by the local authority. This creates the possibility that the disparity between the prices paid by private and public purchasers of care will reduce thereby creating risks around market sustainability and/or the costs paid by the local authority for care.

4.10.3 As recognised in this model, the Care Act introduces a significant increased assessment and care management burden for councils. The spike in demand for staffing may lead to higher staff costs or possibly a lack of workforce supply leading to recruitment problems and difficulties in delivering the new duties of the legislation.

4.10.4 Whilst the model presented in this paper represents a significant improvement in the Council's understandings of the impact of the Act, the number of assumptions made, the complexity of the projections, and the lack of rigorous evidence in some areas means that there is a risk that the modelling may not reflect the realities. Officers will ensure that the Bromley model is cross-checked with models available nationally as these continue to develop over the next few months.

4.11 **Policy summary**

4.11.1 The Care Act replaces over 60 years of piecemeal legislation in adult social care dating back to the 1948 National Assistance Act. The majority of laws passed in that time are repealed and incorporated within the single codified Care Act (2014) including the Chronically Sick and Disabled Persons Act (1970) and the NHS and Community Care Act (1990). A large number of Regulations and Statutory Guidance are also replaced, including the current foundation of eligibility, the Fairer Access to Care Services (FACS) criteria guidance. This is fulfilment of the Law Commission's review of adult social care.

4.11.2 The Care Act incorporates the key national policy themes of the last decade including personalisation and choice and control, support for carers, care markets, integration with the NHS and other partners, prevention, and improved information and advice. Some commentators have noted the significance of the switch to the 'well-being' foundation of the Act rather than the 'independence' foundation of Fairer Access to Care Services. The Government's policy intentions for the sector were set out in the White Paper, *Caring for Our Future: reforming care and support* (2012).

4.11.3 The introduction of financial reforms in the Act is a response to the Dilnot Commission on the Funding of Care and Support. The Government has recognised the catastrophic care costs faced by some individuals and the measures including the Care Cap are designed to reduce this burden on individuals.

5. FINANCIAL IMPLICATIONS

5.1 The financial implications are contained within the body of the report and in Appendix 1.

6. LEGAL IMPLICATIONS

6.1 The changes in the law have been set out under 4.11.

6.2 It should be noted that the regulations and statutory guidance are currently only in draft form. These amount to some 750 pages, setting out in considerable detail the requirements behind the duties in the primary legislation. Officers planning the preparation and implementation of changes for the Act have been working on the basis of the draft documents but until these are released in final form (due October 2014, and subject to Parliamentary scrutiny) there is still a small degree of uncertainty.

6.3 The financial processes introduced in 1 April 2016 has the potential to lead to an increased number of challenges and appeals where, for example, a self-funder disagrees with the rate set for their care account following assessment. As yet, the primary legislation only includes a placeholder clause (s.72) for appeals and it will be important to monitor this aspect as and when the Government issues and consults on its proposals in this area

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

7.1 As a leader of integrated working, the Health and Wellbeing Board should note that the Care Act sections 6 and 7 introduce a new explicit duty of co-operation in exercising duties around individuals with care and support and their carer. This is a duty on local authorities to work with other agencies, and a reciprocal duty on other agencies to co-operate with local authorities.

7.2 The Board should note that the Department of Health's publicised intention is to make no substantive change to the boundary between National Health Service responsibilities and social services responsibilities.

7.3 The Board should continue to support the Better Care Fund schemes in ensuring that outcomes and system improvements are delivered in line with the principles of the Care Act, such as the importance of person-centred ways of working and the emphasis on prevention.

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

The Care Act puts principles into statute that have long been a part of effective social work. Local authorities are required to carry out their care and support functions with the aim of integrating services with those provided by the NHS and any other related service (such as housing), which aligns with planned changes under the Better Care Fund. There is arguably more scope for

joined-up thinking and learning between social workers, occupational therapists and others in different service areas to encourage a whole systems approach. This, and the principle of assessments and services focused on wellbeing, means holistic consideration of individuals' situations and the creation of person-centred responses, recognising both their needs and also their abilities, preferences and personal 'circles of support' which may increase effective prevention and improved long-term health and which may also reduce state-funded intervention.

The Care Act undoubtedly will have a quantitative impact for adult social care, with larger numbers of carers and self-funders requesting assessment. This paper sets out the current assumptions that have been made based upon which further preparations for implementation will take place over the next 6 months before the Act takes effect in April 2015.

Non-Applicable Sections:	None
Background Documents: (Access via Contact Officer)	Care Act Impact - [no reference number] Care Services PDS 2 October 2014 Adult Social Care – Impact of the Care Bill and Future NHS Funding. Report CS13049 Executive 20 November 2013 Care Act, May 2014 Draft Regulations, and Draft Statutory Guidance, June 2014 Caring for Our Future: reforming care and support (2012)