NCF response to consultation on draft operational guidance to implement a lifetime cap on care costs 31.3.22

Introduction

At the beginning of March, DHSC published a consultation on its proposed operational guidance to implement a lifetime cap on care costs. While the consultation is geared towards Local Authorities, we have chosen to submit a written response in order to represent the voice of social care providers who will also be impacted by the implementation of this policy. The content of our response has been informed by a workshop held with our membership on 17.3.2022.

The implementation of a cap on care costs is one part of a much bigger set of reforms and is dependent upon the reforms, particularly a fair price for care, being adequately resourced. Our members have raised a number of concerns to do with the operational guidance relating to the substance of the policy in some parts, and the clarity of the intention in others. Below we have grouped their concerns around a number of the key elements of the policy. One overarching concern is the interdependency of these charging reforms and the fair cost of care exercises which appear to have been pre-decided with £1.4bn set aside.

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What is the National Care Forum?

The National Care Forum brings together 160 of the UK's leading social care organisations, representing large numbers of care providers, offering thousands of services across the country, which are not-for-profit and always at the heart of community provision. Collectively, these organisations deliver more than £2.3 billion of social care support to more than 220,000 people in over 8,200 settings. The NCF membership body collectively employs more than 117,000 colleagues.

The Cap: Personal Budgets, Independent Personal Budgets, Care Accounts

The operational guidance sets out how progress towards the £86,000 cap on care costs is to be measured. Briefly, our understanding is that where a person's eligible needs are met by the Local Authority, they will receive a Personal Budget (PB) which sets out the costs that count towards the cap – the proportion the individual pays themselves, rather than the state (depending on legislative approval of changes to Care Act 2014). Where a person fully funds and arranges their own care, they will receive an Independent Personal Budget (IPB). The IPB sets out the costs which count towards the cap – these are the cost it would have been to the LA if the LA arranged and paid for the care, meaning it might be different from what the self-funder actually pays. Any eligible needs paid for by other legislation, top-ups and daily living costs (more below) do not count towards the cap. All individuals who want to progress towards the cap need to have had their needs assessed as being eligible by the Local Authority. The information from the PB and IPB is used to keep the Care Accounts up to date which keep track of an individual's progress towards the cap, with regular statements given to the individual.

Our members have raised a number of comments about the above.

1. Given the current pressures on LAs capacity and resources, how will the government ensure that LAs are able to handle the complexity of the new administrative arrangements to keep timely and accurate records for people? Similarly, the implications of this policy means that a lot more people will require needs assessments than in the past – these are already backlogged. The operational guidance suggests that 'Trusted Assessors' might be able to add some capacity but the experience of providers historically is that LAs may be reluctant to trust providers or external partners with this responsibility. What can the government do to put more capacity into the system so that ordinary people can benefit?
2. How will the government ensure that the policy is communicated to ordinary people? The government needs to ensure that current self-funders, and future self-funders, are aware that they need to be assessed for eligible need. People's rights need to be made very clear, as does the way policy will work in practice for them when they need to call upon it. It is reasonable to expect that people's expectations will be high, given that the government has grasped the social care reform challenge – how will the communications on the limits of this policy be communicated so that people's expectations be managed in practice?
3. We think there will need to be a separate complaints process than that of the Local Government and Social Care Ombudsman or internal LA complaints' processes. The Ombudsman process in particular, is simply not fast enough to deal with concerns and complaints about the way the LA is recording progress towards the cap on care costs or arranging care.
4. There is a grey area over how the LA is expected to set the IPB. The operational guidance states that the LA does not need to undertake a full care and support plan in the process of setting an IPB. If the LA does not undertake the full care and support plan, how can they understand the eligible needs of a self-funder, and therefore the cost of their eligible needs which count towards the cap on care costs?
5. There is a very real danger that continuing pressure on the entire system, including lack of resources, staff and capacity in LAs, will result in eligibility requirements becoming stricter in practice and people finding it harder to access care and support which counts towards the cap. The government must ensure that these changes are backed by the funding required. The County Councils Network has already flagged the shortfall in the amount of money the Treasury has been willing to allocate to the charging and fair price of care reforms. Their report estimates that the government is underestimating the cost of its proposals by at least £854m a year for care homes alone.

Section 18(3)

This was one of the biggest areas of concern for our members who run care home services. The operational guidance expands Section 18(3) of the Care Act 2014 across all social care services. It is our understanding that the extension of Section 18(3) will allow all self-funders to have their eligible care and support needs met by the LA at the price the LA would pay. In doing so, the self-funder would be given a PB rather than an IPB.

Our understanding is that the policy intention behind this is to equalise the amount of money self-funders and the state are paying their care and support in order to bring more fairness to individuals. The key issue raised by members is one of transitional risk:

1. Our members are concerned that not enough money is being provided to ensure a stable transition away from the current cross subsidy arrangements between self-funders and the state. Currently the transition will happen in one go in October 2023 but the money in the current spending review doesn't enable LAs to move swiftly enough to the fair price for care needed to make this happen. We would suggest either a faster move towards a fair price for care so it is in place by October 2023 or the need for a more pragmatic, staged introduction of section 18(3) if we are to ensure it works.
2. The government appears to have made an assumption that not every self-funder will want to use Section 18(3) but this is still an unknown, and a risk to providers particularly if more than anticipated ask the LA to arrange their care and support and a fair price for care is not yet realised. We need to use the Trailblazers to get a real sense of how many self-funders are likely to take up Section 18(3) and then review the timings of the introductions of the policy and the pace of the move towards the fair price for care.
3. As an amount of money has already been set for a fair price for care (£1.4bn), there is widespread concern amongst providers that the Fair Price for Care exercises, and the Capacity Tracker Survey of fee rates, will be constrained to that cost envelope even if the reality is that it needs to above £1.4bn, and will simply formalise the underfunding that is already baked into those LA fee rates. This would make charging reforms unsustainable.
4. There is a significant risk: Will people choose not to have care and support until their need is assessed as eligible and it starts to count towards the cap? How can we work to prevent this and invest in prevention services that people want to use? There is a risk that eligibility requirements will become narrower due to pressures on resources in LAs, and if this happens, we may see more and more people with increasingly higher levels of need waiting until they are assessed as having eligible care needs. We need to ensure these reforms are funded properly to avoid this.

In short, providers understand that the focus of charging reform is about a achieving a fair deal between the individual and the state, but they are concerned that this policy risks undermining the sustainability of the sector rather than achieving the long-term stability that is needed to give people the care and support they need, when they need it. Since there is no end date for achieving the fair price for care, the policy also risks an undefined period of transition (which could be a number of years) where the direct impact of the policy to actually reduce the amount of money within the social care system to meet people's needs, rather than increase it, despite the increase in National Insurance.

Daily Living Costs and Top Ups

The term Daily Living Costs (DLCs) has greatly confused social care providers of care homes. The examples in the operational guidance and previous policy papers are unclear. We are confident that the government does not intend to imply that providers must charge around £200 per week for the costs of accommodation and other non-care parts of a care and support package, however, the current phrasing could imply that. We think the government needs to make the policy intention clearer.

We believe the actual policy intention is as follows. Our understanding is that the nominal, national DLC of around £200, is better thought of as the contribution an individual receiving care in a care home might be reasonably expected to make towards the non-care costs of a care and support package such as accommodation or energy costs. It is an attempt to level the playing field with people who receive home care who would be paying their living costs anyway. As a result, the DLC nominal charge does not count towards the cap on care costs. This also means that the nominal charge **is not representative of what a provider might actually charge for those living costs.** It is merely the amount the individual is being expected to contribute towards. Is our understanding correct? Could we have some provider-facing communications of this policy to reassure the sector? Would 'Daily Living Contributions' be a better name for this aspect of the policy?

A related issue is that of 'Top-Ups' to care packages. It seems to us that there may be a fine line between what counts as a DLC and what counts as a Top-Up; we note that both do not apply to care cap. What happens if a LA regards some living costs as a top up? The policy intention behind the introduction of top-ups is clearly to give people the choice of extras in their care provision, perhaps an additional service, beyond what is provided to meet their eligible needs, or perhaps a specific type of room. However, there is a danger that if the wider policy isn't adequately funded, we simply create a new mechanism to cross-subsidise the state via top-ups. How can our members work with DHSC to avoid this?

Another concern members had is if the LA deems a certain care home too expensive to meet someone's needs despite paying staff better wages, having a better quality of care and food. Would people really opt to top-up their care and support for this? Much of the not-for-profit sector might find itself in a situation where the system actually benefits services that do not pay their staff as well, and have lower qualities of care.

Finally, could we have more clarity on what support is available for an individual who is unable to pay their Daily Living contributions for whatever reason? What happens in this scenario?

Verification of Costs & Reassessments

The operational guidance appears to have introduced something new which wasn't included in the original Dilnot Proposals, and that's the requirement for LAs to verify the costs accrued by self-funders in their IPBs. The guidance suggests that digital processes could be set up to enable this verification.

We believe that the policy intention is for this to be a light-touch process which might be part of an annual review. It might involve showing the LA care receipts or talking to the provider. However, following the experience of our members throughout the pandemic with relation to data collection requests from LAs, we are concerned that LAs themselves may 'over implement' this policy proposal and require regular checks, counting minutes and hours of care delivered. This would be a massive backwards step if this happens. Can we make the policy intention clearer to avoid this scenario?

Finally, we need to also have more detail about what might trigger a reassessment of need outside of annual reviews, and what this would mean for someone's PB/IPB and Care Account. There is a sense amongst our members that LA are reluctant to recognise changes in need in residential settings in a timely way unless it is obvious the need has 'reduced' on review.

Conclusion

Throughout our workshop with members, it was clear that the success of policy to implement a lifetime cap on care costs and Section 18(3) is completely dependent upon an adequate fair price for care being agreed. As things currently stand, the fair price for care exercises feel like they have already been decided as £1.4bn has already been allocated. As the County Councils Network has already flagged the government is underestimating the cost of its proposals by at least £854m a year for care homes alone. A cap on care costs is a step forward in setting a fair deal between the state and the individual, but without more resource that deal is going to be broken, with less money available to meet people's care and support needs and the inability to meet people's expectations of what reform will actually mean. We need to see additional resource pumped into LAs and the wider sector to enable these reforms to be a success. We would also suggest that a staggered approach to the implementation of the cap, alongside a faster move to a fair price for care would remove some of the risk.

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