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CCN Consultation Response

Operational Guidance to Implement a Lifetime Cap on Care Costs

Introduction

1. The County Councils Network (CCN) represents 36 English local authorities that serve counties. The 23 county and 13 unitary authorities that make up CCN are the largest part of the local government family. They represent all four corners of England, from Cumbria to Cornwall, Durham to Kent, North Yorkshire to Suffolk, Derbyshire to Essex. The essential services our members provide touch on the everyday lives of residents and businesses across 86% of England's landmass and 47% of its population, with our councils constituting 48% of all local government expenditure on adult social care services in England.

2. CCN welcome the opportunity to respond to this consultation on the *operational guidance to implement a lifetime cap on care costs,* and convey the perspective of our member councils regarding the feasibility of charging reforms and key implementation challenges they face – in particular reflecting the spirit of the clear message from ministers and the DHSC around the importance of working to deliver successful reform in partnership with the sector.

3. Over recent years, CCN has published a range of evidence to support the government in developing its reform proposals. Most notably, this included CCN's report in early 2021 in conjunction with Newton *The Future of Adult Social Care*[1] which described the tenets of a new 'optimised model' for adult social care. Moreover, our September 2021 report, *The Stat of Care in County and Rural Areas*[2], extensively evidenced the existing pressures within the system, alongside the headline challenges of implementing the initial proposals for reform contained in *Building Back Better: Our Plan for Health and Social Care*.

4. Since this point, CCN has committed to provide further evidence to DHSC on the impact of charging reforms in England to inform policy development. In January 2022, CCN commissioned LaingBuisson to undertake an independent impact assessment of the introduction of a fair cost of care and Section 18(3) of the Care Act. Throughout the project CCN has sought to engage DHSC officials in the financial modelling and research, with the full report published in March.[3]

5. In considering this consultation response, DHSC should be aware that CCN recently partnered with Newton to undertake further analysis of the implementation of adult social care reforms in England. As part of our work, we are building a robust analysis of the operational and financial impacts of the four key components of reform: implementing the new means test, the cap on care costs and section 18(3) of the Care Act. Newton will be developing a methodology to analyse these costs, building on the evidence base and understanding CCN and Newton have from working closely with local authorities. We will be testing this methodology with a wide range of stakeholders, and have representation from chief executives, finance directors, directors of social care, providers and residents steering the work.

[1] Newton: The Future of Adult Social Care (2021) http://www.countycouncilsnetwork.org.uk/download/3392/
[2] CCN and Rural Services Network - The State of Care in County and Rural Areas (2021) http://www.countycouncilsnetwork.org.uk/download/3806/
[3] LaingBuisson - Impact Assessment of the Implementation of Section 18(3) of the Care Act 2014 and Fair Cost of Care (2022) http://www.countycouncilsnetwork.org.uk/download/4124/

6. While this research project will consider in detail the draft operational guidance and regulations presented in this consultation, the timing of its publication means that we are unable use findings of Newton's research within our response. However, over the coming months we will seek to engage DHSC on the emerging findings to inform the next stages in the implementation of charging reforms.

7. Drawn from consultation with our member councils since the announcement of reforms, alongside existing research and analysis, this consultation response concentrates on providing a top-level view of the implementation challenges in relation to certain aspects of the guidance and our current policy position.

8. In responding to this consultation CCN has not sought to provide detailed commentary in relation to the operational guidance or draft regulations. Our member councils will be best placed to consider the specific impact of the operational elements and will be responding individually in this regard.

Overview

9. CCN has been calling for a long-term funding solution for adult social care for a number of years in light of the well documented financial and service pressures on the existing system. CCN also recognise the commitment of successive administrations to reform the charging system for adult social care in England through the introduction of a life-time cap on care costs and greater financial support through an extended means-test threshold. This comes alongside the introduction of a new Fair Cost of Care (FCC) and enacting existing duties under Section 18(3) of the Care Act, which will allow self-funders to ask their local authority to arrange their care, and crucially to access local authority fee rates.

10. Since the reforms to the social care system were announced, our network has outlined our strong support for the proposals and the principles that underpin them, including the introduction of a lifetime cap on care, extended means-test, and much needed system reform. CCN recognises the proposed reforms announced across the autumn reflect many of the key tenets of the 'optimised model' set out in CCN's 2021 report with Newton, *The Future of Adult Social Care*, and rightly place local government at heart of delivering reforms.

11. More widely, CCN have also outlined our support for the principles underpinning the introduction of FCC and Section 18(3): namely that councils' fees have, for too long, been at an unsustainably low level. Moreover, self-funders deserve to pay fairer fee levels, with more direct support from local authorities to meet their care needs.

12. Whilst CCN supports the overall package of reforms, the focus now must be on successfully implementing them a time of significant existing pressures. CCN have consistently highlighted the need to ensure we fully consider the impact of the reforms on an already strained system of adult social care in England. Moreover, as highlighted throughout this response, due to their unique demographics, service user profile and structural nature of their care markets, the implications for CCN's 36 county and unitary authorities needs particular attention.

13. As detailed in our September 2021 *The State of Care in County and Rural Areas*[4], demand and costs for social care continues to increase, outpacing the level of government resources

[4] CCN and Rural Services Network - The State of Care in County and Rural Areas (2021) http://www.countycouncilsnetwork.org.uk/download/3806/

provided. At present, funding challenges necessarily lead to high thresholds for eligibility to access services - meaning 58% of those requesting support are currently not ending up receiving any formal care service.

14. Most importantly, social care reforms come at a time when councils and their local providers are experiencing considerable operational headwinds and a raft of post-pandemic issues, notably acute staffing shortages, increases in demand for a range of community-based services, and the ending of short-term financial support, which have created a 'perfect storm' in the sector. There are also considerable backlogs in assessments and provision of care support as a result of the pressures generated by the pandemic. This has been evidenced extensively by ADASS, showing 461,289 people are awaiting an assessment, care and support, a direct payment to begin or for a review in England.[5]

15. Individually, each element of charging reform represents a positive move forward which promises to address challenges faced by service users, care providers and councils alike. However, it is important the government recognises that the simultaneous introduction of all these elements together may create unintended consequences from the complex interaction they will have with each other. The first priority of reform must be to ensure the system remains stable during a period of great change in the lead up to the introduction of reforms in 2023. Any planned new investment must not only focus on extending financial protection and support to those that currently fund their own care, but also the very real pressures already within the care sector, including high levels of unmet need.

16. As outlined below, CCN remain concerned that additional new burdens associated with this guidance to facilitate metering towards the cap, such as the rapid expansion in assessments, the establishment of care accounts and Independent Personal Budgets (IPBs), come within the aforementioned extremely challenging context, particularly existing staff storages and wider labour market pressures. Additional investment will be required to cover additional recruitment and training to respond to a marked increase in assessments and record keeping.

17. CCN supports protecting more people from catastrophic care costs and extending the means-test threshold, but these reforms alone and the level of investment in the short-term – compared to the NHS – will not deal with existing problems within the system and could potentially exacerbate them unless carefully managed.

18. We are not convinced that the Social Care Charging Reform Impact Assessment sufficiently addresses this important issue and underestimates the funding required to support these elements of reforms. Moreover, given the unique impact on counties, current funding distribution formula will need to be revised to recognise the disproportionate impact on CCN member councils. CCN is currently undertaking detailed analysis of the potential costs of the cap on care, means test and associated infrastructure (i.e. additional staffing requirement) as part of our project with Newton.

19. Of particular concern for CCN and its member councils is the interrelated impact of expending duties to self-funders to meet their needs under Section 18(3) of the Care Act, alongside the introduction of FCC. As we detail further on, our recent research with LaingBuisson demonstrates these elements of reforms are severely underfunded in supporting the concurrent introduction of these policies without preventing unsustainable risks to local care markets. In the absence of additional funding or substantial policy mitigations, this in turn raises very serious questions over whether these elements of the

[5] See ADASS response to consultation.

operational guidance are workable in practice and if the timescales for implementation of Section 18(3) duties are at all achievable.

20. The risk posed to both councils and providers from the introduction of Section 18(3) underpinned by an underfunded FCC policy could severely undermine the success of the reforms and the stability of an already fragile care market. Based on the evidence presented in LaingBuisson's report, it is our firm view that a commitment to further funding will be required to support the implementation of the guidance currently set out.

21. **If the government is unable to bring forward further funding for FCC and develop appropriate mitigation policies, we believe a reassessment of the timescales for implementation of Section 18(3) will be required, to both fully understand the impact of the policies and allow for greater resources to be invested from the Health and Social Care Levy from 2025 onwards.**

22. As we move forward and gain a deeper understanding of the implementation challenges, the government may need to consider prioritising different elements of the reforms, whether this be the cap, means test or wider system reform. Alongside the trail blazer programme, it is imperative that the government now closely engages with all local authorities over the practical steps needed to implement the new duties outlined in this guidance. This will require the Department to keep under constant review the funding allocations for implementing new duties, alongside the timescales for delivery.

<u>Cap on Care Costs and Means Test</u>

23. CCN welcomes the underlying principles for the introduction of the cap on care costs. The introduction of the cap will go some way to protecting residents from catastrophic care costs and protect those people who unfairly faced investing all of their hard-earned life savings to pay for their care needs. Moreover, CCN supports the intention to provide more direct financial support for those with care needs under the extended means test threshold.

24. As stated above, CCN supports protecting more people from catastrophic care costs and extending the means-test threshold, but these reforms alone and the level of investment in the short-term – compared to the NHS – will not deal with existing problems within the system and could potentially exacerbate them unless carefully managed. We are not convinced that the Social Care Charging Reform Impact Assessment sufficiently addresses this important issue and underestimates the funding required to support these elements of reforms. Moreover, given the unique impact on counties, current funding distribution formula will need to revise to recognise the disproportionate impact on CCN member councils.

25. CCN is currently undertaking detailed analysis of the potential costs of the cap on care, means test and associated infrastructure (i.e. additional staffing requirement) as part of our project with Newton. In relation to the means-test, initial analysis suggests this is an area we believe requires considerable further work, beyond the initial Impact Assessment, to account for asset depletion, which we believe will markedly increase the estimate of the local authority contribution.

26. In considering the impact of these proposals, it is clear that the cap on care and requirements for associated implementation infrastructure will have a disproportionate impact on county areas due to a unique set of demographics and service user profiles:

- **Counties have significantly higher proportions of elderly residents**, with 5.8m – some 22% of our member councils' population – aged 65 and over. This percentage is significantly higher than metropolitan boroughs (17.8%) and London Boroughs (12.9%).[6]

- **The scale of existing service delivery is significantly larger**. County and rural unitary councils on average each received 23,667 requests for care in 2019/20, some 64 requests on average per day. This compares to 14,055 and 38 respectively in an average metropolitan borough.[7]

- **County areas account for the largest proportion of occupied care home beds in England**. Some 56% of all occupied independent sector beds in England are in the 36 CCN member councils, with 58% of all care home provider revenues generated in these areas.[8]

- **The proportion of self-funders is higher in CCN member councils,** with an average self-funder rate of 46% compared to a national average of 37%. Some 32 of CCN 36 member councils have a self-funder rate *above* the national average, with 11 councils above 50%. This compares to 25 metropolitan boroughs with self-funder rates *below* the national average, and just three councils above 50%.[9]

Operational Guidance

27. As indicated in the overview, CCN believes that its member councils will be best placed to comment on the precise details of the Operational Guidance. However, CCN recognises that charging reform is a highly complex undertaking. Whilst the Operational Guidance feels exhaustive and very detailed, it is nonetheless extremely complicated. This means it is likely to be difficult for councils to express some of the outlined process in simple terms to those with less background understanding of the operation of care markets and may lead to confusion among those with care needs and the wider public.

28. The draft guidance feels as though it as workable as possible at this stage. However, as with all policy making there are likely to be unforeseen circumstances in certain cases which will require interpretation. The flexible nature of the guidance is helpful but local authorities are also cautious at this stage about whether it may potentially leave councils open to some forms of legal challenge in some circumstances – such as those permitted in 1.52 where people with similar care needs may find they are paying different amounts towards the cap.

29. It is also important to note that the draft operational guidance has been published without the statutory regulations that will be in place alongside guidance for the implementation. It is therefore difficult to know if the guidance will be consistent with the regulations. Local authorities have found some differences between the Care and Support (Charging and Assessment of Resources) Regulations 2014 and the Care and Support statutory guidance that have opened some local authorities to legal challenge. It would assist councils if the draft regulations were to be published as soon practicable.

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[6] CCN and Rural Services Network - The State of Care in County and Rural Areas (2021) http://www.countycouncilsnetwork.org.uk/download/3806/

[7] CCN and Rural Services Network - The State of Care in County and Rural Areas (2021) http://www.countycouncilsnetwork.org.uk/download/3806/

[8] Independent Sector Older / Dementia occupied beds by funding source at Jan 2022 (est) and Independent Sector Care Home Revenue 2021/22 taken from LaingBuisson modelling underpinning *Independent Impact Assessment of FCC and Section 18(3) of the Care Act*.

[9] Care homes and estimating the self-funding population, England: 2019 to 2020 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/carehomesandestimatingtheselffundingpopulationengland/2019to2020

30. The interaction between the cap on care costs, the varying capital threshold limits and the calculation of daily living costs and top ups will be difficult for people in need of care and support to understand. It is important for the Department at a national level and local authorities at a more local level to ensure that this information is communicated in an accessible manner to residents and those organisations that provide information and advice on such matters. The Transforming Social Care website which is now live should have more practical and realistic case examples to help address this issue so that the public can better understand how and what the charging reform could mean for individuals.

Assessments

31. The Operational Guidance indicates the extent to which new administrative burdens will fall upon local authorities, particularly the rapid expansion in assessments and establishment of care accounts to facilitate metering towards the cap. The government have provided additional funding to support the implementation of this aspect of reform, but the establishment of this new function in the time frames set out in the guidance will be extremely challenging. As outlined above, the nature of CCN's demographic and service user profile means the administrative challenges posed by the reforms will be more acute in these areas due to the high levels of self-funders resident in county areas.

32. From our engagement with councils through our project with LaingBuisson, it was clear there was general lack of consultation and unpreparedness for the new reforms, particularly in terms of technical infrastructure to handle a substantial prospective cohort of assessments from those wishing to take up the care cap and the arrangement of their care under Section 18(3). In addition, there are number of areas in which the content of this guidance may increase the administrative burden and cost for councils beyond those expected and/or are necessary, such as:

    - The need to conduct early needs assessments and financial assessments of people from April 2023, preparing much less time to prepare the necessary IT, staffing capacity and resources.
    - The care account statement will need to be sent six monthly rather than annually to each client.
    - The local authority is expected to raise awareness of the reforms amongst their residents.
    - Retaining care cap statements for 99 years – this will require additional IT archiving.
    - Given the likely length of stay of care home residents 65+, the guidance may risk information being collected for assessment purposes which then are found to be redundant because the person had died in the intervening time. In short, this risk avoidable additional workload.

33. CCN's member councils are particularly concerned about the speed at which they will be able to secure the skilled workforce to be able to deliver the number of assessments that the cap and associated reforms are likely to generate. This problem is likely to be compounded by the 'front-loading' of assessments generated by the policy, with existing self-funders understandably likely to want to get their 'metering' towards the cap underway as soon as possible. It may be some time before local authorities are able to get a sense of the regular and ongoing demand for assessments going forward given that at present many self-funders often have no contact at all with the council during their care journey.

34. In relation to self-funder assessments under Section 18(3) of the Care Act, not only will there need to be more staff to undertake assessment, but it will also identify activity which

the local authority should be addressing such as Safeguarding and Mental Capacity. It is right to address these needs, but the increased demand will come with further costs in other council services.

35. In line with the recommendations of LaingBuisson, we urge the government to provide details of infrastructure and technology to allow for current assessment capacity to be significantly extended to cope with the demand for such assessments which will be triggered by both the cap and also Section 18(3).

Dispute resolution

36. Due to the rapid expansion in local authority duties in relation to assessments and meeting the needs of those that current fund and arrange their own care, there is likely to be increased levels of complaints and disputes arising from the reforms. Moreover, much of the guidance is open to interpretation and it is felt that this will result in it being interpreted differently by local authorities, clients and their families leading to disputes.

37. The current local government complaints system whereby individuals' resort to the Local Government and Social Care Ombudsman could potentially be overwhelmed and leave local authorities in a position where they spend more money on contesting disputes than providing the care for that person.

38. It will be helpful for the Department to clarify this issue in its response to this consultation. The draft guidance states there is no evidence that the implementation of the Care Act has found the dispute resolution processes not to be effective. However, CCN member councils have fed back that the operation of the cap is a different factor with family's heritage at stake an therefore the relative impression of the implementation of the Care Act should not be taken as the definitive reference evidence.

Top-ups

39. CCN councils are concerned about the potential impact of how the introduction of more defined top-ups may interplay with the wider reforms around Fair Cost of Care and 18(3) and how they will be implemented practically.

40. Despite the policy reference to top ups being 'permitted' under the proposed reforms, top-ups have been widely used in many parts of the country for some time. Typically, they are paid by the residents themselves ('first-party top-ups') or by members of their family ('third-party top ups') to the provider, to meet the provider's 'ratecard', that is the fee at which the provider is prepared to sell the room / bed in a given care home (not necessarily its self-funder rate).

41. Some local authorities have not allowed top ups historically, primarily because of their tendency to fail; that is for the source of the additional funds to run out. In these cases, local authorities have often had to step in and pay the provider the top up themselves, until an alternative is agreed. It should be noted that the alternative can also be an arrangement that the care provider will continue to accommodate the resident at the reduced rate, i.e. without a top up, especially if that resident has been at the care home for some time.

42. Notwithstanding the above, although top-ups are widely used currently, they are, in the vast majority of cases, in the range of £50-100 per week. The proposed reforms may see significantly higher top-ups, running into several hundred pounds if providers wish to

maintain their current fee levels (DHSC acknowledges that top ups 'will allow providers to maintain additional self-funded revenue').

43. All the providers interviewed for CCN and LaingBuisson's research acknowledged that if there was a wide gap between a determined Fair Cost of Care and a care home placement, top-ups are potentially likely to offer the main means for offsetting any shortfall in funding for providers caused by other changes to charging reform.

44. As concluded in LaingBuisson's report for CCN, while this may be necessary to prevent the financial challenges for providers, the widespread use of top-ups at high levels is likely to negatively impact public perception as to whether the reforms are creating a 'fairer deal' for self-funders, with corresponding reputational implications for central and local government.

45. There are also concerns in relation to how top ups will work in practice. The guidance provides further detail of 'first-party' top-ups (i.e. those made by a resident him/herself). To allow for premium care beds to continue in the market and preserve residents' choice, here called 'preferred accommodation':

> *The local authority must arrange the preferred accommodation if they judge that the person paying the top up is willing and able to pay for the likely duration of the care journey, the paying person enters into a written agreement with the local authority that must be regularly reviewed.*

46. Conditions which must be met to allow for this, include the condition that 'the accommodation is of the same type as that specified in the care and support plan' and that 'the provider of the accommodation is willing to enter into a contract with the local authority to provide the care at the rate identified in the person's personal budget on the local authority's terms and conditions'. It is this last condition which LaingBuission in their report for CCN outlined will be particularly problematic, given the desire of providers to preserve their ratecards. LaingBuisson's research made the following observation on this issue:

> *While it may seem logical to attach top ups to enhanced, additional or 'extra' services, in practice it would be a significant departure from current practice, where top ups are not agreed against specific services, care or hospitality offers, but instead simply to meet their own all-in ratecard. Developing a menu-based approach to justify top ups would entail very significant change to most operators' charging model.*

47. More widely, CCN member councils have highlighted the potential operational challenges on implementing a more wide-spread use of top ups at significantly higher levels. For instance, financial assessments may be more complex as the local authority has to assess if the client will have sufficient funds to continue to pay any first party top ups for the expected duration of their care journey.

48. Moreover, where a first party top up is agreed, the written agreement should state that the local authority will move the client if they can no longer afford top up. In reality this would be very difficult to achieve and result in a lot of anguish, complaints and, in some cases, will be detrimental to the person's health. There is well established research evidence that when older frail people are moved to a different care home, a high percentage of them die within 28 days of such a move. This is already an issue when third party top-ups are no longer affordable, and consideration is given to moving a person which is disputed due to person not wanting to move/it is in their best interest to remain.

49. In the likely case that the authority does not move the client, this will open the local authority to additional cost and service user debt burden. The CASS guidance states in paragraph 8.33 '*Where a local authority is meeting needs by arranging a care home, it is responsible for contracting with the provider. It is also responsible for paying the full amount, including where a "top-up" fee is being paid'.* The increased management of self-funder care arrangements from Section 18(3) and likely increase of top-ups as a result of the construction of the draft guidance means that local authorities may face additional debt risk burden and costly debt recovery processes.

50. In considering the use of first- and third-party top ups, CCN agree with LaingBuisson's recommendation that the DHSC should undertake further research the way top ups currently work and the way in which they may now assume particular importance to providers which require higher fee rates than offered by a FCC.

Technology

51. One way in which the present costs of adult social care may be alleviated is through the adoption and deployment of technological solutions. This was explored in CCN's report with Tunstall *Employing Assistive Technology in Adult Social Care* (2021). Subsequently CCN was very pleased to see the specific £150m in the reform package for social care for this purpose.

52. We believe that improved systems could, over time, help both to reduce in-house administrative costs as well as the direct costs of providing some elements of both residential and domiciliary care. However, this will take time for new systems to be introduced and staff trained to use them.

53. Additionally, there may need to be common standards for systems to be able to effectively talk to each other across local authority boundaries, and indeed between the NHS and local authorities in order to reduce the potential bureaucracy of ensuring a smooth transition for service users moving between administrative boundaries on their care journeys.

Requesting that the local authority meets needs – Section 18(3)

54. Since the reforms were announced in September 2021, CCN has consistently outlined that the most significant challenges related to the reforms are likely to arise from the implementation of Section 18(3) of the Care Act. As outlined in the consultation, enacting these existing duties will allow self-funders to ask their local authority to arrange their care, and crucially to access local authority fee rates.

55. The DHSC commentary within the draft guidance notes that the implementation of 18(3) 'will be a big adjustment for local authorities, providers and users'. It confirms that from October 2023, once a self-funder decides to ask their local authority to meet their needs by arranging their care, '*the local authority will treat them in the same way it treats other users. All of the guidance local authorities must follow about how to meet individuals' needs will apply in the same way, regardless of how someone funds their care*.' Overall, the direction of travel outlined in the proposed guidance on 18(3) remains in line with the government's previous announcements, indicating a hard implementation of new duties from October 2023.

56. At the same time, the government intends to introduce a new Fair Cost of Care (FCC), which the consultation makes clear is not only intended to make local authority fee rates more sustainable but underpin the sustainable implementation of 18(3). We recognise that

separate guidance has been published on FCC which is outside of the scope of this consultation. However, in considering the consultation's content under section 3.6, and specifically whether the guidance and thus 18(3) policy is 'workable', it is critical that these two interlinked policies are considered in tandem.

57. It is clear that these changes have unprecedented implications for both councils and providers, but particularly those operating in the areas served by CCN member councils. Alongside aforementioned data showing the unique demographic and service user profile in these areas, the below data on the structural nature of county care markets demonstrates that these areas will be acutely impacted by the proposed changes under Section 18(3):

    - **Private paying occupancy in England is disproportionately concentrated in CCN member councils.** Overall, 63% of privately occupied care home beds in the independent sector in England are within CCN member councils. Some 51% of all independent sector occupied residential and nursing care home beds (excluding NHS placements) in CCN member councils are private paying. This compares to 45% in England, and 35% in metropolitan boroughs.[10]

    - **Care home revenues are heavily reliant on private payer income from within CCN member council areas.** Some 65% of all provider revenues in England from private fee payers in residential and nursing care homes are within CCN member councils. Income from private payers (£4.5bn) in CCN member councils represents 32% of the entire revenues of care home providers in England and constitutes the single largest component of total revenues.[11]

    - **CCN member councils, on average, currently have higher weekly fee levels than metropolitan boroughs, but still have a larger private payer fee premium.** Private pay premium is currently 43% in county areas compared to 33% in metropolitan boroughs.[12]

58. To further evidence the impact on CCN member councils and the wider sector, CCN commissioned healthcare specialist LaingBuisson to independently assess the impact of Fair Cost of Care and 18(3) on residential and nursing care homes in England.

59. Building on their expertise on the independent care sector, LaingBuisson have assessed in detail the government's own impact assessment on the proposals. Using their unrivalled access to provider data on fee levels, and long-established Care Cost Benchmark model, detailed financial analysis has also been undertaken on the combined financial impact of Fair Cost of Care and Section 18(3). Alongside this, LaingBuisson have undertaken extensive engagement with commissioners, providers and sector stakeholders to gather qualitative evidence on the impact of these proposals to inform their analysis.

60. The full report's findings were published in March, with a summary of the key conclusions outlined below:

    - DHSC appears to have severely underestimated the cost of implementing a Fair Fees policy. LaingBuisson's estimates of costs to councils of implementing Fair Fees that are

[10] Independent Sector Older / Dementia occupied beds by funding source at Jan 2022 (est) taken from LaingBuisson modelling underpinning *Independent Impact Assessment of FCC and Section 18(3) of the Care Act*.
[11] Independent Sector Care Home Revenue 2021/22 taken from LaingBuisson modelling underpinning *Independent Impact Assessment of FCC and Section 18(3) of the Care Act*.
[12] Average private pay premium (residential and nursing combined). Taken from LaingBuisson modelling underpinning *Independent Impact Assessment of FCC and Section 18(3) of the Care Act*.

sustainable for the care sector are orders of magnitude higher than those cited in the DHSC's Impact Assessment document. This in turn raises concerns that the government has seriously underestimated the amount of new funding required to make the combined FCC / 18(3) strategy work effectively.

- In its Impact Assessment, the government have not sought thus far to estimate the combined financial impact of Section 18(3). But our analysis demonstrates that based on a 50% take up rate of 18(3) and current FCC funding levels for councils, providers across the country would experience significant financial challenges as a result of lost revenues amounting to £560m per annum. Providers in County & CCN Unitary authorities would account for 86% of all net financial losses to the social care sector, with the largest loses in the South-East, East of England and South-West, reflecting these council areas geographical spread and high levels of self-funders.

- In order to prevent the widespread market instability that would result from these revenue losses, councils' FCC would need to be raised significantly compared to current government funding estimates to offset these losses and ensure on-going investment in the social care sector, particularly in the short term.

- LaingBuisson's central estimate is that this would require government to raise funding allocations by at least £854m per annum for FCC in residential and nursing care homes to enable councils to pay fee levels at a sustainable rate and avoid market disruption. However, even if councils were funded at this FCC level, some care economies would still face financial significant pressures as a result of the impact of 18(3).

- Given past and current funding challenges already facing councils, they are extremely unlikely to be in the position to fund fee increases above current funding allocations without a detrimental impact on existing social care services or challenging their own financial sustainability.

- Therefore, without additional resources from central government, councils will face the possibility of provider failure and market exits. This will negatively impact on the ability of councils to secure high quality care placements for those eligible for local authority arranged care, in addition to market exits impacting on the availability of provision for the NHS of continuing health care.

- The reforms introduce new market shaping and fee negotiations duties for councils hitherto not witnessed before. It is important to consider the significant historical challenges in fee negotiations with providers and the success in undertaking fair cost of care exercises. Even if government were to provide further resources for FCC, there are likely to be significant challenges in conducting these exercises with providers within a relatively short timescale on behalf of both local authority and new self-funder clients, alongside new administrative burdens for councils.

- The DHSC Impact Assessment is based on somewhat limited understanding of how care homes currently work commercially, and an idiosyncratic view as to how negative effects of equalisation of fees might be managed, for example, 'reducing the size of home or transferring elsewhere'. More seriously, the DHSC impact assessment statement that providers will have to 'consider options, including but not limited to seeking self-funders from elsewhere, reducing the size of home or transferring elsewhere' will likely be met with widespread scepticism, as well as alarm, in the care sector.

- Overall, LaingBuisson questions whether the intention to fully implement Section 18(3) of The Care Act 2014 is the right policy at the right time. The implementation of such wholesale changes to funding models comes at a time when the care market is particularly fragile in the aftermath of the COVID-19 pandemic, with significant regional blackspots.

61. Throughout this project, CCN has sought to be open and transparent with the department on our emerging findings. We have met with the Care Minister to discuss the research, alongside detailed engagement with officials on the assumptions and methodology that lay behind the analysis. Provider organisations, with whom we have engaged with these findings already, including Care England, strongly support the report's findings and conclusions.

62. As outlined earlier in this response, CCN support the principles underpinning the introduction of Section 18(3), including tackling the unfairness currently inherit in the cross-subsidisation of fee levels and providing self-funders with greater support and expertise from local authorities in arranging their care. However, we strongly disagree with the statement contained in the guidance that Section 18(3), when combined with FCC funding, will make the overall system more sustainable, particularly in the short-term.

63. The findings of the report alongside the work that councils are doing themselves pose serious questions over whether the funding provided to date for FCC is sufficient to make 18(3) workable without posing an unsustainable risk to local care markets. The introduction of Section 18(3) with an underfunded FCC policy could severely undermine the success of the reforms and the stability of an already fragile care market

64. Based on the evidence presented in LaingBuisson's report, and a conservative estimate of a 50% take up of 18(3), it is our firm view that a commitment to further funding will be required to support the implementation of these policies as they are currently set out. **CCN therefore take the view that, based on current funding levels, the guidance contained in the consultation in relation to these new duties is not workable in practice**.

65. **If the government is unable to bring forward further funding for FCC and develop appropriate mitigation policies, we believe a reassessment of the timescales for implementation of Section 18(3) will be required, to both fully understand the impact of the policies and allow for greater resources to be invested from the Health and Social Care Ley from 2025 onwards.**

66. In particular, we have concerns that the government have not undertaken any detailed research to understand the behavioural side and likely take up of 18(3) and the pathway for residents, both existing and prospective. DHSC predicts an 80% take-up in registration for the care costs cap, but it has made no detailed forecasts for the take-up by the public of 18(3). Despite this, the guidance clearly pursues a hard implementation of the policy, including new requirements for councils to provide information to people accessing the cap to make them aware they can ask the local authority to meet their needs.

67. As such, there is a clear disconnect between a stated policy of 'moving towards' a fair cost of care, but at the time as fully implementing Section 18(3). While the guidance states that this will lead to a fairer and more sustainable system 'in the long-term', there is little understanding of the extent of the impact on providers revenues of 18(3) and whether current funding levels for FCC *in the short term* is able to offset the scale of potential revenues loses to providers.

68. CCN and member councils want to engage government in further policy mitigations, including how Section 18(3) will apply to those already in residential care before October 2023.

69. The draft guidance says that *'The local authority must make self-funders who want to progress towards the cap aware that they can ask the local authority to meet their needs by arranging their care at any time'*. Our interpretation of this is that anyone who has already moved into a care home on a private contract before October 2023 is entitled to ask the local authority to make future arrangements for them. The Impact Assessment also appears to make that assumption, though it is not explicitly spelled out in either document. The guidance gives no specific advice about the duties of the local authority in that situation, and the Impact Assessment makes such generalised suggestions about long-term options that it is hard to imagine any local authority being able to implement between now and October 2023, such as promoting the development of new 'fair cost care homes'.

70. Given the scale of the funding shortfall identified in our LaingBuisson analysis, the government should at the very least consider initially implementing section 18(3) only for new care home residents moving into a care home in or after October 2023. This would help reduce the funding shortfall and better manage immediate demand, while also reducing the risk of a chaotic start to the new arrangements, with widespread disputes between local authorities, care home providers, and existing residents and their representatives.

71. Moreover, while we recognise that the cap will be calculated based on how much a local authority pays for care, CCN and its member councils would like to further understand the government's assertions that implementation of 18(3) must be implemented alongside the cap on care and why a decoupling of the policies could not be developed to prevent short-term instability.

72. DHSC should also engage with the providers and the investor community more broadly to explain its vision for 18(3) and to canvass views from investors, lenders and other financial stakeholders, so as to avoid a potential 'cliff edge' adverse reaction in the coming months.