Care Act: regulations and guidance

LGA and ADASS joint consultation response

August 2014

About us

1. The Local Government Association (LGA) is here to support, promote and improve local government. We will fight local government's corner and support councils through challenging times, focusing our efforts where we can have real impact. We will be bold, ambitious, and support councils to make a difference, deliver and be trusted.

2. The LGA is an organisation that is run by its members. We are a political organisation because it is our elected representatives from all different political parties that direct the organisation through our boards and panels. However, we always strive to agree a common cross-party position on issues and to speak with one voice on behalf of local government.

3. We aim to set the political agenda and speak in the national media on the issues that matter to council members.

4. The LGA covers every part of England and Wales and includes county and district councils, metropolitan and unitary councils, London boroughs, Welsh unitary councils, fire, police, national park and passenger transport authorities.

5. We work with the individual political parties through the Political Group Offices.

6. Visit www.local.gov.uk

7. The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in councils in England. As well as having statutory responsibilities for the commissioning and provision of adult social care, ADASS members often also share a number of other responsibilities for the commissioning and provision of housing, leisure, library, culture, arts, community services and a significant proportion also hold statutory role of children's services Director.

A note on our response

8. The LGA and ADASS have been at the forefront of calling for reform of our care and support system for a number of years and we welcome the opportunity to comment on this important consultation. The local government sector is fully behind the reform agenda and there is consensus on the need for change from across the political spectrum. This cross-party support at the local level must also be matched by cross-party support at the national level.

9. Our response to the consultation provides a high-level commentary on some of the key issues facing local authorities as the sector prepares for implementation of the

first wave of the reforms in April 2015. It sets out some of the key points raised during the Care Act regional events and those contained within the more detailed and technical thematic submissions that ADASS Associates have prepared with ADASS policy leads. These have already been submitted to the Department of Health.

10. The response should also be read alongside the comments that the LGA and ADASS submitted earlier this year to the Department on the Impact Assessments (IA) accompanying the Care Act. Although this submission was in relation to the previous version of the IA, many of the points are still valid (see Annex A).

Supporting the ambition and the approach

Ambition

11. The LGA and ADASS have long called for reform of adult social care and our desire to see real change transcends political colour, having supported the intent of the previous Government's Green Paper and 'Big care debate', and the Coalition's White Paper, and Care Bill. We also engaged closely and productively with both the Law Commission's inquiry on adult social care law, and the Dilnot Commission's inquiry on funding reform.

12. We are committed to achieving a care and support system that is based around the needs of individual people and focused on maximising their wellbeing and independence. Where people do have higher levels of need we are committed to working closely with the private and third sectors to deliver quality and efficient services that keep people safe and protect their dignity. To realise this we firmly advocate the leadership role of democratically accountable local government in bringing together the public, private and third sectors within communities to help prevent the development or escalation of need.

13. In particular we believe strongly in the important role that Health and Wellbeing Boards can play in coordinating one process of system-wide transformation that incorporates the Care Act reforms, the Better Care Fund, other integration activity, and the contribution of public health in supporting healthy lifestyles. It is essential that the inevitable process and bureaucracy accompanying each of these agendas does not stifle the drive toward a clear and single approach to transformation.

14. In the main, the regulations and guidance bring us closer to the realisation of such a system and are a helpful 'next stage' in the journey towards a truly reformed system. In particular we welcome the following:

    a. The overarching principles of the Act with its focus on wellbeing and preventing, reducing and delaying needs.
    b. The new rights for carers and the mainstreaming of carers' issues throughout the legislation.
    c. The importance of personal outcomes, alongside the asset-based approach, which underpins the national eligibility criteria.

d. The fact that the legislation puts safeguarding on a statutory footing and that inquiries into suspected abuse or neglect should not be subject to the national eligibility criteria.
e. The establishment of an extended deferred payment agreements scheme.

Approach

15. We have valued the co-production with the Department of Health in preparing for implementation that has been a hallmark of the last twelve months. Whilst there have been some inevitable differences of opinion during the process, a productive collaboration has been maintained, which has enabled a better joint understanding of key issues, a much better collective understanding of implementation risks and issues, and the development of regulations and guidance. We believe this approach should be extended and replicated in preparing for future legislation across government.

16. We also do not underestimate the enormous amount of work that colleagues in the Department have done in getting the regulations and guidance to their current state. Local government colleagues from a number of local authorities must also be acknowledged for the significant amount of time and expertise they have given to the process, along with third sector colleagues. Local government's input has been, and continues to be, essential in ensuring that secondary legislation and guidance reflect the realities of implementation on the ground.

The context to implementation

Funding for local government

17. The Care Act will go live at a time of real financial pressure on local government as a whole. Councils are facing a 40 per cent reduction in funding from central government over the course of this Parliament. The LGA's updated 'Future Funding Outlook for Councils' (July 2014) shows that, from 2010/11 to 2013/14, councils have made savings of £10 billion, largely through finding efficiencies in existing services – but there is a limit to what can be achieved.

18. The LGA report also shows that the funding gap, created by a combination of funding cuts and spending pressures, is growing at an average of £2.1 billion a year, adding up to £12.4 billion by the end of the decade. Between March 2014 and the end of 2015/16 the total funding gap will stand at £5.8 billion[1].

[1] The funding gap for councils in England between March 2014 and the end of 2015/16 will be £5.8 billion. The gap is the disparity between the total money councils will have next year (£46.3 billion) and the amount of money they would need to maintain 2013/14 levels of service. - See more at: http://www.local.gov.uk/finance/-/journal_content/56/10180/6309034/NEWS#sthash.caZx4tIB.dpuf

The impact on adult social care and support

19. The impact of these cuts is inevitably being felt within adult social care. The LGA estimates that the funding gap between March 2014 and the end of 2015/16 for adult social care alone stands at £1.9 billion[2].

20. The annual ADASS Budget Survey (July 2014) shows that a further £850 million has come out of the system this year in response to the pressures on council budgets, leading to total reductions in the adult social care budget of £3.53 billion over the last four years.

21. A budget reduction on such a scale is significant in itself. But it is also significant in terms of its potential impact on local authorities' ability to shift the focus of the care and support system from crisis response to prevention and early intervention. The ADASS Budget Survey shows that the cash sum invested in prevention in 2014/15 is largely the same as compared to 2013/14; £923 million and only 6.8 per cent of the net budget.

22. The Department are aware of this context and the sector's continued efforts to raise awareness of it. However, over-familiarity with the figures must not lead to desensitisation to their magnitude, and the impact on the people who need care and support. The clear reality is that 2014/15 is already extremely difficult and 2015/16 will be a crunch year, with the largest real-terms reductions in funding yet; reductions of over 12 per cent to funding levels that have already been reduced by a third in the four years to 2014/15. The impact of reductions on this scale will include cuts to frontline services and, in some cases, the cessation of services altogether. As the LGA's report, 'Under Pressure: how councils are planning for future cuts', notes: "2015/16 is the year in which 60 per cent of councils say they are currently considering some degree of service reduction to help meet the budget gap"[3].

23. We are not alone in being concerned about the impact of overall cuts to local government funding on adult social care and support.

    a. "At its simplest, too little public money is spent on social care [and] too much is demanded of individuals and the friends and families who care for them…Social care has been subjected to draconian cuts as the coalition government has sought to reduce the deficit" (Barker Commission, 2014).

    b. "The scale of reductions in spending and provision are almost certainly without precedent in the history of adult social care" (PSSRU, 2013).

    c. "Pressures on the care system are increasing. Providing adequate adult social care poses a significant public service challenge and there are no easy

[2] The share of the funding gap for adult social care over that period is £1.9 billion. This projection is based on the proportion of council budgets allocated to adult social care in 2013/14.
[3] 'Under Pressure: how councils are planning for future cuts', LGA, 2014. http://www.local.gov.uk/documents/10180/5854661/Under+pressure.pdf/0c864f60-8e34-442a-8ed7-9037b9c59b46

answers…Need for care is rising while public spending is falling, and there is unmet need. Departments do not know if we are approaching the limits of the capacity of the system to continue to absorb these pressures" (National Audit Office, 2014).

24. To local government's credit, councils are doing what they can to protect adult social care given its central importance in supporting and safeguarding some of the most vulnerable people in our communities. The ADASS Budget Survey demonstrates that the service accounts for an increasing proportion of council spending; now 35 per cent in 2014/15 compared to 30 per cent in 2010/11.

25. The issue of system funding has perhaps been over-simplified, with concerns about resources regularly being countered with the position that Government has provided adequate funding for social care and its attendant reforms. We believe that an exchange on this level potentially misses a bigger and more fundamental question about the level of priority we are prepared to ascribe to care and support as a society. Total spending on adult social care and support accounts for just two per cent of total public expenditure and we are keen to have a national debate on whether that is a proportion we are willing to accept for supporting the wellbeing and independence of working age disabled adults and older people[4].

Other system pressures

26. Pressures on adult social care budgets as a result of the wider reductions in local government funding are being compounded by other developments. For instance, the recent Supreme Court ruling on Cheshire West and deprivation of liberty safeguards is likely to add a further significant cost pressure. An ADASS survey of 100 local authorities suggests that, for those councils, the implications of the ruling will cost at least £40 million; nationally we estimate that the figure would be at least £88 million. This will be an annual recurring cost arising from increased assessment activity, training, and recruitment of Best Interest Assessors, and excludes legal costs.

27. Whilst the Better Care Fund (BCF) provides rigour to the protection of adult social care (and Care Act costs funded through the BCF are given top priority), recent changes to the BCF are also a real concern. We believe that the revisions to the BCF undermine the core purpose of promoting locally-led integrated care. Furthermore, they reduce the resources available locally to protect adult social care and prevention initiatives. Just as importantly, since the Care Act is part-funded through the BCF in 2015/16, any squeeze on the local pot has the potential to make prioritising Care Act costs through the BCF more difficult.

28. Concerns with the BCF are compounded by a lack of clarity concerning exactly what Care Act-related policies the BCF must cover and the amount allocated to them nationally.

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[4] In 2014/15 the adult social care budget is £14.650 billion, compared to total managed expenditure of £732.0 billion. Adult social care is therefore 2.001 per cent of total public expenditure. Source: Revenue Account budget returns, DCLG, July 2014 and Budget 2014, HM Treasury, March 2014.

29. On the provider side we know that there are continued concerns about fee levels and the potential impact this may have on the sustainability of providers' businesses. We disagree with assertions that the setting of fee levels is something that is 'done to' providers; our experience is of councils working with their local provider market so that each side better understands the other's pressures, priorities and drivers. Agreeing fee levels in this open and collaborative way is the only way to do business.

30. We are concerned by the repeal of the HASSASSA regulations and the removal of the ability to routinely place charges on property. This creates two risks. Firstly, that the cost of care is not repaid when someone dies or sells their property. This will increase the costs of adult social care and impact on other service users. Secondly, that it increases the prospect of more older people being involved in complicated and potentially distressing court cases.

Funding the Care Act reforms

31. Against the deeply challenging backdrop outlined above any programme of major change that carried significant cost implications would be a cause for some concern. Implementation of the Care Act reforms is no different and the concern is more pronounced for the following reasons:

    a. We are dealing with a number of variables that are difficult to quantify. The number of carers and self-funders who will present to their local authority for assessment and support are unknown and there is no good national data which can robustly predict take-up. Various modelling exercises are underway to try and capture this but there is an inherent behavioural determinant to this activity that is extremely hard to translate into estimated demand. Similarly, much will depend on the extent to which the reforms are promoted and awareness is raised. We would welcome the Department's latest thinking on this.

    b. There are a number of potential unintended consequences that could have a cost implication, and which we do not believe are adequately covered in the IAs. These include:

        i. The impact on the provider market of fee levels becoming more transparent.

        ii. The change that gives councils the discretion to charge for residential care and which ends the current requirement for them to do so. Assuming the status quo – i.e. charging for residential care – councils will need to develop detailed new policies that are subject to full public consultation, political sign off and an assessment of compliance with the Public Sector Equalities Duty. This will carry a cost.

        iii. The withdrawal of informal care so that the cared for person reaches the cap on care costs sooner than they would have otherwise done if informal care continued.

iv. The potential, in the context of more people receiving independent financial advice, for people to be advised on how to avoid making contributions to care fees. Linked, we would like to see more information on the impact of changes to pensions (specifically the end of the requirement to purchase an annuity) on individuals' contributions to their care fees.

v. The duty to mitigate provider failure and have an overview of the market is likely to exacerbate providers' concerns about the fee levels local authorities are willing to pay.

vi. 'Wellbeing' (largely councils' sphere of influence) and 'promoting independence' (more of a role for the individual) are used almost interchangeably as concepts. There is a danger of the former trumping the latter in case law or guidance, which may impact on the possibility of achieving a sufficient emphasis on an asset approach to care (and the linked expectation that individuals should take some responsibility for their own lives).

c. There is potential for certain elements of the reforms to ultimately be shaped through case law. It is likely that some aspects of the reforms, such as national eligibility, and application of the reforms, such as self-assessment, may be defined over time through test cases. This will carry a cost – both in terms of the process itself and the implications of any ruling. For this reason we strongly challenge the Impact Assessment assumption that legal reform will lead to £13.6 million worth of savings from 'staff time and reduced complaints and litigation'.

32. In the context of funding pressures for local government overall, and the consequent impact on adult social care, it is clear that the sector remains concerned about the adequacy of funding for implementation in 2015/16.

a. In the recent Care Act Stocktake undertaken by the joint Programme Management Office, 'total implementation costs' was the second most frequently selected risk associated with delivery (89 per cent/134 respondents). The top risk, 'identifying the number of self-funders locally', is inextricably linked to cost.

b. In the recent ADASS Budget Survey Directors were asked about their level of confidence in the sufficiency of their council's indicative share of the £470 million Year 1 costs as provided by the LGA 'Ready Reckoner'. This shows that:

i. 33 per cent of 102 respondents have no confidence in the sufficiency of indicative funding for early assessments.
ii. 43 per cent of 102 respondents have no confidence in the sufficiency of indicative funding for workforce capacity.
iii. 43 per cent of 103 respondents have no confidence in the sufficiency of indicative funding for carers assessments.
iv. 40 per cent of 101 respondents have no confidence in the sufficiency of indicative funding for carers services.

v. 38 per cent of 103 respondents have no confidence in the sufficiency of indicative funding for a national eligibility threshold at 'substantial'.
vi. 60 per cent of 101 respondents have no confidence in the Government's assumption that legal reform will lead to savings.

33. It is not only the local government sector that is concerned about the adequacy of funding for the reforms in 2015/16. For instance, the recent Public Accounts Committee report on adult social care noted that: "The Care Act will introduce new duties on local authorities…as local authority budgets become increasingly constrained. The Departments [DH, DCLG, DWP] neither understand the scale of some of these changes nor how much it will cost to implement the changes the Care Act will introduce". The PAC report also questioned the feasibility of local authorities being able to "implement all the proposed changes to the intended timetable", and recommended that: "The Departments should quantify the new burdens the Care Act will introduce for local authorities, establish a realistic timetable given the financial constraints, and acknowledge the limits on the sector's capacity to absorb the growing need for care with falling public funding" (Public Accounts Committee, 2014).

34. To the Department's credit it has acted on the sector's concerns about the adequacy of funding in Year 1. Both the LGA and ADASS – along with other local government representative organisations – are committed to working with the Department to better understand the likely costs in 2015/16. If the results from that work suggest a potential gap in what the reforms will cost and what money has been made available then we believe there are broadly three options to pursue.

    a. Delay some or all of the 2015/16 reforms.
    b. Amend the scope of some of the 2015/16 reforms.
    c. Re-open the 2015/16 Spending Round envelope.

35. These options were discussed at the LGA's Community Wellbeing Board on 23 July. The Board was clear that they would be reluctant to either delay or significantly alter the scope of the reforms given the disappointment this would rightly cause amongst citizens who need support, and their carers. We therefore urge the Government to revisit the 2015/16 funding envelop if the latest modelling provides further evidence of inadequate funding for Year 1.

36. Adequate funding for the reforms – both for 2015/16 and 2016/17 and beyond (which will be an order of magnitude far higher than Year 1 costs) – is essential given the significant overall pressures on local authority budgets as outlined above. It is also essential for realising the aspirations of the Act and, ultimately, supporting the people the legislation is aimed at. Inadequate funding will put councils in an even more difficult position, requiring them to decide what not to do or what not to offer.

37. With adequate resources councils will be able to:

    a. Really make the shift toward a more preventative care and support system, and away from an emphasis on costlier 'crisis care'. This in turn will increase the opportunity for local government to help alleviate pressures on health.

b. Provide comprehensive information and advice that helps people understand the system and relevant services that are available locally, thus reducing people's frustration with what remains a complicated system.
c. Promote a diverse and quality provider market that is fairly funded and responsive to the needs of local people.
d. Provide assessments for more people, which will have added importance now that the assessment is, in many ways, a service in its own right.
e. Support informal carers, thus stabilising the bedrock of our care and support system.
f. Support people with their care costs.

Timing and detail

38. In addition to our main concern around funding the Care Act reforms there are two other broad messages to note:

    a. **Timing** remains a concern. The regulations and guidance comprise a substantial body of material and it will take time to do justice to the many consultation responses the Department is likely to receive. Until local authorities have a final set of regulations and guidance (and final IA) incorporating feedback from the consultation they will not be able to nail down all elements of their preparations.

    b. The consultation on the allocation formula for 2015/16 costs is another important document for local authorities and we are conscious that publication of this was delayed. Local authorities are already working to an incredibly tight schedule as they prepare for implementation and we are keen to avoid any further delays – particularly given frustration locally with the BCF process, which is affecting the same part of the council in most areas.

    c. Linked to the above we are conscious that councils are having to work through a significant amount of **detail** within the tight timescales noted above. This includes the aforementioned allocation formula consultation and, looking ahead, the policy decisions that will be made in light of the responses to the regulations and guidance consultation. This will particularly be the case on issues where councils have raised concerns about subjectivity of definition on some key policy issues, such as eligibility. Later this year councils will also have to carefully consider, and respond to, the separate consultation on draft regulations and guidance on funding reform from 2016/17 onwards.

39. Additionally, we believe there is a need to develop templates, agreements and good practice guides to supplement some areas of the regulations and guidance. This will make it easier for new systems to be developed, to ensure those systems are simple, and to minimise administrative costs.

Thematic issues and concerns

40. The remainder of this response sets out headline concerns and issues with certain parts of the regulations and guidance and the policy areas they cover.

Prevention

41. We welcome the Care Act's aspirations for wellbeing and prevention and a move away from a focus on meeting crisis cases. Meeting needs at the preventative end of the spectrum should not simply be about the provision of adult social care. Consideration of the support provided by other council services (housing, leisure, transport etc), as well as that provided by wider community infrastructure and the private sector must also be part of the equation – particularly at the early stage of lower level needs being identified. This includes local authority-funded community support outside social care and other third sector activity and support.

42. However, this aspiration is being severely undermined by the wider financial strain local authorities are under. Wider universal wellbeing services that councils provide (such as libraries or swimming) are precisely those that are being cut as local authorities attempt to protect essential frontline, statutory services.

43. As the Care Act allows for some prevention services to be charged for, a careful balance needs to be struck between affordability and ensuring uptake of services.

Assessment and eligibility

44. This remains a difficult area, particularly given the need to balance a focus on outcomes and an asset approach on the one hand with sufficient clarity of definition to support practical application on the other. We acknowledge the difficulty of getting this balance right and believe that careful consideration will need to be given to the outcomes of the PSSRU work with local authorities on eligibility.

45. We welcome the Department's position that 'national eligibility' will be framed in such a way that it is consistent with the current level of 'substantial'. However, many local authorities have provided a clear steer that the current regulations constitute a more generous definition of 'substantial' than that used currently, despite revisions to restrict their scope. This carries an obvious cost implication and greater clarity (which will also minimise the risk of legal challenge and associated costs) is therefore sought.

46. **Three tests of eligibility**: inevitably there is a degree of concern with these tests. '*Unable to achieve* an outcome', '*significant* impact on *wellbeing'*, and 'carrying out *some or all* basic care activities' remain inherently subjective definitions that may lead to inconsistent application. It is also questionable whether a focus on activities of daily living is an appropriate model for people with mental health problems.

47. There is therefore considerable concern amongst many local authorities that, in relation to the funding available to meet assessed needs, the new eligibility criteria are too widely drawn, not defined clearly enough and linked to broad areas of well-being. Amongst those local authorities who have attempted to model the likely costs of a national 'substantial' threshold as currently drafted, many remain concerned that the threshold is likely to lead to a significant increase in responsibilities and

costs. Greater clarity will minimise risk of legal challenge and therefore help to keep costs to a minimum.

48. **Balance**: the statutory guidance should provide a balanced focus on people's assets, the outcomes they want to achieve, their needs, and personal responsibility for their own wellbeing. We do not feel the current draft of the guidance quite achieves this balance and instead retains, in part, a deficit model based upon the activities a person cannot do, rather than those that they can and their role in helping to deliver identified outcomes.

49. **'Proportionate and appropriate'**: we support the need for a flexible approach to the way in which assessments are carried out and the extent to which any tool is used depending on the person's needs, circumstances and preferences. However, there must be a proper balance between that which is' appropriate' and that which is 'proportionate', and the avoidance of light-touch assessments where people may have complex needs.

Carers

50. To achieve the intentions of the Care Act we need an effective balance between early intervention and prevention, support to carers and targeted and integrated interventions through clear eligibility criteria. As above, we are not convinced this balance has yet been achieved and remain concerned about the impact and burden this may have on carers – particularly given that the 'carers' element of the Impact Assessment's assumes savings of £390 million/year and monetised benefits of £1.34 billion/year.

51. There is clear consensus that costs related to carers – in terms of both assessments and associated services – pose one of the greatest financial risks to the reforms going live in 2015/16.

52. **Communications**: the mainstreaming of carers' issues within the regulations and guidance is welcomed but its success will require significant and sustained communications, learning and development activity. This is needed for both front line staff and their managers and local carers and local carers' organisations.

53. **Eligibility threshold**: as set out above, the term "significant impact" is one of several instances in the regulations and guidance where language is a concern due to its subjectivity. Linked, in order to achieve an eligibility framework that is grounded more in outcomes we would like to see a clearer link between the support carers provide and the impact this has on the supported person's outcomes.

54. **Partnership**: local carers' organisations play a valuable role in the provision of information, empowerment and choice and will be instrumental in taking the Care Act forward. We would like to see the Guidance acknowledge the third sector's role more strongly. We also know that GPs and other health facilities are critical contact points for carers; more could be said in the Guidance about the link between integrated working and the provision of information.

55. **Timeliness**: there are very few references to things being done in a 'timely way' (which is broader in meaning than 'right time') and carers could rightly expect to see this feature more strongly in the Guidance.

56. **Charging**: charging carers for support is provided for under the Care Act and it is helpful to recognise the general sensitivities associated with this (such as the different approaches local authorities may take in respect of charging carers, and the impact charging may have on carers' willingness and ability to continue caring). This recognition could be strengthened further to reassure councils.

Information and advice

57. Information and advice will be a key feature of the new system and in many cases people's first interaction with it. It is therefore essential that the offer is clear, affordable and deliverable.

58. **Definition**: given the importance of information and advice in the new system the guidance could more clearly and consistently differentiate between the two terms.

59. **Reach**: the information and advice function must not be seen as a responsibility solely for local authorities, but local partners as well. There are also clear links between the service offer and the national public awareness campaign, with a need for materials for health audiences to support referral and signposting.

60. **Financial advice**: facilitation of access to independent financial advice is potentially the most problematic aspect of the Guidance on information and advice and an area of concern. The draft guidance states that financial advice should be independent of the local authority. It is critically important that this advice is also independent of any provider of financial products, or their subsidiary or linked organisations, and complies with financial services legislation. It is not easy for non-financial services industry personnel to detect such a link and even more difficult for the public. The mention of the Money Advice Service is therefore helpful.

61. As above, we also have a degree of concern about the potential for people to receive financial advice that encourages care fees avoidance.

Charging and deferred payment

62. **Extension**: it is helpful for individuals that the Deferred Payment Agreements (DPA) scheme is being made universal. Consideration should be given to extending the scope of DPA to include those people with high level needs who are supported in the community.

63. However, the Department will be aware of our concerns regarding deferred payment agreements, particularly in relation to recovery rates and cash flow. And this is another policy area that will also be impacted by the level of national (and local) awareness raising campaigns.

64. **Property renting**: we support the practice of people with a DPA in residential care renting out their home, but recognise the logistics involved may deter them from doing so. Rental would partly resolve the inherent policy tension between the government wanting to provide more homes on the one hand, yet encouraging homes to remain vacant and unoccupied through DPA on the other.

65. Renting properties that are vacant owing to a DPA opens up more houses in a difficult housing market and, if managed well, offers the scope to improve the condition of the property. Where property is in poor condition mechanisms must be put in place to bring it up to standard – these costs must be recoverable if they are picked up by the local authority.

66. **Interest rate**: there are a number of considerations for interest rates including offering an interest rate ceiling (i.e. tied to the Bank of England base rate), offering a higher rate for discretionary elements, and ensuring administrative systems can cope with compound interest rates to ensure that the real costs associated with DPAs are picked up.

67. **Security**: we strongly disagree that local authorities should be required to accept any legal charge on a property as security – they should only accept security which is sufficient to enable the full recovery of the deferred debt.

68. **Pensions**: we have some concern that changes to pensions announced in the Budget (the removal of the requirement to purchase an annuity) will potentially mean more income and capital disregards, thus reducing charging income for local authorities. We would like to see guidance refer specifically to the changes to pensions

Other issues

<u>Workforce</u>

69. The workforce challenge inherent in delivering the reforms cannot be overstated. This is partly about recruitment and retention but it is also very much about ensuring staff at all levels have the appropriate skills and knowledge required to implement the reforms. This has clear links to comments made below where we raise concern about the Department's assumptions to do with the level (and cost) of training required.

70. We anticipate significant capacity challenges on assessments (even with an assumption that self-assessment becomes default where appropriate), information and advice and DPA administration.

71. Local authorities may wish to work together regionally to maximise capacity (such as on training) and further consideration will need to be given to the 'delegation of function' powers and how they could be used to alleviate workforce pressures within local authorities. However, whilst the use of delegation powers may reduce capacity pressures they will not reduce cost pressures as organisations will need to be commissioned to carry out the delegated activity.

IT and informatics

72. The challenge here is broadly twofold. In preparing for 2015/16 reforms the focus will be more on ensuring that IT is fit for purpose for activity such as case recording, managing DPA administration and the provision of online information and advice. In the main we are confident this is on track, though there is some uncertainty in cases where local authorities may be in the middle of changing or upgrading their systems.

73. In preparing for the 2016/17 changes the issues are more strategic and require councils to think about how data flows across the local health and social care system to the benefit of the individual and the professionals working to support them. In short, we need to develop an IT and informatics service that supports the drive to person-centred care (including portability) and optimum system efficiency. This will come with a cost – particularly in terms of systems being compatible both within and between local authorities.

Boundary with health

74. The policy intention to maintain the boundary between local authority and NHS responsibilities (and so responsibilities for funding and in particular of the contributions people make for treatment, care and support) is enacted in Section 22 of the Care Act. There are, however, a number of places at which the draft regulations and guidance lack this clarity and need to be amended, including the sections identified below.

    a. In the draft care and support (eligibility criteria) regulations, identifying needs which meet the eligibility criteria at Section 2(2)(d) currently reads: “accessing necessary facilities or services in the local community including medical services, public transport, educational facilities and recreational facilities or services”. This appears to give local authorities responsibility for accessing medical services and therefore needs to be amended or removed.

    b. In the draft guidance (information and advice, Section 3) paragraph 3.23 sets out the breadth of circumstances under which information and advice must be provided by local authorities. It further states that councils: “must ensure…that this goes further than a narrow definition of care and support”. Whilst we agree with this in principle, this paragraph goes on to suggest that this includes: “effective treatment and support for health conditions”. This suggests social care staff giving information and advice outside of their knowledge base. It would be helpful for further clarification on this issue to ensure that the requirements on social workers are appropriate and fair.

    c. Paragraph 6.63 sets out the need for local authorities and CCGs to work together where a person has both health and care and support needs. Although this makes explicit that local authorities should ensure that healthcare professionals’ views and expertise are taken into account, it would be helpful to also make explicit that, where appropriate, the person is referred for assessment for NHS continuing healthcare. Where there is a move to more integrated

assessments it should be recognised that health tends to be far behind local government on personalised assessment processes.

Delayed transfers of care

75. Paragraph 15.42 sets out that the NHS and local authorities should work together to reduce delays where a person is ready to be transferred from NHS acute medical care to other settings. It also indicates that the NHS may seek reimbursement from local authorities in certain circumstances. For the avoidance of doubt, it would be helpful to also make explicit that this is not the case where a person is waiting for assessment, or has been determined as eligible, for NHS continuing healthcare.

Safeguarding

76. Further consideration needs to be given as to what should be included in statutory guidance and what should be included in practice guidance. Currently there is a lack of continuity in regard to the appropriateness of information provided in regard to safeguarding.

77. Although it is welcome that councils remain leaders in regard to safeguarding, greater emphasis needs to be placed on the safeguarding responsibilities of key partners in order to explicitly promote multi-agency working throughout.

78. In order to best emphasise and meet our twin aims of reducing the incidence of harm and abuse and improving outcomes for and with people once concerns have been raised, more reference to safeguarding should be made throughout the statutory guidance.

Advocacy

79. The requirement to place advocacy on a formal footing is generally seen as extremely positive and is welcomed across the sector. The recognition that additional resources will be required to provide the necessary levels and to ensure timely and equitable access is critical.

80. The primary link between independent advocacy and an individual's capacity is broadly welcomed as this should ensure that the most vulnerable and those least able to navigate the system are most supported.

81. Inevitably descriptions or definitions of functions are extremely difficult. As a starting point the term 'advocacy' has at least quasi legal, formal and informal meanings. Anything that can be done to clarify this would be helpful.

82. Similarly, the description of determining the circumstances in which a person would need to have an independent advocate appointed to support their involvement is somewhat confusingly written due to the number of caveats and circumstances on which this depends. Any clarity or more simplified language would be welcome (paragraphs 6.27 – 6.30).

83. There is perhaps some tension in the current drafting between prescriptive step by step descriptions of process rather than more specific clarity of the circumstances where advocacy should be applied. Emphasis on conditions rather than process would be welcomed.

84. While practice guidance will assist in the implementation of the Act, the regulations should be as clear as possible, recognising that this will refer to adults and children and to carers who themselves may have a range of conditions and circumstances.

Conclusion

85. The LGA and ADASS remain committed to the reform agenda and continuing to work collaboratively with the Department of Health to successfully deliver the Care Act. Implementation is not without significant challenges, however. The financial context in which local government is operating is unquestionably impacting on adult social care budgets. This heightens the need for the reforms to be fully costed and fairly funded. The timetable for implementation is also a challenge, particularly with important information still to be published.

86. The draft regulations and guidance are, in the main, a helpful next stage in the process. However, a number of issues need to be addressed, some of which have been raised above. For a more in-depth treatment of the issues please refer to detailed thematic submissions provided by ADASS Director leads and associates. The full list of submissions is set out below.

    a. Carers
    b. Safeguarding
    c. Prisons
    d. Assessment and eligibility
    e. Advocacy
    f. Charging and financial assessment
    g. Information and advice

Annex A

Care and support legal reform: LGA/ADASS initial views on 2015-16 costs and impact assessments (submitted May 2014)

KEY ISSUES

The tables below give some comments / queries on the detail of the existing impact assessments which we hope will be helpful in developing the updated versions.

CONSOLIDATION/MODERNISATION OF LEGISLATION

Paragraph reference	Comments
1.54	We do not agree with the assumption that because info/advice duties in the Bill clarify/update existing duties, there is no likely additional cost. Existing information will need to be completely updated to explain how the new system works, for example. This may also require a substantial overhaul of existing web sites, the procurement of new software systems, and relevant training for staff.

PORTABLE ASSESSMENTS (P26)

Paragraph reference	Comments
2.41	'The impact assessment for the eligibility regulations will provide detailed costings of setting the eligibility threshold at the specified level' – yet to see that happen, because what we have is by no means a detailed costing. The IA states that this will include implementation costs and the cost of staff training.
2.50	Could the next version set out the assumptions, what the ranges are, and what they are based on?
2.51	Assessment cost of £450 and average weekly domiciliary care cost of £192 per week, or £16 per hour at 12 hours per week. What is the source? These figures seem low - fewer than 2 hours per day is quite unusual but we are not aware of any good national data on this.
2.53	Para 2.53, table 9 – need to build demographic growth in to later years. We are not confident that it is realistic to assume a build-up over 3 years . We would be reluctant to assume that councils will be able to manage

	demand to keep within these limits because this causes significant problems in terms of presentation and reputation locally.

ASSESSMENT AND SUPPORT TO CARERS (P32)

Paragraph reference	Comments
3.27	Unit cost of a carer assessment is based on a range provided by Surrey Council (£90-£120). The IA then goes for a 'central' estimate of £100, arguing that costs at the top of the range arise with qualified social workers. We agree that councils will need to find cheaper ways to respond to demand for large numbers of assessments, but very helpful to make this transparent – in particular that the Government does not expect all assessments to be carried out by qualified social workers.
3.28 (p32)	Is there newer data available now? It is not clear how the calculation takes into account those carers who care for someone who does not have eligible needs could come forward for an assessment. It would be very helpful to have a further conversation with colleagues about this, as we fear this could be a substantial under-estimate and this may be an area where we need to do more work collectively (and rapidly).
3.29 (p32)	Why the 90th percentile, why not the top performing council? There would be a massive jump in the number of assessments, with the % of carers assessed going up from 39% to 69%
3.30	How many councils provided that data in the 2009/10 survey? This might be out of date because of the trend of tightening care eligibility thresholds in the face of falling budgets, hiding the true demand for carer services.
3.31	What about Carers not known by association?
3.36	Will this data be updated? It does not seem to take into account demographic changes and the inevitable increase in carers both for older people and those with physical and /or learning disabilities living longer and more independently.
3.28-3.29 (p34)	This comes back to the 90th percentile point
3.34	Why 20-40%? We couldn't see any basis for this range in particular, rather than (say) 10% for example.
3.36	Don't understand why service cost growth is spread over 5 years but the

(table)	assessment growth spread over 3 years – which is the more realistic scenario? Also, no demographic growth built into later years
3.44	The results in the first bullet imply that about 10-18% carers (FTE equivalent) had to leave employment. The 20-40% range in para 3.34 above therefore appears to be an optimistic estimate.

ACCESS TO INDEPENDENT ADVOCACY (P40)

Paragraph reference	Comments
4.11 (table)	How do 230,000 additional assessments in 2015/16 turn into 255,000 additional reviews in 2016/17? Who are these 25,000 people?
4.15	RAP data just a few pages ago puts this at 189,000.
4.15-4.16	Most of these assumptions based on 'discussions with experts' – without any hard data to back these up we are concerned that the assumptions made may be over-cautious.
4.17	Why four years, and not 3 or 5 as in previous section?

CARE AND SUPPORT TO PEOPLE IN PRISON (P46)

Para 5.16, tables 17 and 18 – is the data in the tables up to date?

IMPLEMENTATION OF LEGAL REFORM (P59)

We do not agree with the assumption that 'simplifying the law will reduce the administrative burden on social workers as they will spend less time interpreting legal issues'. It feels more likely – at least in the early years – that social workers will spend *more* time interpreting legal issues as the system beds down.

Similarly, the assumption that 'clearer and simpler law will mean that better decisions are made with fewer mistakes, which will in turn result in fewer complaints' is questionable. Rather than a reduction in complaints we may well see an increase, particularly in the early years.

On training, costs are determined based on an assumption of 4 days per social worker in Y1 and 2 days in Y2. Given the changes involved this may be an underestimate of the training required – particularly in the context of a shortage of social workers and a dependency on agency staff. Costs are also based solely on training for social workers, but other staff groups – such as legal teams – will also require training.