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Health, Public Health and Social Care

Care and Funding Reform – Making Sense of the Costs - Before and After the Election

Programme

- Social Care Reform
- Adass Budget Survey and Spending Review
- Workshop Discussion on Care Reform
- Funding Reform
- Modeling the Reforms
- Workshop Discussion on Funding Reform
- Summary

Social Care Reform

- Social Care Reform - Financial Context
- Future Funding and feeding into the Spending Review
- Deferred Payments Implementation
- Advocacy
- Self Funders
- Carers Activity, Costs and Benefits
- General Health and Social Care Financial Context
- Better Care Fund and General Context
- Monitoring Activity, Costs and Benefits

Social Care Reform – 2015-16

Funding	**15/16 (£m)**
Better Care Fund	135
DoH Grant Prisons	11.2
Grant - Additional Carers, etc	50
Formula Grant	229.5
Capital Grant	50
Total	**475.7**

Updated Impact Assessment – Oct 2014

Social Care Reform and Funding Reform - From Updated Impact Assessment for Consultation					Oct-14
2015-16 prices	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**
	£m	**£m**	**£m**	**£m**	**£m**
Continuity of care – moving into areas until reassessment	4.4	9.9	13.4	13.4	13.4
National Eligibility - transition costs	3				
National Eligibility - total recurring costs	25.3	25.3	25.3	25.3	25.3
Carers - Assessments - Original 15/16 - Updated future years	22	36.6	41.8	41.8	41.8
Carers - Support - Original 15/16 - Updated future years	47.4	187.4	233.3	247.5	251
Access to advocacy	14.5	34.6	49.5	67.1	67.1
Safeguarding - Implementing statutory Safeguarding Adult Boards	6.4	6.4	6.4	6.4	6.4
Market oversight regime	1.8	1.7	1.7	1.7	1.7
Implementation of legal reform	4.7	2.3			
Other	5.5				
Total Costs excluding Universal Deferred Payments - (BCF - 15/16 only)	**135**	**304.2**	**371.4**	**403.2**	**406.7**
Assessment,provision of care & support in prisons (DoH Grant)	11.2	10.3	10.3	10.3	10.3
Universal Deferred Payment Scheme (UDP)	83.5	121.1	132.1	118.5	87.3
Additional Carers and Implementation (grant)	50				
Social Care Costs Associated with Funding Reform					
Assessment of Self Funders	116	274.1	132.3	136.1	141.1
Reviews of Self Funders		89.3	173.3	179.2	185.5
Capacity Building	20				
Information	10				
Total UDP & ASC Funding reform (£229.5m form grant 15/16 only +£50m)	279.5	484.4	437.7	433.8	413.9
Total Costs	**425.7**	**798.9**	**819.4**	**847.3**	**830.9**
Capital Costs	50				
Total Revenue and Capital Costs	**475.7**	**798.9**	**819.4**	**847.3**	**830.9**

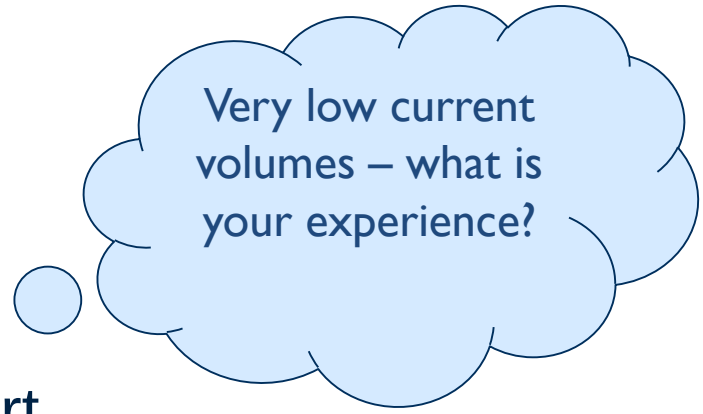
Note - all except social care costs associated with reform drawn from impact assessment & consultation on funding distribution

Costs for assessment and review of self funders based on published figures for 15-16 and estimates for future years

More Realistic Scenario– 2015-16

Social Care Reform and Funding Reform - A Scenario - Sept 2014	15/16 (£m)
Continuity of care – moving into areas until reassessment	4.4
National Eligibility - transition costs	3
National Eligibility - total recurring costs	25.3
Support for carers - Put carers on a par with users for assessments - up to	50
Support for carers - Introduce a new duty to provide support for carers - up to	125
Access to advocacy	14.5
Safeguarding - Implementing statutory Safeguarding Adult Boards	6.4
Market oversight regime	1.8
Implementation of legal reform	4.7
Other	5.5
Available at least	47.4
Total Costs excluding Universal Deferred Payments	**288**
Assessment,provision of care & support in prisons (DoH Grant)	11.2
Universal Deferred Payment Scheme (UDP)	18.5
Social Care Costs Associated with Funding Reform	
Assessment of Self Funders - focus on those likely to reach the threshold - up to	78
Reviews of Self Funders	
Capacity Building	20
Information	10
Total UDP & ASC costs with Funding reform - (formula grant - 15/16 only)	126.5
Total Costs	**425.7**
Capital Costs	50
Total Revenue and Capital Costs	**475.7**

Deferred Payments



- Deferred payments scheme in place
  - Approximately 40 at any one time
- IT system being introduced to support the scheme
- Expecting to require more staff capacity but difficult to anticipate

Advocacy

- Working across the Council to retender all advocacy to deliver efficiencies
- Expecting to maintain or increase investment to meet requirements of the Care Act
- New arrangements will be tendered during 2015/16 with contract in place from April 2016
- During 2015/16
  - Current capacity to be targeted to comply with the Care Act requirements
  - Demand & capacity will be monitored closely
  - Increased investment within the year if required

Self-funders (1)

- 50% of residential/nursing home beds not purchased by the Council or the CCG
- Estimating demand: Lincolnshire model
  - 890 in Residential/Nursing homes
  - 1741 using Home Care Agencies
- Aim to start assessments from October 2015 onwards
- Information campaign
  - Building on National publicity
  - Timing to fit with assessments starting from October 2015
  - Decision on how hard we promote assessments to current self-funders & ability to intensify or scale back the campaign

Self-funders (2)

- Capacity to assess
  - Ensure assessments are proportionate for person's situation
  - Short financial assessment, recognising the person is funding their own care
  - Balance ongoing capacity for the future with the need to assess current self-funders
    - Mix of permanent & short term contracts?
    - Mix of permanent staff & outsourcing of current self-funders?
  - Role of providers – potential to delegate assessments?
  - Early stages of developing on-line self assessment

Funding Reform - Early Assessments

Targeted Assessment

- Initial focus on those people with modest assets, who would benefit from the rise in the upper capital limit, and may become eligible for financial support from the local authority.
- But dependent upon final decisions about proposals by a new government and final regulations and guidance not available until October 2015 at the earliest. \
- Develop plan and identify means of delivery but only implement once proposals are confirmed.

Social Care Reform - Carers

- We currently only offer support to 354,000 carers
- Yet 900,000 carers providing more than 50 hours of care a week – have at least one long term health condition
- 500,000 carers provide support to someone with dementia
- Are people expecting to offer more targeted support to carers?

Family Carers

- Census 2011
  - 60,000 people identified themselves as carers
  - Ambition to “reach out” to as many of these carers as we can
- New model of support for carers developed
  - Community Support & Contingency Planning
    - Preventative approaches including information & advice
    - Specialist responses
    - Contingencies
  - Delegation of some assessments
    - When we do not know the person being cared for
    - Carers of self-funders
    - Young Carers who will be caring after 18
  - Tender completed & new contract starts 1 April 2015
- Additional capacity for assessments of other carers

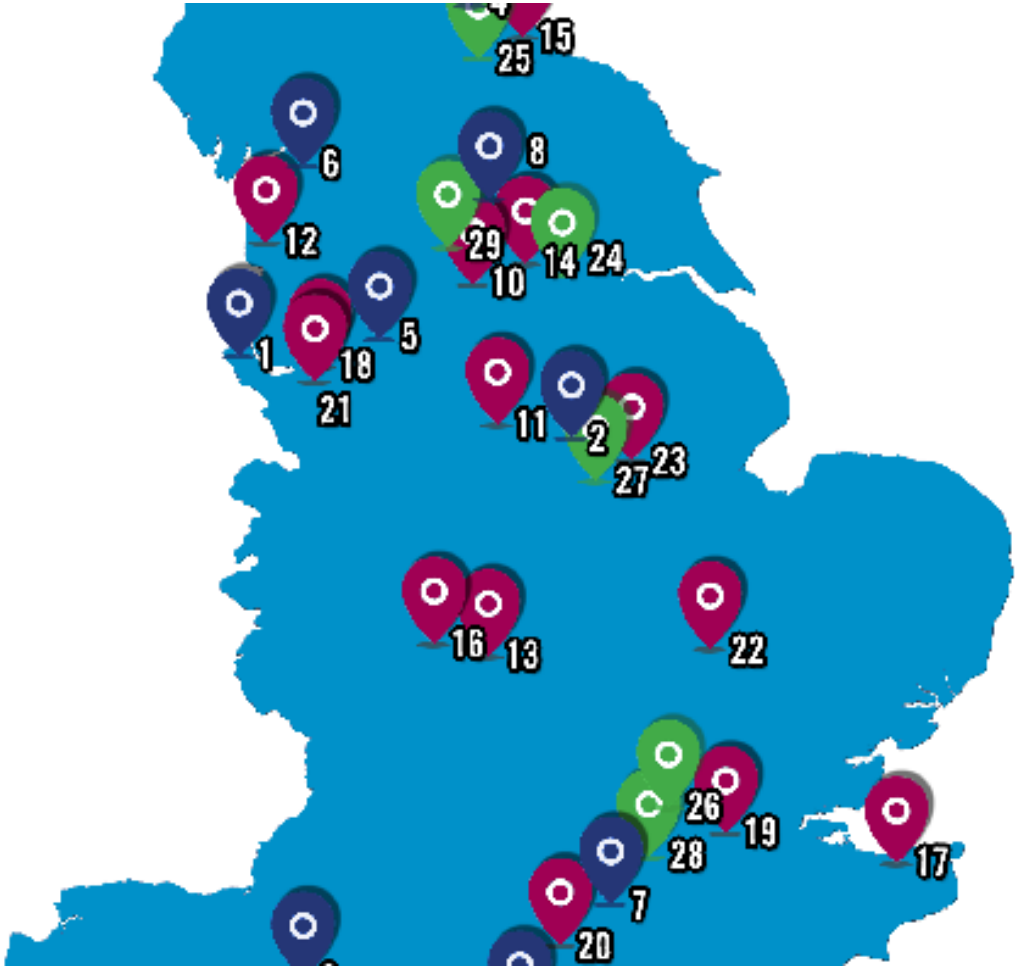
Social Care Reform – 2015-16

Social Care Reform Costs & Benefits - Updated Impact Assessment					**Oct-14**
2015-16 prices	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**
	£m	**£m**	**£m**	**£m**	**£m**
Support for Carers					
Costs					
Put carers on a par with users for assessments	31.3	36.6	41.8	41.8	41.8
Introduce a new duty to provide support for carers	73.3	187.4	233.3	247.5	251
Total	104.6	224.0	275.1	289.3	292.8
Benefits					
Recurring Savings	154.7	196.3	282.1	355.7	429.3
Monetarised Health Benefits	683.7	1607.4	2110.5	2262.9	2308.8

Source – Final Impact Assessment October 2014

Worth investing in carers given very substantial savings to health

Health and Social Care Recent Developments and Context



29 NHS Vanguard Sites

9 Integrated Primary and Acute Care Systems - Blue

14 Multispecialty Community Providers – Red

6 Enhanced Health in Care Homes – Green

Greater Manchester

Who would like to be like Greater Manchester ?

Whole System
Early Involvement of Finance

evidence for better health care

nuffieldtrust

4 The role of money

Assumption

Commissioning decisions will be guided largely by concerns about money

What we found

- Money did not seem to be central to a lot of the discussions we observed;
- Money often appeared late on in the story;
- The major decisions appeared often to happen in parallel to the 'nitty-gritty' of commissioning.

High cost patients have diverse needs – elderly patients with multiple long term conditions use community care heavily

Preliminary

Average high cost elderly patient with multiple comorbidities and risk factors
(1,300 patients in segment)

Details

Name 65+, 2+ co-morbidities, 1+ risk factors

Age 78 (avg.)

Health

Top Comorbidities
- COPD (50%)
- Myocardial Infarction (42%)
- Diabetes (41%)

Top Risk Factors
- Hypertension (92%)
- Addictions (18%)
- Obesity (5%)

Service utilisation

		2013[1] Utilisation	2013[1] Spend
Primary[2]	Appointments	18	£500
Inpatient	Spells	3	£7,300
Outpatient	Episodes	10	£1,000
A&E	Attendances	2	£200
Mental Health	Clusters	0	-
Community	Visits	47	£1,700
Social	Visits	*Expected high user of social care*	
Total		**80**	**£10,700**

Reasons for admission (Top Primary Diagnosis CCS Codes)
- 87 – Retinal detachments; defects; vascular occlusion; and retinopathy (8%)
- 122 – Pneumonia (except that caused by tuberculosis or sexually transmitted disease) (5%)
- 127 – Chronic obstructive pulmonary disease and bronchiectasis (5%)
- 159 – Urinary tract infections (4%)
- 59 – Deficiency and other anemia (4%)

Whole System
Make The Most of Opportunities

evidence for better health care

nuffieldtrust

5 The nature of change

Assumption

Commissioning is a mechanism which allows you to make abrupt and radical changes to service provision (de-commissioning and re-commissioning)

What we found

- Change can be very slow to bring about;
- Commissioners are sensitive about disrupting the local health economy;
- Change often entails moving staff between organisations;
- Easier to bring in something new than to decommission;
- Senior and sustained project management is critical.

The biggest 'Efficiency Frontiers' are where the major costs in healthcare are:

- Management of people with long-term medical conditions
- Care of older people
- Care for people at the end of their lives
- And so not just reducing avoidable emergency admissions

Source: Nuffield Trust (2010): Making Progress on Efficiency in the NHS in England – Options for System Reform

Care Act – Better Care Fund

- Likely to be ***more effective as part of larger scale transformation*** in acute, primary and community care – for example – Greater Manchester
- ***Need to be realistic*** about the scale of what can be achieved for the moment and ***hope to grow the size of the Fund.***
- Need ***Early Involvement from Finance – better financial information on groups of individuals***
- Still ***Make the Most of the Opportunities*** – ***however small - Avoid just a focus on Acute Care***
- Recognise ***Long Term Commitment – Life Time Opportunities***
- ***Adass/LGA view that new care act burdens should not be funded through BCF.***

Adass Budget Survey

- Budget Survey 2014-15
- Budget Survey – Adass Context
- Barker Commission – Funding Proposals
- Funding Contrasts – Health & Social Care
- Budget Issues and Opportunities
- Spending Review Timetable and Context

Social Care Budget Analysis Key Messages – 2014

- 3 years of cash reductions in social care spend
- 5 years of real terms reductions
- Cumulative saving over last 4 years of - £3.53bn
- Saving of 26% over this 4 year period - which coincidently is the the percentage reduction in formula grant

Budget Survey Analysis
Key Messages

Department of Health
Department for Communities and Local Government

Adult social care in England: overview

- Care Needs rising especially Older People.
- Yet Older Peoples Spending reduced by 12% 2010/11 and 2012/13 and expected to fall further.
- Central Government intention to protect spending but scale of grant funding reductions has not enabled this to happen.

Budget Survey
Key Messages

- **Protecting investment in prevention** – with the cash sum largely the same in 2014-15 compared to 2013-14 – at £923m – although still only 6.8% of the net budget;
- **Funding 83% of demographic change of £391m**; and
- **Seeking further efficiency savings of £679m** – a 4.9% saving.

Budget Survey
Key Messages for 2015-16

Significantly more Directors agree than disagree that:

- ***Fewer people*** *will be able to access support;*
- *Councils will face* ***increasing legal challenge****;*
- ***Providers*** *will face* ***financial difficulty*** *with increasing risks of provider failure or worse;*
- *The* ***NHS*** *will come under* ***increasing*** *rather than reducing* ***pressure.***

ADASS – Budget Survey - Context

- Intention to protect ASC have been wholly overtaken by overall need to make savings - ASC is the largest percentage component of the budget
- Funds transferred from NHS have helped. BCF funding needs to be on recurrent footing - protecting ASC the goal – also ensure BCF is not used as a mechanism to fund new burdens – unless clearly identified through whole of NHS England Funding Arrangements
- Local authority reluctance to see ASC ring fenced but support for aligned 5 year settlements for health and ASC
- We probably need current funding to be put on steady state basis, and get demography and inflation.
- Independent views (e.g. NAO and Barker Commission) express concern about further scope for ASC savings.
- The funding reform proposals only look at how much people will contribute not the overall funding of social care.

Funding Reform
Future Funding

Immediate measures – £3bn

- **Targeted Benefits –** for example - Winter Fuel, TV Licences - £1.4bn
- **Prescription –** £1bn
- **Consistent Accommodation Costs across Continuing Care and Residential and Nursing Care** - £200m
- **NI – Working Pensioners** - £475m

Funding Reform Future Funding

Longer Term

- **National Insurance– 1% for those over 40 as a Health and Care Contribution -** £2bn
- **National Insurance – Higher Earners -** £800m
- **Review of Wealth Taxes - ?**

Commission on the Future of **Health** and **Social Care** in England

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A new settlement for health and social care

Final report

Chair
Kate Barker

Budget Survey – Some Contrasts

- How much claimed extra spending power for Local Authorities in CLG statement - £1.795bn?
- NHS Trust Hospitals deficit ? - £635m
- Foundation Trust Hospitals deficit ? - £235m
- How much extra real extra spending power for LA's through Better Care Fund?
- How much overall cash increase for NHS £3bn?
- How much overall cash decrease for LAs ?

We will find out some of the answers through the ADASS Budget Survey

Health Cash & Real Terms Growth

1- Funding growth between 2014/15 and 2015/16

Budget excluding depreciation and impairments (on same basis as DH spending review settlement)	2014/15	2015/16	Cash growth on previous year	Real terms growth on previous year
Department of Health total DEL (Departmental Expenditure Limit)	113,036	116,389	3.0%	1.5%
NHS England total revenue and capital funding (including section 7a but excluding surplus carry forward)	98,142	101,138	3.0%	1.6%

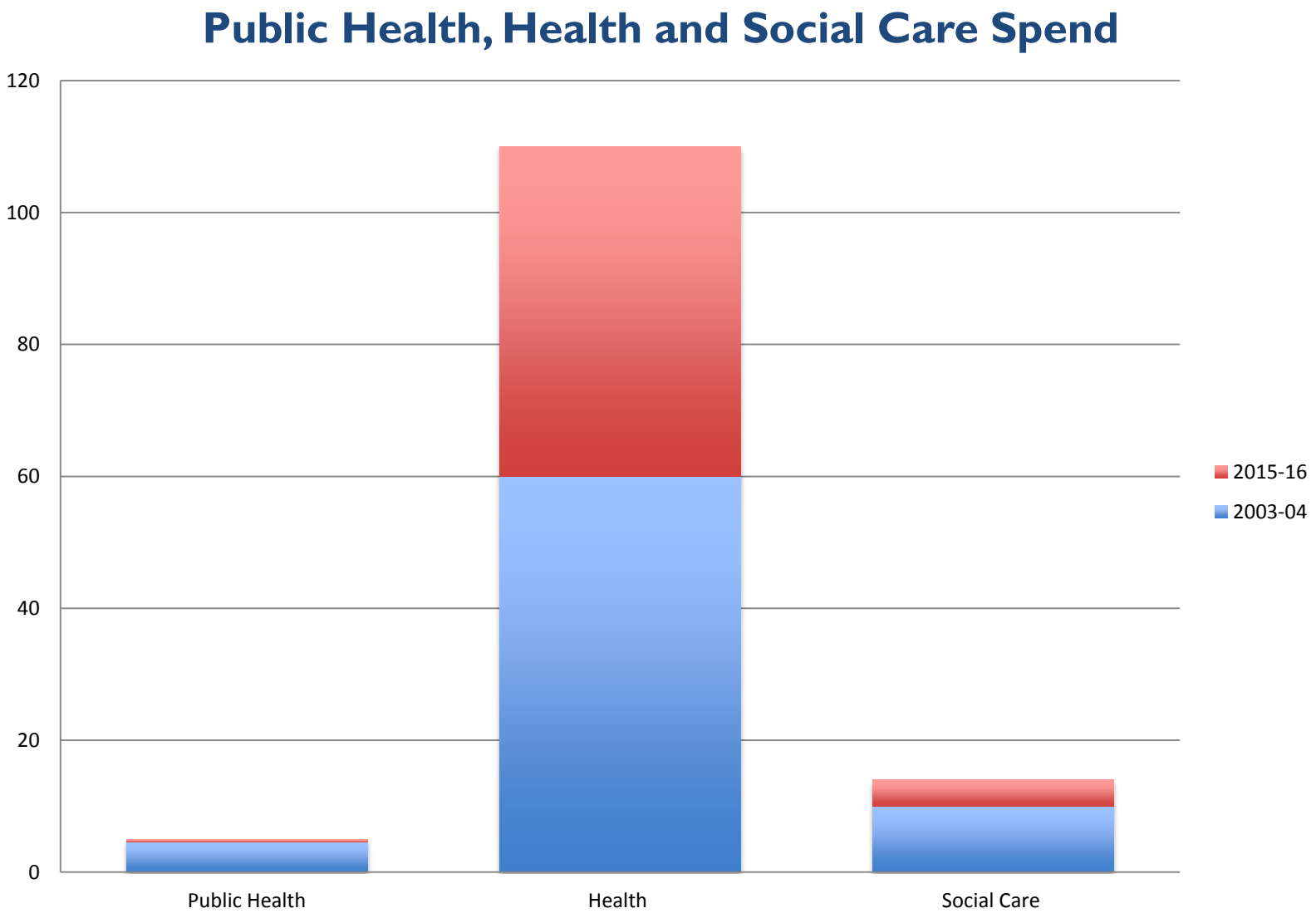
Budget Survey – Issues/Opportunities

- Are we reaching a tipping point?
- Has 'efficiency' covered lower volume and pegged prices?
- Is a 'flat cash' situation sustainable?
- Do new statutory duties remove room for manoeuvre?
- Will integration with health save social care money?
- Should we cost up the 'fair price' of care?
- If more money was available – where would you invest this across health, public health and social care?
- Is there a combined heath, public health and social care spend plan across the LA – akin to the arrangements that will presumably need to be in place in Greater Manchester?

Health and Well Being Opportunities

- In 12 years since Wanless - how much additional Public Health investment - £500m – 10% increase
- We have seen dramatic reductions in smoking - how much does this cost - £100m
- What about Health Checks - £250m
- NHS spending - how much additional spending over same period - £50bn plus - 80% increase
- Social Care Spending - £4bn – 40% increase
- How much does current extra demand cost us a year - £4bn - £6bn plus a year ?

Spend Change 2003-04 – 2015-16



Public Health England

NHS Health Check: benefits to health

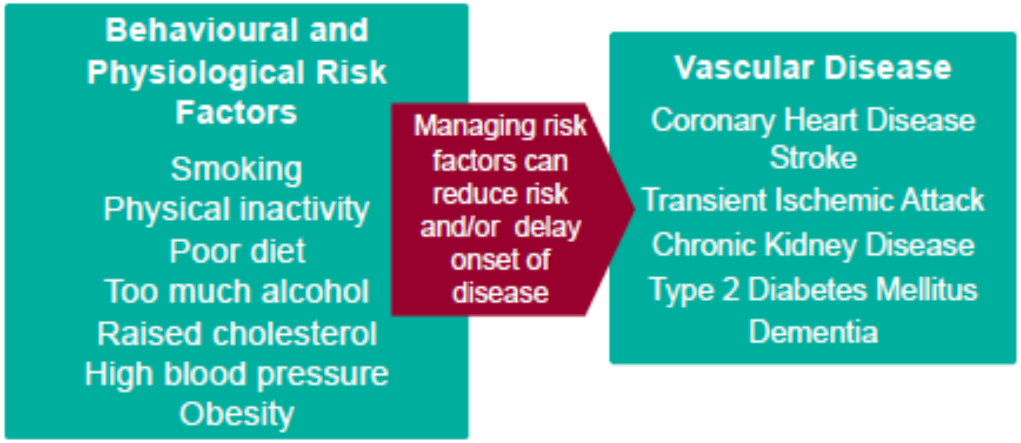
Reducing and managing risk factors will reduce prevalence and effects of disease

Vascular disease: over four million people in England are estimated to have vascular disease, which is recognised as the largest single cause of long term ill-health, disability and death. Vascular diseases are responsible for over a third of deaths and a fifth of hospital admissions in England each year.

Dementia: more common in people as they get older, it is estimated that 670,000 people are living with dementia in England. Over half have Alzheimer's disease and up to a third vascular dementia. In many cases however these conditions coexist and are thus likely to be subject to delay in symptoms if we manage the common risk factors that predispose to them.

Alcohol consumption: over 10 million people in England are drinking at levels which increase their risk of ill-health. [Ref 5-7]

The NHS Health Check programme helps to prevent the onset of vascular disease and vascular dementia by supporting changes to and management of behavioural and physiological risk factors.



- it is estimated that around 850,000 people are unaware that they have type 2 diabetes; half of all people diagnosed have serious complications [Ref 8]
- in more than 90% of cases the first heart attack is related to preventable risk factors [Ref 9]

Public Health England

NHS Health Check: responsibilities

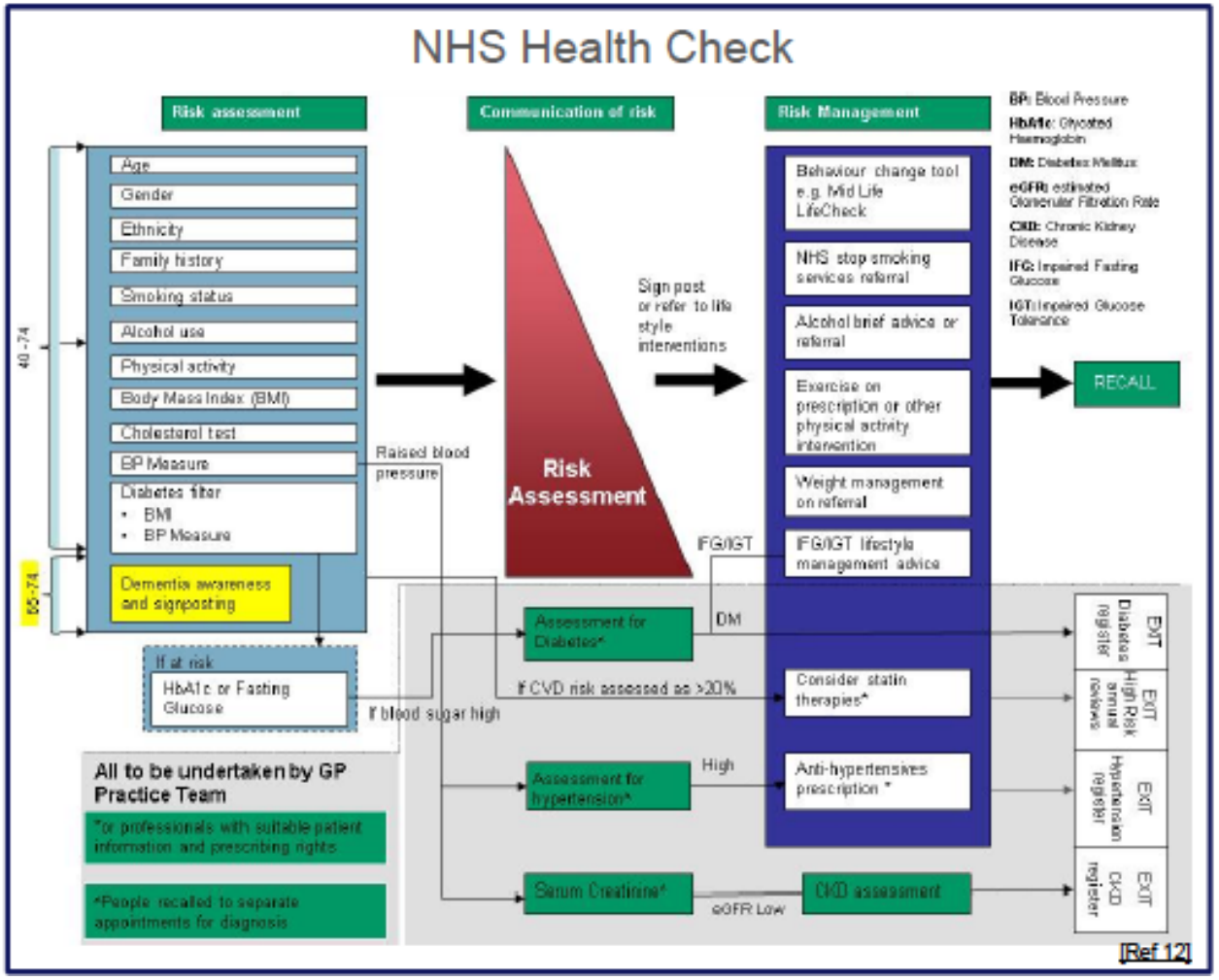
Local authorities are mandated to commission the NHS Health Check and are encouraged to work with the HWBs to commission local interventions

From April 2013 local authorities are mandated to provide the NHS Health Check programme. Money has been allocated as part of the public health ring fence to provide NHS Health Checks for 20% of the eligible population per year.

For benefits to be secured, local authorities will need to ensure the programme is seen as part of a strategic approach to tackling morbidity and mortality from vascular disease and have a clear sense of how it impacts on local priorities.

They will need to provide:

- strong leadership at the health and wellbeing boards (HWBs) and work closely with the clinical commissioning groups (CCGs) to ensure a co-ordinated response
- risk assessment and follow-up interventions, with clear links to commissioned staying healthy initiatives and community development programmes [Ref 11]



[Ref 12]

Public Health England

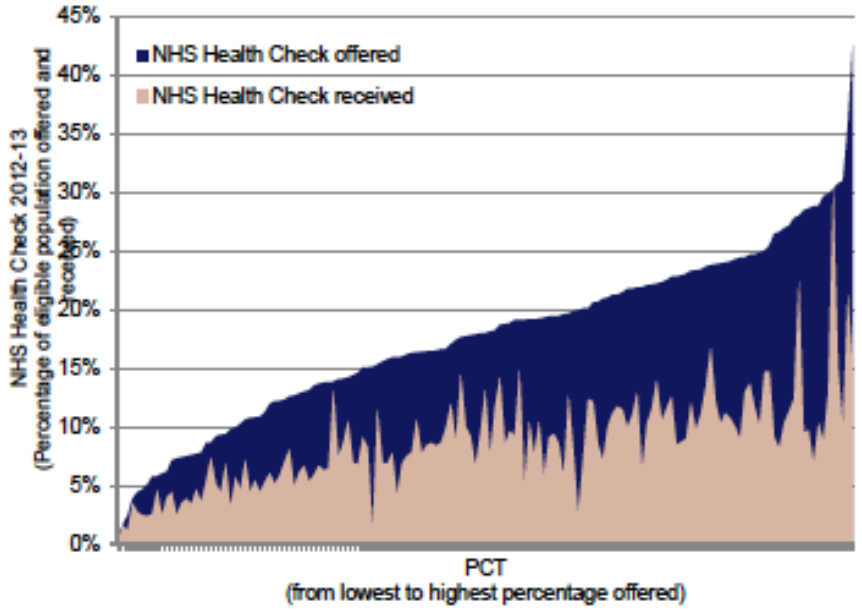
NHS Health Check: varying implementation

Local authorities will be taking on programmes at varying stages of implementation and performance

Before April 2013, primary care trusts (PCTs) had responsibility for commissioning the programme. Phased implementation began in 2009. The number of NHS Health Checks offered and received has varied significantly across England. Therefore local authorities will be taking on programmes in varying stages of implementation and with widely varying performance.

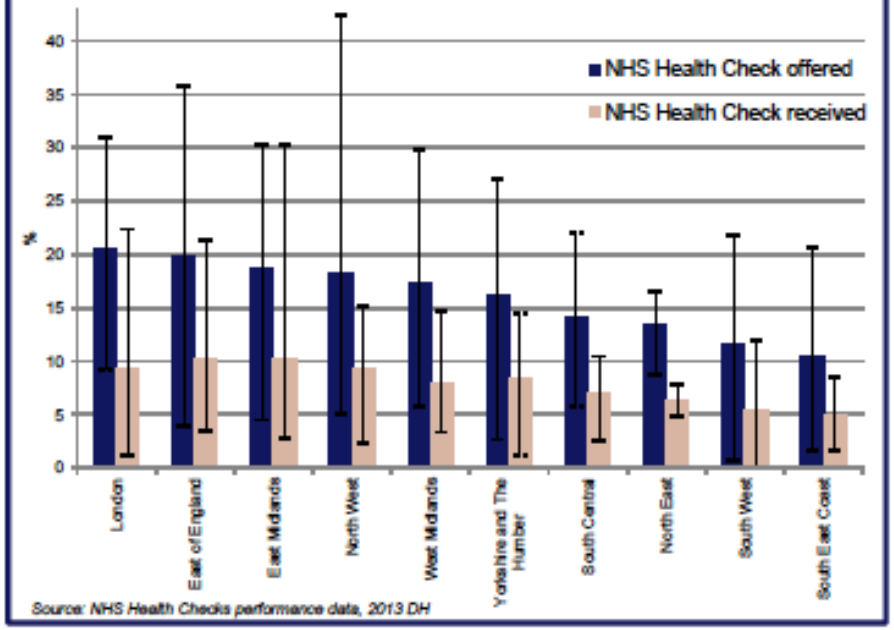
Learning from similar programmes has demonstrated that it takes time to increase uptake rates and with the programme still in its early stages, it is encouraging that the national take-up rate in 2011/2012 was 52% and that during transition, in 2012/13 it was 49%.

A comparison of offered and received NHS Health Checks by PCT (2012/2013)



Source: NHS Health Checks performance data, 2013 DH

Variation in NHS Health Check offers and take-up rates across SHAs (covers all 2012/2013; each year 20% of eligible population should be offered an NHS Health Check)



Source: NHS Health Checks performance data, 2013 DH

Public Health England

Making the case: the rising costs of social care

Current trends suggests that the cost of social care and continuing healthcare will continue to rise

As the number of older people living in England increases and public expenditure becomes more constrained, meeting the need for social care will become more challenging.

The Office for National Statistics (ONS) 2010-based principal population projections for England project that between 2010 and 2022 the number of people aged 65 or over will rise by 27% and the number aged 85 or over will rise by 44%.

Eighty percent of those aged 65 and over will need care in their later years of their life.

Current trends suggest that the cost of social care and continuing healthcare will continue to rise; reasons include:

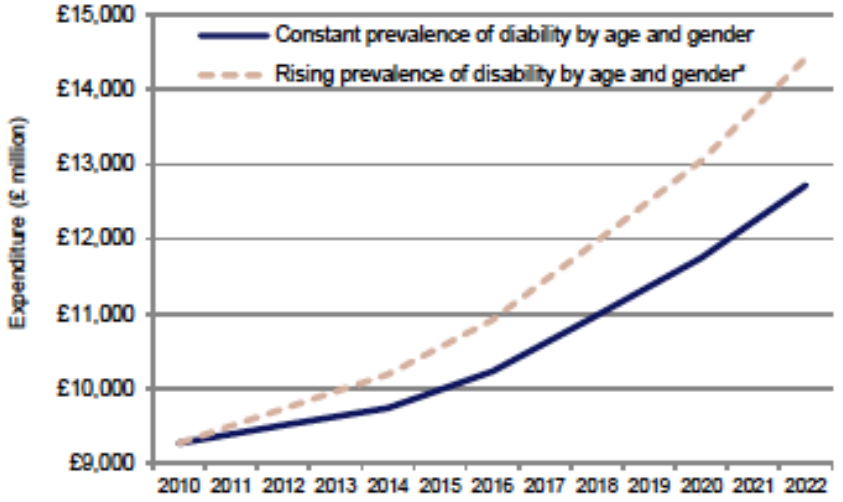
- 2% yearly increase in obesity, increasing prevalence of arthritis, stroke, CHD and vascular dementia
- emergence of minority ethnic groups in significant numbers within the older population adds to prevalence of stroke and CHD
- 2% bi-yearly increase in prevalence of arthritis, stroke, CHD and mild dementia from 2012 (moderate/severe dementia from 2016)
- 10% increase in disabling effects of arthritis, stroke and CHD from 2012 and a reduction in mortality of 5% from mild dementia, stroke and CHD from 2016

The NHS Health Check programme offers us an opportunity to stall some of these trends, and reduce current cost predictions.

[Ref 13]

Personal social services net and continuing health expenditure on over-65s in England under base case (BC) and continued trends assumption (CTA), 2012-2022 [Ref 13]

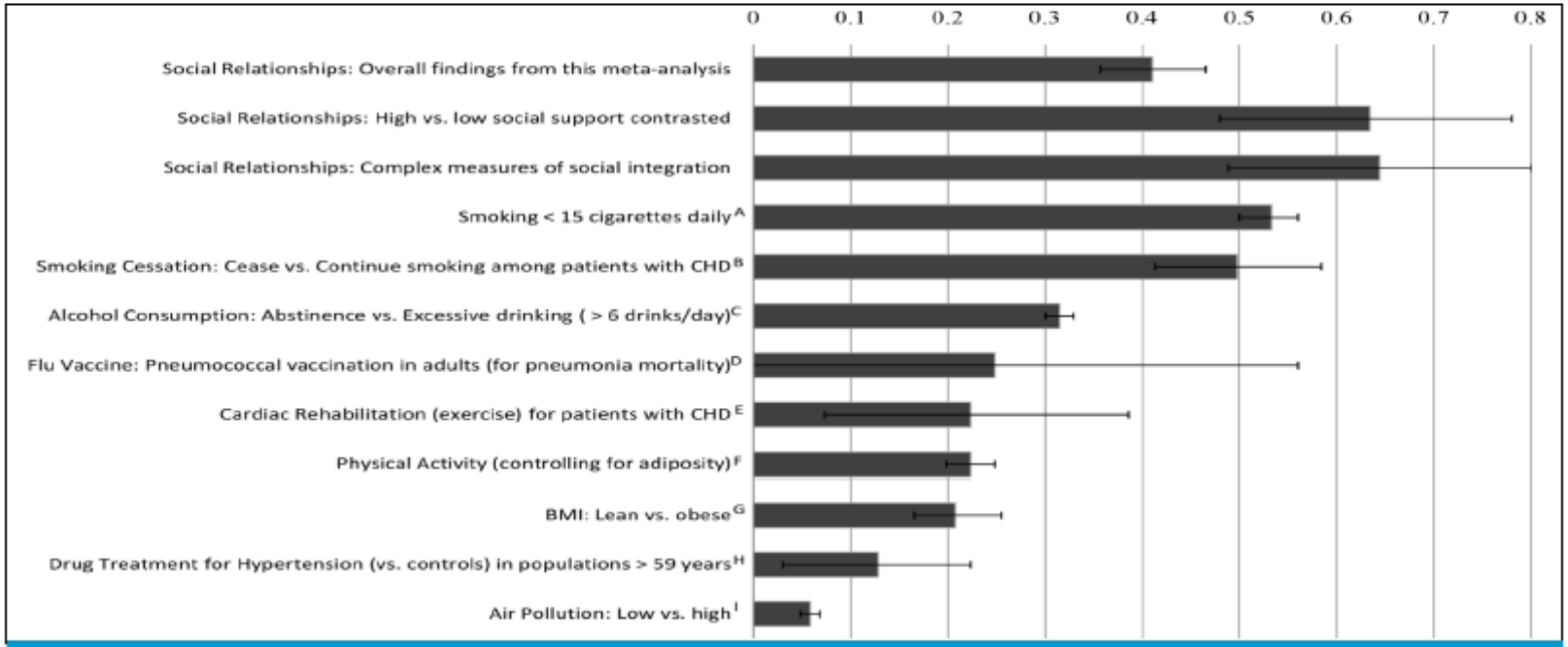
Scenario	BC	CTA
Rise in number ≥ 65 years with a moderate or severe disability by 2022	32%	54%
Cost of social and continuing healthcare by 2022	£12.7 billion	£14.4 billion



*The rising prevalence of rates of disability reflects continuation of recent trends in prevalence rates of chronic conditions.

Higher levels of social capital and 'connectedness' is linked to lower mortality

Comparison of odds of decreased mortality across several conditions associated with mortality



The effect of good social relationships and support is comparable to the effects of the major lifestyle factors on health.

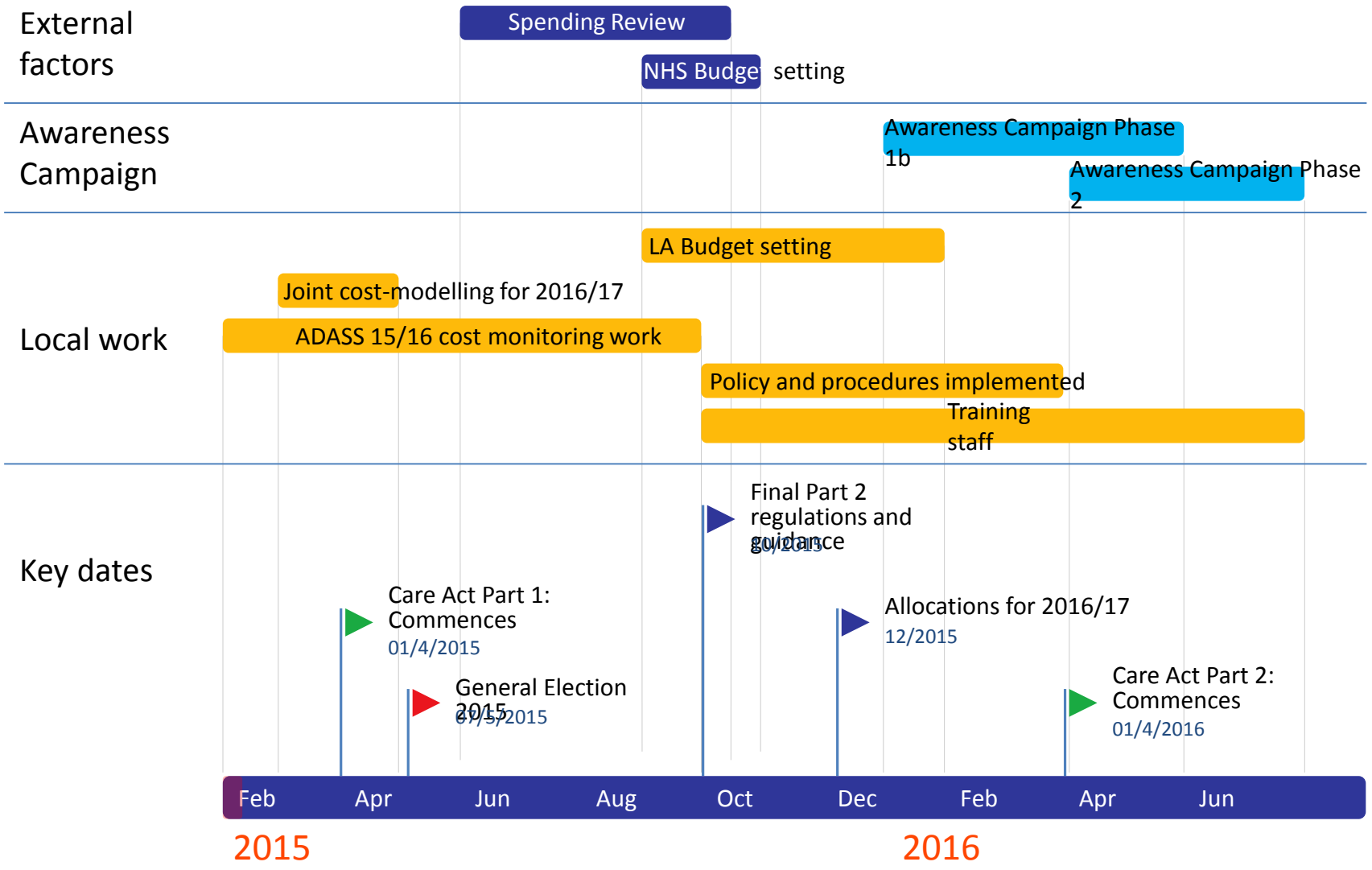
Source: http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316

The Kings Fund

Ideas that change health care

Don't forget family / community stability / reducing isolation

Spending Review Timetable & Context



Social Care Reform – Key Issues

- Continue work on confirming Self Funder Numbers
- Use approach to providers to gain a better understanding of self funder and LA rates – and impact on rates and the market if rates change
- Develop targeted plan for early assessments
- Ensure impact of revised eligibility framework monitored
- Monitor increased number of carers and increased care support existing as well as new
- Continue to flag up issues about BCF funding of new care burdens
- Continue to ensure adequate funding available to manage the changes – and raise this as an issue if this is not the case.

Workshop on Care Reform

Overall Issues **-** What are the overall issues we face?

Service planning, budgeting and monitoring – How can we best manage these issues in our activity and financial planning, budgeting and monitoring arrangements?

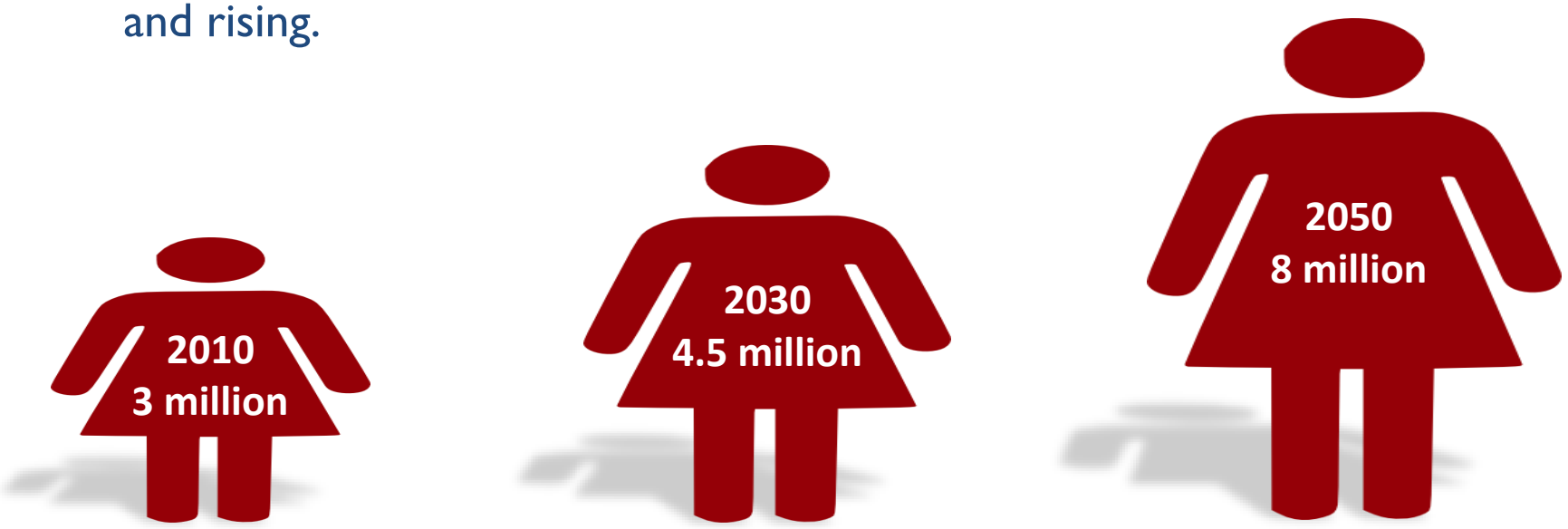
Funding Reform

Funding Reform - Consultation on Regulations and Guidance

- Proposals Overview
- Consistent Framework
- Daily Living Costs
- Independent Personal Budgets
- Market Impact
- Working Age Adults
- Appeals
- Timetable

Why is reform needed?

- Care and support has never been free, but most people do not realise.
- Current system is no longer fit for purpose:
  - It is outdated in how we define rich and poor
  - It was created in 1948 when average life expectancy was 68 - it is now 80 and rising.



- Those unlucky enough to have high care needs for a long period risk losing nearly everything they have to meet that cost.

Resentment at having to pay for help in old age

- Our sample were typical of hard-working people who have looked after themselves
  - Worked, paid taxes, had children, bought their own homes
- They can feel let down by a system that makes them pay for services they feel should be a right in older age
  - From home help, home adaptations to residential care
- Some have fallen on hard times since retiring / becoming ill, but still don't qualify for the help they think they should have

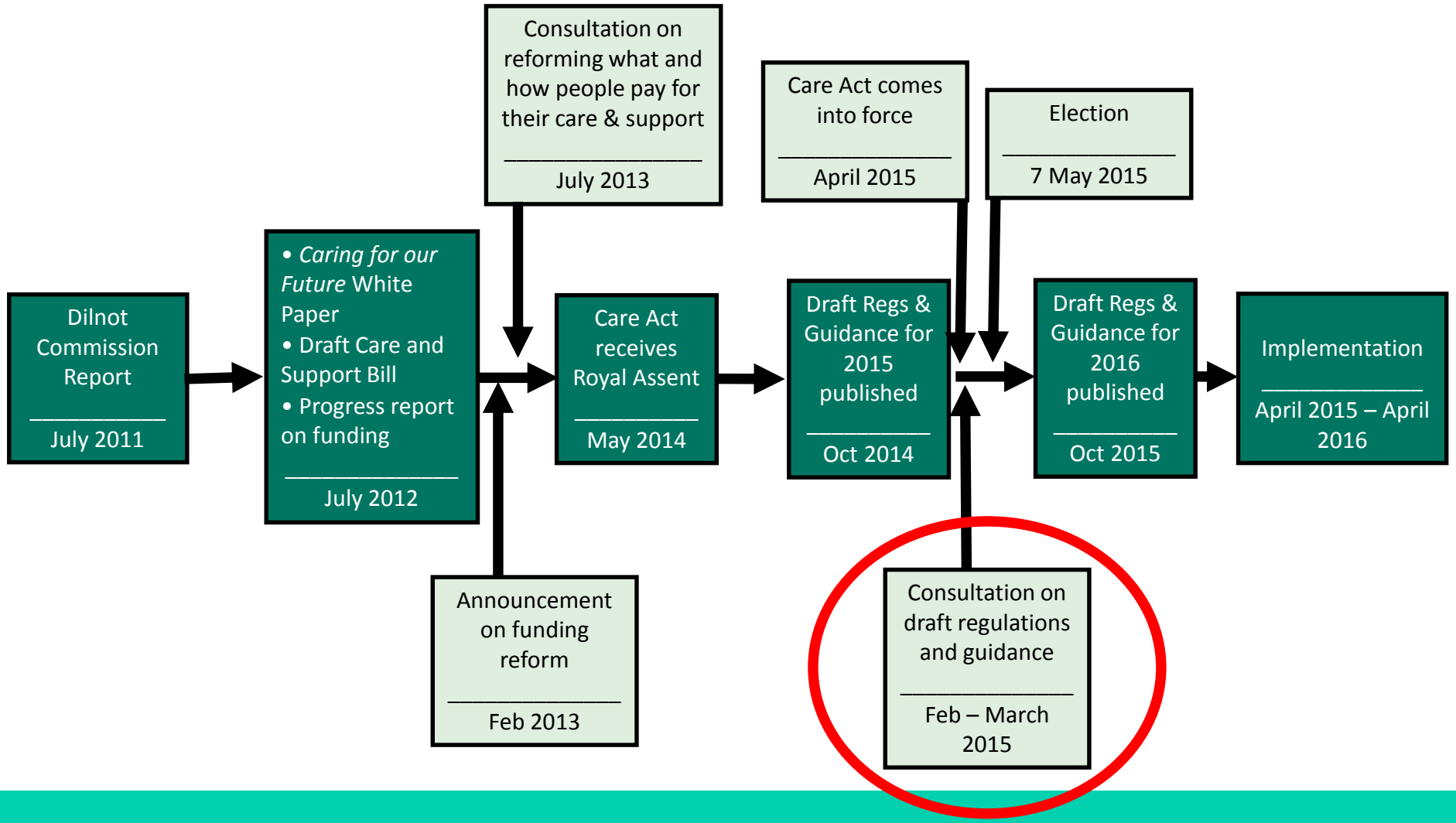
"I really need a step -in bath, I have asked at Social Services but they say I don't qualify and I cant afford it"

"People who have nothing get their care paid for, while we don't qualify!"

The ultimate anger, and fear, is having to sell your home to pay for residential care – it feels wrong, unjust

The reform timeline

This consultation is the latest step in delivering the Government's *Vision for Adult Social Care* document and White Paper.

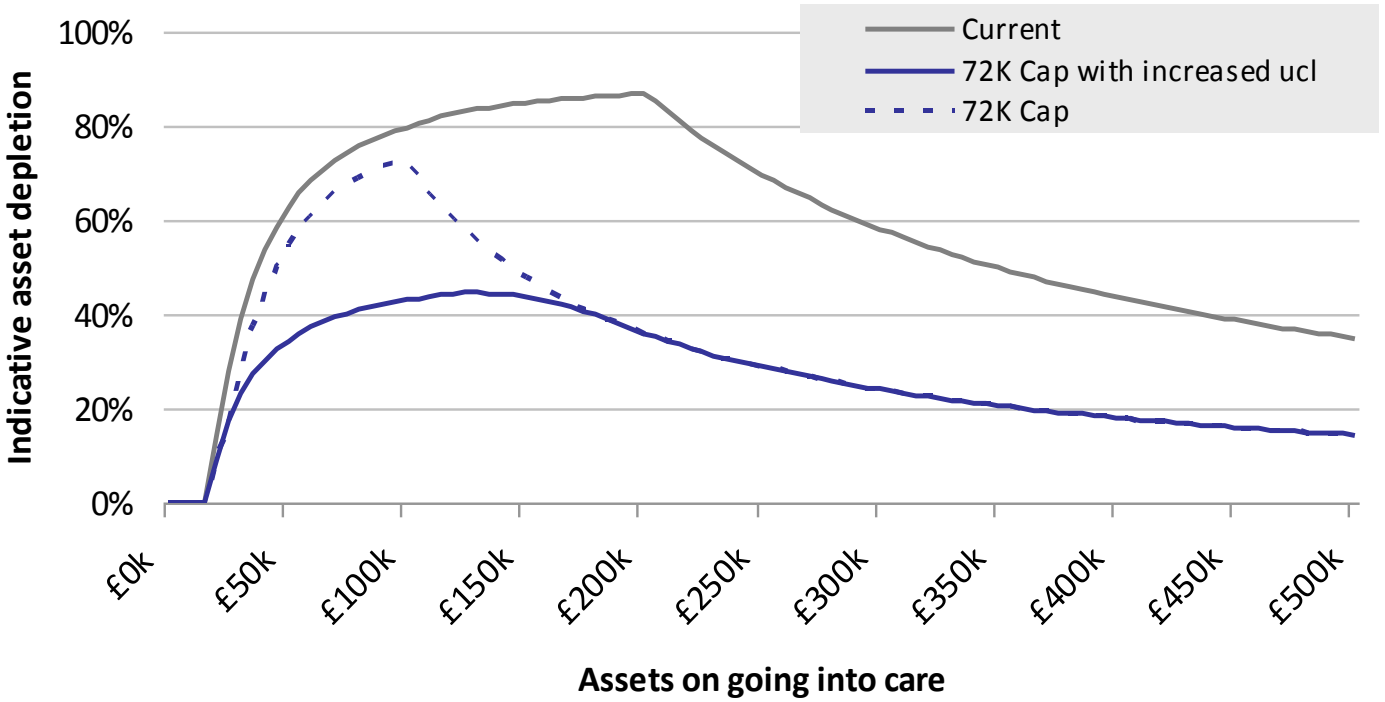


A quick re-cap

- Aim: To protect people from catastrophic costs
- By: limiting the amount they will pay for care in their lifetime
- What counts? " Unmet" Eligible care needs
- What doesn't count?
  - Daily living costs
  - NHS funded care
  - Any services provided for free e.g. reablement
- Benefits:
  - Protection for those with the longest, most costly journeys
  - Peace of mind for everyone

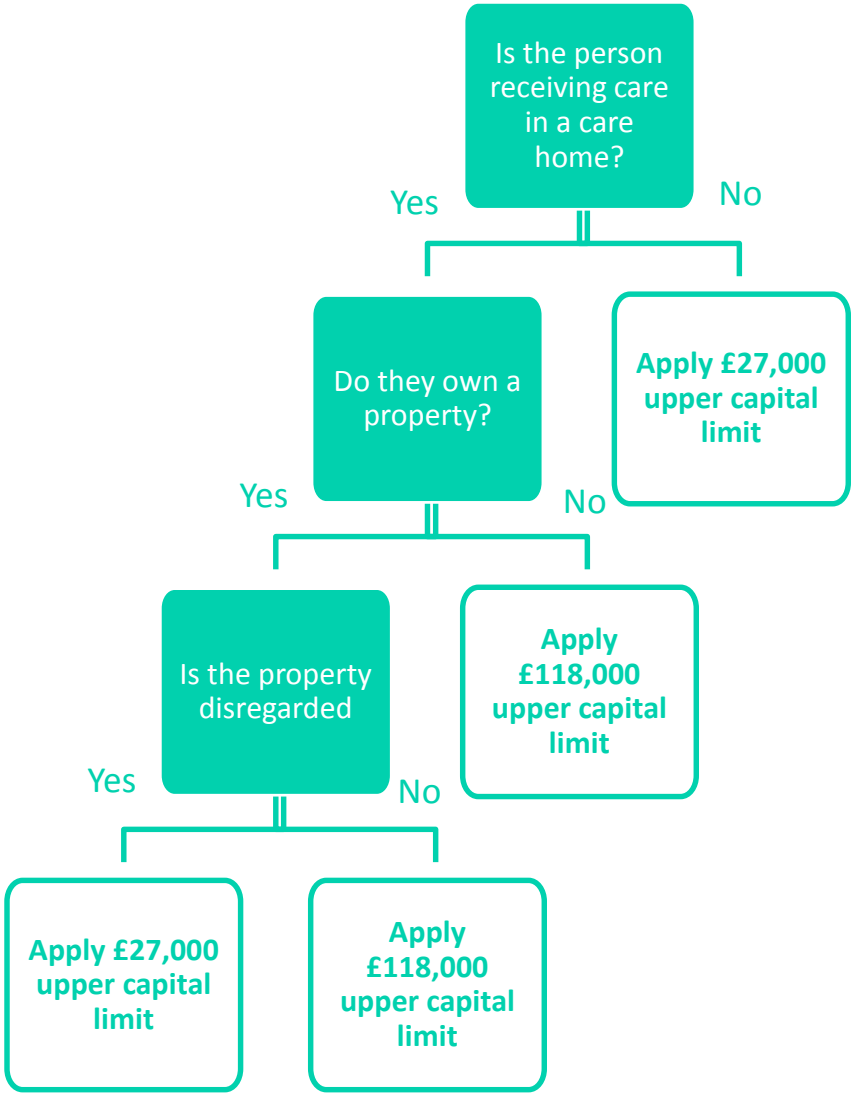
The aim is to protect people against catastrophic costs

- Current system can force people with average and lower wealth to spend >80% of their assets on care & support
- The cap provides protection from costs rising above £72,000
- But it is combining the cap **with** the extension to the means test that delivers protection from significant asset depletion



Increased financial support

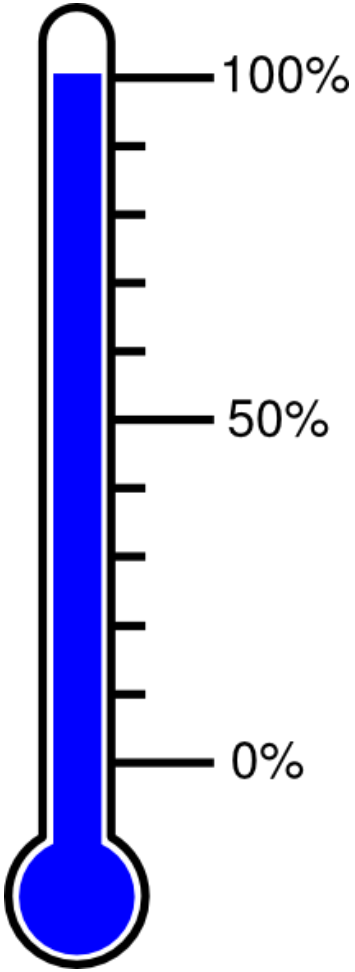
- DH are proposing to increase the capital limits used to determine what people can afford to pay.
- This will mean more people get financial help as they progress towards the cap.
- DH are also proposing to make a change to ensure no-one is worse off as a result of the interaction with benefits.



Reaching the cap

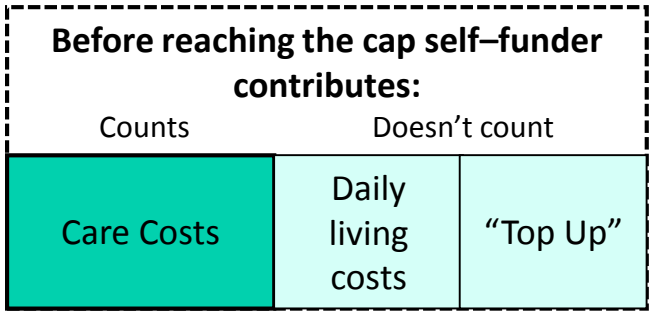
- When a person reaches the cap, the LA will take over paying the **care** component
- The person remains responsible for any:
  - Daily living costs
  - Top up payments

- The LA should work with the person in the 18 months before they are expected to reach the cap to ensure a smooth transition.
- This includes setting out what:
  - The LA will do
  - The person may need to do

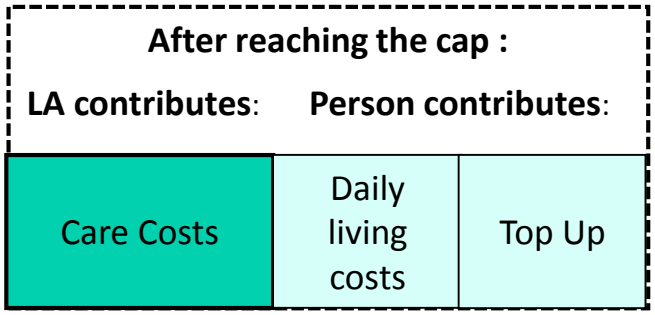


What does reaching the cap look like?

- Laura is in a care home and pays the full cost of her care.
- For the purposes of working out what counts towards the cap, her costs are broken down into:
  - Care costs
  - Daily living costs
  - "Top up"
- This has no impact on what the provider receives



- When she reaches the cap, the full amount is still paid to the provider
- The only change is that the LA pays the amount identified as care costs
- She chooses a direct payment
- The contract is maintained.
- The provider sees no difference



Interaction with benefits

- When a person starts to receive financial help from the local authority to pay for care home fees payment of certain benefits stops.
- With the extension to the means test some people could be worse off.
- The more assets they have, the less LA support they will receive under the means test.
- For some, this would be less than the benefits they lose.
- We committed during passage of the Care Act that no-one would be worse off.
- For people who qualify for help to pay their care home fees the draft regulations would require LAs to give a minimum level of financial support.
- This is equal to the maximum a person would stand to lose in benefits (£81.30).

This consultation

- Covers the cap on care costs and appeals
- For the cap on care costs it:
  - Sets out draft regulations and guidance
  - Responds to the last consultation
  - Sets out work since
- For appeals it:
  - Sets out policy proposals
- The consultation will run until 30 March 2015

The Department of Health want to hear what you think

- They welcome views on the draft regulations & guidance. Do they provide a robust framework? What have we missed?
- What do you think of the policy proposals?
- It is available at www.careact2016.dh.gov.uk

Funding Reform Framework

- The proposals claim to create a level field between different care settings
- However there is not a consistent framework between being supported in the community and being supported in residential/nursing care and community care – as recommended by Dilnot
- Nor a consistent framework between residential/nursing care and continuing health care as recommended by the Barker Commission.
- People contribute on a very different basis as highlighted in the next slide.

Funding Reform Framework

Contribution Policy / Care Setting	Supported at Home	Residential and Nursing Care	Continuing Health Care
Financial Wealth taken into account	Yes	Yes	Free
Housing Wealth taken into account	No	Yes	Free
Net Accommodation/Food Costs per month	350	1000	0

Based on pensioners household expenditure per person over 75 updated

Funding Reform Framework

- The differences between what people will be expected to contribute in the community and what people contribute in residential care are substantial.
- Let us take a fairly typical example of someone who owns their home with a value of £125,000, has cash assets of £17,500, and an income of just £255 a week.
- Supported in the community at a cost of £370 a week – they then pay a further £80 a week for their net accommodation and food costs – making a total of £450 a week. Their housing assets are not taken into account in assessing their wealth.

Funding Reform Framework

Contribution Policy Example		Care Setting: Supported at Home	Care Setting: Residential and Nursing Care
Monthly Care, Food, Accommodation Cost at £450 per week		1950	1950
Monthly Contribution - based on cash savings of £17,500; house value of £125,000 and income of £255 a week	Care Cost Contribution (£)	540	950
	Real/Notional Contribution to Food/Accommodation (£)	350	1000
	Total Contribution (£)	**890**	**1950**
	Contribution %	46%	100%
Annual Contribution Care, Food & Accommodation (£)		**10680**	**23400**

£350 - Based on pensioners household expenditure per person over 75 updated

Funding Reform Framework

- Their maximum contribution based on them retaining £90.50 a week under the fairer charging policy would result in them paying £890 a month.
- Because the value of the house is taken in to account for those in residential care – then those in residential care would pay 100% of the charge - more than double the amount they would pay in the community.
- This is the main reason why under the current framework those in residential and nursing care – pay more than double the percentage rate (35% of costs) compared to those supported at home – at just 16%.

Proposed Inconsistent Framework

Contribution Policy Example		Care Setting: Supported at Home	Care Setting: Residential and Nursing Care
Income - Fairer Charging - Contributions to Care - £m		369	1685
Costs £m	Gross Costs	2673	5060
	Less NHS Income etc	350	282
	Gross Costs after NHS income	**2323**	**4778**
Income - as a percentage of cost	%	**16%**	**35%**

Based on 2013-14 income and expenditure

Daily Living Costs (1)

- Recommendation from Dilnot Report.
- Recognised that we all face certain costs for things such as rent, food and utilities wherever we live, and said that we should remain responsible for these costs, irrespective of where we receive care.

- About ensuring fairness in the way people progress towards the cap
- Does **not** affect what the provider receives.
- The person is responsible for these costs and remains responsible after they reach the cap.

Daily Living Costs (2)

- Financial support available for people who cannot afford them
- Not meant to be a precise science. Will be a notional amount set out in regulations.
- Proposed £230 a week.
- Consultation asks for views on
  - The Level
    - Is it too high?
    - Does it reflect an average level of income? -
  - Operation
    - Is there a risk people could still face catastrophic costs?
    - Once the cap is reached, should people only pay from income?

Should this not be cost?

Proposed Inconsistent Framework
Daily Accommodation/Food Cost

- Average net housing and food costs for a person over 75 are £350 per month.
- The current proposal involves someone in residential care paying 3 times this at £1,000 per month
- A married couple in residential care would pay £2,000 a month for a shared room.
- For the same money they could get a 4 bed house, with enough money for food, and other housing costs.

Flat Amount of Accommodation Cost

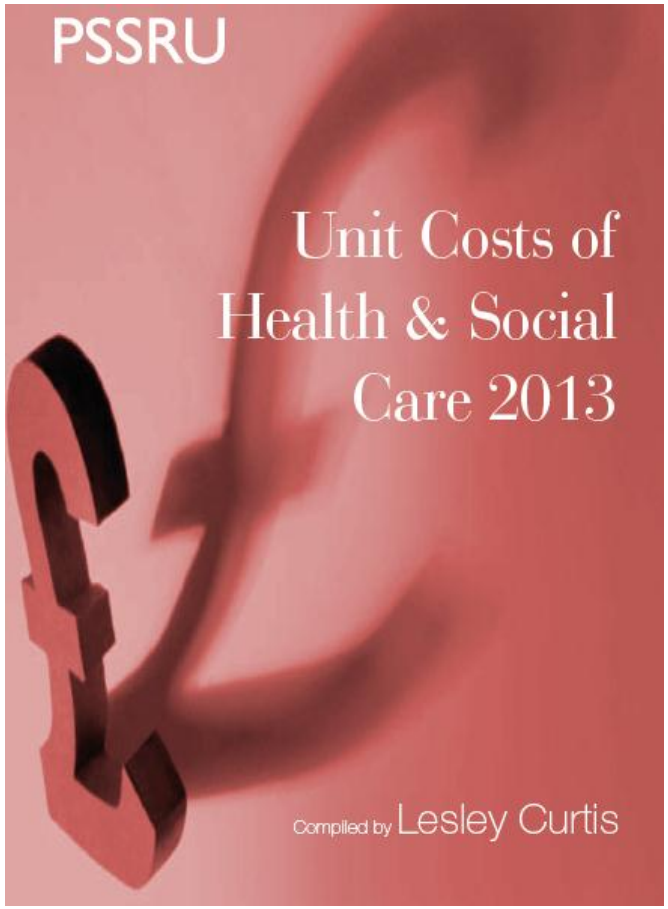
Authority	Residential Care Cost	Flat Amount of Accommodation Cost	Implied Care Cost
	Per Week (£)	Per Week (£)	Per Week (£)
A	360	230	130
B	450	230	220
C	635	230	405
D	720	230	490

Flat Amount of Accommodation/Food Cost

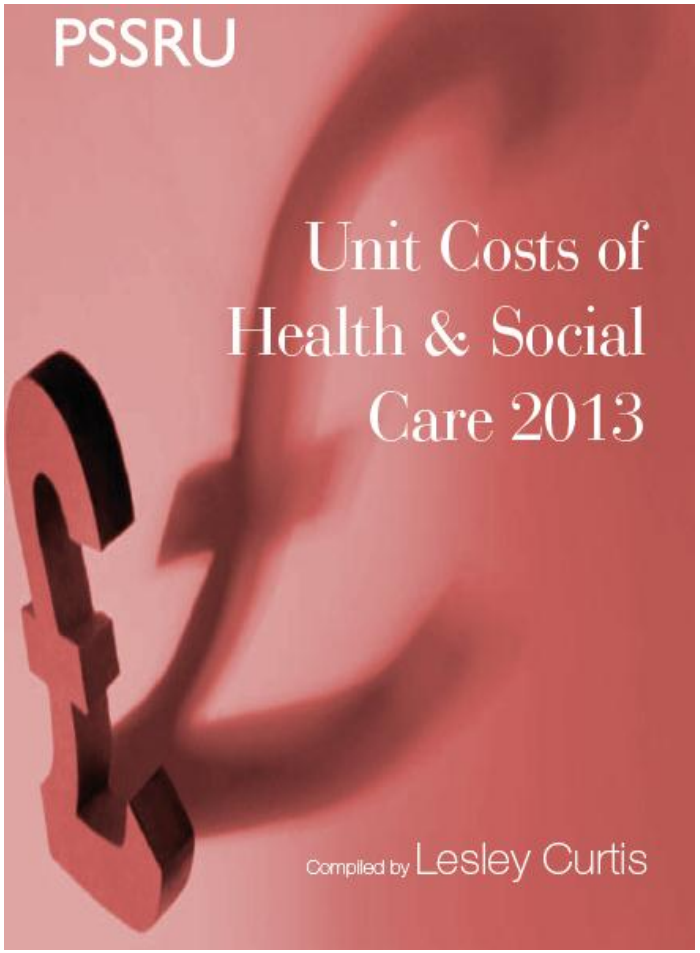
- Have seen a range of weekly residential costs from £360 to £720 a week – although the latest PSSEX Unit Costs return shows rates as low as £330 a week.
- Deducting a flat rate of £230 a week from these residential costs would imply a range of care costs from £130 a week to nearly four times this rate at £490 a week.
- In two of the examples the accommodation cost is more that the care cost. In one case the accommodation costs are nearly twice the care costs.

Daily Living/Accommodation Costs

- Useful source of national costs for older people and working age adults and occupancy information



Daily Living/Accommodation Costs

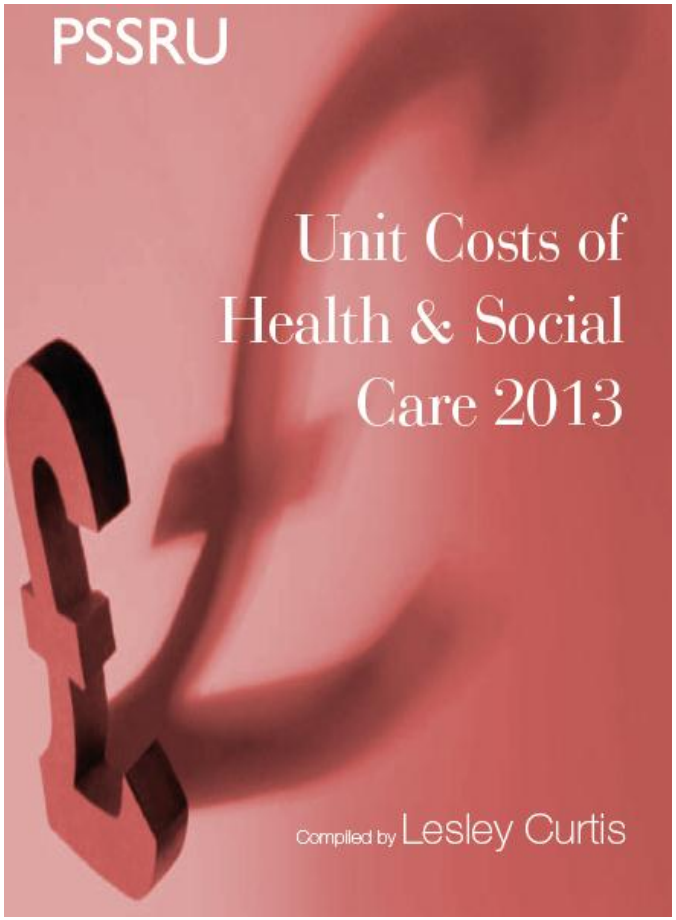


- This work suggests: -

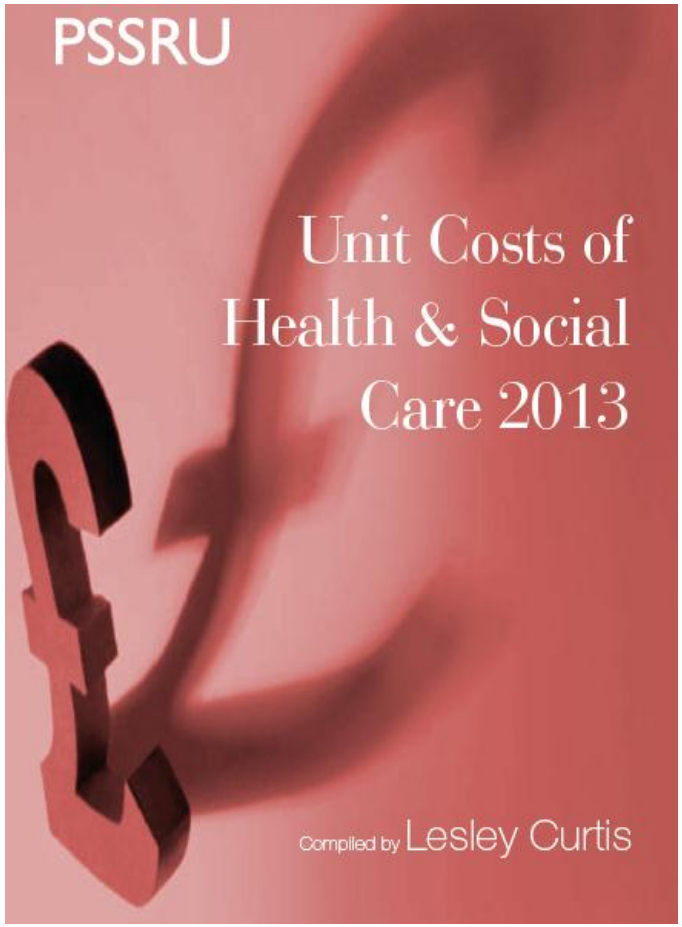
- Average Accommodation costs of £150 a week and
- Prepared Meal Costs of £90 a week
- Hence the average figure of £240 a week – **but**

Daily Living/Accommodation Costs

- Meals are being prepared because people are not able to prepare meals for themselves
- Meal preparation is included in care support for Daily Living Activities and funded by the LA
- If we base the costs on food costs then – average spend for those over 75 is no more than £40 a week.



Daily Living/Accommodation Costs



- This would suggest average costs of £190 a week – close to the figure suggested in the Dilnot review.
- The major component of these costs £150 a week is accommodation costs and these vary significantly across the Country because of variations in land and building costs and values – as confirmed in the recent Centre for Cities report.

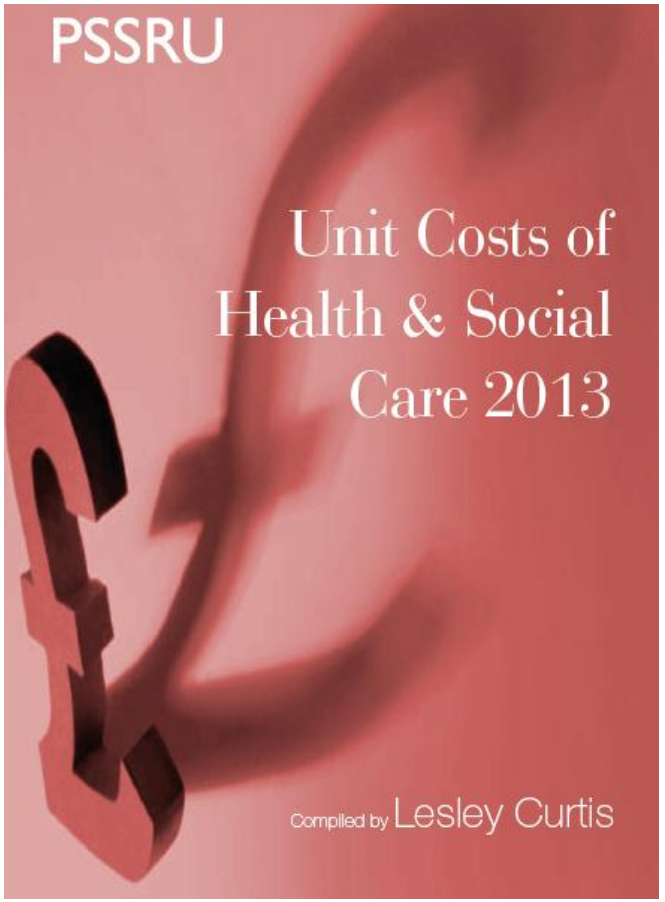
Daily Living/Accommodation Costs

City	2014 Average House Price £	Pecentage Difference %
Hull	102,100	
Stoke	117,000	15%
Bradford	145,000	42%
Leeds	174,500	71%
Milton Keynes	226,000	121%
Reading	307,900	202%
Brighton	320,400	214%
Cambridge	412,600	304%
London	501,500	391%

- Average House Prices in London are almost **five** times average house prices in Hull.
- Property and other costs do vary very significantly across the country.

Daily Living/Accommodation Costs

- Hence the suggestion to base this on a percentage of total costs – **37.5% -** with an initial ceiling of **£240** a week or higher.



Percentage Rate Accommodation Cost

Authority	Residential Care Cost	Percentage Rate Accommodation Cost (37.5%)	Implied Care Cost
	Per Week (£)	Per Week (£)	Per Week (£)
A	360	135	225
B	450	169	281
Average	500	188	313
C	635	238	397
D	720	270	450

Percentage Rate Accommodation/Food Cost

- Much fairer arrangement as a percentage of care costs.
- Care Costs vary with total residential care costs.
- Average residential care costs of £500 a week would give rise to the suggested average of £190 accommodation and food costs.
- Current proposal based on £231 a week – but minimum income that someone is left with is only £205 – so £148 pension guarantee - £81 attendance allowance – less £24 personal allowance.

Independent Personal Budgets

- The cost of care to meet the person's eligible needs will be set out in their **independent personal budget** (IPB).
- The cost **must** be based on what it would cost the person's local authority to meet their eligible care and support needs.
- Local authorities will need to have processes in place to determine what this cost would be.

Independent Personal Budgets: *What are the requirements?*

- S28 of the Care Act defines the IPB and sets out requirements relating to revision and review.
- There are no regulation making powers under s28.
- The only "must" is that the IPB specifies what the cost would be to the local authority of meeting the person's eligible needs for care and support.
- The draft guidance:
  - recognises that the process for setting an IPB should be proportionate;
  - sets out the general principles for calculating an IPB; and
  - is intended to be permissive.
- Assessment must be the same for self-funders but is there flexibility around the next steps in the process?

Independent Personal Budgets: *How should they be calculated?*

- You may choose to undertake care and support planning for self-funders.
- You may choose to base IPBs on a framework of averages. If so:
  - it should be based on personal budgets given to people with similar levels of needs;
  - consideration should be given to when a more tailored approach may be required; and
  - the averages used will need to be kept up to date.
- Or there may be alternative approaches.
- Whichever approach is taken, it should not re-introduce the concept of the 'usual rate' and must be reflective of actual costs

Market Impact
Care Act Part 1 : Section 18(3)

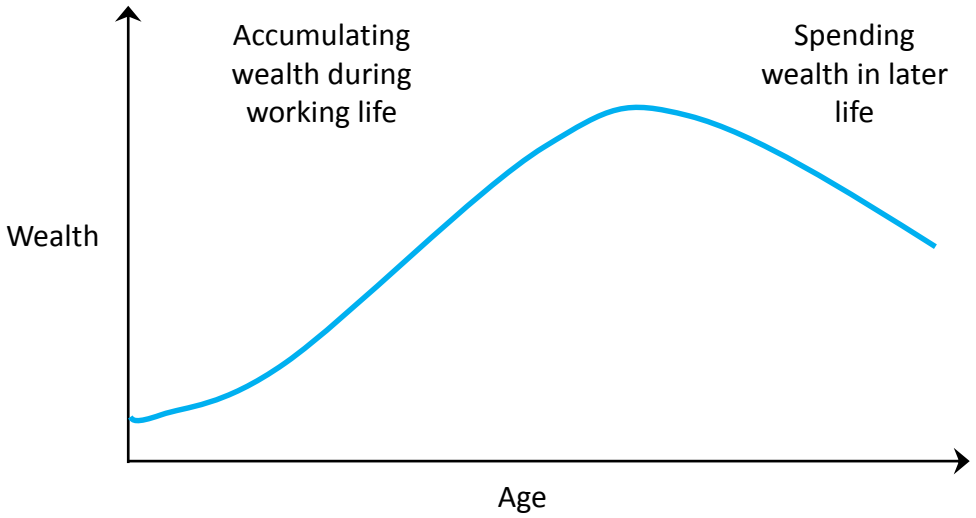
- Self-funders accessing local authority rates
- Claim that allowing all self-funders to access care at local authority rates would remove £1.5bn from the care economy now
- How is this gap going to be addressed?
- Implementation deferred until April 2016 for the moment – but could be deferred further – but
- Impact also influenced by response to funding reform

Market Impact
Care Act : Sustainable markets

- New duty to provide a sustainable care market
- Much of the efficiency has been pegging back fees to the private and independent care sector
- Care volumes commissioned have also reduced (15 minute calls – although this now subject to challenge and 'enablement' services)
- Volumes may have to be constrained further through preventative approaches Some work started by the Office for Public Management. Some work has been underataken by Laing and Buisson for the County Councils for a sample of Councils
- This needs to feed into a restarted national review

Working Age Adults - Background:
What was the starting point?

- Older people have had a chance to accumulate assets during their working lives.
- Adults who develop a care and support need during their working life may have less opportunity to accumulate wealth.



- The Dilnot commission recognised this challenge and recommended:
  1. A zero cap for people who turn 18 with eligible care needs.
  2. A lower cap for people of working age

Working Age Adults - Background:
Consultation in 2013 and further work

- In 2013 DH consulted on three options including a tapered cap for working age adults and two variants on a tiered cap.
- Responses were mixed and questions were raised:
  - If working age adults can afford to contribute more towards their care, shouldn't they be asked to do so?
  - Is age a fair way to judge a person's ability to plan and save?
  - How easy is a tapered or tiered cap to understand and communicate?

- We worked with stakeholders to better understand the priorities for this group.
- Two key priorities emerged:
  - That people who developed an eligible need before the age of 18 should have a zero cap
  - That working age people should not be left with less income after charges than older people

What are DH consulting on now?

Three options

1. A tiered cap as recommended by the Commission:

	Age when eligible care needs identified				
	<18-39	40-49	50-59	60-State Pension Age	State Pension Age and older
Cap	Zero	£21,000	£45,000	£65,000	£72,000
Minimum Income Guarantee	Unchanged				

- A person's cap would be set for life based on the age they are assessed as having an eligible need
- Everyone would remain responsible for their daily living costs

What are we consulting on now?

Three options

2. Two levels of the cap and change to the minimum income guarantee

	Age when eligible care needs identified	
	<18-24	25+
Cap	Zero	£72,000
Minimum Income Guarantee (MIG)	N/A	Phased equalisation with MIG for older people

- The phased equalisation would start with an increase in 2016.
- A person's cap would be set for life based on the age they are assessed as having an eligible need
- Everyone would remain responsible for their daily living costs

What are we consulting on now?

Three options

3. A single level of the cap and changes to charging and the minimum income guarantee

	Age when eligible care needs identified	
	<18-49	**50+**
Cap	£72,000 But no charge for meeting eligible needs up to age 50	£72,000
Minimum Income Guarantee (MIG)	N/A	Phased equalisation with MIG for older people

- The phased equalisation would start with an increase in 2016.
- Everyone would remain responsible for their daily living costs.

Appeals Why?

- We know that the NHS, Education, Benefits system have an appeals system – should adult social care decisions, that have such a significant impact on a vulnerable cohort of the population also be open to an independent review?

Department for Education

NHS

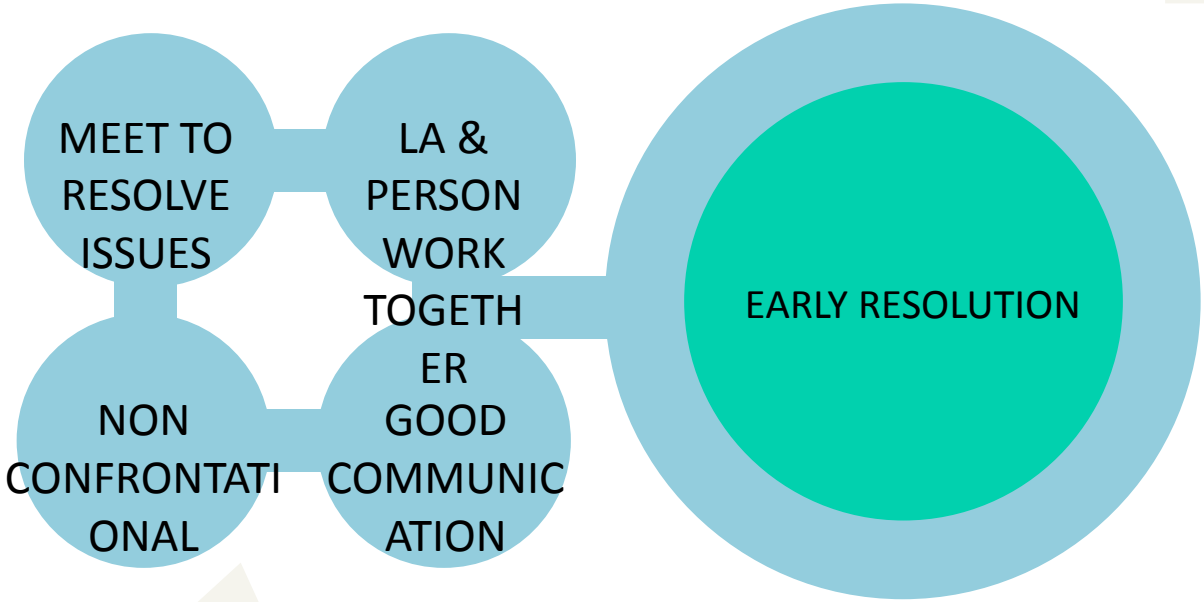
Department for Work & Pensions

Adult Social Care ?

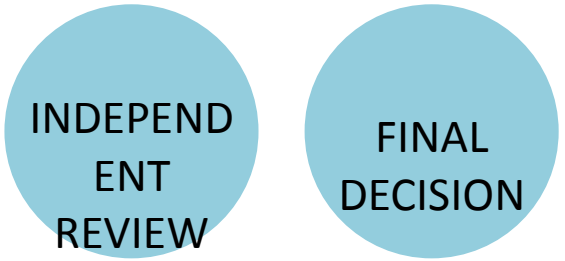
- "Adult social care is the fastest growing area of our work and with the highest uphold rate.." - *Local Government Ombudsman Dr Jane Martin*

- Andrea Sutcliffe, Chief Inspector of Adult Social Care at the Care Quality Commission, said: "I welcome today's report which demonstrates how important it is for adult social care services to respond positively to the concerns that may be raised by people using these services or their family and friends."

Proposed Appeals System



- LA and the person work together to try and resolve differences, early, wherever possible

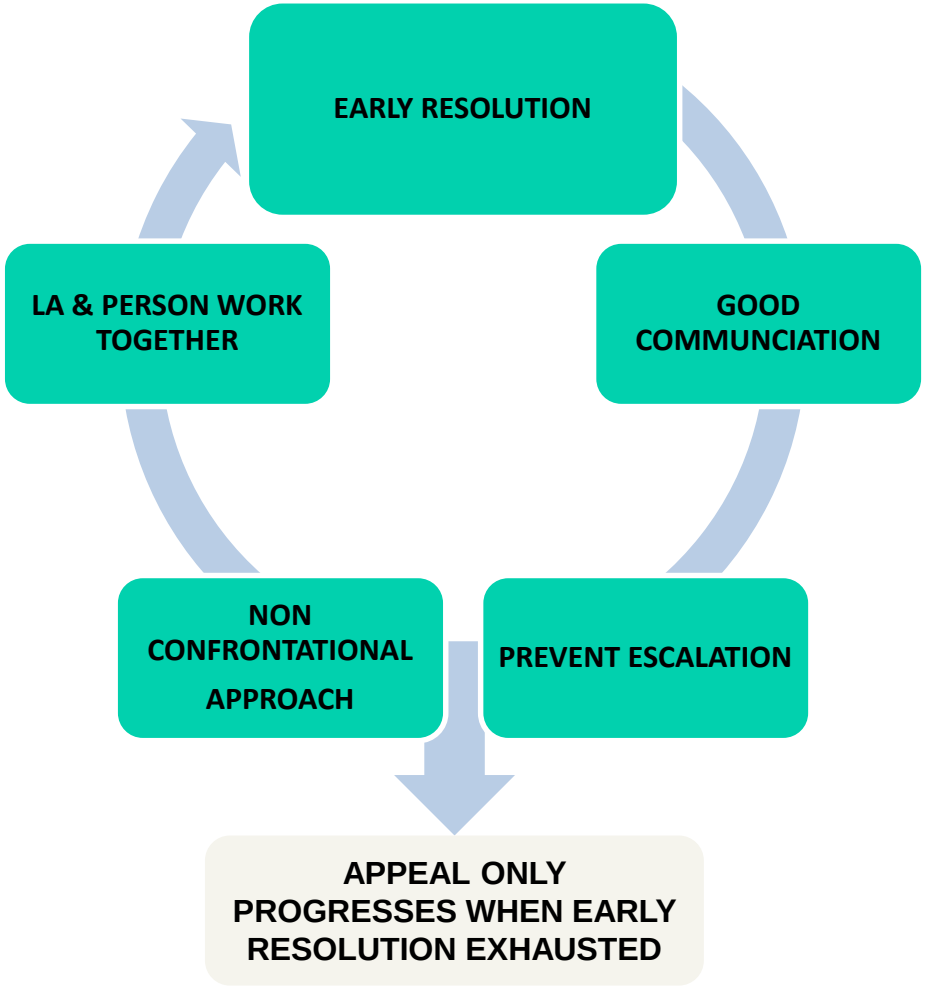


- An Independent Reviewer (IR) is appointed to make a recommendation to the LA

The Local Authority makes a final decision with reference to IR's recommendation

Appeals Overview

Policy Intention



Principles

Early Resolution…

Communication…

…Independence

Equality…

Fairness…

…Accessibility

…Proportionality

Appeals / Complaints

COMPLAINTS

PROCESS

Local Resolution → Ombudsman

- The local resolution stage is carried out by a complaints manager or nominated person to act on their behalf
- There is no independent review of the actual decision, the LGO can review on process or maladministration grounds

APPEALS

DECISION

Early Resolution → Independent Review → LA Decision

- The proposals set out that someone but not the original decision maker should review the LA's original decision
- The Appeals proposals set out that an Independent Reviewer is appointed to review the LA's decision
- The LA makes a final decision with reference to the IR's recommendation

Appeals Potential Benefits

- People avoid the stress and cost of going to court while councils could reduce the administrative and cost pressures of legal challenges, freeing up resource.

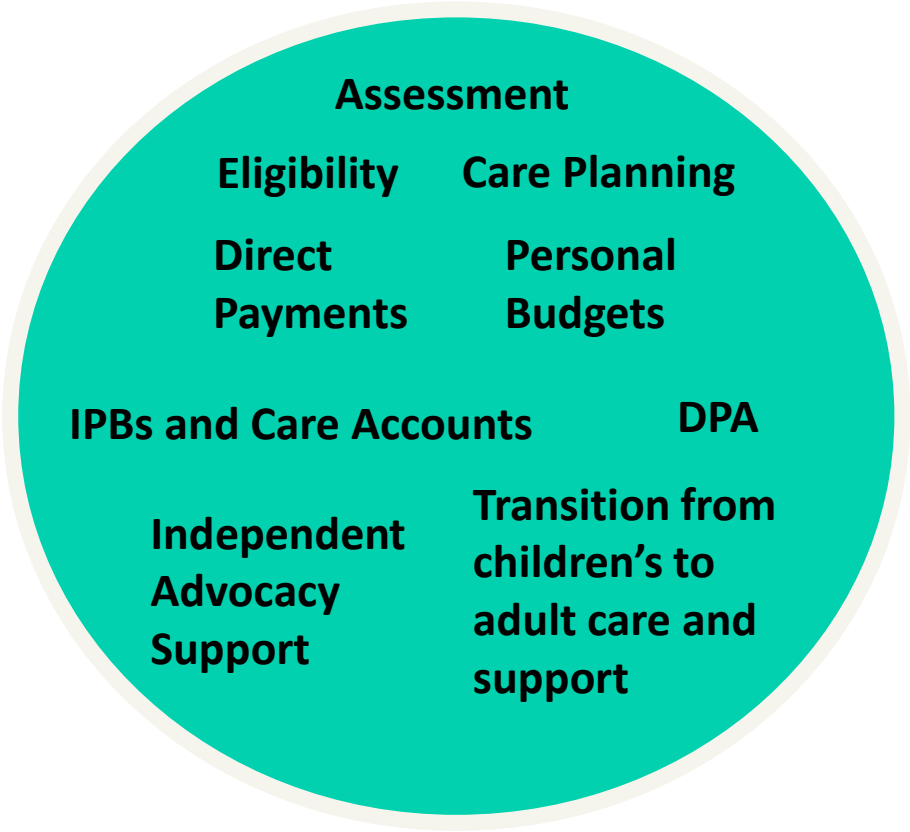
- The proposed Appeals system has early resolution built in as a primary focus of the policy. The emphasis is to talk through issues between a person and the local authority.

- People are helped to understand why decisions have been made in a particular way and have their concerns addressed quickly. This helps protect a vulnerable cohort where disagreements arise.

- The Appeals system introduces an independent review of the local authority's decision. This means people can be confident that they have received a fair and equitable review of their appeal. Councils receive a cost effective, independent means of ensuring they are getting their care and support decisions correct.

Appeals Scope

- We have included the following to be within scope of the Appeals system – is there anything else that we should include?



Consultation Questions

- Do you agree the areas identified should be within the scope of the appeals system? Are there any other areas under part 1 of the Care Act 2014 that should be included?
- Do you think that charging should be part of the adult social care appeals system?

Independent Review

We are proposing introducing the role of an Independent Reviewer (IR)

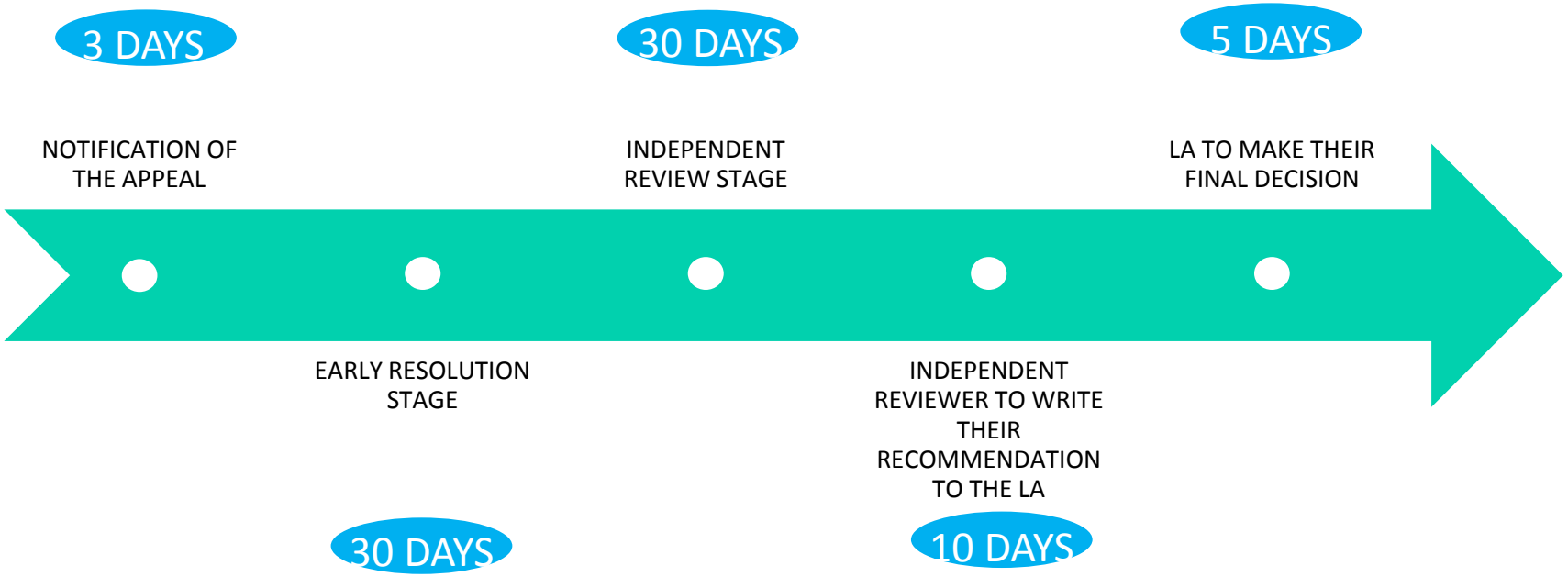
- The IR would be recruited to independently review appeals once they had progressed to the second stage of the appeals system.
- The IR's role would be to review the original decision and make a recommendation based on whether they viewed the Local Authority decision as being correct. We need your views on what this role should look like.

Consultation Questions

- Do you have suggestions as to the expertise, knowledge and person specification for the role of an Independent Reviewer?
- Do you think the local authority or another body should be appointing the Independent Reviewer?
- Do you think a 3 year gap in the independent reviewer's employment from the local authority concerned is sufficient to provide independence? Should this period be longer? Or should they have never previously been employed by the local authority concerned?
- Do you agree that the Independent Reviewer's role should be to review decisions with reference to relevant regulations, guidance, facts and local policy to ensure the local authorities decision was reasonable?
- How do you think we can promote consistency in decision making for care and support appeals?

Timescales

We are proposing as a general principle the appeal should be resolved in the shortest timescale that is practically and effectively possible. However, some appeals may be more complex to effectively review so we are proposing that when this happens that the timeline could be extended. *Please note that all times expressed are working days.



Consultation Question

- Do you think the timescales proposed to process appeals are right? If not, which timescales would be more appropriate?

Funding

- A main objective of introducing the appeals system is to save time and money for both the person and local authority, particularly when compared with legal means of redress in resolving disputes in adult care and support.

- The appeals system encourages an alternative to legal dispute resolution with a specific emphasis on avoiding potential cost accumulation by encouraging early resolution.

- The administration of the appeals system will be funded by the Dept. of Health which will sit alongside funding to local authorities for meeting the local population's care and support needs.

- Where an appeal results in the local authority overturning their original decision they will be responsible for any remedial action.

Consultation Questions

- Do you feel that the appeals system, as set out, will aid the early resolution of disputes, and thus help avoid costs and delays associated with challenging decisions in the courts?

- In the impact assessment we have set out the costs to administer the appeals system. Do you agree with the funding as set out in the appeals impact assessment?

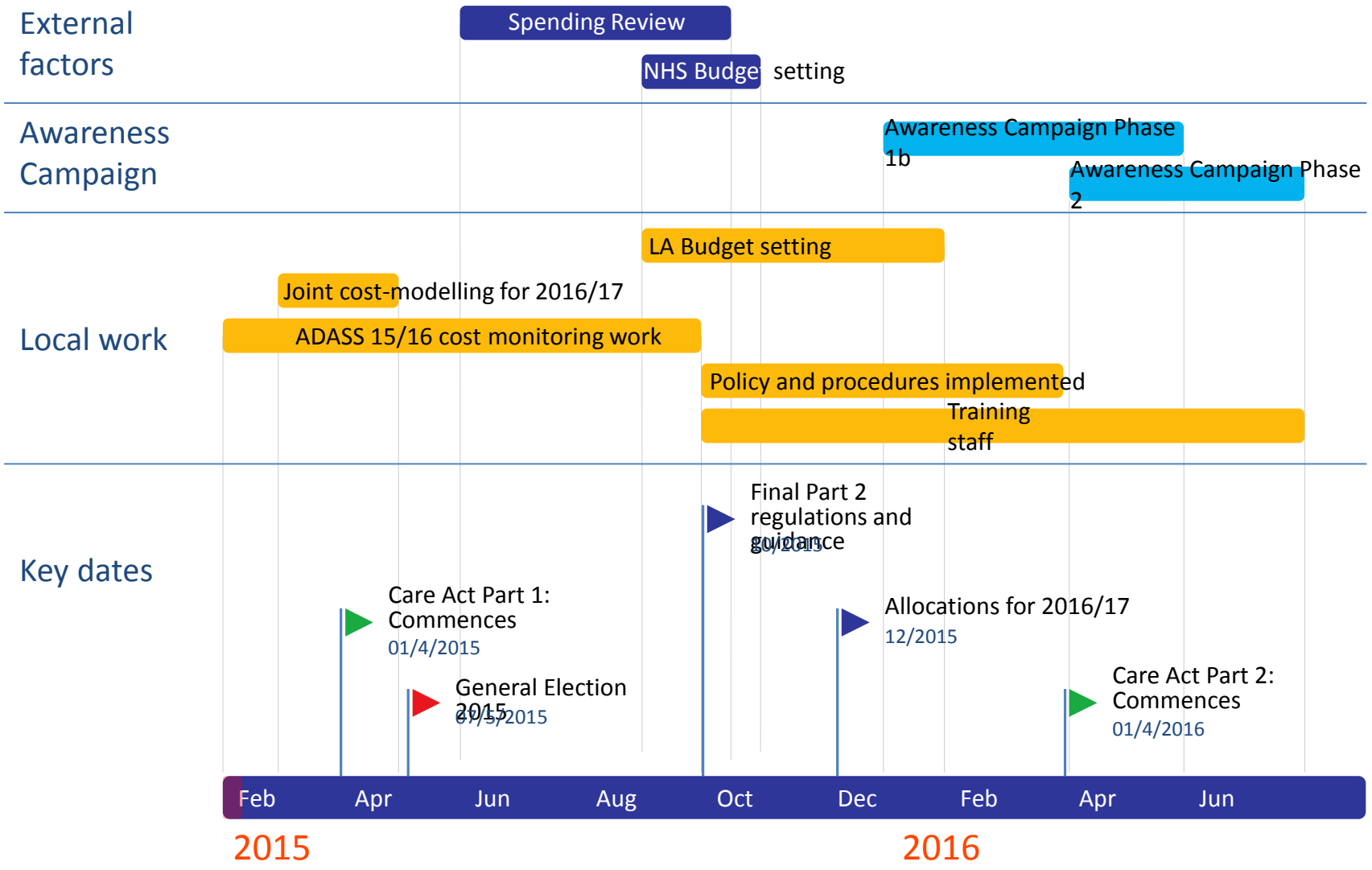
DH Impact Assessment – Feb 2015 – Appeals

Social Care Appeals

£ millions, 16/17 prices undiscounted	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	Discounted Total
Assessment, PB and IPB appeals	9.85	8.02	8.15	8.29	8.44	8.59	8.80	8.98	9.16	9.33	75.28
Carers appeals	6.32	6.39	6.49	6.60	6.71	6.81	6.96	7.09	7.20	7.30	58.13
Review appeals	5.08	5.70	5.81	5.92	6.03	6.14	6.30	6.44	6.56	6.67	51.84
Additional LGO reviews	0.46	0.21	0.21	0.21	0.21	0.21	0.22	0.22	0.22	0.23	2.08
TOTAL	21.70	20.32	20.65	21.01	21.39	21.75	22.27	22.73	23.15	23.52	187.33
TOTAL INCLUDING UPLIFT	23.87	22.35	22.72	23.11	23.53	23.92	24.49	25.01	25.46	25.87	206.07

Note: numbers may not add due to rounding

Key dates and phases of work



Timetable Challenges

- Care Act – Part 1 come out of a very detailed review of the existing legal framework by the Law Commission and the detailed guidance the subject to a 12 month preparation period and a full 3 month consultation period.
- These more far reaching proposals have had a much shorter preparation and consultation period – with an election intervening before final proposals which need to address some significant concerns with the existing proposals.
- Proposals not finalised until October 2015 at earliest
- Market Impact not yet assessed
- Systems cannot be finalised until proposals are known
- Lots of challenge in informing people of a major change

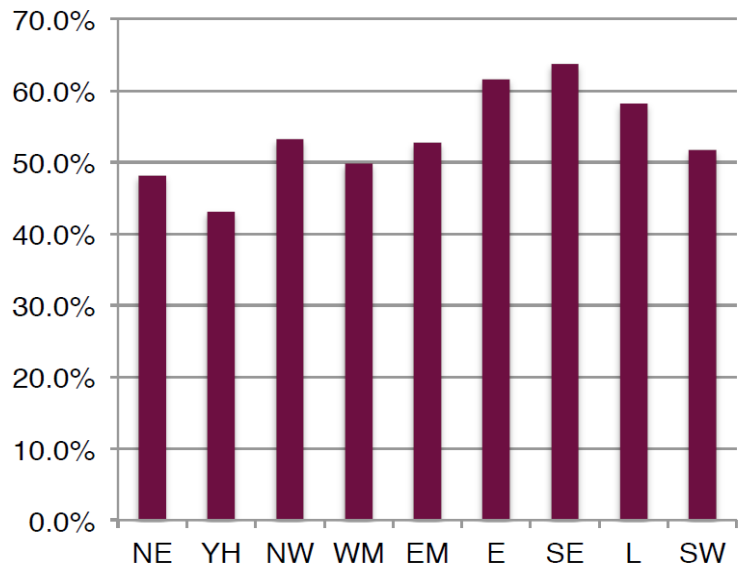
Knowledge of Care Act

- Awareness of the Care Act is very low
- No existing awareness of the care cap but respondents reacted positively to it…
- …until the details where explained; then people thought it would be of limited value
- No awareness of Money Advice Service, SOLLA and Carers' Direct
- The term 'means testing' needs explaining
- Current users of the care system assume that any mention of 'change' will be negative – they associate it with cuts.

Sources of information and advice

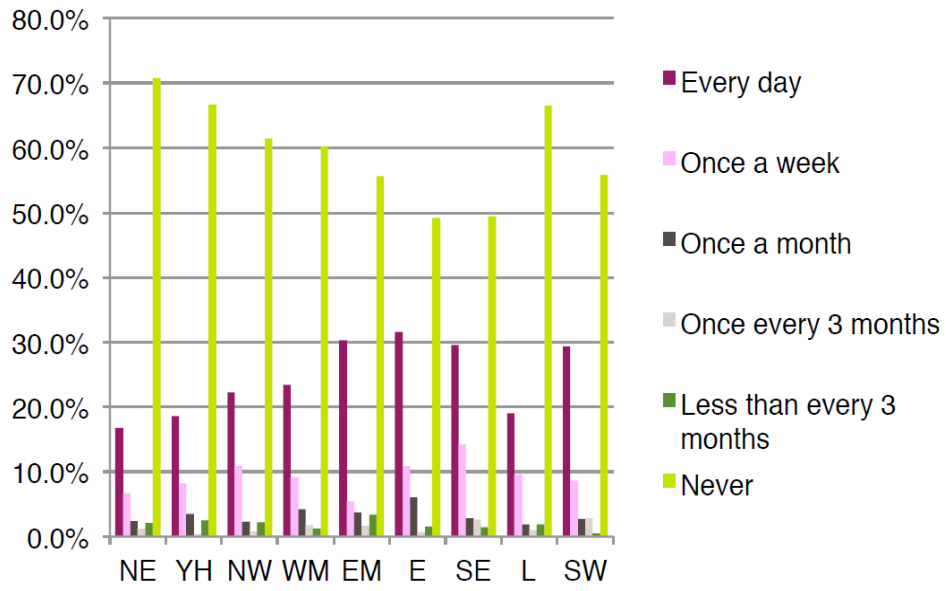
- Websites (typically younger service users)
- Informal carers (older people)
- NHS, council for existing service users
- ‘A source of advice independent of the local authority would be welcomed
- There was a high level of trust in third sector organisations

Internet usage, all 65+



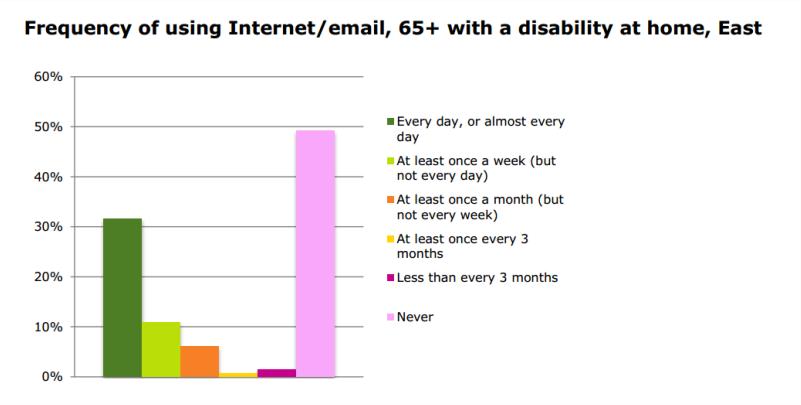
Whether has Internet connection, 65+ at home with limited day-to-day activities, English Regions (ELSA)

Internet usage, 65+ with disability



Frequency of Internet use, 65+ at home with limited day-to-day activities, English Regions (ELSA)

Channels



- Around half of older people with disability in East region have NEVER used internet or email

The Bigger Picture:
Independent Age/Strategic Society, November 2014

Financial Modelling of 2016/17 Funding Reforms

Funding Reform – Modeling the Costs

- The DoH & other Models and crucial components of modeling – self funder numbers, local care costs, local housing values -
- Continuing work to estimate the number of self funders – in care homes and in the community -
- Progress on modeling with a representative group of councils around the country
- How the results of this work can be used for every local authority
- Developing and Modeling the impact of alternative proposals
- Influencing the Spending Review

Funding Reform Model

- New simpler model to be co-produced – fed with consistent council data and based on clear assumptions
- Testing to take place during March – April across a sample of c. 30 councils
- Additional capacity to be provided to support data collection
- Single transparent model that is endorsed by DH and ADASS
- Credible, robust data available for local and central government to plan implementation of funding reforms
- Thorough sense check of ‘ assumptions’ (eg number of self funders, daily living costs)
- Exercise to be concluded prior to election in May

Department of Health

Funding Reform

The Care Act 2014

Consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system for care and support

Based on DH modelling at the average local authority rate of around £570 per week and 8 years in residential care, by initial level of housing wealth (2016/17 prices)

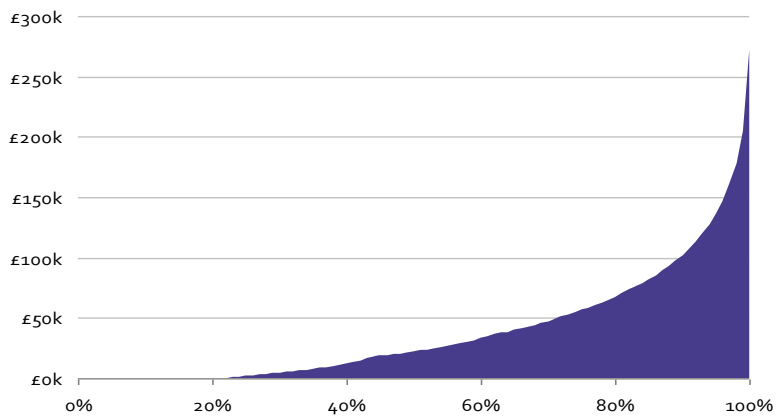
Figure 1: Maximum asset depletion over course of long care journey showing the impact of extended means test support

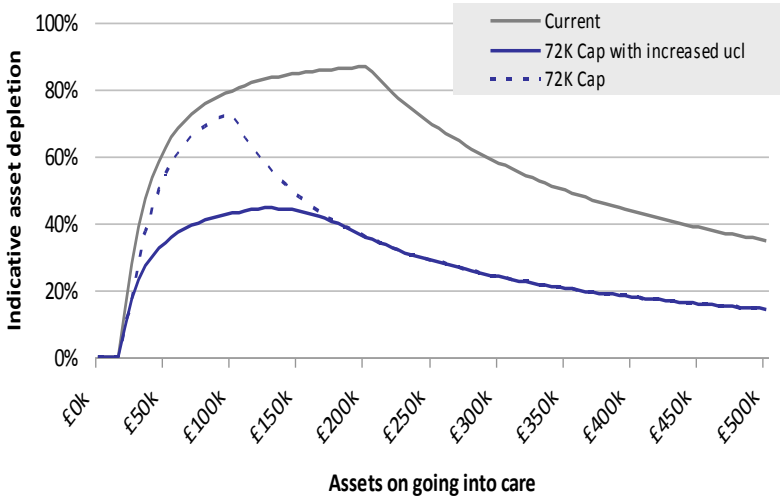
February 2015

The 2016/17 Funding Reforms

The Cap on Care costs limits the amount an individual will have to pay towards their care.

The Cap is currently proposed to be set at £72,000 and people 'meter' towards the cap at the rate the LA would pay to meet their eligible needs.





The Extended Means Test ensures that more people are entitled to LA-funded support before they reach the cap.

The Upper Capital Limit (UCL) is proposed to be £27,000 or £118,000 (depending on whether a property is included)- an increase from the current £23,250 threshold.

What this Exercise does and doesn't do

What it does

- Helps LAs to understand the profile of costs as well as aspects of the policy that drive costs.
- Helps DH test the assumptions and data sets that feed into the final Impact Assessment and Spending Review

What it doesn't do

- Inform allocations for Local Authorities for 2016/17 – *(to avoid people using the exercise to distort allocations)*
- Accurately calculate the costs associated with each Council's cost for introducing the reforms – *(to avoid people using this as a basis for challenging any subsequent allocation – but it will provide a helpful starting point to refine at a local level)*

Drivers of the Costs for Local Authorities

Short Term (1-3 Years)

- Costs are driven by the extended means test
  - The number of people who come within the threshold for means-tested support.
  - The costs of meeting their eligible needs

Long Term (4-10 Years)

- People start reaching the cap
  - The number of self funders in the LA
  - The cost to the LA of meeting their eligible needs when they reach the cap.

Overview of the Model: structure

- **Broken down** into:
  - Older Adults (OA)
  - Working Age Adults (WAA)

- **OA**: Treats cap and extension to means test separately

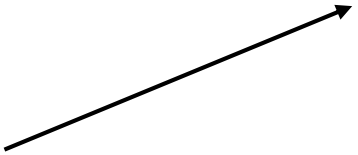
- **WAA**: Models Option 2 from the current consultation for WAA
  - A £0k cap for those who develop an eligible need under 25
  - A £72k cap for those who develop an eligible need over 25.

Overview of the Model: main data

- **Users numbers** (broken down by age for WAA)
- **Care fees:**
  - Weekly rates for residential and WAA community care
  - Hourly rates for OA home care
- **Lengths of stay (Bupa 2011):** for everyone receiving care, what is the range of times they have been receiving care
- **Average housing prices:** proxy for wealth in a particular LA
- **ELSA Wave 5 sample:** used for deriving MT costs.
- **Amount of prior home care for OA:** influences rate at which cap is met

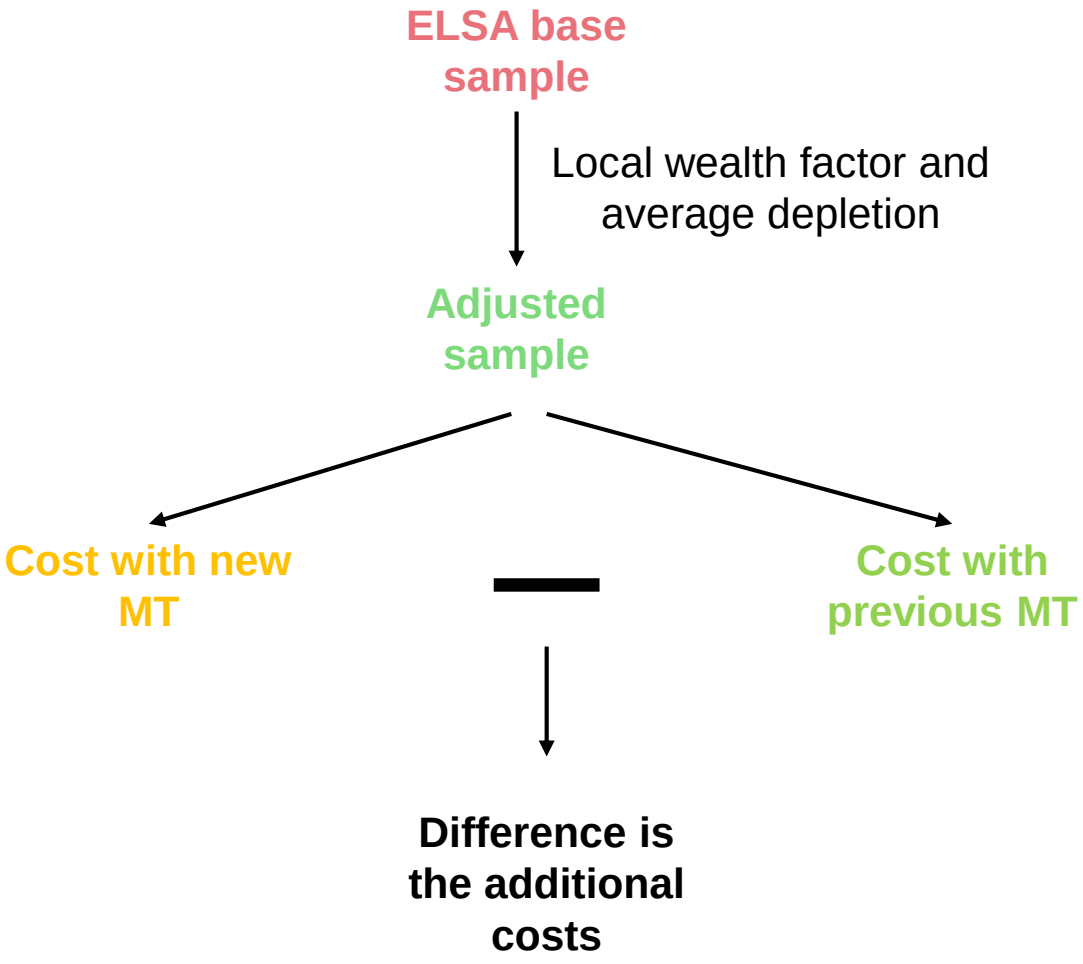
Modelling cap costs

Uptake and eligibility

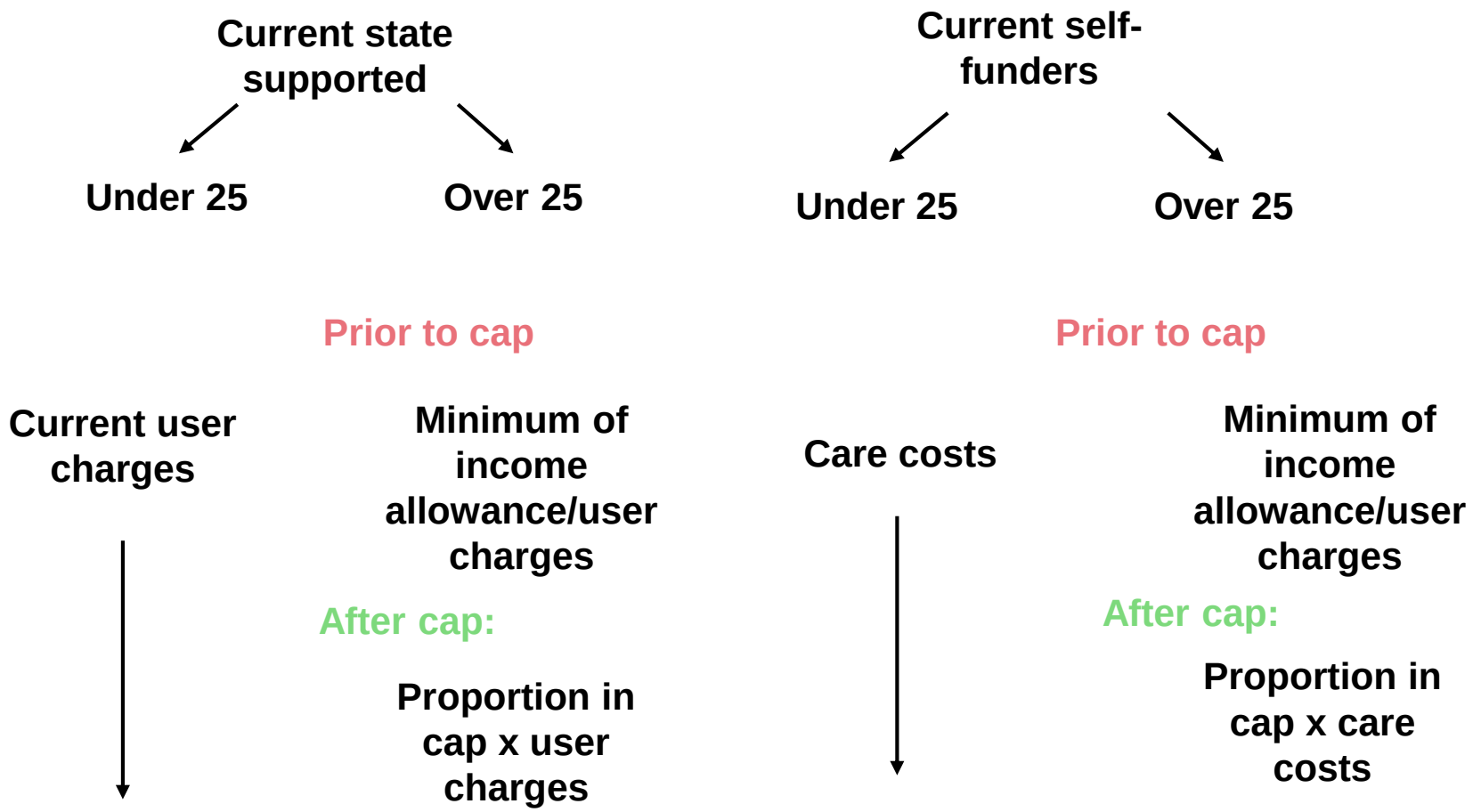


This is influenced by prior home care

Modelling Means Test Costs



Modelling WAA costs



DH Impact Assessment – Feb 2015 – Funding Reform

Social Care Funding Reform

£ billions, 16/17 prices undiscounted	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	Discounted Total
Older People												
Cap and means test		0.32	0.33	0.45	0.73	1.07	1.32	1.47	1.57	1.68	1.79	8.78
Assessment, Case Management and Review Costs	0.11	0.26	0.21	0.22	0.23	0.24	0.25	0.27	0.28	0.30	0.31	2.30
Working Age												
all costs		0.09	0.13	0.15	0.23	0.26	0.36	0.40	0.41	0.42	0.43	2.38
Total care and support cost	0.11	0.66	0.67	0.82	1.19	1.57	1.93	2.14	2.26	2.40	2.54	13.46
Benefits												
Reduced eligibility		-0.06	-0.07	-0.08	-0.11	-0.16	-0.20	-0.22	-0.23	-0.24	-0.24	-1.32
Potential increased take up											To be quantified in the final IA	
Net cost to benefits		-0.06	-0.07	-0.08	-0.11	-0.16	-0.20	-0.22	-0.23	-0.24	-0.24	-1.32
Net Cost	0.11	0.59	0.60	0.74	1.07	1.41	1.74	1.92	2.04	2.17	2.30	12.14

DH Impact Assessment – Funding Reform - Feb 2015

Figure B12: Projection of number of self-funders in care homes

Self-supported

	15/16	16/17	17/18	18/19	19/20	20/21	...	25/26
residential care	74,692	77,247	79,803	82,358	84,914	87,469		107,460
nursing care	67,201	69,413	71,626	73,839	76,051	78,264		95,134

Self-supported – eligible [10% reduction applied]

	15/16	16/17	17/18	18/19	19/20	20/21	...	25/26
residential care	67,223	69,522	71,822	74,122	76,422	78,722		96,714
nursing care	60,481	62,472	64,463	66,455	68,446	70,438		85,621

Impact Assesment based on around 150,000 in res /nursing care - then applying a 10% reduction to 135,000 – with £320m based on an 80% take up so that the £320m means test figure will only come from 108,000 self funders

Older Adults – Means Test Costs – Year 1

The latest stock take suggests that the number of self funders in Residential/Nursing Care is closer to 180,000.
It is likely that all the subset of people in this group who are eligible for the means test will apply and receive additional support – two thirds more than the Impact assessment – with year 1 costs of £535m

Modeling Other Options

Means Test – introduced in combination with cap to offer protection of assets at the lower end. If cap is not back dated and only has an impact in year 3 – is there scope to put back the start of the means test to year 3?

Figure 1: Maximum asset depletion over course of long care journey showing the impact of extended means test support

Modeling Other Options

Inconsistent Framework – leads to an added incentive for people to be supported in the community – rather than in residential care – if half of this group move – we lose £850m of income and self funder costs would increase – by at least £400m.

Contribution Policy Example	Care Setting	Supported at Home	Residential and Nursing Care
Income - Fairer Charging - Contributions to Care - £m		369	1685
Costs	Gross Costs	2673	5060
	Less NHS Income etc	350	282
	Gross Costs after NHS income	**2323**	**4778**
Income - as a percentage of cost	%	16%	35%

Based on 2013-14 income and expenditure

Modeling Other Options

Inconsistent Framework – if we have the same framework across residential/nursing and the community – while still offering protection to those currently in care – we would generate an additional £350m of income – all of which could be deferred by the individual. This was a Dilnot expectation.

Contribution Policy Example		Care Setting: Supported at Home	Care Setting: Residential and Nursing Care
Income - Fairer Charging - Contributions to Care - £m		369	1685
Costs	Gross Costs	2673	5060
	Less NHS Income etc	350	282
	Gross Costs after NHS income	**2323**	**4778**
Income - as a percentage of cost	%	16%	35%

Based on 2013-14 income and expenditure

Modeling Other Options

Inconsistent Framework – the Barker Commission suggested that we need to consider introducing an appropriate daily living costs for those receiving continuing health care. Again protection could be offered to those already in care. The commission suggested this would generate around £200m.

Modeling Other Options

Percentage Rate Accommodation Cost –

- the impact assessment would suggest that the impact of varying the daily living cost would not dramatically increase costs – given the lower proportion of people who are self funders who have lower accommodation costs – with most closer to the higher figure.
- Overall this proposal would cost less than the current option of reducing the daily living cost universally to £213 a week at a cost of £120m in 2021/22.
- Indeed this income figure is still too high as the current minimum income less the personal allowance is £205 – with likely costs closer to £180m in 2021/22.

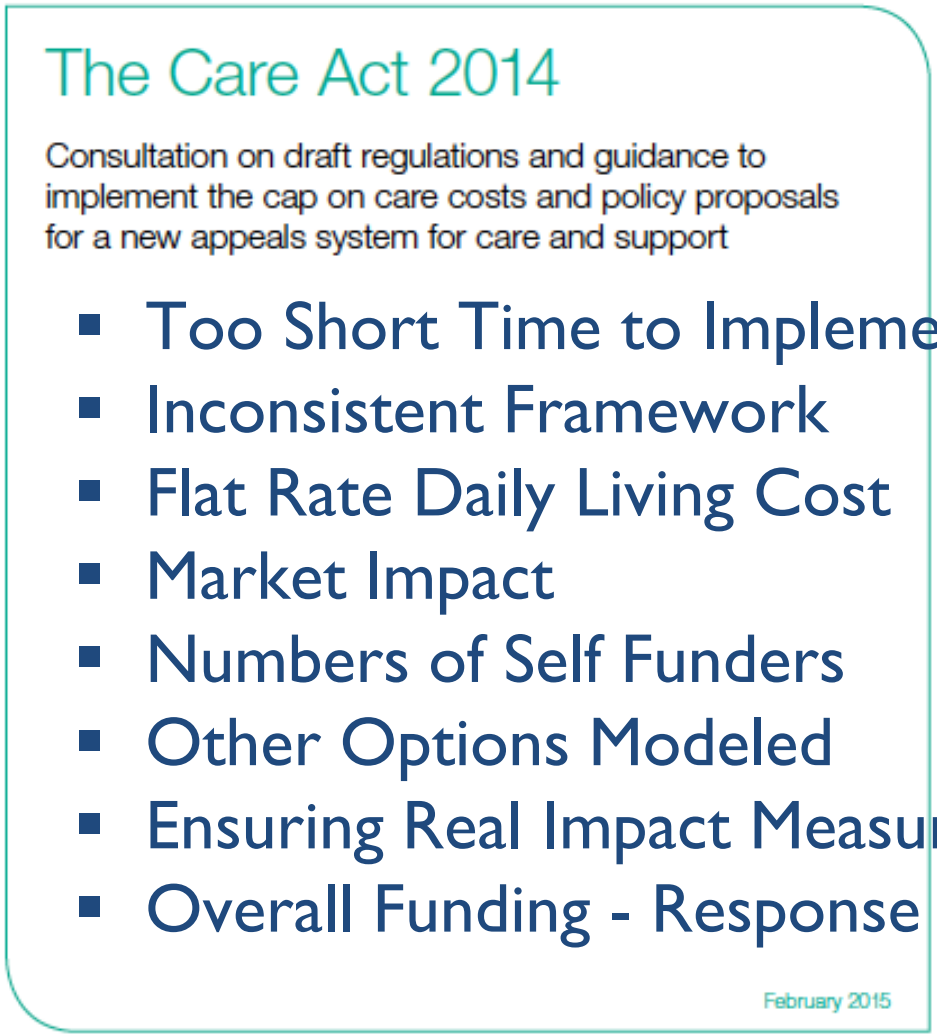
Modeling Other Options

Summary

- ***Percentage Daily Living Cost*** – less than pitching costs at minimum level of income after personal allowance.
- ***Introduce cap in first year – but bring in increase in means test in year 3*** – saving - £650m to £1bn over first 2 years.
- ***Introduce Dilnot recommendation to have a consistent contribution framework across all care settings*** – in the community and residential and nursing care – this would generate around £250m in income and forestall the potential loss of income and increased costs of over a £1bn if people move from res care into the community.
- **Progress the Barker Commission proposal to introduce daily living cost to continuing health care -** that we need to consider introducing an appropriate daily living costs for those receiving continuing health care. Again protection could be offered to those already in care. Based on the commission's analysis this would progressively generate around £200m.

Department of Health

Funding Reform – Key Issues



- Too Short Time to Implement - so April 2017?
- Inconsistent Framework
- Flat Rate Daily Living Cost
- Market Impact
- Numbers of Self Funders
- Other Options Modeled
- Ensuring Real Impact Measured and Funded
- Overall Funding - Response to Barker Commission, etc

Workshop on Funding Reform

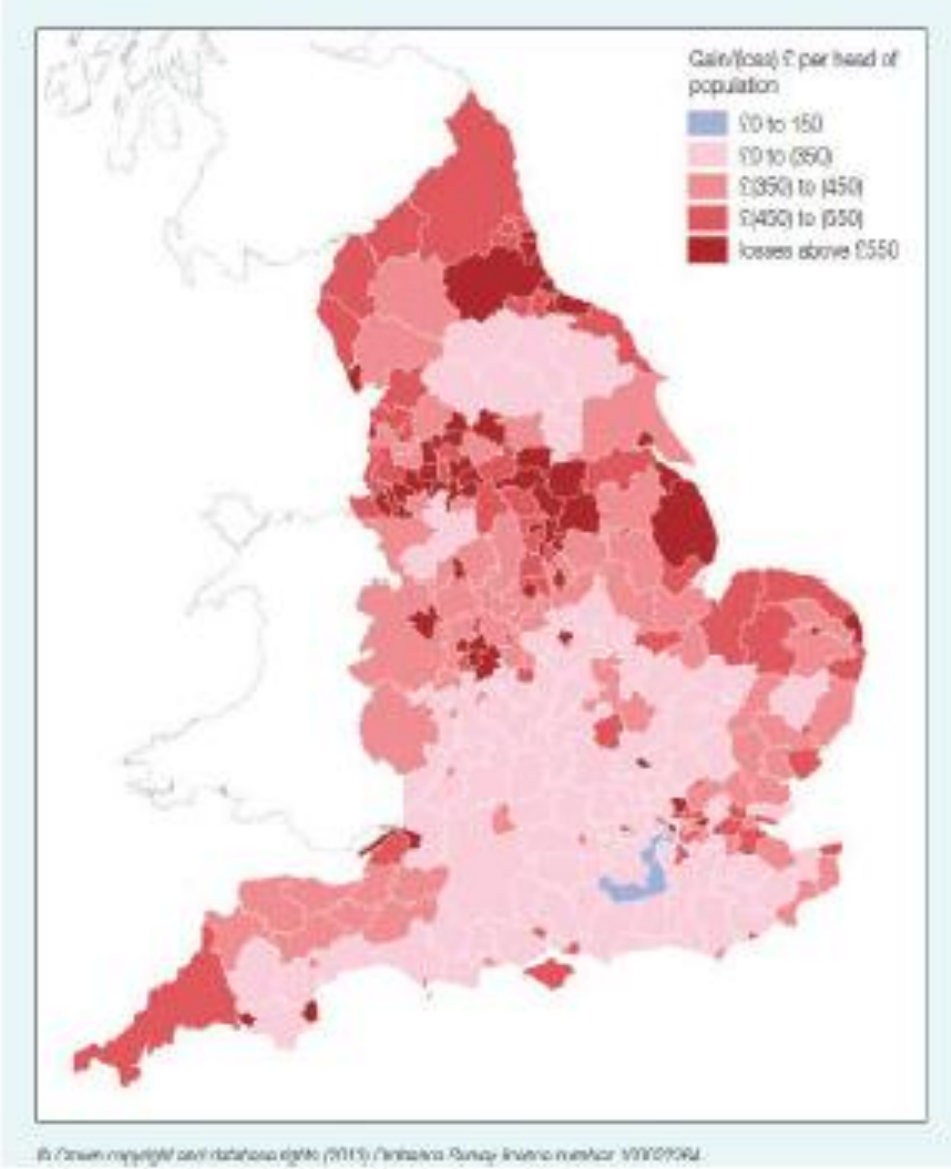
Issues – what do you see as the key issues with funding reform?

Overcoming these issues – have you identified any ways of overcoming these issues?

Spending Review Context

Extra Slides

LA - Significant Cash Reductions in Funding Support per Head Across England

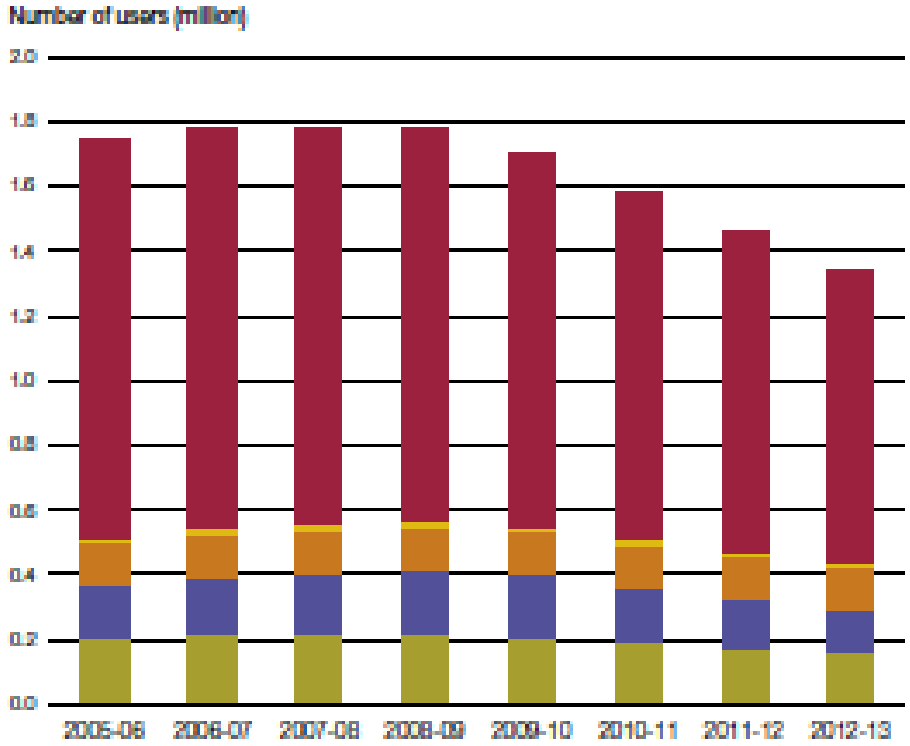


Leading to fewer people receiving support

Figure 4

Adults receiving local authority social care services, 2005-06 to 2012-13

The number of adults receiving state-funded care fell from around 1.8 million in 2008-09 to around 1.3 million in 2012-13



Number of adults aged:	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
65 and over	1.23	1.23	1.22	1.22	1.15	1.06	0.99	0.90
18 to 64 other	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.01
18 to 64 with a learning disability	0.12	0.12	0.13	0.13	0.13	0.13	0.13	0.13
18 to 64 with a mental health problem	0.17	0.19	0.19	0.20	0.20	0.17	0.15	0.13
18 to 64 with a physical or sensory disability	0.21	0.21	0.22	0.22	0.21	0.19	0.17	0.16

Source: National Audit Office analysis of Health and Social Care Information Centre data, RAP 2005-06 to 2012-13

Proportion of Adults with limiting activities to their daily living – highest where cash reductions greatest