advice and support for older age
Independent Age

Independent Age response to the Department of Health consultation on implementation of parts of the Care Act 2014 coming into force from April 2016

March 31 2015

About Independent Age

Founded over 150 years ago, Independent Age is a growing charity helping older people across the UK and Ireland through the 'A, B, C' of advice, befriending and campaigning. We offer a free national telephone and email advice service focusing on social care, welfare benefits and befriending services, which is supported by a wide range of free printed guides and factsheets. This is integrated with on-the-ground, local support, provided by a network of over 1,500 volunteers offering one-to-one and group befriending.

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Independent Age is also a member of the Care and Support Alliance: a consortium of over 75 organisations that represent and support older and disabled people campaigning to keep adult care funding and reform on the political agenda.

Independent Age response to the Department of Health consultation on implementation of parts of the Care Act 2014 coming into force from April 2016

Overview

- Independent Age supports the principle of a cap that aims to protect people from catastrophic care costs and pools the risk that anyone of us could face care costs in later life.

- However, the introduction of a cap alone will not solve all the problems facing the chronically underfunded social care system. What is urgently needed alongside the introduction of a care cap is a review of the means-tested system, as recommended by the Commission on the Funding of Care and Support in 2011.

- Whilst the proposed cap will go some way to protect a minority of people who spend more than £72,000 on their care, it won't do anything to help the 362,000 fewer older people getting care in 2013-14 compared with 2008-09[1]. As such, we support the Care and Support Alliance's calls to lower the national minimum eligibility threshold to include people with so-called moderate needs, not just adults with substantial care needs.

- We do not accept the premise that there is a fixed spending envelope for adult social care. Rather, we support the Care and Support Alliance's calls for a new consensus on the additional public funding that is urgently needed for the chronically underfunded care system. The Office for Budget Responsibility (OBR) estimates that approximately 1.2% of GDP is currently spent on social care and 8% on health care.[2] The Barker Commission[3] has recommended that over the next 10 years the proportion of GDP spent on health and social care should rise to between 11 and 12% (9.1% on health and 2.2% on social care if their recommendations were implemented).

- We call for an improved settlement for care that provides more support to those both currently locked out of the system *and* those who receive care, but who face very high care costs.

- We welcome the extension to the means test but propose for it to be followed up with a reduction in weekly tariff income to a ratio of £1:£500 in line with Pension Credit rules. This will make sure more people with savings of £118,000 or less will get local authority support over and above the equivalent level of Attendance Allowance.

[1] Community Care Statistics 2013-14, Health and Social Care Information Centre, Figure 3.1 p35 (taken from Referrals, Assessments and Pack ages of Care Return: P1)
[2] Fiscal Sustainability Report, Office for Budget Responsibility, July 2014
[3] A new settlement for health and social care: final report, Commission on the Future of Health and Social Care in England, The King's Fund, 2014, p. 22

- Effective communication on how the cap will operate is crucial. We understand that the Department of Health awareness campaign due to launch in early 2016 will cover a range of different types of media from radio advertising and door drops, through to media and digital communications. This must be a well-resourced and comprehensive communications campaign, which works in the interest of individuals while also ensuring that the public is provided with realistic expectations of what paid support they may be entitled to.

- Independent Age believes reaching the cap may well be a difficult, costly and lengthy task. As such, local authorities must be clear with older people about what costs actually counts towards the cap. There will be many older people shocked to learn that their care needs aren't considered high enough for any money they spend on their care to count towards the cap. The local authority must also be clear about what a person will continue to be financially responsible for once they have reached the cap.

- The rate set for an independent personal budget should be calculated with reference to the person's individual assessed needs. Where it isn't practical for the local authority to carry out a full calculation in every case, the rate should be based on a targeted local market average for good quality care.

- We support a level of daily living costs linked to universal benefits, based on Single Tier State Pension (to be set above the level of Pension Guarantee Credit) plus Attendance Allowance minus Personal Expenses Allowance.

- We welcome greater freedoms for people to top-up the cost of their own care when it is as a result of a genuine informed choice. However, no one should feel compelled to top-up the cost of their care themselves. With regard to first party top-ups, we call for further clarity on what 'affordable and sustainable' means in practice, so no one is put at risk of using up all their assets.

- Finally, we call on the government to review the adequacy of the Personal Expenses Allowance (PEA) as part of the reforms. The Dilnot Commission raised the case for increasing it in the future (currently set at £24.90 for April 2015). It is important to ensure older people in care homes getting local authority funding have a dignified amount to live on to meet personal, day-to-day costs[4].

[4] The Real Cost of Care, An analysis of calls to Independent Age's Counsel and Care Advice Service from April 2011 to end March 2012, Independent Age, 2012, p13

The Care Cap

1. Do you agree that the draft regulations and guidance will provide a robust framework that will protect the 1 in 8 of us that will face catastrophic care costs? Please state yes or no along with any rationale.

Yes. Independent Age supports the principle of a cap that aims to protect people from catastrophic care costs, as recommended by the Commission on Funding of Care and Support in 2011. We agree there needs to be a cap on the amount of money any one individual has to pay for their care. We have to end the unfairness of, and fear caused by, unlimited care costs. The value of the cap together with the extended means test lies in the greater certainty created for the 1 in 8 people in the care system facing catastrophic care costs. The risk anyone of us may face care needs will be shared across society, with greater certainty about the maximum level of money individuals would have to pay to meet complex needs.

Only 23,000 people will immediately benefit from the reforms - a relatively small number. However, we note that 92% of those predicted to benefit from the cap will be over 75 and nearly 80% will be women[5]. In addition, we welcome the fact that self-funders who previously may have had difficulty in accessing support from the local authority will be encouraged to come forward to have a needs assessment and access information and advice.

However, further reform is required to make sure that the care system will also be robust enough to offer wider protection to those currently not receiving any care and support. The Commission on Funding of Care and Support presented the option of a cap on care costs with the central tenet that 'everyone is protected from extreme costs, as they are in every other major area of their lives'(p2) and to provide 'peace of mind for all'. The Commission offered two further key areas for reform, based on an extension of the means test threshold for residential care to provide 'extra protection to those with the lowest incomes

[5] Social Care Funding Reform Impact Assessment, Department of Health, p39

and wealth' (p2) and a new national eligibility threshold to improve consistency and fairness'(p6).

We propose that four additional areas should be the focus for the 2016/17 funding reforms: in order to meet the original tests set by Dilnot and to ensure a more comprehensive framework is established for those facing high or catastrophic care costs:

- **Firstly, a review of how people access the care system is urgently required alongside reform of the care cap.** Whilst the cap will go some way to protect a minority of people who spend more than £72,000 on their care, it won't do anything to help the 362,000 fewer older people in 2013-14 getting services compared with 2008-09[6]. **We support the Care and Support Alliance's calls to lower the national minimum eligibility threshold to include people with so-called moderate needs, not only adults with substantial care needs.** The Commission on the Funding of Care and Support acknowledged that a national eligibility threshold set at 'a minimum' of substantial was a 'short-term' measure[7] and therefore, we suggest, open to the possibility of future review. Keeping the eligibility threshold at substantial level will leave significant numbers of people with moderate needs and below without access to care and support.

  According to LSE estimates, by not setting the national minimum eligibility threshold at the level equivalent to "moderate" in the Fair Access to Care Services Framework, around 235,000 older people who would otherwise be eligible will in fact find themselves unable to get help with activities such as washing, getting dressed and getting out the house[8]. New updated LSE PSSRU figures for 2015 clarify the additional cost of including people with moderate needs in the social care system. Forder and Fernandez estimate that the cost to lower the eligibility criteria to cover people with

[6] Community Care Statistics 2013-14, Health and Social Care Information Centre, Figure 3.1 p35 (taken from Referrals, Assessments and Pack ages of Care Return: P1)
[7] Ibid. p6
[8] Implications of setting eligibility criteria for adult social care services in England at the moderate needs level. Fernandez JL et al, PSSRU, LSE, London 2013

moderate needs will cost **£2.4bn** in total for all client groups in 2015 and would be projected to rise to **£3.2bn** by 2020 for all client groups. The 2015 cost for older people is **£1.5bn**.

People with needs assessed at moderate level for a long period of time will be at risk of privately paying out large sums of money towards their care without any of the costs metering towards the cap. For many people with progressive conditions, the high eligibility threshold means they will spend significantly more than £72,000 before they reach the cap. Those people with progressive conditions without the means to pay for support are most at risk if the eligibility threshold remains quite so high, leading to extra pressures on families, carers and hospitals.

- **Secondly, another area the Government should still focus on is reviewing how the level of cap is up-rated (the level of the cap).** A £72,000 cap falls outside the range of between £25,000 and £50,000[9] and therefore does not meet the Dilnot Comission's original criteria on fairness or sustainability. It believed a cap set above £50,000 could mean people on lower incomes and lower wealth would not receive adequate protection. One option could be to fix the level of the cap at £72,000, which would over time reduce the real terms value of the cap down to the range recommended by Dilnot of between £25,000 and £50,000.

  Currently, Section 16 of the Act provides for an annual adjustment to the cap where the Secretary of State considers there has been a change in the level of average earnings. In addition, Section 71 of the Act requires the Secretary of State to carry out a detailed review on the operation of the cap and to publish a report on the outcome of that review every five years. We suggest that this review period offers an opportunity to fix the cap at £72,000 for the next five years in order to remove any arbitrary increases and shore up public support for a new system that will take around five years to properly bed in.

[9] Fairer Care Funding, The Report of the Commission on the Funding of Care and Support, July 2011, p6

It is important that if the cap is to increase in the future it must do so in relation to a predictable set of defined rules that enable people to establish in advance what the approximate level might be in the future and plan properly for their care. If the Secretary of State does decide to review the level of the cap each year, the level of daily living costs, the means test thresholds and also the level of independent personal budgets must be considered as part of that review.

- **Thirdly, we propose another area of focus, which would involve reviewing how tariff income is applied to ensure that more people will benefit from the extended means test for residential care.** We welcome the extension to the means test but propose for it to be followed up with a reduction in weekly tariff income to a ratio of £1:£500 in line with Pension Credit rules. This will make sure more people with savings of £118,000 or less will get local authority support over and above the equivalent level of Attendance Allowance.

The current rate of tariff income to be charged on a person's assets between £17,000 and £118,000 - £1 for every £250 - means that a person with £118,000 will be assessed as having £404 a week notional tariff income in addition to their actual income. They are likely to be judged able to afford the majority - if not all - of their care fees and as a result get little or no financial support. Pensioners with median income will in effect be required to self-fund from their actual and notional income until their savings deplete down to an average upper capital limit of £79,600[10] before the local authority will begin to contribute.

- Lastly, **we support the Department of Health's proposal to link the level of daily living costs to universal benefits, based on Single Tier State Pension (to be set above the level of Pension Guarantee Credit) plus Attendance Allowance minus Personal Expenses Allowance.** Without reform, the risk is that people with limited wealth will

[10] A Cap that Fits: the 'capped cost plus' model, James Lloyd, The Strategic Society Centre, 2013, p41

have to use their assets to supplement their income to pay daily living costs both before and after they reach the cap. According to the Department of Health's analysis, a reduced level of national daily living costs set at £213[11] would financially benefit 68,000 people with a greater amount of state support by 2025-26, and include 2,600 extra people by 2025-26 at a cost of £130m. Reducing daily living costs to a more affordable rate in line with universal benefits would benefit many people from the moment that they enter the care system as they will be able to pay an affordable amount of daily living costs from income right from the start rather than only on reaching the cap.

These four key measures are needed in order to ensure the protection provided by the funding reforms being introduced in 2016/17 are as comprehensive as possible and guarantee full 'peace of mind benefits' for the public. **As such, we are not willing to accept the premise that there is a fixed spending envelope for adult social care. The Better Care Fund is a welcome initiative, but does not in itself solve the problems caused by years of chronic under-funding in adult care.**

We support the Care and Support Alliance's calls for a new consensus on the additional public funding that is urgently needed for a badly underfunded care system.

The introduction of a cap alone will not relieve all the pressures facing the current social care system. Social care spending has seen five consecutive years of real term reductions with £3.5 billion less in council social care budgets since 2010, a fall of 26% according to the Association of Directors of Adult Social Services[12]. By 2020, councils in England will face a funding shortfall estimated at £4.3bn just in order to provide care services at today's levels – almost a third of their current total care budget[13]. These cuts in local authority funding have been combined with growing demographic pressures and increased charging.

[11] Social Care Funding Reform Impact Assessment: Annex C, Department of Health, 3 February 2015, p79
[12] Distinctive, Valued, Personal: Why social care matters: The next five years, Directors of Adult Social Services, March 2015, p. 6
[13] Ibid. p. 7

Concerns are also being raised by adult social care directors in England that they may not be able to meet the duties placed on them under the Care Act. Research by Independent Age and the MJ, the UK's leading weekly magazine for council chief executives and senior managers, recently revealed that 24 Directors of Adult Social Services supported the aims of the Care Act, but many didn't feel realistic levels of funding have yet been put in place to properly implement the legislation.

Our analysis from March 5th 2015 found that:

- none of the councils who took part in the research said the funding they had been given to implement the Care Act is entirely sufficient
- councils are concerned one of the biggest impacts of insufficient funding is putting in place the IT systems to implement the Care Act, so for example checking when people will reach the new care 'cap' of £72,000
- no councils who responded are fully confident they will have enough money to implement the new 'wellbeing' duty – one of the main features of the Care Act.

As a result, alongside the introduction of the cap, further investment in social care as a whole is urgently needed. We call for an improved funding settlement for social care; that both expands eligibility to provide more support to those currently locked out of the system *and* additional financial support to those who receive care, but face very high care costs.

Independent Personal Budgets

2. Do you agree that independent personal budgets should generally be set according to an average of personal budgets allocated to people with similar levels of need? Please state yes or no along with any rationale.

No. The rate of an Independent Personal Budget (IPB) should be based on the results of a comprehensive assessment of a person's individual needs at the time they need care and support. Whilst we recognise that this may not be practical in every case, it is important that the norm is for a self-funder to have an accurate and costed independent personal budget that reflects local market provision for good quality care.

Given local authority fee settlements are typically lower than fair market rates for delivering care, and indeed the rates private payers often have to pay, setting the independent personal budgets self-funders receive according to an *average of local authority-set personal budgets* will perpetuate many of the most unfair aspects in the current system. We worry allocating an IPB based on the average cost of meeting similar needs will be fraught with difficulties, and not only prove unfair for self-funders, but problematic for councils too. Below we provide some context.

Focusing on residential care, it is likely that a local authority-set fee (for example in the form of a personal budget) will be lower than the fair market rate in most local areas. Laing & Buisson have highlighted a shortfall in local authority fee settlements of £42 per week, a significant increase in the shortfall documented last year of £31 per week. They have argued this shows that local authority measures to cut budgets are "forcing rates to slip even further behind in terms of keeping abreast with the real costs of providing residential care".

It is well recognised that self-funders often pay more for the same type of care in a care home compared with council-funded residents, largely as a result of local authority block purchasing powers. Self-funders are commonly understood to cross-subsidise the fees of local authority-supported care home residents.

Furthermore, we are concerned that differences in local authority personal budget rates will mean big variances in the length of time it takes before people reach the cap. It may mean some people will have to pay more for the same amount of care both before and after they reach the cap. An individual aged 85 entering a care home in London is expected to reach the cap in around 4 years and incur a personal cost for care and accommodation of around £117,000 before reaching the cap. While in the West Midlands, it is predicted to take 7 years for a person aged 85 entering a care home to reach the cap, with personal costs of around £170,000 (Institute and Faculty of Actuaries, May 2014). This is because the usual costs of care vary so much from one region to another, so

where weekly costs of residential care, for example, are generally lower, it will take an individual longer on average to reach the cap and cost more.

The Government still needs to clarify how a system where self-funders "meter" towards the cap at cheaper local authority rates, yet are required to pay above those rates in higher care home costs, can be argued to provide peace of mind benefits to all. Clearly a risk still remains that self-funders will experience frustration not all their (typically higher) care costs are in fact being counted towards the care cap.

Returning to the draft guidance itself, section 11.15 on calculating the IPB is ambiguous, when in fact it needs to be much more explicit what Government wants local authorities to do. While we all want to minimise bureaucracy for councils, what is most practical for the local authority to administer must not be at the expense of people using services. Guidance should emphasise that local authorities need to offer independent personal budgets that are an accurate reflection as far as possible of the cost of a self-funder's individual care costs.

To find an appropriate fix, we at the very least want to see a middle ground established, which enables councils to provide a range of accurate IPB rates based on *local market costs*, and crucially, not *personal budget averages*.

Commissioning is traditionally based on the type of setting or support to be delivered (for example older residential care, mental health care, care for people with complex needs, care for people with nursing needs etc.) A challenge for local authorities is making sure they reflect a diverse and representative range of adult needs in the setting of IPB rates, and not defaulting to a one-size fits all 'setting' or service based calculation as to how they calculate an IPB rate.

We strongly welcome the suggestion that local authorities propose a period of time, following the calculation of IPB, during which the person is invited to consider the IPB rate and contact the local authority with any queries. However, section 11.21 in the draft guidance on independent personal budgets needs to

be stronger, so that local authorities *routinely* propose a period of time in which a person is invited to consider their IPB rate.

At present, the guidance on timeliness is too weak, simply suggesting local authorities "may" propose a period of time for the IPB rate to be reviewed. Routinely providing a "window" for a self-funder to review the IPB rate should give self funders time to independently consider the adequacy of their independent personal budget. During this period, they may obtain care fee quotes from a range of sources. This may reduce the number of unnecessary appeals presented to local authorities at a later date.

This is of particular importance for people who are new to the system and being presented with an IPB following the onset of care needs. For 'new' IPB holders, having a period of time in which to consider the IPB rate should take place in conjunction with any offer of a 6-8 week 'light touch' review of needs and an opportunity to engage in care and support planning.

3. Is the guidance sufficiently clear as to the principles for calculating independent personal budgets? Please state yes or no along with any rationale.

Yes. We support the principles set out for calculating independent personal budgets (IPBs) in particular, those of transparency, timeliness and sufficiency. We also agree that the way in which IPBs are calculated must have regard for the wellbeing principle. It is welcome that links with personal budgets principles will be maintained.

Our overarching concern in regard to how sufficient personal budgets and IPBs can be delivered is the widely recognised and growing shortfall in local authority funding, particularly for council-procured residential care. We are concerned that cuts to overall budgets will diminish or negate councils' ability to deliver personal budgets and IPBs that are sufficiently costed to help promote individual wellbeing.

It is vital that local authorities keep the adequacy of IPBs and Personal Budgets under review. With respect to IPBs, this is important in order to reduce any risk that residents routinely feel compelled to enter into a top-up agreement at the point they reach the cap and as they get transferred over to a personal budget.

When a person reaches the cap, the local authority must revisit the personal budget decision and then review the person's financial circumstances. Where a person has reached the cap and may need to pay a top-up fee to stay in the accommodation they currently live in, the local authority should have due regard to Annex A of the guidance supporting the Care Act 2014, and the Choice of Accommodation rules. In the new guidance on independent personal budgets, a note on first party top-ups and Choice of Accommodation would fit most appropriately with the section on the principle of 'sufficiency' (11.22).

Discussions on top-up fees should be entered into well in advance of a self-funder reaching the cap, as there is a possibility that being transferred from an independent personal budget to a personal budget could present a self-funder with a choice about whether to pay a future top-up to remain within their care home. These discussions should ideally take place within 18 months of a self-funder being predicted to reach the care cap. We believe this 'lead in' time should allow for appropriate arrangements to be made and reduce the risk someone makes a crisis decision to top-up in order to avoid moving home.

As a key part of this process, the local authority should review the rate it would pay for the care home place, and in collaboration with the provider, consider whether there are grounds for adjusting rates or fees in good time, i.e. at least 3 months before the self-funder is due to be moved onto a local authority funded personal budget.

Care Accounts

4. Does the draft guidance provide sufficient clarity about the operation of care accounts to ensure consistency between local authorities and reduce the risk of challenge? Please state yes or no along with any rationale.

5. Can more be done to ensure that the care account is a useful tool to support people in planning for care costs?

Local authorities will have an important role to play in monitoring and recording a person's progress towards the care cap through individual care accounts. We welcome the emphasis in the guidance on using the care account as a vehicle to ensure a smooth transition to local authority funding on reaching the cap. Effective planning in advance, with access to information and advice at an early stage, is vital to ensure that when the cap is reached there is no disruption to a person's care.

We hope that the introduction of care accounts will encourage a clear entry point to the care system, especially for people with assets above the upper capital limit, 80% of whom the Department of Health predicts will be incentivised to contact their local authority to have an assessment and get their care account set up.

In terms of the content of the care account (at 12.5 and 12.20 of the draft guidance on care accounts), in addition to including the weekly amount of daily living costs, it would be useful to include the amount of the first or third party top-up being paid.

It will be a useful way for local authorities to maintain oversight of top-up agreements in their area, a core responsibility under the Act. It will also be an important opportunity for self-funders to be provided with information and advice by the local authority on the costs that count towards the cap and those that won't.

It will be important for a self-funder to be aware that if, when their care account is opened and their independent personal budget rate is set up, they make a genuine choice to move into an expensive care home and are therefore required to pay higher fees now, they may be required to pay a top-up once their care costs reach the cap.

It must remain clear in the accounting that daily living costs and the top-up amount are excluded from the total amount that will be used to judge a person's progress towards the cap.

We are concerned about what the increased bureaucracy associated with care accounts might mean for a person's freedom to move from one local authority area to another. The guidance requires a local authority (the first authority) to inform a new authority (the second authority) that a self-funder is moving to their area and pass on their care account and details of their independent personal budget. The second authority is then required to assure themselves that this intention to move is genuine and then carry out a new assessment and set up a new independent personal budget. The increased bureaucracy alone may put off some self-funders from moving.

There is also a risk that the new IPB might be set at a lower rate depending on the personal budget average rates of the new area. If this is the case it may slow down the speed with which a person progresses towards the cap. A person with an independent personal budget may be discouraged from moving to a new area if they are aware that the new personal budget rates are lower than their current area. One way of avoiding this would be to ensure that if a person with an IPB moves to a new area, the new local authority is required to carry out a full review of their care costs based on their assessed needs rather than an average rate. The updated care account would then be based on the most accurate calculation of their care costs in the new area.

It would be useful to have more clarity in the guidance about what happens if a person is forced to pay care costs over and above the cap for an extended period of time due to a delay by the local authority in reviewing a person's finances.

Cap for working age adults

6. Do you agree that the preferred option best meets the principles and priorities identified? Please state yes or no along with any rationale.
7. What are your views on how people of working age can be supported further to enable them to save and plan?

Daily living costs

8. Is there evidence to support further consideration of the level and/or approach to daily living costs? Please state yes or no along with any rationale and provide any evidence you may have to support the rationale.

We believe it is fair that people in care homes should pay towards their daily living costs in the same way as people in their own homes and should continue to do so once their care costs hit the £72,000 cap. We understand the reasoning behind the Department of Health's attempt to create a level playing field for both those receiving care at home and those in a care home, so neither are unfairly advantaged or disadvantaged as a result.

However, the Department of Health must communicate this position effectively so that the general public understands as far as possible that only eligible care costs count towards the cap and people in a care home are aware they will still be required to contribute towards their daily living costs both before and after they reach the cap.

We agree with the Commission on Funding of Care and Support's view that any such living costs should be fixed across the country, be predictable and add greater transparency[14]. It is welcome that the Department of Health has accepted the Commission's recommendation for daily living costs to be a 'notional amount set nationally'[15] for those receiving care in a care home. However, it is important that the amount people are required to contribute towards their daily living costs remains affordable both before and after they reach the cap. We are concerned that one of the downsides of standardising daily living costs will, in effect, be to embed the idea of top-ups in parts of the country where people's personal budgets simply fail to reflect higher accommodation costs.

People on low incomes should not be required to deplete their savings in order to cover daily living costs. It is important that people should be left with sufficient income after meeting their care and daily living costs to pay for any disability-

[14] Fairer Care Funding, The Report of the Commission on the Funding of Care and Support, July 2011, p. 26
[15] Caring for our future: consultation on what and how people pay for their care and support, Department of Health, 2013 p. 20

related expenditure and have a good quality of life. As such, we support the requirement for local authorities to provide financial support to people who cannot afford the full amount of daily living costs from income alone. But more clarity is needed on how an affordable rate of daily living costs will be calculated.

The government's recommendation of £12,000 a year, is according to the Strategic Society Centre, approximately equivalent to 'median pensioner income'[16]. In addition, the Commission on the Funding of Care and Support also made reference to the median net income for a single person over 65[17] when establishing the rate to set for daily living costs. However, we are concerned that a notional figure for daily living costs set at £230 a week is still too high for those with incomes below median level. The median net income for a single person over 65 in 2012-13 was £238 a week before housing costs and £195 after housing costs[18]. However, in 2012/13, around one in ten (13%) of pensioners were in relative low income After Housing Costs. 15% were in absolute low income and 8% in material deprivation. This means that around a fifth of pensioners live on a low income or in material deprivation.

Furthermore, the Department of Health's modelling highlights that for self-funders with low to modest incomes, their entitlement to Attendance Allowance stops after they reach the cap which leaves a gap of 'around £70 per week between their income and the level of daily living costs which they would be required to cover from their assets'.[19] It also illustrates how people on the full new state pension can face 'asset depletion in excess of 50%' as a result of the current rate of daily living costs. Without reform, the risk is that people with limited wealth will have to use their assets to supplement their income to pay daily living costs both before and after they reach the cap. According to the Department of Health's analysis in the impact assessment a reduced level of national daily living costs set at £213[20] would financially benefit 68,000 people with a greater amount of state support by 2025-26, and include 2,600 extra people by 2025-26 at a cost of £130m. **As such, we would support the**

[16] A Cap that Fits: the 'capped cost plus' model, The Strategic Society Centre, 2013, p14
[17] Fairer Care Funding, The Report of the Commission on the Funding of Care and Support, July 2011, p. 26
[18] Pensioners' Incomes Series 2012/13, Department for Work and Pensions.
[19] Social Care Funding Reform Impact Assessment: Annex C, Department of Health, 3 February 2015, p. 79
[20] Ibid: p. 79

Department of Health's proposal to link the level of daily living costs to universal benefits, based on Single Tier State Pension (to be set above the level of Pension Guarantee Credit) plus Attendance Allowance minus Personal Expenses Allowance. This would benefit 100% of people in the care system right from the start that they enter the care system as they will be able to pay an affordable amount of daily living costs throughout their care journey, and not just on reaching the cap.

Finally, this focus on income in care homes also represents a real opportunity for government to review the current level of Personal Expenses Allowance (PEA) as recommended by the Dilnot Commission. Currently the Personal Expenses Allowance is set at £24.90 a week for 2015/16. This is for care home residents to buy all items for essential living and day-to-day expenditure. From April 2016, more people may become aware of the restrictions of the PEA for the first time.

This allowance is intended to provide enough money to cover the costs of clothes, footwear, toiletries, and hairdressing, as well as stationery, newspapers, books, taxis, activities and gifts. Families often find that they have to pay for essential everyday items for their older relatives, such as toiletries and underwear, as the Personal Expenses Allowance simply does not cover the cost of all their weekly expenses. Older people in care homes resort to making difficult choices about everyday purchases and interactions that most of us take for granted. We call on the government to review the Personal Expenses Allowance as part of this consultation to ensure older people in care homes getting local authority funding have a dignified amount to live on[21].

[21] The Real Cost of Care, An analysis of calls to Independent Age's Counsel and Care Advice Service from April 2011 to end March 2012, Independent Age, 2012, p. 13

First party top-ups

9. Do you agree that the extension of the existing requirements for third party top-ups to cover first party top-ups will provide both the local authority and the person with the necessary clarity and protection? Please state yes or no along with any rationale.

Yes. We welcome greater freedoms for people to top-up the cost of their own care, both as they work towards and once they have reached the care cap. However, paying a top-up must always be a genuine choice. The guidance must be clear that on no account should an individual feel compelled to top-up the cost of their own care. We are therefore pleased that existing legal requirements covering third party top-ups, including that a resident must be willing and able to meet top-up payments before they can be agreed to, will be extended to first party top-ups. We also welcome plans to extend the legal requirement for written agreements to cover first party top-ups under the new arrangements.

In our 2013 report, Short Changed[22], and following in-depth research with 13 local authorities[23] in the summer of 2014, we argued to the Department of Health that, despite clear guidance governing third party top-ups, the rules are not being consistently enforced and monitored by local authorities.

In particular:

- Many councils do not know the full extent of top-ups in their area and so cannot ensure that all relatives are "willing and able" to pay them. Nor can they have a true picture of their full liability were top-up arrangements to break down.
- Councils are not following good practice by signposting individuals to independent advice before they are asked to sign top-up fee agreements. In addition, councils are not regularly reviewing top-up payments to monitor whether residents remain able and willing to make the payments.

Throughout the consultations on the Care Act, we have worked to make sure that improved rules on top-ups are put in place from April 2015.

[22] Short changed: The Care Bill, top-ups and the emerging crisis in residential care funding, James Lloyd with Independent Age, November 2013
[23] Care home top-up fees: research with local authorities, Independent Age, August 2014

The reforms include:

- making sure no one has to pay an additional fee, or top-up payment, unless they choose more expensive care home accommodation
- clarifying that anyone paying a top-up can request a review if they are no longer able to pay an additional care home fee
- councils must ensure adults considering paying a top-up for a care home are provided with sufficient information and advice to help them with their decision.

The same rules for third party top-ups should also apply to first party top-ups. In particular it must be clear that where either the 'first party' or 'third party' can no longer afford the top-up the "local authority is responsible for the total cost of the placement". The onus should remain on the local authority to review the personal budget or independent personal budget rate.

The amendments to introduce first party top-ups also offer a good opportunity to review the scope of the third party top-up rules. We welcome the stronger guidance being introduced for this area in April 2015, but suggest that further amendments help improve overall practice for both residents paying first and third party top-ups. Additional changes that could be introduced in April 2016 – to cover all types of top-up payment – could include:

- Expanding the requirement that local authorities offer "at least one" choice of accommodation, so they have to offer more than one choice of accommodation within the cost of someone's budget
- Strengthening the provisions for reviewing the top-up agreement so that it is a clear requirement on local authorities that all top-ups are reviewed at least *annually* - in line with deferred payments rules
- And, requiring local authorities to signpost people to **independent** advice prior to signing a top-up agreement, but also when a self-funder receives an independent personal budget and as they approach the care cap; so people can make clear and confident decisions about how to meet the costs of their future care.

It would be useful to have more detail on the specific circumstances when a first party top-up is permitted, in particular, whether all people who reach the care cap will be included regardless of their total remaining assets, and if those with assets between the new lower and upper capital limits are intended to benefit from these rules, how tariff income is affected. Guidance must make specific reference to the need for local authorities to check the financial sustainability of a first party top-up arrangement. In practice, this means councils needing to engage with residents so that where a resident agrees to a first party top-up, they understand the risks and how this could see them deplete their assets.

Guidance needs to clarify whether first party top-ups are only intended to cover people with capital greater than the lower capital limit. When the new capital limits are introduced, people with £118,000 or less will be local authority funded for the first time and so will be able to enter into a third party top-up and also top-up their care from their own assets. We agree that it may be appropriate for people with between £118,000 and £17,000 to top-up their care from their assets, but unless it is defined in the guidance, there is a risk that people with less than £17,000 will enter into top-up agreements which may not be sustainable in the future. We are particularly concerned about any risk that individuals may spend down capital that should have been disregarded by the local authority in the means test, i.e. capital under the lower capital limit of £17,000.

Guidance must also determine whether there are any situations where both a first party top-up and third party top-up can be enacted simultaneously. We can foresee situations where a person may want to split the cost of a top up with a relative or third party in order to make a choice of accommodation more affordable. We acknowledge that this should be a possibility but only when it is a result of a resident expressing a genuine choice for preferred accommodation. Guidance must clarify the key processes that would need to get underway, such as written agreements, if two types of top-up are permitted at the same time.

It is hard to predict how many people could be affected by liberalising the rules on first party top-ups. The rules could benefit many thousands of older people,

over and above the 54,000[24] people currently estimated to be paying a third party top-up. As a minimum measure, local authorities must regularly monitor and review all top up payments to ensure themselves of the potential overall financial liability that they are exposed to should any top-up agreements break down. It is important the Department of Health maintains active oversight to ensure that local authorities are aware of their total financial liabilities for both third party and first party top-ups. We also recommend data is collected from local authorities on uptake of the total number of top-up agreements local authorities are party to, including first party top-ups. This data could be collected as part of the Health and Social Care Information Centre's annual social care collections.

Extensions to means tested support

10. Do you agree that the guidance is clear on how the extensions to the means test will work and that the draft regulations achieve their intended purpose? Please state yes or no along with any rationale.

Yes. We welcome the extension of the means test for people in a care home with savings or property of £118,000 or less. The new means test will comprise two upper financial thresholds for a care home: £118,000 or £27,000 when a property is disregarded and one lower threshold of £17,000.

We anticipate that new reforms may encourage more people to approach the local authority to get a needs assessment. This is positive as it results in people getting access to community services, advice and information, preventative support and so on. However, we are concerned that it might result in disappointment if only 'notional support' is provided.

Extending the means tests thresholds is of course a welcome and bold step. However, we are concerned the funding implications have not all necessarily been thought through. *The Bigger Picture*, Independent Age's research[25] highlights that in the North East, around 60% of older people living at home with

[24] Laing & Buisson, Care of Elderly People UK Market Survey 2013/2014, London, 2014

[25] The Bigger Picture: Understanding disability and care in England's older population, Independent Age and the Strategic Society Centre, 2014, p. 7

limited day-to-day difficulties had total housing and financial wealth below the £118,000 upper capital limit in 2016 prices. However, the equivalent figure for the South East is around 17%. Some local authorities are more exposed financially to the introduction of the extended means test than others. Local authority funding formulae must be weighted accordingly in order to take account of these regional variations.

While the upper capital limit governing access to local authority funding will be £118,000, eligibility for the 12-week property disregard and deferred payments will be based on the alternative £27,000 upper capital limit. It must be made clear to the public which capital threshold will apply depending on the situation and why.

Local authorities must effectively communicate which thresholds are relevant, so for example, when a person in a care home whose property has been disregarded in the financial assessment (as his spouse is still living at home) understands the £118,000 upper capital limit won't apply. For deferred payments in particular, it would be useful to have further clarity about what happens when the amount deferred against the property results in a person's overall assets reducing down to the £118,000 upper capital limit.

We support the Department of Health's proposal for a person living at home in a rented property to also be eligible for the upper capital limit of £118,000 rather than £27,000. This will aim to protect people who don't own property from future catastrophic care costs. In particular, it would benefit those people who have sold their family home to move into rented extra-care housing or sheltered housing and so may have a large amount in non-housing assets. It also supports the principle of a level playing field with regards to asset protection whether or not you are living at home, in extra-care housing or in a care home and whether or not you have housing or non-housing wealth.

The rate of tariff income must also be reviewed alongside plans to extend the current means test for local authority social care funding. The current rate of tariff income to be charged on a person's assets between £17,000 and £118,000 - £1 for every £250 - means that a person will be assessed as having £404 a week notional tariff income in addition to their actual income. They are likely to be judged able to afford the majority if not all of their care fees and as a result

get little or no financial support. Pensioners with median income will in effect be required to self-fund from their actual and notional income until their savings deplete down to an average upper capital limit of £79,600[26] before the local authority will begin to contribute.

Any reform must work to reduce rather than increase complexity in the care system. The risks of keeping tariff income at the level of £1 in every £250 are, according to the Strategic Society Centre, 'disappointment, confusion and anger' – not least where residents reach the upper capital limit, or reach the cap and become local authority-funded, but then realise they will have to spend their assets well beyond £118,000 before they get a local authority contribution. Nick Kirwan from ILC-UK also notes that the current ratio represents a 20% return[27] on investment, a figure unlikely to be achieved with current saving options.

We support the Department of Health's guarantee of a minimum local authority contribution of at least the equivalent of higher rate Attendance Allowance (AA) once a person's assets reach £118,000, in order to ensure that no one is worse off as a result of the interaction with non-means tested benefits. However, this proposed change does not go far enough. It may be that some self-funders did not claim AA prior to spending down their assets. We would like to see all benefit from an AA level of local authority contribution. For those that were already receiving AA, the person would have the expectation that they would be entitled to receive local authority financial support over and above AA level.

Turning to tariff income, proposing a reform of tariff income would work to ensure more people who have assets of £118,000 or less will benefit from the extended means test and receive some local council support. One option could be to modify the ratio by which tariff income is calculated to £1 for every £500, bringing it in line with current Pension Credit rules. A person with £118,000 in assets would have a reduced tariff income of £202 a week and would get some financial help from a local authority with an average personal budget rate of £550 (based on the 2013-14 weighted average private care home fee[28]).

Another possible option would be to remove the raised lower capital limit of £17,000 so that savings under £27,000 are ignored in the financial assessment

[26] A Cap that Fits: the 'capped cost plus' model, James Lloyd, The Strategic Society Centre, 2013, p. 41
[27] Nick Kirwan, ILC-UK in Money Marketing article, 13 September 2013
[28] Laing & Buisson Care of Older People twenty-sixth edition, Laing & Buisson 2014 p. 229

for care homes. There is a precedent for this in Wales where one single financial threshold of £24,000 has been set and capital of £24,000 or less is fully disregarded in the financial assessment as stated in the Welsh Charging for Residential Accommodation Guide. Removing the proposed lower capital limit of £17,000, and therefore removing tariff income completely for people with savings of less than £27,000 would inject more clarity in the system. People with £27,000 or less would not pay tariff income and would be local authority assisted from the moment they reach £27,000, less their income contribution. People with £118,000 would pay less tariff income as they would only be assessed on assets between £27,000 and £118,000, and not on assets above £17,000.

Part 2 - Appeals

11. Do you think there is a need to introduce a new appeals system to allow people to challenge care and support decisions? Please state yes or no along with any rationale.

Yes. There is a need to introduce a new appeals system as existing complaints provision for care and support is inadequate. It does not effectively allow for people to challenge key care and support decisions. The 2009 regulations need to be replaced so that in future disabled and older people can access a system of dispute resolution and redress that clearly distinguishes between:

- *complaints*, i.e. where an adult wishes to query or challenge a process, the way in which a decision has been made, or indeed the way in which a service has been delivered; and
- *appeals*, i.e. where an adult wishes to challenge the reasonableness of a decision that has been taken, on a point of fact or law and by doing so, they are asking that the merits of a decision are independently reviewed if they cannot be resolved at the early resolution stage.

We hope the introduction of a focused appeals system would empower older people who do not feel that making a 'complaint' or challenging poor decision-making is an appropriate response to tackling a perceived injustice. There is a large body of evidence suggesting that many people do not complain about public services, including social care. This can be explained by a wide range of factors, including people thinking it would not be worth the effort[29] to complain, a reluctance on the part of many to complain, and the defensiveness of public bodies that many people still sat they encounter[30].

In 2013/14 the Local Government Ombudsman found that complaints about local authority social care increased by 16%. The three areas most complained about were assessment and care planning; fees, grants and payments; and residential care, with 48% of complaints investigated by the Ombudsman upheld. The Ombudsman's 2013 review of adult social care complaints also noted that complaints about fees generally concerned people being charged in

[29] 'Complaints Must Count in Public Services', Which?, March 2014
[30] More Complaints Please! Twelfth Report of Session 2013-14, House of Commons Public Administration Select Committee (PASC), March 2014. p. 15

circumstances where they should not have been, including unlawful request of top-up fees[31].

A new appeals system should lead to a rise in the numbers of people confident they can challenge decisions that local authority complaints procedures are not set up to address. The Department of Health should advise local authorities on the most appropriate way to inform people about the new system, not least through the provision of information and advice.

12. Do you think that the appeals reforms are a priority for reforming care and support redress? Please state yes or no along with any rationale.

Yes, we support the views set out by the Law Commission[32] that the current complaints system does not offer an appropriate framework to tackle the expected increase in people who might want to challenge decisions made under the Care Act 2014. This reform has been long overdue. Local authorities have had to manage challenges about direct payments and personal budgets through a system that is not specifically set up to deal with issues of fairness or sufficiency and instead focuses on maladministration.

The appeals system needs to be clear and consistent and include a wide range of decisions relating to charging, including decisions on the payment of top-up fees. Local authorities must be clear with residents what can be tackled through the appeals system, and what will otherwise be managed through the complaints system.

It is vital that councils should learn from the outcome of appeals and regard common cases brought forward for appeal as an opportunity to review or improve local practice.

The Department of Health has anticipated appeal rates of between 1.4% and 3.4% for all assessments. Local authorities should be strongly encouraged to use unusually high appeal rates in particular areas of provision (so for example appeals following assessments or personal budget allocations) as an indicator that quality assurance measures may need to be undertaken.

[31] Review of Adult Social Care Complaints 2013, Local Government Ombudsman, May 2014, p. 11
[32] Adult Social Care (LAW COM No 326), The Law Commission, 2011, p194

In order to manage demand from self-funders looking to set up an IPB and care account, the Department of Health has explained councils can carry out assessments from November 2015 in preparation for the April 2016 reforms. As such, it is important for guidance to clarify whether any assessments carried out in this period, which residents want to go on and challenge, will be dealt with under the appeals system or complaints system.

13. 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?

We welcome the proposed scope of the appeals system, particularly as the sufficiency of the personal budget will be able to be appealed, but feel that it needs to be broadened to include other charging and funding issues. While we appreciate that the intention is that "specific care and support decisions" are the focus of appeals, any guidance must provide further instruction for local authorities on how to implement any changes to their overall systems, particularly where, for example, an appeal on the fairness of a personal budget decision has been successful and may have wider implications for how the local authority reviews the sufficiency of personal budgets or independent personal budgets. High numbers of successful appeals against residents' personal budget calculations should trigger a review of local policy and practice.

Further clarification is needed on how local authorities should manage different types of appeal, in particular whether there is merit in prioritising cases concerning decisions about eligibility and provision of care to meet immediate or critical care needs. It is of the upmost importance that older people's eligible care needs are not left unmet whilst awaiting a decision, so for example where there is an appeal about the adequacy of a personal budget. It must be clear that the local authority retains responsibility for meeting needs while the appeal is underway in order to ensure that urgent care needs are not left unmet.

14. Do you think that charging should be part of the adult social care appeals system? Please state yes or no along with any rationale.

Yes, charging and financial assessment should be included as part of the adult social care appeals system as it is vital people should be able to appeal the level of charges, including the proportion a person is required to contribute from their own income. The Local Government Ombudsman noted that for 2013, 17% of complaints about adult social care included concerns about the financial element of care provision, with more than half having as their root cause issues of fees being charged in circumstances where they should not have been charged.

In light of the Local Government Ombudsman's findings, we believe that it would be incoherent to treat decisions on charging as though they were outside the scope of the appeals system. Charging is a key element of the care and support planning process and the calculation of a final budget. It would be inappropriate for a person wanting to appeal both their personal budget, and the proportion of income they are being asked to contribute to meet their care costs, to have to enter two separate systems of appeal and complaint.

15. Do you have suggestions as to the expertise, knowledge and person specification for the role of an Independent Reviewer?

16. Do you think the local authority or another body should be appointing the Independent Reviewer? If another body, please specify

17. Do you think a 3 year gap in the Independent Reviewer's employment from the local authority concerned is sufficient to provide independence, or should this period be longer, or should they never have been previously employed by the local authority concerned?

It is important that the person employed as an Independent Reviewer can reasonably be called an expert or specialist in the field of adult social care. As such we believe it vital that the person has extensive experience in social care either as a qualified social worker or equivalent, or in a management role within a social care organisation.

On balance, we are satisfied there will be some circumstances where it is alright for a local authority to appoint a person to the Independent Reviewer role, providing this is managed in such a way all parties can still trust the Reviewer remains impartial and objective. It would be wrong of course for the local authority to appoint a person they currently employ, or who works for a contracted partner.

We believe the approach taken to the recruitment of Independent Experts in Northern Ireland[33] offers a useful model as it asks that Independent Experts are "impartial, objective and independent of any parties (to the complaint)…(and) recruited from another Local Commissioning Group area to ensure impartiality."[34]

Another alternative more appropriate to the English system of adult care could be for the Independent Review function to report directly to the local Health and Wellbeing Board, with Health and Wellbeing Boards responsible in some way for their appointment. While local authorities may want to deliver share information on their own local policies and procedures, in the interest of independence it wouldn't be appropriate for local authorities to train their own Independent

[33] Complaints in Health and Social Care: Standards & Guidelines for Resolution and Learning, Department of Health, Social Services and Public Safety, Northern Ireland, April 2009

[34] Ibid. p. 76

Reviewers. It would be much better if a national body could deliver core training, which would enable any Independent Reviewer to work with any English local authority.

As local authorities are the main employer and provider of qualified social work staff, we don't believe it would be right to specify independent reviewers can't in any case, have taken a previous paid role within local government. In fact, we do not believe that previous employment with the local authority in question should be a bar on future employment to the role of independent reviewer, but as stated above, the Independent Reviewer must not be a current employee of the local authority.

18. 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 authority's decision was reasonable?

Yes. We also believe the Independent Reviewer's recommendation should be binding on the local authority to implement apart from the most exceptional circumstances.

As appeals cannot be brought more than once (16.49), should a person remain dissatisfied with a decision their local authority has taken, they should be able to approach the Ombudsman for adjudication. We support the Department of Health's proposal that the Ombudsman should still be an ultimate form of redress. Local authority information and advice needs to be clear how residents can proceed should they not accept the outcome of their appeal. In approaching the Ombudsman, the person's original appeal should form a key piece of independently reviewed evidence. The Ombudsman should not be limited to just focusing on the decision to reject the appeal, but should cover the whole process that first led to the appeal, including the initial assessment and both the recommendation of the Independent Reviewer and the final decision.

19. How do you think we can promote consistency in decision making for care and support appeals?

We support the idea that independent reviewers could work in pools. However, this working arrangement must ensure that the proposed rules regarding

reviewers being independent from specific local authorities are still adhered to. For example, it would not be appropriate for an independent reviewer with a relationship with the local authority to whom the appeal relates to check the consistency of a colleague's work.

We also believe that the Department of Health should consider how differences of opinion between independent reviewers should be resolved, and what quality assurance measures should be implemented to ensure the appeals process feels consistent wherever someone takes forward an appeal.

Lessons from other areas of care subject to appeal should be adopted. The appeals system for NHS Continuing Care is a case in point. A recent report has shown that independent panels at a local level can lead to inconsistency in eligibility[35] leading to recommendations that "Department of Health/NHS England should provide national oversight and use data, quality assurance and auditing mechanisms"[36].

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

We agree with the general principle that the local authority should aim to resolve an appeal in the shortest timescale that is practically possible in order to carry out an effective review.

For the early resolution stage we would prefer a timescale similar to that in Wales where discussion must take place within 10 working days of an issue being acknowledged. The acknowledgement itself should be issued to the person no later than 2 working days after an appeal is made. This approach would also mean writing to the person within 5 working days should early resolution be achieved.

For the Independent Review stage, again we believe that this should be undertaken in a way that balances the need for a thorough review with the need to quickly reach an outcome. As such, the timescale should mirror the process in Wales where a person should receive a response within 25 working days of the

[35] Failing to Care: NHS Continuing Care in England, All Party Parliamentary Group on Parkinson's, p.26
[36] Ibid p.29

start date of the independent investigation (the acknowledgement itself issued to the person no later than 5 working days after receipt).

The guidance therefore needs to apply improved timescales to all parts of the process, in order to prevent unnecessary delays. Guidance must also clarify what a person can do if an appeal is taking a disproportionately long time to resolve and whether this can, or should be a matter for a formal complaint.

21. 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? Please state yes or no and any rationale.

Yes. While we are unable to make an estimate of the savings, we do agree with the Department of Health's expectation that the new appeals system may work to reduce the overall number of judicial reviews. A system that encourages councils to constructively engage appellants through early resolution and independent review could reduce the overall proportion of disputes that remain unresolved and end up in judicial review. The appeals system could also support improved local authority decision making.

However, we are strongly in favour of ensuring that people continue to have recourse to judicial review, as it forms a vital role in holding public bodies to account. Judicial reviews have helped improve social care policy and practice, so we strongly caution any future Government not to restrict access to this vital part of our system of public law.

Generally, we welcome more people feeling empowered to make either a complaint or to appeal decisions where they have received a poor service or have concerns about the way in which a decision has been taken. In each case, it is important that the person is supported to use the most appropriate process and to receive the appropriate information and advice to help them understand their rights.

22. In the accompanying Impact Assessment we have set out the costs to administer the Appeals system. We would welcome

your comments on this and any evidence that you are able to provide.

Response completed by:

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