

Consultation on draft regulations and guidance for implementation of part 1 of the Care Act in 2015/16

Response of: South East Strategic Leaders (SESL) South East England Councils (SEEC) South East Councils Adult Social Care (SECASC)

15 August 2014

SUMMARY

1. Introduction

- 1.1. This is a joint response of South East Strategic Leaders (SESL), South East England Councils (SEEC) and South East Councils Adult Social Care (SECASC) which together represent County, Unitary and District authorities across the South East, representing over 8.8m residents. This submission focuses on the key issues of most concern to our members and is intended to complement the more detailed responses of individual South East councils.
- 1.2. SESL, SEEC and SECASC welcome the opportunity to respond to this consultation, which marks a further step towards realising a reformed health and care system characterised by person-centred, coordinated care and a fairer approach to funding. **Democratic, locally-led councils are optimally placed to lead the local integration of health, social care and wider public services. We have the leadership role, now we need the freedom, flexibility and funding to deliver.**

2. South East Context

- 2.1. To help us deliver, it is imperative that the regulations, guidance and funding formulae take into account the unique combination of South East characteristics, including:
- **Our large population** – At 8.8m people, the South East has England's largest population, projected to increase to over 10m by 2032. The impact of such a vast population on services is massive – both in terms of demand pressures and resultant costs. This has often been masked by percentage comparisons rather than looking at absolute numbers.
 - **Our large elderly and ageing populations** – The South East has England's largest and fastest growing group of elderly and ageing people with those aged over 75 expected to increase to well over 1m by 2024. This is again pushing up demand for services and increasing costs to South East councils. Aspects of social care funding should give greater weighting to numbers of older residents than levels of deprivation.
 - **Our rural population** – The South East comprises both densely populated urban centres alongside sparse rural communities, where it is more costly to deliver public services.
 - **A higher-cost area** - Higher property costs and salaries mean that it costs more to deliver services in the South East, which competes with London-based organisations.
 - **Our high number of self-funders** – The South East has the highest proportion of self-funders, some 55% (compared to 45% nationally), rising as high as 80% in some areas.
 - **Our high number of carers** – The South East is home to 920,796 unpaid carers, 634,445 more than the North East (286,351).
 - **Our prison population** - The South East has over 15% of the prison population at 12,941 prisoners. Kent and Surrey, in particular, have a large prison population, 5,342 and 2,351 people respectively. Consequently, new duties towards offenders in prison settings will have significant impact on resources in the South East.

3. Funding

- 3.1. **Devolution** – We have consistently made the case to Government for the devolution of powers and freedoms – with the right central funding and powers to raise local finance, South East councils can go further, faster to deliver better, more cost effective public services for residents.
- 3.2. **Long term sustainable funding** – The sheer scale of demand pressures on South East councils' social care services mean that public service reform and system-wide integration, although important, will on its own be insufficient. It is imperative that Government works to identify a long term, sustainable funding solution for social care.

- 3.3. **Implementation funding** – We support the partnership approach that the Department has taken to working with the sector to understand the cost pressures on local authorities arising from the Act. It is important that this work continues and emerging evidence informs funding decisions. We also welcome the recent announcement to make further funding for implementation available. It is important that funding is sufficient and recurrent to meet the costs of on-going demand. We are particularly concerned that some new duties that will impact significantly in the South East, such as duties towards carers, have not yet been allocated funding. We also remain concerned about the impact of reforms on local markets and cost implications for councils, particularly the ‘duty to arrange’ care and support services for self-funders in 2015/16.
- 3.4. If evidence points to higher implementation costs, we support the wider view of the sector that Government has three options: to delay all of the 2015/16 reforms, amend the detail or scope of some of the 2015/16 reforms or reopen the 2015/16 spending round. As we are reluctant to delay or significantly alter the scope of reforms, our preferred option would be for Government to revisit the 2015/16 funding envelope.
- 3.5. **Better Care Fund (BCF)** – Our members have welcomed the BCF as a source of funding (albeit not new money) and we fully support the fund’s aims. We urge Government to reconsider proposed changes to the BCF, which could undermine these aims. It is also important that the social care element of the BCF is recurrent.
4. **Headline issues**
- 4.1. More detailed comments are provided under the consultation headings in our main submission but, in addition to funding, there are several cross-cutting themes and specific issues relating to the draft regulations and guidance that are important to highlight upfront:
- 4.2. **Integration and partnership working**
- **The role of District councils** – A greater acknowledgment of local authorities’ public health role and wider preventative work is needed. The role that District councils play in encouraging good health and enhancing wellbeing, particularly through their responsibilities in relation to housing but also in other areas, ought to be explicitly recognised.
 - **Cost shunting** – The legal boundary between free NHS services and means-tested social care is not upheld and redrafting is needed to draw a consistent boundary between the two. Without clearer distinctions, cost-shunting between NHS providers and councils could arise, placing additional pressures on council budgets. There is also a risk of cost shunting between prisons and councils with regard to prison duties.
 - **The importance of partners** – councils are best placed to act as system leaders and drive forward the reforms but success also hinges on the cooperation and vital contribution of other local partners, particularly NHS partners, and national organisations. Partners’ responsibility to cooperate with councils should be underscored.
- 4.3. **Local flexibility**
- **Case law** - Although there are specific areas where further clarity and examples are necessary, we support giving councils’ local discretion to deliver the best outcomes for local residents. We are mindful, however, that this leaves open the possibility for less clearly defined, or particularly contentious, areas to be defined in time through case law. Alongside the LGA, ADASS and CCN we therefore question the Impact Assessment assumption that legal reform will lead to savings.
 - **Eligibility** – Greater clarity may be needed on the national minimum eligibility criteria and the eligibility criteria for carers, which provide for a more generous threshold than current ‘substantial’ levels. South East councils are able to deliver a more generous threshold but only if it is fully funded.
- 4.4. **Personalisation and prevention**
- **Personalisation** - more could be done to ensure that reforms result in a more personalised system of care centred on individuals’ desired outcomes. Individuals should be encouraged to take greater responsibility and use their own assets and informal support networks to meet their own needs where appropriate.
 - **Prevention** - to achieve a greater shift from acute care to preventative, “out of hospital”, community care, payment methods and contractual models must be changed to incentivise longer term planning and the realignment of commissioning budgets.
- 4.5. **Building blocks of reform**
- **The workforce** - various aspects of reforms, including increased demand for assessments, will have significant impact on the workforce. We recommend that national work is undertaken to consider future demand and how this might be met across the whole market. The time needed to achieve cultural change and the required investment in skills should not be underestimated.
 - **IT and informatics** – implementation funding must take into account the system changes required to implement reform. An update on the Departments’ work to support IT system readiness would be helpful.
 - **Timing** - Councils are working to a very tight schedule to prepare for implementation. Government should avoid any delays to making outstanding detailed information available and ensure timely communication, targeted at different audiences.

MAIN SUBMISSION

INTRODUCTION

5. Our submission

5.1. This is a joint response of South East Strategic Leaders (SESL), South East England Councils (SEEC) and South East Councils Adult Social Care (SECASC), which together represent County, Unitary and District authorities across the South East, representing over 8.8m residents. This submission focuses on the strategic issues of most concern to our members and is intended to complement more detailed responses of individual South East councils.

5.2. SESL, SEEC and SECASC welcome the opportunity to respond to this consultation, which marks a further step towards realising a reformed health and care system characterised by person-centred, coordinated care and a fairer approach to funding. **Democratic, locally-led councils are optimally placed to lead the local integration of health, social care and wider public services. Many South East councils are already delivering integrated care and several are pioneering the integration of health and social care with wider public services.** For example, integration pioneer Kent County Council piloted integrated personal budgets in the South Kent Coast area and has been running its Health and Social Care Integration Programme since 2011. Oxfordshire has plans for the largest pooled health and care budget in the country with £330m committed across all client groups. **With the right funding and powers to raise local finance, South East councils can go further to deliver better, more efficient public services for residents.**

6. The South East context

6.1. **SESL, SEEC and SECASC have repeatedly argued that to ensure effective delivery of our shared ambitions for integrated services and improved outcomes for residents, health and care reforms and associated funding must take into account the following unique combination of South East characteristics:**

Our large population

6.2. At 8.8m people, the South East has England's largest population, approximately 400,000 more residents than London and a population greater than both Wales and Scotland combined. Our population is projected to grow by 1m over the next 15 years and increase to a total of over 10m by 2032. The impact of such a vast population has often been masked by percentage comparisons instead of looking at absolute numbers; for example, the South East has 248,901 people over 60 years old living in income deprivation, some 13% of the older population. In contrast, the North East has a higher percentage of older people living in income deprivation at 23.3% but this translates into significantly fewer people at 138,442¹. As a result, **Government formula has tended to overlook the impact on services of the South East's vast and growing population.** Deprivation measures are also often used in funding formulas without questioning whether they are always appropriate or proportionate. Given the South East's large elderly and ageing population (see below), and the pressure this places on services, **there is a compelling case that aspects of social care funding should give greater weighting to numbers of older residents than levels of deprivation.**

Our large elderly and ageing populations

6.3. The South East also has England's largest and fastest growing group of elderly and ageing people. By 2024, those aged 65+ will increase from 1.6m to over 2m and those aged 75+ will increase from nearly 800,000 to well over 1m. **The sheer scale of our population and number of elderly residents is increasing demand for health and care services, which is placing significant, additional cost pressures on South East councils.** This impact is exacerbated by increasing complexity of health and care needs and advances in medical knowledge and technology, which are enabling more people to live longer.

Our rural population

6.4. **The South East comprises both densely populated urban centres alongside sparse rural communities, where it is more costly to deliver public services.** This issue is widely documented and currently the focus of a joint DEFRA – DCLG review. Costs incurred in the South East include: travel costs, limited opportunities to achieve economies of scale and the need for more service delivery hubs.

A higher-cost area

6.5. **Higher property costs and salaries mean that it costs more to deliver services in the South East,** which competes with London-based organisations. This 'South East' premium is often not recognised in funding formula.

High number of self-funders

6.6. Although the exact number of self-funders in any area is difficult to quantify, estimates based on the number of self-funders in residential care settings suggest that the South East has a higher number of self-funders compared to other parts of the country.

¹ Figures exclude SESL member authorities Central Bedfordshire and Wiltshire councils.

- 6.7. The King's Fund states that the South East has the highest proportion of self-funding care home residents at 55%. Surrey County Council estimates that the county has substantially more self-funders than the UK average (approx. 45%) at around 80%. While it is difficult to predict how many self-funders will choose to approach their council for an assessment under the new system, it is likely that many will want to start accumulating costs towards the care cap and take advantage of local authority rates. **Due to the high numbers of self-funders in the South East, these cost pressures are likely to be significant and place further strain on the social care workforce.**

Our high number of carers

- 6.8. The South East is also home to a large number of carers. There are 920,796 unpaid carers in the South East, 634,445 more than the North East (286,351), **creating a significant potential pool of additional residents eligible for local authority assessment and support services.**

Our prison population

- 6.9. The South East has over 15% of the prison population at 12,941 prisoners. Kent and Surrey, in particular, have a large prison population, 5,342 and 2,351 people respectively. **This again presents high potential demand for council services under the Act.**

7. Funding

Devolution to support delivery

- 7.1. We have consistently made the case for greater devolution of finance and powers to South East councils to enable us to deliver better, more efficient public services. **With the right central funding and more powers to raise local finance, South East councils can lead the successful delivery of more cost effective, integrated health and social care for residents.** We continue to make this case recognising that the unprecedented and rising demand for social care services in the South East means that this is an area where additional central funding is also needed.

Long term sustainable funding

- 7.2. The unique combination of the South East's characteristics place increasing pressure on council services at a time when our members are reducing their budgets significantly out of necessity. SESL and SEEC County and Unitary authorities have taken £1.3bn out of their budgets since 2010 and estimate that a further £1.4bn savings are needed by 2017/18. Some evidence suggests that areas experiencing the highest spending reductions also appear to be those facing greatest demand, including: social care, health and housing, community and children's and adults' services. In Central Bedfordshire, these categories account for 87% of total reductions since 2010, with the largest of these being adult social care, health and housing at £16m. Analysis by the Local Government Association (LGA) estimates that the funding gap between March 2014 and the end of 2015/16 for adult social care nationally is £1.9bn and the Association of Directors of Adult Social Services (ADASS) estimates that £3.53bn has already been taken out of adult social care budgets nationally over the past four years.

- 7.3. South East councils have managed reductions by becoming more efficient, sharing services and driving forward wider system change. The integration of health, care and wider public services will be critical moving forward, as will a greater shift towards preventative services, to drive down demand for more costly interventions upstream. However, this alone is insufficient to meet the scale of demand and cost pressures on South East councils and **it is imperative that Government works to identify a long term, sustainable funding solution for social care.**

Implementation funding

- 7.4. **We support the partnership approach that the Department has taken to working with the sector to understand the cost pressures on local authorities arising from the Act. It is important that this work continues and that emerging evidence informs funding decisions.** A welcome example of this is the Department's recent acknowledgement of the need to provide additional implementation funding and changes to the distribution formula for the £283.5m of Care Act funding for 2015/16, announced recently in the Department's consultation on Funding Formulae for Implementation of the Care Act in 2015/16. Additional funding for new prison duties, increased assessments and deferred payments will help to meet more of the implementation costs that our members face. **It is important that this funding is sufficient and recurrent to cover on-going new duties and not just one-off, funding implementation costs only.**

- 7.5. If evidence points to higher implementation costs, we support the wider view of the sector that Government has three options: to delay all of the 2015/16 reforms, amend the detail or scope of some of the 2015/16 reforms or reopen the 2015/16 spending round. **As we are reluctant to delay or significantly alter the scope of reforms, our preferred option would be for Government to revisit the 2015/16 funding envelope.**

- 7.6. **We are also concerned that some new duties, which will have significant impact in the South East, have not yet been allocated implementation funding, in particular funding for new duties towards carers.**

The Better Care Fund

- 7.7. **The Better Care Fund is one source of funding (albeit not new money) that our members have welcomed and we fully support the aims of the fund** – to drive local integration, prevent unnecessary and costly admissions to acute care settings and place care funding on a more sustainable footing. We are concerned that these objectives could be undermined by proposed changes to the BCF, whereby BCF money could be used to fund NHS services if local integration efforts fail to reduce emergency admissions significantly. This change could also reduce the funding available for implementing the Care Act as a proportion of implementation costs are intended to be met through the BCF in 2015/16, although clarity is needed on which aspects of implementation the BCF is intended to cover. In view of these concerns, **we urge Government to reconsider proposed changes to the BCF**. Given the increasing demand pressures on social care budgets, **it is also important that the social care element of the BCF is recurrent as it is responding to baseline social care pressures**. If this funding is discontinued after 2 years, this will increase the already significant funding gap for social care.

GENERAL DUTIES AND UNIVERSAL SERVICES

8. Wellbeing

- 8.1. **We support the shift from existing duties on local authorities to provide ‘particular services’ to the notion of ‘meeting needs’ in a way that promotes wellbeing. The guidance also positively takes a holistic approach, considering individuals in relation to their families, friends and communities, and leaves the interpretation of wellbeing open to the discretion of local areas.** While we support this local flexibility, some further examples could usefully help practitioners to interpret how an individual’s needs impact upon their wellbeing – this is particularly important given the potential impact on the eligibility decision (as the case studies in point 6.89 of the guidance illustrate).

9. Preventing, reducing or delaying needs

- 9.1. In view of the significant and increasing demand pressures on services in the South East, **we fully support efforts to shift emphasis onto prevention and early intervention to drive down demand while improving quality of life.** As drafted, the guidance states that local authorities are to ‘provide for or arrange for services, facilities or resources which would prevent, delay or reduce individuals’ needs for care and support, or the needs for support of carers’ (2.17). This is particularly broad, both in terms of the prevention activity it could encompass and its application to the population at large. While we support the flexibility to interpret what constitutes sufficient provision locally in line with locally determined outcomes, this could lead to legal challenge in the courts and associated costs.

- 9.2. **A greater acknowledgment of local authorities’ public health role and wider preventative work is needed.** As well as County and Unitary councils’ formal public health role, much of councils’ wider preventative work is the responsibility of District councils, which are, for example, responsible for housing provision and the commissioning of leisure services. These areas alongside others, such as employment services, are central to supporting people’s health and wellbeing and should be acknowledged as part of the primary prevention agenda. **We recommend that the regulations and guidance explicitly recognise the role that District councils play in encouraging good health outcomes and enhancing wellbeing, particularly through their responsibilities in relation to housing but also in other areas.**

10. Integrated Information and Advice

- 10.1. The provision of good quality information and advice, delivered in an integrated way, is a cornerstone of the new system and critical to helping people do more for themselves, reducing demand on local authority services and improving customer experience. **With the right funding, Councils with their system oversight can lead the provision of information, advice and guidance (IAG) for their whole populations and we support the notion that this duty should extend beyond social care to encompass the wider determinants of health and wellbeing, such as employment and housing.** There is a risk, however, that because the statutory duty lies with local authorities, other partners may not regard themselves as having an active and central role in the provision of information and advice when in fact this is critical to ensuring that the whole system works effectively. For example, the involvement of local carers’ organisations and health agents, particularly GPs, will be important for the successful implementation of new duties towards carers. Integrated information and advice across partners, not just the local authority, will also be needed during the hospital discharge process. **The shared responsibility for the provision of information and advice across local partners ought to be underscored in the guidance, as should partners’ responsibility to cooperate with councils.**

- 10.2. As system leaders in this regard, councils ought also to be able to ensure that other partners are fulfilling their responsibilities effectively so that when an individual is signposted to other resources in the voluntary or private sectors, the service continues to operate smoothly and in an integrated way. **The regulations and guidance should state explicitly what powers councils have to enforce good practice in the provision of information and advice across the whole system.**

11. Financial Information and Advice

- 11.1. **The regulations and guidance must make clear that local authorities will not be recommending financial advice or promoting a certain provider but signposting individuals to advice which is independent of the local authority and of any provider of financial products, their subsidiary or related organisations.** Some South East councils already have mechanisms in place for signposting residents to independent advice; for example, Buckinghamshire County Council, Milton Keynes Council and Bucks Care Association have appointed three firms of independent financial advisors to provide free consultations to residents on the best ways to pay for their care.
- 11.2. If under proposed pension changes in 2015 independent organisations, like Citizens Advice or Age UK, are to take a greater role in advising people on how to manage their pension pots, it would make sense for these organisations to also be equipped to advise residents on financial planning for their potential care and support needs. **It would be helpful if Government could develop national tools, complementing local approaches, to signpost individuals to independent financial advice focused on care and support funding while encouraging independent organisations, such as Citizens Advice, to play their part in the provision of independent financial advice. Government could also helpfully endorse relevant IFA qualifications. Early information about the extent and progress of national work taking place on information, advice and guidance in the lead up to implementation is needed.**

12. Market shaping and commissioning

- 12.1. **We remain concerned about the impact on the market, and subsequent costs to South East councils, of the reforms, in particular the introduction of the Care Cap and other Dilnot-related changes in 2016 due to our high number of self-funders.** At present there is a significant difference between the rate paid by local authority-placed and private residents. Under the reforms, particularly due to the increase in the upper threshold for means tested support to £118,000, more people will be eligible for council funding and a significant number of self-funders are likely to opt for their local council to arrange their care. These additional people are likely to expect to pay the council rate for residential care rather than the higher private rate. This will inevitably put pressure on providers who, in turn, may attempt to increase the rate that local authorities pay for residential care placements, raising local authority costs significantly - a key challenge given the South East's high delivery cost-base.
- 12.2. A number of South East authorities are involved in financial modelling work, led by Buckinghamshire County Council, to understand the impact of the reforms on local markets and to evaluate and evidence potential risks, which we believe have not yet been fully appreciated, costed or funded by the Department. As the duty on councils to arrange the care of self-funders applies in 2015/16, these risks could start to be realised earlier than 2016, when the Dilnot-related reforms come into effect.
- 12.3. A further risk to the current social care market is workforce capacity. This is not just an issue for providers but also for local authorities, particularly those in the South East due to the South East premium. **We recommend that national work is undertaken to consider future demand on the workforce and how this will be met across the whole market.** Current national work should be used to evidence the most effective use of social work staff, taking into account the aim of reform to enable individuals to do more for themselves, drawing on informal support networks. **The time required to change cultures and the need for investment in training social care staff should also not be underestimated.**

FIRST CONTACT AND IDENTIFYING NEEDS

13. Assessments

- 13.1. The South East's very large elderly and ageing populations, high number of self-funders and large carers population together create a significant potential pool of people with eligible needs who are likely to approach South East councils for an assessment, with some local authorities predicting a doubling of their caseloads. **As stated above, we welcome Government's recent announcement making more funding available for assessments in 2015/16. It is important this funding is recurrent to fund on-going demand and not just one-off.**
- 13.2. New assessment duties will also increase demand on an already stretched workforce and some of our members expect that they will not have the capacity to undertake the volume of additional assessments anticipated. Due to the South East premium, it is unlikely that councils will be able to substantially increase the workforce or attract a sufficient number of high quality social workers. **It is therefore important that the regulations and guidance provide sufficient flexibility to allow councils to delegate assessment functions and do not unnecessarily limit the involvement of existing local authority staff in undertaking assessments.** For example, we question the need for those carrying out assessments to have relevant NVQs, as stated in point 6.72 of the guidance. Further clarity on this point is needed as well as the distinction between 'assessors' and 'professional staff' carrying out assessments (point 6.74, guidance).

13.3. **To encourage personalisation while helping councils to meet increased demand for assessments at lower costs, we recommend that the guidance gives councils the option to offer residents online assessments** - an approach we advocated in our response to the Department's *Caring for our Future* consultation last year (October 2013). Oxfordshire County Council already gives residents the option of undertaking an online self-assessment. Those who cannot, or choose not to self-assess, are able to access an assessment with a social worker and all assessments are reviewed by professionals within 4-6 weeks to provide assurance that they accurately reflect need.

13.4. Regulation 3(2)(a) states that a local authority must carry out an assessment in a manner which is 'appropriate and proportionate' to the needs and circumstances of the individual to whom it relates. While we welcome the flexibility that this affords councils to determine locally what constitutes an 'appropriate and proportionate assessment', we are also cautious that this could leave local authorities open to costly legal challenge in the courts.

14. **Eligibility**

14.1. We welcome the efforts that the Department has taken to engage with our members to test the new national eligibility criteria. However, despite revisions, the majority of our members still consider that the draft regulations on eligibility constitute a more generous definition of 'substantial' than used currently. The new eligibility threshold for carers is similarly broad. This will lead to a greater influx of people, including a significant number of carers, eligible for local authority services, placing significant additional cost burdens on councils. **We are not opposed to a more generous threshold, so long as it is fully funded.** We are also concerned that the eligibility regulations are insufficiently outcome focused or clearly enough defined. **We recommend that the three tests for whether or not an adult is eligible give greater attention to the assets and support networks that individuals have available to help meet their own needs.**

15. **Independent Advocacy**

15.1. While we support the proposal to give independent advocacy a statutory footing, the guidance currently defines those who have 'substantial difficulty' in being involved in the assessment process, and therefore eligible for independent advocacy, very widely. As a result, we expect this will lead to a significant increase in demand and eligibility for advocacy support, for which the Government has yet to make funding provision. **We ask that an assessment is made of the cost implications of these new duties and that funding is made available to fully cover costs. A clearer definition of what it means in practice to provide independent advocacy** could also aid the assessment of additional funding required.

CHARGING AND FINANCIAL ASSESSMENT

16. **Choice of accommodation and additional payments**

16.1. **We support the notion that individuals should be able to choose to pay a top-up to access their preferred residential accommodation but only where they can afford to sustain that accommodation for a reasonable length of time. This needs stating explicitly in the guidance** otherwise there is a risk that residents will be encouraged by providers to invest in top-ups that they cannot afford over the longer term. As a result, they may default, leaving the local authority to pick up the gross fee. **We also support the application of top-ups to Shared Lives schemes and Extra Care housing.**

16.2. **Unlike the Charging for Residential Accommodation Guide (CRAG), the legislation drafted to replace CRAG has not been written in way that is accessible to non-specialists and, as such, requires redrafting. We also retain our view that the treatment of compensation, particularly rules regarding personal injury compensation, need to be simplified further.** As drafted, the legislation could add to the budget pressures on councils where individuals receive 'double support' – both from the court and from the local authority, where the individual has eligible needs. To mitigate this, **we recommend that councils are able to take into account both capital and income in personal injury cases.**

17. **Deferred Payments**

17.1. From April 2014, local authorities will have powers to charge interest on deferred payment agreements. The consultation proposes that interest rates are set between 3.5% and 5%, which signals a move away from the Department's initial plans to set interest at a rate that would apply nationally. **We recommend that interest rates are linked to the Bank of England base rate with local flexibility.**

17.2. As argued in our response to the Department's *Caring for our Future* consultation, **the Care Act should retain Section 22 of the Health and Social Services and Social Security Adjudications Act (HASSASSA) 1983 or include a similar provision to allow a charge to be placed in the interim period before a deferred payment is set up.** Removing this provision reduces a local authority's ability to effectively protect itself from incurring bad debts. It will also increase legal / transactional costs for councils as they will be forced to seek County Court approval to place a legal charge on the properties of people in receipt of non-residential services – a lengthy and costly process.

- 17.3. **We are generally supportive of people with a Deferred Payment living in residential care renting out their homes.** This policy could make a positive contribution to opening up more housing in the South East which, due to our very large and growing population, faces high demand for housing. With average house prices around 11 times average earnings, housing affordability is a key challenge in the South East, pushing up demand for rental properties.
- 17.4. **We are also supportive of giving councils the discretion to choose to extend Deferred Payments to Shared Lives schemes and Extra Care Housing and, beyond this, to people who want to stay in their own homes but access a care package which is more expensive than their personal budget.** Across the South East, councils are investing significantly in the development of Extra Care provision as an effective means of improving people's health outcomes and preventing the need for more costly, institutional accommodation. Hampshire County Council, for example, is investing £45m in the expansion of Extra Care assisted living schemes as an alternative to residential care. Deferred Payments are already being offered to service users in Extra Care housing and supported living in Oxfordshire on a discretionary basis.
- 17.5. We recognise the benefits to carers of people with eligible care and support needs, whose financial resources are above the threshold, being able to have the option for the local authority to arrange their care on their behalf. **We do not, however, think this should extend to providing care where this involves contracting on an individual's behalf with a provider** as this is contrary to ambitions to create a market in which as many people as possible are involved in commissioning their own care and support.
- 17.6. We believe it is important that councils have the freedom to determine locally where the cap on the maximum loan to value for Deferred Payment Agreements should be set.

PERSON-CENTRED CARE AND SUPPORT PLANNING

18. Personal budgets and direct payments

- 18.1. While personal budgets are an important part of delivering a more personalised system, it is not the only part; personalisation can be achieved through good quality assessments and support plans. **Personal budgets also need to be administered in a way that supports individuals do to more for themselves, accessing community and family resources where possible.** We suggest this is not aided by specifying a personal budget amount to an individual following an assessment as this raises hopes around the funding a person can expect rather than facilitating a discussion about how they can support themselves and draw on informal networks to achieve their desired outcomes.
- 18.2. We object to point 12.53 in the guidance that states, as a general rule, direct payments should not be used to pay for a local authority service provided from a home local authority. **This goes against reducing bureaucracy, speeding up access to care and support and reducing restrictions on individuals' choice and control and should be removed.**
- 18.3. We support the notion that direct payments should not necessarily be suspended while an individual is in hospital but we seek further clarity on how direct payments would be funded if, for example, the care received changed to that which would otherwise be provided under the NHS or if a person went on to receive a specific programme of intermediate care for 6 weeks. **Further thought is needed on the different circumstances that could arise and information is required on how these would be funded.**

INTEGRATION AND PARTNERSHIP WORKING

19. Integration, co-operation and partnerships

- 19.1. To achieve whole system integration, it is imperative that national incentives for "out of hospital" community health and social care are created. **Currently the payment mechanism and contractual models do not incentivise longer term planning and realignment of commissioning budgets and this must be addressed.**
- 19.2. The regulations and guidance rightly recognise the leadership role of local authorities in driving forward the reformed system. Success is, in part, dependent upon the cooperation of the many other local partners, particularly health partners, with councils. The Care Act does introduce a new mechanism by which a local authority or a partner organisation can request the other to cooperate with respect to a specific case where more targeted cooperation is required. While the guidance gives a few examples of cases where the mechanism may be used, its application is still left open to considerably interpretation. It is also unclear what constitutes a 'reasonable timeframe' for a council or partner to respond to a request for co-operation. **We therefore recommend that the regulations and guidance set out more clearly partners' duties to cooperate with councils and, in particular, specify the expectations on primary care partners.**

20. **The boundary with the NHS**

20.1. Despite Government's intention (which we support) to uphold the current legal boundary between NHS services, free at the point of need, and means tested social care, this is not supported by the draft regulations and guidance. To the contrary, these reflect incremental changes to this boundary over time, e.g. resulting from reduced funding for community nurses and a move towards more care provided in the community. Examples of this include:

- Section 2(2)(d) of the draft regulations states that adults with care and support needs are eligible if they are unable to access 'necessary facilities or services in the local community *including medical services, public transport, educational facilities...*'. This implies that councils have a responsibility for helping people access medical services, for example travel to appointments, which has previously been considered a health responsibility.
- Point 4.88 in the draft guidance implies it is a social care function to arrange short home care visits to check whether medication has been taken – a function previously carried out by community healthcare services and funded by the NHS.
- Point 2.2 of the guidance states that in fulfilling their duty to prevent needs for care and support, councils can provide 'training to carers to feel confident in performing basic healthcare tasks'. The regulations provide for councils to charge for such services. In the past, such training would have been discharged by nurses and regarded as an NHS funded responsibility.
- Section 3 and paragraph 3.23 of the draft regulations states that local authorities must provide information and advice beyond the narrow definition of care and support, including 'effective treatment and support for health conditions'. This implies specialist medical knowledge above and beyond that required of social workers.
- Point 6.68 in the draft guidance states, in relation to NHS continuing healthcare, that the local authority 'may provide or arrange healthcare services where they are simply incidental or ancillary to doing something else to meet needs for care and support'.

20.2. These examples illustrate how the draft regulations and guidance do not uphold the current legal boundary between the NHS and social care but actually support the shift of several services previously the responsibility of, and funded by, the NHS to social care. **It is important that these areas are clarified and that a clear demarcation of chargeable social care and 'free' healthcare services is achieved to prevent unnecessary cost-shunting between NHS partners and local authorities and to support integration.**

20.3. Another area where cost shunting and disagreements can arise between social care services and NHS partners is around whose responsibility it is to fund aftercare services for certain categories of patients with mental disorders under Section 117 of the mental Health Act 1983. **The opportunity for the Care Act to address this issue by bringing clarity should not be missed.**

21. **Delayed transfers of care**

21.1. On the whole we feel that **this section is too focused on processes and does not go far enough to improve outcomes for service users.**

21.2. In the South East context, it is important to recognise that due to our large self-funder population, there is likely to be an increase in the number of self-funders in hospital settings with which the local authority is involved, which will have resource implications. Within paragraph 15.42 of the draft guidance, **it would be helpful to state explicitly that the NHS may not seek reimbursement from local authorities where a person is waiting for an NHS continuing healthcare assessment or has been accepted as eligible for such care.**

22. **Transition to adult care and support**

22.1. It is important that the Department of Health and the Department for Education undertake detailed work to ensure that the Care Act is aligned with the Children and Families Act, in particular around responsibilities towards young carers and legislation relating to direct payment processes.

23. **Prisons, approved premises and bail accommodation**

23.1. The new duty on councils, in which a prison, approved premises or bail accommodation is based, to assess and meet the care and support needs of residing offenders will apply to a number of councils across the South East. While we welcome these new responsibilities we are very concerned about the resource implications. Although the extent of the work required and potential costs are currently areas of unknown risk for councils, we estimate both will be significant with costs, for example, arising from independent advocacy, prisoners' rights to make complaints regarding their care and support and the need for specialist workforce training and development. **We welcome the recent announcement of funding to help councils implement these new duties in 2015/16 and it is important that this funding is both sufficient and recurrent.**

23.2. **We have concerns about the potential for cost-shunting between local authorities, prison establishments and NHS England / Clinical Commissioning Groups. Point 17.35 in the guidance in particular could helpfully be revised to state explicitly where responsibility lies.**

24. **Delegation of local authority functions**

- 24.1. As stated above with regard to assessments, we believe **it is important that the regulations and guidance afford councils flexibility to delegate certain care and support activities to third party organisations** as this will both encourage innovation as well as help local authorities respond to increasing demand. A further important way that demand can be managed is through encouraging individuals to take greater responsibility and do more for themselves, where possible utilising informal support networks within communities. **We recommend that this emphasis is brought out much more clearly in this section of the guidance.**

ADULT SAFEGUARDING

25. **Adult Safeguarding**

- 25.1. Given that the scope of councils' adult safeguarding duties is towards adults with *care and support needs* who are experiencing, or at risk of, abuse and neglect, it would be helpful if the regulations provided a clear definition of *care and support*. Secondly, to further support making safeguarding everyone's business, it would be helpful if the guidance could provide further examples of how local partners can achieve this in practice.

MOVING BETWEEN AREAS

26. **Ordinary Residence**

- 26.1. Parts of the South East receive significant numbers of service users moved by councils from other areas, for example London. Although the sending council retains funding responsibility under Ordinary Residence rules, this increases demand and brings a significant impact on the market price for care in receiving councils, which needs to be factored into the future funding formula. The draft regulations and guidance still do not provide sufficient clarity about when 'deeming provision' prevails and the original home authority must cover the costs of an individual's care. To avoid all possible doubt, **we retain the view that legislation should specify that the original home authority is liable for lifetime care costs in residential, extra care and supported living settings.** This would prevent disputes and enable councils to plan their care costs more accurately. **We also recommend that the regulations and guidance reference the important role of the Mental Capacity Act regarding the placement of individuals that lack capacity.**

OTHER AREAS

27. **Appealing decisions**

- 27.1. We concur that establishing a formal tribunal system would not be an effective or efficient system for appeals. **The regulations and guidance need to clarify that during the interim period when external appeals processes are being established, is it not the case that all appeals will be handled through the complaints process.**

28. **IT and informatics**

- 28.1. We have consistently argued that **implementation funding must take into account the IT system changes required to implement reforms**, which will range from relatively minor changes to existing systems to the development and introduction of new systems. Areas that will require IT development include: the provision of information, advice and guidance across a wide range of areas; the implementation of Care Accounts and Customer Accounts and systems for charging and Deferred Payments. Work is also needed to ensure that systems support the flow of information and data sharing across the whole system, which is central to supporting the integration of services. Given the importance of IT platforms, we are surprised that the consultation does not make reference to system readiness. **An update on the Department's work in this area would be helpful, alongside assurance that the costs to councils of implementing systems in compliance with the Act will be funded.**

29. **Drafting**

- 29.1. As drafted, the regulations and guidance cross-reference numerous additional pieces of legislation without explanation, leaving practitioners to review these in order to make sense of the new legislation. **We ask that clearer explanations of what is meant are provided rather than simply referencing previous legislation.**

30. **Timing**

- 30.1. Local authorities are working to a very tight schedule to prepare for implementation. **We therefore urge Government to avoid any further delays and make outstanding detailed information, particularly around funding, available as early as possible, while taking into full account feedback from the sector. We need timely, effective communications from Government around the Care Act, targeted at different audiences, which local areas can reinforce.**

ABOUT US

South East Strategic Leaders (SESL)

SESL is a partnership of upper tier authorities committed to nurturing the engine room of the UK economy and promoting public service excellence. SESL supports its members to create the conditions within which individuals, communities and businesses thrive. We aim to:

- **Influence** – speaking with a stronger, united voice for South East strategic councils.
- **Inform** – producing robust evidence relevant to practice.
- **Inspire** – connecting people, sharing ideas, sparking innovation.

SESL is chaired by Cllr David Burbage MBE, Leader of Royal Borough of Windsor and Maidenhead.

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South East England Councils (SEEC)

South East England Councils (SEEC) was established in 2009. It is a membership organisation representing all tiers of local authority. The SEEC area covers Berkshire, Buckinghamshire, East and West Sussex, Hampshire, Isle of Wight, Kent, Oxfordshire and Surrey. SEEC's objectives are:

- To strive for a fair funding deal for the South East
- To promote the South East's position as a leading global economy
- To act as single democratic voice for South East interests
- To monitor the pulse of the South East.

SEEC is chaired by Cllr Gordon Keymer CBE, Leader of Tandridge District Council.

Contact:

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South East Councils Adult Social Care (SECASC)

The SECASC group is made up of 19 local authorities (Single Tier and County Council) with adult social care responsibilities. The group has been established to inform regional and national debate, sharing good practice information between Lead Members, as well as raising the general profile of adult social care issues.

SECASC is chaired by Cllr Patricia Birchley, Cabinet Member for Health and Wellbeing, Buckinghamshire County Council

Contact: Rachel Rothero, Service Director for Commissioning and Service Improvement, Buckinghamshire County Council rrothero@buckscc.gov.uk
