NEWTON CCN COUNTY COUNCILS NETWORK

Preparing for reform

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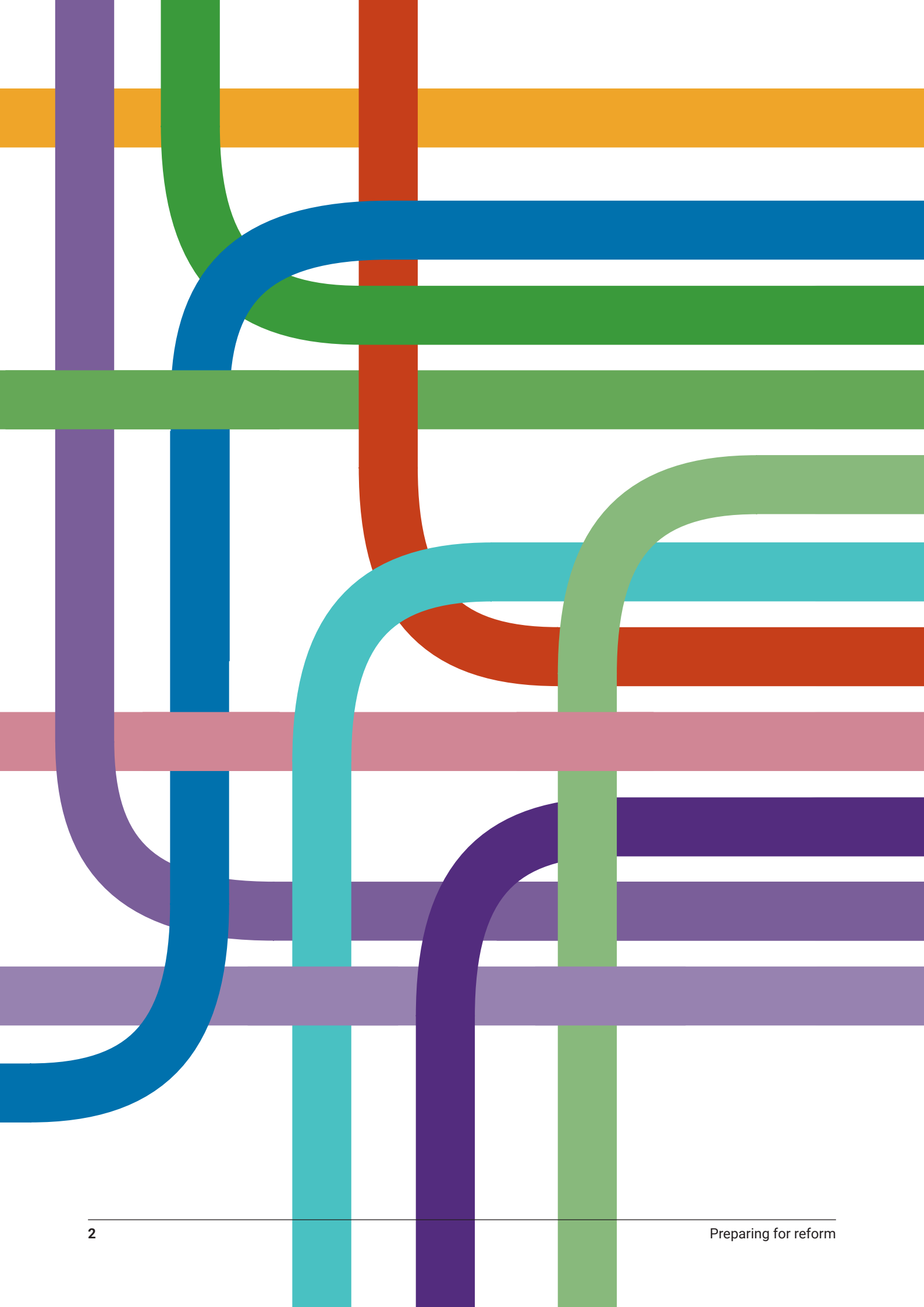
Understanding the impact of adult social care charging reform and planning for successful implementation



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1. Executive summary

Introduction

In 2021 the Government published the *Build Back Better* and *People at the Heart of Care* white papers, setting out their plans to fundamentally reform the funding and delivery of adult social care. These reforms have been broadly welcomed, but there is still much detail yet to be confirmed about how they will operate in practice.

Building on the *Future of Adult Social Care* report[1] published by the County Councils Network (CCN) and Newton in 2021, the purpose of this new report is to specifically assess the financial and operational impact of the **charging reforms** and provide recommendations for local systems and central government to support effective implementation.

The primary aim of the charging reforms is to redistribute the financial responsibility for paying for an individual's care between the individual and the local authority. At its simplest, the cost to the individual will reduce, and the cost to the local authority will increase.

To achieve this aim, there are four key components: a cap on the amount any individual can spend on their personal care over a lifetime; a more generous system of means testing; a 'fair' cost of care will be established to support providers; and enactment of section 18(3) of the Care Act which will mean all individuals can ask the local authority to arrange their care. Over the next three years to 2024/25, £3.6 billion has been committed by Government to fund the implementation of the reforms.

The charging reforms are being introduced against a challenging backdrop. Local government is already grappling with a significant change agenda, including devolution and 'county deals'; the special educational needs and disabilities (SEND) green paper; the *Opportunity for All* schools white paper; as well as the various and ongoing demands of recovering from the Covid-19 pandemic. This is in addition to existing challenges with the current adult social care system including preparing for assurance; provider sustainability; workforce recruitment and retention; and the evolving relationship with the NHS, including understanding the implications of the white paper on integration, and the implementation of Integrated Care Systems.

This report has been developed through a collaborative process involving CCN's member authorities and beyond; unique, in-depth data analysis has been combined with extensive sector engagement with over 100 individuals. Following the report's publication there will be an opportunity for all local systems to receive an analysis pack from Newton tailored to their own area, to assist with local implementation planning.

Findings - the financial and operational impacts of charging reforms

A central component of this report has been to assess the financial and operational impacts of the four key components of charging reform in England. Various sources of national data have been analysed to help to understand the impact of the proposals at a national and regional level. This centres around bespoke postcode level wealth and asset data to help model the financial impact for each region, supplied by CACI[2]. A full methodology underpinning the analysis can be found in Section 6.

The analysis from this programme suggests that the reforms will have a greater financial impact than estimated in the Government's Impact Assessment over the 10-year period (**£29bn - £32bn vs. £19bn**). In order to properly fund these reforms, social care will require approximately **50%** of the Health and Social Care National Insurance Levy (**£5.6bn - £6.2bn** per year by 2031/32 of a total levy of **£12bn**).

All numbers presented are estimates, based on assumptions which have been developed and tested with input from subject matter experts; however, there will always be a degree of uncertainty. To this end, a lower and an upper scenario are presented for the older adults means test and cap analysis. Both rely on the same methodology, and postcode level asset and wealth data, supplied by CACI, however two key assumptions are varied in each case, providing a range for the analysis.

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
Older Adults (65+) Means Test & Cap	£319m	£985m	£1,735m	£2,602m	£3,165m	£3,317m	£3,425m	£3,532m	£3,638m	**£17,074m**
Working Age Adults (18-64) Means Test & Cap	£170m	£380m	£460m	£520m	£540m	£560m	£570m	£590m	£690m	**£3,421m**
Total Means Test & Cap	£489m	£1,365m	£2,195m	£3,122m	£3,705m	£3,877m	£3,995m	£4,122m	£4,328m	**£20,495m**
Operational Spend	£241m	£248m	£256m	£263m	£271m	£279m	£288m	£296m	£305m	**£1,901m**
FCC Spend (Residential / Nursing only)	£1,232m	£1,269m	£1,307m	£1,346m	£1,386m	£1,428m	£1,471m	£1,515m	£1,560m	**£9,714m**
Total	**£1,962m**	**£2,882m**	**£3,758m**	**£4,732m**	**£5,363m**	**£5,584m**	**£5,754m**	**£5,933m**	**£6,194m**	**£32,110m**

Figure 1 - Summary financial impact of charging reforms (upper scenario)

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
Older Adults (65+) Means Test & Cap	£241m	£744m	£1,340m	£2,074m	£2,585m	£2,743m	£2,837m	£2,928m	£3,016m	**£13,885m**
Working Age Adults (18-64) Means Test & Cap	£170m	£380m	£460m	£520m	£540m	£560m	£570m	£590m	£690m	**£3,421m**
Total Means Test & Cap	£411m	£1,124m	£1,800m	£2,594m	£3,125m	£3,303m	£3,407m	£3,518m	£3,706m	**£17,306m**
Operational Spend	£241m	£248m	£256m	£263m	£271m	£279m	£288m	£296m	£305m	**£1,901m**
FCC Spend (Residential / Nursing only)	£1,232m	£1,269m	£1,307m	£1,346m	£1,386m	£1,428m	£1,471m	£1,515m	£1,560m	**£9,714m**
Total	**£1,884m**	**£2,641m**	**£3,363m**	**£4,204m**	**£4,783m**	**£5,010m**	**£5,166m**	**£5,330m**	**£5,572m**	**£28,922m**

Figure 2 - Summary financial impact of charging reforms (lower scenario)

The findings from this programme of work demonstrate that perhaps more significant than the financial impact of reform is the operational impact - particularly the requirement to find large numbers of additional staff if substantial changes to the operating model are not made.

Overall, analysis suggests approximately **200,000** more assessments per annum will need to be conducted, compared to a government estimate of **150,000**. This includes **105,000** Care Act Assessments and **93,000** financial assessments. As a result, an additional **4,300** social work staff will be needed to carry out the additional Care Act assessments, reviews, and case management (a **39%** increase in posts currently filled). An additional **700** financial assessors will also be needed to carry out the additional Financial Assessments (a **25%** increase in posts currently filled) if no changes to existing ways of working are made.

Findings – regional variation

Since the bespoke analysis conducted for this programme has been carried out at a postcode level, it has enabled regional as well as national comparisons. The report concludes that there is significant regional variation in the impact of charging reforms.

	Lower Scenario			Upper Scenario								
	OA Means Test	OA Cap	Total	OA Means Test	OA Cap	Total	# Additional SWs	# Additional Means Test	Operational Spend	FCC	Lower Scenario Total	Upper Scenario Total
East Midlands	£472m	£143m	£614m	£641m	£102m	£743m	221	45	£100m	£802m	**£1,516m**	**£1,645m**
East of England	£1,405m	£388m	£1,793m	£1,989m	£280m	£2,269m	684	97	£298m	£1,173m	**£3,264m**	**£3,740m**
London	£911m	£254m	£1,165m	£1,268m	£179m	£1,448m	538	39	£224m	£586m	**£1,974m**	**£2,257m**
North East	£359m	£70m	£429m	£448m	£51m	£499m	108	16	£47m	£673m	**£1,149m**	**£1,219m**
North West	£1,088m	£258m	£1,346m	£1,459m	£186m	£1,645m	448	65	£195m	£2,327m	**£3,868m**	**£4,167m**
South East	£3,533m	£858m	£4,391m	£4,804m	£626m	£5,430m	1186	250	£540m	£1,010m	**£5,941m**	**£6,979m**
South West	£1,729m	£492m	£2,221m	£2,374m	£352m	£2,726m	507	88	£225m	£510m	**£2,956m**	**£3,462m**
West Midlands	£629m	£224m	£853m	£828m	£160m	£988m	214	38	£95m	£1,365m	**£2,313m**	**£2,448m**
Yorkshire & The Humber	£881m	£193m	£1,074m	£1,193m	£140m	£1,333m	398	67	£176m	£1,269m	**£2,520m**	**£2,779m**
Total	**£11,005m**	**£2,880m**	**£13,886m**	**£15,004m**	**£2,078m**	**£17,082m**	**4304**	**705**	**£1,901m**	**£9,714m**	**£25,501m**	**£28,697m**

Figure 3 - Regional summary of analysis, showing the cumulative costs over 10 years (note this excludes working age adults)

Findings – the challenges and opportunities of implementing reform

Drawing on the depth and breadth of stakeholder engagement conducted as part of this work programme, different perspectives on the challenges and opportunities of implementing charging reforms have been analysed. The key headlines, explored in the report in detail, include:

Local authorities:

- There is support for the broad principles underpinning different elements of charging reform. However, local authorities are concerned about the scale of the financial and operational challenge.
- It will be challenging for local authorities to make more funding available for adult social care, especially of the order described here, and there is reticence to further increase Council Tax, or to re-allocate existing budgets.
- Positively, the local authorities engaged through this work were keen to explore the potential presented by these reforms, building on the opportunity to change the operating model and move to more effective and efficient practices.
- However, central government, local government, and local partners will have to consider how the operating model for conducting assessments and managing caseloads fundamentally changes moving forward. It is not a feasible solution to find the additional workforce required.

Care providers:

- This programme identified mixed levels of understanding amongst providers in relation to the impact of the reforms.
- Providers highlighted the potential cost and complexity if different models are used by local authorities for the fair cost of care exercises and called for consistency nationally wherever possible.
- There is substantial apprehension amongst providers about the fair cost of care exercise.

Residents:

- This programme identified low levels of understanding amongst residents in relation to the impact of the reforms.
- The main point of confusion is how the £86k cap will be applied, and the understanding (or lack thereof) that only 'eligible care costs' will be counted.
- If not made clearer, it is anticipated that this will result in a significant increase in the number of complaints received by local authorities, as well as anxiety and confusion for individuals. This is likely to negate some of the positive impact of these reforms in reducing personal contributions to care costs.
- What remains unclear (and needs to be a key focus of further work) is the proportion of residents expected to 'take up' the option of the local authority assessing and arranging their care.

Perspective from local authorities

This programme surveyed senior councillors and officers with responsibility for implementation of the reforms. The results provide important insights into their perceptions of the reforms, their readiness for implementation, and the challenges they see from a local authority perspective. The survey received 42 responses from Leaders and Lead Members of CCN member councils, Chief Executives, and Directors of Adult Social Services from across 28 different local authorities. The key headlines are:

- There is widespread support for the principles underpinning different elements of charging reforms; **82%** of respondents support the cap on care costs; **89%** the extended means test; **87%** the introduction of a fair cost of care; and **69%** arranging care for self-funders under section 18(3) of the Care Act.
- While understanding of the reforms is high at **87%** of respondents, only **25%** of these understand the reforms 'very well'.
- Respondents highlighted the following implementation challenges:
    - The scale of the financial challenge, with **97%** very concerned about a lack of appropriate funding, with a further **3%** quite concerned.
    - The workforce challenge, with **88%** very concerned about recruiting additional staff for care assessments, with a further **10%** quite concerned.
    - Additional demand, with **80%** very concerned about the demand from self-funders for arranging care packages, with a further **18%** quite concerned.
    - The implementation timescales, with **77%** very concerned about having enough time to properly implement the reforms, with a further **20%** quite concerned.
    - The IT and technology requirements, with **59%** very concerned and a further **41%** concerned about this.
    - A shortage of care placements, with **60%** of respondents very concerned and a further **38%** of respondents quite concerned about this.
- As a result of these challenges, only **35%** of respondents said they were 'quite well prepared' for the reforms, with **63%** stating they were 'not well prepared'.
- There is support for a phased implementation beyond October 2023. **69%** of respondents supported delaying the implementation of the cap on care costs; **67%** supported a delay to the introduction of the extended means test and fair cost of care; while **90%** of respondents supported a delay to arranging care for self-funders under section 18(3) of the Care Act.

Recommendations for central and local government

Despite the obvious challenges, this report seeks to highlight the opportunity from reform in providing a catalyst to continue to transform social care. However, this can only be achieved given the right support from Government. The report identifies several important recommendations for central policy makers, with the aim of facilitating the reforms' implementation and improving outcomes for residents:

1. Urgently invest in a national recruitment and workforce development campaign for local authorities and providers.
2. Fully fund the increase in cost of these reforms to local authorities.
3. Phase the implementation of the components of reform, allowing local authorities, providers, and residents the necessary time to prepare, mitigating the risks and fully capitalising on the opportunities for innovation.
4. Provide additional implementation support and funding, to ensure local authorities have the right project and change management capacity and capability.
5. Support local authorities to address the shortage in capacity of community support.
6. Carry out, in full, the recommendations from the *Future of Adult Social Care* report, to support local authorities to optimise delivery and mitigate the increase in cost.
7. Ensure funding is made available in line with need at a local level.
8. Fully account for the wider costs of these reforms, most notably the Continuing Healthcare cost to the NHS.
9. Provide clear guidance for how those currently in receipt of services will transition into the new system, including how means testing and top-ups should be applied.
10. Develop a clear communications plan for residents, supporting them to understand the impact of reform, including how much cost they will be liable for.

The report also makes several recommendations to local systems as they prepare for implementation of the reforms:

1. Develop a comprehensive communication and engagement plan for residents, in partnership with Government.
2. Continue to promote independence and maximise effective and appropriate use of community support.
3. Continue to increase the productivity of the social care workforce, including exploring the role that digital and technology can play.
4. Develop a tailored approach to means testing, assessments, and case management.
5. Engage colleagues in IT and Digital to ensure the right systems will be in place.
6. Ensure there are detailed plans to address the lack of homecare capacity.
7. Continue to develop an open, two-way dialogue with care providers, specifically regarding the fair cost of care.
8. Engage system partners, through Integrated Care Systems (ICSs), to ensure the impact of the reforms is fully understood and to build local support.
9. Ensure that implementation of the reforms is effectively resourced.

2. Introduction

There has been a desire from successive governments to fundamentally reform the funding model for adult social care in England. In September 2021, the Government published its *Building Back Better* plan for reforming the funding of adult social care in England. This was followed in November 2021 by the publication of the white paper for reforming the delivery of adult social care, *People at the Heart of Care*.

The objectives of the charging reforms are to:

- Provide greater financial security for people who require care in their lifetime.
- Limit the personal financial contribution an individual must make towards their care.
- Ensure a fair rate for care is paid to care providers, to enable providers to sustainably offer a high quality of care.
- Provide more support from local authorities to those that currently arrange and fund their own care, ensuring they can access the same rates as the local authority.

While the Government has begun to set out details of the reforms and draft operational guidance, many of the details about how these reforms will work in practice are yet to be confirmed. As such, and given the tight timescales for implementation, stakeholders across the sector are currently attempting to extrapolate what they are likely to mean for residents, for businesses providing care, for people working to deliver care, and for the local authorities who fund and commission care.

What is evident is that they will result in significant change for local authorities, for providers, and for residents. As a result, the County Councils Network (CCN) and Newton have partnered on a programme of work to:

- Explore and quantify the operational and financial implications of charging reforms for all stakeholders.
- Build a set of evidence-driven recommendations which will support local implementation.
- Create evidence-driven recommendations to outline the national support offer required to support local implementation (namely by central government).

Purpose and rationale for this work

These reforms are coming at a time of pressure and change for adult social care. They are also complicated, both in terms of their long-term impact and in the breadth of changes that will be required to successfully implement them. These changes go beyond funding - which is critical - and include the operational detail of how the right systems, processes, and ways of working will be put in place; how key messages will be communicated with all stakeholders; and how the right numbers of staff will be made available.

This work has therefore sought to provide an evidence base which brings greater clarity to this complex picture; offer practical guidance for local authorities, providers, and residents to support implementation; and provide a set of recommendations for central government to consider, to help ensure that these reforms are successfully delivered locally.

Previous work

This work follows two substantial programmes of work already conducted by CCN and its partners, which provide a strong basis upon which to build:

The Future of Adult Social Care (2021)[3], delivered in partnership with the Association of County Chief Executives (ACCE) and Newton, provided an evidence base for a future optimised adult social care system. It included a series of recommendations to be taken forward nationally and locally. The current reforms, together with other elements of the *People at the Heart of Care* white paper and the integration white paper, have already begun to deliver on elements of these recommendations, helping to move the system closer towards the optimised model set out in the report.

The Impact Assessment of the Implementation of Section 18(3) of The Care Act 2014 and Fair Cost of Care (2022)[4], delivered by LaingBuisson, provided a detailed analysis of the financial impact of the introduction of the fair cost of care and section 18(3) of the Care Act (whereby any individual, including those who pay for their own care, can ask the local authority to assess their needs, and arrange care on their behalf). The findings of the report are referenced throughout.

3. Methodology

Overview of approach

This programme of work has been a collaborative process across CCN's member authorities (and beyond), supported by Newton. In total, over 100 individuals have contributed, including Chief Executives, Directors of Adult Social Services, and Directors of Finance from local authorities; care providers; resident representatives; voluntary sector representatives; and other industry bodies.

Whilst inevitably the analysis presented in this report relies upon a set of assumptions and estimates, the extensive engagement, substantial data analysis, and Newton's own evidence base, have sought to qualify and sense-check the figures quoted. The contents of this report should be used as a starting point for local and national planning conversations, and figures should be updated and refined with the application of local knowledge and assumptions.

Following publication, there will be an opportunity for all local systems to receive an analysis pack from Newton tailored to their own area, to assist with refining the estimates and making local plans.

CCN and Newton would like to extend their thanks to all those involved in this programme of work for being so generous with their time, expertise, and support. Both organisations expect that this will only be the beginning of the conversation about successful implementation of these reforms, at a local and national level, and very much look forward to continuing to support and facilitate this.

The programme's methodology is explained below.

1. Engagement with the sector

Engagement with a wide range of stakeholders was fundamental to the programme's approach, reflecting the far-ranging impact of the reforms across councils, providers, and residents. This engagement included:

- Ten round table discussions with local authority Chief Executives, Directors of Adult Social Services, and Directors of Finance; small, medium, and large care providers; resident representatives; and voluntary sector representatives.
- Engagement with individuals representing the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS), Society of County Treasurers (SCT), the National Care Association, Care England, Healthwatch, and Age UK.
- 1:1 discussions with other relevant stakeholders including health representatives and other voluntary sector organisations.
- A number of 1:1 discussions with key subject matter experts from across the sector.

Furthermore, CCN and Newton conducted qualitative surveys with Leaders and Lead Members of CCN member councils; Chief Executives and Directors of Adult Social Services; residents; as well as small, medium, and large providers of care services. The purpose of the surveys was to gather quantitative and qualitative data about the ways in which they and their organisations are preparing for reform. Over 70 responses were received.

2. Financial modelling

Using national and local data, this programme has sought to develop new financial modelling to estimate the costs and workforce requirements of charging reforms in England, namely the cap on care costs, extended means-test, and extension of duties in relation to assessments. Other existing and previously published analysis was also drawn upon, for example the research commissioned from LaingBuisson by CCN on the impact of the 'fair cost of care'[5].

Various sources of national data were analysed to help to understand the impact of the proposals at a national and regional level. This included a review of the Government's *Social Care Charging Reform Impact Assessment*[6], as well as bespoke postcode level wealth and asset data to help model the financial impact for each region, supplied by CACI[7]. For each postcode, 25 data fields were gathered and analysed, including individuals' savings, income, investments, and house value, along with factors such as if a house is owned, and if individuals live in couples or alone. Together this data provided the basis to assess chargeable assets, which underpins this analysis. A full methodology can be found in Section 6.

'Deep dive' data collection was carried out with a selection of local authorities to understand the operational change that will be required to successfully implement charging reforms. Existing processes were mapped, analysed, and costed, and individuals and teams were shadowed and took part in studies.

Newton also drew upon operational evidence and experience from their programmes with 13 county councils and over 40 local authorities.

All numbers presented are estimates, based on assumptions which have been developed and tested with input from subject matter experts, however, there will always be a degree of uncertainty. To this end, a lower and an upper scenario are presented for the older adults means test and cap analysis. Both rely on the same methodology, and postcode level asset and wealth data, supplied by CACI, however two key assumptions are varied in each case, providing a range for the analysis. Both scenarios are presented here, thereby providing a range for the overall cost of reforms, reflecting the uncertainty in any modelling undertaken.

3. Steering Group

The purpose of the Steering Group was to oversee and guide the development of the analysis and final report; provide subject matter expertise and expert input to the work; and represent the voice of all those impacted by reform. The Steering Group members were:

- Chair: Cllr Martin Tett, Leader of the Council, Buckinghamshire County Council and Adult Social Care Spokesperson, County Councils Network
- Chris Bain, Chief Executive, Healthwatch Warwickshire
- Gary Fielding, Corporate Director of Strategic Resources, North Yorkshire County Council and past President, Society of County Treasurers
- Ian Gutsell, Chief Finance Officer, East Sussex County Council and Health and Adult Social Care Lead Advisor, Society of County Treasurers
- James Bullion, Executive Director of Adult Social Services, Norfolk County Council and Trustee, Association of Directors of Adult Social Services
- Jane Robinson, Corporate Director of Adult and Health Services, Durham County Council
- Lorna Baxter, Director of Finance, Oxfordshire County Council and past President, Society of County Treasurers
- Professor Martin Green, Chief Executive, Care England
- Nadra Ahmed OBE, Chairman, National Care Association
- Rachael Shimmin, Chief Executive, Buckinghamshire County Council and Social Care Lead, Association of County Chief Executives
- Richard Ayres, Social Care Advisor, Care England
- Richard Webb, Corporate Director Health and Adult Services, North Yorkshire County Council and Co-chair, County Councils Network's Health and Social Care Forum
- Simon Williams, Director of Social Care Improvement, Local Government Association

Report scope

Home care

For the purposes of consistency, home care has not been included within the estimates of fair cost of care, as the LaingBuisson research modelled only residential and nursing care. Home care has, however, been included in the analysis of the impact of the care cap and the means test.

Working age adults

In recent years, long-term support for working age adults (aged 18-64) has become the most significant area of net expenditure for local authorities[8]. This is due to a combination of factors, including rising demand and rising costs, together with older adults' services being the more common target of efficiency programmes.

This report seeks to understand the impact of the Government's charging reforms on **all adults**, including those of working age. It is expected, however, that the impact will be less significant on this cohort. This is because, in general, a lower proportion of working age adults have accrued sufficient wealth and assets to fund their own care, or contribute to the cost of their own care, even in the current system of means testing.

Whilst working age adults will therefore feature less strongly throughout this report, engagement through this work programme has consistently pointed to a system of support that is in equal need of reform.

4. Context

History of reform

The 1945 introduction of the Welfare State and the creation of the National Health Service left social care to be run by charitable and voluntary organisations. It was expected that these services would either be provided free of charge (by those charities) or paid for by individuals who had the means to do so. This has remained the position for social care over the subsequent years with means tested charging slowly introduced as the public sector took more responsibility for both delivering and commissioning the care services that were required.

There has been much debate over the years on how to reform the way in which adult social care is delivered and funded. The debate has often focused on the funding and charging for adult care. The Labour Government in 2009 laid out proposals to better fund social care through increasing the level of tax that people pay on their estate when they die, alongside a proposal for free personal care. This proposal did not survive the 2010 General Election. The new coalition Government set up a commission under the leadership of an economist, Sir Andrew Dilnot, and his report was accepted at the time (2011). His principle that there should be a maximum cap on the cost of care for any one individual was widely accepted and then enshrined in the Health and Care Act passed in 2014.

There was no agreement on how the introduction of this cap would be implemented and so the proposal was initially shelved. However, the basis of the principle of a cap on the amount a person would be charged for their social care has remained strongly supported and was picked up by the new Conservative-led Government in 2019. The in-coming Prime Minister, Boris Johnson, said he would "fix the crisis in social care". In the first budget after the Covid-19 pandemic had subsided, the Government introduced a levy on the cost of National Insurance to both employers and employees to fund a change in the charging thresholds and to introduce a cap on the cost of social care. The new arrangements also focused on section 18 (3) of the Care Act which put a duty on local authorities to arrange care for any individual who had eligible needs irrespective of who was going to pay for that care.

There is now a significant reform agenda in place for adult social care. There has been a white paper, *People at the Heart of Care*, published in December 2021 and a separate integration white paper published in February 2022, in addition to the wider strategic changes for health and social care contained in the more health-focused Health and Care Bill in February 2021. There has also been a range of proposals on charging and the fair costs of care; assurance of social care; and designing a social care system where people with lived experience are put at the heart of what local authorities should be doing. This has set a big and complex agenda of change for those commissioning and providing social care in England.

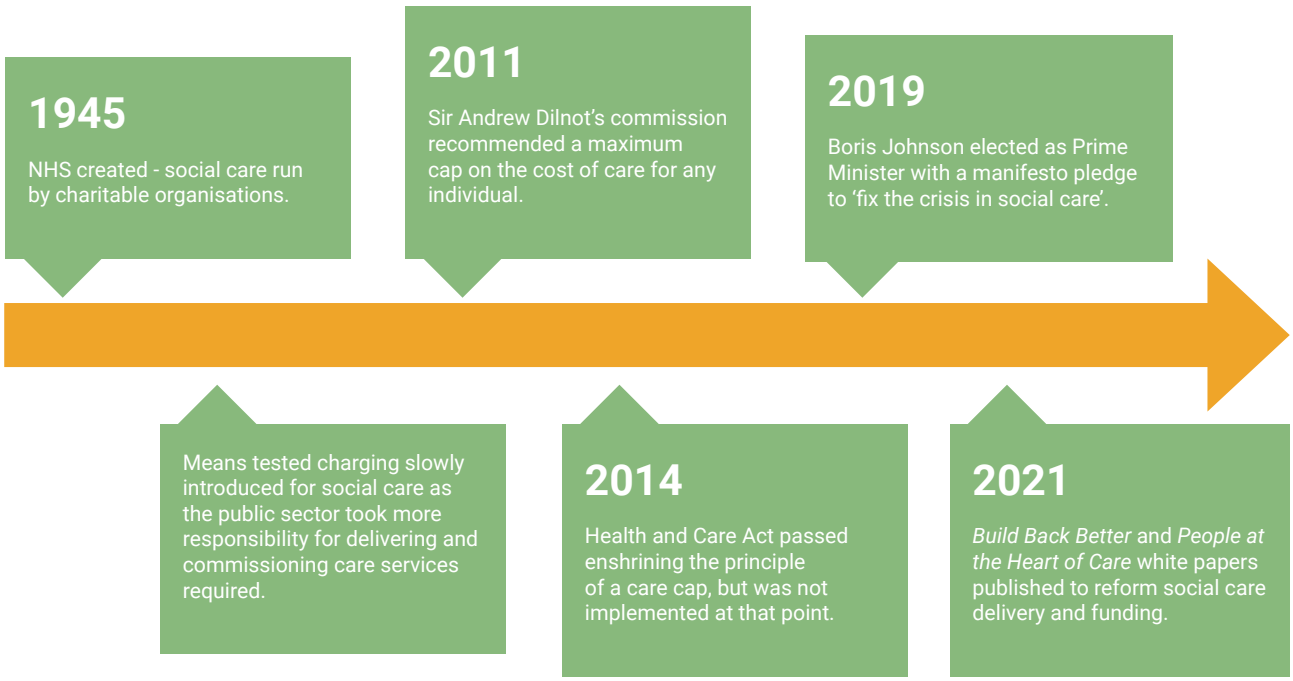

Figure 4 - Overview of the history of adult social care reform

This paper focuses on the four main aspects of the reform which impact on the charging of individuals for social care: the introduction of the care cost cap; the changes to the charging thresholds; the work required on the "fair cost of care"; and the enforcement of section 18 (3) of the 2014 Health and Care Act.

National context

The charging reforms are set to be introduced against a challenging backdrop. It is a time of significant change for health and social care systems including recovery from the waves of the pandemic that led to national and local lockdowns, and particularly working through the associated NHS backlogs; preparing for the introduction of assurance across adult social care; the implementation of new Liberty Protection Safeguards; the development of Integrated Care Systems; and preparing for the implications of the integration white paper.

For local government more broadly, the reforms come alongside a wider change agenda, including ongoing financial challenges as a result of inflationary pressures; devolution and 'county deals'; the SEND green paper; the Schools white paper; and the Homes for Ukraine scheme.

The consequences of these parallel challenges include:

- Limited capacity for senior leaders and system partners to engage in successfully implementing the reforms.
- Availability of the social care workforce, with some leaving the sector altogether, and many still suffering from ill health.
- Rising demand for adult social care[9], potentially caused by:
    - suppressed demand during successive Covid-19 national lockdowns.
    - increased prevalence of mental and physical health complaints caused by the pandemic and by the current geo-political instability.
    - an increase in elective inpatient stays, as the NHS seeks to clear its backlogs.
    - preparation for the new quality assurance regime which will apply to adult social care and local authorities identifying unmet need.
- Limited capacity of project management and change management staff to manage the implementation of the multiple changes.
- Increasing difficulty for residents, staff, and other system partners to fully comprehend the total effect of the various changes and how they will be impacted as individuals and organisations.

Challenges with the current system

The adult social care system delivers high quality outcomes for thousands of residents every year. It is a sector that many feel proud to work within and support, and it has succeeded in continuing to evolve in line with the changing national context, pressures, and requirements over many decades. However, as with any system, the adult social care system faces some major structural and contextual challenges. These include:

System of means testing:

Unlike in the NHS, where services are generally free at the point of access, social care is means tested. This adds an additional complexity for both councils and the public. Individuals may be required to either meet all the costs of their care, or contribute, depending on their personal wealth, which at present can expose an individual to potentially unlimited personal financial liability.

A mixed market and self-funding:

The number of people who pay for their own services ('self-funders') can make a significant difference to both the domiciliary and residential care market. Recent ONS data shows that the average self-funder rate in residential care in England is **37%**, and **46%** in CCN member council areas. 32 of CCN's 36 member councils have a self-funder rate above the national average, with 11 councils above **50%**.

Where the private market flourishes, there are likely to be some providers who do not work with local authorities and others who subsidise local authorities paying lower fees by charging higher fee rates to self-funders. Data obtained as part of LaingBuisson's recent report for CCN shows that private pay premium in residential and nursing care is on average **43%** in county areas.

There is also the issue of self-funders whose funding 'runs out'. Some people do not approach their local authority for advice before they make a decision about the care they may need, which can sometimes mean that they establish themselves in a care setting prematurely, whilst funding their own support. Some of these people will later run out of money or assets, and then turn to the local authority for help. This puts pressure on the local authority's resources and can make it harder for the council to judge future demand for care.

Provider sustainability:

Many care providers believe that at present, local authorities do not provide an adequate rate to properly fund their business model, guarantee they can operate sustainably, and deliver a high-quality service. The disparity in fees between self-funders and local authority funded care mentioned above, has led to an estimated **£1.2bn** 'fee gap' in England, with **£550m** of this shortfall in CCN member councils.[10] The Homecare Association, which represents over 2000 care providers, calculates the true minimum cost of providing an hour of homecare in the UK is £21.43. However, data collected for the Homecare Association shows the average rate paid by councils in Great Britain and health boards in Northern Ireland is £18.45[11]. In turn, local authorities feel unable to increase the rates paid for care, due to historic difficulties in agreeing a 'fair cost of care' with independent providers[12] and their own funding constraints.

Workforce:

Recruiting and retaining a highly skilled care workforce is a persistent challenge for local authorities and care providers. Many will cite the low rates paid by local authorities to care providers as one of the reasons for this, resulting in care providers being unable to pay an attractive wage nor to invest in workforce development. These challenges have been exacerbated by the perceived unattractiveness of the care sector relative to other sectors such as retail and hospitality, and by the Covid-19 pandemic, which has increased workforce attrition. Vacancy rates fell at the start of the pandemic, however, as of August 2021, they are now back above their pre-pandemic levels[13]. In addition, levels of staff sickness nearly doubled over the course of the pandemic[14]. As a result, workforce availability is markedly reduced.

The relationship with the NHS:

The relationship between adult social care and the NHS has long been cited as both a challenge and an opportunity. The challenges presented are numerous and well documented and are considered to centre around a lack of parity of esteem between the two parts of the health and care system. These challenges include:

- Recruitment, with the NHS being considered a more attractive, more prestigious, and higher paying employer, which exacerbates the workforce pressure in social care.
- Different governance and leadership arrangements, which can inhibit joined up decision-making.
- Different funding and commissioning arrangements, which make it difficult to make joined-up commissioning decisions.
- Conflicting pressures, whereby acute providers need to maintain flow to minimise length of stay whilst community providers (including social care) must provide the right intermediate support and best long-term care plan. Through the Covid period, changes to national funding arrangements and guidance on discharge have largely supported earlier discharges. However, some systems have struggled to build new resilient processes quickly, resulting in increased demand for long-term care which brings with it associated costs.

Rising costs:

Local authorities will witness a significant increase in need for adult social care over the coming period as a result of rising costs and demand. Figure 5 shows the projected rise in spending need according to analysis undertaken[15] for CCN.

	2022 - 2023	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030
County and Unitary authorities	8,927	9,328	9,758	10,069	10,398	10,743	11,103	11,473
Non-CCN unitary authorities	3,047	3,180	3,323	3,427	3,536	3,651	3,771	3,894
London boroughs	2,779	2,909	3,048	3,142	3,240	3,344	3,452	3,563
Metropolitan boroughs	4,020	4,191	4,375	4,512	4,657	4,810	4,968	5,131
England	**18,786**	**19,620**	**20,519**	**21,164**	**21,847**	**22,564**	**23,309**	**24,079**

Figure 5 - The change in requests for support over time

It is important to note that these figures represent core demand growth, and do not include any reform impact or additional legacy impact as a result of the Covid-19 pandemic. As a result, costs for local authorities are likely to be even higher due to rising demand for adult social care[16], potentially caused by:

- suppressed demand during successive Covid-19 national lockdowns.
- increased prevalence of mental and physical health complaints caused by the pandemic and by the current geo-political instability.
- an increase in elective inpatient stays, as the NHS seeks to clear its backlogs.
- preparation for the new quality assurance regime which will apply to adult social care and local authorities identifying unmet need.

5. Overview of proposed reforms

Objectives of charging reform

The Government has set out three overarching objectives for social care reform. These are to:

1. Offer choice, control, and independence to care users – so that individuals are empowered to make informed decisions and live happier, healthier, and more independent lives for longer.
2. Provide an outstanding quality of care – where individuals have a seamless experience of an integrated health, care, and community system that works together and is delivered by a skilled and valued workforce.
3. Be fair and accessible to all who need it, when they need it – ensuring that fees are more transparent; information and advice is user-friendly and easily accessible; and no one is subject to unpredictable and unlimited care costs.[17]

It is primarily this third objective which the current charging reforms seek to achieve. These reforms are designed to:

- Provide greater financial security for people who require care in their lifetime.
- Limit the personal financial contribution an individual has to make towards their care.
- Ensure a fair rate for care is paid to care providers, to enable providers to sustainably offer a high quality of care.
- Provide more support from local authorities to those that currently arrange and fund their own care, ensuring they can access the same rates as the local authority.

They intend to achieve this by:

- Providing a more generous means test, such that residents are required to contribute less of their personal wealth to fund their care costs.
- Providing more certainty for residents by limiting the potential costs they may need to meet for their care, by placing a cap on personal contributions.
- Improving transparency of costs, by giving every resident access to their own 'Personal Care Account'.
- Ensuring fairness in the rates paid for self-funded and state-funded care and provide greater support to those who currently arrange their own care, by allowing everyone to request that the local authority arranges their care, regardless of how it is funded.
- Paying a fair rate for providing care to care providers.

The means by which the Government is seeking to achieve this is covered below.

Key components of charging reform

There are four key components of charging reform:

1. **Care cap**: There will be a cap of £86k on the amount any individual can spend on their personal care over a lifetime. The local authority will help individuals 'meter' towards the cap through a 'Personal Care Account' accounting for any money that they spend on care, based on the budget the local authority determines as appropriate for the level of eligible need, excluding any top-ups. Once this cap is reached, care will be funded by the local authority. This will mean that residents' personal contributions to the cost of their care will be limited, regardless of the level of wealth and assets they have. There will be key exclusions from 'care costs', which will not count towards the care cap, such as a £200 per week daily living cost (DLC).
2. **Means testing**: The introduction of a more generous means test will mean that anyone with assets of less than £23,250 will not pay for their care at all, and anyone with assets between £23,250 and £100,000 will receive some assistance. This compares to the current system whereby the local authority will only assist in part if a resident has assets of below £23,250 and will only contribute in full if they have assets of less than £14,000. The Minimum Income Guarantee (MIG) and Personal Expenses Allowance (PEA) will also be unfrozen, ensuring that individuals keep more of their own income. Where a person receives support from the state, the £86k cap will still apply to the individual's personal contribution.
3. **Fair cost of care:** Local authorities are required by October 2023 to 'move towards' paying a 'fair cost of care'. This is intended to ensure that providers receive sustainable funding, to deliver high quality, consistent care.
4. **Care brokerage:** Implementing section 18(3) of the Care Act will mean that self-funders can request an assessment from their local authority. They will also be able to ask the local authority to source and broker their care for them. This should mean that self-funders start to pay the fair cost of care, if the local authority arranges their care. It is expected that, as a result, care providers will lose income from this cohort, who in most cases currently pay a higher rate, unless local authorities are resourced at a level which enables them to make up the shortfall through the fair cost of care exercise.

Funding committed so far

The new National Insurance Levy is designed to raise £12 billion per year in additional revenue, in part to fund these reforms. In total, over the next three years, £3.6 billion (£1.2 billion per year) of this is allocated to pay for the cap on care costs and the extension to the means test, and to support progress towards local authorities paying a fair cost of care.

On the fair cost of care specifically, in December 2021 the Government launched the Market Sustainability and Fair Cost of Care Fund which will allocate £1.4 billion of the total £3.6 billion injection from the Levy to achieving this aim. £162 million of this £1.4 billion will be allocated in 2022/23 to support local authorities as they prepare their markets for reform. A further £600 million will be made available in both 2023/24 and 2024/25[18]. Up to 25% of allocated funding in 2022/23 can be used to fund implementation activities associated with meeting the fund's purpose[19].

Over time, it is envisaged that an increasing share of the £12bn will be spent on social care. The findings of this programme indicate that the share of this sum that will be required by social care will rise to **£5.6 - £6.2 billion** by 2031/32.

6. Financial and operational analysis

The four key components of these reforms, as described in Section 5, will fundamentally redistribute the financial responsibility for paying for an individual's care. The cost to the individual will reduce, and the cost to the local authority will increase. The contribution of care providers will be determined by how the fair cost of care and section 18(3) of the Care Act are implemented, which will reduce the level of cross-subsidy between self-funded and local authority-funded individuals.

This section provides details of the financial and operational analysis of the main components of the charging reforms. It takes each in turn, providing an overview of the methodology, followed by a summary of the main findings. The section concludes by bringing all the results together into a summary.

The Government's Impact Assessment

The Government has completed its own detailed Impact Assessment of the reform proposals[20] which seeks to quantify the financial impact for local authorities.

It is important to note that there will always be uncertainty in modelling the impacts of these reforms. However, the assumptions and approximations made throughout this report have been tested and iterated with subject matter experts. It is noted where the conclusions of this paper differ from the Impact Assessment. Wherever possible, it is also noted where a different assumption has been made and the logic for this. It is not always possible to directly compare the methodologies, as the Impact Assessment does not share the full detail of how the modelling has been carried out.

Extended means test and cap on care costs

Methodology for analysing the impact of the new means test

The implementation of charging reform will result in a more generous means test, which will mean more individuals receive some financial assistance in paying for their care. Practically, this will be achieved by increasing the asset thresholds which determine when an individual contributes to the cost of their care. These thresholds are referred to as the Lower Capital Limit (LCL) and the Upper Capital Limit (UCL).

The new means testing system will be structured such that:

- Anyone with chargeable assets below the LCL does not contribute to the cost of their care from their assets.
- Anyone with chargeable assets above the UCL pays for the full cost of their care from their assets.
- Anyone with chargeable assets between the LCL and the UCL has a 'tariff income' applied, meaning they contribute £1 per week to their care costs for every £250 of assets.

Charging reforms will increase the LCL from £14,250 to £23,250, meaning more people will not contribute to the cost of their care from their assets. The UCL will increase from £23,250 to £100,000, meaning more people will benefit from some support from the Government, with fewer people paying the full cost of their care from their assets.

Currently, individuals also contribute to the cost of their care from their income. The Personal Expenses Allowance (PEA) for people in residential or nursing care and the Minimum Income Guarantee (MIG) for people receiving care at home set out a minimum amount of an individual's income that is protected. Income above this level is contributed towards the cost of care. Having previously been frozen, PEA and MIG will rise with inflation as a result of these reforms.

To be able to estimate the impact of the new means test for local authorities, the objective of this programme was to build a picture of the distribution of chargeable assets belonging to residents in England who are likely to need care (and are over the age of 65).

To do so, the starting point was to look at the asset distribution across England's whole population, including savings, house values, and other assets held, before drawing out the over 65 cohort. Using data supplied by CACI, for each postcode, 25 data fields were gathered and analysed, including individuals' savings, income, investments, and house value, along with factors such as if a house is owned, and if individuals live in couples or alone. Together this data provided the basis to assess chargeable assets. The granularity of this approach has also enabled regional variation to be analysed and understood.

Not all assets are considered chargeable within this calculation, since there are specific rules relating to whether property value is included. The current rule is that where the individual remains living in their own home, or a close relative or family member remains living in that home, including a spouse, partner, former partner, civil partner, child under 18, or any family member aged over 60, the value of the property is disregarded. This rule is not changing as a result of reform.

The analysis in this report is therefore based on 'chargeable assets' which seeks to account for this disregard of house value. The following methodology has been used to approximate the housing disregard, with each factor being calculated per postcode, and the average nationwide figures shown below:

- The house value is only included for residential or nursing care, not the community (**40%** of the care population).
- The house value is only included where the property is owned by the individual.
- It is only the individual's proportion of the property which is considered chargeable (**42%** of the care population).
- The house value is only included where the individual does not live 'in a couple' (varied between **25%** and **51%** in the lower and upper scenarios).

This results in the house value being disregarded between **87%** and **91%** of the time. The assumption about living 'in a couple' rather than being married, is a key distinction, and allows for a broader range of situations where the house value is disregarded to be accounted for (i.e., where there is a partner, civil partner or former partner remaining in the house, as well as if a spouse remains at home).

Further analysis then adjusted this picture to consider the lower relative wealth of the population who receive social care support. This was done by comparing the full distribution of wealth to data provided by Office of National Statistics for the wealth and assets of the care population, and by sampling locally. This resulted in the wealth and assets data being scaled down by **50%**, to provide a proxy for the care population.

The analysis has been conducted nationally, and then repeated for each individual local authority to build up regional analysis.

Figure 6 below can then be used to understand the relative increase in local authority contributions to care costs in the new system.

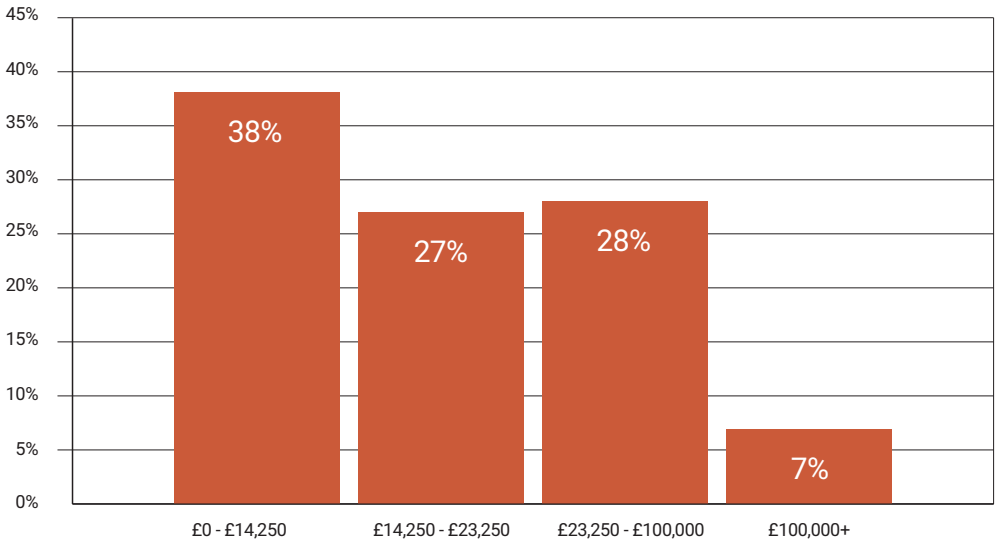

Figure 6 - The estimated distribution of chargeable assets for England's older adult care population for the upper scenario

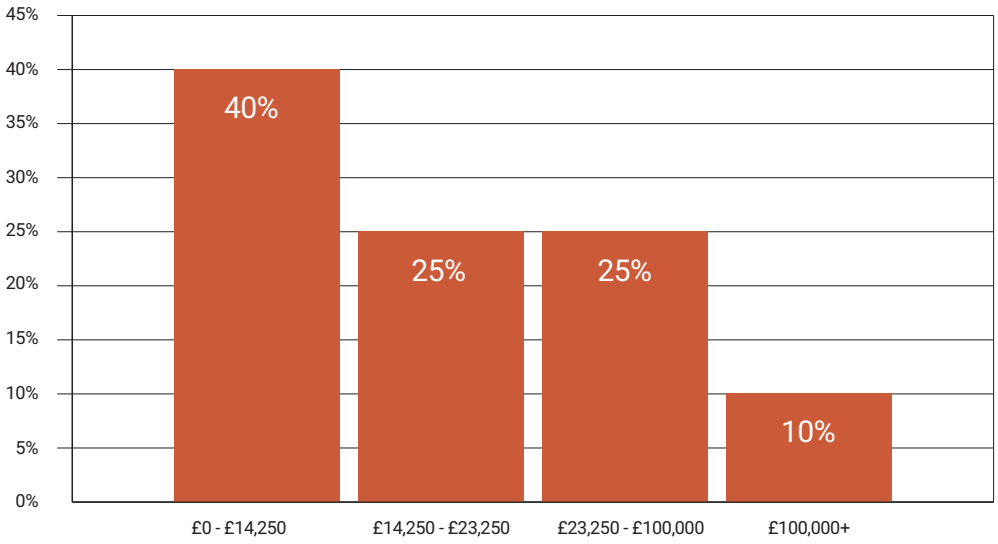

Figure 7 - The estimated distribution of chargeable assets for the older adult care population for the lower scenario

Older adults (65+)

The total impact of the new means test for older adults (65+) is estimated as:

- The proportion of people receiving full local authority support to increase from **38%-40%** to **65%**.
- The proportion of people receiving some level of local authority support to increase from **65%** to **93%**.
- The average contribution from the local authority for those between the LCL and the UCL to decrease from **70%** of care costs, to between **49%** and **59%** of care costs, taking into account the modelled income of individuals between the LCL and the UCL.

Explaining the Range

Recognising that any analysis of this kind will always rely on assumptions, this programme presents a range for the potential financial impact of the charging reforms. The range is driven by varying two critical assumptions in the methodology:

- **Treatment of the housing disregard:** there is a lack of clear available data regarding the likelihood of the older adult care population to live in a couple. The lower scenario takes data from the English Longitudinal Study of Ageing and the Census, to estimate **25%** of the the older adult care population are married, and **75%** are not. The upper scenario takes the average of the older adult population at large, to estimate that **51%** of the population do not live in a couple. This means the house value is disregarded between **87%** and **91%** of the time.
- **Treatment of Income for people between the LCL and the UCL:** Depending on how the income guidance is interpreted, differing conclusions can be drawn about what is considered chargeable income. Therefore, two different calculation methods are used to provide estimates of this, which result in a **49%** local authority contribution for the means-tested population in the lower scenario, and **59%** in the upper scenario.

The impact of varying these two assumptions on the assumed chargeable asset distribution can be seen by comparing Figure 6 and Figure 7.

Methodology for analysing the impact for local authorities of the £86k cap on care

In order to understand the percentage of older adults who will reach the cap on care, an initial assumption has been made that only self-funders (i.e. those paying 100% of their own care costs) will reach the cap. Anyone with assets below the UCL is highly unlikely to receive care for long enough to reach the £86k cap. This analysis therefore assumes that an individual must have more than **£186,000** in assets so as to not be at all impacted by the means test.

Following this assumption, the likelihood of having a sufficiently long care duration has been calculated, assuming older adult care durations are normally distributed. These two factors combine to indicate that, for the upper scenario, **3.7%** of older adults will reach the cap on care and for the lower scenario, **5.3%** of older adults will reach the cap on care.

Working age adults (18-64)

The same analysis has been carried out for working age adults (18-64). Given the wide-ranging needs of working age adults, it is more complex to adjust the assets data to give a reliable estimate. Applying the same assumptions that were applied for older adults, it is estimated that **98%** of working age adults receiving care have chargeable assets below £14,250. Based on this, this report does not seek to build on the analysis carried out through the Impact Assessment, which appears a conservative estimate.

Based on the above methodology and assumptions, Figure 9 below shows the results of the upper scenario of this programme's analysis for the extended means test compared to the estimate contained within the DHSC Impact Assessment (Figure 8). Figure 10 shows the lower scenario. Figure 11 and Figure 12 provide a regional breakdown of the analysis.

Inflation has been included at 3% per annum on all costs. Cumulative totals have been discounted at 3.5% per annum, as per the Impact Assessment, to 2020. Demand growth is not accounted for. Costs are profiled assuming:

- The means test starts from day one, with all those entitled to local authority funding having this backdated to 1st October 2023.
- The older adult means test costs are phased around an average care package duration of approximately 2 years, assuming a normal distribution.

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
Older Adults (65+) Means Test & Cap	£240m	£740m	£710m	£1,360m	£2,000m	£2,270m	£2,440m	£2,600m	£2,750m	**£11,360m**
Working Age Adults (18-64) Means Test & Cap	£170m	£380m	£450m	£510m	£530m	£549m	£559m	£579m	£678m	**£3,410m**
Total Means Test & Cap	£410m	£1,120m	£1,170m	£1,880m	£2,540m	£2,830m	£3,010m	£3,190m	£3,440m	**£14,770m**

Figure 8 - DHSC Impact Assessment estimate of costs of the means test and cap

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
Older Adults (65+) Means Test & Cap	£319m	£985m	£1,735m	£2,602m	£3,165m	£3,317m	£3,425m	£3,532m	£3,638m	**£17,074m**
Working Age Adults (18-64) Means Test & Cap	£170m	£380m	£460m	£520m	£540m	£560m	£570m	£590m	£690m	**£3,421m**
Total Means Test & Cap	£489m	£1,365m	£2,195m	£3,122m	£3,705m	£3,877m	£3,995m	£4,122m	£4,328m	**£20,495m**

Figure 9 - Upper scenario estimates of the costs of the means test and cap

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
Older Adults (65+) Means Test & Cap	£241m	£744m	£1,340m	£2,074m	£2,585m	£2,743m	£2,837m	£2,928m	£3,016m	**£13,885m**
Working Age Adults (18-64) Means Test & Cap	£170m	£380m	£460m	£520m	£540m	£560m	£570m	£590m	£690m	**£3,421m**
Total Means Test & Cap	£411m	£1,124m	£1,800m	£2,594m	£3,125m	£3,303m	£3,407m	£3,518m	£3,706m	**£17,306m**

Figure 10 - Lower scenario estimates of the costs of the means test and cap

The tables below provide a regional breakdown for both scenarios. Please note that these tables exclude working age adults, where the analysis has not been undertaken regionally.

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
North East	£9m	£27m	£47m	£71m	£86m	£91m	£93m	£96m	£99m	**£466m**
North West	£29m	£89m	£157m	£235m	£286m	£300m	£309m	£319m	£328m	**£1,542m**
Yorkshire & The Humber	£23m	£72m	£127m	£190m	£231m	£242m	£250m	£258m	£265m	**£1,246m**
East Midlands	£13m	£40m	£71m	£106m	£129m	£135m	£140m	£144m	£148m	**£696m**
West Midlands	£17m	£54m	£95m	£143m	£174m	£182m	£188m	£194m	£200m	**£937m**
East of England	£40m	£123m	£217m	£326m	£397m	£416m	£429m	£443m	£456m	**£2,140m**
London	£45m	£138m	£243m	£365m	£444m	£465m	£480m	£495m	£510m	**£2,393m**
South East	£96m	£295m	£520m	£780m	£949m	£995m	£1,027m	£1,059m	£1,091m	**£5,119m**
South West	£47m	£146m	£258m	£387m	£470m	£493m	£509m	£525m	£540m	**£2,536m**
Total	**£319m**	**£985m**	**£1,735m**	**£2,602m**	**£3,165m**	**£3,317m**	**£3,425m**	**£3,532m**	**£3,638m**	**£17,074m**

Figure 11 - Regional profile of the upper scenario financial impact of the means test and cap for older adults (regional analysis not carried out for working age adults)

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
North East	£7m	£23m	£41m	£64m	£80m	£85m	£88m	£91m	£93m	**£429m**
North West	£23m	£72m	£130m	£201m	£251m	£266m	£275m	£284m	£292m	**£1,346m**
Yorkshire & The Humber	£19m	£58m	£104m	£160m	£200m	£212m	£219m	£226m	£233m	**£1,074m**
East Midlands	£11m	£33m	£59m	£92m	£114m	£121m	£126m	£130m	£133m	**£614m**
West Midlands	£15m	£46m	£82m	£127m	£159m	£168m	£174m	£180m	£185m	**£853m**
East of England	£31m	£96m	£173m	£268m	£334m	£354m	£366m	£378m	£389m	**£1,793m**
London	£20m	£62m	£112m	£174m	£217m	£230m	£238m	£246m	£253m	**£1,165m**
South East	£76m	£235m	£424m	£656m	£818m	£867m	£897m	£926m	£954m	**£4,391m**
South West	£39m	£119m	£214m	£332m	£413m	£439m	£454m	£468m	£482m	**£2,221m**
Total	**£241m**	**£744m**	**£1,340m**	**£2,074m**	**£2,585m**	**£2,743m**	**£2,837m**	**£2,928m**	**£3,016m**	**£13,885m**

Figure 12 - Regional profile of the lower scenario financial impact of the means test and cap for older adults (regional analysis not carried out for working age adults)

Operational costs and workforce requirements

Methodology for analysing the impact on local authorities of managing additional demand for assessments

Analysis has been carried out of social work staff and financial assessment staff to understand the increase in workforce required to manage the additional demand for assessments. This analysis assumes the operating model does not change, and that the processes, systems, and ways of working continue as they do currently. To meet this demand, the operating model will need to change, and this is explored in Section 9.

There will be three primary sources of additional demand for local authorities:

1. The increased financial and needs assessments, care management, and brokerage responsibilities for those residents who will now receive local authority funding for their care (with up to £100,000 of assets).
2. The increased financial and needs assessment workload for those self-funders seeking to open a care account.
3. The increased financial and needs assessments, reviews, and brokerage workload for self-funders seeking to access care brokerage via section 18(3) of the Care Act.

There are three key assumptions that support this part of the analysis:

1. **100%** of people entitled to local authority funding (i.e., with wealth and assets below the £100,000 UCL) will come forward for financial and needs assessments and care management.
2. **80%** of self-funders will come forward for a financial and needs assessment to open a care account (aligned to the Impact Assessment assumptions).
3. **50%** of self-funders will come forward to access care brokerage (aligned to the assumptions used in the LaingBuisson report on the fair cost of care).

With these assumptions, the analysis finds that there will be, in total, almost 200,000 additional Care Act and financial assessments per year. This is summarised in Figure 13 and breaks down as follows:

- **88,000** additional Care Act assessments for those people with assets below the new UCL.
- **17,000** additional Care Act assessments for those people who will pay for their own care, but will meter towards the care cap.
- **93,000** additional financial assessments.

In addition, it is assumed that anyone who receives a Care Act assessment will also receive an annual review and, those with assets below the new UCL will have a requirement for ongoing care management.

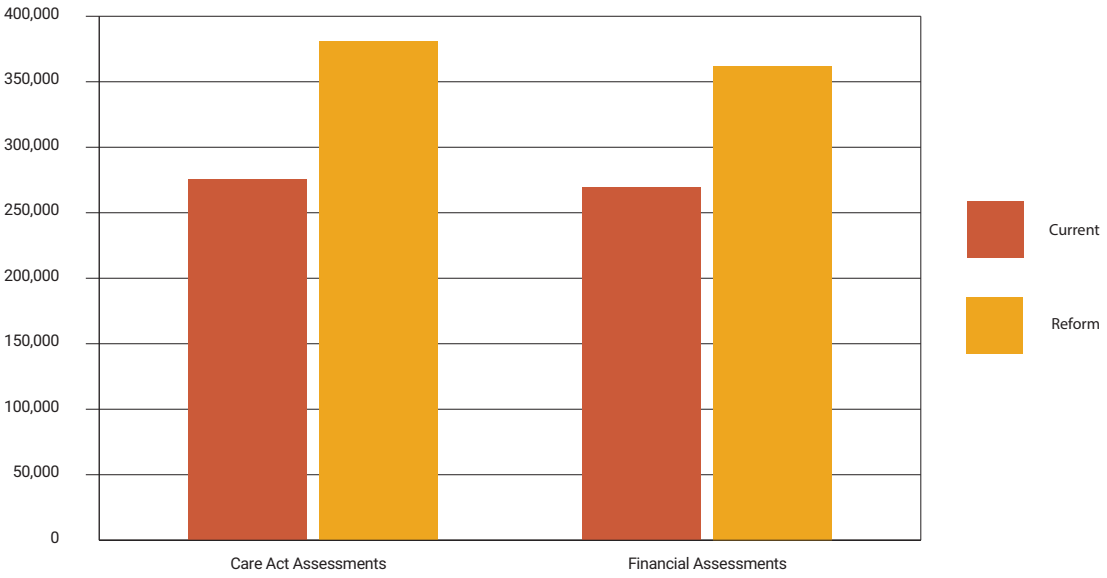

Figure 13 - The change in volume of assessments required

In order to estimate the additional workforce required, three steps have been taken:

1. The current workforce is scaled for the increased number of people under the UCL who will be receiving care management support.
2. The workforce to carry out the additional assessments and reviews for those people who pay for their own care has been calculated assuming a member of staff can carry out either 3.5 assessments per week or five reviews.
3. The workforce to carry out the financial assessments assumes a member of staff can carry out three financial assessments per week.

As a result:

- An additional **4,300** social work staff will be required.
    - This is from an existing workforce of **17,400**, which currently carries **1,782** vacancies.
    - This means the total increase required of social work staff is **6,082**, or **39%** more posts than are filled currently.
- An additional **700** financial assessment staff will be required.
    - This is from an existing workforce of approximately **2,700**, representing a **25%** increase.

Salaries of £38,500 for social work staff and £28,000 for financial assessment staff have been used, with a 30% allowance for 'all-up' salary costs. The operational costs are assumed to start from April 2023 to manage additional demand.

Based on the above methodology and assumptions, Figure 15 below shows the results of the programme's analysis for the operational costs compared to the estimate contained within the DHSC Impact Assessment (Figure 14). Figure 16 provides a regional breakdown of the analysis.

Inflation has been included at 3% per annum on all costs. All cumulative totals have been discounted at 3.5% per annum, as per the Impact Assessment, to 2020. Demand growth is not accounted for.

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
Operational Spend	£170m	£150m	£160m	£150m	£150m	£150m	£160m	£160m	£170m	**£1,109m**

Figure 14 - Operational costs as modelled by the DHSC impact assessment

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
Operational Spend	£241m	£248m	£256m	£263m	£271m	£279m	£288m	£296m	£305m	**£1,901m**

Figure 15 - Preparing for Reform analysis of the operational costs

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
North East	£6m	£6m	£6m	£7m	£7m	£7m	£7m	£7m	£8m	**£47m**
North West	£25m	£26m	£26m	£27m	£28m	£29m	£30m	£30m	£31m	**£195m**
Yorkshire & The Humber	£22m	£23m	£24m	£24m	£25m	£26m	£27m	£27m	£28m	**£176m**
East Midlands	£13m	£13m	£13m	£14m	£14m	£15m	£15m	£16m	£16m	**£100m**
West Midlands	£12m	£12m	£13m	£13m	£14m	£14m	£14m	£15m	£15m	**£95m**
East of England	£38m	£39m	£40m	£41m	£43m	£44m	£45m	£46m	£48m	**£298m**
London	£28m	£29m	£30m	£31m	£32m	£33m	£34m	£35m	£36m	**£224m**
South East	£68m	£71m	£73m	£75m	£77m	£79m	£82m	£84m	£87m	**£540m**
South West	£29m	£29m	£30m	£31m	£32m	£33m	£34m	£35m	£36m	**£225m**
Total	**£241m**	**£248m**	**£256m**	**£263m**	**£271m**	**£279m**	**£288m**	**£296m**	**£305m**	**£1,901m**

Figure 16 - Regional breakdown of operational costs

More significant than the financial analysis is the requirement to find large numbers of additional staff unless substantial changes to the operating model are made. This poses a major operational challenge, and opportunity, for local authorities. Figure 17 shows the summary of this analysis.

	No. Social Work Staff	No. Financial Assessors
North East	108	16
North West	448	65
Yorkshire & The Humber	398	67
East Midlands	221	45
West Midlands	214	38
East of England	684	97
London	538	39
South East	1186	250
South West	507	88
	4304	**705**

Figure 17 - the additional staff required, by region

Additional operational workload

In addition to the specific demands outlined above, it is anticipated there will be an increase in the number of queries and complaints received by local authorities. This is expected to, in part, be due to more people being supported by the local authority, but also the increased complexity of the funding system, with residents seeking to understand their progress towards their cap or seeking to challenge the local authority's decision regarding their eligibility.

Whilst this additional workload has not been specifically analysed through this programme, it was clear from engagement with residents that there is a low level of understanding of what the reforms will mean for individuals. Without being addressed, this will lead to significant additional demands.

Furthermore, there will be increased workload from activities such as administering care accounts, safeguarding, and invoicing. Again, this analysis only seeks to analyse the impact on the numbers of social work staff and financial assessment staff but recognises that there will be wider implications.

Fair cost of care and section 18(3)

Methodology for analysing the impact on local authorities of the fair cost of care and section 18(3) of the Care Act

To estimate the cost of the introduction of a fair cost of care and section 18(3) of the Care Act, this programme has incorporated the estimates carried out by LaingBuisson on behalf of the County Councils Network[21].

The estimate for the introduction of a fair cost of care has been taken at the 'mid-point' of LangBuisson's analysis, beginning in 2023/24.

When compared to the Impact Assessment, it is important to note that the LaingBuisson analysis only includes residential and nursing care and does not analyse the impact of the fair cost of care for domiciliary care. It also does not assume any cost for market management functions, nor cost estimates on the interaction of fair cost of care with charging reforms. As such, for the purposes of this analysis, these cost estimates have been removed from the DHSC Impact Assessment and only costs associated with fair cost of care introduction in residential and nursing care are included.

This analysis assumes full implementation for 2023/24. However, the guidance indicates 'moving towards' a fair cost, therefore some further phasing may be required.

Based on the above methodology and assumptions contained in LaingBuisson's analysis, Figure 19 below shows the results of the analysis for the fair cost of care compared to the estimate contained within the DHSC Impact Assessment in Figure 18. Figure 20 provides a regional breakdown of the analysis.

Inflation has been included at 3% per annum on all costs. All cumulative totals have been discounted at 3.5% per annum, as per the Impact Assessment, to 2020. Demand growth is not accounted for.

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
FCC Impact (Resi / Nursing only)	£378m	£390m	£403m	£417m	£430m	£445m	£460m	£477m	£494m	**£3,020m**

Figure 18 - The cost of the fair cost of care as per the DHSC Impact Assessment

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
FCC Spend (Resi / Nursing only)	£1,232m	£1,269m	£1,307m	£1,346m	£1,386m	£1,428m	£1,471m	£1,515m	£1,560m	**£9,714m**

Figure 19 - The cost of the fair cost of care as analysed by LaingBuisson

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
East Midlands	£102m	£105m	£108m	£111m	£114m	£118m	£121m	£125m	£129m	**£802m**
East of England	£149m	£153m	£158m	£163m	£168m	£173m	£178m	£183m	£189m	**£1,173m**
London	£74m	£77m	£79m	£81m	£84m	£86m	£89m	£91m	£94m	**£586m**
North East	£85m	£88m	£91m	£93m	£96m	£99m	£102m	£105m	£108m	**£673m**
North West	£295m	£304m	£313m	£322m	£332m	£342m	£352m	£363m	£374m	**£2,327m**
South East	£128m	£132m	£136m	£140m	£144m	£148m	£153m	£157m	£162m	**£1,010m**
South West	£65m	£67m	£69m	£71m	£73m	£75m	£77m	£80m	£82m	**£510m**
West Midlands	£173m	£178m	£184m	£189m	£195m	£201m	£207m	£213m	£219m	**£1,365m**
Yorkshire & The Humber	£161m	£166m	£171m	£176m	£181m	£187m	£192m	£198m	£204m	**£1,269m**
Total	**£1,232m**	**£1,269m**	**£1,307m**	**£1,346m**	**£1,386m**	**£1,428m**	**£1,471m**	**£1,515m**	**£1,561m**	**£9,714m**

Figure 20 - Regional analysis of the fair cost of care by LaingBuisson

Summary of findings

This programme has analysed and quantified each aspect of the charging reforms, and the financial impact for local authorities has been quantified and profiled over time. The analysis is summarised in Figure 21 and Figure 22.

Inflation has been included at 3% per annum on all costs. All cumulative totals have been discounted at 3.5% per annum, as per the Impact Assessment, to 2020. Demand growth is not accounted for.

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
Older Adults (65+) Means Test & Cap	£319m	£985m	£1,735m	£2,602m	£3,165m	£3,317m	£3,425m	£3,532m	£3,638m	**£17,074m**
Working Age Adults (18 - 65) Means Test & Cap	£170m	£380m	£460m	£520m	£540m	£560m	£570m	£590m	£690m	**£3,421m**
Total Means Test & Cap	£489m	£1,365m	£2,195m	£3,122m	£3,705m	£3,877m	£3,995m	£4,122m	£4,328m	**£20,495m**
Operational Spend	£241m	£248m	£256m	£263m	£271m	£279m	£288m	£296m	£305m	**£1,901m**
FCC Spend (Residential & Nursing)	£1,232m	£1,269m	£1,307m	£1,346m	£1,386m	£1,428m	£1,471m	£1,515m	£1,560m	**£9,714m**
Total	**£1,962m**	**£2,882m**	**£3,758m**	**£4,732m**	**£5,363m**	**£5,584m**	**£5,754m**	**£5,933m**	**£6,194m**	**£32,110m**

Figure 21 - Upper scenario for the total financial impact of charging reforms

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
Older Adults (65+) Means Test & Cap	£241m	£744m	£1,340m	£2,074m	£2,585m	£2,743m	£2,837m	£2,928m	£3,016m	**£13,885m**
Working Age Adults (18 - 65) Means Test & Cap	£170m	£380m	£460m	£520m	£540m	£560m	£570m	£590m	£690m	**£3,421m**
Total Means Test & Cap	£411m	£1,124m	£1,800m	£2,594m	£3,125m	£3,303m	£3,407m	£3,518m	£3,706m	**£17,306m**
Operational Spend	£241m	£248m	£256m	£263m	£271m	£279m	£288m	£296m	£305m	**£1,901m**
FCC Spend (Residential & Nursing)	£1,232m	£1,269m	£1,307m	£1,346m	£1,386m	£1,428m	£1,471m	£1,515m	£1,560m	**£9,714m**
Total	**£1,884m**	**£2,641m**	**£3,363m**	**£4,204m**	**£4,783m**	**£5,010m**	**£5,166m**	**£5,330m**	**£5,572m**	**£28,922m**

Figure 22 - Lower scenario for the total financial impact of charging reforms

Both scenarios show a significant difference to the Government's Impact Assessment. The comparable elements of this are summarised in Figure 23 below.

	2023 - 2024	2024 - 2025	2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030	2030 - 2031	2031 - 2032	**Cumulative Total** Discounted to 2020 at 3.5% per year
Older Adults (65+) Means Test & Cap	£240m	£740m	£710m	£1,360m	£2,000m	£2,270m	£2,440m	£2,600m	£2,750m	**£11,360m**
Working Age Adults (18 - 65) Means Test & Cap	£170m	£380m	£450m	£510m	£530m	£549m	£559m	£579m	£678m	**£3,410m**
Total Means Test & Cap	£410m	£1,120m	£1,170m	£1,880m	£2,540m	£2,830m	£3,010m	£3,190m	£3,440m	**£14,770m**
Operational Spend	£170m	£150m	£170m	£160m	£160m	£161m	£171m	£171m	£182m	**£1,165m**
FCC Spend (Residential & Nursing)	£378m	£390m	£403m	£417m	£430m	£445m	£460m	£477m	£494m	**£3,020m**
Total	**£958m**	**£1,660m**	**£1,743m**	**£2,457m**	**£3,130m**	**£3,436m**	**£3,641m**	**£3,838m**	**£4,116m**	**£18,956m**

Figure 23 - Total financial impact of charging reforms from DHSC Impact Assessment

Key differences from the DHSC Impact Assessment

The analysis from this programme suggests a greater financial impact than the Government's Impact Assessment over the 10-year period (**£29bn-£32bn** vs. **£19bn**). In order to properly fund these reforms, social care will require approximately **50%** of the Health and Social Care National Insurance Levy (**£5.6bn** - **£6.2bn** per year by 2031/32 of a total levy of **£12bn**).

There are four main differences between this analysis and the Government's Impact Assessment:

- In the upper scenario, the older adults means test and cap analysis suggests a more significant total cost.
- The proposed phasing of this cost suggests it will be recognised earlier.
- The fair cost of care analysis suggests a higher cost to local authorities.
- The operational analysis suggests a greater workforce requirement and associated cost.

Whilst the total proportion of individuals above and below the £23,250 LCL are very similar, one of the key drivers of difference between the two sets of analysis is that this programme estimates a more significant proportion of individuals will fall between the LCL and the UCL. In turn, this leads to an increased cost of the means test component compared to the DHSC Impact Assessment, and a reduced cost of the cap. This also drives cost being recognised sooner, with the means test having a financial impact from day one, whereas the cost of the cap will take a number of years to be realised. For comparison, the DHSC Impact Assessment estimates **17%** of the total older adult care population has chargeable wealth between the LCL and UCL, whereas this analysis estimates **25%** to **28%** fall in this bracket.

The treatment of the housing disregard, detailed earlier in this section, is one of the key factors driving this. This analysis assumes that the value of an individual's house is disregarded, on average, **91%** of the time with regional variation accounted for. As explored earlier in this section, a lower scenario has been modelled, using data from the *English Longitudinal Study of Ageing and the Census*. This indicates an individual's house is disregarded **87%** of the time, rather than **91%**.

DHSC have been engaged as part of this programme and there have been open and constructive discussions between the Department and the programme team. This report recognises that this programme's analysis will always be an estimate, and as such, welcomes the opportunity to continue to collaborate with DHSC to share data and understanding. This will enable the analysis to be continued to be refined and improved in order to provide the best possible resource for local authorities, and central government, when preparing for reform. This is demonstrated by presenting the two scenarios throughout this report and indicates the level of uncertainty in any modelling of this kind. The assumptions around housing disregard and asset distribution are key, and should be tested locally, wherever possible, to assist local systems with interpreting this analysis.

Regional analysis

There is very significant regional variation, primarily driven by the variation in population wealth and house values. As part of this programme, the impact of reform has been modelled at a per local authority level and is summarised regionally in Figure 24 and Figure 25 (excluding working age adults means test and cap, which was not analysed regionally).

	Lower Scenario			Upper Scenario								
	OA Means Test	OA Cap	Total	OA Means Test	OA Cap	Total	# Additional SWs	# Additional Means Test	Operational Spend	FCC	Lower Scenario Total	Upper Scenario Total
East Midlands	£472m	£143m	£614m	£641m	£102m	£743m	221	45	£100m	£802m	**£1,516m**	**£1,645m**
East of England	£1,405m	£388m	£1,793m	£1,989m	£280m	£2,269m	684	97	£298m	£1,173m	**£3,264m**	**£3,740m**
London	£911m	£254m	£1,165m	£1,268m	£179m	£1,448m	538	39	£224m	£586m	**£1,974m**	**£2,257m**
North East	£359m	£70m	£429m	£448m	£51m	£499m	108	16	£47m	£673m	**£1,149m**	**£1,219m**
North West	£1,088m	£258m	£1,346m	£1,459m	£186m	£1,645m	448	65	£195m	£2,327m	**£3,868m**	**£4,167m**
South East	£3,533m	£858m	£4,391m	£4,804m	£626m	£5,430m	1186	250	£540m	£1,010m	**£5,941m**	**£6,979m**
South West	£1,729m	£492m	£2,221m	£2,374m	£352m	£2,726m	507	88	£225m	£510m	**£2,956m**	**£3,462m**
West Midlands	£629m	£224m	£853m	£828m	£160m	£988m	214	38	£95m	£1,365m	**£2,313m**	**£2,448m**
Yorkshire & The Humber	£881m	£193m	£1,074m	£1,193m	£140m	£1,333m	398	67	£176m	£1,269m	**£2,520m**	**£2,779m**
	£11,005m	**£2,880m**	**£13,886m**	**£15,004m**	**£2,078m**	**£17,082m**	**4304**	**705**	**£1,901m**	**£9,714m**	**£25,501m**	**£28,697m**

Figure 24 - Impact of charging reforms by region – these are cumulative figures, discounted by 3.5% to 2020 and inflation adjusted by 3% year-on-year. Note these figures do not include the working age adults means test and cap, which was not analysed regionally

	Lower Scenario			Upper Scenario								
	OA Means Test	OA Cap	Total	OA Means Test	OA Cap	Total	# Additional SWs	# Additional Means Test	Operational Spend	FCC	Lower Scenario Total	Upper Scenario Total
CCN	£7,021m	£1,856m	£8,877m	£9,629m	£1,343m	£10,971m	2506	495	£1,131m	£4,338m	**£14,347m**	**£16,441m**
Met Borough	£1,262m	£317m	£1,579m	£1,665m	£227m	£1,892m	558	83	£244m	£3,043m	**£4,867m**	**£5,179m**
London	£911m	£254m	£1,165m	£1,268m	£179m	£1,448m	538	39	£224m	£586m	**£1,974m**	**£2,257m**
Non-CCN Unitary	£1,811m	£454m	£2,265m	£2,442m	£328m	£2,770m	702	88	£302m	£1,747m	**£4,314m**	**£4,819m**
	£11,005m	**£2,880m**	**£13,886m**	**£15,004m**	**£2,078m**	**£17,082m**	**4304**	**705**	**£1,901m**	**£9,714m**	**£25,501m**	**£28,697m**

Figure 25 - Impact of charging reforms by local authority type - these are cumulative figures, discounted by 3.5% to 2020 and inflation adjusted by 3% year-on-year. Note these figures do not include the working age adults means test and cap, which was not analysed regionally

Assuming that funding is provided according to the DHSC Impact Assessment, the potential funding that will be provided has been compared to this programme's estimated costs of the reforms by region and local authority type. This is shown in Figure 26, below. The distribution of resources is based on the only currently available formula, the adult social care relative needs formula (ASC RNF).

	Funding estimate from RNF (Cumulative, discounted)	Total Estimated Cost, Lower Scenario (Cumulative, discounted)	Total Estimated Cost, Upper Scenario (Cumulative, discounted)
East Midlands	£1,295m	£1,516m	£1,645m
East of England	£1,573m	£3,264m	£3,740m
London	£2,400m	£1,974m	£2,257m
North East	£893m	£1,149m	£1,219m
North West	£2,305m	£3,868m	£4,167m
South East	£2,163m	£5,941m	£6,979m
South West	£1,562m	£2,956m	£3,462m
West Midlands	£1,730m	£2,313m	£2,448m
Yorkshire & The Humber	£1,578m	£2,520m	£2,779m
	£15,550m	**£25,501m**	**£28,697m**

	Funding estimate from RNF (Cumulative, discounted)	Total Estimated Cost, Lower Scenario (Cumulative, discounted)	Total Estimated Cost, Upper Scenario (Cumulative, discounted)
CCN	£6,729m	£14,347m	£16,441m
Met Borough	£3,800m	£4,867m	£5,179m
London	£2,400m	£1,974m	£2,257m
Non-CCN Unitary	£2,571m	£4,314m	£4,819m
	£15,550m	**£25,501m**	**£28,697m**

Figure 26 - Comparison of potential funding and estimated cost, by region and by local authority type (excluding the working age adults means test and cap)

Given these findings, it is critical that not only is the right total funding made available for these reforms, but that it is appropriately regionally distributed. CCN councils, and those in the South East, East of England, the South West, the North West and Yorkshire and The Humber all appear to face a significant funding shortfall, if this is how funding is ultimately calculated and allocated. As outlined in Section 8, the Government will need to develop a new formula to distributing additional funding for the reforms, as previously proposed when similar reforms were intended to be enacted in 2015.

7. Implementation

Drawing on the wider stakeholder engagement conducted as part of the programme, the perspectives of different stakeholders on the implementation of charging reforms, and the challenges and opportunities it presents, are considered below.

Local authorities

Operational challenges

A survey was carried out for this programme amongst senior councillors and officers from CCN authorities with responsibility for implementation of the reforms. It provides important insights into their perceptions of the reforms, their readiness for implementation, and the challenges they see from a local authority perspective.

This survey indicated that there is widespread support for the principles underpinning different elements of charging reforms; **82%** of respondents are supportive of the cap on care costs; **89%** the extended means test; **87%** the introduction of a fair cost of care; and **69%** arranging care for self-funders under section 18(3) of the Care Act. However, local authorities are concerned about the vast scale of the financial and operational challenge posed by these reforms.

While understanding of the reforms is high at **87%** of respondents, only **25%** of these understood the reforms 'very well', with respondents describing a lack of available detail of policy and operational guidance as the reason. The introduction of a fair cost of care is perceived to have the biggest impact on local authorities, followed by arranging care for self-funders under section 18(3), the extension of the means test, and then the cap on care costs.

Respondents highlighted the following implementation challenges:

- The scale of the financial challenge, with **97%** very concerned about a lack of appropriate funding, with a further **3%** quite concerned.
- The workforce challenge, with **88%** very concerned about recruiting additional staff for care assessments, with a further **10%** quite concerned.
- Additional demand, with **80%** very concerned about the demand from self-funders for arranging care packages, with a further **18%** quite concerned.
- The implementation timescales, with **77%** very concerned about having enough time to properly implement the reforms, with a further **20%** quite concerned.
- The IT and technology requirements, with **59%** very concerned and a further **41%** concerned about this.
- A shortage of care placements, with **60%** of respondents very concerned and a further **38%** of respondents quite concerned about this.

As a result of these challenges, only **35%** of respondents said they were 'quite well prepared' for the reforms, with **63%** stating they were 'not well prepared'.

The financial and operational analysis carried out for this programme indicates that the impact is more substantial than the Government's initial Impact Assessment suggests. It will be challenging for local authorities to make more funding available for adult social care, especially of the order described here, and particularly given the apparent reticence to further increase Council Tax or to re-allocate existing budgets. Only **23%** respondents to the survey said they would be willing to allocate resources from other council budgets to support any unfunded costs arising from the reforms.

Perhaps more challenging than the financial costs are the operational implications, with this report estimating that up to **39%** more social work staff will be required to manage the additional workload. A report published by ADASS in May 2022 demonstrated that there are currently 506,131 people waiting for an adult social care assessment or review of any kind[22]. Whilst, in part, this is driven by local authorities' capacity to carry out these assessments (which will be further impacted by the increase in assessment volume through these reforms), this is also driven by an existing lack of capacity in the homecare market to begin packages of care.

Given the challenges currently facing the social care workforce, it is unlikely to be feasible to recruit the scale of additional workforce estimated in this analysis to carry out the additional assessments required, particularly in the short-term. It is clear that in approaching reform, central government, local government, and local partners will have to consider how the operating model for conducting assessments and managing caseloads fundamentally changes moving forward.

Positively, the local authorities engaged through this work were keen to explore the potential presented by these reforms, building on the opportunity to change the operating model and move to more effective and efficient practices. However, considering the aforementioned preparedness for the reforms, and concerns over IT and technical infrastructure amongst councils, it will be extremely challenging within current implementation timescales to capitalise on these opportunities. Some of the positive steps local systems could take are considered in Section 9.

Role of first-and-third party top-ups

The role of first- and third-party top-ups will become more significant as these reforms are implemented. The Fair Cost of Care Guidance requires that there must be the option to place a resident in a package, within the local authority, which could be procured at the fair cost of care appropriate to the resident's level of eligible need.

However, many residents will choose an alternative placement, which may bring extra cost. For example, they may choose to be supported in a specific home, or to receive support over and above that which they are considered eligible for by the local authority. In these cases, the difference will be made up by first- or third-party top-ups - whereby the person themselves, or someone on their behalf, funds the difference.

The ‘meter’ to the £86k cap will be based on the fair cost of care only, not the top-up. Once the cap is reached, the local authority will only pay the fair cost of care, with the difference paid by the resident or third-party via a top-up.

The same also applies where a resident is funding their own care and is paying above the fair cost but has been assessed by the local authority as per section 18(3) of the Care Act. This cohort are, in effect, also paying a top-up.

These situations pose a challenge for local authorities. Once the £86k cap is reached, if the resident is unable to continue to pay their top-up, the local authority will have to either:

- move the resident into a lower cost placement (at the fair cost of care), risking significant disruption for the individual; or
- pay the top-up amount.

Specifically, those who are choosing to pay for support over and above that which they are considered eligible for by the local authority represent a substantial risk. This cohort may choose to challenge the decision of the local authority if they believe they should receive a greater level of funding for a higher level of need.

This issue will be particularly acute when applied to those receiving support at the point of the reforms’ implementation. For example, individuals with more than £14k of assets who currently fund their own care will be in placements they have chosen for themselves. As such, local authorities will have to make a judgement on how they apply eligibility, the fair cost of care, and top-ups to this group.

Providers also raised a significant concern about the backdating of financial assessments to the date of the assessment request. In the case of there being a gap between the fair cost of care and the self-funder rate, providers are concerned about the financial risk to their businesses if the costs of care during this period are not covered by the local authority and subsequently challenged by the self-funder.

Larger providers engaged through this programme indicated that they are expecting to use top ups as the means by which to mitigate the financial impact of the fair cost of care. Positively, some providers note the opportunity presented, to provide a much clearer, tiered offer of support, where top-ups are used to enable residents to access differentiated levels of support and amenity.

Care providers

Engagement with small and medium sized care providers through this work revealed a lack of understanding of the potential impacts of charging reform, and how the local authorities they work with would be supporting implementation. None of the care providers engaged reported that they had received any detailed information about the reform from local authorities, with only limited information shared so far regarding the fair cost of care exercises. Likewise, **91%** of senior councillors and officers in CCN member councils surveyed reported feeling quite or very concerned over how to engage their providers to determine a fair cost of care. This is leading to concerns around trust and transparency, especially given the commercially sensitive information required to be shared. However, providers recognised that local authorities themselves do not yet have a complete picture, and that a significant amount of detail is still to be worked out.

Larger providers engaged with through this programme appeared to have a more detailed understanding of the reforms and their potential impact. However, they also shared significant concerns about the implementation process. In particular, they highlighted the potential cost and complexity for them if different models are used by local authorities for the fair cost of care exercises and called for consistency nationally wherever possible.

There is substantial apprehension amongst providers about the fair cost of care exercise. Whilst the principle is welcomed, there is a widespread concern that, given the low levels of engagement so far, providers will not have sufficient opportunity to contribute and therefore the result will be inadequate. There is also some confusion around how this differs from previous exercises, and even how this differs from discussions around annual uplifts.

Providers recognise that implementing section 18(3) of the Care Act, enabling self-funders to access local authority rates, poses a significant threat to their income and will risk them remaining viable businesses, unless an adequate fair cost of care is in place.

The approach outlined so far by Government refers to 'moving incrementally towards a fair cost of care' which suggests that local authorities will be able to pay below this rate initially. However, section 18(3) of the Care Act will be implemented immediately, which will lead to a further funding gap in the medium-term if councils are to compensate providers for the revenue losses experienced as a result of section 18(3). These revenue losses were estimated at **£560m** annually by LaingBuisson, if councils only pay a fee-uplift in line with current funding allocations for this policy.

Workforce continues to be a major challenge for care providers, as well as local authorities. The turnover rate is approximately **30%**[23] and a study by business analysts for Radio 4's You and Yours programme found **715** of the **2,731** home care operators in the UK are in danger of closure[24]. If properly funded, these reforms provide an opportunity to support provider viability, by enabling providers to fully reward and retain their staff. However, without this, and with any further financial pressure placed on providers, there is a risk that capacity will reduce, and the necessary level of care and support will simply not be available in the market.

In light of these concerns, and in addition to the discussions held with various providers, a small sample of seven providers were surveyed to understand concerns around the viability of their business in the context of these reforms. Some **71%** reported that they are considering moving to an alternative business model or into an alternative market, and **100%** reported that they have concerns about their long-term financial sustainability because of the reforms.

This financial risk to local providers is something that CCN councils are acutely aware of; some **65%** of senior councillors and officers were very concerned, and a further **35%** quite concerned, over the sustainability of local providers as a result of the reforms.

Residents

Two of the objectives of these reforms are to provide greater financial security for people who require care in their lifetime and to limit the personal financial contribution an individual has to make towards their care. In their current form, the reforms will significantly reduce the personal contribution an individual has to make towards their care, mostly driven by the more generous means test.

However, individuals with lived experience, their families, and carers (hereafter referred to as residents) who were engaged through this work programme, shared how complex they already find accessing the right support, and understanding how this should be funded. In addition to the discussions held, a small sample of 18 residents were asked in a survey how well they understand the current social care funding system, with some **50%** responding 'not well'.

There was widespread concern that this will only be made more challenging with charging reform. The same group of residents was asked how well they understand the changes to social care funding and **72%** responded 'not well'. This lack of understanding of the reforms amongst residents was recognised by the senior councillors and officers surveyed; some **54%** said they were 'very concerned' and further **46%** 'quite concerned' that residents will not understand the changes.

The main point of confusion is how the £86k cap will be applied, and the understanding (or lack thereof) that only 'eligible care costs' will be counted. Residents raised concerns that the current communication is unclear, since it implies that an individual will not pay more than £86k for their care, which is not the case. This lack of understanding also gives rise to the concern about whether the reforms will be perceived as being fair. Some **36%** of the senior councillors and officers surveyed said they were 'very concerned' that residents will think the changes were unfair, with a further **54%** 'quite concerned'.

If not made clearer, it is anticipated that this will result in a significant increase in the number of complaints received by local authorities, as well as anxiety and confusion for individuals, negating some of the positive impact of these reforms in reducing personal contributions to care costs. Linked to this, residents suggested that as the reforms will give individuals more control over the funding of their care through the new care account, some older people may find this addition quite stressful.

Residents are also very aware of the existing delays in carrying out assessments and the long waiting lists. They are therefore concerned whether local authorities will be able to recruit enough staff to support the increase in demand resulting from the reforms. In particular, residents raised concerns about the potential for delayed hospital discharges if more people are waiting for a local authority assessment.

Finally, residents are worried that this increased pressure on staff's time will result in a more 'tick box' approach to assessments, reducing the quality of service.

What remains unclear (and needs to be a key focus of further work) is the proportion of residents expected to 'take up' the option of the local authority assessing and arranging their care. Based on the survey conducted, and the residents engaged directly, there was approximately a 50:50 split in responses from self-funders. However, one agency engaged through this work commented that they would be encouraging all self-funders to take up section 18(3). For the purposes of this analysis, it is assumed that **80%** of self-funders will come forward for an assessment to open a care account, aligned to the Impact Assessment, and that **50%** of people will use section 18(3) of the Care Act to request that their care be brokered by the local authority, however, this warrants further analysis.

NHS, including continuing healthcare and free nursing care

The care provider market does not only serve local authorities; it also serves the NHS by providing services funded through continuing healthcare (CHC) and free nursing care. Many care providers simultaneously provide services to both local authorities and the NHS.

The NHS is exempt from section 18(3) of the Care Act, which means it does not have to ask the local authority to arrange Continuing Healthcare on its behalf. This will mean there is potential for further cross-subsidisation, with the CHC rates being driven up by providers seeking to preserve their income. In turn, this may make it more challenging for the local authority to procure care at the fair cost, as well as incurring additional cost to the NHS. This is reflected in the survey carried out of CCN member councils, with **98%** of respondents 'quite concerned' or 'very concerned' about the availability of placements for local authorities.

Engagement with Directors of Adult Social Care through this programme suggests that NHS partners are focused on the significant reforms facing the health service, and that they may not yet have fully understood the potential implications for them of the social care reforms. A particular area of concern is the interaction between this reform and the NHS policy on discharge pathways and funding. Despite the national funding ending in March 2022, local authorities typically are still required to meet the cost of discharge pathway requirements. It is currently unclear how this is funded for people who pay for their own care, and this will be further complicated by these reforms, with what is considered eligible care and as such what will count towards an individual's personal care account. Operationally, these reforms also have the potential to risk delays to discharge whilst additional Care Act and financial assessments are carried out.

8. Recommendations for central policy makers

There has been a widespread view that along with the need to mitigate the potential operational and financial risks associated with the reforms, there is a clear opportunity to view them as a catalyst for further innovation across social care.

However, the evidence from this programme suggests that local authorities require appropriate support from Government for this opportunity to be realised, and for implementation to be successful. Several recommendations to Government are therefore made below, and in Section 9 recommendations are also made for local systems as to how they might best manage implementation.

1 To urgently invest in a national recruitment and workforce development strategy for local authorities and care providers

The analysis conducted for this report has indicated that nationally:

- **4,300** additional people will be required to carry out needs assessments, requiring a **39%** increase in current staffing levels to be fully staffed.
- **700** additional people will be required to carry out means tests (a **25%** increase on the number of posts currently filled).

This requirement comes against a backdrop of current vacancy rates of **7%** and current agency rates also of **7%**[25]. The analysis conducted for this programme suggests that the salaries for these additional staff would cost an additional **£241m** per annum, with further cost and effort required to drive recruitment.

Further to the local authority workforce, recruiting and retaining the right care provider workforce remains a significant challenge, as detailed in Section 4. Without urgent action, capacity in the care market will continue to be a major issue facing local authorities, limiting the choice of residents and the potential positive impact of these reforms. In May 2022, ADASS reported that almost **170,000** hours a week of home care could not be delivered because of a shortage of care workers[26].

A recruitment and workforce development campaign delivered at a national level would help gain greater profile and attract more candidates, similar to national teacher recruitment campaigns already run by the Government. This would also be more cost-effective than individual local authorities running their own campaigns. It would need to include a plan to ensure all staff are properly rewarded and retained, develop attractive terms and conditions, provide parity with other, competing employment (such as with the NHS), and have clear career progression and professional development routes.

However, even with such a national campaign in place, the greatest concern is the practical challenge of recruiting and retaining this quantum of additional workforce. The survey carried out for this programme amongst senior councillors and officers with responsibility for implementation of the reforms showed that **88%** were 'very concerned' about recruiting additional staff for care cap assessments.

To help to mitigate this risk, local authorities require support to look beyond the traditional social care workforce. A social work assistant qualification should be rapidly developed, to increase the pool of workforce who can complete assessments and reviews. This would need to be developed as an attractive career path into social care, but with a comparatively short period of qualification to help to provide the workforce in a timely way.

2 To fully fund the increase in cost of these reforms to local authorities

In order to properly fund these reforms, this programme estimates that social care will require approximately **50%** of the Health and Social Care National Insurance Levy (**£5.6bn - £6.2bn** per year by 2031/32 of a total levy of **£12bn**). So far, **£3.6bn** of funding has been committed, equating to **£1.2bn** per year over three years.

Given the wider demands facing local government referenced in Section 4 (such as the SEND green paper), other areas of local authorities' budgets are already facing significant pressure and there is expected to be minimal scope for further reductions elsewhere.

Local authorities engaged through this work reported reticence from councillors to dedicate a greater proportion of the local authority's budget to social care (which already sits at **33%**[27]), given the comparatively small proportion of the population impacted. This is supported by findings from the survey conducted with CCN council Lead Members about their appetite for funding the additional cost of social care from other areas of their budget, with only **23%** of respondents reporting they would be willing to allocate resources from other council budgets to support any unfunded costs arising from the reforms.

This difference will need to be addressed to provide local authorities with adequate funding to successfully implement the charging reforms and ensure that they do not result in authorities being unable to set balanced budgets.

3 To phase the implementation of the components of reform, allowing local authorities, providers, and residents the necessary time to prepare, mitigating the risks and fully capitalising on the opportunities for innovation

There has been overwhelming agreement that it will be very challenging to implement reform in line with current timescales, in a way which enables local systems to realise the opportunities of reform, as well as mitigate the risks. This is exacerbated by the context within which the reforms are being implemented, including the post-Covid workforce and market recovery, and the introduction of the new quality assurance framework. This results in **63%** of CCN members surveyed saying they are 'not well prepared' for reform.

The evidence gathered through this programme suggests that local authorities will need an extended window of time to successfully embed these reforms. This will ensure that local authorities have time to transform, to both mitigate the potential financial and operational risks associated with the reforms, and to capitalise on the opportunities for innovation that they bring.

This will also allow sufficient time for central government to put in place the necessary support mechanisms to ensure successful implementation. By doing so, the reforms are more likely to be implemented in a way that will make best use of available resources, and as smoothly as possible for local authorities, providers, and residents alike.

Importantly, it will also allow time for learning to be gathered from the Trailblazer sites, to the benefit of all local authorities and providers. A clear structure can be put in place around the Trailblazers to formalise and share learning and best practice. This could take the form of a cross-authority working group, in addition to regular communications and close connections with key organisations such as ADASS, LGA, and CCN.

Further to this, the timing of introducing and funding the fair cost of care must be in step, or ahead of, the implementation of section 18(3) of the Care Act. Without this, a substantial medium-term funding gap will be created for providers, risking their viability.

The survey carried out for this programme amongst senior councillors and officers with responsibility for implementation of the reforms showed support for a phased implementation beyond October 2023. The detail of this is shown in Figure 27. Some **69%** of respondents supported delaying the implementation of the cap on care costs; **67%** supported a delay to the introduction of the extended means test and fair cost of care; while **90%** of respondents supported a delay to arranging care for self-funders under section 18(3) of the Care Act.

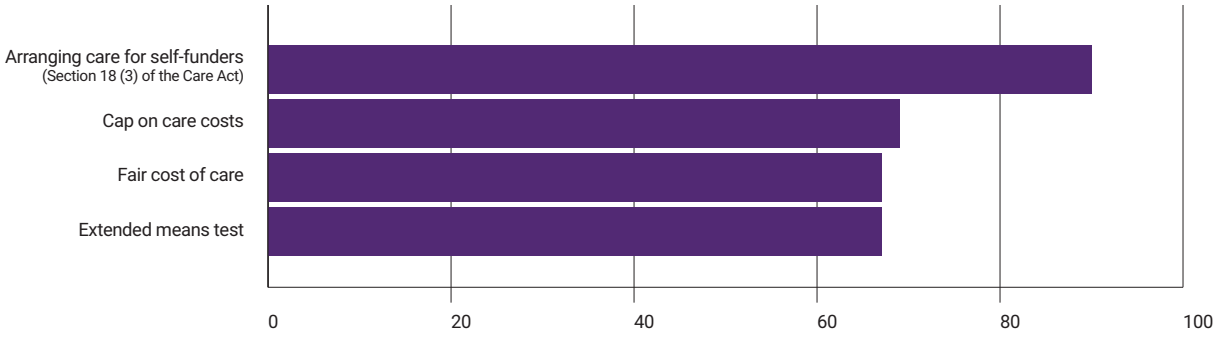

Figure 27 - Support for delaying implementation of aspects of reform from CCN members survey

Acknowledging the quantity of change the sector is currently working through, one approach would be to consider three distinct phases:

1. **Recover** from Covid-19.
2. **Reform**, including charging reform, assurance, Liberty Protection Safeguarding, and the integration white paper.
3. **Transform**, both to enable reform and to enable new models of care.

The timeframes and relative priority of each phase need to be taken into account in a single, joined up plan for social care. Criteria can be defined for when a phase is complete, with a gate review to progress to the next phase which has requirements for both central government and local authorities. In this way, the goal of reforming and transforming social care can be achieved in a controlled way. This is summarised in Figure 28.

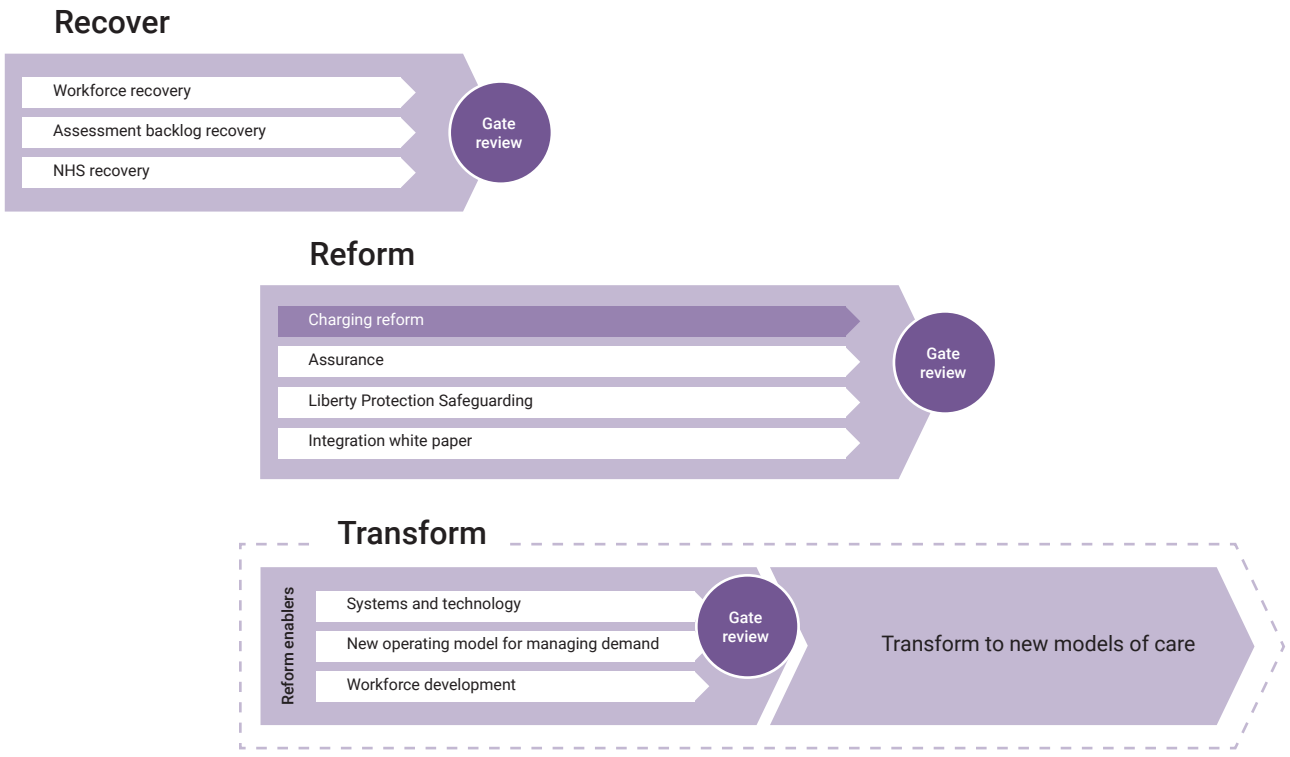

Figure 28 - An indication of how social care recovery, reform, and transformation could be phased

4 To provide additional implementation support and funding, to ensure local authorities have the right project and change management capacity and capability

The scale of change encompassed by these reforms demands substantial project and change capacity from local authorities, which is reported as being in short supply, given the changes already being implemented.

Building on the concept of the Trailblazers, there is an opportunity for the Government to develop a structured approach to supporting all local authorities through implementation, including ensuring there is sufficient resource, data, and funding made available. Providing a small number of authorities with significant additional support to work through the detail of implementation, developing much more detailed operational guidance as they go, would provide a valuable resource for all authorities. This guidance could then be shared in a structured way, including by having those who have been involved in implementation with these authorities working more widely across the sector.

As part of this, a resource and funding model could be developed for implementation. As a starting point, the workstreams highlighted in Figure 29 will all need to be considered locally, with resource and funding allocated to each.

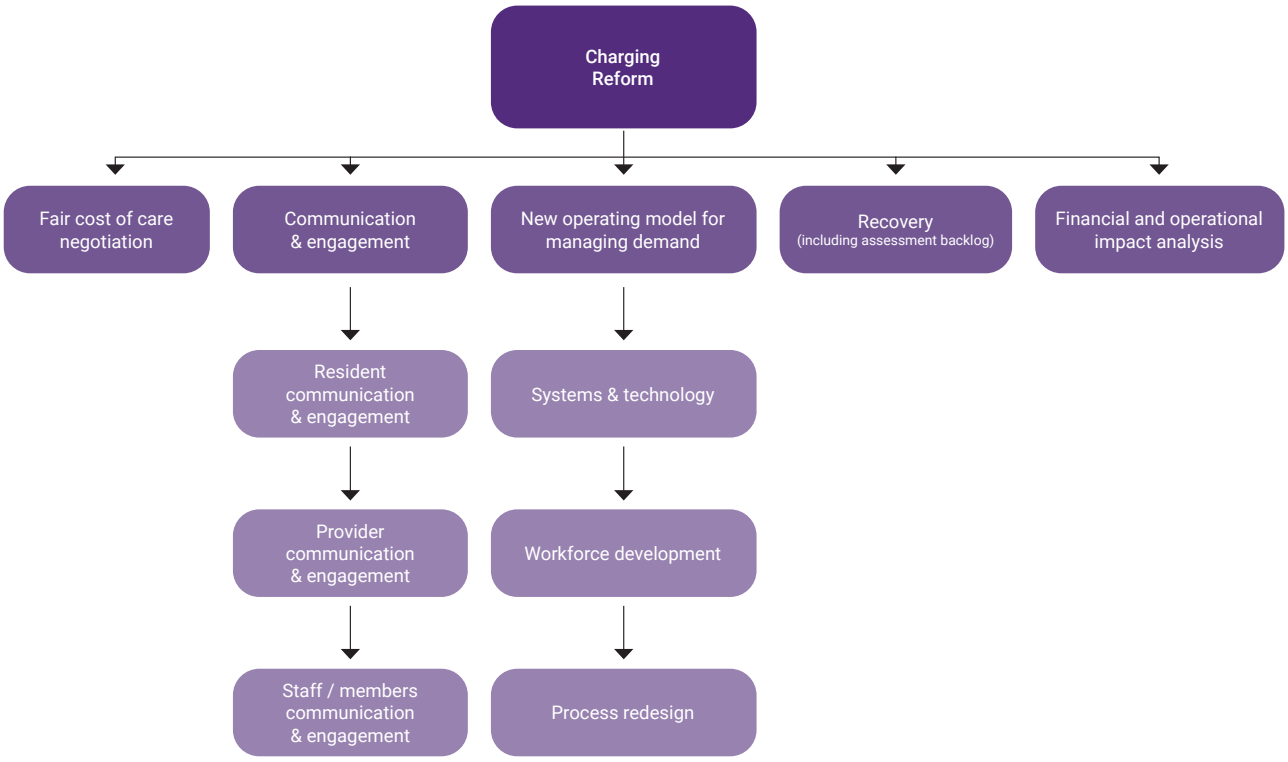

Figure 29 - A potential outline workstream structure

Care providers engaged through this programme have highlighted the importance of having a dedicated cross-council project team with whom they can effectively engage (comprising social workers and finance leads) responsible for overseeing the implementation of these changes. However, at present, many authorities involved have indicated that they lack the available capacity to manage the implementation of the reforms in this way.

5 To support local authorities to address the shortage in capacity of community support

The increasing backlog in social care poses a significant risk to residents, resulting in unmet need, whilst also having an impact on the wider system, for example affecting length of stay in hospital. A shortage of capacity in the community is one cause of this backlog. This is resulting in increased use of residential and nursing care, whereas there may have been an opportunity to better support the individual in the community. In May 2022, ADASS reported that almost **170,000** hours a week of home care could not be delivered because of a shortage of care workers[28]. To tackle this issue, a strategy for increasing community care capacity and sustainability is needed. This could include areas such as:

- Lowering the barriers for providers to build more extra care housing and supported living schemes.
- Ensuring domiciliary care is fully included when funding the fair cost of care, enabling care providers to pay a sustainable wage.
- Developing a workforce strategy, which supports providers to fairly reward and retain staff.

6 To carry out, in full, the recommendations from the *Future of Adult Social Care* report, to support local authorities to optimise delivery and partially mitigate the increase in cost

The LGA estimates that by 2025 there will be a **£3.6bn** shortfall in funding for adult social care, before the increase in cost described in this report[29]. The *Future of Adult Social Care* report published by CCN and Newton estimated that delivering its full optimised model for adult social care would help mitigate the existing rising costs and funding gap by **£1.6 billion** per annum[30]. This opportunity now becomes even more valuable, and an important step to partially offset the rising costs of delivering adult social care.

The recommendations of that report, which require significant support from Government, should be swiftly implemented to capitalise upon this opportunity.

7 To ensure funding is made available in line with need at a local level

The analysis conducted through this programme has been developed at a postcode level, enabling summaries to be provided per local authority, per region, and per local authority type. This has demonstrated the local variation in the impact of these reforms, as a result of the varying levels of wealth and house values across the country.

It is essential that the funding is allocated in a way which reflects the varying impacts, to ensure that each area is adequately resourced to implement the reforms. This is illustrated in Figure 26, earlier in this report, which provides a basis for funding allocations to be considered.

8 To fully account for the wider costs of these reforms, most notably the Continuing Healthcare cost to the NHS

Despite the social care reforms not yet being a high priority for many parts of the NHS (given the other challenges they are facing), this programme has shown that the fair cost of care reforms are likely to have a knock-on effect elsewhere in local systems, in particular on Continuing Healthcare costs to the NHS. Likewise, with the NHS exempt from section 18(3) of the Care Act, Continuing Healthcare may have a significant impact on the availability of care placements for local authorities.

There is a concern amongst some engaged through this programme that the goal of removing cross-subsidies may be unintentionally undermined should NHS-commissioned placements be costed separately to placements brokered by the local authority.

It is recommended that these wider costs be fully accounted for by Government so that these costs can be appropriately funded, and a solution developed.

Further work is also required to provide clarity on the interaction of these reforms with the NHS policy on discharge pathways and funding. Despite the national funding ending in March 2022, local authorities are still typically required to meet the cost of discharge pathway requirements. It is currently unclear how this is funded for people who pay for their own care, and this will be further complicated by these reforms, raising questions about what is considered 'eligible' care and as such what will count towards an individual's personal care account. Operationally, these reforms also have the potential to risk delays to discharge whilst additional Care Act and financial assessments are carried out.

9 Provide clear guidance for how those currently in receipt of services will transition into the new system, including how means testing and top-ups should be applied

Through this programme it has been evident that there are many questions still to be answered about how those currently in receipt of social care services will transition into the new system. This is making it difficult for local authorities and providers alike to plan for the impact of the reforms for this cohort. It is also likely to be causing anxiety for those residents who may be concerned about whether they will be able to stay in their existing placement and any potential financial impact.

It is recommended that clear guidance be issued immediately by Government regarding the way in which residents currently in receipt of services will transition into the new system. This guidance will need to include the way in which the new means testing arrangements should be applied, as well as how first and third-party top ups will operate.

10 Develop a clear communications and engagement plan for residents, supporting them to understand the impact of reforms, including how much cost they will be liable for

Although there are clear financial benefits to residents resulting from these reforms, engagement with residents through this programme has also highlighted concerns. Those engaged from local authorities and care providers also expressed a concern that there is widespread misunderstanding about the scope and impact of the reforms, and as a result, they are expecting a substantial level of complaints when the actual impact of the changes becomes clear.

To mitigate this risk, it is recommended that a national communications and engagement plan be developed and implemented, potentially building on the successful public health campaigns carried out during the pandemic, to raise awareness of the reforms and their impact.

It is important that these communications with residents be sufficiently detailed to ensure that they understand the nuances of the reforms, such as the eligible care needs that count towards the cap, to avoid misunderstandings when the reforms come into effect.

It is also important that the national communications show residents where they can go to estimate their own likely care costs, including daily living costs, so that they can plan their care and their finances accordingly.

9. Recommendations for local systems

The analysis conducted through this report indicates there is likely to be significant financial and operational pressure faced by all local systems in implementing charging reforms. Building on the support required from central government detailed in the previous section, there are a number of positive steps that some local systems are already taking, and will need to continue to take, to both mitigate the risks brought about by these reforms and to capitalise on some of the opportunities. There will need to be renewed imperative for local systems, with local authorities at the heart, to 'go again' with transformation, recognising that most have been constantly 'transforming' throughout recent memory.

This transformation will take time to be fully implemented. Staff will need to be recruited; digital tools developed; and systems, processes, and culture will need to be changed and adapted in order to make implementation a success. Local systems need to be afforded the time to do this well, along with the right implementation support. This includes both funding and resource support, recognising the backdrop of extensive existing pressures, as explored in Section 4.

Recognising the need for the full support of Government, based on the evidence gathered through this programme, the following recommendations are made for local systems:

1 Develop a comprehensive communication and engagement plan for residents, in partnership with Government

To address the concerns raised by residents who were engaged in this work, clear and consistent communication needs to be designed and delivered by central and local government in partnership. It is important that this sets clear expectations for residents in terms of how the new means test and cap will work, to minimise confusion leading to queries and complaints. It should spell out what will be considered as eligible care costs, and the role of first- and third-party top-ups (discussed in Section 7).

Beyond communication and engagement, residents will need enhanced support to navigate the system, both now and in the future. This will require work at a local, regional, and national level, including the provision of improved information, advice, and guidance as acknowledged in the *Build Back Better* white paper.

2 Continue to promote independence and maximise effective and appropriate use of community support

Many local authorities have been working to promote independence and maximise the effective use of community support for decades. Despite this, opportunities still exist to support more people to live independently at home and avoid or delay the need for more dependent levels of care. Not only is this the right thing to do for the resident, but with the cost of care increasing to the local authority under a reformed system, there is an even stronger financial imperative than ever before to manage demand.

60,000 older adults move into a publicly funded care home each year for long-term care, with 1 in 3 coming from hospital, and the rest from the community. Evidence from the *Future of Adult Social Care* report indicated that up to half of these people could have been supported in a more independent setting, for example in their own home with rehabilitation[31].

The new system may serve to incentivise residents to contact the local authority who otherwise may not have done so, or who may have done so later. There is a risk that this may draw more people in to the social care system, increasing the number of people moving into more dependent settings or settings that provide higher levels of support than they really need. However, if this initial contact can be positioned as an 'opportunity for prevention' rather than a request for an assessment, both within the local authority and with the public, this may be able to improve prevention and help to promote independence.

This could be achieved through creating the right environment to support practitioners to make the best decisions; health and social care front door pathways that are designed to prevent need escalating; and effective strategic commissioning. The latter would ensure people's needs are met with the right services with the right capacity, including more creative solutions such as supported accommodation and extra care.

Reablement is a key part of this solution; for every £1 spent reabling someone, **£7** is saved, on average, in ongoing care costs[32]. This is dependent on how effective services are at achieving the maximum levels of independence for all those who use them and there is significant variation today between services, with the most effective service adding five times the value as the least. Were effectiveness increased nationally, up to **90,000** more people could benefit from reablement each year, equivalent to a **40%** increase.

This can also be achieved by looking further 'upstream', taking a Population Health Management approach to identify groups of people who are likely to require social care support, and working with them proactively.

Case study

One county council is using data to learn more about their population and identify how to tailor different community support and preventative services to avoid their need escalating. Having segmented their population into 59 groups, they have carried out analysis to better understand which groups are most likely to contact social care services.

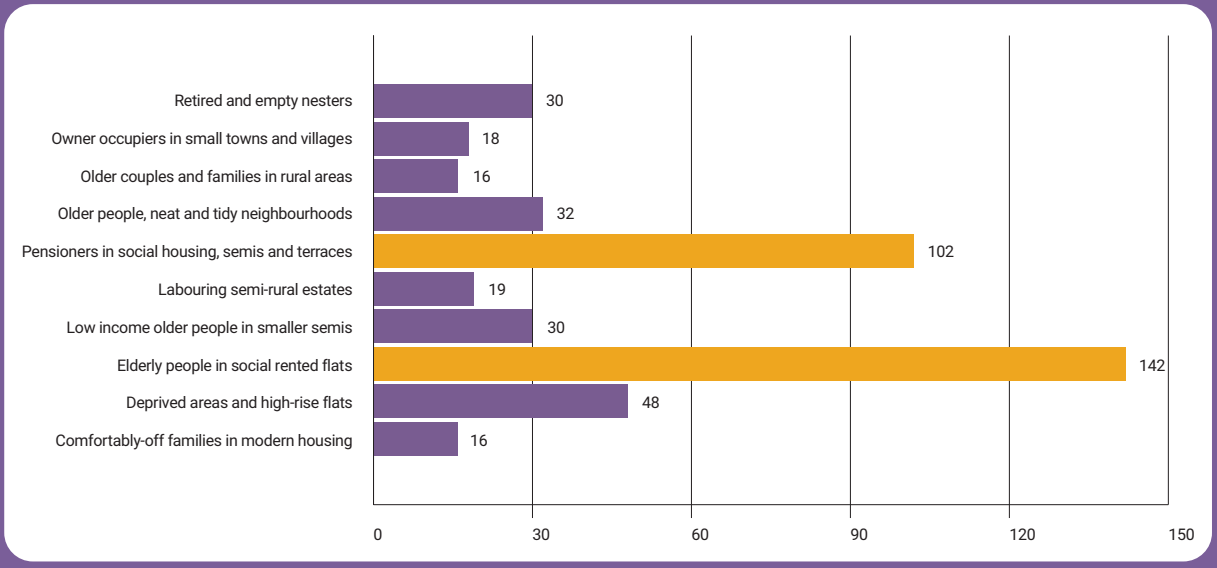

Figure 30 - Analysis of the population groups making most contact with social care

As shown in Figure 30, this analysis demonstrated that elderly people in social rented flats and pensioners in social housing are making the most contact with social care.

With this understanding, the analysis explored the characteristics of each group (an example is shown in Figure 31), and the regional spread of contact. As shown in Figure 32 for the 'pensioners in social housing' cohort, more individuals were getting in contact from the Eastern region. Work is now underway to ensure preventative community support is further developed in the east of the County.

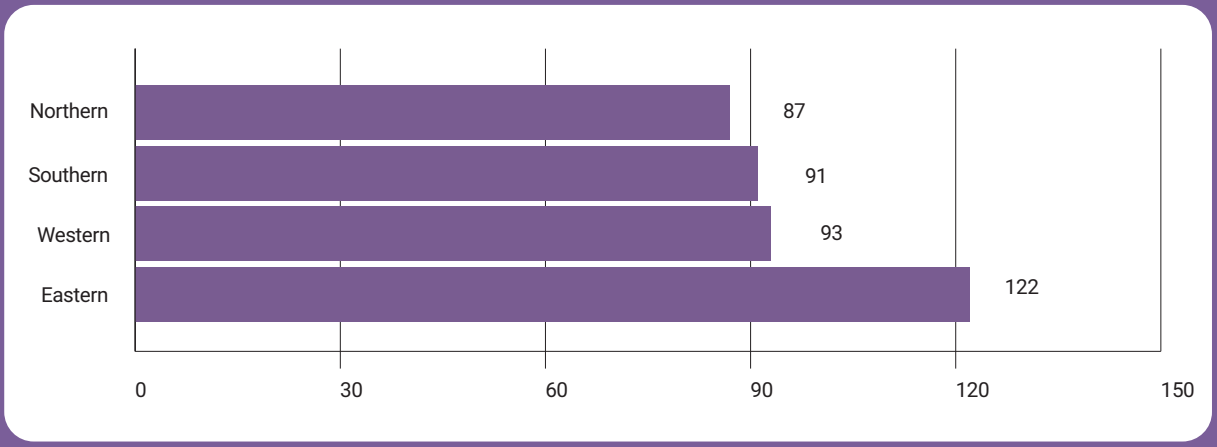

Figure 32 - analysis of the 'pensioners in social housing' population group

Pensioners in social housing, semis and terraces

9k County individuals | 1% of population | 5% of front door demand

This group often live alone or as a couple in flats or houses in sheltered or retirement developments that cater exclusively for older people in social housing, and that incorporate design features and/or services to meet their needs.

Family situation

This group can suffer from loneliness due to a lack of family or increasing caring responsibilities.

Most likely to be an informal carer per 10k population	More likely than average to live alone	More likely than average to be childless
16.4	**53%**	**81%**
County average: 4.6	County average: 20%	County average: 46%

County adult social care service interaction

ASC provides this group a disproportionately high number of low-level packages.

High demands for social care per 1k population	Average age at first service	Average duration of long term service (weeks)	Low spend per service user	More likely to receive homecare than most
102	**78**	**96**	**£5.8k**	**Nursing: -1.8%** **Residential: -1.9%** **Homecare: 3.8%**
County average: 21	County average: 77	County average: 95	County average: £6.8k	

Demographics

Single and couple retirees, living in 1 or 2 bedroom properties.

Age range	House tenure	House type	Higher Education
65+	**Social renting**	**Terraced**	**17%**
			UK average: 32%

Communication

Preferred communication channel: **Leaflets**

Vulnerability

They usually have less money to meet their increasing health and social care needs.

Much more likely to self-assess as having fair or worse general health	Household income is less than half the UK average
47%	**£16k**
UK average: 17%	UK average: £40k

Figure 31 - summary of the pensioners in social housing group

3 Continue to increase the productivity of the social care workforce, including exploring the role that digital and technology can play

This report has shown that, if the operating model does not change, **4,300** additional social care staff will be required to meet the additional demand for assessments, reviews, and case management, along with an additional **700** staff to manage the increase in demand for financial assessments and means testing, representing a **39%** and **25%** increase respectively from the number of posts currently filled.

It is well understood that it will not be possible to train and recruit this many additional staff within the timescales currently set out for the implementation of reforms and given the recruitment challenges already faced by the sector. Therefore, one option that local authorities are exploring is to radically increase workforce productivity. Local authorities commonly find that approximately only **15%** of their social work staff's time is spent working directly with residents, conducting assessments, or reviews. The analysis in Figure 33 below, carried out with one county authority, indicates some of the other activity carried out.

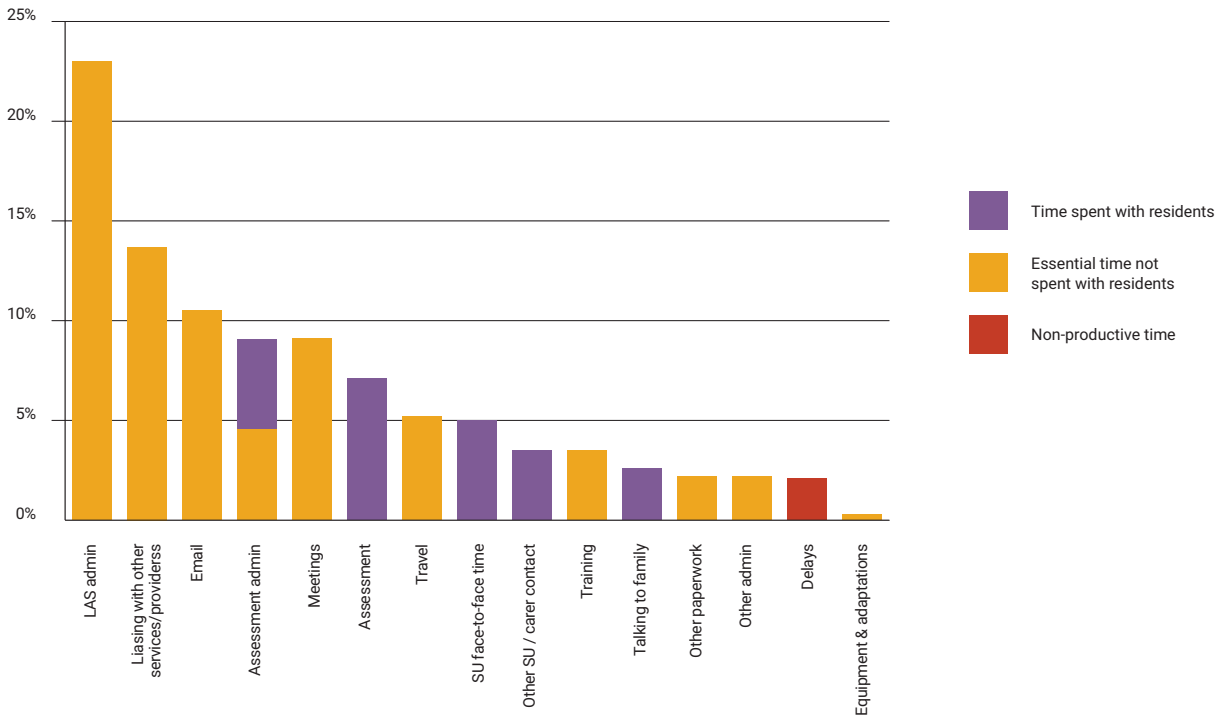

Figure 33 - A breakdown of how social work staff's time is spent, based on analysis of 150 days of working time

By streamlining processes, time not spent with residents, as described above, can be minimised, creating more time to work directly with residents. When combined with effective scheduling, some local authorities have been able to increase their assessment and review throughput from two to three assessments per social worker per week to around five. This increase in productivity could enable authorities to manage a proportion of the additional demand being forecast.

'LAS admin', referring to data entry and admin associated with the Case Management system, is the most significant area of focus. By working with colleagues in Digital and IT, and with systems providers, local authorities can make this an area of focus for streamlining and ensuring systems are more user friendly.

4 Develop a tailored approach to means testing, assessments, and case management

A recommended strategy to deal with the increasing demand brought about by these reforms is to segment the demand according to risk and potential complexity, and then develop a targeted approach to work with different groups. Some potential approaches include:

- **Digital self-assessments** to gather information from residents, including for means testing, and to signpost alternative support. It is critical that digital solutions are used carefully here; if implemented incorrectly, they can have the effect of drawing demand into social care, through a simple access point. While a full assessment will always need professional input, using a self-assessment tool in combination with professional oversight could simplify and streamline this process, particularly in less complex situations.

- **Trusted assessments** carried out by partners, including healthcare professionals. Care providers can also assist as trusted assessors, especially where a resident is already receiving long-term support, which is an opportunity highlighted by both local authorities, and providers themselves. It is highly unlikely that a resident, especially an older adult, would be moved to a different setting in this situation, and therefore a provider's assessment could be accepted more readily.
- **Provider-led reviews and outcomes-based working**, where providers are trusted to adjust care packages, carry out reviews, and flex their support according to independence goals set with residents. Not only does this minimise the workload for social care staff, but it also provides more flexibility for providers, in turn helping them to increase their capacity. Furthermore, evidence from the *Future of Adult Social Care* report suggested that this can also lead to more independence for residents, with a **5%** reduction in formal care and support and greater use of community assets[33].
- **Focussing qualified social worker time** onto only the most complex casework. However, this will require more non-qualified staff, including social work assistant roles – albeit these may be easier to train and recruit into.

5 Engage colleagues in IT and Digital to ensure the right systems will be in place

Administering personal care accounts will require systems development, both to develop the capability initially, and to maintain it. Given the relatively limited number of case management systems used across social care, this work can be coordinated nationally with key systems providers to develop the right capability. However, local authorities can also start to lay the groundwork for a smooth implementation by focussing on:

- **Ensuring systems are up to date**, recognising that any new capability will likely require the most current version of a case management system to be in place. Considering upgrading wherever feasible will help to ensure authorities are best placed to be able to quickly implement enhanced solutions that are developed.
- **Assessing data quality**, and in particular, consistency, between case management data and financial data. Data quality in case management systems can be poor and this could lead to errors in residents' personal care accounts, with associated queries and confusion. Focussing on timely and accurate updates to care records with care package changes and accurate cost information will support this.
- **Considering system integration**, to help ensure that systems can 'talk to' one another and share information between local authorities when a resident moves area and needs to transfer their care account and meter. This will need to be considered by both local authorities and developers.

6 Ensure there are detailed plans to address the lack of homecare capacity

Local authorities will need to continue to maximise the availability of community support, including homecare, which can offer more independent support and avoid unnecessary placements into more expensive residential and nursing settings. This will require continued prioritisation from local authorities, along with focus, funding, and a national strategy from Government to ensure funding and market sustainability plans are able to support the homecare market. This report has already mentioned the role of trusted assessments, provider-led reviews, and outcomes-based working, which will be key elements of this strategy.

There is a more tactical action that local authorities can take in the shorter-term to maximise homecare capacity. Some authorities are already working with their providers to minimise their travel time by intelligently allocating work, and supporting 'package exchange' forums, where providers can swap work between themselves to improve efficiency.

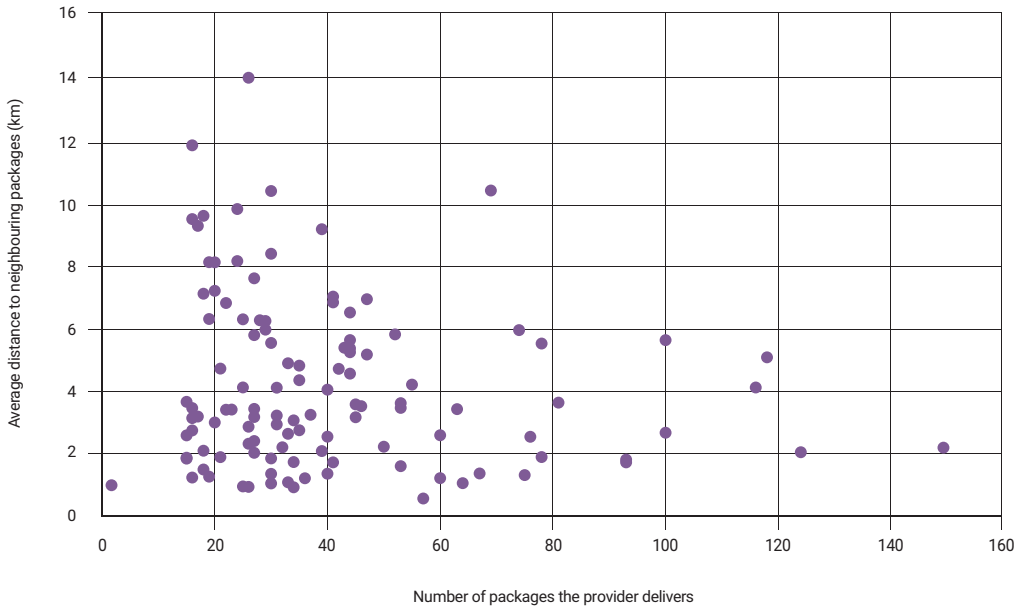

Figure 34 - Analysis from one county authority of the distance between packages by provider

The analysis in Figure 34 shows the distribution of each provider's packages for one county authority. Each dot represents one provider, with the x axis showing the number of packages, and the y axis showing the average distance between each resident's address. Where a provider has a large number of packages, and a substantial average distance between them, there is an opportunity to support those providers to exchange their packages and reduce the average distance. In so doing, this work seeks to improve their efficiency and allow them to increase their capacity.

7 Continue to develop an open, two-way dialogue with care providers, specifically regarding the fair cost of care

To address the concerns raised by providers engaged through this work, local authorities need to continue to seek to engage the broadest range of providers possible in an open, two-way dialogue. Local authorities require assistance in this, including being provided with consistent and clear communications materials to share with their providers, recognising that many work with multiple local authorities.

Providers are calling to be engaged as early as possible in a longer-term discussion about their viability and the overall make-up and stability of the market. Recognising the significant operational pressures providers face, some local authorities are considering how to create the best environment for these discussions, by creating working groups, carrying out joint away days, and exploring how to communicate through a broader range of channels.

The LGA's Care and Health Improvement Programme has provided tools to facilitate the work with providers to develop the fair cost of care[34]. These tools provide a consistent methodology and will help to provide clear communication and a single message to the care market. Providers engaged through this programme emphasised the difficulties of dealing with multiple contrasting fair cost of care exercises in different areas of the country and called strongly for a consistent approach nationally.

8 Engage system partners, through ICSs, to ensure the impact of the reforms is fully understood and to build local support

Many of those engaged through this work reported that their system partners lacked an understanding of the potential impact of these reforms. Not only will these reforms introduce a cost to the NHS through increased spend on Continuing Healthcare (CHC), but there is also potential for the reforms to reduce flow through the health and care system with more residents receiving a social care and financial assessment.

System partners need to raise this as a priority discussion through their Integrated Care System (ICS) (and elsewhere in appropriate local governance arrangements) to ensure that NHS commissioners are prepared. More importantly, system partners can play a positive role in developing the new operating model required to implement these reforms, for example by helping to manage demand.

9 Support effective resourcing of implementation

Local authorities are reporting a lack of resources with the necessary skills to manage implementation of these reforms, however, wherever possible and with support from Government, local authorities need to do all they can to appropriately resource this significant change. Where resources are limited, a number of local authorities are starting to pool expertise around key areas. This should also assist with providing a more consistent message to residents, providers, and system partners.

An outline programme structure is suggested in Figure 29 which could provide a starting point for this planning.

10. Conclusions

This programme has engaged extensively across adult social care, including with residents, providers, and local authorities. This has been supported by in-depth analysis of the operational and financial impacts of charging reforms. Newton, CCN, and the Preparing for Reform Steering Group are grateful to all those who have been generous with their time, energy, and contributions.

This report, the output from that work, demonstrates that a significant financial and operational impact will be brought about by the implementation of the adult social care charging reforms. Most notable is the requirement to find up to **4,300** additional social care staff, an increase of **39%**, in an already scarce workforce. The financial impact is significant too, estimated to be some **£29bn - £32bn** over 10 years, compared to the **£19bn** estimated by the DHSC Impact Assessment. In order to properly fund these reforms, social care will require approximately **50%** of the Health and Social Care National Insurance Levy (**£5.6bn - £6.2bn** per year by 2031/32 of a total levy of **£12bn**).

However, despite the obvious challenges, this report also finds opportunities, as long as the right support is provided by Government, and that realistic timelines are set. The level of transformation required by local authorities to successfully implement charging reforms must not be underestimated. However, with the appropriate resource, funding, and ways of working between local and central government, implementation can be carried out successfully, realising benefits for those in need of social care.

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