Implications of the Care Act 2014 on social care markets for older people

Guest Editorial

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Introduction

The Care Act contains crucial reforms in law for the care and support of individuals in England. The Act is person- centred. Local authorities (LAs), instead of promoting certain types of care, now have a legal responsibility to promote individual wellbeing when exercising a care and support function; people should not fit into available social care, now social care must be tailored for the individual. The Act also reflects that social care is not just about crisis management; it is about intervening early to help people retain their confidence and prevent, or delay, needs occurring.

LAs have many legal responsibilities set out in the Care Act to help promote the wellbeing of people for whom they are providing care and support, including: provide information and advice on available social care, promote integration, and shape the local social care market. For the first time, the entitlement to support for carers is equivalent to that of cared-for individuals.[1]

The Care Act establishes a set of national eligibility criteria which sets the minimum threshold of needs for LA support.[2] The Act also establishes Deferred Payment Agreements (DPAs) whereby a person, subject to having eligible needs and a means test of non-housing assets, can delay paying for their residential care for a period of time, which can be the entire length of their stay, with LAs covering the cost.[3] DPAs will prevent the worry of having to sell homes promptly at a time of potential distress. In addition, the Act prevents individuals from losing their support for care if they move between LAs; an individual can move between LAs and their social care will continue at its current level until the new LA has assessed them. All of these changes will have implications for the funding of social care.[4]

The above came in to force in April 2015 and puts the individual at the centre of the social care market. Three key groups will be affected by the Act: the individuals in need of care, the providers of care (the market), and LAs. Each group is now briefly discussed.

Individuals and the Care Act

A key goal of the Care Act is increased personalisation. Any individual can go to their LA for information and advice on not just care and support, but complementary areas including financial considerations and prevention of needs. The availability of this support is irrespective of need and wealth level. Every person is allowed to be assessed for their level of need. Those assessed as having eligible needs for LA support will agree a care and support plan with their LA, in which the person with needs (or carer) will be the primary leader of the development of the plan. This will include a personal budget, which will outline how much services to support individual needs will cost the LA. The personal budget can be received as a direct payment, which will give individuals more control over the services they choose to meet their needs.

Carers

The Care Act gives LAs the duty to meet the eligible support needs of carers. Prior to the Care Act, LAs had only been legally obliged to assess those who provided a substantial amount of unpaid care on a regular basis, and support for carers was available at LA discretion. Now, if it appears that a carer requires support, LAs must assess their needs, including any potential future needs. If eligible for support, LAs will help carers to improve their outcomes, be it with direct support to the carer or support provided to the cared-for person to provide respite for the carer.[5]

[1] For full details on LA responsibilities, see Department of Health (2014).
[2] LAs can provide support and care for people with needs below this threshold if they wish.
[3] The length of deferral will also be subject to having adequate housing assets and an interest rate based on the cost of government borrowing will be applied to all deferrals.
[4] Further changes to public funding of social care, Phase II of the Care Act, including a social care cost spending 'cap' and increased means tested support, are now delayed until April 2020 (Department of Health, 2015).
[5] If eligible, any support a carer receives may be means tested.

LAs already provide support for carers: 334,000 carers received direct support in 2014/15, more than half of these (59%) receiving information and advice only, and a further 56,000 cared-for individuals received forms of carer support such as respite care (HSCIC, 2015). However, almost two million carers in England provided at least 20 hours of care a week according to the 2011 Census, and projections suggest there will be a shortfall between the supply of informal care provided by adult child carers and the demand for care from parents (Pickard, 2015). Therefore, increased carer support will be of great consequence.

Eligibility criteria

Individuals will be assessed according to national eligibility criteria, which replace the Fair Access to Care Services (FACS) guidelines. The national eligibility criteria examine not what needs an individual has, but whether they are unable to meet certain outcomes and, if so, whether this has a significant impact on their wellbeing. This ensures where a person has eligible needs their care plan is developed, with their input, to meet the outcomes they want to achieve.

There is likely to be increased equality in LA social care support receipt with the new national eligibility criteria. Although these criteria will necessarily be open to interpretation across LAs (as before with FACS, e.g. Fernandez & Snell, 2012), this should remove a great deal of needs-based variation of social care receipt. A small increase in eligibility is also likely under the new criteria (Fernandez et al*.,* 2014).

Impact

At the individual level the key advantage that the Care Act brings is choice. There will be increased choice of care delivery given local markets will offer a range of services, direct payments and increased information and advice. There will also be choice in how much to pay for a service given competitive, diverse, local markets and when to pay with DPAs.

Markets and the Care Act

For individuals to have choice requires a thriving social care market. The social care market is large and competitive, with a total value of over £20 billion (Laing & Buisson, 2012). The market involves individuals, providers and LAs alike, and so is crucial to the success of the Care Act. At the same time, the Care Act will be crucial to the market. It has a great number of supply-side reforms through the responsibilities given to both LAs and the Care Quality Commission (CQC), the independent health and social care regulator for England. For LAs this includes market-shaping responsibilities (see LAs and the Care Act below), and the provision of information and advice to individuals, which is also likely to influence market outcomes (see Forder et al., forthcoming).

The role of CQC

A successful social care market therefore requires strong regulation to assure quality. The Care Act amends the Health and Social Care Act 2008 and gives the Care Quality Commission the formal power to grant a rating based on the level of care provided. The CQC now assesses the performance of social care providers using a star rating system based on the 'Mum Test'.[1]

Following the collapse of Southern Cross,[2] the Act also gives the CQC the statutory responsibility to assess the financial viability of large and difficult-to-replace social care providers, providing a warning to LAs if these providers are likely to become unable to deliver a service. If a provider does fail, LAs have a legal duty, temporarily, to meet the needs of the individuals affected, irrespective of how the care is funded (CQC, 2015). This should reduce the potential negative effects on individual wellbeing of care provider failure.[3]

Market pressures

Certain factors outside of the Care Act may have wide-ranging consequences for social care markets. There are concerns that private (self-funded) placements cross-subsidise LA-funded placements, particularly in the care homes market (Office

[1] http://www.cqc.org.uk/content/making-mum-test-real-our-new-model-inspecting-adult-social-care-has-launched-today [accessed 20 October 2015]
[2] http://www.theguardian.com/business/2011/jul/11/southern-cross-landlords-take-over-all-homes [accessed 20 October 2015]
[3] There can be negative consequences to involuntary relocation between care homes unless well managed (Holder and Jolley, 2012).

of Fair Trading 2005; Laing & Buisson, 2012; Hancock et al., 2013). This could then have implications for quality and, in turn, care home viability (Forder & Allan, 2014; Allan & Forder, 2015).

Social care markets also face a number of cost pressures. First, the introduction of the National Living Wage from April 2016 for all those over the age of 25 (Department for Business, Innovation & Skills, 2015). Second, under current immigration rules, from April 2016 any migrant worker who has worked in the UK for five years must be earning more than £35,000 to be able to attain indefinite leave to remain.[1] Third, issues around working time and pay for home care workers in particular.[2] It is likely that there will be at least some upward pressure on costs and potential negative implications for outcomes given the composition and remuneration of the social care workforce (e.g. Skills for Care, 2015).

Impact

The delayed phase II component of the Care Act was seen as most likely to impact on the care homes market (Forder et al., forthcoming). Nonetheless, the Care Act will result in increased interaction between self-funders and LAs which may still impact on the market. Increased assessments, and information and advice, may lead to increased demand for earlier forms of social care intervention. Overall, the impact of the Care Act on individuals, LAs and the CQC will provide the foundations for diverse local social care markets which provide high-quality services to meet the needs of individuals.

LAs and the Care Act

The Care Act gives LAs an increased role within local social care markets. Increased support through provision of information and advice includes LAs providing this service directly and indirectly ensuring the sufficiency of information across the local market. The Care Act also places responsibility with LAs to increase integration and cooperation with not only the NHS and relevant stakeholders in the local market, but also other LA services that are linked to health and social care, e.g. housing.

Market-shaping and budget cuts

Market-shaping involves promoting diversity of providers and quality across a spectrum of options that meet the needs of local residents. LAs will interact with the whole market and not just providers that LAs purchase from directly. Market-shaping will include the use of LA commissioning. This should focus on outcomes for individuals, possibly incorporate payments-by-outcomes, and ensure that local markets remain sustainable through sufficient, yet cost-effective, funding (Department of Health, 2014a).

Therefore, market-shaping is a potential solution to the supply-side issues that care providers are facing. LAs could ensure that social care providers receive sufficient payments so as to maintain the long-term sustainability of the market, and the outcomes individuals achieve. However, at the same time, the cost-effective, value-for-money, use of public funds must also be carefully considered. LA budgets continue to be squeezed, and with social care funding not ring-fenced, there will be continued pressure on the prices that LAs pay for social care (e.g. Local Government Association, 2013). Further downward pressure on LA fees for social care could then affect the sustainability of social care markets and individual outcomes.

Impact

The Care Act itself will bring increased costs to LAs through assessments, appeals, greater financial support, and increased overheads. The Department of Health had allocated funds to cover these costs (Department of Health, 2014b). Therefore, the Care Act should not negatively affect the ability of LAs to fund social care and support for eligible individuals. Yet there is concern that demand for, and costs of, assessments may have been underestimated (National Audit Office, 2015).

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117953/tiers125-pbs-overseas-soi.pdf [accessed 20 October 2015]

[2] See the recent European Court of Justice ruling on working time for those without a fixed office (http://curia.europa.eu/jcms/upload/docs/application/pdf/2015-09/cp150099en.pdf) and the UK employment appeal tribunal: Whittlestone v BJP Home Support Limited [2013] UKEAT 0128_13_1907, [2014] IRLR 176, [2014] ICR 275 (http://www.employmentcasesupdate.co.uk/site.aspx?i=ed18895) [accessed 20 October 2015]

Conclusion

The Care Act, and the reforms included therein, will have far-reaching implications for social care, and comes at a time when the sector is under pressure (e.g. ADASS et al., 2015). As such, it will be of interest to see if the intended aims of the Care Act are achieved. Future research can help inform in this respect.

For LAs, the Care Act brings increased costs and responsibilities. Crucially, LAs having to maintain a sustainable, diverse, social care market in a time of austerity will be a careful balancing act. This is particularly important given cost pressures on the supply side for care providers and the expected rise in demand for social care (e.g. Wittenberg et al., 2011). The effect of the Care Act on providers is more difficult to assess given it depends on the effect the Act has on individuals, LAs and the CQC. A competitive, diverse and high-quality market meeting the needs of individuals is the intention of the Act. Markets should provide high-quality and continuous care given the regulatory powers of the CQC.

Most importantly, the Care Act puts individuals first, increasing their choice while easing some of their financial burden; social care is about achieving outcomes and ensuring wellbeing.

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