

CCN

COUNTY COUNCILS NETWORK

# County Care Markets: Market Sustainability & the Care Act

JULY 2015

LaingBuisson

The healthcare experts



# Executive Summary

## UNDERLYING MARKET SUSTAINABILITY

- ➔ Faced with unprecedented pressures on social care budgets, councils have sought to act in the interests of their residents and negotiate even harder with providers to secure further efficiencies in social care commissioning. Local authorities have rightly exercised their strong market position as a 'bulk' buyer of social care placements to secure discounted rates from providers' over time. This has led to a widening gap between local authority residential and nursing care home fees and providers' costs. However, to a significant extent, it has only been possible for councils to continue to secure discounted care fees because providers have been able to charge self-funder fees in excess of the cost of care, to compensate for this shortfall in council fees.
- ➔ There is now clear evidence that self-funding older persons pay a growing premium for residential and nursing care compared to care arranged and funded by local authorities. The average premium shown in this research is over 40% on a 'like for like' basis, across the 12 councils participating in the study.
- ➔ This research shows that the widening gap between council fees and excessive prevalence of 'cross-subsidies' has had an adverse effect on the profitability of many providers of nursing and residential care. This is having a severe impact on the sustainability of the market. All of the major care home groups with high exposure to council funded residents have seen a continuing fall in operating profits as a percentage of revenue, over recent years while the profitability of care home groups focused on private pay has typically been increasing, stable or, at least, more stable. **The growing level and extent of cross-subsidy is now unsustainable in many areas, and a direct consequence of insufficient funding for social care.**
- ➔ The sustainability of the care market depends on the profitability achieved from the overall mix of self-funders, local authority and health residents. With the above trends taking place, the mix of funding is changing significantly. **There is already strong evidence of a growing 'polarisation' within the social care market, with many providers focusing almost exclusively on the self-funder market. This is resulting in a shortage of places for council placements and fee levels that increasingly councils cannot afford.**

## CARE MARKET EQUALISATION UNDER THE CARE ACT

- ➔ The Care Act actively encourages self-funders to approach their councils for the first time, either to access the Cap on Care or ask commissioners to arrange care on their behalf. In addition, many self-funders will now become local authority supported care users under the new asset threshold. Increased contact between councils and self-funders will change the balance in the market and weaken the sustainability of the market as a whole even further.
- ➔ Our consortium research provides detailed evidence and analysis on the potential erosion in fee levels of those who fund their own care, as a result of these key aspects of the Care Act, and how this might lead to additional costs for councils, further market polarisation, and create serious risks to the delivery of health and social care services.

- It is likely that self-funder fees will fall, to some extent, as a result of the increased transparency brought forward by care accounts and the significant difference they will reveal between self-funder and council fee levels for similar levels of care. This transparency is likely to have an impact on self-funder purchasing behaviour, with individuals potentially asking their council to arrange their care at their lower fee rates or seeking to negotiate lower fees from providers. Even if it is not obligatory for councils to help to arrange care for self-funders 'under Section 18(3) of the Care Act', at their usual cost of care fee erosion is highly likely. Based on the dynamic model predictions, it could have a severe negative impact on the profitability of providers.
- The polarisation in the social care market between publicly and privately funded care placements is likely to increase due to the Care Act and market equalisation. **Polarisation will weaken councils' position in the market, leading to additional unfunded costs for councils, with councils having to raise fees to sustain a functioning market and prevent provider exits.**
- Crucially, local authorities and Health (NHS) will find it increasingly difficult to arrange care at market discounts, or worse, difficult to arrange care at all. This will **lead to escalating costs to the health service and could also lead to increasing delayed discharges, with councils and health providers being unable to find quality and affordable residential and nursing placements to reduce demand on acute healthcare.** This would put more pressure on already under-funded local authority and health budgets, severely impacting on the quality and outcomes of local services across local health economies which will negatively impact on service users.
- If the average cost of care arranged by local authorities' increases, more residents will also reach the care account cap of £72,000; and this will increase the new financial burden of the care cap on councils.

## FINANCIAL IMPLICATIONS

- Our research estimates that the existing 2014 'care home fee gap' to be **£236m** for the 12 consortium councils. The care home fee gap is defined as the amount by which council fees fall short of the care cost benchmark (see page 10 for details) required to achieve market sustainability and maintain local capacity, without resorting to cross-subsidies from self-funders or the relatively small amount of third party top-ups. Extending these findings through extrapolation to all 37 CCN member councils produces an estimate of an existing 2014 care home fee gap amounting to £630m.
- Given the underlying sustainability issues which are already within the market, projections using our dynamic modelling show that the fee gap for older peoples' care homes is likely to increase over time. Self-funder fee erosion would reduce the ability of care homes to cross-subsidise the shortfall in council fees and threatens to place a major additional cost burden on the 12 counties. The cost burden on the 12 councils of eliminating the need for such cross-subsidies is estimated as **£256m** in 2016/17. This is the estimated net funding cost to the 12 counties of bridging the difference between the care cost benchmark and the fee levels currently paid by councils. Through extrapolation to the 37 CCN member councils the care home fee gap is £684m.

- ➔ The threshold extension adds a net cost burden to the 12 counties amounting to **£27m\*** in 2016/17, which increases with demographic pressures in future years to £30m by 2020/21. It is noted that government has committed to fully funding the costs of the threshold extension. Through extrapolation to the 37 CCN member councils, this figure is £72m, growing to £80m by 2020/21.
- ➔ It is estimated that demographic pressure will add a further projected **£87m\*\*** (at constant 2016/17 prices) to the annual net costs of the 12 counties by 2020/21 and £232m for the 37 CCN member councils. This is the amount by which all other elements of cost are projected to rise, specifically as a result of population ageing. This is expected to accelerate during the coming decade.
- ➔ In total, the additional net care home fee costs, including the unfunded 'care home fee gap' and the additional demand from population ageing is projected to reach **£370m** a year by 2020/21 for the 12 councils participating in this research. Through extrapolation to the 37 CCN member councils this figure is **£988m** by 2020/21.
- ➔ The net funding cost represents the additional cost of paying the full cost of care, after taking into account means-tested tariff income and other charges levied on individuals receiving this support. If council fees were progressively increased it is likely that extra tariff income would level off quite quickly, after which further increases would just result in higher costs to councils.

These figures exclude the cost impact of home care clients, working age adults, the cap on care (the largest single element in the DoH costings) and associated costs such as additional assessments, system changes and other overheads. **This suggests that the DoH total national cost estimate of £2.5bn by 2025/26 may substantially understate the potential cost to councils.**

#### Financial Impact Summary – Council Funding

	12 COUNTIES aggregate		37 COUNTIES aggregate	
	2016/17	2020/21	2016/17	2020/21
	£m	£m	£m	£m
Care home fee gap	256	285**	684	761
Threshold extension to £118,000	27	30**	72	80
Market Equalisation (up to care cost benchmark)	283	315	756	841
Demographic Demand	-	55**	-	147
<b>TOTAL</b>	<b>283</b>	<b>370</b>	<b>756</b>	<b>988</b>

\* LaingBuisson Wealth model estimates of the net cost of the threshold extension still need to be checked against the Department of Health's own estimates to identify any significant differences in assumptions. Therefore the results should be considered as provisional at this stage. The LaingBuisson estimates will be further refined following permission to use the Original Wealth in Great Britain data set.

\*\*This comprises the pure increase in demographic demand, the increase in the care home fee gap, and the increase in the threshold extension by 2020/21.

## POLICY & FUNDING RESPONSE

In presenting this evidence to Government on the underlying sustainability of the residential and nursing care home market, both ahead of Care Act implementation and in the following years, our ground-breaking modelling has incorporated a number of scenarios that will need careful analysis when considering appropriate policy and funding responses.

The main scenario, which arrives at the funding shortfall described above, simply calculates the total net cost of taking council fees up to the full cost of care. This would totally eliminate the need for any cross-subsidies to be paid by self-funders, based on fees levels estimated for 2016/17, when the second phase of the Care Act comes into force. This would directly address the root cause of the problem of cross-subsidisation in the market, this being the shortfall in council fees. If the councils received sufficient extra funding to increase fees to this extent then this should be sufficient to *stabilise* the market, at least before consideration of *full* or *partial* market equalisation of council and self-funder fees.

A further scenario used in this research looks at the additional impact of also bringing self-funder fees (or at least those charged for standard rather than enhanced levels of care) down to the care cost benchmark level. This will clearly reduce provider profitability again, offsetting the positive impact of increased council fees. However, it is expected that the increase in council fees up to the care cost benchmark should also be sufficient to manage the impact of the Care Act on their local market. The extra amount self-funders pay to contribute cross-subsidies would be progressively eliminated over time as council fees are raised. This would be consistent with new requirements that councils ensure market sustainability and the overarching Care Act principles and implications to deliver greater transparency and a 'fairer deal' for those funding and arranging their own care needs.

**However, CCN are of the view that while the level and extent of cross-subsidy is currently unsustainable and a consequence of inadequate funding for social care, the ability of councils to secure care at discounted rates due to their market position and ability to bulk purchase should remain a component, though smaller, of the social care market.** It is neither desirable nor practicable for council fees to rise to fully to the care cost benchmark used in this exercise, even though fees are on average unsustainably low. This is explored further in the section 'Market Equalisation in theory and practice' on page 34. Additionally, given the fiscal climate, the Government may not be able or willing to meet the total funding gap in the market identified.

In responding to the challenges outlined in this paper, Government will need to work closely with the sector to assess what the acceptable scale of cross-subsidisation and market risks are, given underlying instability and the additional pressures created by the Care Act. The modelling and scenarios explored need to be analysed in detail and tested. This will ultimately determine whether Government meets the **total** funding gaps presented, alters regulatory frameworks or devises market interventions in collaboration with the sector to mitigate the risks described. This particularly applies to those associated with market polarisation and its impact on the health service.

The new Conservative administration has committed to a similar approach in the childcare market following the introduction of the Childcare Bill.<sup>7</sup> Given the scale of the challenges facing the adult social care sector is far greater, similar market analysis and mitigation work must be undertaken.

However, what is undeniable is that councils, particularly in ‘high risk’ stressed markets, do need additional funding in the short-term to uplift fees and stabilise their markets. Moreover, market equalisation will lead to additional costs and a dangerous **polarisation** for **all** local authorities, assuming that they need to respond with at least some increase in their own fees, to offset the adverse impact of fee erosion on provider profitability following the introduction of the Care Act. This will impact on the shape and capacity of local markets, requiring **additional new burdens funding** to be identified and allocated accordingly.

## SUMMARY RECOMMENDATIONS

**Recommendation 1) The Government engages extensively with sector stakeholders, including CCN, ADASS and care providers, to analyse the social care provider market, devising national and local policy responses and strategies to stabilise the residential and nursing care market in the short, medium and long-term.**

**Recommendation 2) The Government provides additional in-year, targeted, funding to CCN member councils to *reduce the reliance on cross-subsidy* in local care markets to achieve market sustainability and maintain local capacity.**

**Recommendation 3) Government recognise the scale of the instability within local care markets and use the 2015 Spending Review to deliver a fair and sustainable funding settlement for adult social care to ensure the medium to longer-term sustainability of local care markets.**

**Recommendation 4) Government continues to delay the implementation of Section 18(3) Duty to Meet Needs (in care home settings), and ensures that all Care Act statutory guidance and regulations do not lead to further unsustainable pressures in local care markets.**

**Recommendation 5) The Care Act Impact Assessment is revised, acknowledging that there is now sufficient evidence to suggest the Care Act will lead to a significant new financial burden for CCN member councils from market equalisation. As part of its commitment to fully fund the Care Act, the Government provides an indicative cost and allocates resources according to need as part of the 2016/17 local government funding settlement.**

**Recommendation 6) In the absence of additional funding and continuing uncertainty on the impact on local care market, the Government considers delaying the implementation of Part 2 of the Care Act whilst a detailed market analysis is undertaken to ascertain the impact of the Care Act on local care markets across England.**

**Recommendation 7) The Government explores the reforms outlined in the *State of Care in Counties: the integration imperative* and *CCN County Devolution: Health and Social Care* to achieve long-term sustainable reductions in demand for residential and nursing placements.**

The data within this report has been extracted from the **LaingBuisson Main Report**, produced on behalf of the consortium councils. The views and recommendations contained within the report have been developed by the County Councils Network using this information. The **LaingBuisson Main Report** providing a full technical analysis of the project, modelling exercise and results can be found at [www.laingbuisson.co.uk/MarketReports/FreeReports](http://www.laingbuisson.co.uk/MarketReports/FreeReports).

When the Care Act came into force in April 2015 it marked the biggest change to adult social care provision for over 60 years.

# Introduction

When the Care Act came into force in April 2015 it marked the biggest change to adult social care provision for over 60 years. Despite strong support from the CCN for the Act, CCN has consistently raised concerns over financial shortfalls and its potential impact on social care funding.

With local authority budgets witnessing reductions of 40% since 2010, the Local Government Association (LGA) estimates that the funding gap for social care budgets stands at £1.9bn growing to £4.3bn by 2019/20.<sup>2</sup> One consequence of the financial pressures on councils is the growing recognition that funding reductions have severely limited their ability to pay sufficient fees to providers to maintain a competitive and diverse social care market.

Following four years of funding reductions and unavoidable reductions in fees paid to providers the sustainability of the social care market is now coming into sharp focus ahead of the implementation of Care Act Funding Reform from April 2016. It is widely reported that all major care home groups with high exposure to council funded residents are witnessing consistent falls in operating profits as a percentage of revenue. There are real fears that local authorities and providers, many with an over reliance on cross-subsidises between public and private care users, will be unable to sustain the added pressures of funding reductions and pressures brought forward by the Care Act.

CCN first raised concerns over underlying market instability and the impact of the Care Act in March 2014<sup>3</sup> CCN has consistently argued that market instability and the potential for 'market equalisation' – erosion in private fees as a consequence of transparency introduced by the Care Act - could further add to the deterioration and polarisation in social care markets.

If such a situation developed, it could prevent councils from fulfilling their new duties to facilitate a vibrant, diverse and sustainable market and lead to additional unfunded costs for councils. More importantly, it could pose serious risks to service users at a time of growing demand, limiting the supply of good quality homes and have severe consequences for wider local health economies, the NHS and acute providers.

The Department of Health (DoH) has acknowledged the need to engage with these concerns, but to date has failed to quantify any underlying or future sustainability risks, concluding that they do not believe that there is sufficient evidence at this time to estimate if the Act will lead to additional market instability and unfunded new burdens for councils.<sup>4</sup>

To provide firm evidence and better understand these financial and sustainability risks, a consortium of 12 county and unitary councils, facilitated by the CCN, commissioned independent research into the potential impact of the Care Act on local care markets. **LaingBuisson**, the healthcare market specialists, were tasked with evaluating the sustainability of residential and nursing care homes in the short and long-term in light of changes brought in by the Care Act.

The conclusions of this study reveal the reality facing county care markets ahead of the biggest shake up to social care funding since the inception of the Welfare State. Not only does it provide evidence that the social care system is already unsustainably reliant on cross-subsidisation, but also that the Care Act could lead to a significant alteration in the funding model that is currently keeping many local markets afloat. **Unless concerted action is taken across Whitehall, local authorities, providers and the health sector, the issues discussed in this report could have profound implications for the sustainability, quality and safety of health and social care services across England.**

# Project Details

## DEFINITIONS

The following definitions are used throughout this report:

Term	Definition
<b>Care cost benchmark</b>	For the purposes of this exercise a care cost benchmark has been used to compare fee levels and arrive at estimates on underlying sustainability and funding gaps. The benchmark is based on latest estimates of the cost of providing care and support at the sustainable levels of cost required locally to keep efficient care homes in operation and earning sufficient margins or surpluses necessary to promote investment in building new homes. This is to match the increasing need for such new homes. Anyone being paid the full care cost benchmark rate should be expected to be rated 'good' by CQC.
<b>Care home fee gap</b>	The 'care home fee gap' is the difference between the 'care cost benchmark' and the weighted average fees (for nursing and residential care) currently paid by councils, multiplied by the number of residents to give a global figure which represents the incipient cost to councils of 'market equalisation'.
<b>Market equalisation</b>	The process by which currently universal cross-subsidies from private to publicly funded residents are eliminated as both council supported residents and self-funders gravitate towards the same fee level.

## MODEL OVERVIEW, ASSUMPTIONS & RESULTS

LaingBuisson has developed two inter-related models to assist in projecting the financial impact of the Care Act on residential and nursing care homes:

- ➔ A **Wealth and Income model** (so-called because it uses the distribution of wealth and income in each county to estimate charges to service users); the model outputs include, among other things, the NET additional cost burden on councils arising from:
  - The upper asset threshold extension; and
  - Knock-on effects of price transparency:- private pay fee erosion, destabilisation of care home markets and pressure to raise council fees as part of a process of market equalisation;
- ➔ A **Dynamic Market model**, which focuses on the sustainability of local care home markets, and projects openings and closures in response to dynamic changes in fees, costs and profitability.

This analysis presented in this document focuses on the key findings from four of the main scenarios evaluated by LaingBuisson within the study. We also focus specifically on the largest element of additional cost to councils, which is the **payment of care home fees**. Other additional cost burdens from the Care Act, including those relating to home care clients, working age adults and the associated costs of assessments and back office overheads are not covered. Nor are care cap costs considered explicitly. These are difficult to model because of the uncertainties regarding take-up of independent budgets and in any case councils, are unlikely to incur significant costs from the care cap for the first three years, and in most cases longer. The four scenarios are:

1. The **'base case'** which allows for demographic growth in demand based on the increase in elderly frail people (of around 3% per annum, although this varies by county), but assumes that councils will continue

to succeed in reducing age-specific council funded demand for care home places by 0.5% per year, offsetting this demographic growth slightly. This shows the effect of this net extra demand on supply, given assumptions about cost and fee increases, before consideration of the extra impact of the Care Act. **This is the scenario which involves the lowest cost burden to councils (outlined in table 1), though still highly challenging, given existing sustainability risks in the market;**

A further variant of this has been considered in the study (the ‘**base case plus**’ scenario), which allows for a reduction of 1.5% per year in age-specific council funded volume of demand (in place of the ‘base case’ 0.5%). This is as a result of managing to keep an increased proportion of those needing care in their own homes, rather than needing to admit them to care homes. This does allow for a reduced cost burden to councils, but only in so far as savings in care homes fees more than offset additional home-based care costs. It is considered that there will be limitations to the further scope to reduce demand in this way, given that older people entering homes are now only typically those who are extremely old and frail.

2. The ‘**most likely**’ scenario. This super-imposes the minimum effects of the Care Act on top of the changes in demand assumed in the base case. It includes the funding cost of the extension to the upper asset threshold, and its implications for providers, including the probability that they will ask for fee top-ups from in situ residents who switch from private to public pay under the threshold extension, as well as from the extended cohort of newly admitted residents. While no allowance is made for council fees to rise towards the care cost benchmark, the ‘**most likely**’ scenario does include a moderate adjustment for estimated self-funder fee erosion on the assumption that Care Act section 18 (3) proceeds **without** obligation for councils to arrange care for self-funders at their usual cost of care. This modest fee erosion may be all that occurs without specific initiatives to achieve substantial market equalisation.

The assumption made is that self-funder fees only fall by 50% of the differential between these fees and the care cost benchmark. This equates to a fall of 7.5% on average, although this varies significantly between councils. It should be emphasised that it is not possible to predict the likely extent of private fee erosion with any high degree of confidence, at this stage, and that the scenario title ‘most likely’ does not necessarily imply that the private fee erosion will prove to be 50%. But it does beg the question of what councils’ response will be given the destabilising effect on the market of even moderate private fee erosion.

3. The ‘**most likely with 100% council response**’ scenario addresses this question and assumes that, on top of the assumptions made in the ‘most likely’ scenario, councils increase the average fees they pay - in five annual steps-right up to the care cost benchmark, eliminating 100% of the ‘care home fee gap’, which should broadly be sufficient to avoid market destabilisation. **This is a highly financially challenging scenario for councils.**
4. The ‘**market equalisation with 95% council response**’ scenario mitigates the cost to councils to some extent, in that council fees do not move right up to the care cost benchmark but leave a minimum fee discount to full cost of 5% in place. At the same time self-funder fees are brought right down to only 10% above the care cost benchmark. (N.B. This only applies to self-funder fees relating to ‘like for like’ support; those for higher specification services are not addressed in the study). This recognises that there will be

some remaining local authority fee discount in place, and also some price variation in the market, so that some slightly greater ongoing premium is needed to manage these shortfalls and risks. This is again intended to be illustrative rather a definitive estimate of what should or might happen.

This scenario is 5% less costly than the 100% council response scenario, in terms of funding of the fees shortfall but entails much higher levels of risk in terms of market sustainability, given the offsetting major reduction that is assumed in self-funder fees. As to whether this produces a net improvement or deterioration in provider profitability and market sustainability will be very much dependent on;

- o The average mix of residents by county;
- o The current levels of fees, and;
- o Extent of adjustments needed to reach close to the care cost benchmark, in terms of either a discount or premium.

The net financial impact for councils has been projected using Laing Buisson's Wealth and Income model for each of the 12 councils to 2025/26, though the figures cited below focus on the five years ahead to 2020/21. Adverse impacts on funding shortfalls and sustainability are much greater over a ten year timeframe as negative trends continue.

Comparable estimates have been prepared for the 37 councils within the CCN aggregate, simply by extrapolating the results for the 12 councils; this has been based on the ratio of older people in the relative overall population numbers, slightly skewed to the numbers over 80, within the totals of those over 65. On the assumption that the 12 counties are representative of the 37 (see page 14), this has produced estimates which can be viewed as indicative of the scale of financial impact across the authorities that constitute the CCN membership.

While the net impact on councils' net costs is calculated in the Wealth and Income model, the effects of the various scenarios on provider profitability and sustainability are addressed in the Dynamic Market models. Projections are provided for each major component of additional cost and shortfalls for the 12 councils in aggregate.

The results from the Wealth and Income model are set out in Table 1 for the 12 counties in aggregate, showing the impact on net council costs (described as the 'net cost envelope') for each of the principal scenarios. Table 2 then draws on these results to identify and summarise the individual elements of the additional cost burdens faced by councils for the most costly of the scenarios - **'most likely with 100% council response'**.

The overall results are illustrated graphically in Figure 1a, for 12 councils, and Figure 1b, extrapolated for all 37 councils. In Table 1 the 'Net council costs (pre-existing) BASE CASE' line includes for future years the effect of net increases in funding required as a result of increases in demand arising from demographic growth of the 'pre-existing' cohort of council supported residents within the former, £23,250, upper asset threshold.

The 'Council cost envelope - MOST LIKELY' line includes the net costs of both the 'pre-existing' and 'threshold extension' cohorts. The 'Council cost envelope - MOST LIKELY + 100% council response' includes in addition the increases in council fees in response to self-funder fee erosion. This calculates the full cost of increases to council fees which would be necessary for market equalisation, at the level of the care cost benchmark. More

extensive fee erosion to actually achieve market equalisation, by reducing the need for cross-subsidies to closer to zero is only considered in the following MARKET EQUALISATION scenario. This increase in council fees is phased in over 5 years.

Finally, the 'Council cost envelope – MARKET EQUALISATION + 95% council response' allows for council fees being at a 5% discount to the care cost benchmark, as well as like for like self-funder premiums being brought down to a residual 10% premium above the 'care cost benchmark'.

Table 1 Financial consequences of the upper asset threshold extension and market equalisation, combined with demography driven increases in demand. 12 Counties aggregate projections to 2025/26 by principal scenario (care home fees only)

	2014	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
<b>Constant 2016/17 prices</b>											
<b>Three net cost scenarios for councils are highlighted in the box</b>											
A) Net council costs (pre-existing) BASE CASE	433	479	490	504	518	533	550	572	593	611	627
B) Net council costs (threshold extension)	-	27*	28	29	30	30	31	33	34	35	36
C) Council fees rise to 'care cost benchmark' in 5 annual steps)	-*	51	105	162	222	285	294	306	317	327	336
D) Resident charges (pre-existing)	322	357	365	375	386	398	409	426	442	455	467
E) Resident charges (new threshold)	-	103	106	109	112	115	118	124	128	132	136
Council cost envelope - MOST LIKELY (= A + B)	433	506	518	533	548	564	581	605	627	646	663
Council cost envelope - MOST LIKELY + 100% council response' (= A + B + C)	433	557	623	694	770	849	875	911	944	973	999
Council cost envelope - MARKET EQUALISATION + 95% council response (with SF fees down to 10% premium) (= A + B + 95% x C)	433	544	610	681	756	835	860	895	928	957	982
Gross cost envelope including resident charges (= Sum (A : E))	755	1,017	1,094	1,179	1,268	1,361	1,402	1,461	1,514	1,560	1,602

\*The private to public cross subsidy (care home fee gap) is estimated at £236m in aggregate in 2016/17 for the 12 counties. To the extent that councils absorb the cross subsidy by increasing their fees under market equalisation, nearly all of what is absorbed will represent an additional NET cost to councils, since at that fee level nearly all supported residents will have already reached their maximum ability to pay charges.

Table 2 identifies the elements of additional cost for councils. For the 12 counties only, the additional net cost of the threshold extension is estimated at **£27m\*** with the bulk of gross costs will be clawed back in resident charges.

The cost of bridging the 'care home fee gap' is shown as **£256m**. This illustrates what the net cost to councils would be if the full impact of Section 18(3) were felt immediately and councils were forced to respond with 100% market equalisation in Year 1. Such a scenario is unlikely and is not modelled, but for illustrative purposes the £256m can be viewed as the full annual cost of immediate market equalisation.

Demography driven demand increases are calculated to add a further **£87m\*\*** by 2020/21, and all three together add **£370m** a year to the 12 counties' net costs. By extrapolation, the corresponding increase in the net costs of CCN's 37 councils is calculated at **£988m**.

Table 2 Breakdown of NET additional care home costs to councils, 12 counties and extrapolation to 37 CCN counties, 5 year projection at 2016/17 prices ('most likely with 100% council response' scenario)

	12 COUNTIES aggregate		37 COUNTIES aggregate	
	2016/17 £m	2020/21 £m	2016/17 £m	2020/21 £m
<b>A) Additional net care home costs from threshold extension</b>	27	27	72	72
<b>B) Additional net costs from market equalisation, in the (illustrative only) event that councils were to increase fees to the 'care cost benchmark' in one step in Year 1</b>	256	256	684	684
<b>TOTAL for threshold extension and market equalisation (excludes Care Cap costs, Assessment, System Change and Overheads)</b>	283	283	756	756
<b>C) ADDITIONAL DEMOGRAPHY DRIVEN DEMAND, comprising:</b>	-	87	-	232
'BASE CASE' (additional demand from below the former £23,250 upper asset threshold)	-	55	-	147
'PAYOR SHIFT' (additional demand from residents newly qualifying under the upper asset threshold extension to £118,000)	-	3	-	8
'MARKET EQUALISATION' (balance of additional demand relating to item B), above)	-	29	-	77
<b>TOTAL increase in net costs to councils (at 2016/17 prices) due to upper asset threshold extension, market equalisation and demography driven increase in demand</b>	<b>283</b>	<b>370</b>	<b>756</b>	<b>988</b>

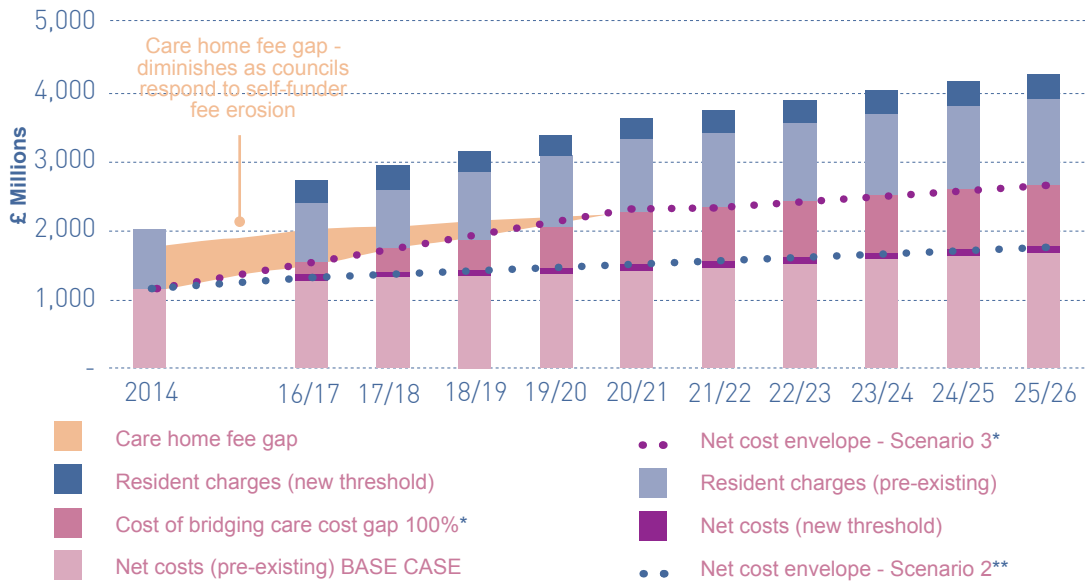
Source: Table 1

\* LaingBuisson Wealth model estimates of the net cost of the threshold extension still need to be checked against the Department of Health's own estimates to identify any significant differences in assumptions. Therefore the results should be considered as provisional at this stage. The LaingBuisson estimates will be further refined following permission to use the Original Wealth in Great Britain data set.

\*\*This comprises the pure increase in demographic demand, the increase in the care home fee gap, and the increase in the threshold extension by 2020/21.

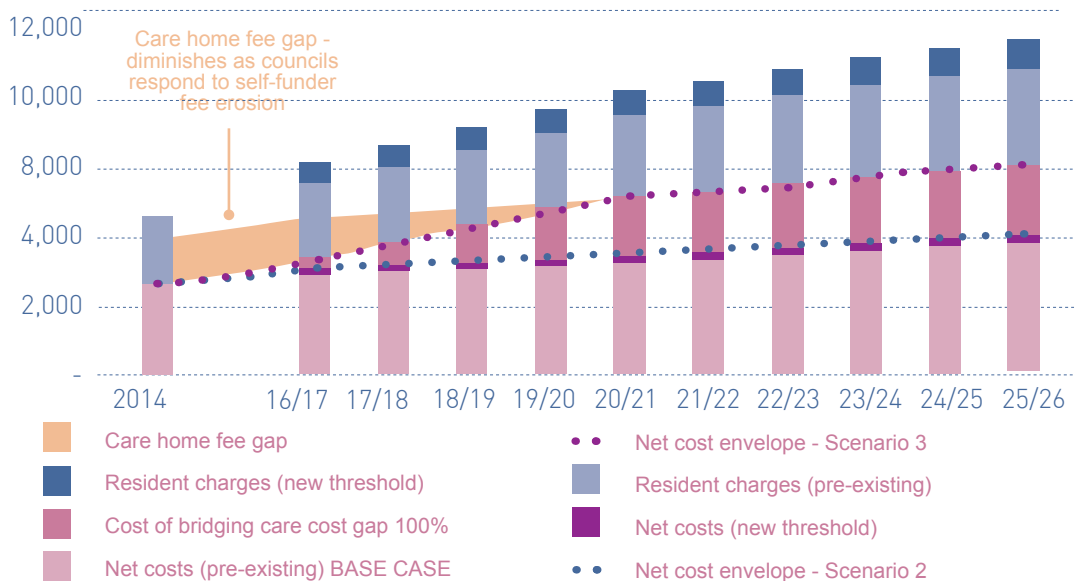
Figure 1 Financial consequences of the Care Act, comparing Scenario 2 ('most likely' - no market equalisation) with Scenario 3 ('most likely' with 100% council response'), projected cost of council supported care home fees, (2014 at 2014 prices, from 2016/17 at constant 2016/17 prices), excludes Care Cap costs

**A) 12 COUNCILS aggregate**



See Source and Notes below B) 37 Counties extrapolation

**B) 37 CCN COUNCILS extrapolation**



Source: Data derived from Table 1 for 12 Counties; 37 Counties extrapolated from 12 Counties by a multiplier of 2.67.  
 Notes:

\* Under Scenario 3, councils respond to self-funder fee erosion by raising their own fees 100% to the 'care cost benchmark'; the response takes place over 5 years, during which time the care home fee gap (pink area) is absorbed by councils.

\*\* Under Scenario 2 there is no council fee rate response to self-funder fee erosion and councils' net cost envelope tracks upwards in response to additional demographic driven demand only.

## PARTICIPATING COUNCILS

The 12 councils taking part in the study constitute a *representative* sample of the 37 county council and county unitary authorities represented by the CCN, in population size, location, demographics, and service user profile. The councils have a combined total population of **9.8m**, of which **1.86m** are older people, over 65, representing **20.5%** of the social care market for older people in England.

## 'HIGH RISK' & 'LOW RISK' COUNTIES

The level of relative affluence within an area can have a significant impact on the mix of funding within home and residential care markets and lead to a significant variation in the financial impact of different aspects of the Care Act. Although 'less affluent' and 'more affluent' do not always uniformly equate to *high risk and low risk areas*, to describe the impact differentiation over time, these terms have been used. This simplified description is particularly important when discussing the differences in average wealth, with implications for asset thresholds, the care cap and the impact on the market equalisation over time. For instance, as explored below, less affluent areas characterised by large numbers of council placements and self-funders tend to have a more immediate sustainability risk within their market. Note also that a county could be viewed as high risk even if residents are, on average quite affluent, if the county happens to pay very low fees relative to the care cost benchmark of care (see cross-subsidy risk discussion on page 23).

The analysis described below shows that it is necessary to consider these risks in the context of the underlying financial health of each local market, not in isolation. Providers in council areas with low local authority fee rates, large cross-subsidy requirements and few self-funders are more exposed overall to further downturn in any fee levels, and this will often tend to override the self-funder fee erosion alone.

However, it should also be recognised that there are often significant differences in affluence levels and demand and supply market conditions **within** counties themselves. It has only been possible in this research and modelling to make assessments at an 'average' county level. Averages may, in practice, conceal differences in prospects independent of affluence, for example, with some areas being more susceptible to further loss of care homes, whilst other areas might have more favourable conditions to support investment in the construction of new care homes, despite profitability on average being insufficient. Councils will need to use their local knowledge to tailor overall conclusions to cater for differences locally within their own modelling and decision-making, with national policy makers engaging with specific implications in these areas.

The importance of the overall funding requirements for the 12 councils (and expanded figures for the 37 member councils), are vital in demonstrating the challenge facing county care markets. **The key conclusion is that despite localised differences in the magnitude and timescale of the impact, the market is simply not fit-for-purpose ahead of the implementation of the Care Act. Over time all local authorities will witness significant new funding burdens and financial risks which the Government doesn't currently recognise.**

## SECTOR COMPARISONS

Building on the above points and reflecting on the potential implications for non-county areas, it must be remembered that counties are unique, with a considerably higher proportion of older people on average compared to more urban authorities. The 12 councils, whilst representative of CCN member councils, are not necessarily representative of all local authority areas across the country. The points below should be considered in reviewing the wider implications for all authorities in England, and whether the financial impact will be greater or smaller in different local authority types:

- ➔ CCN member councils account for 47% of all local government expenditure on adult social care services in England. LGA projections show that by 2020 adult social care will account for 49% of the average county council budget.
- ➔ Counties have the highest proportions of +65s on average within their populations (20%), +75s (9.2%) and +85s (2.7%) in England. In total, 55% of all those aged 85 and over in England reside in county areas.<sup>5</sup>
- ➔ CCN analysis of a Joint ADASS, LGA, CCN and DoH Care Act modelling exercise showed that CCN member councils account for two-thirds of the estimated costs of early assessment and reviews in 2015/16.<sup>6</sup>
- ➔ On average counties have relatively lower levels of deprivation. However, affluence and deprivation varies across counties. Some counties are relatively high in terms of deprivation and other more affluent counties still hold pockets of real deprivation and complex needs. In fact, three of the top ten most deprived areas in the country are within counties.<sup>7</sup>

In practice the net effect will vary around the country, and by local authority type, and needs to be modelled to determine likely local outcomes.

The data within this report has been extracted from the **LaingBuisson Main Report**, produced on behalf of the consortium councils. The views and recommendations contained within the report have been developed by the County Councils Network using this information. The **LaingBuisson Main Report** providing a full technical analysis of the project, modelling exercise and results can be found at [www.laingbuisson.co.uk/MarketReports/FreeReports](http://www.laingbuisson.co.uk/MarketReports/FreeReports).

The squeeze on local authority budgets has led to councils negotiating hard with providers to secure better value for money.

# Market Sustainability

The adult social care system is facing a funding crisis of epic proportions. The underlying issues impacting upon the sustainability of adult social care provision and local markets are well known:

- ➔ Local authority budgets have been reduced by 40% since 2010.
- ➔ Since 2010, adult social care departments have had to make savings of 31% in their budgets - £4.6bn.<sup>8</sup>
- ➔ The LGA estimates that the funding gap between March 2014 and the end of 2015/16 for adult social care alone stands at £1.9bn, rising to £4.3bn by 2019/20.

Whilst all local authorities are facing similar pressures, the situation is particularly acute for county and county unitary authorities. The recent report *The State of Care in Counties*<sup>9</sup> outlined the financial and demand-led pressures facing adult social care services in counties, including;

- ➔ CCN research has shown that after four years of significant budget reductions, existing adult social care budgetary pressures ahead of Care Act implementation are described by over three quarters of CCN member councils (77%) as 'severe' or critical.
- ➔ Counties have the highest proportions of over 65s (20%), over 75s (9.2%) and over 85s (2.7%) in England. 85% of all over 85s in England currently reside in counties.
- ➔ They receive four-times less 'older persons relative needs formula funding' per head for over 75s, compared to London.

Counties have been at the forefront of driving out efficiency savings and innovation in order to find new more affordable solutions for social care. A recent Capita and CCN survey found that traditional ways of meeting the financial challenge through improved efficiency, reducing unit costs, and re-negotiating external care contracts are becoming increasingly difficult to implement. Crucially the survey showed that whilst renegotiating external care contracts was perceived as being the most effective way of easing the financial pressures, it was the *least likely* to be implemented.<sup>10</sup>

The results of this Capita/CCN Survey show that the squeeze on local authority budgets has led to councils negotiating hard with providers to secure better value for money. But they are now reaching the limit to what they believe can be achieved while maintaining a sustainable and functioning social care market.

## LOCAL AUTHORITY FEES

Traditionally, local authorities have rightly exercised their strong market position as a 'bulk' buyer of social care placements to secure discounted rates from providers' overtime. Faced with the unprecedented pressures on social care budgets described above, councils have sought to act in the interest of their residents and negotiate even harder with providers to secure further efficiencies in social care commissioning. This has led to a widening gap between local authority residential and nursing care home fees and providers' costs.

Our research shows clear evidence that self-funding older people pay much higher fees for places in residential and nursing care homes than the councils do for equivalent support. Councils have been able to secure discounted rates from the market, at least in part, due to the extra profit generated by providers from self-funders paying higher fees.

This type of cross-subsidisation is not unique to local care markets. A National Audit Office (NAO) report

Total ASC Revenue  
 Expenditure of CCN  
 Member Councils

**£6.8bn**

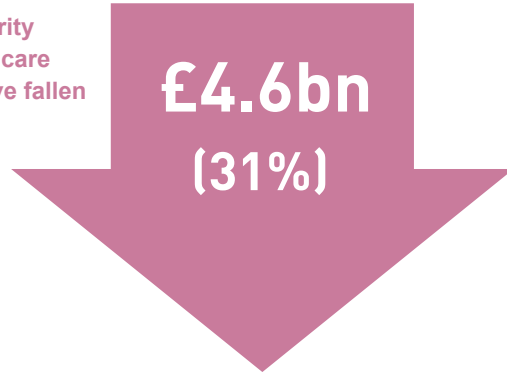
**47%**

of all local Government expenditure

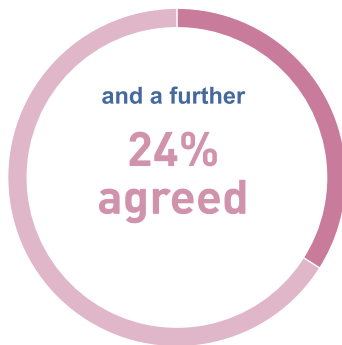
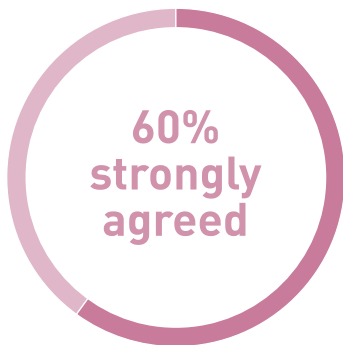
Budget Reductions Since 2010

Local authority  
 adult social care  
 budgets have fallen

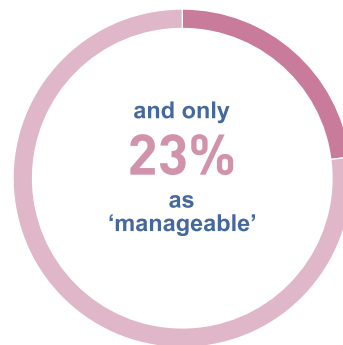
**£4.6bn**  
**(31%)**



County Financial Pressures



that adult social  
 care was the  
 biggest financial  
 pressure facing  
 their council.



*(Capita and CCN Transforming Adult Social Care Survey 2015)*



long-term issue by **96%** of respondents.

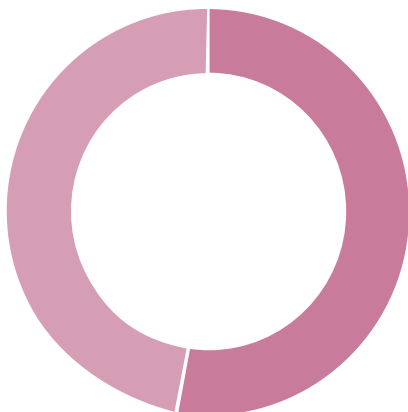
## County Demand-Led Pressures

### Ageing population

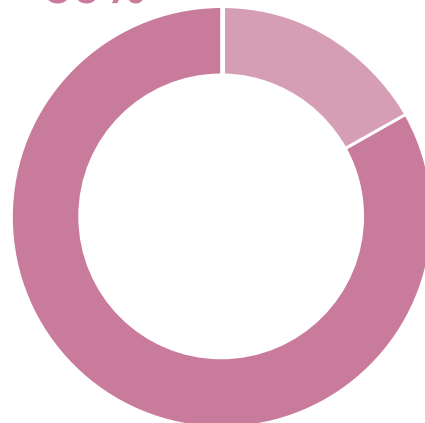


### Service user profile

Counties have on average **53%** self-funders



Some counties as high as **80%**



Current and future demand higher in counties

on pricing in public service markets stated that cross-subsidisation can be ‘a typical feature of private and public service markets’, for example, the childcare market.<sup>11</sup> Many nurseries operate complex cross-subsidy mechanisms; they rely on working parents of three and four year old children to purchase extra hours on top of their existing 15 hours of free provision.<sup>12</sup> Without this cross-subsidy some providers would not be financially sustainable. This, similarly to residential and nursing homes, is leading to a polarisation of the market (see page 29) whereby some providers have decided not to offer free childcare places as they feel the hourly rate is not sustainable. Government proposals to increase free childcare for 3 and 4 year olds to 30 hours per week could exacerbate the issue. To counter this, a Government taskforce has been established to examine the cost of provision and in turn Government have committed to review the level of subsidy they pay to providers.

Table 3 Relationship between self-funder fee rates, the ‘care cost benchmark’ and local authority fee rates, 12 counties average 2014

£ per week	Nursing Care (incl. FNC)	Residential Care
Self-funder fee rate	912	754
“care cost benchmark” of care	783	615
LA fee rate	631	511
Self-funder surplus over LA rate	281 (45%)	243 (49%)
LA rate vs “care cost benchmark”	-152 (-19%)	-104 (-17%)

## What is a care cost benchmark?

**For the purposes of this exercise a ‘care cost benchmark’ has been used to compare fees levels and arrive at estimates on underlying sustainability and funding gaps.** The benchmark is based on latest estimates of the cost of providing care and support at the sustainable levels of cost required locally to keep efficient care homes in operation and earning sufficient margins or surpluses necessary to promote investment in building new homes. This is to match the increasing need for such new homes. Anyone being paid the full care cost benchmark rate should be expected to be rated ‘good’ by CQC.

**Cost benchmarks have been estimated for each individual council, based on LaingBuisson costing models and provider surveys,** tailoring national costs for local differences in operating and capital costs. These are separately calculated for residential and nursing homes, and ‘for profit’ and ‘not for profit’ providers.

**The care cost benchmarks used in this research are not nationally agreed and approved ‘standard’ costs of care and have only been devised specifically for the purposes of conducting the analysis required within this study.**

Cross-subsidisation can be 'a typical feature of private and public service markets.'

## SELF-FUNDER CROSS-SUBSIDY

In response to reductions in local authority fees, providers have been able to charge a higher cost to those individual self-funders who have the assets to pay a higher cost for care. This they have done as part of their normal business arrangements.

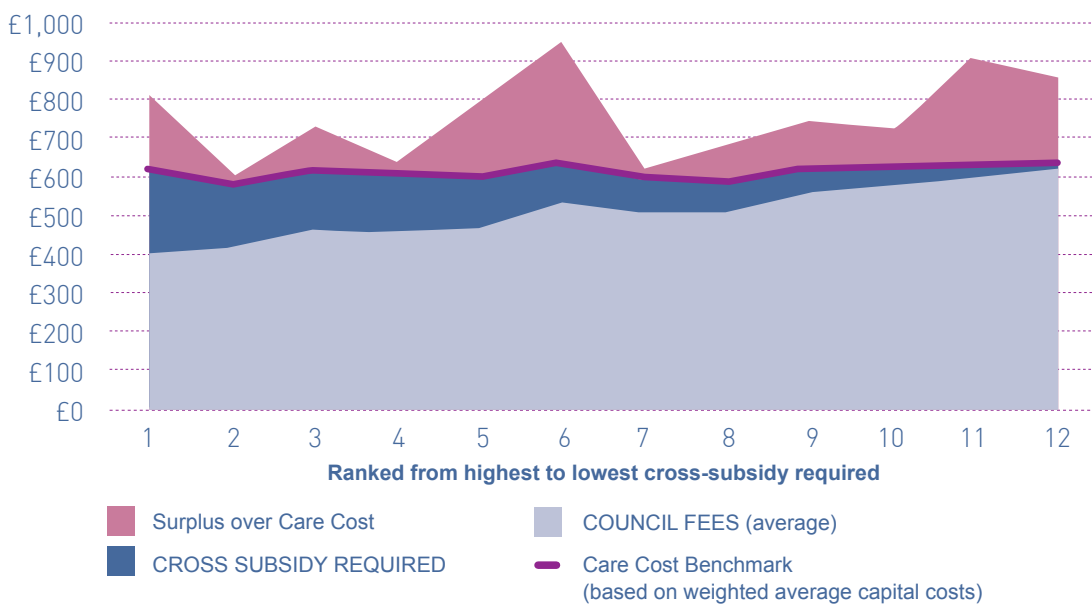
The question as to whether operators typically charge a premium to self-funders - in order to ensure that there is sufficient surplus to cover the cross-subsidy required to make their businesses sustainable - is to some extent still open for debate. Some providers claim that they do not charge self-funders excessive fee levels and that their fee levels just reflect market rates. Others admit that they do charge more because local authority fee levels are too low. There are also those who charge more for higher than standard levels of support, for which people wish to pay and should be able to do so.

Although during our study it has been possible to compare fees for standard levels of service and facilities with council fees and the care cost benchmark, actual or purported differentiation of services offered in the marketplace does make wider scale comparison difficult. It is clear, however, from the LaingBuisson analysis that in many cases self-funder fees for 'like for like' care and support are in excess of the care cost benchmark.

With councils unable to afford to pay the care cost benchmark, the financial sustainability of the current nursing and residential care provider cost model relies on cross-subsidisation from those clients who have the means to fund their own care. This inevitably leads to them paying in excess of the care cost benchmark.

Our study reveals that cross-subsidisation is in operation within the local markets of all 12 councils participating in the study. However, the extent to which cross-subsidies are sufficient to cover any shortfalls in council fees varies significantly around the country.

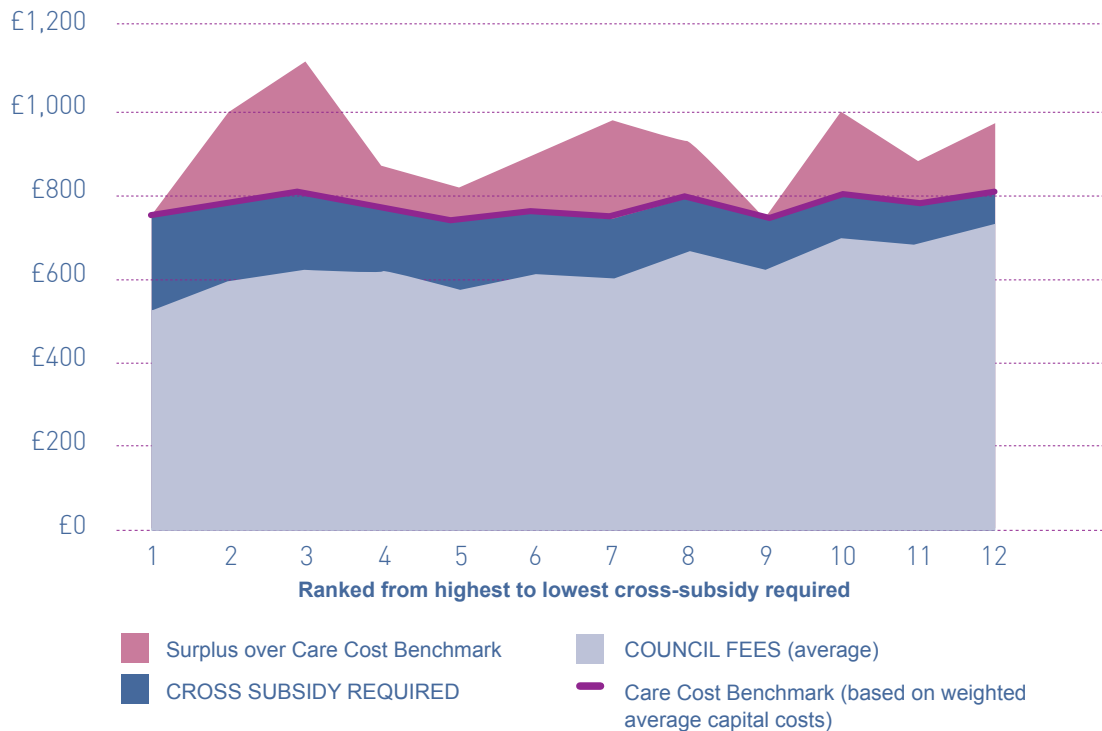
Figure 2 Cross-subsidies required and self-funder surpluses across all 12 counties, 2014 (Residential Care)



Counties which are characterised by large numbers of council placements are likely to be at greater overall financial risk. (They frequently have a higher proportion of less affluent residents and a relatively small number of more affluent self-funders to contribute to the cross-subsidies required).

The extent to which council fees fall short of the care cost benchmark, and the extent to which self-funder fees exceed care cost benchmark, also contribute to the risk that cross-subsidies will not be able to cover the deficit. Counties with a higher proportion of less affluent residents also tend to be under greater budgetary strain and find it harder to meet the care cost benchmark, given that there are more residents to support. So all of these factors can, though not necessarily in all cases, tend to compound each other and increase the overall risks to both provider profitability and council funding shortages.

Figure 3 Cross-subsidies required and self-funder surpluses across all 12 counties, 2014 (Nursing Care)



### NHS CONTINUING HEALTHCARE RESIDENTS

It should be noted that in nursing homes, in particular, there will be a proportion of residents who are funded by the NHS. Their primary care need has been agreed as a health care need, as opposed to a social care need, and the extent of their need has meant that they have satisfied the eligibility criteria for continuing healthcare (CHC) funding. CHC placements account for 15% of nursing home placements, as shown in our mix of funding graphs.

It is important to recognise that consideration of the adequacy of NHS CHC fees, to cover a similar care cost benchmark has been outside the scope of this study. Whilst CHC fees are on average considerably higher than local authority fees, it has not been established whether on average there is any shortfall or surplus in

comparison to the care cost benchmark. This would, in any event be quite difficult to ascertain given that fees vary quite widely with variation in individual needs, as do specific support costs needing to be incurred

However, if any shortfall did exist, this would add to the cross subsidy required to be contributed by self-funders, to bring overall fees in any home up to a sustainable level. The burden to address any overall shortfall should therefore logically be shared between councils and the NHS proportionately. Alternatively, if a surplus was being paid over the care cost benchmark, then logically the NHS would argue that they are entitled to eliminate this, by reducing their fees paid. As a result, this would no longer be available to help prop up the viability of nursing homes, putting providers under further financial pressure. It should also be recognised that there has been no consideration given in the study, to supply and demand trends and issues in relation to CHC. This should be addressed, in the near future; early initiatives to promote integration of health and social care should facilitate this.

## MARKET CAPACITY

The care home market in England, both for residential care homes and nursing homes is dominated by private sector provision, with steadily reducing numbers of council run homes. The majority of homes are now operated by commercial and small independent 'for profit' providers, but with a sizeable minority of homes run by 'not-for-profit' providers. Whilst there are quite a high number of larger national and regional providers, there are also a wide range of smaller operators, though market concentration is increasing. The market is characterised by a mixture of people paying for their own care, those less well-off being subsidised by local authorities and a smaller number of residents as continuing health care residents paid for by the NHS.

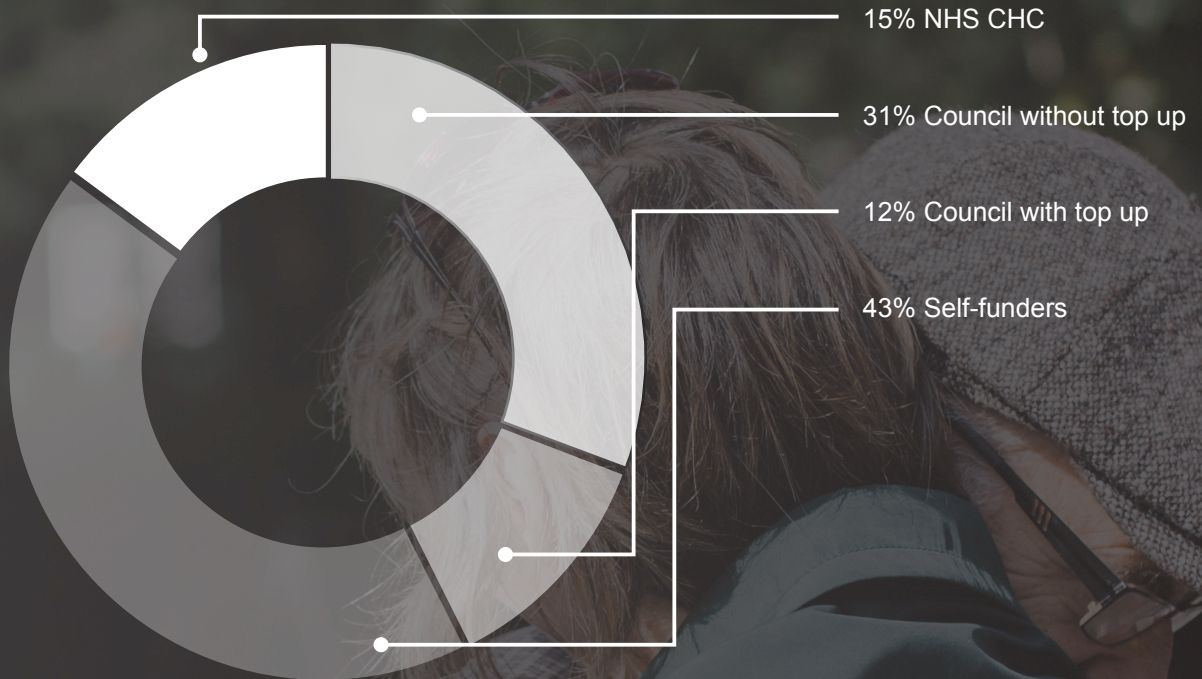
With the reduction in fees, particularly in higher risk areas, there has been very little investment in new capacity and more closures, typically of small, older homes. However, unviable homes tend to take a long time to close. They reduce costs wherever they can first, before eventually closing. High occupancy levels, at nearly 90%, on average as demand has increased, have helped in the retention of capacity and despite falling profitability in higher risk areas, there has still only been a limited 'shake out' of stock. Until recently, this averaged at approximately 1% per annum around the country.

Provider profitability in higher risk areas is therefore typically very low, and care homes are having to reduce costs to lower 'stressed cost' levels to survive. These lower costs are considered unsustainable, particularly with significant shortages of nurses and care workers necessitating paying higher wages to recruit and retain sufficient staff to provide a good service and meet increasing demand.

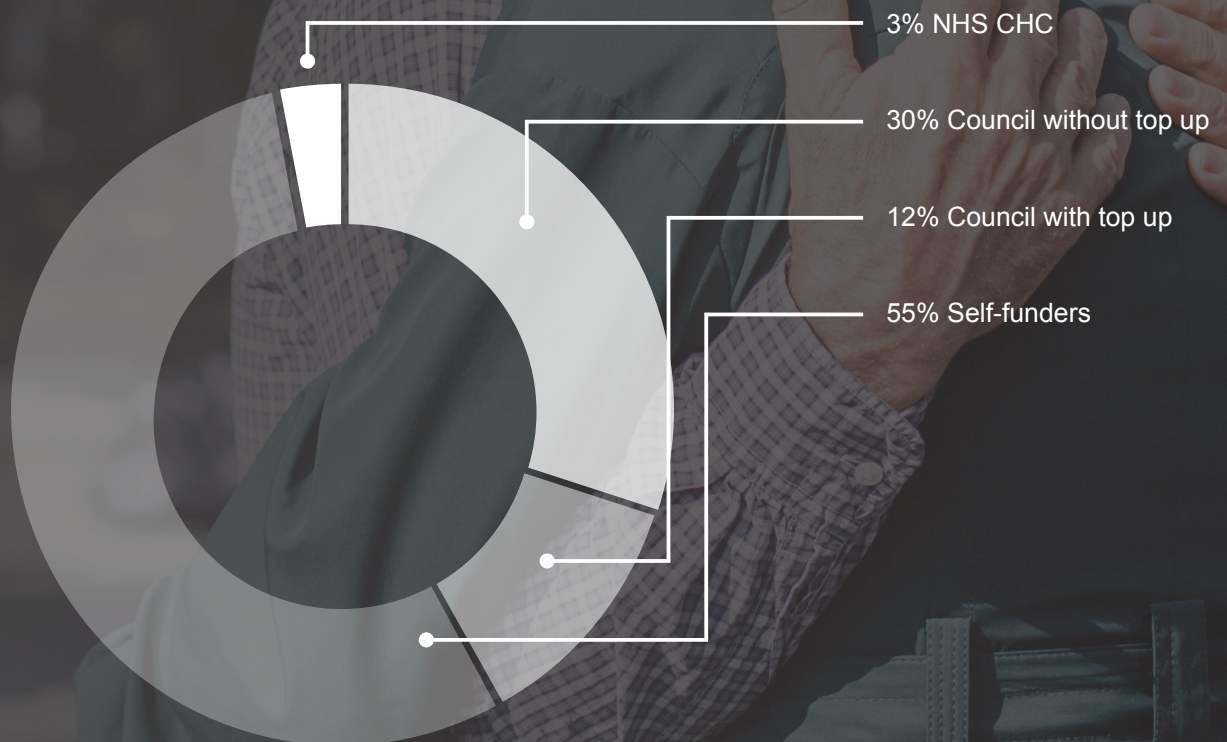
There are many factors affecting profitability; and therefore influencing the likelihood of home closures, as well as the cross-subsidy and mix of funding risks discussed above. Drivers of profitability also include occupancy, the size of home (economies of scale) and the level of staffing costs.

Figure 4 Funding sources across all 12 counties, 2014

**A) NURSING CARE AVERAGE MARKET SHARE**



**B) RESIDENTIAL CARE AVERAGE MARKET SHARE**



# Stabilising Fees & Local Markets

## UNDERLYING SUSTAINABILITY

Combining these risk factors (cross-subsidy and mix of funding) has provided the basis for drawing conclusions on the overall risk to survival of care homes by county and financial estimates on the potential **additional** funding required *immediately* to maintain a functioning market and prevent market instability.

Our research estimates that the existing 2014 'care home fee gap' to be **£236m** for the 12 consortium councils. The care home fee gap is defined here as the amount by which council fees fall short of the care cost benchmark required to achieve market sustainability and maintain local capacity, without resorting to cross-subsidies from self-funders or the relatively small amount of third party top-ups.

Extending these findings through extrapolation to all 37 CCN member councils produces an estimate of an existing 2014 care home fee gap amounting to **£630m**. This funding shortfall in the market is *in addition* to the funding gap of £1.9bn estimated by the Local Government Association (LGA) for 2015/16. The LGA projection is for *all* 152 upper-tier councils with social care duties and based on the shortfall in local authority funding to meet overall social care demand for 2015/16, given the cutbacks in local authority funding and not recognising **any** shortfall in the level of council fees being paid.

The financial risks tend to be mutually reinforcing and lead to confirmation of the initial presumption that care homes in high risk counties, with low LA fees and few self-funders, paying relatively low fees are already in a parlous state, with a high current risk of going out of business.

## LONG-TERM MARKET SUSTAINABILITY

Alongside an analysis of the financial implications of the *existing* funding gap, our study has used the development of dynamic market models for each of the 12 councils to track the impact of changes in demand, funding, fees and other variables on supply and sustainability of care homes over time.

Looking ahead and modelling future fee levels, our research shows that further funding shortfalls are highly likely and largely due to council fee increases over the next five years or more failing to keep up with likely sector-specific cost inflation.

Despite current low overall inflation, severe ongoing shortages of nurses and to a lesser extent care workers are already putting pressure on unsustainably low wage levels. These will need to increase to attract and retain good staff, in competition with the NHS for nurses and rising wages elsewhere with respect to care workers. Pressure to increase fees to maintain provider profitability and stabilise local markets will come at a time when local authority funding will be further reduced during this Parliament. With adult social care constituting almost **49%** of an average county council budget by 2019/20, councils will have no choice but to seek further substantial savings in this area of council expenditure.

Given the underlying sustainability issues which are already facing the market, projections using the models show that the fee gap for older peoples' care homes is likely to increase to around **£256m** (other things being equal) by year one of the threshold extension in 2016/17 for the 12 councils and of the order of **£684m** for the 37 CCN members, see Table 2, even before considering the impact of the Care Act.

On this basis, with costs outstripping council fees even slightly, shortages in capacity for many councils will start to arise within the next five years. Shortages in capacity will arise earlier in nursing care, which is usually less profitable than residential care. In counties defined for the purposes of this study as ‘high risk’, with large numbers of council funded residents and relatively small numbers of self-funders, it is predicted that increasingly care homes will close and very few more will be built. Modelling shows that it will take only a modest shortfall of council fees relative to the cost of inflation to lead a significant cumulative effect in reducing provider profitability in these areas over the coming years.

## MARKET POLARISATION

There is also strong evidence of ‘polarisation’ within the social care market, with this polarisation between publicly and privately funded care increasing. Currently around 30% of homes now have less than 10% of council funded residents. There is growing evidence that many new care homes focus almost exclusively on the self-funder market, with higher specifications, facilities and services where possible to help justify higher fees. The remaining homes have proportionately less self-funders and a higher risk that cross-subsidies required to remain sustainable will not be sufficient.

The issue of market polarisation is often particularly evident in counties with high proportions of self-funders. In these counties, providers may have maintained profitability by focusing on expansion of high end services to increase self-funder fees. This increases the cross subsidy between self-funder and local authority fees and makes it more likely that local authorities will become reliant on a smaller pool of providers in their areas whose business models are more geared to the provision of what might be classed as “standard” care.

The pressures faced by these providers will be very similar to those described above in counties with fewer self-funders, whereby any shortfalls in council fees could severely threaten market sustainability. If these providers are not able to continue to operate their existing business models, then local authorities will have to resort to seeking placements with providers who have developed more bespoke services, inevitably leading to significant increases in local authority fees. Where this is not possible, either due to financial constraints, lack of availability or willingness from providers, capacity issues will quickly emerge for local authorities with significant knock-on effects across the whole health and social care system.

It is considered highly likely that, with additional pressure on providers to reduce fee levels for self-funders as a result of the Care Act (see below) the trend towards further polarisation will accelerate, with providers seeking to differentiate their services where possible to justify retaining higher fees. There is the potential that a two-tier care market could become the norm, with a differentiation in quality of care giving rise to substantial risks to the safeguarding of clients. From the research, based on identification of actual fee levels and mix of funding sources from providers and councils, it has been possible to build up a profile of the different risks by county. We have to consider these alongside typical profitability levels, by home type, to predict the impact of trends, as well as the effect of Care Act provisions.

# Care Act Implications

## BACKGROUND

The Care Act will add to the numerous financial implications and the growing pressures on local services which, as described above, are leading to instability in local care markets.

CCN has consistently argued that the Care Act poses a number of financial uncertainties for councils. CCN is also one of the only national organisations which have consistently raised the issue of market equalisation. CCN first raised concerns in March 2014, with research showing that 43% of CCN member councils had 'concerns' and a further 30% of councils had 'major concerns' over the impact of the reforms on local care markets.<sup>13</sup> CCN has subsequently argued that market equalisation could potentially be the single biggest financial and reputational burden arising from the Care Act, posing risks for service users, local authorities and providers of residential and nursing care.<sup>14</sup>

Following active engagement between the DoH and CCN, it has been recognised that there is the potential for the Care Act to have an impact on care markets. For instance the DoH acknowledged this uncertainty by delaying the implementation of section 18 (3) of the Care Act, which would require local authorities to meet the needs of self-funders in care home settings, in acknowledgement of this uncertainty. However, despite acknowledging this and committing to evaluate the impact, the most recent Care Act Impact Assessment does not allocate additional funding or acknowledge the financial risk for local authorities or to the wider market.

Our research has analysed key aspects of the Care Act and its potential to lead to market equalisation. Below we provide further details on this, alongside commentary on the analysis undertaken, financial and policy implications.

## CARE ACCOUNTS & SELF-FUNDER BEHAVIOURS

The introduction of the Care Act and the subsequent requirement on local authorities to be more transparent about the cost they pay for care is likely to lead to a reduction in the level of cross-subsidisation by self-funders described in the previous section.

While it still remains unclear whether councils will be obliged to arrange care for self-funders at their usual cost of care fee rates under section 18(3) of the Care Act, our research provides evidence that it is likely that self-funder fee levels will come under pressure independent of this new duty.

Self-funder fees will fall to some extent as a result of the increased transparency in relation to the significant difference between self-funder and council fee levels for similar levels of care. It will become increasingly apparent that a significant cross-subsidy exists once people start opening up care accounts. Increased awareness will also result from greater publicity about the difference in rates, as well as lobbying from those acting on behalf of older people trying to find suitable care homes at lower costs of care.

Whilst the behaviours of self-funders are hard to predict, the result of the relatives' self-funder survey supporting this project suggests that relatives will utilise their improved knowledge of public and private fee rates to either drive a harder bargain with providers when arranging care, or alternatively request the local authority to arrange care on their behalf.

### Box 1 Relatives Self-Funder Survey \*

- ➔ Only half of respondents indicated that the resident had sold, or intended to sell their home to pay for care.
- ➔ 47% considered the fees paid to be about right, with 41% suggesting that they were too high (for the care & support being provided – especially in relation to poor pay of staff and low numbers of staff).
- ➔ The majority were aware of the cap on care costs, but only a minority were aware of the extension to deferred payments, or provision for local authorities to help self-funders in arranging their care.
- ➔ 28% would probably not advise setting up a care account, as compared with 48% likely to do so. Some (of 28%) do not believe their (parent) would have lived long enough to gain from the cap, or believe that their assets would reduce to below the new £118,000 threshold for council support before the cap was reached.
- ➔ 56% said they would be less than likely, compared to only 22% likely, to suggest entering into a deferred payment arrangement. Some would not need or want to sell their house, having sufficient wealth, while others are put off by the possible charges/ roll up of interest.
- ➔ The majority seem to think that the resident is paying significantly higher fees than the council, but in some cases they recognise that top-ups are needed for the facilities provided and that these are sometimes at a higher level than what the council pay for care.
- ➔ 83% would be very concerned or concerned, if their relative was paying more than the council, for the same care.
- ➔ 28% would not ask for council help in arranging care, as compared with the 26% who would (although 32% are currently undecided).

## MEANS-TEST THRESHOLD

Increasing the minimum wealth threshold from **£23,250 to £118,000** will bring more care home 'in situ' residents immediately under the responsibility of the councils from April 2016. However, given that own resource top-ups (first-party) are also going to be allowed under the Care Act, there is a high probability that most of these residents will need to pay a top-up to bring the total fee paid back up to the self-funder fee level, if these individuals are to remain in their existing care homes.

Those older people needing care who have minimal levels of wealth, and so would have had their care paid for under the existing lower threshold, cannot be expected to pay any greater top-ups than third parties do now on their behalf. Others needing care are likely to be expected to pay own resource top-ups, but will not have the pressure of wishing to remain 'in situ' (unlike those already in a care home) they will probably not be obliged to pay top-ups to the full amount of the self-funder price.

## CAP ON CARE COSTS

The financial impact of the introduction of the care cap will probably not be felt directly for between three to six years, depending on the average level of prices that different councils will pay, and the extent to which council fee rates rise over time. This is the time it will take for individuals to build up care costs to £72,000 with only

\*A survey of relatives of residents in care homes who had contacted the Relatives and Residents Association for advice on care planning for their family members was conducted. This was on the basis that the residents themselves would not generally have been in a position to respond to the questions directly (many being very frail and many having dementia, and not easily accessible in their care homes). Relatives were therefore asked to speak on behalf of the residents, as well as commenting on what had influenced their own input to the decisions taken on paying for care.

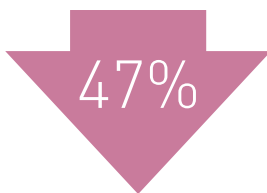
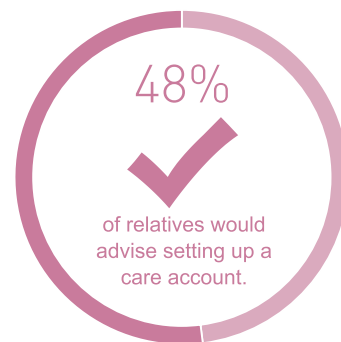
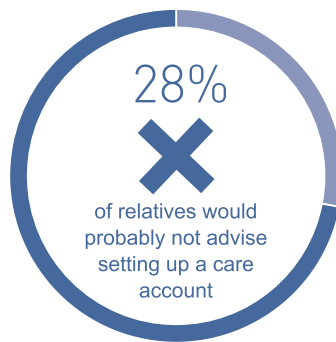
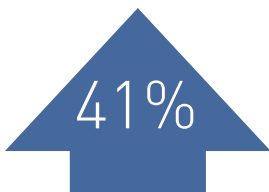
eligible care and support costs at council average care fee rates accruing towards the cap. Many residents will therefore die before reaching the cap, even if they have previously been receiving eligible home-based care, which can also be credited to their care accounts first.

In high risk areas, many recipients of support in care homes will have quickly depleted their assets to below the new wealth threshold before reaching the cap, so councils will become responsible for paying for their care earlier than expected. As for others falling under the threshold, care homes will expect them to pay as much as they can, by way of 'own resource' top-ups, rather than the homes having to suffer the full reduction in fees down to council fee rate levels. Given that these residents will also be 'in situ', there will be pressure on them to pay full top-ups if they want to remain in their existing care homes. This will depend on their incomes as well as remaining assets. There may therefore be some additional fee erosion, at this later time, and thereafter for subsequent older people who through paying for care over several years deplete their assets below the higher assets threshold.

It is important to note that where assets fall to below the threshold before the cap is reached, there is a greater additional burden on councils to fund the costs both of care and accommodation (hotel costs) than there is if older people reach the cap while still having assets above the threshold. In the latter case the council only becomes responsible for meeting care costs.

Relatives Self-Funder Survey

41% of relatives suggested the care home fees they pay were too high



47% considered the care home fees they pay to be about right



83% of relatives would be very concerned, if their relative was paying more than the council, for the same care

# Funding & Policy Implications

## FEE EROSION

Our consortium research provides evidence on the potential erosion in fee levels of those who fund their own care as a result of these key aspects of the Care Act, and how this might lead to additional costs for councils.

The impact of all these Care Act changes has been modelled by super-imposing assumptions about wealth and the size of top-ups which will be paid plus the likely extent of self-funder fee erosion, to assess the further downward effect in reducing provider profitability. In particular, it has been assumed, for the purpose of modelling outcomes in the 'most likely scenario' that self-funder fee levels fall by 50% of the difference between self-funder and local authority fee levels over 5 years. As emphasised above, the 50% reduction in the fee differential assumption equates to a fall of 7.5% on average; and this varies significantly between councils. However, it is still believed that fee erosion will be material across all councils.

None of the assumptions are set in stone and any can readily be flexed to consider the sensitivity of results and financial impact to changes in key variables. As would be expected, the combined effect of all these adjustments closes further homes across the 12 councils, and severely restricts the building of new homes. This adds to the shortage of sufficient capacity to meet expanding future demand for care home places with the greatest impact being felt in the counties which have a combination of high risks.

The most important mitigating factor is likely to be the availability of more top-up funding. This is because of the greater affluence of the cohort of residents with assets of up to £118,000 who will be able to seek council support and because of the availability of first party top-ups for the first time. It is expected that such is the threat to market sustainability from the other negative factors, councils will have little alternative but to promote top-ups after 2016.

As described above, currently the differential between the price which self-funders pay and what the councils can afford to pay is substantial and effectively acts as a cross-subsidy to make up some of the shortfall in what the councils pay relative to the full care cost benchmark.

**Even if it is not obligatory for councils to help to arrange care for self-funders under Section 18(3) of the Care Act at their usual cost of care fee erosion is therefore highly likely.**

Based on the dynamic model predictions, this could have a severe negative impact on the profitability of providers. Introduction of higher minimum wealth thresholds could also further reduce fees paid to providers, as more people fall within council funding responsibility, to the extent that reductions in fee levels are not fully made up by additional top-ups from those receiving care themselves (which is now allowed under the Act) or their relatives.

Both these Care Act provisions are likely, in turn, to lead to more homes closing and not enough investment in building the numbers of new homes required to meet the increasing demand within the care home sector. The impact of supporting more people falling under the higher wealth threshold, in particular, is also likely to lead to additional funding requirements for councils, even if council fee rates are not further increased specifically to help those already in care homes by paying any more than usual cost fee levels.

## MARKET EQUALISATION IN THEORY AND PRACTICE

The principles and reforms set out in the Care Act seek to rebalance local care markets in favour of service users and protect them from catastrophic care costs. Market equalisation, the elimination of the difference between self-funder fees and council fees, is likely to occur as a result of greater self-funder awareness and behaviour change, resulting from both the promotion of the reforms (locally and nationally) and transparency of care home fees bought forward by Care Accounts.

The DoH to date has failed to quantify any underlying or future sustainability risks within the impact assessments that accompany the Care Act. They have concluded that they do not believe that there is sufficient evidence at this time to estimate if the Act will lead to additional market instability and unfunded new burdens for councils. Without recognition and significant funding intervention from government to reduce cross-subsidies in the sector, market equalisation is not desirable or financially viable. It is important to note at this stage that *'Cross-subsidisation can be a typical feature of private and public service markets'*.<sup>15</sup>

Local authorities commonly utilise block contracts in the care market to bulk purchase care beds at a discounted rate. Providers are willing to enter in to such mutually beneficial arrangements as they also receive compensating and offsetting benefits such as guaranteed numbers of new placements or payment for voids. It is a common market practice for businesses or groups of individuals who bulk buy a commodity to receive a discount compared to a business or individual purchasing the same commodity on a solitary basis.

It should be recognised that the models are being used to estimate the broad level of funding required to pay sufficient fees to stabilise local care markets, rather than to suggest that prices are always set at the care cost benchmark level. The extent to which self-funder fee premiums are eliminated and should move down towards the care cost benchmark level also needs careful consideration, in terms of what is appropriate and achievable in practice.

There is an argument to suggest that local authorities should still be entitled to a reasonable, though lower discount than they receive at present, against the care cost benchmark when local authority commissioners enter into block contract or any specific arrangements with providers. Therefore, it would be more justifiable and realistic to plan for a market where a modest discount for local authorities utilising bulk contract arrangements exists. Such a scenario must be considered by government when evaluating the level of funding shortfall which needs to be met to ensure local care markets are sustainable, alongside the extent to which self-funder fee premiums need to be reduced.

As within any other market where forces of supply and demand are at work, councils would expect to pay lower fees to providers when there is surplus capacity of care homes, and quite possibly a higher premium when there is a shortage. Prices will still be negotiable and expected to vary over time and with changing conditions. This is how the market adjusts to bring supply into line with demand. Self-funders would also possibly acknowledge that they might expect to pay slightly more than a standard price for care if there was a shortage of homes, and less if there was a lot of choice.

Of course, where residents are receiving an enhanced or 'premium' service, with higher cost rooms, facilities and levels of service than standard, then providers are entitled to continue to charge residents receiving this

At a time when  
Government is focusing  
on improved health and  
social care integration  
allowing instability and  
polarisation in care  
markets to worsen  
would be highly  
counterproductive.

higher cost care at a higher self-funder fee rate. However, where services provided are at a more standard level then, if councils pay up to or closer to the care cost benchmark then there should be no reason in principle why self-funder fees should not be brought down nearer to this level. One reason for not doing so fully, from the provider perspective will be if councils continue to justify paying slightly less than the care cost benchmark. Providers will then feel that they need to continue to charge fees to self-funders which include an element of premium, though clearly only a much smaller element, to cover the cross-subsidy still required to maintain the viability of their homes, on or around average fees which cover the full cost of care.

The level of additional public funding required to make up the funding shortfall as a result of market equalisation will vary dependent on how far towards the care cost benchmark self-funder fees fall and local authority fees rise. If local authorities received a 5 or 10% discount below the modelled care cost benchmark, the 'mix of funding' as previously discussed in this study, would suggest that for the market to be sustainable self-funders would still be required to pay a premium above the care cost benchmark. However, the extent to which this premium will be required will be dependent upon the proportion of local authority funded residents in care homes compared to self-funders. For example, in counties where there are a higher proportion of self-funders it is likely that the premium required for a sustainable local care market would be lower than the 5 or 10% discount the local authority receives for block contract arrangements.

Looking at care market equalisation overall, if fees were equalised at the care cost benchmark level, this would tend to mean that in less affluent, typically 'higher risk' county areas, bringing provider fees down to care cost benchmark levels whilst increasing council fees would tend to increase provider profitability generally from current levels (as there are more council residents than self-funders). Whilst in more affluent, typically 'lower risk' county areas, it will tend to reduce provider profitability (as there are more self-funders than council-supported residents). This is a generalisation, and possibly not always true, because it will also depend on the extent to which council and self-funder fees are currently below or above the care cost benchmark; however it is reasonable assumption. There will also be quite different results between nursing and residential care, because of very different proportions of self-funders

The extent to which market equalisation will occur will either increase or decrease the levels of risk for each county in maintaining a sustainable care market. A key question is to what extent and how self-funder fees can be reduced if funding is provided to bring local authority fees closer to care cost benchmarks. In such circumstances, bringing self-funder fees down in practice is likely to be problematic. This may not be easy to achieve in the marketplace, in view of the polarisation which has taken place, and the market position of providers, to be able to resist attempts to negotiate down the fees they charge to self-funders. How this might work in practice is not the focus of this overall report, and will need to be considered in some depth separately.

The results of this study, in part, demonstrate that providers in some counties (on average) are charging too much to self-funders (i.e. more than is needed to pay the cross-subsidies required), whilst in others they are receiving insufficient in self-funder cross-subsidies to be sustainable.

In conclusion, it can be appreciated that whether the results will actually show that all the markets will be sustainable as a result of this equalisation depends on the specific estimates which can be made and underlying assumptions about the extent of the changes which can be effected. There will be other factors in relation to existing supply and demand etc. which might mean that sustainability will not always be achievable with this level of overall extra funding estimated for councils, to bring local authority fees up to the care cost benchmark

level. In other situations, this funding will be more than enough to ensure sustainability. In practice sustainability can only be addressed county by county.

## TOTAL FINANCIAL IMPLICATIONS

After the impact of Care Act market equalisation and threshold changes has been incorporated into the models, projections of net financial costs to councils and total funding shortfalls can be arrived at. The results are summarised in Tables 1 and 2 and Figure 1a and 1b in the section on Model Overview, Assumptions and Results above. In order to avoid confusion we do not repeat the analysis here, other than to state that the additional **£988m** annual net care home costs for all 37 CCN counties by 2020/21 translates into cumulative additional net care home costs of **£3.1bn** for the five full years from 2016/17 to 2020/21.

As noted previously but restated here, these figures exclude costs relating to home care clients, working age adults, the cap on care (the largest single element in the DoH costings) and other associated costs such as additional assessments, system changes and other overhead costs. **This suggests that the DoH national total estimate of £2.5bn ‘by 2025/26 may substantially understate the potential cost to councils.** These additional costs due primarily to ‘market equalisation’ and are unfunded in the impact assessment.

The estimates of the cost of the response required also allow for a small reduction in overall needs in residential care, through continuing to follow a policy of providing support to keep people in their own homes whenever possible. However, given the typical age at which people now enter care homes and their condition (many around 85 years old and most extremely frail), the scope for so doing is considered to be limited, and therefore only a **0.5% per annum reduction** in residential care needs over the ten years of the projections has been allowed for. Development of more extra care housing could help, but there are constraints on implementing extra care housing plans as quickly as councils would like, and residents tend to move into care homes from there anyway once they become very frail and/ or ill.

At this stage, no additional costs for councils relating to the care cap have been calculated. This will not represent an imminent additional cost to councils, given that it could typically take up to four to five years to reach the cap, from 2016 onwards. However, it will start to further increase council funding requirements, possibly from 2019/20 onwards, and adjustments to increase funding estimates still need to be included in the estimates.

## IMPACT ON COUNCIL BUDGETS

Looking at councils’ financial positions from 2016/17 onwards, the projections set out the extra costs associated with each contributory factor, in accordance with the different scenarios - ‘base case’, ‘most likely’ and ‘most likely plus response’. The results are summarised in Tables 1 and 2, above, which sets out the numbers for each component of change for each year until 2025/26, while Figures 1 and 2 illustrates them graphically.

Even under the ‘base case’ scenario (before consideration of the impact of the Care Act), it will become increasingly challenging for councils to deliver an acceptable social care service for older people, in the absence of more Central Government funding. Accelerating demographic pressure in the coming decade (at the equivalent of about 3% per annum in volume terms) threatens to overwhelm the capacity of councils to continue

to divert demand to less costly non-residential care options.

**Under the ‘most likely plus response’ scenario the current model for funding publicly paid social care in England is simply unsustainable without a substantial injection of new funding.**

### IMPACT ON THE HEALTH SERVICE

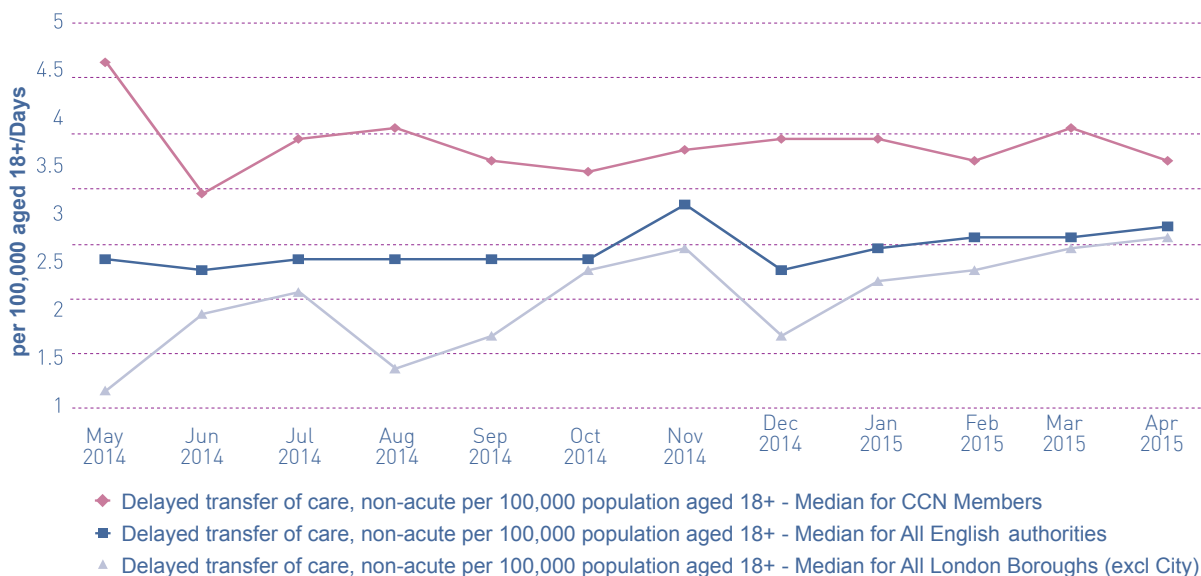
It is critical that we do not lose sight of the impact that continuing market instability and unfunded duties under the Care Act could have for the wider health economies of county areas. In particular, the growing trend toward market polarisation.

If local authorities are unable to pay a higher cost than they currently do to stabilise the market, then care home providers will have to consider how best to ensure their business stays financially viable. This is likely to mean many providers seeking to secure business from a higher proportion of self-funders, with new investment concentrated in this segment of the market.

The problem is likely to be that these will not typically be accessible to the local authorities (in both high and low risk areas) and the health sector for residential, nursing or continuing health care placements, as they will concentrate on higher specification support, with high fees, way beyond what councils can afford to pay. Local authorities and the health service will find it increasingly difficult to find suitable and affordable care arrangements for the increasing numbers of state supported clients.

At a time when Government is focusing on improved health and social care integration, to shift funding away from acute to preventive care, allowing instability and polarisation in care markets to worsen would be highly counterproductive. Local authorities and Health (NHS) will find it increasingly difficult to arrange care at market discounts, or worse, difficult to arrange care at all. This will **lead to escalating costs to the health service and increasing delayed discharges, with councils and health providers being unable to find quality and affordable residential and nursing placements to reduce demand on acute healthcare.** The delayed discharge rate is already 56% higher in counties than the national average (May 2014- April 2015).

Figure 5 Non-acute patients whose transfer of care is delayed (monthly snapshot) per 100,000 population aged 18+ (raw values)



# Conclusions & CCN Recommendations

Through a comprehensive analysis of council fees and the use of dynamic modelling, this study has scoped the underlying sustainability risks within local care markets. It has shown that the market is under considerable strain and this will continue to grow over time. The shortfall in council fee rates, largely due to Government funding cuts, is the root cause of the existing instability in the market and much of the projected shortage in future care home capacity.

Crucially this study has described how specific elements of the Care Act interact with this underlying instability. A core aim of the Care Act is to inject greater transparency into the social care system, allowing self-funders to better plan for their care needs, in the process bringing many into contact with local authorities for the first time. But this increased transparency and contact could lead to a gradual equalisation in self-funder and local authority fees, leading to currently unfunded additional costs to local authorities, a reduction in market capacity, and a further 'polarisation' in the market.

The findings of this study have wide ranging ramifications for the local government and health sector and ask difficult questions of policy makers and the Government on the future of social care funding and the Care Act. **What is clear and apparent is that the Government must work collaboratively with local authorities, providers and the NHS to address the issues discussed in this study or face up to the likely consequences of care home shortages, poorer quality care, increased prevalence of system blockages, delayed discharges, and escalating health and social care costs.**

## RECOMMENDATIONS

Based on the analysis undertaken by LaingBuisson, we have estimated the financial implications of existing market instability and equalisation overtime. In presenting this evidence to Government on the underlying sustainability of the residential and nursing care home market, both ahead of Care Act Implementation and in the following years, this ground-breaking modelling has incorporated a number of scenarios that will need careful analysis when considering appropriate policy and funding responses.

The main scenario, which arrives at the funding shortfall described above, simply calculates the total net cost of taking council fees up to the full cost of care. This would totally eliminate the need for any cross-subsidies to be paid by self-funders, based on fees levels estimated for 2016/17, when the second phase of the Care Act comes into force. This would directly address the root cause of the problem of cross-subsidisation in the market, this being the shortfall in council fees. If the councils received sufficient extra funding to increase fees to this extent then this should be sufficient to stabilise the market, at least before consideration of *full* or *partial* market equalisation of council and self-funder fees.

A further scenario used in this research looks at the additional impact of also bringing self-funder fees (or at least those charged for standard rather than enhanced levels of care) down to the care cost benchmark level. This will clearly reduce provider profitability again, offsetting the positive impact of increased council fees. However, it is expected that the increase in council fees up to the care cost benchmark should also be sufficient to *manage* the impact of the Care Act on their local market. The extra amount self-funders pay to contribute cross-subsidies would be eliminated, progressively over time, as council fees are raised. This would be consistent with new requirements that councils ensure market sustainability and the overarching Care Act principles and implications to deliver greater transparency and a 'fairer deal' for those funding and arranging their own care needs.

**CCN are of the view that while the current level and extent of cross-subsidies is clearly unsustainable and a consequence of inadequate funding for social care, councils should be able to continue to secure care at discounted rates, due to their market position and ability to bulk purchase.** It is neither desirable nor practicable for council fees to rise to *fully* to the 'care cost benchmark' used in this exercise, even though fees are on average unsustainably low. This was explored at length in the 'Market Equalisation in theory and practice' above. Additionally, given the fiscal climate, the Government may not be able or willing to meet the total funding gap in the market identified.

In responding to the challenges outlined in this paper, Government will need to work closely with the sector to assess what the acceptable scale of cross-subsidisation and market risks are given underlying instability and the additional pressures created by the Care Act. This will include a more in-depth analysis of fee levels right across the country and the extent of excessive self-funder fee levels and provider profitability.

This will ultimately determine whether Government meets the **total** funding gaps presented, alters regulatory frameworks or devises market interventions in collaboration with the sector to mitigate the risks described, particularly those associated with market polarisation and its impact on the health service. The new Conservative administration has committed to a similar approach in the childcare market following the introduction of the Childcare Bill. Given the scale of the challenges facing the adult social care sector, a similar market analysis and mitigation work must be undertaken.

**Recommendation 1) The Government engages extensively with sector stakeholders, including CCN, ADASS and care providers to analyse the social care provider market, devising national and local policy responses and strategies to stabilise the residential and nursing care market in the short, medium and long-term.**

This study has emphasised throughout that while councils have rightly used their market position to secure lower fees overtime to secure the efficiency savings demanded of them, dramatic reductions in social care budgets is now creating a situation where the level of cross-subsidy is now unsustainable ahead of Care Act implementation.

CCN recognise the reality of the fiscal situation that the Government has committed to addressing through further reductions in local government expenditure, while at the same time significantly increasing NHS funding by at least £8bn by 2020. *Our Plan for Government 2015-20* set out our member councils' commitment to play their role in reducing the deficit through a continuation of achieving further efficiency savings, wide-ranging public sector reform, and the full integration of health and social care. However, it is only through a combination of *fairer* funding for social care, policy amendments, radical integration and *devolution* that we can overcome the challenges facing county care markets.

Increasing funding to councils to enable them to begin to address low council fee rates has to remain the obvious and necessary starting point response. The future pressures on funding on local authorities are well known, enormous and increasing, so this will not easily be achieved, particularly in the context of Government commitments to reduce the deficit. However, given the current funding shortfalls in the market, coupled with the continuation of austerity over the course of this Parliament, paying higher fees without an immediate funding

injection from Government would be financially unviable for many local authorities.

In allocating funding in the short, medium and long-term, the Government must consider the wider ramifications that care market instability and potential failure could have on the wider health economy of an area. As previously discussed, while councils will feel the direct financial burdens of continuing instability, declining capacity and market polarisation, the additional service and financial pressures created for primary, secondary and acute health providers could be equally damaging.

In taking tough decisions on spending the Government must take holistic view on its commitment to increasing health expenditure, recognising that funding at the expense of highly disproportionate cuts to local authorities will only lead to higher system costs within the NHS and poorer outcomes for local residents. Consideration should be given to allocating a proportion of the committed £8bn for the NHS to local partnerships between health and social care to shore up local care markets and prevent cost-shunting.

**Recommendation 2) The Government provides additional, targeted, funding to CCN member councils to reduce the reliance on cross-subsidy in local care markets to achieve market sustainability and maintain local capacity.**

**Recommendation 3) Government recognise the scale of the instability within local care markets and use the 2015 Spending Review to deliver a fair and sustainable funding settlement for adult social care to ensure the medium to longer-term sustainability of local care markets.**

The eventual costs of continuing market instability and market equalisation is highly reliant on out-standing Care Act policy decisions. CCN continue to have concerns over the implications of Section 18(3) of the Care Act (duty to meet the needs of self-funders). We believe that the uncertainty surrounding what this new duty means in practice requires further detailed analysis and engagement with the sector. We also believe that this study has highlighted a number of potential inequities in funding reform for both service users and local councils, which vary between regions and need careful consideration. In line with the on-going consultation on Part 2 Regulations and Guidance, the DoH must consider the findings of this study when finalising guidance and regulations, working with the sector to mitigate risks.

Independent of specific policy decisions, this study has also suggested that market equalisation will occur from greater self-funder awareness and behaviour change, resulting from both the promotion of the reforms (locally and nationally) and transparency in fees bought forward by Care Accounts. Clearly, we do not believe that individuals should be discouraged from taking advantages of new rights enshrined under the Act. CCN has long maintained that the additional contact self-funders and future care users have with the formal care system has wider benefits of embedding prevention and early intervention. This additional contact over time will lead to better care planning, community-based services and home care options which will act as an important tool in managing demand for residential and nursing care.

However, increased awareness of rights, contact and transparency will lead to some extent of market equalisation and additional costs for local authorities. Currently, the impact assessment neither recognises this, nor provides any indicative costs. CCN has consistently supported the principles that lay behind Part 1 and Part 2 of the Care Act, but have maintained that implementation can only take place if the Government is

able to accurately quantify costs and any associated risks. In the absence of additional funding and continuing uncertainty, the Government must consider whether pausing the implementation of part 2 of the Care Act will allow greater scope to analyse the implications of this study and seek a greater understanding of the implications for the whole of England. A failure to fully fund or understand market risks will undermine the intentions of their own policy.

**Recommendation 4) Government continues to delay the implementation of Section 18(3) Duty to Meet Needs (In care home settings), and ensures all Care Act statutory guidance and regulations do not lead to further unsustainable pressures in local care markets.**

**Recommendation 5) The Care Act Impact Assessment is revised, acknowledging there is now sufficient evidence to suggest the Care Act will lead to a significant new financial burden for CCN member councils from market equalisation. As part of its commitment to fully fund the Care Act, the Government provides an indicative cost and allocates resources according to need as part of the 2016/17 local government funding settlement.**

**Recommendation 6) In the absence of additional funding and continuing uncertainty on the impact on local care market, the Government considers delaying the implementation of Part 2 of the Care Act whilst a detailed market analysis is undertaken to ascertain the impact of the Care Act on local care markets across England.**

Although a sustainable funding settlement and clarity over the impact of funding reform will go some way to addressing the crisis in local care markets, the long term solution to stability in the adult social care sector lies in radical new approaches to health and social care integration. Long-term reductions in recurring demand for social care services, whether home-based, residential or nursing, requires *locally-led* whole-system change driven by the principles of public service reform and *devolution*. Part of the solution to the declining capacity highlighted in this study is reducing the number of those needing residential and nursing care.

Both the current Secretary of State for Health and NHS Chief Executive have undeniably shown their commitment to the cause of health and social care integration, and more recently devolution. Innovative approaches to integration under the Better Care Fund (BCF), backed by pooled funding, have allowed health partners in county areas to begin to shift provision to prevention and early intervention; while the landmark £6bn health devolution settlement to Greater Manchester, and 29 'vanguard pilots, have signalled their intention to place greater local freedom, powers, flexibility and pooled funding at the heart of achieving better join-up, cost-effective, services.

Although these are welcome developments, we believe the Government must go further and faster on locally-led integration and public service devolution to county areas. The findings of this study only add weight to the argument that local services must intensify their focus on integration to secure further whole-system efficiencies and redesign services around preventative care.

The recent County APPG inquiry *The State of Care in Counties: The integration imperative* highlighted that whilst the BCF had been a catalyst for improved integration, any extension in the policy required significant changes to its implementation and increased centrally pooled funding to reap the rewards of integration. The

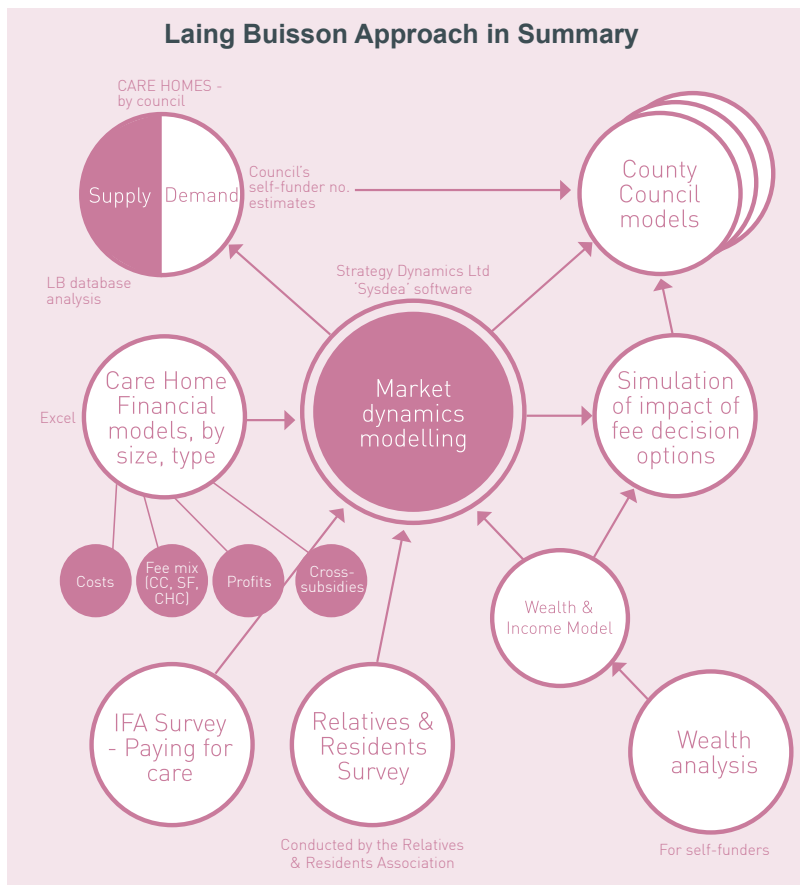
Government should engage in the findings of this study when proposing any extension in the BCF.

Moreover, CCN have argued that the devolution model for health and social care must be applied in county areas to meet the challenges of an ageing population, funding reductions, and the implications of the Care Act. CCN's recent report *County Devolution: Health & Social Care* lays out detailed policy proposals on how devolution across health and social care in county areas can quicken the pace of change to deliver improved outcomes and whole-sector efficiencies.

**Recommendation 7) The Government explores the reforms outlined in the *State of Care in Counties: the integration imperative* and *CCN County Devolution: Health and Social Care* to achieve long-term sustainable reductions in demand for residential and nursing placements.**

# Appendix: Approach Adopted

The approach adopted has been first to gain a thorough understanding of the care home market for each council, in terms of demand for and supply of residential and nursing care homes for older people. This has utilised the LaingBuisson care home database of all care homes registered through the Care Quality Commission (CQC, coupled with use of results from regular surveys conducted with providers of care homes.



Cost and profitability data from the latest LaingBuisson profitability models has been used as a starting point, to derive 'care cost benchmarks' for the provision of good quality care home services, at economic and efficient levels. Cost data has been tailored for local differences in costs between counties, allowing principally for regional differences in wage levels and council related differences in capital values, based on differences in Land Registry house prices.

In addition, providers of care homes in the 12 counties were asked whether they would be willing to provide detailed analyses of the fees paid from all sources of funding within their care homes, in confidence. A

sufficient sample of care home operators were willing to do this, enabling a comparison to be made between council fee levels and self-funder fees on a 'like for like' basis. The fee data collated was then used in combination to calculate cross-subsidies existing as a result of the shortfall in council fees being paid relative to the full cost of care, as compared with the surplus which average self-funder fees represent over the full cost of care.

A range of estimates and assumptions were made about future demand and changes in financial parameters, such as fee levels and cost inflation, to provide the basis for developing projections for market trends.

Future demand for care home places was estimated based on movement in the demographics, using Office of National Statistics data for population growth in the higher age cohorts, coupled with understanding the relationship between the number of older people in these age cohorts within each county and the number of care homes places required.

Market data has then been supplemented by surveys undertaken to ascertain the views of relatives of

residents in care homes, independent financial advisors and providers, concerning their attitudes to the Care Act proposals and implications, as well as their possible responses. These views have been used to inform consideration of the implications from the Care Act provisions, assumptions formulated and the models then re-run, to predict the financial impact over time.

Models have then been used to explore various scenarios about fee levels and responses which might be made by councils and others to the impact of the Care Act provisions, as well as to the underlying sustainability issues within the market.

## DYNAMIC MARKET MODEL

All this information has then been fed into a dynamic market model for each council, designed specifically for this purpose, which is capable of reflecting the impact of changes in demand and the key financial parameters, such as fee and cost levels, on supply of adequate numbers of care home places for the future. The expected relationships between demand, supply and price have been incorporated in the models, together with assumptions about when homes might close and what returns are needed to justify opening new homes.

Market data has then been supplemented by surveys undertaken to ascertain the views of relatives of residents in care homes, independent financial advisors and providers, concerning their attitudes to the Care Act proposals and implications, as well as their possible responses. These views have been used to inform consideration of the implications from the Care Act provisions, assumptions formulated and the models then re-run, to predict the financial impact over time.

Models have then been used to explore various scenarios about fee levels and responses which might be made by councils and others to the impact of the Care Act provisions, as well as to the underlying sustainability issues within the market.

## WEALTH AND INCOME MODEL

A specially designed Wealth and Income model has also been used to consider levels of property and other wealth around the country and to use this to estimate the different impacts on the number of people likely to fall beneath the extended asset thresholds, in addition to the impact this could have on both gross and net funding costs (after re-computation of the contribution people will make to the cost of their own care through tariff income charges).

This model is based on looking at the total placements made by each council, which include 'exports', being the placements made by each council in care homes outside county boundaries. This is the most appropriate approach when considering the total funding cost to each council, and lends itself to being able to calculate net costs after tariff income charges, as well as gross costs.

Output data from the Wealth and Income Model, on estimates of numbers of older people falling under the new, higher asset threshold, has been fed into the market models, along with estimates of fee top-ups which might become payable to providers. Results of model scenarios have, in turn, then been fed back into the Wealth and Income Model, to calculate the net funding implications for councils.

# References

- <sup>1</sup> BBC News. 1st June 2015 <http://www.bbc.co.uk/news/education-32928117>
- <sup>2</sup> LGA. *Adult social care funding: 2014 state of the nation report (2014)*
- <sup>3</sup> CCN. *Counties & the Care Bill (2014)*
- <sup>4</sup> DoH. *Social Care Funding Reform Impact Assessment (2015)*, p.37
- <sup>5</sup> County APPG. *State of Care in Counties (2015)*
- <sup>6</sup> CCN. *Care Act Funding Statement (2014)*
- <sup>7</sup> CCN. *County Devolution: Employment (2015)*
- <sup>8</sup> ADASS. *Budget Survey 2015 (ADASS, 2015)*
- <sup>9</sup> County APPG. *State of Care in Counties (2015)*
- <sup>10</sup> *Transforming Adult Social Care, Capita/CCN, February 2015*
- <sup>11</sup> *Deciding prices in public services markets: principles for value for money, National Audit Office, December 2013*
- <sup>12</sup> *Childcare Costs Survey 2015, Family and Childcare Trust, 2015*
- <sup>13</sup> CCN. *Counties & the Care Bill (2014)*
- <sup>14</sup> County APPG. *State of Care in Counties (2015)*
- <sup>15</sup> *Deciding prices in public services markets: principles for value for money, National Audit Office, December 2013*




Founded in 1997, the County Councils Network (CCN) is a network of 37 County Councils and Unitary authorities that serve county areas. We are a cross-party organisation, expressing the views of member councils to the wider local government association and to Central Government departments.

To discuss any of our proposals in greater detail, please contact:

**James Maker**  
Policy Manager  
020 7664 3009  
james.maker2@local.gov.uk

If you would like further information on CCN, including the latest policy briefings, publications, news and events, please visit our website at [www.countycouncilsnetwork.org.uk](http://www.countycouncilsnetwork.org.uk)

Follow us on twitter  @CCNOffice

Founded by William Laing in 1986, LaingBuisson is the UK's most and most highly regarded provider of information and market intelligence on the independent health, community care and childcare sectors. Key contacts:

**William Laing**  
CEO  
0207 923 5399  
william@laingbuisson.co.uk

**David Roe**  
Senior Consultant  
01306 731311  
david@laingbuisson.co.uk

If you would like further information on LaingBuisson, please visit [www.laingbuisson.co.uk](http://www.laingbuisson.co.uk)

Follow us on twitter  @LaingBuisson