Impact Assessment of the Implementation of Section 18(3) of The Care Act 2014 and Fair Cost of Care

A Report Commissioned by The County Councils Network

MARCH 2022

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1. EXECUTIVE SUMMARY

Care sector stakeholders, interviewed and debated for this report, are universally supportive of the general principles of fairness and equity for current and prospective care and nursing home fee-paying residents. Likewise, there is unanimity about the need for such residents to continue to have choice in care settings, acknowledging that care and nursing homes vary considerably in terms of build, amenities and services which are additional to the core care offer.

The social care reforms, including the cap on lifetime care costs, announced by the UK Government in September 2021 are broadly welcomed by councils and providers. For the cap on care to work in practice and deliver a 'fairer deal' for those that currently arrange and fund their own care ('self-funders') the Government also proposes to implement Section 18(3) of the Care Act 2014 in relation to care homes in England.

When Section 18(3) comes into full effect for care homes in October 2023, it will mean that privately paying care home residents will be able to ask their upper-tier council to arrange care for them, at the usual council rate. The Government recognises that council fee rates are in many cases unsustainably low at present, and it plans to support moves towards a Fair Cost of Care (FCC) with new injections of central Government money, starting in financial year 2022/23.

Looking at these two parallel policies, Section 18(3) and FCC, within the context of other elements of the Government's social care funding reforms, the County Councils Network (CCN) has commissioned LaingBuisson to undertake an independent assessment of the potential impact of these policies on both councils and providers.

FINANICAL ANALYSIS - KEY FINDINGS

- Using its longstanding Care Cost Benchmarks model, LaingBuisson has made independent estimates of the costs to councils/increased revenue to providers of implementing FCC for council supported residents in residential and nursing care homes. Public data sources and a set of sector-standard assumptions have also been used to analyse providers' potential loss of private payer income as a result of 18(3). Four different FCC benchmarks, including a 'Funded FCC' based on current Government funding levels for the policy, have been analysed.

- LaingBuisson calculates that additional FCC costs from a 'Floor' of £783m to a 'Ceiling' of £1,681m, with a 'Mid-Point' £1,232m. This range is between 2.0x – 4.5x higher than the Government funding allocation of £378m. LaingBuisson believes that this Mid-Point (operating costs + operators' profit + 6.0% pa return on accommodation valued at £62,000 per bed) most closely represents the average capital value attributable to a care home place in England. Our estimates at the Mid-Point are in line with the conclusion of the Competition and Markets Authority, who estimated back in 2017 that if local authorities were to pay the full cost of care for all residents they fund, the additional cost to them of these higher fees would be £0.9 to £1.1bn a year.

Estimated Cost of Implementing FCC for Council-Supported Care Home Residents Aged 65+ / Region

GBPm	HM Government	LaingBuisson Estimates		
	FCC Funding Allocations for Councils in 2023/24 (Residential & Nursing Only)	'Floor' FCC	'Mid-Point' FCC	'Ceiling' FCC
England	**377.9**	**782.6**	**1,231.8**	**1,681.1**
East Midlands	31.6	58.6	101.7	144.7
East of England	38.4	98.9	148.8	198.7
London	58.5	32.6	74.3	116.0
North East	21.8	54.2	85.3	116.4
North West	56.2	226.9	295.1	363.2
South East	52.8	54.1	128.0	201.9
South West	38.1	17.5	64.6	111.8
West Midlands	42.2	126.6	173.1	219.6
Yorkshire & Humber	38.5	113.0	160.9	208.9

- In its own impact assessment, the Government have not sought thus far to estimate the combined financial impact of Section 18(3) and FCC on care providers. But our analysis demonstrates that based on a 50% take up rate of Section 18(3) and current FCC funding levels for councils, providers across the country would experience significant financial challenges as a result of lost revenues amounting to £560m. Providers in County & CCN Unitary authorities would account for 86% of all net financial losses to the social care sector, with the largest loses in the South-East, East of England and South-West. reflecting these council areas geographical spread and high levels of self-funders.

Net Financial Impact of FCC and 18(3) on Stakeholders - Funded FCC and 50% 18(3) Penetration, by Region

GBPm	LaingBuisson Estimates		HM Government	Outputs		
	Cost of 18(3) to Providers	Cost of FCC to Councils	HM Government Funding	Net Financial Position for Councils	Net Financial Position for Providers	Net Impact on Social Care Sector
East Midlands	51.9	31.6	31.6	0.0	(20.3)	(20.3)
East of England	156.0	38.4	38.4	0.0	(117.6)	(117.6)
London	72.3	58.5	58.5	0.0	(13.8)	(13.8)
North East	11.8	21.8	21.8	0.0	9.9	9.9
North West	92.7	56.2	56.2	0.0	(36.5)	(36.5)
South East	278.6	52.8	52.8	0.0	(225.9)	(225.9)
South West	122.9	38.1	38.1	0.0	(84.8)	(84.8)
West Midlands	93.0	42.2	42.2	0.0	(50.9)	(50.9)
Yorkshire & Humber	58.2	38.5	38.5	0.0	(19.7)	(19.7)
England	**937.4**	**377.9**	**377.9**	**0.0**	**(559.5)**	**(559.5)**

- In order to prevent the widespread market instability that would result from these revenue losses, councils FCC would need to be raised significantly higher than planned Government funding allocations to offset these losses and ensure on-going investment in the social care sector, particularly in the short term.

Net Financial Impact of FCC and 18(3) on Stakeholders – Mid-Point FCC and 50% 18(3) Penetration, by Region

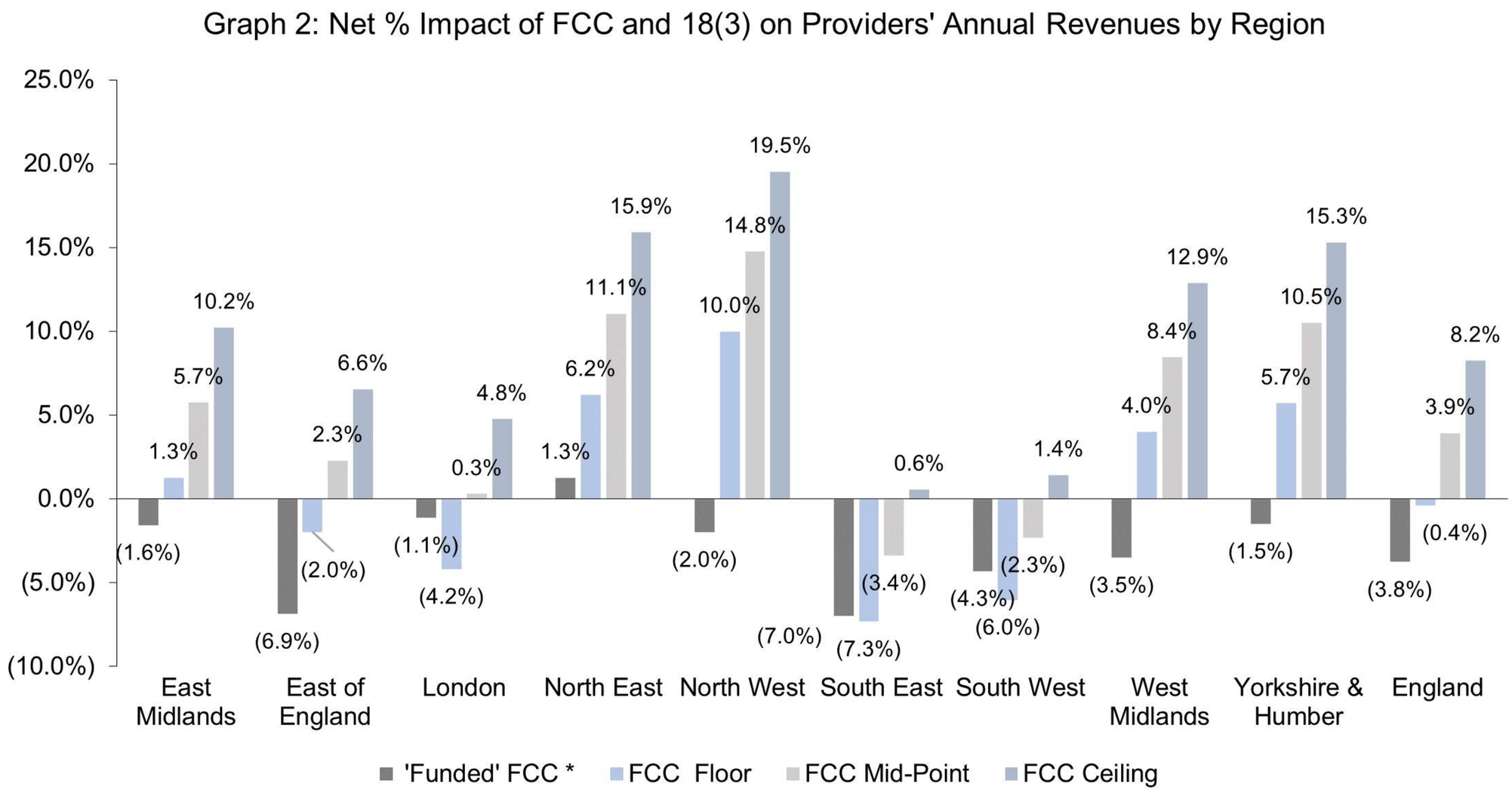
GBPm	LaingBuisson Estimates		HM Government	Outputs		
	Cost of 18(3) to Providers	Cost of FCC to Councils	HM Government Funding	Net Financial Position for Councils	Net Financial Position for Providers	Net Impact on Social Care Sector
East Midlands	26.6	101.7	31.6	(70.1)	75.1	5.0
East of England	109.4	148.8	38.4	(110.4)	39.4	(71.0)
London	70.7	74.3	58.5	(15.8)	3.6	(12.2)
North East	(1.6)	85.3	21.8	(63.5)	86.9	23.4
North West	22.5	295.1	56.2	(238.9)	272.6	33.7
South East	237.3	128.0	52.8	(75.3)	(109.3)	(184.6)
South West	109.9	64.6	38.1	(26.6)	(45.2)	(71.8)
West Midlands	50.4	173.1	42.2	(130.9)	122.7	(8.2)
Yorkshire & Humber	21.3	160.9	38.5	(122.5)	139.6	17.1
England	**646.5**	**1,231.8**	**377.9**	**(853.9)**	**585.3**	**(268.6)**

- Our central estimate is that this would require Government to raise funding allocations by at least £854m per annum for FCC in residential and nursing care homes to enable councils to pay rates at the Mid-Point FCC benchmark. However, even if councils were funded at this FCC level, some care economies would still face financial significant pressures as a result of the impact of 18(3). It is important to note that the costs outlined represent annually recurring costs to councils, which would need to be uplifted by inflation each year.

- If actual FCC levels reach the calculated FCC Mid-Point or above, providers in England would witness an increase in aggregate revenues as a percentage annual revenue of 3.9%. Providers operating in care economies in all areas outside of the South East and South West of the country can expect to see an increase in aggregate revenues as a result of FCC and 18(3) policies. Aggregate revenue loss will be limited to the South East (-3.4%) and the South West (-2.3%).

- If, however, actual FCC levels reach the calculated FCC Floor only, or are constrained at Funded FCC level (this is the amount councils could pay based on current allocations), then aggregate revenue losses will be significant and could cause severe sustainability risk to care markets across the country. Reductions in aggregate revenues as a percentage of providers annual revenues will spread to care economies in regions across England, rising to -7% in the South East, -6.9% in the East of England, and -4.3% South West, but also falling in every region apart from the North East.

- LaingBuisson's analysis therefore indicates the Government has significantly underestimated the cost of implementing a FCC policy. LaingBuisson's estimates of costs to councils of implementing FCC fees that, in its view, are sustainable for the care sector are orders of magnitude higher than those cited in the DHSC's Impact Assessment document. This in turn raises concerns that the Government has very substantially underestimated the amount of new funding required to make the combined FCC / 18(3) strategy work effectively.



IMPLICATIONS FOR COUNCILS - KEY FINDINGS

- From our analysis and engagement with councils during this project there are several common concerns about the implications of our analysis on Section 18(3) and FCC.

- The financial impact estimated in our analysis comes at a time when there are considerable operational headwinds for councils' adult social care commissioning. As demonstrated by the engagement with councils through this project, social care reforms, including the implementation of 18(3), come at a time when councils and their local providers are experiencing a raft of post-pandemic issues, notably acute staffing shortages and increases in demand for a range of community-based services, which have created a 'perfect storm' in the sector. This is against a backdrop of councils are only just emerging from over a decade reduced resources for social care, at the same time of increasing demand for services.

- Individual councils each set their own budgets, including those for adult social care. But given past and current funding challenges already facing councils, they are extremely unlikely to be in the position to fund fee increases above the Funded FCC level from existing resources or alternative sources of income (i.e. council tax) without a detrimental impact on existing social care services or challenging their own financial sustainability.

- Therefore, without additional resources from central Government, councils will face the possibility of provider failure and market exits, while destabilising the overall care market within an area. This will negatively impact on the ability of councils to secure high quality care placements for those eligible for local authority arranged care, in addition to market exits impacting on the availability of provision for the NHS of continuing health care. There is also likely to be a greater polarisation between local authority arranged care and self-funder placements, with a growing divide in the quality of care received by the two cohorts of care recipients.

- Final statutory guidance in relation to charging reforms will potentially have an important impact on the extent of the financial challenges facing both councils and providers, as will the experiences gained in the 'Trailblazer' pilot studies in terms of take up of 18(3).

- Regulations regarding the use of first- and third-party top-ups could reduce the financial impact for both councils and providers. However, as noted in our roundtable discussions with providers and councils, top-ups may run into several hundred pounds. While this may be necessary to prevent the financial challenges for providers, the widespread use of top-ups at high levels is likely to negatively impact public perception as to whether the reforms are creating a 'fairer deal' for self-funders, with corresponding reputational implications for central and local Government.

- Moreover, Government guidance could enable councils to limit or ration access to Section 18(3). However, it is not clear how this would work in practice given the current Government stated policy position, with the possibility of leaving councils open to increased legal challenges. Moreover, it is not clear how the market would respond in terms of the percentage or numerical allocation of beds to councils against those accessing a placement via a top up.

- The reforms introduce new market shaping and fee negotiations duties for councils hitherto not nowitnessed before. It is important to consider the significant historical challenges in fee negotiations with providers and the success in undertaking fair cost of care exercises. Even if Government were to provide further resources for FCC, there are likely to be significant challenges in conducting these exercises with providers within a relatively short timescale on behalf of both local authority and new self-funder clients, alongside new administrative burdens for councils.

- From our engagement with councils, it was clear there was general lack of consultation and unpreparedness for the new reforms, particularly in terms of technical infrastructure to handle a substantial prospective cohort of assessments from those wishing to take up the care cap and the arrangement of their care. There were already significant staff shortage in the care sector and structural funding pressures which may be exacerbated by the proposed reforms, in the pursuit of 'equalisation' or 'harmonisation' of fee metrics. There were concerns that bureaucracy would increase significantly at a central administration level, and fears that, ultimately, outcomes will be worse for the public. Participants were keen to see quality improvements across the sector and fees reflect such improvements.

IMPLICATIONS FOR PROVIDERS - KEY FINDINGS

- The DHSC Impact Assessment is based on somewhat limited understanding of how care homes currently work commercially, and an idiosyncratic view as to how negative effects of equalisation of fees might be managed, for example, 'reducing the size of home or transferring elsewhere'. More seriously, the DHSC impact assessment states providers will have to 'consider options, including but not limited to seeking self-funders from elsewhere, reducing the size of home or transferring elsewhere' will likely be met with widespread scepticism, as well as alarm, in the care sector.

- Our financial analysis shows that the implementation of 18(3) alongside council-paid fees which continue to be below the 'Mid-Point' risks destabilising the care home sector in many areas. However, the combined financial impact of FCC and 18(3) will vary widely from provider to provider. Care homes operate in discrete geographies, with particular care offers (residential care, nursing care, residential dementia care and nursing dementia care being the core categories), and with varying degrees of self-funder and local authority revenues. The combinations of these characteristics will affect how they are impacted.

- Care homes which serve an exclusively public paid clientele by definition are not exposed to any 18(3) risk. They stand to benefit from FCC, whatever the quantum of upward movement from current council fee rates turns out to be. But there are relatively few of them. Operators with current high levels of self-funders paying premium rates will likely be affected disproportionately. Those with a large operating base but overall lower average fees may also fare badly. Conversely, operators with broader based, 'mixed economy' models will tend to approach the Government's aim of 'equalisation' with the net financial effect broadly flat. Those care homes which have low fixed financing costs (interest, mortgage repayments, lease payments, etc) may, however, have scope for reducing their profits, while still remaining viable.

- The DHSC's impact assessment speaks of some providers having to change their business models, but the flexibility of most providers will be limited. Operating cost reduction is unlikely to be an option, in such a highly regulated environment, since reductions in staff hours may be unsafe, pay reductions might haemorrhage staff and there will typically be few significant savings opportunities in non-staff operating costs.

- Provider failure, which has been evident in the past two years during the pandemic, notwithstanding emergency and continuing financial support from local authorities, would be the inevitable consequence of a negative investment environment. Where this is seen in historically underperforming regions, there will likely be a 'holllowing out' of services. This is particularly significant in the context of a 'market' where the provision of care from independent or charitable providers has been actively encourage by successive governments dated back over twenty years.

- The consequences flow beyond providers and will impact on investors. At the least damaging end, providers may have to renegotiate banking covenants. Where operating margins are more strongly affected, loan repayments may have to be rescheduled and leases renegotiated. In the event that a care home becomes non-viable (its expenses exceed its income and reserves and financial support from other sources are not sufficient) then businesses may go into administration. Some will be sold for alternative use, resulting is a loss of capacity. In most cases, however, care homes have more value (stripped of capital costs) as going concerns than for alternative use. If so, then care homes may remain in operation under new management, but investors will lose their investment.

- Should this scenario become frequent, there is a strong risk that investor sentiment will turn against the care home sector and that the flow of capital that has financed the modernisation of the care home sector in recent years will cease. It is possible that modified business models could be developed in the future which mitigate provider risk in a post-FCC and 18(3) market. But is unlikely that many care home businesses with sunk capital costs have the flexibility to modify their models for existing assets to any significant extent.

RECOMMENDATIONS

The following the recommendations are made by LaingBuisson for consideration by central and local Government.

- The Government urgently reassess funding allocations to support the combined implementation of FCC and 18(3). Our central estimate is that this would require Government to raise funding allocations by at least £854m per annum for FCC in residential and nursing care homes to enable councils to pay rates at a rate that is sustainable to providers and able to offset the impact of Section 18(3).

- Overall, LaingBuisson questions whether the full implementation of Section 18(3) of The Care Act 2014 is the right policy at the right time. The implementation of such wholesale changes to funding models comes at a time when the care market is particularly fragile in the aftermath of the COVID-19 pandemic, with significant regional blackspots.

- The timetable implied by a full implementation in October 2023, with a handful of 'Trailblazer' local authorities potentially working towards implementation in January 2023, is ambitious, given the multiple stakeholders and dimensions of the proposed reforms. The timetable should be reconsidered, and robust pilots be given more time.

- DHSC predicts an 80% take-up in registration for the care costs cap, but it has made no detailed forecasts for the take-up by the public of 18(3). Research should be undertaken into the behavioural side of the policy implementation and the pathway for residents, both existing and prospective.

- The FCC must be agreed by each local authority working with local care provider associations, or where such associations do not exist, with groups of providers. Guidance for such exercises has not been disseminated. DHSC should revisit previous evidence of the difficulties of agreeing such fair cost of care.

- Despite the increasingly collaborative relationship between local authorities and NHS bodies, particularly Clinical Commissioning Groups and the advent of Integrated Care Systems, it appears NHS-funded residents (those with both a health and care need) will not be included in the 18(3) provisions. Clarity on the direction of travel would be welcome.

- Although DHSC has confirmed it will encourage top ups where appropriate, it should further research the way top ups currently work and the way in which they may now assume particular importance to providers which require higher fee rates than offered by a FCC

- DHSC should release details of infrastructure and technology to allow for current assessment capacity at county council to be significantly extended to cope with the demand for such assessments which will be triggered by 18(3).

- DHSC should engage with the investor community to explain its vision for 18(3) and to canvass views from investors, lenders and other financial stakeholders, so as to avoid a potential 'cliff edge' adverse reaction in the coming months.

"LaingBuisson's analysis therefore indicates the Government has significantly underestimated the cost of implementing a Fair Cost of Care policy."

2. INTRODUCTION

In September 2021, the UK Government announced a new Adult Social Care charging reform policy for England, with a cap on the amount people will have to spend on their personal care during their lifetime, an extended means test, and the implementation of existing legislation in The Care Act 2014 to allow more people to access care through their local authorities. It is the last element of this policy, which is linked to the care cap and with the goal of achieving a 'fair' price for care, which is the principal subject of this report.

For the cap on care to work in practice and deliver a 'fairer deal' for those that currently arrange and fund their own care ('self-funders') the Government proposes to implement Section 18(3) of the Care Act 2014 in relation to care homes in England. When the Section comes into full effect for care homes in October 2023, it will mean that privately paying care home residents will be able to ask their upper-tier council to arrange care for them, at the usual council rate.

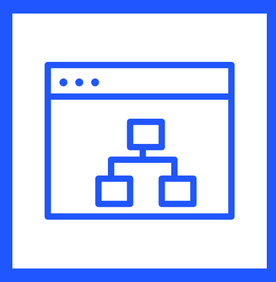
The Government recognises that council fee rates are in many cases unsustainably low at present, and it plans to support moves towards a Fair Cost of Care (FCC) with new injections of central Government money, starting in financial year 2022/23.

Looking at these two parallel policies, 18(3) and FCC, within the context of other elements of the Government's social care funding reforms, the County Councils Network (CCN) has commissioned LaingBuisson to undertake an independent impact assessment of the potential impact of these policies on both councils and providers.

Building on previous research conducted by LaingBuisson for CCN in 2015[1] and 2017[2] (see Box 1) on market sustainability and the Care Act 2014, and considering the Government's own impact assessment and policy statements published since September 2021, this report has sort to analyse in detail the financial costs of the reforms alongside implementation challenges for both councils and providers. The two principal sources of primary research for this report are:

[1] http://www.countycouncilsnetwork.org.uk/download/122/
[2] http://www.countycouncilsnetwork.org.uk/download/1179/

FINANCIAL MODELLING



Using its longstanding Care Cost Benchmarks model, LaingBuisson has made independent estimates of the costs to councils/increased revenue to providers of implementing FCC for council supported residents in residential and nursing care homes. Public data sources and a set of sector-standard assumptions have also been used to analyse providers' potential loss of private payer income as a result of 18(3).

SIMULATION EVENTS

Two roundtable events were held with senior representatives of care commissioning authorities, alongside senior executives of care home providers, and other stakeholders to discuss the implications of 18(3) and FCC. The commentary at these roundtables has been used throughout our analysis, with a full write up of the discussion provided in Appendix 1.

This report starts by providing key background information in relation to the proposed reforms to Adult Social Care charging policy in England, with a particular focus on the introduction of 18(3) and FCC. It then analyses the Government's impact assessment in relation to 18(3) and FCC. This is followed by LaingBuisson's own independent assessment of the financial impact of the policies, and then an analysis of the policy implications and implementation challenges for both councils and providers. It concludes with a set of recommendations for consideration by Government.

It is important to note that LaingBuisson's estimates for FCC used in this report may be considerably higher than the final amounts agreed in the consultations between councils and providers. The results of our analysis should be considered in the context of current funding levels assigned to councils over the next three financial years to implement the FCC policy at level that LaingBuisson believes to be a sustainable rate to ensure on-going sustainability and investment in the residential and nursing care home sector.

BOX 1 -
CARE MARKET INSTABILITY & THE CARE ACT

Over the last five years CCN and LaingBuisson has published extensively on the topic of county care market instability and the implications of previously planned reforms under the Care Act Part 2. CCN's report with LaingBuisson in 2015, along with an update in 2017, identified the unsustainable nature of county care markets and the potential impact of social care reforms that introduce a cap on care and more rights for self-funders to ask councils to arrange their care.

At the heart of the concerns raised in these reports has been the impact of the limiting of fees paid for publicly funded care home places, which has been compensated for by providers largely through raising fees for those who pay privately. The budget reductions to central government grants faced by local government since 2010 has meant that local authorities were forced by constrained budgets to negotiate significantly lower fees, with providers offsetting this through higher fees for private payers for similar care packages.

Ultimately this has gradually distorted and begun to destabilise local care markets. Public and private fee polarisation has become more deeply embedded as a structural feature of the care home market, with private fees more than 40% higher than publicly paid fees for the same level of amenity, and in all probability the same level of care.

With an already significant sustainability risk within the care market before the introduction of reforms, County Care Markets & the Care Act (2015) analysed how the existing fee polarisation and market instability could be further exacerbated by the reforms contained in Part 2 of the Care Act.
The Care Act proposed actively encouraging 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, potentially at the lower rates paid by councils. In addition, many self-funders as a result of the reforms would become local authority supported care users under the new asset threshold. Increased contact between councils and self-funders would change the balance in the market and weaken the sustainability of the market as a whole even further.

CCN and LaingBuisson warned that the underlying sustainability challenges in the social care market were likely to increase due to the Care Act and market equalisation. With more self-funders accessing local authority rates of care this would undermine the profitability of providers and weaken councils' position in the market. This would lead to additional unfunded costs for councils (impacting on other essential services), with councils having to raise fees to sustain a functioning market and prevent provider exits.

Crucially, the report warned that due to some care home providers focusing almost exclusively on the self-funder market, local authorities and the NHS would be likely to find it increasingly difficult to arrange care with a market discount, or worse, even arrange care at all. This will lead to escalating costs to the health service and could also lead to increasing numbers of delayed discharges, due to councils and health providers being unable to find quality and affordable residential and nursing placements to reduce demand on acute healthcare.

In announcing the recent reforms, the Government have explicitly stated their intention to enable self-funders through Section 18(3) of the Care Act to ask their local authority to arrange their care. This in many ways goes further than the original intention of this policy in 2015, with a stated ambition for self-funders to access local authority rates of care. The challenges that faced the implementation of this reform in 2015 highlighted above remain key issues for serious consideration and assessment in relation to the proposals recently announced.

Even before considering reform, it was imperative that care markets were placed on a sustainable footing, or risk not having sufficient high quality capacity available to meet needs and also to discharge patients from acute settings to. The picture is likely to become significantly more pressing in the wake of COVID in the light of some of the additional pressures and market shifts outlined in this report.

3. SOCIAL CARE REFORMS

The reforms announced in the autumn 2021 can be traced back to policy options considered more than a decade ago.

CARE ACT 2014

In July 2010, the Conservative / Liberal Democrat coalition Government established the Commission on Funding of Care and Support, chaired by Sir Andrew Dilnot, to address the challenges of funding social care. The Commission delivered its findings as Fairer Care Funding in July 2011.

Although the Dilnot Commission, as it became known, made important and radical policy suggestions, most notably a cap on care costs, it was focused almost exclusively on the impact to individuals and, to a lesser extent, on their (often unpaid) carers. It did not address market dynamics in the care sector, nor the relationship between the largely independently run sector and local authorities. Its report did, however, note the '152 different systems across England – one for each local authority':

The result of such local variability is that people in very similar circumstances, with similar levels of need and financial resources, can be treated very differently and experience vastly different outcomes. Access to social care is often labelled a 'postcode lottery' and is seen as unfair. The level of variability adds complexity and leads many to be confused about how the system works.[3]

The Commission's report addressed the introduction of personal budgets, but only briefly alluded to how a reformed system would treat those with the means to fund their own care, with 'notional care packages', essentially related to the proposed cap on costs. It did not address the discrepancy between self-funders' care fees and those paid by local authorities.

The then Secretary of State for Health Andrew Lansley, now Lord Lansley, described the Commission's findings as 'the basis for engagement' and the Government accepted the principles of its recommendations, which most notably included a cap on care costs, in July 2012.

[3] Fairer care funding; The report of the Commission on Funding of Care and Support. 2011.

The Care Act 2014 legislated for many of the Dilnot Commission's recommendations, including a cap on care costs at £72,000. However, the cap was subsequently delayed and then scrapped completely until its revival in 2021.

The Care Act 2014 also made provisions for a significant realignment of the system under which people arrange their care, creating an obligation on local authorities to do this even if a person has substantial financial resources (ie is a self-funder). This was outlined at paragraph 18, as follows:

Duty to meet needs for care and support

(1) A local authority, having made a determination under section 13(1), must meet the adult's needs for care and support which meet the eligibility criteria if—

(a) the adult is ordinarily resident in the authority's area or is present in its area but of no settled residence,

(b) the adult's accrued costs do not exceed the cap on care costs, and

(c) there is no charge under section 14 for meeting the needs or, in so far as there is, condition 1, 2 or 3 is met.

(2) Condition 1 is met if the local authority is satisfied on the basis of the financial assessment it carried out that the adult's financial resources are at or below the financial limit.

(3) Condition 2 is met if—

(a)the local authority is satisfied on the basis of the financial assessment it carried out that the adult's financial resources are above the financial limit, but

(b) the adult nonetheless asks the authority to meet the adult's needs.[4]

The legislation reproduced above was not fully implemented once it had passed onto the statute book and it is the concept contained in 18(3) – a person's right to ask their local authority to arrange their care and the local authority's obligation to do so – which the Government intends to roll out fully from October 2023 onwards.

REFORMS ANNOUNCED IN 2021

On 7 September 2021, the Government announced a series of significant reforms to the Social Care system in the UK. These were summarised in its publication Building Back Better: Our Plan for Health and Social Care.

The principal focus of the document was to set out the revival of the Dilnot Commission-inspired lifetime cap on care costs and extended means tests, and to introduce the Health & Social Care Levy funding mechanism.

In brief, from October 2023 anyone assessed by a local authority as having eligible care and support needs, either new entrants or existing social care users, will begin to progress towards the GBP 86,000 cap on lifetime care costs (costs accrued before October 2023 will not count towards the cap). There will still be a means test for council-funded social care, but more generous than previously with the upper capital limit increased from £23,250 to £100,000. Likewise, the threshold for full council support will increase from £14,250 to £20,000.

[4] HM Government, The Care Act 2014

To enable the start of a person's 'cap journey', the local authority in whose area the person is ordinarily resident will start a care account, called a 'personal budget' or an 'independent personal budget' (IPB), which is personalised to the individual and will monitor their progress towards the cap. The cap will be linked to revised capital limits, which trigger eligibility for financial support from local authorities.

The document also included the following statement, which revived the legislation already on the statute book – Section 18 of The Care Act 2014 – regarding the ability of self-funders to access 'better value care':

We will also tackle persistent unfairness in the social care system. Under the current system, people who fund their own care often pay more than people who are funded through their Local Authority for equivalent care. For the first time, using legislation included in the 2014 Care Act, we will ensure that self-funders are able to ask their Local Authority to arrange their care for them so that they can find better value care.[5]

The announcement of the full implementation of 18(3) received relatively little attention, although it was notably flagged by the UK Homecare Association, which represents domiciliary care providers (Section 18(3) is already implemented for domiciliary care):

In homecare, we are already seeing local authorities put requests for care for self-funders on their procurement portals, which reduces the number of people purchasing homecare at sustainable fee rates.

This could result in even more homecare providers handing work back or ceasing to trade, further limiting capacity to meet need in the community and for hospital discharge. Many providers will be unable to support people unwilling to pay a fair price for care and will not accept such referrals.

This risks leaving people without care, as now, so does not solve the problem of unmet need. This reform is unlikely, therefore, to support stability of the sector and may even further reduce it.[6]

National media commentary on the issue was limited, although it was raised by in a Radio 4 Today programme interview with Sajid Javid MP, Secretary of State for Health and Social Care, who commented: 'We have got to raise the rate that local authorities can afford and that needs to work its way through the system and we're confident this money can do that.'

The Guardian pointed to the potential negative impact on care homes which rely on the current and widespread subsidy which is effectively paid by self-funders for their fellow, local-authority-funded residents:

'Care home operators, many of which are already financially precarious due to the Covid pandemic, fear that the new right could cause a plunge in revenue from private buyers and trigger collapses in services'.[7]

Further commentary on the Government announcement on Section 18(3) came on 16 September 2021, when the County Councils Network, in association with the Rural Services Network, published The State of Care in County & Rural Areas. This report noted the Government's commitments to addressing the unfairness in fee levels paid for care would have 'enormous implications for councils and providers'.

[5] HM Government, *Building Back Better: Our Plan for Health and Social Care*, September 2021. Paragraph 40
[6] UK Homecare Association; Dr Jane Townson, CEO; 8 September 2021
[7] UK care homes say funding shake-up threatens their viability; The Guardian, 8 September 2021

One of the CCN / RSN report's recommendations was that the Government should 'fully assess the impact of new duties for self-funders':

The Government' s intention to actively encourage self-funders to access council-arranged care will lead to greater 'market equalisation' between council and self-funder fees. Unless significant resources are provided this would potentially further undermine the profitability of providers and result in large-scale care home closures, or unfunded commissioning costs for councils to sustain their local provider market. County and rural unitary councils will be particularly exposed to the risks of increased demand and greater financial pressures, given their higher average percentage of self-funders (53%) and proportion of care homes.[8]

Further detail on the Government's plans for FCC and 18(3) were given on 16 December 2021 by Gillian Keegan MP, Minister of State (Minister for Care and Mental Health). Her Commons Statement:

To make social care fairer, we are protecting people from unpredictable care costs; are supporting local authorities to move towards paying a fair cost of care to providers and ensuring that more self-funders will be able to ask their local authority to arrange their care for them to give them a choice of better-value care...

....

Some local authorities are promoting efficient and effective operation of care markets, with sustainable rates of care. However, a significant number of local authorities are paying residential and home care providers less than it costs to deliver the care received. In many areas, this has resulted in higher self-funder fees which we are addressing by further bringing into effect section 18(3) of the Care Act 2014. The market effect of this change will be that some providers will over time need to reduce reliance on subsidising state funded care from self-funders.[9]

Councillor Martin Tett, of the County Councils Network, responded to the Minister's statement, reiterating CCN's concerns about funding the proposed reform:

"We cannot underestimate the cost and implementation challenges of moving towards an equalised price for care. County areas are home to a higher proportion of people who arrange and pay for their own care, and those areas' care markets will be particularly vulnerable to changes. The Government's document recognises this challenge and we want to work with ministers to make sure this policy can be introduced successfully in 2023 without destabilising county care markets or placing unsustainable costs on care providers.

"Looking ahead, it is imperative that any funding for this policy is distributed fairly. While CCN supports the use of the Adult Social Care Relative Needs Formula in the short term, it does not take into account those increased numbers of self-funders in county areas. As part of Government reforms to local Government funding, it is essential that a new adult social care funding formula is introduced to support reforms to the care system.'[10]

FUNDING THE REFORMS

Under the Government's plans, the social care reforms will be primarily funded by an increase in general taxation. As announced on 7 September 2021, employees, employers, and the self-employed will all pay 1.25p more in the pound for National Insurance Contributions (NICs) from 6 April 2022 for one year. From 6 April 2023, the underlying NICs rates will return to their former level and the extra tax will be collected as a new Health and Social Care Levy, 'where the revenue will be ringfenced to support UK health and social care bodies'.[11]

[8] CCN and Rural Services Network, *The State of Care in Rural Areas*, September 2021
[9] Gilliam Keegan MP; Adult Social Care Funding and Reform. Statement made on 16 December 2021
[10] https://www.countycouncilsnetwork.org.uk/adult-social-care-reform-further-details-announced/
[11] HM Revenue & Customs, 13 December 2021

In terms of the quantum of funds, the original estimate was that the Levy would raise £11.4 billion a year over the three years 2022/23 to 2024/25. However, following the announcement, the Office for Budget Responsibility (OBR) published a revised estimate in its Economic and Fiscal Outlook alongside the Autumn 2021 Budget. It is now estimated that the Levy will raise £12.4 billion a year for health and social care over this period.

These monies which will go initially towards easing current pressures on the NHS, principally caused by the effects of dealing with the COVID-19 pandemic. Some £5.4bn will then be moved into social care system over the next three years as these pressures subside.

There were a range of responses to the funding announcements, with some scepticism about whether the quantum of funds allocated for social care would ever reach it, given the very considerable backlog and catch-up requirements of the NHS.

The Institute for Fiscal Studies noted that the £5.4bn earmarked for social care funds over the next three years needed to be seen in context:

At an average of £1.8 billion per year, this funding boost is equivalent to around 9% of what councils spent on adult social care services in 2019–20. However, the early-to-mid 2010s saw big cuts in spending, despite an ageing population and rising numbers of people with learning disabilities. And as a result, adult social care spending per person was 7.5% lower in real-terms in 2019–20, the latest year for which we have data, than in 2009–10.[12]

Further detail on funding came in Gillian Keegan MP's Commons statement, which was accompanied by the publication of the Fair Cost of Care and Market Sustainability Fund: Purpose and Conditions for 2022-23.

This document sets out how Government will provide £1.4 billion – forming part of the £3.6bn confirmed at the Spending Review 2021 – over the next three years 'to support local authorities to prepare markets for reform and move towards paying providers a fair cost of care'. This breaks down into £162m in 2022-23 and £600m in both 2023-24 and 2024-25; of these combined sums, £378m is earmarked for residential and nursing care costs, the core categories of care. This funding is separate to the over £1bn of additional resource specifically for social care that local authorities can make use of in 2022 to 2023. This £1bn includes the increase in Social Care Grant and the improved Better Care Fund, a 1% adult social care precept and deferred flexibilities from last year's settlement.

The Government proposes to distribute 2022-23 funding on the basis of the Adult Social Care Relative Needs Formula, as is used for the Social Care Grant. As a condition of receiving further grant funding in the two following years, the Government 'will expect local authorities to conduct cost of care exercises, set out their plans for driving market sustainability, including progress towards a fair cost of care, and to report to DHSC on how funding is being used. The Department will use this information to monitor progress and provide public assurance that local markets are being managed successfully.'

In summary, the Government has made funding commitments to adult social care on a three-year time horizon. Assuming the principal sum of £5.4bn does indeed flow to adult social care and is not swallowed up by the NHS, this is clearly a significant investment in reform.

[12] Institute for Fiscal Studies

4. EVALUATION OF DHSC IMPACT ASSESSMENT ON FCC & 18(3)

A full implementation of 18(3) alongside FCC will have significant financial impact for both councils and for care providers. For councils, the primary financial impact will flow from meeting a FCC for fees for local authority-funded residents, assuming (as all the evidence suggests and as DHSC acknowledges) that, on a case-by-case basis, current rates do not meet the 'fair' threshold. There will be a secondary impact for council departments in the increased budgets required for assessments and administration.

For care providers, the primary impact will flow from attrition to their current self-funder revenue base. It is central to the current Government proposals that self-funder residents paying 'high' fees effectively cross-subsidise local authority-funded residents paying 'low' fees.

Under the proposed reforms, as self-funders migrate to a FCC level, the DHSC's view is, in essence, that care providers will either lose the excess they currently enjoy, or adapt, downsize or ultimately rely on top-ups to maintain their 'high' fee level.

Following the Government and ministerial announcements, DHSC published its Social Care Charging Reform Impact Assessment on 5 January 2022. This provided the Government's detailed assessment of the likely impact of the introduction of the FCC and the implementation of Section 18(3) for both councils and providers to inform policy and funding decisions. In this section of the report we evaluate key aspects of the DHSC Impact Assessment.

LINK BETWEEN CAP ON CARE COSTS, FCC & 18(3)

The Impact Assessment makes clear – for the first time since the original September announcement of the social care reforms – that there is a direct link between the cap on costs of care, the universal FCC and the implementation of 18(3) to bring self-funders into the net:

To deliver the objectives of the cap on personal care costs, self-funders need to have the option to pay the same price as the local authority would pay to meet their needs, as this is the rate which is used on their behalf to meter them towards the cap.[14]

[14] DHSC Impact Assessment, January 2022, paragraph 50

DHSC states that market mechanisms such as 'a code of practice with providers or price transparency measures' could have been utilised, but have been discounted:

These measures would not deliver the necessary outcomes at the point people begin metering towards the cap because it would take some time for such mechanisms to result in providers offering lower rates to self-funders.[15]

Likewise, the current large differential in self-funder fees and local authority fees, 'means self-funders will therefore spend significantly more on their care than the cap limit unless they can pay the same lower rate paid by local authorities. This means the cap would not limit care costs at the publicly stated amount' .[16]

Allied to the above, and a key element of the DHSC document, is a clearly stated recognition that for too long local authority fees have been set too low:

LAs should be paying rates that allow providers to provide safe, compliant, good quality care whilst investing to improve in future. DHSC analysis suggests, however, that many local authorities pay providers less than it costs to deliver the care provided. This means that the rate used to meter towards the cap is artificially low and doesn't reflect true costs of care. Allowing self-funders....to pay currently unsustainable local authority rates would seriously destabilise the already fragile care provider market.[17]

The Government thus recognises that the care provider market is 'already fragile' but equally it maintains that in order to make the cap on care costs work, it will require the care market to move towards equalisation or harmonisation of self-funder fees and local authority fees by a full implementation of Section 18(3):

To make sure the system is fair, through full commencement of Section 18(3) of the Care Act 2014, everybody would be entitled to ask their local authority to meet their eligible needs, and therefore access care at the same rate that the local authority would pay for a similarly placed individual who does not fund their own care.[18]

DHSC outlines a roadmap to both FCC and implementation of 18(3), which is essentially the period from early 2022 to October 2023. The Impact Assessment document notes that the implementation period will allow local authorities to prepare for the changes, having in place technology and capability for administration of the care costs cap and 18(3).

Up to six 'Trailblazer' local authorities are, at the time of writing, being selected to embark on pilot schemes in their areas, for the initial rollout of the reforms, to 'test key charging reform policy and implementation hypotheses, as well as to identify any unforeseen implementation issues that we can mitigate before other LAs replicate them when implementing charging reform.**[19]**

FCC COSTING ESTIMATES

Regarding the journey for local authorities towards a FCC agreements with their local providers, the DHSC states in the Impact Assessment that the FCC policy is expected to have a positive effect on providers, enabling them to receive a fair price for state funded clients, cover their overheads appropriately, and be less fragile in the face of uncertain times with fluctuating demand from Covid, NHS pressures, and trends in council commissioning.**[20]**

[15] DHSC Impact Assessment, January 2022, paragraph 50
[16] DHSC Impact Assessment, January 2022, paragraph 51
[17] DHSC Impact Assessment, January 2022, paragraph 52
[18] DHSC Impact Assessment, January 2022, paragraph 67
[19] DHSC Impact Assessment, January 2022, paragraph 90
[20] DHSC Impact Assessment, January 2022, paragraph 285

In terms of the costs of introducing FCC, DHSC acknowledges these costs will also depend on 'local factors', the take up of 18(3), the use of top ups and what it calls 'provider business model adjustments'.

As the next section of this report demonstrates, there is a significant discrepancy between LaingBuisson estimates of FCC and the DHSC's estimates. In our view, this may be partly based on current Scottish rates for council-funded residential and nursing care for people aged 65+, with adjustments for higher property costs in England based on differential Local Housing Allowance rates:

Since cost of care exercises are not yet universal and not available to DHSC, we need a separate approach for estimating a potential increase in cost from local authorities if they are to adopt the outcome of cost of care exercises. We have explored a range of evidence, some of it confidential, and judge that a close proxy can be constructed by using area cost and other adjustments to a base rate derived from Scottish LA rates for residential/nursing care users and the minimum price suggested by Mears Care for domiciliary care users.[21]

The use of Scotland as a 'Fair Fee' proxy is based implicitly on the assumption that the rates negotiated between COSLA (Convention of Scottish Local Authorities) and provider representatives genuinely represent 'fair' rates.

In 2021/22 the weekly Scottish rates stand at 2021/22 weekly rates of £653.79 for residential care and £762.20 + NHS FNC of for £87.10 for nursing care. But Scottish care home provides emphatically state that they have not been agreed as fair rates. Nor is cross-subsidisation of public with private fees absent in Scotland, which would be an indicator of 'fair' council-paid fees.

THE IMPACT OF 18(3)

DHSC's reasoning around the differential (current and future) between self-funder fees and local authority fees charged and received by care home operators, and its assessment of the potential commercial consequences from 18(3) are set out in its Social Care Charging Reform Impact Assessment impact assessment under paragraph 290, 'Reasons for high self-funder rates'. We reproduce this in Box 2 below, as it is the key assessment by DHSC thus far of the potential commercial consequences of the reform.

The paragraphs appear to be based on a somewhat limited understanding of how care homes currently work commercially, and an idiosyncratic view as to how negative effects of equalisation of fees might be managed, for example, 'reducing the size of home or transferring elsewhere'.

More seriously, the DHSC impact assessment alludes to potentially very serious consequences for operators, including the comment that 'Where the provider finds that their business is less viable once customers can choose cheaper services, it will have to consider options, including but not limited to seeking self-funders from elsewhere, reducing the size of home or transferring elsewhere'. This comment will likely be met with widespread scepticism, as well as alarm, in the care sector.

[21] DHSC Impact Assessment, January 2022, paragraph 315

BOX 2 -
DHSC IMPACT ASSESSMENT - REASONS FOR HIGH SELF-FUNDER RATES (PARA 290)

There are a number of reasons why current self-funder prices might be higher than the fair cost:

a. Cross-subsidy: where the provider charged higher prices previously in order to cover overheads where there is under-payment by LAs.

• After the introduction of a fair cost for care this should no longer be a factor in the setting of prices by providers as if the council pays a fair cost and there is no longer any need for this increase in price (to cover overheads).

b. Extra services with variable cost: where the provider wants to offer a higher standard of say activities or food or entertainment, and charges accordingly.

• Self-funders who use Section 18(3) will still have the option to pay for these services via top-ups. However, if, following Section 18(3), it becomes apparent that there are fewer self-funders willing to pay for such extra services, the provider will have to consider its position, with one of the options being to reduce costs and services for clients.

c. Extra services with less variable cost: for example, if the capital cost is high, e.g. being a luxury home or in a high cost area, and where a reduction in cost might require a move of care home or similar radical change.

• Where the provider finds that their business is less viable once customers can choose cheaper services, it will have to consider options, including but not limited to seeking self-funders from elsewhere, reducing the size of home or transferring elsewhere. The LA may need to play a role in ensuring that the safety and care of existing care users is managed appropriately.

• Note that where the provider has lower cost providers nearby, and users choose the provider despite that, then Section 18(3) is not likely to have an adverse effect, as in this case users would have deliberately chosen the high-cost provider. It is only really where there is little choice in the area other than a high fixed cost provider where this issue arises. This is because, such a provider may have self-funders that are paying for extra services due to a lack of cheaper alternatives. If that is the case, the council would ideally work with these providers as part of their market shaping responsibilities, to help them understand the likely impacts of Section 18(3) so that they can reduce their cost base where possible. The LA may also offer transitional support to providers where this is essential to maintain market stability and services or may encourage more fair cost provision within the market, and may want to do so urgently recognising the possible demand for Section 18(3).

d. Excess profit, i.e. profit much higher than expected for the type of market.

• If excess profit comes from an efficient provider who is able to squeeze costs without reducing quality of care or workforce conditions, then there will be no impact from the introduction of Section 18(3) in the context of the LA paying a fair cost for care.

• However, if the excess profit comes from charging users more than the fair cost, the provider may find that they need to reduce prices to a fair cost or else lose users who opt for cheaper providers that are available.**[22]**

[22] DHSC Impact Assessment, January 2022, paragraph 290

DHSC also notes, in paragraph 292, that while it expects most providers to manage the inevitable disruption caused by the implementation of 18(3), it is providers 'with high fixed costs' which will 'pose more of a challenge to the provider themselves and...to the council too', adding:

Depending on how fast the change happens, and how widespread it is within the local area, the situation might be quite challenging for the system including the LA to manage.

As this sentence suggests, there is no indication of how much take-up of 18(3) is expected, nor how it might vary from region to region. It is clear that it is the local authority which will be expected to shape the market and manage any provider casualties in the event of some of the negative consequences of the policy implementation as inferred by the DHSC, above.

In considering the likely take up of 18(3) an issue largely unaddressed by DHSC, but which seems fundamental to potential changes to the interaction between care provider and resident, is the customer pathway as it currently stands and how it may change under the reforms.

At present, large numbers of self-funders have little or no interaction with their local authorities. These residents and their families typically negotiate directly with care home managers for bed availability and suitability, fees and so on. They enter into a simple contract with the provider which may often refer to services included and excluded. For example, Barchester Healthcare, one of the country's largest providers, in a sample Resident Contract on its website provides an extensive list of what is and is not included in the Weekly Fee, referencing '24-hour routine care in the Home.....your room (which will be redecorated from time to time as necessary), heat and light, meals (including a choice of menus), snacks and drinks, access to lounges and gardens, bedding and towels including laundry (but excluding dry cleaning)' . There is a similar list of excluded items, for example personal toiletries, hairdressing, dental care, which are paid for separately by the resident. Likewise, the provider outlines annual fee uplifts:

On 1st April each year the Weekly Fee will automatically increase by 5.9%...This increase is intended to cover staff pay increases (including increasing pension contributions and increases in the National Living and Minimum Wage), central Government programmes (e.g. the apprenticeship levy), rental increases, inflation on food, fuel, equipment including medical sundries as well as increases in regulatory fees.[23]

Self-funders remain on such contracts for varying lengths of time; if their care needs change, their fees will also likely change, and they may become eligible for some Government funding in the form of Funded Nursing Care, for example.

If, as the DHSC believes, the majority of self-funders (80% is the current DHSC estimate) register for assessments for the lifetime cap on care from October 2023, this will clearly bring them into the orbit of their local authority, in many cases for the first time. At the same time, an indeterminate number, but likely in our view to be at least 50%, may also take up their rights under Section 18(3) and ask the local authority to arrange their care.

While there is clarity that it is only the care element of any package of care plus accommodation which counts towards the lifetime cap, it is not entirely clear that self-funders will see a line-by-line breakdown of care and non-care costs in the FCC which will comprise their placement by a local authority into a care home.

Likewise, at this point, it may not be disclosed to the care provider that the person is indeed a self-funder, notwithstanding that in order to access certain care facilities they may now be required to top up the local authority rate.

[23] Barchester Healthcare

In any case, the core contractual relationship may in future rest between self-funders who have exercised 18(3) and their local authority, rather than necessarily with the care provider.

It remains to be seen if this is a positive outcome for the self-funder resident. It does, however, indicate that providers may see their self-funder base suffer increasing attrition, and that they will likely have to anatomise further the additional services they provide residents to bridge any gap between the FCC and their own ratecard.

TOP UPS

DHSC policy documents make provision for 'top ups' paid by residents to care providers for 'enhanced or additional services'[24], to augment the agreed FCC fee rates:

Although some cross-subsidy will be lost as individuals move onto LA commissioned rates, first-party top-ups will be permitted under the new system, allowing private-funding to continue to flow into the system even from Section 18(3) users.[25]

Although there is no detail on what it regards as 'enhanced or additional services', DHSC explains the practicalities of introducing top ups as follows:

The local authority determines the adult's eligibility for care and support via a needs assessment and then commissions their eligible care at the local authority-commissioned rate. Self-funders reimburse the local authority, or pay the provider directly at the commissioned rate, and can pay separately for extra services, 'top-ups', if desired.[26]

While it may seem logical to attach top ups to enhanced, additional or 'extra' services, in practice it would be a significant departure from current practice, where top ups are not agreed against specific services, care or hospitality offers, but instead simply to meet their own all-in ratecard. Developing a menu-based approach to justify top ups would entail very significant change to most operators' charging model.

Despite the policy reference to top ups being 'permitted' under the proposed reforms, top-ups have in fact been widely used in many parts of the country for some time. Typically, they are paid by the residents themselves ('first-party top-ups') or by members of their family ('third-party top ups') to the provider, to meet the provider's 'ratecard', that is the fee at which the provider is prepared to sell the room / bed in a given care home (not necessarily its self-funder rate).

Some local authorities have not allowed top ups historically, in some cases for ideological reasons but primarily because of their tendency to fail, that is for the source of the additional funds to run out. In these cases, local authorities have often had to step in and pay the provider the top up themselves, until an alternative is agreed. It should be noted that the 'alternative' can also be an arrangement that the care provider will continue to accommodate the resident at the reduced rate, ie without a top up, especially if that resident has been at the care home for some time.

Notwithstanding the above, although top-ups are widely used currently, they are, in the vast majority of cases, in the range £50-100 per week. The proposed reforms may see significantly higher top-ups, running into several hundred pounds if providers wish to maintain their current fee levels (DHSC acknowledges that top ups 'will allow providers to maintain additional self-funded revenue'[27]).

[24] DHSC Impact Assessment, paragraph 47
[25] DHSC Impact Assessment, paragraph 85
[26] DHSC Impact Assessment, paragraph 51
[27] DHSC Impact Assessment, paragraph 297

In our view, this will significantly change the perception of top ups in the market, and particularly from the perspective of residents and their families. As far as we are aware, there has been no focus group work conducted on this issue, although the 'Trailblazer' programme may well shed further light on whether this will be problematic.

A further issue arising from the DHSC's guidance, as quoted above, is the reference to payment of the top-up 'separately'. It is highly likely that residents who have taken up their rights under 18(3) will have a contractual arrangement with their local authority. If they also wish to pay a top-up, by agreement with the care provider, they may well have to have a separate contract with the care home.

According to the Local Government & Social Care Ombudsman (LGSCO) top ups should always by the Council. In 2020, LGSCO stated the Care Act says that only with the consent of the people involved, and the care home, should someone pay a top-up fee direct to the care home. It also says this method is not recommended. By leaving top-up fee contracts to be agreed directly between people and care providers, it can potentially leave people vulnerable to the risk of fee increases. It also devolves the responsibility to collect any unpaid fees to the care provider sector. Michael King, Local Government and Social Care Ombudsman, said:

"Councils are encouraged to administer the top-up fees, and recoup the money from relatives, because it gives the best security for vulnerable people living in care homes should there be any problems with payments."[28]

The added bureaucracy aside, we suspect that at the very least the new arrangements may be confusing for residents and their families. They will also force providers to justify potentially large additional fees, in order to maintain self-funder ratecards (assuming they do not accept the FCC for all beds in a home), by providing a breakdown of individual services and costs to residents or casting 'premium' services as a package.

DHSC Draft Operational Guidance

Shortly before the publication of the LaingBuisson report, DHSC published Operational guidance to implement a lifetime cap on care costs on 4 March 2022, seeking views on proposed statutory guidance for a consultation by 1 April [29]. The consultation documents address individuals' metering towards the cap on care costs, top-ups, and some of the practicalities of 18(3).

Some self-funders will arrange their own care, much as they do currently. Under the reformed system, they may continue to do so, without taking up 18(3), but still be able to participate in metering towards the £86,000 cap. The metering rate is referred to as the 'would be cost' and will be recorded in an Independent Personal Budget (IPB): 'to ensure fairness, how self-funders who arrange their own care progress towards the cap will be based on what the cost would be to the local authority if it were to meet their eligible care needs.... The IPB [Independent Personal Budget] will be the record that sets out what the cost would be to the local authority of meeting the person's eligible care needs. It will be this 'would be' cost, less daily living costs where applicable, that counts towards the cap'

Those self-funders who do take up 18(3) will have a Personal Budget, rather than an Independent Personal Budget. The Personal Budget will 'set out the cost of the care package that the local authority has arranged for them'. Likewise, this will then be used to calculate their metering to the cap. In summary, everyone with a personal or independent personal budget will have a care account which keeps track of their progress towards the cap.

[28] https://www.lgo.org.uk/information-centre/news/2020/feb/ombudsman-reminds-councils-about-care-home-top-up-fees
[29] https://www.gov.uk/government/consultations/operational-guidance-to-implement-a-lifetime-cap-on-care-costs

Those self-funders who do take up 18(3) will have a Personal Budget, rather than an Independent Personal Budget. The Personal Budget will 'set out the cost of the care package that the local authority has arranged for them'. Likewise, this will then be used to calculate their metering to the cap. In summary, everyone with a personal or independent personal budget will have a care account which keeps track of their progress towards the cap.

Regarding top-ups, the guidance provides further detail of 'first-party' top-ups (ie those made by a resident him/herself), which will be widely implemented in our view, to allow for premium care beds to continue in the market and preserve residents' choice, here called 'preferred accommodation': 'The local authority must arrange the preferred accommodation if they judge that the person paying the top up is willing and able to pay for the likely duration of the care journey, the paying person enters into a written agreement with the local authority that must be regularly reviewed'

Conditions which must be met to allow for this, include the condition that 'the accommodation is of the same type as that specified in the care and support plan' and that 'the provider of the accommodation is willing to enter into a contract with the local authority to provide the care at the rate identified in the person's personal budget on the local authority's terms and conditions'. It is this last condition which we suspect will be particularly problematic, given the desire of providers to preserve their ratecards.

We also note the DHSC's comment on cost variation: 'the guidance will acknowledge that the local authority may not always be able to commission equivalent care at a consistent price, meaning that people with similar needs may progress towards the cap at different rates. The guidance will say that this is permissible, but that the local authority must not consistently treat self-funding people differently to other groups, for example by commissioning care at a higher rate for this group.'

The DHSC commentary notes that its reforms, particularly FCC and the implementation of 18(3) 'will be a big adjustment for local authorities, providers and users'. Overall, however, the direction of travel outlined in the proposed guidance on 18(3) remains in line with the government's previous announcements: 'Once a self-funder decides to ask their local authority to meet their needs by arranging their care, the local authority will treat them in the same way it treats other users. All of the guidance local authorities must follow about how to meet individuals' needs will apply in the same way, regardless of how someone funds their care.'

SUMMARY

Overall, the DHSC's Impact Assessment makes a valiant, if necessarily actuarial attempt, at quantifying the effects which will flow from the conflation of the care costs cap, the implementation of 18(3) and the capturing of the FCC, which has so far eluded many local authorities and their care associations.

We address the potential dislocation to the provider market more fully below, but we note that it will remain the ultimate responsibility of local authorities to, in the DHSC's words, 'ensure market sustainability'.

Leaving aside the estimates of costs to be incurred by local authorities, which we analyse in the next section, our concerns are primarily that although in theory the market should rebalance – an increase in local authority fees offsetting a putative reduction in self-funder fees – in practice, we see considerable difficulties in implementation and negative impacts on particular local markets where there are vagaries in care mix, payor mix and geography.

5. LAINGBUISSON FINANCIAL IMPACT ASSESSMENT

This section of the report provides LaingBuisson's independent assessment of the financial impact of FCC and Section 18(3).

METHODOLOGY

To estimate the cost to councils of a FCC, LaingBuisson has used its longstanding Care Cost Benchmarks model and a proprietary methodology which apportions costs on a per-bed basis and adds industry standard return on capital.

Across three different benchmarks LaingBuisson has calculated the costs to all English councils of implementing these fee levels to their respective provider market participants. Secondly, LaingBuisson has also used public data sources to forecast typical providers' potential loss of private payer income, before any top-ups, as a result of 18(3).

In order to compare our analysis to current Government allocations, a Funded FCC benchmark has also used in the analysis. The Government have announced that for 2022/23 they will distribute £162m to councils to 'begin moving towards' a fair cost for care.

In the first year of implementation (2023/24) £600m will be provided to councils, however this will cover residential, nursing and homecare, alongside a small proportion of funding to support 'market management' and other administrative duties.

For the Funded FCC benchmark, we have assumed the distribution of the £600m across residential, nursing, homecare and market management will be in line with the impact assessment, and therefore £378m for residential and nursing from 2023/24. Furthermore, to arrive at allocations for each local authority type/region, the total £378m has been distributed to councils using the Adult Social Care Relative Needs Formula.[30]

[30] Funding estimates at local authority level provided by Pixel Financial Management on behalf of CCN.

LaingBuisson have calculated the results across four different FCC benchmarks[31];

'FUNDED FCC'

1

This is based on councils uplifting fees fully in line with current estimated funding allocations to implement FCC for residential and nursing care from 2023/24.

'FLOOR FCC'

2

Operating costs + operators' profit + 6.0% pa return on accommodation valued at £25,000 per bed (i.e., bare minimum for acceptable accommodation).

'MID-POINT FCC'

3

Between 'Floor' and 'Ceiling' (operating costs + operators' profit + 6.0% pa return on accommodation valued at £62,000 per bed) - most closely reflects the current balance between new-build and converted care home stock in England.

'CEILING FCC'

4

Operating costs + operators' profit + 6.0% pa return on accommodation valued at £100,000 per bed (i.e., typical new-build constriction and land cost).

An overview of the methodology used in our analysis is provided in the Box 3, with further information provided in Appendix 2. The modelling has been undertaken for each individual upper-tier authority, with all results for England councils/areas aggregated to local authority type/regional level.

LaingBuisson believes that this Mid-Point (£62,500 per bed) most closely represents the English average capital value attributable to a care home place. Therefore, our full analysis prominently focuses on this benchmark alongside Funded FCC. The Funded FCC benchmark currently reflects the amount councils could pay to providers without incurring large financial deficits and/or cross-subsiding higher fee levels from reductions in other council services or raising further income sources to subside higher fees from increased council tax, fees or charges.

It is important to note that LaingBuisson's estimates may be considerably higher than the final amounts agreed in the consultations between councils and providers. The results of our analysis should be considered in the context of current funding levels assigned to councils over the next three financial years to implement the FCC policy at level that LaingBuisson believes to be a sustainable rate to ensure on-going sustainability and investment in the residential and nursing care home sector.

[31] 2023/24 price estimates are used for the analysis, based on latest Care Cost Benchmark figures for 2021/22, inflated by a factor of 1.0609 representing projected care home cost increases of 3% per annum due to National Living Wage and general inflation.

BOX 3 - EVIDENCE BASE FOR LAINGBUISSON'S FAIR COST OF CARE ESTIMATES

'Floor', 'Ceiling' and 'Mid-Point' FCC estimates are derived from a model first developed by LaingBuisson in 2004, in association with the Joseph Rowntree Foundation. The model is now referred to as Care Cost Benchmarks and is available on subscription in the form of an interactive Excel spreadsheet tool and guidance notes. The tool is specifically designed to calculate costs of nursing and residential homes for older people, though it can also be used for care homes for other client types. The model builds up total costs from granular data on each determinant of cost, including staff hours, pay rates, non-staff current costs and capital and financing costs.

There is a strong evidence base for the model, which is described in detail in the guidance notes. The model has been in use for almost two decades. It has been refined over that time and the data used to populate it has been maintained through care home surveys and 'Fair Price' exercises commissioned by local authorities and care associations.

Staffing makes up two thirds or more of care home costs. While staffing levels vary home to home, average hours per resident per week do not vary greatly by location or over time, while pay rates are typically homogenous. Non-staff current costs are variable, but their quantum is relatively small. Nearly all of contentious aspects of Fair Price exercises are related to the cost of capital and operators' profit.

The Care Cost Benchmarks model, however, uses an approach which is as close to objective as possible, starting from the empirical observation that investors will pay approximately nine times annual operating profit (EBITDAR) for a sustainable freehold care home.

The logic of the model is as follows: If investors pay 9.0x annual EBITDAR, that means that they are seeking an 11.0% whole business annual return on capital (the reciprocal of 9.0x). A further empirical observation is that investors in care home property seek a yield of about 6.0% per annum. It follows that the difference (11.0% less 6.0%) is a good proxy for the care home operators' profit, after paying the financing costs of the property (or accommodation). Expressed in a different way, this can be shown to be equivalent to a 10% mark-up on operating costs. Through this logic, the Care Cost Benchmarks model obviates unnecessary debate surrounding the costs of different capital financing structures.

To summarise, it uses the market-based observation that investors typically seek an 11.0% whole business return for the moderately risky business of owning and operating a care home, while property investors will accept a lower yield of 6% on the less risky business of making care home accommodation available, with first call of the gross operating surplus (EBITDAR).

With all other operating costs being the same (or potentially the same) it follows that the fixed cost of capital tied up in the land and buildings occupied by a care home is the sole reason for differences in the 'Fair Price' for a care home operating at reasonable staffing and other current costs in any given locality. The 'Floor FCC' then reflects the minimum capital cost consistent with an adequate physical environment (about £25,000 per bed) and the 'Ceiling FCC' reflects the capital cost of a new-build care home offering single rooms with 12m2 of floor space, excluding ensuite facilities (being the CQC minimum for new homes or extensions).

Premium care homes at the top of the market may have much higher physical environment specifications, at £150,000 per bed or more. But the model regards these as being beyond the range for which a local authority may reasonably pay for a publicly supported resident.

FAIR COST OF CARE ESTIMATES

Using its well-established Care Cost Benchmarks model (see Box) and the methodology summarised in Appendix 2 of this report, LaingBuisson calculates the additional FCC costs in the first year of implementation for council supported residents aged 65+ in residential and nursing care according to our three benchmarks. While the analysis focus on the first year of implementation, it is important to note that the costs outlined represent annually recurring costs to councils, which would need to be uplifted by inflation each year.

The analysis shows these costs range from a 'floor' of £783m to a 'ceiling' of £1,681m, which is between two and four and a half times higher than the Government funding allocation of just £378m. Breakdown by region and local authority type is shown in Tables 1 and 2. Nearly all (144 out of 146) upper tier councils are estimated currently to pay external providers at rates that are below the Mid-Point FCC. Our estimates at the Mid-Point are in line with the conclusion of the Competition and Markets Authority, who estimated back in 2017 that if local authorities were to pay the full cost of care for all residents they fund, the additional cost to them of these higher fees would be £0.9 to £1.1bn a year.[32]

Table 3 and Graph 1 show the extent of the shortfall in funding for English councils between the three different benchmarks and current allocations of funding. For all councils this ranges from a deficit of £405m at the floor, £854m at the Mid-Point, and £1,303m at the ceiling. At the Mid-Point County & CCN Unitary authorities and Metropolitan Boroughs represent 80% of the total funding shortfall across all English councils.

Table 1: Estimated Cost of Implementing FCC for Council-Supported Care Home Residents Aged 65+ by Regions:

Estimated Cost of Implementing FCC for Council-Supported Care Home Residents Aged 65+ / Region

GBPm	HM Government	LaingBuisson Estimates		
	FCC Funding Allocations for Councils in 2023/24 (Residential & Nursing Only)	'Floor' FCC	'Mid-Point' FCC	'Ceiling' FCC
England	**377.9**	**782.6**	**1,231.8**	**1,681.1**
East Midlands	31.6	58.6	101.7	144.7
East of England	38.4	98.9	148.8	198.7
London	58.5	32.6	74.3	116.0
North East	21.8	54.2	85.3	116.4
North West	56.2	226.9	295.1	363.2
South East	52.8	54.1	128.0	201.9
South West	38.1	17.5	64.6	111.8
West Midlands	42.2	126.6	173.1	219.6
Yorkshire & Humber	38.5	113.0	160.9	208.9

Table 2: Estimated Cost of Implementing FCC for Council-Supported Care Home Residents Aged 65+ by LA Type:

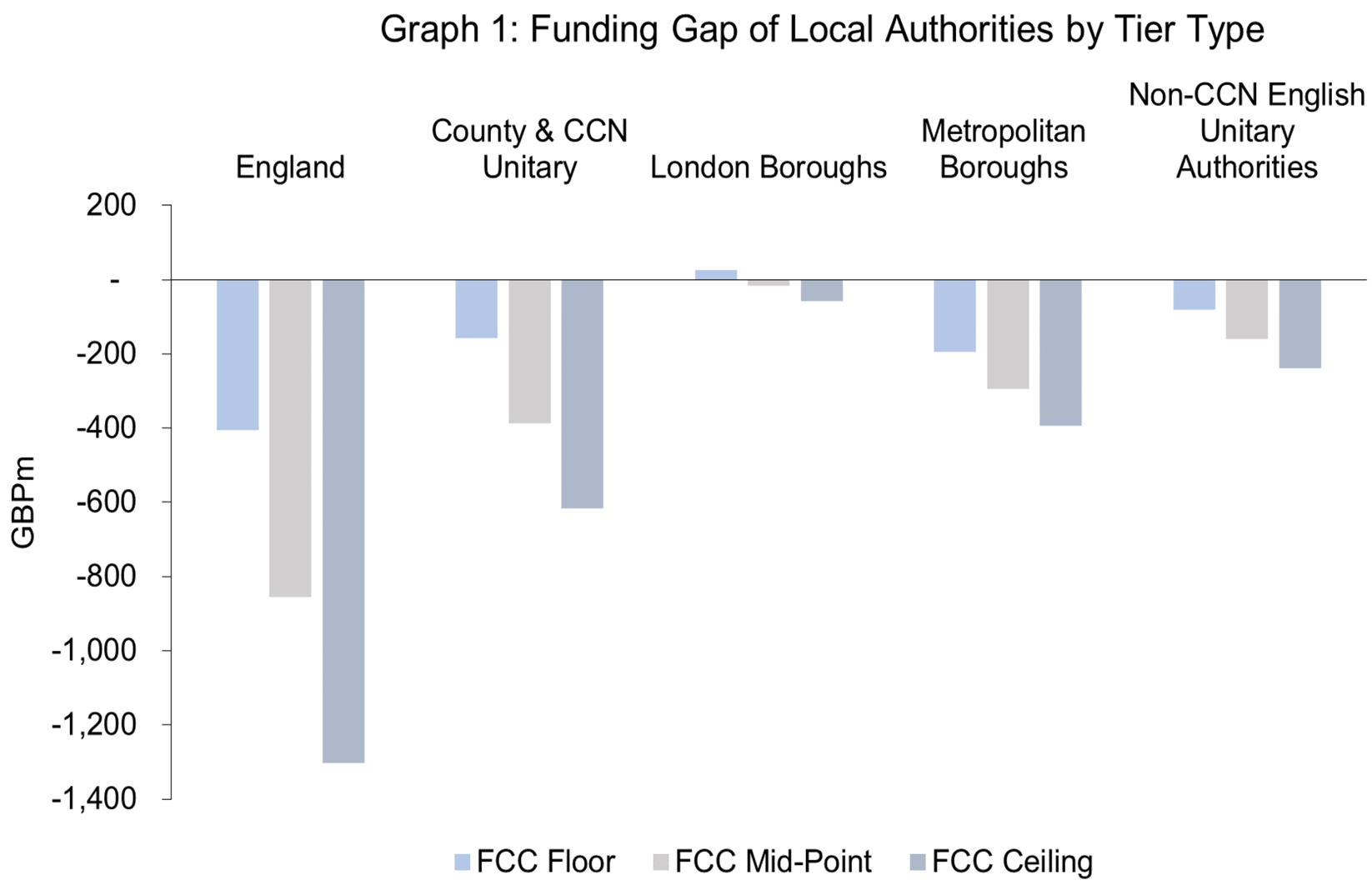
Estimated Cost of Implementing FCC for Council-Supported Care Home Residents Aged 65+ / Tier Type

GBPm	HM Government	LaingBuisson Estimates		
	FCC Funding Allocations for Councils in 2023/24 (Residential & Nursing only)	'Floor' FCC	'Mid-Point' FCC	'Ceiling' FCC
England	**377.9**	**782.6**	**1,231.8**	**1,681.1**
County & CCN Unitary	184.0	320.9	550.1	779.3
London Boroughs	58.5	32.6	74.3	116.0
Metropolitan Boroughs	92.7	286.5	385.9	485.3
Non-CCN English Unitary Authorities	62.7	142.6	221.5	300.4

[32] https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf

Table 3: Funding gap of local authorities by type (funding allocations v Floor, Mid-Point and Ceiling FCC estimates):

Funding Gap of Local Authorities by Tier Type (Funding Allocation v Floor, Mid-Point and Ceiling FCC)			
GBPm	FCC Floor	FCC Mid-Point	FCC Ceiling
England	**(404.7)**	**(853.9)**	**(1,303.2)**
County & CCN Unitary	(156.9)	(386.1)	(615.3)
London Boroughs	25.9	(15.8)	(57.5)
Metropolitan Boroughs	(193.8)	(293.2)	(392.6)
Non-CCN English Unitary Authorities	(79.9)	(158.8)	(237.7)



IMPACT OF SECTION 18(3) ON PROVIDERS REVENUES

The financial impact on care providers of Section 18(3) will vary considerably and be influenced by a range of factors including:

a) the rate of take-up by self-funders of 18(3);

b) the level fee negotiated by the local authority for the self-funder, after taking account of any uplift in fee rates as a result of FCC;

c) the willingness of care providers to accept the FCC and the extent of their requirement to 'top up' to their ratecard

To demonstrate the potential scale of losses and sensitivity to first two factors of these factors Table 4 shows the estimated lost revenue for care providers from Section 18(3) across three different penetration rates of 18(3) and at the Funded FCC and Mid-Point FCC benchmarks. The analysis takes into account the uplifted FCC rates across these two benchmarks for self-funders accessing local authority placements. However, these rates will inevitably still be significantly below current self-funder rates, resulting in revenue losses to providers.

At the Mid-Point FCC losses to providers in England could range from £323.2m at a 25% Section 18(3) penetration rate, £646.5m at 50% and £969.7m at 75%. It is important to note that Funded FCC revenue losses are significantly higher to providers as a result of self-funders transferring to local authority contracts at a lower fee level. Under this benchmark, losses range in England from £468.7m at a 25% penetration rate, £937.4m at 50% and £1,406m at 75%.

Table 4: Estimated Revenue Losses to Care Providers from Section 18(3) for England at Selected Penetration Rates:

Estimated Revenue Losses to Care Providers From 18(3) for England at Selected Penetration Rates

GBPm

18(3) Penetration Rate	Funded FCC - Max with Govt. FCC Funding Allocation Only	Long-Term Full Average Costs - Mid-Point
25%	(468.7)	(323.2)
50%	(937.4)	(646.5)
75%	(1,406.1)	(969.7)

To demonstrate the variation of the impact of 18(3) Tables 5 and 6 show the results for region and local authority type at both the Funded FCC level and Mid-Point FCC.

Table 5: Estimated Revenue Losses to Care Providers from Section 18(3) by Regions at Selected Penetration Rates:

Estimated Revenue Losses to Care Providers from 18(3) by Regions at Selected Penetration Rates

GBPm	Funded FCC - Max with Govt. FCC Funding Allocations Only			Long-Term Full Average Costs - Mid-Point		
18(3) Penetration Rate	25%	50%	75%	25%	50%	75%
East Midlands	(26.0)	(51.9)	(77.9)	(13.3)	(26.6)	(39.9)
East of England	(78.0)	(156.0)	(234.0)	(54.7)	(109.4)	(164.1)
London	(36.1)	(72.3)	(108.4)	(35.3)	(70.7)	(106.0)
North East	(5.9)	(11.8)	(17.7)	0.8	1.6	2.4
North West	(46.3)	(92.7)	(139.0)	(11.2)	(22.5)	(33.7)
South East	(139.3)	(278.6)	(418.0)	(118.7)	(237.3)	(356.0)
South West	(61.4)	(122.9)	(184.3)	(54.9)	(109.9)	(164.8)
West Midlands	(46.5)	(93.0)	(139.6)	(25.2)	(50.4)	(75.6)
Yorkshire & Humber	(29.1)	(58.2)	(87.2)	(10.7)	(21.3)	(32.0)
England	**(468.7)**	**(937.4)**	**(1,406.1)**	**(323.2)**	**(646.5)**	**(969.7)**

Table 6: Estimated Revenue Losses to Care Providers from Section 18(3) by LA Type at Selected Penetration Rates:

Estimated Revenue Losses to Care Providers from 18(3) for Tier Type at Selected Penetration Rates

GBPm	Funded FCC - Max with Govt. FCC Funding Allocations Only			Long-Term Full Average Costs - Mid-Point		
18(3) Penetration Rate	25%	50%	75%	25%	50%	75%
County & CCN Unitary	(323.3)	(646.7)	(970.0)	(236.3)	(472.6)	(708.9)
London Boroughs	(36.1)	(72.3)	(108.4)	(35.3)	(70.7)	(106.0)
Metropolitan Boroughs	(50.3)	(100.6)	(150.9)	(13.2)	(26.3)	(39.5)
Non-CCN English Unitary Authorities	(58.9)	(117.9)	(176.8)	(38.4)	(76.9)	(115.3)
England	**(468.7)**	**(937.4)**	**(1,406.1)**	**(323.2)**	**(646.5)**	**(969.7)**

The analysis shows that not only will the impact of 18(3) will be heavily influenced by the rate of penetration and fee level negotiated by the local authority for the self-funder, but by the region or local authority type the care providers are operating within. The following two key observations from the analysis can be made;

- Providers operating in County and CCN Unitary authority areas are significantly more exposed to revenue losses as a result of 18(3). At a 50% penetration rate under a Mid-Point FCC benchmark, these areas account for 73% of all lost revenue to providers, reflecting these council areas geographical spread within the South-East, South-West and East of England and high levels of self-funders.

- Higher fee levels under the Mid-Point FCC, compared to the Funded FCC, will have a material impact on the level of exposure to financial losses amongst care providers. Lost revenues to providers in Metropolitan Boroughs will reduce by 74% if councils are able to pay fee levels that are reflective of the Mid-Point FCC. However, in contrast, lost revenues will only reduce by 26% in County and CCN Unitary authorities if councils are able to pay fee levels that are reflective of the Mid-Point FCC.

COMBINED IMPACT OF FCC & SECTION 18(3)

Having considered FCC estimates and the impact of Section 18(3) on providers revenues, LaingBuisson have now bought together these two parts of the financial analysis to show the combined net financial impact of the two policies. Firstly, this demonstrates the extent to which increased revenues for providers from FCC will offset losses from Section 18(3).

To enable more detailed analysis on the impact of providers, councils and the social care sector combined, we consider the results at Funded FCC and Mid-Point FCC benchmarks on the basis of a Section 18(3) penetration rate of 50%.

Tables 7 and 8 shows the results of the analysis at the Funded FCC level, where councils are only able to raise fee levels in line with current funding levels for both self-funders accessing Section 18(3) and existing local authority clients.

Table 7: Estimated Net Financial Impact of FCC and 18(3) on Stakeholders – Funded FCC and 50% 18(3) Penetration, by region:

Net Financial Impact of FCC and 18(3) on Stakeholders - Funded FCC and 50% 18(3) Penetration, by Region

GBPm	LaingBuisson Estimates		HM Government	Outputs		
	Cost of 18(3) to Providers	Cost of FCC to Councils	HM Government Funding	Net Financial Position for Councils	Net Financial Position for Providers	Net Impact on Social Care Sector
East Midlands	(51.9)	31.6	31.6	0.0	(20.3)	(20.3)
East of England	(156.0)	38.4	38.4	0.0	(117.6)	(117.6)
London	(72.3)	58.5	58.5	0.0	(13.8)	(13.8)
North East	(11.8)	21.8	21.8	0.0	9.9	9.9
North West	(92.7)	56.2	56.2	0.0	(36.5)	(36.5)
South East	(278.6)	52.8	52.8	0.0	(225.9)	(225.9)
South West	(122.9)	38.1	38.1	0.0	(84.8)	(84.8)
West Midlands	(93.0)	42.2	42.2	0.0	(50.9)	(50.9)
Yorkshire & Humber	(58.2)	38.5	38.5	0.0	(19.7)	(19.7)
England	**(937.4)**	**377.9**	**377.9**	**0.0**	**(559.5)**	**(559.5)**

Table 8: Estimated Net Financial Impact of FCC and 18(3) on Stakeholders – Funded FCC and 50% 18(3) Penetration, by LA type:

Net Financial Impact of FCC and 18(3) on Stakeholders - Funded FCC and 50% 18(3) Penetration, by Tier

GBPm	LaingBuisson Estimates		HM Government	Outputs		
	Cost of 18(3) to Providers	Cost of FCC to Councils	HM Government Funding	Net Financial Position for Councils	Net Financial Position for Providers	Net Impact on Social Care Sector
County & CCN Unitary	(646.7)	164.0	164.0	0.0	(482.6)	(482.6)
London Boroughs	(72.3)	58.5	58.5	0.0	(13.8)	(13.8)
Metropolitan Boroughs	(100.6)	92.7	92.7	0.0	(7.9)	(7.9)
Non-CCN English Unitary Authorities	(117.9)	62.7	62.7	0.0	(55.2)	(55.2)
England	**(937.4)**	**377.9**	**377.9**	**0.0**	**(559.5)**	**(559.5)**

The analysis shows that if fee levels were only to rise to the Funded FCC level, and if there was a 50% take-up by self-funders of Section 18(3), this would result in a net financial loss to providers of £560m. As fee levels only rise to the level currently funded by Government, there is no financial deficit for councils. Providers in County and CCN Unitary authorities would account for 86% of all net financial losses to the social care sector, with the largest loses in the South-East, East of England and South-West.

Tables 9 and 10 shows the results of the analysis if councils were to pay fee levels that were reflective of LaingBuisson calculations at the Mid-Point FCC.

Table 9: Estimated Net Financial Impact of FCC and 18(3) on Stakeholders – Mid-Point FCC and 50% 18(3) Penetration, by region:

Net Financial Impact of FCC and 18(3) on Stakeholders – Mid-Point FCC and 50% 18(3) Penetration, by Region

GBPm	LaingBuisson Estimates		HM Government	Outputs		
	Cost of 18(3) to Providers	Cost of FCC to Councils	HM Government Funding	Net Financial Position for Councils	Net Financial Position for Providers	Net Impact on Social Care Sector
East Midlands	(26.6)	101.7	31.6	(70.1)	75.1	5.0
East of England	(109.4)	148.8	38.4	(110.4)	39.4	(71.0)
London	(70.7)	74.3	58.5	(15.8)	3.6	(12.2)
North East	1.6	85.3	21.8	(63.5)	86.9	23.4
North West	(22.5)	295.1	56.2	(238.9)	272.6	33.7
South East	(237.3)	128.0	52.8	(75.3)	(109.3)	(184.6)
South West	(109.9)	64.6	38.1	(26.6)	(45.2)	(71.8)
West Midlands	(50.4)	173.1	42.2	(130.9)	122.7	(8.2)
Yorkshire & Humber	(21.3)	160.9	38.5	(122.5)	139.6	17.1
England	**(646.5)**	**1,231.8**	**377.9**	**(853.9)**	**585.3**	**(268.6)**

Table 10: Estimated Net Financial Impact of FCC and 18(3) on Stakeholders – Mid-Point FCC and 50% 18(3) Penetration, by LA type:

Net Financial Impact of FCC and 18(3) on Stakeholders – Mid-Point FCC and 50% 18(3) Penetration, by Tier Type

GBPm	LaingBuisson Estimates		HM Government	Outputs		
	Cost of 18(3) to Providers	Cost of FCC to Councils	HM Government Funding	Net Financial Position for Councils	Net Financial Position for Providers	Net Impact on Social Care Sector
County & CCN Unitary	(472.6)	550.1	164.0	(386.1)	77.5	(308.6)
London Boroughs	(70.7)	74.3	58.5	(15.8)	3.6	(12.2)
Metropolitan Boroughs	(26.3)	385.9	92.7	(293.2)	359.6	66.4
Non-CCN English Unitary Authorities	(76.9)	221.5	62.7	(158.8)	144.6	(14.2)
England	**(646.5)**	**1,231.8**	**377.9**	**(853.9)**	**585.3**	**(268.6)**

At the Mid-Point, the analysis shows the net impact on providers of increased revenue from FCC and lost revenue from 18(3). Care home providers, for their part, would see gross revenues increasing by £585m, being the net financial effect of gaining £1,231.8m from FCC and losing an estimated £646.5m from 18(3), again based on an assumed 18(3) penetration of 50%.

The regional impact varies, with the South-East and South-West, where there are a higher number of self-funders relative to local authority-funded residents in care homes, experiencing net revenue loses for providers even after FCC at the 'Mid-Point'. But it is important to note that FCC results in increased revenue for providers who have larger numbers of local authority-funded residents, and this will be particularly noticeable in the Midlands and the North East.

These variations impact on the net position of providers by local authority type, with 61% of all increases in providers revenues concentrated in Metropolitan Boroughs. In contrast, providers in County & CCN Unitary authorities will account for just 13% of all increased revenue for providers.

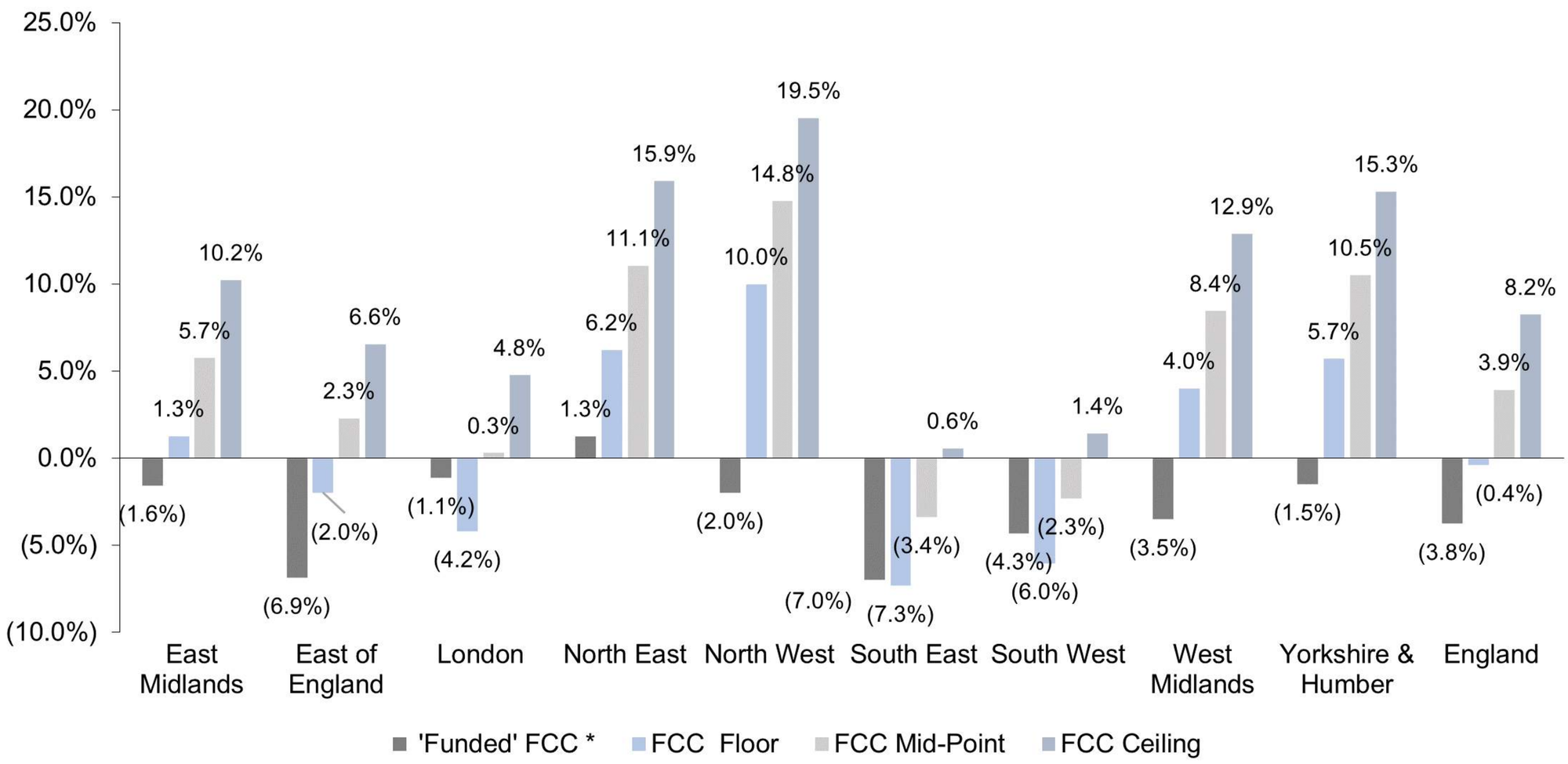
However, in order to realise these increased revenues for providers, councils would need to be paying fee rates that are reflective of the Mid-Point FCC. As our analysis shows, based on current funding levels, this would leave councils facing an annually recurring net deficit £853.9m. County & CCN Unitary authorities account for 45% of this total annual deficit, with Metropolitan Boroughs representing 34%.

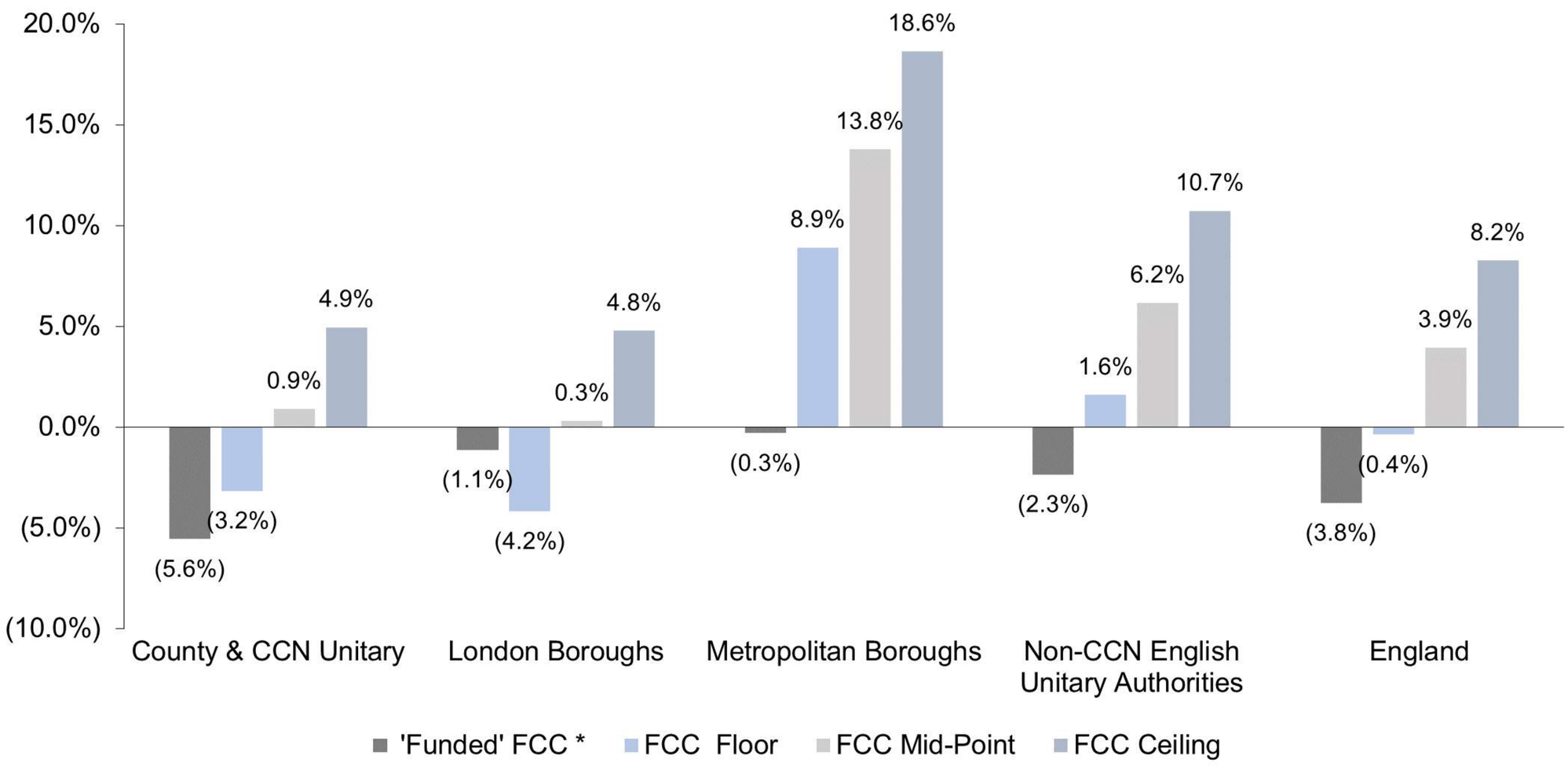
Finally, the LaingBuisson analysis takes these two components to show the net financial position of both councils and providers combined as the 'social care sector'. The net financial position at the 'Mid-Point' would be -£268.6m nationally, with losses almost exclusively concentrated in County and CCN unitary authorities (-£308.6m) while Metropolitan Boroughs experience an overall net gain of an estimated £66.4m. There is again a large regional variation, with losses concentrated in the South-East, South-West and East of England.

CARE MARKET STABILITY ASSESSMENT

The gravity of the risk to the stability of care economies can best be demonstrated by modelling the combined percentage impact of FCC and Section 18(3) on current provider revenues as a percentage of annual revenues. Here, all four of the FCC benchmarks are shown in Graphs 2 and 3.

Graph 2: Net % Impact of FCC and 18(3) on Providers' Annual Revenues by Region





If actual FCC levels reach the calculated FCC Mid-Point or above, providers in England would witness an increase in aggregate revenues as a percentage annual revenue of 3.9%. At local authority type level, providers in County & CCN unitary authorities will see a much smaller 0.9%, while providers in Metropolitan Boroughs would witness a significant increase in revenues of 13.8%. Providers operating in care economies in all areas outside of the South East and South West of the country can expect to see an increase in aggregate revenues as a result of FCC and 18(3) policies. Aggregate revenue loss will be limited to the South East (-3.4%) and the South West (-2.3%).

If, however, actual FCC levels reach the calculated FCC Floor only, or are constrained at Funded FCC level (this is the amount councils could pay based on current allocations), then aggregate revenue losses will be significant and could cause severe sustainability risk to care markets across the country. At the Funded FCC level, aggregate revenues as a percentage of providers annual revenues fall -3.8% in England. At local authority type level, providers in County & CCN unitary authorities will see a larger reduction at -5.6% while providers in Metropolitan Boroughs would also witness reductions of -0.3%.

At a regional level, reductions in aggregate revenues as a percentage of providers annual revenues will spread to care economies right across the country, rising to -7% in the South East, -6.9% in the East of England, and -4.3% South West, but also falling in every region apart from the North East.

SUMMARY

The key conclusions from the LaingBuisson analysis are:

- Based on its well-established Care Cost Benchmarks model, LaingBuisson calculates that additional Fair Fee costs in 2023-24, the first full year of implementation, range from a ‘floor’ of £783m to a ‘ceiling’ of £1,681m, with a ‘Mid-Point’ £1,232m. This range is between 2.0x – 4.5x higher than the Government funding allocation of £378m.

- DHSC therefore appears to have underestimated the cost of implementing a Fair Fees policy. LaingBuisson's estimates of costs to councils of implementing Fair Fees that are sustainable for the care sector are orders of magnitude higher than those cited in the DHSC's Impact Assessment document. This in turn raises concerns that the Government has very substantially underestimated the amount of new funding required to make the combined FCC / 18(3) strategy work effectively.

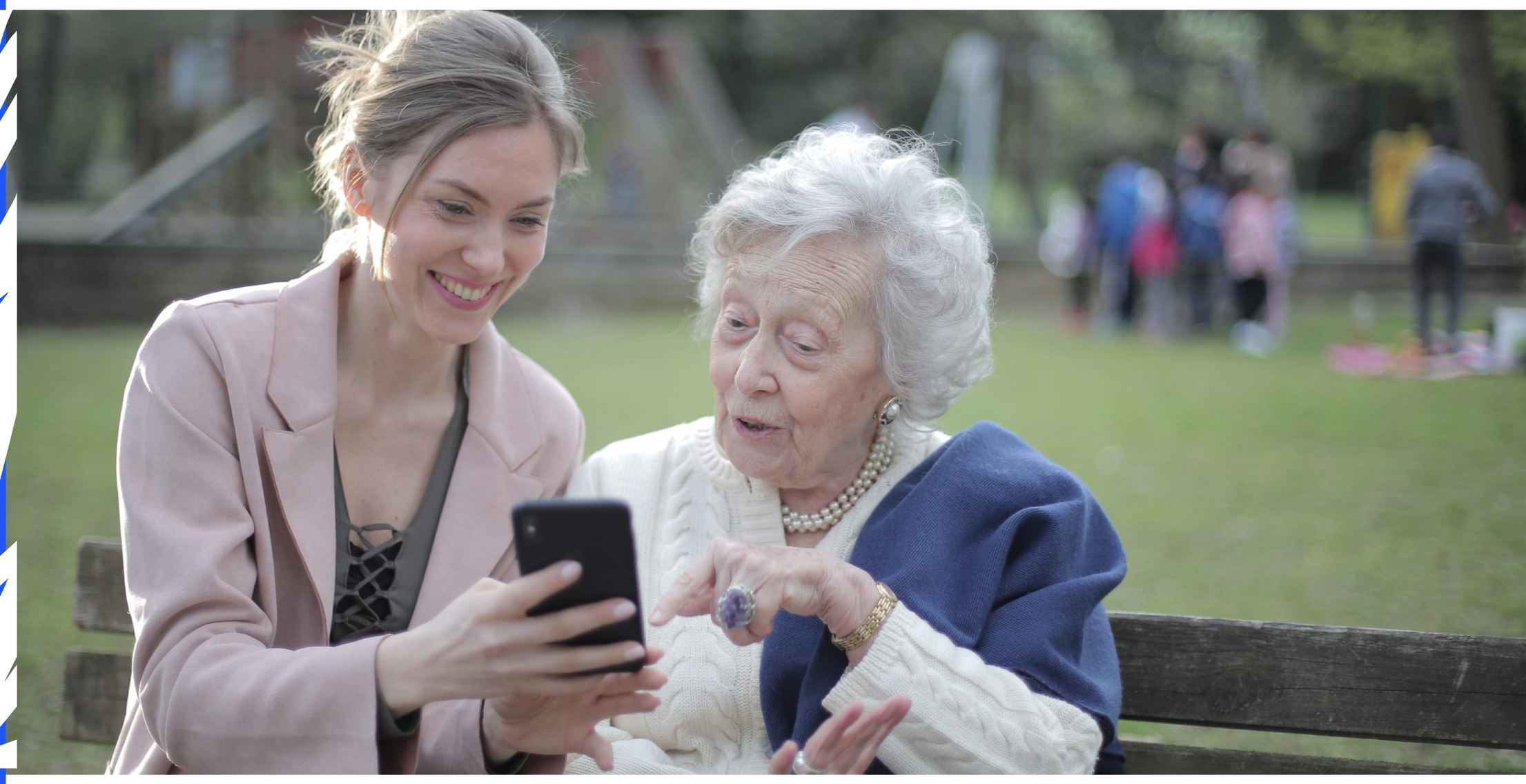
- In its Impact Assessment, the Government have not sought thus far to estimate the combined financial impact of Section 18(3) and FCC on care providers. But our analysis demonstrates that based on a 50% penetration rate and current FCC funding levels for councils, providers across the country would experience significant financial challenges as a result of lost revenues amounting to £560m.

- In order to prevent the widespread market instability that would result from these revenue losses, councils FCC would need to be raised significantly compared to current Government funding estimates to offset these losses and ensure on-going investment in the social care sector, particularly in the short term.

- Our central estimate is that this would require Government to raise funding allocations by at least £854m per annum for residential and nursing care homes to enable councils to pay rates at the Mid-Point FCC benchmark. However, even if councils were funded at this FCC level, some care economies would still face financial significant pressures as a result of the impact of 18(3).

"To prevent the widespread market instability that would result from these revenue losses, councils FCC would need to be raised significantly compared to current Government funding estimates"

6. POLICY IMPLICATIONS ASSESSMENT



Building on the financial analysis conducted above and drawing on the contributions from stakeholders during our simulation events (see Appendix 1), this section of the report analyses the implementation challenges and policy implications for councils and providers.

IMPLICATIONS FOR COUNCILS

For councils, our analysis shows the following high-level implications:

- Our financial analysis confirms that at present there is wide-spread underpayment in council fee-levels for residential and nursing care homes in England. Current Government funding to implement FCC will allow councils to raise fee levels towards a more sustainable level. However, based on current funding levels, the benefits of this are likely to be entirely offset by the simultaneous hard implementation of Section 18(3).
- As a result, the provider market would face significant financial losses on a scale that is likely to be unsustainable for providerbusiness models, particularly in the short-term, and in turn undermine councils' ability meet their statutory duties in relation to care placements and undertake its market shaping obligations.
- In order to ensure market stability if the reforms are to be implemented in full, councils would need to raise fees significantly above both the Funded and Floor FCC benchmarks in order to prevent widespread market disruption. FCC at the Mid-Point level would at least ensure increased revenues for the majority, but not all, local care economies. However, our central estimate is that councils would face an annual recurring shortfall of at least £854m in order to raise fee levels towards this level.

- The financial impact estimated in our analysis comes at a time when there are considerable operational headwinds for councils' adult social care commissioning. As demonstrated by the engagement with councils (see Appendix 1) through this project, social care reforms, including the implementation of 18(3), come at a time when councils and their local providers are experiencing a raft of post-pandemic issues, notably acute staffing shortages and increases in demand for a range of community-based services, which have created a 'perfect storm' in the sector. This is against a backdrop of councils are only just emerging from over a decade reduced resources for social care, at the same time of increasing demand for services. Regarding existing pressures in the market, we heard a number of council representatives describe a sense of slow and enduring crisis, in the post-pandemic climate.

- While the financial impact of 18(3) is uncertain and we are not sighted on individual councils' assessments of 18(3) take-up (many of which are ongoing), given current financial constraints, idiosyncratic care market conditions and councils' historic fee negotiations with providers, councils strongly supported our conclusions that the sums earmarked for FCC are underfunded.

- Individual councils each set their own budgets, including those for adult social care. But given past and current funding challenges already facing councils, they are extremely unlikely to be in the position to fund fee increases above the Funded FCC level from existing resources or alternative sources of income (i.e. council tax) without a detrimental impact on existing social care services or challenging their own financial sustainability.

- Therefore, without additional resources from central Government, councils will face the possibility of provider failure and market exits, while destabilising the overall care market within an area. This will negatively impact on the ability of councils to secure high quality care placements for those eligible for local authority arranged care, in addition to market exits impacting on the availability of provision for the NHS of continuing health care. There is also likely to be a greater polarisation between local authority arranged care and self-funder placements, with a growing divide in the quality of care received by the two cohorts of care recipients.

"Councils and their local providers are experiencing a raft of post-pandemic issues, notably acute staffing shortages and increases in demand for a range of community-based services"

- As a result of potential widespread market instability, our engagement with councils suggests some may be considering market intervention, potentially re-entering or expanding direct provision of care home services. Three council participants at our simulation events, respectively from the South East, the Midlands and the North, said they were looking at investment as a way of bridging service gaps. Some councils said they had already been forced to 'pick up market failures' and were prepared to make acquisitions or take over failing services.

- Council participants in our simulation events also made the point that when considering funding and implementation for the reforms, the NHS should be involved in the discussions. This should flow firstly from the fact that Government funding was, initially at least, directed to the NHS, secondly that with increasing health needs, NHS commissioning and placement was a rapidly growing part of the social care mix and increasingly evident in care homes.

- Moreover, Government guidance could enable councils to limit or ration access to Section 18(3). However, it is not clear how this would work in practice given the current Government statement policy position, with the possibility of leaving councils open to increased legal challenges. Moreover, it is also not clear how the market would respond in terms of the percentage or numerical allocation of beds to councils against those accessing a placement via a top up.

- Concerns regarding legal challenges following the implementation of the reforms were also raised. Our legal practitioner with experience of the care sector noted in the simulation event that the provisions of Section 18(3) were subject to a significant amount of discussion when the Care Act 2014 was first being passed into statute. Likewise, there were other provisions, particularly around individuals' rights to challenge decisions made concerning their care, which will come to the fore as the Act is fully implemented.

- Finally, the reforms introduce new market shaping and fee negotiations duties for councils hitherto to witnessed before. It is important to consider the significant historical challenges in fee negotiations with providers and the success in undertaking fair cost of care exercises. Even if Government were to provide further resources for FCC, there is likely to be significant challenges in conducting these exercises with providers within a relatively short timescale on behalf of both local authority and new self-funder clients, alongside significant new administrative burdens for councils.

- From our engagement with councils, it was clear there was general lack of consultation and unpreparedness for the new reforms, particularly in terms of technical infrastructure to handle a substantial prospective cohort of assessments from those wishing to take up the care cap and the arrangement of their care. There were already significant staff shortage in the care sector and structural funding pressures which may be exacerbated by the proposed reforms, in the pursuit of 'equalisation' or 'harmonisation' of fee metrics. There were concerns that bureaucracy would increase significantly at a central administration level, and fears that, ultimately, outcomes will be worse for the public. Participants were keen to see quality improvements across the sector and fees reflect such improvements.

"Without additional resources from central Government, councils will face the possibility of provider failure and market exits, while destabilising the overall care market within an area."

IMPLICATIONS FOR PROVIDERS

Our financial analysis shows that the implementation of 18(3) alongside council-paid fees which continue to be below the 'Mid-Point' risks destabilising the care home sector in many areas. As the commentary in Box 4 outlines, alongside provider comments as part of our engagement with the sector (see Appendix 1), this will come at a very challenging time for providers emerging from the impact of the Covid-19 pandemic.

However, the combined financial impact of FCC and 18(3) will vary widely from provider to provider. Care homes operate in discrete geographies, with particular care offers (residential care, nursing care, residential dementia care and nursing dementia care being the core categories), and with varying degrees of self-funder and local authority revenues. The combinations of these characteristics will affect how they are impacted. An overview of the implications by care home type can be summarised as follows;

- **Care homes which serve an exclusively public-paid clientele**: These operators by definition are not exposed to any 18(3) risk. They stand to benefit from FCC, whatever the quantum of upward movement from current council fee rates turns out to be. But there are relatively few of them. The Competition and Markets Authority found, in its 2017 study of the care home sector, that the great majority of care homes cater for a mix of publicly- and privately-funded residents and that very few cater exclusively for private payers.[33]

- **Profitable care homes operators positioned at the premium end of their local markets**: Homes which have an established position as local market leaders, typically serving an affluent clientele in the upper decile of fees, may be sufficiently confident of their ability to continue to attract sufficient residents from an 18(3)-depleted pool of private payers. They will have the option of ceasing to engage with councils at all after implementation of 18(3), and to focus exclusively on private payers. They will be encouraged to do so in the knowledge that the most affluent consumers may not seek to use 18(3). This is not only because they will be relatively wealthy, but also because the gap between an upper decile private pay rate and the council's usual rate will only be bridgeable by a substantial first party top-up. And if such a top-up is necessary to access the home, there will be no financial incentive to use 18(3). If premium homes respond in this way, it will lead to a greater degree of polarisation in the care home market. However, many local market leading homes are parts of groups whose other homes may occupy a less secure market position. In this case, group risk from 18(3) may dictate a different strategy.

- **Mid-market care homes catering for significant numbers of publicly paid residents**: This probably describes the majority of care homes for older people. Even if new-build, the physical environment they offer will not be sufficiently distinguished from local competitors to enable them to command substantial first party top-ups. They will gain from councils' fee increases as they move towards FCC but they stand to lose fee revenue from those self-funding customers who avail themselves of 18(3). The less generous their local council's FCC settlement, and the greater the take-up of 18(3) the higher will be their risk of net revenue loss from the combination of FCC and 18(3). They may seek to limit their council-funded residents to a certain level and aim to generate adequate occupancy from those and the 18(3)-depleted pool of private payers, but it is likely to be a tricky call, and one that could have significant downside risk.

[33] Competition and Markets Authority, Care homes market study, Appendix C, Table C8
https://assets.publishing.service.gov.uk/media/5a32947be5274a1fee16bb9b/appendices-and-glossary-care-homes-market-study-final-report.pdf

- **Mid-market homes (and others) with high fixed costs**. This is the segment of the care home market most at risk from an underfunded FCC policy combined with a hard 18(3) implementation with high take-up. Fixed costs include interest, loan repayments and lease rental commitments. Many private pay focused homes achieve EBITDAR margins of 30% or more of revenue. But if high fees are predicated on heavy investment in the asset which can be well in excess of £100,000 per bed including land costs for a high specification home, then loan servicing or rent payments can absorb 20 percentage points or more of that gross margin. The risk that many such operators will face is that they will not occupy a strong enough market position to become exclusively private pay and, if they engage with councils, any revenue gains from FCC for council placements could be more than offset by 18(3) driven reductions in fee levels for 18(3) users who would otherwise have been private payers. The lower the FCC settlements, the higher the usage of 18(3), and the higher the fixed financing costs of the provider, the greater will be the risk of financial failure from adopting a strategy of engaging in a market dominated by council placements.

In order to demonstrate the potential impact on different types of providers at a more granular level, LaingBuisson has undertaken further analysis of three broad types of operators: (1) operators with a 'mixed economy' model; (2) operators with a bias towards self-funders, in the upper-mid market; and (3) premium operators catering predominantly for self-funders and providing higher acuity care. A set of assumptions around self-funder and local authority fees, current sector occupancy averages and care mix has been made, based on publicly available sources. In all cases, an allowance has been made for the proportion of NHS-funded residents, who are excluded from the analysis.

LaingBuisson has used the following estimates for FCC based on its long-established model, as the inputs to assess the impact on revenues for the three types of providers. Clearly, official FCC figures would be established as part of the Government's reforms ahead of the implementation of Section 18(3).

Fair Cost of Care / Estimates	
Residential Care	
Ceiling	819
Mid-Point	785
Floor	711
Nursing Care	
Ceiling	1,101
Mid-Point	1,047
Floor	992
Resi / Nursing Dementia Care	
Ceiling	867
Mid-Point	814
Floor	760

BOX 4 -
THE CARE SECTOR IN 2022

Care providers in England who provide residential, nursing and dementia care have faced increasing commercial pressures over recent years and particularly so in the two years since the COVID-19 pandemic began in the spring of 2020.

Care providers have experienced unprecedented operational difficulties due to the pandemic and its continuing effects; these have included the physical and mental wellbeing of residents and staff, the handling of residents' families and visiting, staff departures and the increased costs of consumables and PPE. Some, but by no means all, costs have been mitigated by emergency support funding from councils.

Rolling care home closures due to outbreaks of COVID-19 have significantly disrupted the admissions pipeline, with many admissions delayed or cancelled; the conversion of enquiries has generally decreased as residents' families have waited for visiting restrictions to be lifted. Many care homes enjoyed occupancy above 85-90% and the sector benchmark was 92-93% prior to the pandemic. At its height, sector averages dipped below 80% and in some cases below 70%; currently, they have recovered to around 80-85%.

Staffing is the most pressing issue facing the sector. The acute staffing shortage in care homes is continuing and have become evident in the entire cycle, from entry-level recruitment to longer-term retention. Shifts in employment patterns have resulted in increasing wage inflation and the care sector has lost many staff to retail, services and logistics.

The Care Quality Commission confirmed negative staffing trends in its Insight report in January 2021, using data from its provider information return (PIR) of residential adult social care from 8,260 services, some 54% of all residential adult social care services. The October-December (Q3) figures showed that the South generally has higher care home staff vacancy rates than the North. The North East and Yorkshire had the lowest staff vacancy rate in Q3 (9.6%), and London had the highest (12.5%).

Care homes have found themselves competing for staff not only with other care homes, but also with NHS hospitals, for staff. Given the fact that care home residents are increasingly arriving at a later stage and with more complex needs, the hollowing out of skilled nursing staff from care homes is particularly problematic. Lack of full-time staff has led to many care homes becoming increasingly reliant on agency staff, adding significant cost; staff costs as a percentage of the revenues in most care homes is currently around 50%-60%.

Staffing aside, the commercial picture is a mixed one. At the premium end of the market, providers have generally seen fee rates rise, albeit within the context of substantial general inflation. Property advisory firm Knight Frank, which surveyed one fifth of the market in late 2021, noted that average weekly fees had increased 6.7% on the year, with local authority fees rising by as much as 8.8%. However, Knight Frank said 'this rise in Local Authority fees is a likely combination of general annual fee growth and the unconditional payment support provided by the Government in response to the pandemic'. (From our own work with local authorities in the same period, we recognise the figure attributed to Wales – a 2.3% uplift – more than the higher figures.)

Despite considerable headwinds, investment and lending to the care home sector has remained relatively strong, particularly in affluent areas with a high concentration of self-funders. New-build activity, often forward-funded by REITs and other investors, is adding significant capacity to the market, but only in these areas, leaving those with poorer demographics looking to their local authority guardians for investment, along with support for failing providers.

In our view, investment theses in the care market in recent years have focused on demographic trends – essentially, more older people requiring more care and at a higher acuity – rather than increasingly structural operational issues, such as staffing, and policy changes, such as those announced by the Government in September 2021.

EXAMPLE 1

An operator with six care homes in Yorkshire and the North East. The homes have a 'mixed economy' model, with around 30% self-funders and 50% local authority-funded and NHS / CCG-funded residents (the latter excluded from the analysis). There is both residential and nursing care. Self-funders currently pay around £1,000 per week, while local authority-funded residents pay around £700 per week. Based on these assumptions, total annual revenues are approximately £13.0m

The table below shows the net revenue impact on an operator with these characteristics, assuming varying percentages of take up of 18(3) and using LaingBuisson Ceiling, Mid-Point and Floor FCC estimates in the table below; it shows the estimated net revenue impacts before any top ups.

Estimated Net Revenue Impact

GBPm

Fair Cost of Care	S18(3) Penetration Assumption	50%	55%	60%	65%	70%	75%	80%
	High FCC	1,081,253	1,056,194	1,031,135	1,006,075	981,016	955,957	930,897
		771,053	738,120	705,188	672,256	639,323	606,391	573,459
	Mid FCC	460,852	420,047	379,241	338,436	297,631	256,825	216,020
		170,938	122,192	73,446	24,700	- 24,046	- 72,792	- 121,538
	Low FCC	- 93,510	- 150,197	- 206,883	- 263,570	- 320,257	- 376,944	- 433,630

Fair Cost of Care	S18(3) Penetration Assumption	50%	55%	60%	65%	70%	75%	80%
	High FCC	8.4%	8.2%	8.1%	7.9%	7.7%	7.5%	7.3%
		6.0%	5.8%	5.5%	5.2%	5.0%	4.7%	4.5%
	Mid FCC	3.6%	3.3%	3.0%	2.6%	2.3%	2.0%	1.7%
		1.3%	1.0%	0.6%	0.2%	-0.2%	-0.6%	-0.9%
	Low FCC	-0.7%	-1.2%	-1.6%	-2.1%	-2.5%	-2.9%	-3.4%

EXAMPLE 2

An operator with 30 care homes in the Home Counties and East Anglia, predominantly providing residential care. Some 75% of residents pay for their own care, with the balance local authority-funded and NHS/CCG-funded (the latter excluded from the analysis). Average weekly fees of £1,150 for self-funders and £875 for local authority-funded residents. Based on these assumptions, total annual revenues are approximately £74.0m.

The table below shows the net revenue impact on an operator with these characteristics, assuming varying percentages of take up of 18(3) and using LaingBuisson Ceiling, Mid-Point and Floor FCC estimates in the table below; it shows the estimated net revenue impacts before any top ups.

Estimated Net Revenue Impact

GBPm

Fair Cost of Care	S18(3) Penetration Assumption						
	50%	55%	60%	65%	70%	75%	80%
High FCC	- 7,296,350	- 8,026,590	- 8,756,830	- 9,487,070	- 10,217,309	- 10,947,549	- 11,677,789
	- 8,020,406	- 8,822,446	- 9,624,487	- 10,426,527	- 11,228,568	- 12,030,609	- 12,832,649
Mid FCC	- 8,738,413	- 9,612,254	- 10,486,095	- 11,359,937	- 12,233,778	- 13,107,619	- 13,981,461
	- 9,459,079	- 10,404,987	- 11,350,895	- 12,296,803	- 13,242,711	- 14,188,619	- 15,134,527
Low FCC	- 10,179,746	- 11,197,720	- 12,215,695	- 13,233,669	- 14,251,644	- 15,269,619	- 16,287,593

Fair Cost of Care	S18(3) Penetration Assumption						
	50%	55%	60%	65%	70%	75%	80%
High FCC	-9.8%	-10.8%	-11.8%	-12.8%	-13.7%	-14.7%	-15.7%
	-10.8%	-11.9%	-12.9%	-14.0%	-15.1%	-16.2%	-17.2%
Mid FCC	-11.7%	-12.9%	-14.1%	-15.3%	-16.4%	-17.6%	-18.8%
	-12.7%	-14.0%	-15.3%	-16.5%	-17.8%	-19.1%	-20.3%
Low FCC	-13.7%	-15.1%	-16.4%	-17.8%	-19.2%	-20.5%	-21.9%

EXAMPLE 3

An operator with four nursing homes on the south coast of England, which are at the premium end of the market. There is a high percentage of self-funders at 80%, with the balance local authority and NHS / CCG-funded residents (the latter excluded from the analysis). Average weekly fees are around £1,500 for self-funders and £1,000 for local authority-funded residents; fees reflect higher-acuity needs. Based on these assumptions, total revenues are approximately £14.0m.

The table below shows the net revenue impacts on an operator with these characteristics, assuming varying percentages of take up of 18(3) and using LaingBuisson Ceiling, Mid-Point and Floor FCC estimates in the table below; it shows the estimated net revenue impacts before any top ups.

Estimated Net Revenue Impact

GBPm

Fair Cost of Care	S18(3) Penetration Assumption						
	50%	55%	60%	65%	70%	75%	80%
High FCC	- 1,992,277	- 2,199,874	- 2,407,470	- 2,615,066	- 2,822,662	- 3,030,258	- 3,237,854
	- 2,127,182	- 2,346,277	- 2,565,373	- 2,784,469	- 3,003,565	- 3,222,661	- 3,441,757
Mid FCC	- 2,262,086	- 2,492,681	- 2,723,277	- 2,953,873	- 3,184,468	- 3,415,064	- 3,645,659
	- 2,398,602	- 2,640,822	- 2,883,042	- 3,125,261	- 3,367,481	- 3,609,700	- 3,851,920
Low FCC	- 2,535,119	- 2,788,963	- 3,042,806	- 3,296,650	- 3,550,494	- 3,804,337	- 4,058,181

Fair Cost of Care	S18(3) Penetration Assumption						
	50%	55%	60%	65%	70%	75%	80%
High FCC	-14.3%	-15.8%	-17.3%	-18.8%	-20.3%	-21.8%	-23.3%
	-15.3%	-16.9%	-18.5%	-20.0%	-21.6%	-23.2%	-24.8%
Mid FCC	-16.3%	-17.9%	-19.6%	-21.3%	-22.9%	-24.6%	-26.2%
	-17.3%	-19.0%	-20.7%	-22.5%	-24.2%	-26.0%	-27.7%
Low FCC	-18.2%	-20.1%	-21.9%	-23.7%	-25.5%	-27.4%	-29.2%

The above three examples demonstrate that estimated impacts of 18(3) vary considerably, not simply by the percentage of people taking up their rights under the legislation, but also depending on the individual care home's 'care economy' and geography.

Operators with current high levels of self-funders paying premium rates will likely be affected disproportionately. Those with a large operating base but overall lower average fees may also fare badly. Conversely, operators with broader based, 'mixed economy' models will tend to approach the Government's aim of 'equalisation' with the net financial effect broadly flat.

The DHSC's impact assessment speaks of some providers having to change their business models, but the flexibility of most providers will be limited. Operating cost reduction is unlikely to be an option in such a highly regulated environment, since reductions in staff hours may be unsafe, pay reductions might further haemorrhage staff and there will typically by few significant savings opportunities in non-staff operating costs.

Provider failure, which has been evident in the past two years during the pandemic, notwithstanding emergency and continuing financial support from local authorities, would be the inevitable consequence of a negative investment environment. Where this was seen in historically underperforming regions, there would be a 'holllowing out' of services. This is particularly significant in the context of a 'market' where the provision of care from independent or charitable providers has been actively encourage by successive governments dated back over twenty years

The consequences flow beyond providers and will impact on investors and lenders. At the least damaging end, providers may have to renegotiate banking covenants. Where operating margins are more strongly affected, loan repayments may have to be rescheduled and leases renegotiated.

In the event that a care home becomes non-viable (its expenses exceed its income and reserves and financial support from other sources are not sufficient) then businesses may go into administration. Some will be sold for alternative use, resulting is a loss of capacity. In most cases, however, care homes have more value (stripped of capital costs) as going concerns than for alternative use. If so, then care homes may remain in operation under new management, but investors' returns may be affected.

Should this scenario become frequent, there is a strong risk that investor sentiment will turn against the care home sector and that the flow of capital that has financed the modernisation of the care home sector in recent years will cease.

It is possible that modified business models could be developed in the future which mitigate provider risk in a post-FCC and 18(3) market. But is unlikely that many care home businesses with sunk capital costs have the flexibility to modify their models for existing assets to any significant extent.

7. CONCLUSIONS & RECOMMENDATIONS

From our engagement with sector stakeholders during the course of this project, there is a generally agreed view that the principles of fair and equitable care and the fair cost of such care remain longstanding goals for all stakeholders in adult social care.

Likewise, that councils and providers have a joint interest in promoting person-centred care, providing accommodation that is fit for purpose and supporting a sector which could continue to attract inward investment and deliver more services to meet more – and increasingly complex – demand.

However, the question which arises from our analysis and engagement with the sector is ultimately devolved to whether 18(3) is 'the right policy at the right time?' The debate was summed up by a senior representative of a sector stakeholder as follows during one of our simulation events:

It is positive that this nettle has been grasped. And certainly, from an inequality point of view, removing the difference in fees is a step in the right direction, but as everyone acknowledges the journey that we've got to navigate between commissioners, providers and Government around the funding is a huge one.

As previously stated, stated, forthcoming statutory guidance in relation to charging reforms will potentially have an important impact on the extent of the financial challenges facing both councils and providers, as will the experiences gained in the 'Trailblazer' pilot studies in terms of take up of 18(3).

However, it is hard to disagree with the conclusion of the Institute for Fiscal Studies, writing in October 2021, on the social care reforms package:

Without further increases in central Government funding to pay for these reforms, councils would face the unenviable choice between very large council tax increases (potentially requiring winning a local referendum), cuts to other services, and failure to improve adult social care services. And even if additional funding is forthcoming, other issues – such as raising the pay of social care workers, and relaxing the needs assessments to undo some of the previous reductions in the numbers receiving care – would cost billions per year more. Adult social care services are therefore likely to remain a headache for both councils and the Chancellor for years to come.[34]

RECOMMENDATIONS

- The Government urgently reassess funding allocations to support the combined implementation of FCC and 18(3) from 2023/24 onwards. Our central estimate is that this would require Government to raise funding allocations by at least £854m per annum for FCC in residential and nursing care homes to enable councils to pay rates at a rate that is sustainable to providers and able to offset the impact of Section 18(3).

- Overall, LaingBuisson questions whether the full implementation of Section 18(3) of The Care Act 2014 is the right policy at the right time. The implementation of such wholesale changes to funding models comes at a time when the care market is particularly fragile in the aftermath of the COVID-19 pandemic, with significant regional blackspots.

- The timetable implied by a full implementation in October 2023, with six 'Trailblazer' local authorities potentially working towards implementation in January 2023, is ambitious, given the multiple stakeholders and dimensions of the proposed reforms. The timetable should be reconsidered, and robust pilots be given more time.

- DHSC predicts an 80% take-up in registration for the care costs cap, but it has made no detailed forecasts for the take-up by the public of 18(3). Research should be undertaken into the behavioural side of the policy implementation and the pathway for residents, both existing and prospective.

- The FCC must be agreed by each local authority working with its local care association, or, where such associations do not exist, with groups of providers. Guidance for such exercises has not been disseminated. DHSC should revisit previous evidence of the difficulties of agreeing such fair cost of care.

- Despite the increasingly collaborative relationship between local authorities and NHS bodies, particularly Clinical Commissioning Groups, and the advent of Integrated Care Systems, it appears NHS-funded residents (those with both a health and care need) will not be included in the 18(3) provisions. Clarity on the direction of travel would be welcome.

[34] he IFS Green Budget, The Institute for Fiscal Studies, October 2021

- Although DHSC has confirmed it will encourage ‘top ups’ where appropriate, it should further research the way top ups currently work and the way in which they may now assume particular importance to providers which require higher fee rates than offered by a FCC.

- DHSC should release details of infrastructure and technology to allow for current assessment capacity at county council to be significantly extended to cope with the demand for such assessments which will be triggered by 18(3).

- DHSC should engage with the investor community to explain its vision for 18(3) and to canvass views from investors, lenders and other financial stakeholders, so as to avoid a potential ‘cliff edge’ adverse reaction to the proposed reforms in the coming months.

APPENDIX 1 - Simulation Events: Key Findings

LaingBuisson invited a number of Adult Social Care stakeholders to two roundtable events in January and February 2022, held under the Chatham House Rule. These forums allowed senior representatives of local authorities and care providers to discuss the implications of the implementation of Section 18(3) and the adoption of FCC.

Attendees included senior executives from six local authorities, including several directors of adult social services, and senior executives from sector stakeholders. Providers were represented by chief executives and colleagues from several of the country's largest care operators. Legal perspectives came from a well-known law firm with expertise in the care sector.

The roundtable events considered the risks of destabilisation of care economies and the impact on investors; to work through possible scenarios including how councils and providers may respond to the challenges; and to feed back to Government recommendations on how the risks identified might be mitigated.

Below we provide an overview of the discussion that took place at the events from the council and provider perspective, which alongside LaingBuisson's existing market knowledge and financial analysis, has informed the findings of this report.

Council Perspectives

From our engagement with councils during the simulation events there were several common concerns when considering the implications of our analysis on Section 18(3).

Firstly, that social care reforms, including the implementation of 18(3), were coming at a time when councils and their local providers were experiencing a raft of post-pandemic issues, notably acute staffing shortages, which have created a 'perfect storm' in the sector. Regarding existing pressures in the market, we heard a number of council representatives describe a sense of slow and enduring crisis, in the post-pandemic climate, For instance, at our simulation event a council commented:

We now have 150 people waiting to leave hospital. We've got about 600 people waiting for care. They're in the wrong type of care, so injury care, home, bed in a reablement service. All my discharge services and reablement services are full. They're all meant to be short term. They're all providing long term care. And the driver is not Omicron. So, I'm expecting about 1% increase in capacity and staff return back from isolation. But we've got a gap of about 15% gap between capacity and demand older adults at the moment. So those are our signs of collapse, in a nutshell.

A further council noted:

On my worry list is the contraction of the workforce, which is going to drive up costs further between now and October 2023. We saw Skills for Care report a 3% contraction in the care workforce just in the third quarter, and that's probably likely to continue even with some temporary changes to immigration rules. We've got some severe pressures in agency costs and markets. So the inflationary pressures, both national inflation, retail inflation, but also care sector inflation I think are quite unpredictable at the moment and certainly going upwards. The things that we face in counties more generally is the diversity of our housing, labour and land markets. They can be quite different in different parts of large county areas to compact urban authorities.

The worst effects of the pandemic have been felt in areas where the provider market is characterised by smaller, family-run care businesses. This was highlighted by Local Authority A:

The challenge for us as a Council is that the vast majority of people providing residential and nursing care are small, family-run businesses. We don't tend to have any larger providers operating in the county boundaries. We've already started to see a significant haemorrhaging of people stepping away from the market, I think just exhausted due to the fragility of how things have been and handing back quite a sizable amount of business tools which we've been able to manage and contain because we've got quite still an extensive range of provision. My concern is that the capital element. Most of these family businesses have moved in many years ago when the needs and complexity not as significant as they are and are wholly unsuitable premises, if I am honest, for the types of care that we now expect and will be projecting forward.

Three council participants, respectively from the South East, the Midlands and the North, said they were looking at investment as a way of bridging service gaps. Council N said it had been forced to 'pick up market failures' and was prepared to make acquisitions or take over failing services. Council N2 said:

We're currently working up business cases about some of the very specialist areas where we've got a shortage. So very challenging places to support, similar to specialist dementia services, specialist services for people with learning disability and autism are two of the areas that we're looking at. And we've also been primed to provide support and step in if needed, if we've got a significant care home provider [that cannot be allowed to fail].

But Council B drew a distinction between investing and operating:

We are definitely looking at investment...and that's investment from a number of perspectives. One is investing in the care market, where investment is needed to enhance quality. And we've had to do that over the past twelve months to help some of our providers out. And then the second aspect is investing in new developments or redevelopments, particularly where we've got a specific need for particular types of care provision. In terms of whether we would want to provide any of those services? Absolutely not. I think that's something I would avoid like the plague.

Secondly, that there was general lack of consultation and unpreparedness for the new reforms, particularly in terms of technical infrastructure to handle a substantial prospective cohort of those wishing to take up the care cap and the arrangement of their care. There were already significant and structural funding pressures which may be exacerbated by the proposed reforms, in the pursuit of 'equalisation' or 'harmonisation' of fee metrics.

Council N said:

What I'm particularly concerned that [we] can't afford the equalization exercise; [we] certainly can't afford to move to a price of care that I believe then would incentivise providers to change their models and we're reliant on family run businesses. They have very fixed business models with very little scope to change. They are not the sorts of extra care, home care, local support type reablement hubs that we would want to see. So [we are] really concerned about how we undertake this exercise, but how we compensate the market for driving the sort of care change in standards that we need to see through social care reform.

Council B noted:

In terms of equalization of fees, I think that makes sense in principle, but I don't think it's fair unless the quality is equalized, too. And I'm not talking about CQC ratings for quality here. I'm talking about the difference between some of the very high-end residential care homes with beautiful bars and high spec gyms and saunas and whirlpools that we've got versus the standard residential care homes. We've got to have some way of differentiating on price for those when we use them. And I think the other point for me really is, again, this point about how much work has to be done to prepare us for these changes. We do not have the capacity to do the fair price of care exercise and the market capacity exercise.

We're already dealing with massive backlogs post COVID and our commissioners have got a backlog of commissioning activity that had to be delayed through COVID.... the Government has also promised that there will be standard models for us to use to carry out these exercises. But if they don't appear quickly, they're going to be too late.

Likewise, another Council participant was concerned about the education required to implement the reforms:

The messaging will become really important. I can see that the first six months will be difficult, because it's not just the public that will be confused, it's our staff as well having to try and help people make sense of this system, because I can see what the public will say: 'You've got a responsibility to put me in the home that I choose'. And so that sort of education piece, I think, is going to be really important. And when I talk to my assessment colleagues, they're really worried about this. So it's not just the public we need to be educating and helping with scripts. It's the staff that work within councils as well, because it is a big shift and I'm not convinced I think this is 'transformation'. If we are talking about transformation of adult social care, that is s around how we deliver things like homecare and the outcomes that we get.

Regarding the amount of funding required to implement a fair cost of care, one Council participant noted that it needed to be seen in the context of overall central Government funding and regional disparities:

It is not a level playing field... So I think there's something like the fair funding formula from Government that this needs to be linked into as well, because if you've got a very low Council tax base and you don't have business rates that are significantly high, even though there may be a disparity between what we pay in the North, compared to the South, you've got very limited opportunity to level up to anywhere reasonable. So I think it does need to be attributed into that bigger piece of work that Government we're doing around fair funding.

Concerns regarding legal challenges following the implementation of the reforms was also raised. Our legal practitioner with experience of the care sector noted in the simulation event that the provisions of Section 18(3) were subject to a significant amount of discussion when the Care Act 2014 was first being passed into statute. Likewise, there were other provisions, particularly around individuals' rights to challenge decisions made concerning their care, which will come to the fore as the Act is fully implemented. He noted:

One of the key concerns that was raised at the time was the likelihood that there would be significant challenges faced by local authorities when they had set rates and individuals wanted to challenge those rates and challenge the assessments and challenge their personal budgets. And therefore, there were provisions included in the Act allowing for an appeals mechanism. And as far as I'm aware, there's no sign yet that appeal mechanism is going to be brought into force. But it may be advantageous that that is looked at again. The alternative is going to be either judicial review or more likely recourse to the Social Care Ombudsman, who's clearly very keen to get more closely involved in how the social care system works and has been increasingly assertive in terms of supporting individual people's rights and how those unfold.

Council participants made the point that the NHS should be involved in the discussions and implementation of social care reform. This should flow firstly from the fact that Government funding was, initially at least, directed to the NHS and Social Care in toto, secondly that with increasing health needs, NHS commissioning and placement was a rapidly growing part of the social care mix and increasingly evident in care homes: 'Most of our business comes from the NHS...we spend an inordinate amount of time arguing and fracturing over that, and that's where the vast majority of the funding is going':

Nowadays, the distinction between residential and nursing home care is artificial because the vast majority of people who are going into residential care now have significant and complex needs. And I think we do need to be opening up this discussion around what greater role and function the NHS is going to play, especially given the vast majority of the additional [Government funding] will, in the first instance be going to the NHS and not flowing through to local Government. And so I think we've got to make Government aware that if we're going to be making policy decisions of this kind, it's got to include that other very key partner.

In the same vein, Council N noted:

We're currently coming to the end of the NHS discharge pathway, which I think has seen many of us take on responsibility for lots more people who wouldn't traditionally come to social care. So some of the people in predicting the numbers of take up will be quite difficult because some people may well have come through that NHS discharge pathway during the pandemic. But I suspect there is a latent demand beyond that where we'll have to pick up additional numbers too. Having different rules potentially for the NHS is quite difficult for implementation because wherever possible, councils are trying to make sure we have common fees and agreements and protocols with NHS funders. It would be helpful if we had a common approach across the NHS and local Government.

Finally, there were concerns that, bureaucracy would increase significantly at a central administration level, and fears that, ultimately, outcomes will be worse for the public. Participants were keen to see quality improvements across the sector and fees reflect such improvements.

I'm not particularly clear how this [set of reforms] is going to be driving choice, quality and personalization, and I'm not convinced that we can differentiate on quality and a fair price for care because that's about equalization. So that means equal price for different bits of quality. That's not being tackled in the proposal so far. So we would need to be convinced of got a of that rationale and how we would be assured as a local authority as to how this to drives up quality and sustains the market.

<u>Providers' Perspectives</u>

Care providers will face particular pressures in balancing the effects of the social care reforms, when dealing with multiple commissioning authorities. A single care home may have 3-4 local authority relationships. Provider G, a large national operator, noted that it deals with a total of 89 commissioning authorities and that negotiating fair cost of care, besides the administration of personal budgets and independent personal budgets was a daunting prospect.

All the care providers noted that their costs have risen significantly in recent months. The highest cost in all care homes remains staffing. The recent increase in the National Living Wage, along with recruitment and retention issues are particularly concerning, and will feed directly into the proposed Fair Cost of Care discussions.

A key point raised by Providers was clarity around both facts and attendant messaging in the legislation and guidance. Provider B said their concern was that it should be made very clear that fee harmonisation was not 'mandated' and that prospective residents of care homes should be able to make their own choices around paying a premium for enhanced packages of care and accommodation:

The key thing is when the guidance comes out [is] about implementation, that it is absolutely made specifically clear because we know every local authority acts in different ways and interprets guidance in their own way sometimes.

One major provider, Provider E, articulated its concerns about balancing fairness and customer choice:

We all agree that fairness is important, I think, and if the principle of the intention behind the legislation is to create fairness, we need to be very careful and ensure that it doesn't also take away choice. Because if the principle of top ups and the ability to provide third party funding still exists, then what inevitably is going to happen here is that those homes that can attract top ups will attract top ups, and they will simply manage based on supply/demand.

For those homes that are unable to attract top ups, they won't be able to provide them. So therefore, their cost of care will be reduced, which means that you'll end up with polarization in the sector. I think if you think through what the inevitable outcome of this is, if it's implemented poorly, is, you're going to end up with an increasingly differentiated system of residential care. You're going to have better homes that get better, and you're going to have poorer homes that get poorer, and that can't be ultimately driving a fair outcome for all.

Provider E stated that increasing regulation would run the risk of effecting poorer outcomes:

By all means, address the issue of cross subsidization, which I think is what is at the heart of this point about fairness. But don't remove choice. And I would suggest is that regulation rarely achieves the right outcome. All it does is it adds complexity to a system that's already struggling under the burden of complexity. Agility is very important. More regulation will simply reduce agility. And if what we end up doing here is focusing more of our resources on recruiting more people to manage the system as a consequence of regulation, we're not going to improve the outcome.

Providers discussed the practicalities of how many care homes operate commercially, essentially providing the same experience to all residents regardless of whether they are a self-funder or Local Authority-funded. Addressing the question of what elements of the service are open to price differentiation, Provider B said:

Too often people have tried to go down the route of saying, well, does a self-funder get a bigger room or a better aspect or newspapers or a different dining experience or different other experience? The bottom line is generally they don't. Sometimes and in some homes there are different room sizes. But in all of our new builds, all the rooms are pretty much the same.

The fact is it's the totality of the home, all the services amenity, the furnishing of it, the presentation of it, the facilities within it and they're equally accessible. Our starting principle is: you can choose this home which has these facilities, it's 30, 40 years old, it's not been invested in, you've got small rooms, there's no ensuite wet rooms, you've got no cinema room, no fine dining. Or you can choose our home, and we're not differentiating the service because it would be totally wrong to offer a two-stream service in the same home; and in the end if we accept the local authority with or without the top up, they get exactly the same service. If we can't fully fill [a home] we'll accept a lower fee [from a Local Authority]. And that's just the nature of how the market dynamics work and I don't think there's fundamentally anything wrong with that.

Provider B added that ultimately, 'we believe our self-funders are paying what is the true cost of that service, with all everything that goes with it, not just the care' but they accepted that Local Authority funding was a large part of the market and providers had long been accustomed to accepting the current 'market dynamic'.

Provider H, which is operates a portfolio of care homes and retirement housing, noted that it was already receiving enquiries from prospective residents about the proposed social care reforms, ahead of an anticipated move into services:

From a national provider perspective, trying to understand the different moving parts and how they interrelate is something that's causing us to try and work out the impact for our current residents and our future residents and the organization. We're a housing association, so we don't have shareholders to feed, but we do need to be financially viable and where if we're not able to make a surplus within a particular area of the organization, our only alternative is to draw across from our rented housing service which is funded by housing benefit and the tenants who live in it. We haven't really got any kind of levers to pull in terms of endowments or other income streams.

The issue of top-ups paid by residents, or their families was widely commented upon. One participant described top-ups as a potential 'safety valve' for providers. All acknowledged that if there was a wide gap between a determined Fair Cost of Care and a care home's existing rate, top-ups would need to be both larger and more called upon.

Provider H said the issue was not 'being considered as part of the overall policy in any great detail', adding that 'at the moment, top ups are used to fill a gap rather than being a payment for any kind of defined additional service...' Participants pointed to the fact that currently most services, whether they are external activities, catering or housekeeping are bundled into the overall fees charged by care providers. If such services are required to be split out and costed, to justify top-ups, this would be a fundamental change.

It was broadly agreed that care providers who operated a mixed economy services could face the most disruption from the implementation of the reforms. A senior sector stakeholder representative made the following comment on the current shape of the market, which could be divided into three groups: local authority focused, those with little or no local authority-funded residents, and those operating hybrid models:

Those which are predominantly local authority focussed you could reasonably expect to do better out of [the reforms]. There will be other providers at the opposite end of the spectrum, the hotel style provision, where my understanding is that there's no compulsion for providers to be contracting with local authorities. For these, it will very much come down to the provider's confidence in the strength of the catchment area that supports that home. And if they believe it's sufficiently robust so that they don't need to take local authority placements, then they'll completely step away from it and might have a limited impact. Where the challenge is and it doesn't help because of the way that the market is shaped, is those hybrid operators, which is obviously the majority of the market, where you could, for argument's sake, have a self-funder resident next to a local authority placement.

Provider failure, which has been evident in the past two years during the pandemic, notwithstanding emergency and continuing financial support from local authorities, would be the inevitable consequence of a negative investment environment. Where this was seen in historically underperforming regions, there would be a 'holllowing out' of services. Provider F said:

I don't think the system is going to totally fall over. You're not going to have one of those burning platform moments where everything collapses overnight and has to be picked up. It's like anything, isn't it? You just accept every year a gradual, less good service being delivered. And what will happen is that the quality of life for those people in poorly invested, hollowed out parts of the country just gets slightly worse each year and gradually [providers] will drop out of the system because they can't make a return.

Provider F added that large groups have long recognised that parts of their operations in some regions were loss-making and maintained out of a sense of public good:

We have services in the North East of the country in particular that haven't been invested in properly for years and years. They are, in many cases, barely fit for purpose, and those assets need substantial investment. We have services where we're being offered £550 and £560 a week [by Local Authorities]. And when you strip out the cost of running those services, they're effectively being cross subsidized by the rest of the group. They're being run at a loss. So we have two choices. Either we continue to operate those services or you simply shut all of them. But the consequence for the local populations in that area would be catastrophic were we to do that.

Regarding investor and lender confidence in the sector, it was noted that the financial community was only just becoming familiar with the potential impacts of proposed social care reforms. It was felt the current guidance could cause uncertainty and negatively affect investment and credit committee decisions at least in the short- and medium-term. Provider B said:

I think the unintended consequences of the implementation in terms of market confidence, both in terms of equity providers and debt providers to carry on investing is my biggest concern, and that comes down to the reassurance is that the guidance should be absolutely detailed as to what this means and how it's implemented.

APPENDIX 2 - Overview of Financial Analysis Methodology

The commentary below provides a step-by-step description of the methodology deployed to conduct the financial analysis, including data sources.

1. Calculation of current (January 2022) number of residents in care homes for older people (65+) in each upper tier councils in England

- Use CQC registered independent sector beds in England at Jan 2022 as a measure of capacity

- Apply occupancy rate (estimated by LaingBuisson at 80% of registered beds (was 85% pre-Covid) and segment into nursing and residential care using LaingBuisson survey data on the share of nursing home beds in receipt of residential care only to give estimated resident numbers at Jan 2022

2. Segmentation by source of funding and upper tier council

- Further segment into council paid and privately paid (ignoring NHS continuing healthcare residents), using evidence from a variety of sources, including LaingBuisson proprietary data

3. Average weekly fees by source of funding and upper tier council

- Take latest (2020/21) average council-paid fees for residential care and nursing care for clients aged 65+ from iBCF (improved Better Care Fund) returns for each County / Unitary authority, as published by ONS:[35]

- Project councils' residential and nursing paid fee rates for 2020/21 to 2021/22 (+2.3% being the weighted average increase in NLW and non-staff inflation)

- Add NHS FNC (£187.60 pw) to each upper tier council's nursing average

4. Calculation of 'Fair Cost' for nursing and residential care of older people, by region

[35] https://www.google.com/search?q=Table+A%3A+Fees+paid+to+external+care+providers%2C+Self-reported+local+authority+returns%2C+2020-21&rlz=1C1GCEU_en-GBGB956GB956&oq=Table+A%3A+Fees+paid+to+external+care+providers%2C+Self-reported+local+authority+returns%2C+2020-21&aqs=chrome..69i57.448j0j15&sourceid=chrome&ie=UTF-8

- Calculate three different 'Fair Cost of Care' amounts for each Region, for both residential care and nursing care, using LaingBuisson's 'Care Cost Benchmarks' model. The three 'Fair Cost for Care' amounts are the 'Floor' based on a bare minimum capital cost of £25,000 per bed, the 'Ceiling' based on new-build turnkey land and building costs of £100,000, and the mid-point which is half-way between the Floor and the Ceiling (LaingBuisson believes that this mid-point (£62,500 per bed) most closely represents the English average capital value attributable to a care home place)

5. Difference between 'Fair Cost' and council fees

- Calculate the differences between each of the three Fair Cost of Care amounts and the council-paid fee rates, for each upper tier authority - the 'Fair Cost gap'

- Multiply the Fair Cost gaps for each upper tier council by the numbers of residents aged 65+ currently (2021/22) supported by the council, to give estimates of the additional annual cost to the council of paying at the three 'Fair Cost' rates for current (2021/22) placements

- On the other side of the coin, these additional costs to councils represent additional revenue for providers

6. Potential loss of care home revenue from implementation of 18(3)

- Calculate the differences between the three 'Fair Price for Care' rates and current (2021/22) average private pay fees for each upper tier council (using proprietary data from LaingBuisson surveys)

- Multiply the differences by the number of private payers, to give providers' maximum potential loss of private pay revenue from implementation of 18(3), for each upper tier council

7. Sensitivity of providers' revenue impact to 18(3) penetration

- Test the sensitivity of the providers' revenue loss by populating Cell BQ1 in the model with the assumed penetration of 18(3), i.e. the share of private payers that will take advantage of it. The central estimate for main analysis is a 50% take up.

- Add providers' revenue gains from Fair Cost of Care for council-funded placements to their losses from private payers making use of 18(3), to give the net impact on providers' revenues

8. Revalue to 2023/24 prices

- All 2021/22 costs and revenue loss numbers are projected to 2023/24 by applying a (conservative) annual inflation rate of 3% per annum and no change to other parameters. A 3% inflation assumption is considered conservative because the main National Living Wage rate, which is the principal driver of care home cost inflation, will rise by 6.6% in April 2022 and cost of living inflation is likely to lead to a significant further uprating of NLW in 2023.

Impact Assessment of the Implementation of Section 18(3) of The Care Act 2014 and Fair Cost of Care

A Report Commissioned by The County Councils Network