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Caught in the Act

The Care Act 2014 champions personalisation and preventative care, but fails to address burgeoning financial pressures on the care sector, finds ***Sunniva Davies-Rommetveit***

After years of debate that has garnered plenty of press coverage the Care Bill has finally made its way through parliament and become the Care Act 2014. It promises great things: to bind "threads from over a dozen different Acts into a single, modern framework for care and support". So, six decades, plus countless governments (and scandals) later, how effective will it be?

The first part of the Act aims to achieve the aspirations outlined in the white paper, Caring for our Future, itself released following the Winterbourne View care scandal. The white paper states that the system presently only reacts to crises; that care access varies too much across the country; that carers themselves are not supported enough and that the inconsistencies of care across councils are unacceptable.

The focus of parts two and three of the Act is on more personalised and autonomous care for individuals, emphasising preventative care and introducing Ofsted-style ratings, along with a more independent Health Research Authority, Care Quality Commission and Health Education England.

Impact on operators

The Act will have three big impacts on care providers if it is implemented correctly: the type of services local authorities commission will change due to the focus on personalised care. Secondly, local authorities will increasingly scrutinise operators' service costs. Finally, the Care Quality Commission will act like an independent body, along with the Health Research Authority and Health Education England.

Increased personalisation

The focus on increasingly personalised and outcome-focused care packages has received a positive response from the sector. Local authorities will have to ask individuals what outcomes they want and build a care package around this. Operators could be commissioned differently as a result, and may need to rethink how they provide care.

Fifteen-minute domiciliary care appointments, for example, will become extremely difficult for local authorities to justify. Scheduling such short appointments will only be acceptable for simple tasks, to check if someone has taken their medication for instance. "You can't offer dignified personal hygiene care in 15 minutes, so that's off the cards," says Sue Brown, vice chair of the Care & Support Alliance.

The new, national care eligibility criteria, moreover, is a potential sticking point. How can councils and operators be expected to increasingly focus on preventative care, when the eligibility criteria has been ratcheted up, and no longer covers people with "moderate" and "low" needs? According to Age UK 13% of people still receive moderate-level care, meaning they could lose services depending on how the Act is implemented.

"You can see why this has happened though," say Patel, "If it was open-ended, it would likely be too expensive."

These individuals run the risk of becoming more ill without the moderate care they previously had, however, and ultimately could end up costing the taxpayer more.

The official argument to introduce a new national framework is to avoid a postcode lottery, as happened with the previous criteria, when local authorities interpreted the band levels differently. But a national framework will not necessarily mean uniform interpretation.

"Part of the appeals [of the Act] will be around working out exactly what these care levels mean, with the aim of getting to a point where they are being used consistently," says DAC Beachcroft partner Corinne Slingo. The jury's out, therefore, about whether these bands will be used consistently, and how their implementation will affect those who were previously in the moderate category.

Cooperation and the Duty of Candour

Another impact of the Act is that providers will have to get more accustomed to justifying the service costs to local authorities, which are expected to scrutinise how money is deployed more. Barchester is already

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moving towards increased cooperation in light of the Act, says its chief executive Peter Calveley.

More conversations will also occur around care quality. The Francis Inquiry said failure to provide correct information contributed to poor care continuing. Under the Act, providers will have a duty of candour to report failings committed by themselves or their employees. And there will be a new criminal offence if false or misleading information is supplied, to deter attempts to skew data.

Coupled with the duty of candour is the CQC's new Ofsted-like rating system, which comes into full effect in October 2014. It asks five key questions: are services safe, effective, caring, responsive and well-led. Care providers who score highly will be rewarded with fewer CQC visits in future.

However, operators should be wary of a single rating for all its services. "Even if you have five excellent sites, but one is mediocre, the provider will end up with a single rating that's brought down by that one site," Slingo points out.

The CQC will also become more independent under the Act, which will perhaps allow it to act quicker when holding services which are not up to scratch accountable. The same effect could be had with both the Health Research Authority (HRA) and Health Education England, which will turn from Special Health Authorities to Non Departmental Public Bodies (NDPBs). Increased scrutiny on all fronts, therefore, is certainly on the cards for operators in social care.

Local authorities: change instigators?

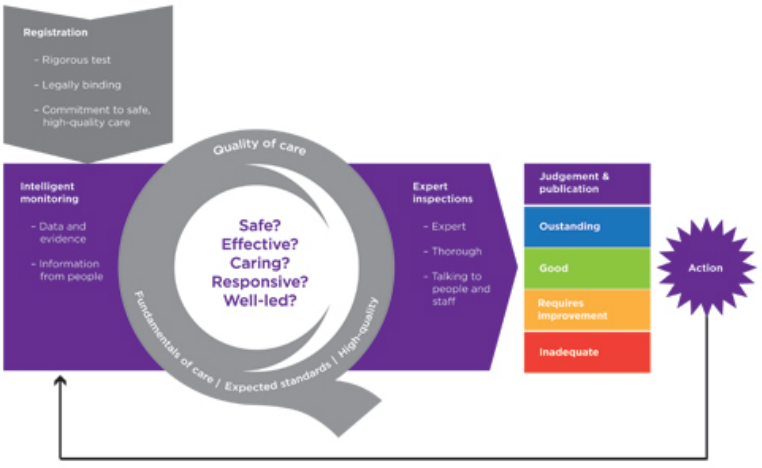
The onus on implementing the Act is very much on local authorities. They will be required to encourage preventative care, offer personalised care packages, "drive market forces" to encourage service diversity and offer clients much more financial advice about care funding. That's a pretty heavy burden.

Also sneaked under the auspices of the Act is the ruling that adult boards will become statutory. Safeguarding Adult Boards (SABs) are to be made up of local police and NHS service representatives. Before now, only children's boards were statutory. This will make adult safeguarding a corporate duty for councils, who will be compelled to fund vulnerable individuals' assessments. These boards should publish a "safeguarding plan" and formulate annual reports on its progress.

Councils will also have a lot more outsourcing capabilities. Assessing needs, putting together and managing care plans, as well as managing personal budgets and direct payments will all be potentially outsourced in the new Act.

However, it is questionable whether councils can aspire to be "commissioning hubs", when budgets are still being frozen as the cost of care continues to rise above inflation.

Overview of the CQC's future operating model



Missed opportunity

Indeed, the Care Act 2014 does not – or indeed refuses to – address how care will be paid for. The NHS will have a funding gap of £2 billion next year, which a Monitor report, published in October 2013, says could grow to an annual gap of £30 billion by 2021. This has been caused by the fact that the DH has frozen NHS funds throughout the recession.

Local authorities' care budgets are also trailing behind the cost of care. Market analysis company, Laing & Buisson, found in 2012 that English councils paid £480 a week for state-funded residential home placements, between £50 and £140 less than what it deemed to be a fair market price.

There's only so much operators can do to combat this issue. "The industry has become very efficient under austerity. However, we're reaching the end of the line now. There's a need for higher wages and higher regulatory requirements," says HC-One chairman, Chai Patel.

This won't change, says Martin Green, chief executive of Care England, if there are no mechanisms put in place to punish local authorities when they cut quality by commissioning cheaply. Unfortunately, this is something that the Act does not attempt to do.

A care cap on the amount an individual has to pay towards their care before the government steps in has also been set at £72,000, more than double the £35,000 that was recommended by the independent Dilnot Commission in July 2011. According to a new report from the Institute & Faculty of Actuaries, only 8% and 15% of men and women who are aged 85 and entering care today are likely to reach it in their lifetimes. "The dilution of the Dilnot proposals and the raising of the cap on charges is less…welcome," says Calveley, "We believe that a vital opportunity to introduce…clarity and focus to… long term care needs may have been lost."

So close yet so far

The 2014 Barker interim report, titled 'A new settlement for health and social care', makes it starkly clear that without funding, an improvement to quality is unlikely: "In 2012-13, 26% fewer people aged over 65 were receiving publicly funded social care, along with 24% fewer younger disabled people, compared to 2008-9,"

it says.

It goes on to say that the decline has been sharpest among those receiving care in their own home – now down 30%. This is despite home care likely reducing "the demand on the NHS and postponing entry to a residential or nursing home".

And this is the crux of the issue. Ultimately, the Act has many positives: personalised care packages and the new opportunities for providers that come with them, plus increased scrutiny of operators due to a new ratings system and more independent bodies. However, local authorities can still commission based on cost alone, countering a push for quality before it's even left the blocks. Unfortunately, this is not something that the Care Act 2014 is seeking to change.

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