



# Personal Care at Home Consultation

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## Ophira's response to the proposed personal care at home

### Intensive Support

The proposed regulations in the 'Personal Care at Home Bill' around a period of 'intensive support' may operate at the margins to mitigate the financial impositions that will be imposed upon local authorities as a consequence of free personal care at home. However, in practice reablement programmes together with jointly funded intermediate care schemes have long been established as cost efficient and acclaimed methods of diversion from long term care. Indeed, many authorities already extend active intervention beyond the 6 week cut off although charges frequently apply thereafter. It may be true that such schemes have rarely been used to lower eligibility banding, but certainly they operate effectively to reduce eligible needs in general and underpin a period of 'knowledge acquisition' that can then translate into a well informed person centred overview assessment under Section 47 NHS and Community Care Act 1990.

Given that there is no proposed minimum or maximum period of intensive support it is to be assumed that most authorities would seek to make free personal care 'conditional'. There would undoubtedly be concerns if expensive time specific reablement programmes were considered compulsory when such actions were clearly inappropriate and beyond 'reasonable' in terms of maximising independence. Indeed, in this context sustaining provision for existing service users is liable to be problematic as applications for free personal care are invited or requested by service users and their carers. There are a number of complexities associated with reablement programmes (unless they are tokenistic) in relation to established services. Providers are placed on hold or even worse there is a withdrawal from routine care arrangements which then prove difficult to re-establish. The suspension of personal budget payments is equally difficult in terms of the continuity of effective support plans. Of course such complications already arise through hospital admissions, but it would seem ill advised to replicate these difficulties without a clearly evidenced rationale. In such instances it would

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seem prudent for authorities to limit 'conditional' free personal care to new referrals or those existing service users who upon reassessment are entering critical bands for the first time.

It is encouraging to note that there is no mention in the proposals of cursory self assessments and early indicative budgets which have little legitimacy. However, with new developments around universal services, portals and third sector options it may be unrealistic to suggest that councils will decide that "all those approaching councils for the first time...may be offered a period of intensive support". Signposting mechanisms are already fully integrated in most authorities and deliver a service for those individuals who are unlikely to be eligible to social care services even in the short term. Applicants are in practice sifted not to limit access but rather to prevent disillusionment after lengthy formalities and raised expectations.

Legislative requirements cannot be circumnavigated on the basis that promoting independence is an overriding imperative. Yet, the proposals are silent upon the statutory duty of the authority to assess need and all aspects of ongoing health liabilities, at an early stage. Explaining that "intensive support will usually need to precede a community care assessment" may sound straight forward but what challenge - proof documentation is intended to precede it? It would seem that compliance with the principles and aspirations around the Common Assessment Framework have never been more relevant so that referral processes, contact assessments and discharge formalities are co-ordinated in a cohesive and professional framework.

### **Qualification for free personal care**

The proposed qualification for free personal care through aligning access to free 'highest needs' personal care with the critical band, as referenced in the FACS guidance appears entirely appropriate. However, the proposals seem to be extrapolated from common practice rather than the stipulated guidance. Individuals cannot be classified as critical. It is the need not the person, as defined by the seriousness of risk to independence, which determines the eligibility status and the level of support to be provided (in accordance with available resources).

Thus, the criteria for free personal care could more accurately be scripted as 'there is an inability to carry out vital personal routines'. For free personal care 'vital personal routines' are defined as essential needs in four or more distinct categories of the Activities of Daily Living.

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The interjection of the word 'significant', as proposed will not mitigate the inevitable confusion between the critical eligibility statements around need and the substantial band of eligibility as defined in relation to personal care needs: 'there is, or will be, an inability to carry out the majority of personal care routines'. The suggested determination of those with the 'highest needs' for personal care is compromised, FACS stipulates that there is no hierarchy of needs but the proposals clearly indicate that such needs being given pre-eminence. All forms of determining status must surely be consistent within the existing criteria and it is inappropriate to pick and mix banding, activities of daily living and other sections of the eligibility framework in order to select a chosen cohort for special dispensation.

It is assumed that guidance will make explicit that the determination of personal care needs must be through an adequate lawful assessment under Section 47 which investigates all potential needs. The intention of the Department of Health to develop a standardised assessment tool is welcomed subject to the assessment covering the full range of obligations at the level of sophistication required for accurate determination of eligible need and the allocation of resources through a point determination process.

### **Personal Budgets**

The proposals are explicit on exclusions for the purposes of free services i.e. domestic tasks such as cleaning, shopping and sitting services. However, the thrust towards choice and control (Indicator N130) will inevitably mean that free support resources allocated through personal budgets will be spent on those very activities that have been excluded. Without highly prescriptive auditing regimes, it is likely that social care staff will front load personal care sections of resource allocation schemes to minimise charges for their clients. Schemes are already developing into a financial morass as a consequence of Fairer Charging guidance which (quite rightly) exempts from charges, services which the authority ordinarily excludes, such complexities will then be exacerbated by the identification of personal care exclusions. Furthermore it seems reasonable to assume that the split between personal care and other services will be mirrored in respect of Disability Related Expenditure income reductions. Is there a danger here that charging computations will be reaching a point where considerations around fairness and transparency cannot even be an aspiration?

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### Indicative Budgets

The rationale for wholesale indicative budgets has always been weak. In respect of those presenting the requisite qualifying needs for free care personal care they are largely irrelevant. The support planning arrangements for care at this level are liable to be extensive and in any event there will have been the knowledge acquisition phases of active/ intensive support which would inform detailed requirements. Finance managers will be able to predict with reasonable accuracy the care costs of those reaching the level of 'highest needs', as defined by the proposals, as a consequence of their familiarity with their locality and the supply costs of the available market.

### Financial Projections

Financial projections in relation to individual care costs are relatively routine for most local authorities given that the client grouping will be predominately older persons. Calculating charging regime losses are somewhat more difficult given that the majority of authorities are unlikely to have made a point of scrutinising the allotment of either critical or substantial banding to levels of need and therefore unpicking the relationship between cost and eligibility will not be straightforward. However, both individual care costs and charging loss projections will pale into insignificance in relation to 'guesstimate' projections around the additional number of referrals that might emerge as the result of:

- a) personal budgets (around which much speculation remains in terms of additional numbers)
- b) Those individuals who will not move into residential or nursing homes as independent funders as a consequence of the introduction of free personal care at home.

Neither the assumptions which have been drawn in the proposals or the illustrative grant allocation options are necessarily indicative of the patterns of change that will occur and the additional financial pressures which could accrue in any given authority. It would seem that in these circumstances the optimum grant allocation and the projected efficiency estimate is unlikely to meet the actual cost of these proposals in most, if not all authorities. Indeed in reality the DH statement "...it seems plausible that the net benefits are substantial" may be optimistic in the extreme and even if such benefits materialise, it will not be local authorities which harvest the rewards.

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## Market Impact

The market impact and the associated costs of free personal care at home have not been factored in the proposals but in practice there will be major repercussions which should not be ignored. Indeed, in the survey of director's (ADASS) the capacity of the market to respond to the changes around personal budgets was identified as the primary area of concern. Those issues are still at large and will now be magnified. For example, many private residential establishments base their fee rate on the ratio between public and privately funded residents. As fewer self funders move into residential care, rates may drop in some areas as a result of increased vacancies but more probably they will rise as a consequence of lower self funder subsidy. Domiciliary care markets also will be reshaped by free personal care at home as private purchasing at premium rates reduces or is focused on fully chargeable services. Care markets undoubtedly are under enormous pressure and the capacity of providers to respond to free personal care at home from October 2010 cannot and should not be taken for granted.

## Conclusion

Is it Machiavellian, prudent or essential that authorities consider at an early stage how they will address the advent of free personal care? The practical outcome of the Bill proposals may be that those authorities liable to be most heavily impacted will re-badge Intermediate Care programmes with the hope that health will not retract from joint funding agreements (especially in the light of increased nursing care requirements as individuals remain at home for longer). In addition there will surely be covert activity to push the identification of existing need levels down into the Substantial band of the eligibility criteria (reviews) in order to categorise service users below the free personal care threshold. Training to assist practitioners correctly determine the fine line between 'vital' (critical) and the 'majority of personal care needs' (substantial) will become a pre-requisite of economic stability and safeguard authorities in the face of the legal challenges which will inevitably ensue. Is it way, way too cynical to suggest that outcomes here could be that the vast majority of service users may find themselves classified without any critical needs over the coming years only for authorities to then change their eligibility criteria to critical.

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