THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE *FOR* EMPLOYMENT & SOCIAL SECURITY

SUPPORTED LIVING AND AGEING WELL STRATEGY: EXTENDING THE LIFE OF THE LONG-TERM CARE INSURANCE SCHEME

The States are asked to decide:-

Whether, after consideration of the Policy Letter entitled 'Supported Living and Ageing Well Strategy: Extending the Life of the Long-term Care Insurance Scheme', dated 29th June, 2020, they are of the opinion:-

1. To agree that the 'co-payment', when aggregated with the Long-term Care Benefit in payment for a care home bed, results in a sum too low to ensure the stability of the private care market and to promote the ongoing investment required to ensure that there is a sufficient supply of care to meet the long term demand of the market.

2. To agree that the 'co-payment' is increased from £209.37 to £229.37 per week with effect from 5th October, 2020.

3. To agree that the weekly rates payable in respect of Long-term Care Benefit are increased from 5th October, 2020 as follows:

Residential care	£521.00	(current rate £463.89)
Residential respite care	£750.37	(current rate £673.26)
Residential dementia care	£681.00	(current rate £611.24)
Residential respite dementia care	£910.37	(current rate £820.61)
Nursing care	£940.00	(current rate £866.11)
Nursing respite care	£1,169.37	(current rate £1,075.48)

4. To approve the draft ordinance entitled the 'The Long-term Care Insurance (Guernsey) (Rates) Ordinance, 2020', attached at Appendix 2 to the Policy Letter, and to direct that the same shall have effect as an Ordinance of the States.

5. To note that the increase in the co-payment of £20 per week, from £209.37 to £229.37 will increase Income Support formula-led expenditure by £40,000 in 2020.

6. To agree that the 'co-payment' shall be further increased, over two years, to be £280 per week from January 2023, in line with the lower estimates for the cost of providing 'living and accommodation' services indicated by the LaingBuisson analysis.

7. To agree that the total of the 'co-payment' aggregated with the Long-term Care Benefit rate for the provision of residential care beds, residential dementia care beds and nursing beds should be increased to the mid-point indicated by the LaingBuisson benchmarking by 2023 with allowance made for inflation (RPIX) in the intervening period; and the mid-points in 2020 terms are as follows:

Residential care	£801.00	(current rate £673.26)
Residential dementia care	£961.00	(current rate £820.61)
Nursing care	£1,220.00	(current rate £1,075.48)

8. To agree that a review of the adequacy of benefit rates should be conducted in conjunction with each five-yearly actuarial review of the Long Term Care Fund to ensure that benefit rates remain appropriate; and that additional or interim reviews should be conducted by the Committee *for* Employment & Social Security if there is evidence of significant pressure on the cost of delivering Long-term Care services.

9. To agree in principle to introduce a higher rate of benefit payable for exceptional and complex cases to be provisionally set at £1,112.00 per week, and to direct the Committee *for* Employment & Social Security and the Committee *for* Health & Social Care to develop suitable eligibility and assessment criteria for access to this benefit by no later than December 2020.

10. To note that if the foregoing propositions are approved, and future benefit rates are maintained in line with the same methodology, it is estimated that the contribution rate necessary to ensure the sustainability of the Long-term Care Insurance Fund will need to increase by 0.9%, taking it from 1.8% to 2.7% for people under pension age and from 1.9% to 2.8% for people above pension age.

11. To agree, in principle, that the Long-term Care Scheme should be extended to incorporate care provided at home and to direct the Committee *for* Employment & Social Security and the Committee *for* Health & Social Care to develop detailed implementation plans for this proposal no later than June 2022 and to agree that such plans should include:

a. A minimum care need threshold to be eligible for subsidised care from the Long-term Care Insurance Fund;

b. Additional rates of benefit, lower than those that apply to care homes, to support people receiving care in their home;

c. A scheme whereby claimants receiving a subsidy towards residential or nursing care could in the future have the option of using this subsidy towards care in their own home

d. Criteria for establishing long-term need (for example care requirements likely to persist for at least six months or until end of life) which would qualify for a claim from the Long-term Care Insurance Fund; and

e. A suitable assessment process capable of establishing eligibility for benefit for those requiring care at home in a time and cost-efficient manner.

12. To note that if proposition 11 is approved, the estimated contribution rate necessary to ensure the sustainability of the Long-term Care Insurance Fund, referred to in proposition 10 will need to increase by a further 0.4%, taking it to a total of 3.1% for people under pension age and 3.2% for people above pension age.

13. To note that if the above propositions are approved and there is no substantial change in the financing methodology, the necessary increase of 1.3% in the contribution rates for the Long-term Care Insurance Fund will be an increase of approximately 70% over the current rates.

14. To agree that a reliance on increased contribution rates to ensure the financial sustainability of the Long-term Care Insurance Fund, in the context of the changing demography, risks an increasing and significant intergenerational unfairness.

15. To direct the Policy & Resources Committee, in conjunction with the Committee *for* Employment & Social Security, to investigate the formation of a States-run or supported scheme for deferred property loans to be made available to those seeking or receiving Long-term Care and to report to the States no later than December 2021 and to agree that such a scheme should be fair and equitable and include protections for any spouse, partner or dependant relative resident in the property.

16. To agree in principle that, subject to the development of a suitable deferred loan scheme, those with property assets (including their primary residence) with a value in excess of £350,000, should not be entitled to income support to assist in meeting the cost of the personal allowance and co-payment payable in respect of care beds under the Long Term Care Scheme and to direct the

Committee *for* Employment & Social Security to provide updates on the implementation of this policy in its annual 'non-contributory benefit rates' Policy Letter.

17. To direct the Committee *for* Employment & Social Security and the Policy & Resources Committee to report to the States, by December 2021, on the options that exist to moderate the increase in contributions which will otherwise be required and to agree that those options should include a model similar to the scheme in place in Jersey, which includes a requirement that those with assets above £350,000 (including their primary residence) must meet the first £35,000 of the costs otherwise covered by the Long-term Care Benefit Scheme.

18. To note that, subject to the outcomes of the States' decisions on the report set out in Proposition 17, the Long-term Care Fund will require additional funding of up to £25million per annum, equivalent to an increase in the social security contribution rate of 1.3%, in order to become financially sustainable; and

    a. to direct the Policy & Resources Committee, as part of the Review of Taxation and in consultation with the Committee for Employment & Social Security, to identify a suitable source of funding to ensure the long term stability of the Long-term Care Fund, in accordance with the principles of the Fiscal Framework; and

    b. to direct the Committee *for* Employment & Social Security, if the Review of Taxation does not identify measures to ensure the long-term stability of the Long-term Care Fund, to propose within its annual contributory benefit report an increase in the social security contribution rate of a maximum of 1.3% with effect from January 2022.

19. To direct the Committee *for* Employment & Social Security, in co-operation with the Committee *for* Health & Social Care, to continue to work towards establishing contractual arrangements with some or all care homes providers in order to provide certainty of income for the care home and certainty on the number of beds available at 'States rates'.

20. To rescind Resolution 6 of the 1st March, 2001 on Article VII of Billet d'État No. III of 2001 ('Long-term Care insurance scheme for Guernsey and Alderney') which has the effect of requiring the Committee for Health & Social Care to set the standard charge for occupants of long-term residential and nursing care beds provided by the States of Guernsey at an amount equivalent to the standard Long-term Care Insurance Scheme co-payment.

The above propositions have been submitted to Her Majesty's Procureur for advice on any legal or constitutional implications in accordance with Rule 4(1) of the Rules of Procedure of the States of Deliberation and their Committees.

THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE FOR EMPLOYMENT & SOCIAL SECURITY

SUPPORTED LIVING AND AGEING WELL STRATEGY: EXTENDING THE LIFE OF THE LONG-TERM CARE INSURANCE SCHEME

The Presiding Officer
States of Guernsey
Royal Court House
St Peter Port

29th June, 2020

Dear Sir

1. Executive Summary

1.1. The Long Term Care-Insurance Scheme (the Scheme) was launched in 2003 and for 17 years it has supported islanders in need of residential or nursing care. The scheme was intended to insure islanders against the risk that they would face significant personal costs if they needed care; and to encourage investment in the private care market which at the time was considered to be supplying too few beds to meet demand. The Scheme is funded by the Long-term Care Insurance Fund (LTCF), which in turn is financed from social security contributions and the Fund's investment income.

1.2. However, the Scheme faces some very significant challenges, including five key issues:

- **Issue 1: The demand for care beds is growing** as the population ages. The number of care beds required is expected to increase by more than 40% by 2030 and to have more than doubled by 2040.
- **Issue 2:** The private sector providers who offer these beds are reporting significant financial strain. Analysis suggests that **the minimum amount paid for a care bed in the current scheme it too low to sustain the market.** As a result there are concerns about whether the system as currently structured is capable of meeting the current level of need or providing the necessary investment incentives to meet the rising demand for care.

- **Issue 3**: Analysis suggests that **the current co-payment is insufficient to meet the cost of providing for an individual's accommodation and daily living costs.** The co-payment is the minimum weekly payment that an individual is required to pay before the Long-term Care benefit is paid from the Fund. The co-payment is also the maximum weekly amount that is paid by Income Support for people living in a care home, apart from a small personal allowance.
- **Issue 4: The current scheme is limited to supporting care in a care home setting**, with community and care at home services provided by the Committee *for* Health & Social Care under a different funding model and subject to its own challenges around adequately meeting the growing demand as the population ages. The division of the two arms of Long-term Care provision complicates the management of patient care, risks creating inequalities and inconsistencies and may limit patient choice.
- **Issue 5:** In its current form **the scheme is not financially sustainable**. Without a change in revenues or a change in policy the scheme is projected to run out of money by 2047, before anyone currently under the age of 50 is likely to gain any benefit from it.

1.3. These issues were raised in the Supported Living and Ageing Well Strategy (SLAWS); approved by the States in 2016 (Article XIV of Billet D'État No. III of 2016, Volume II). The resolutions on the Policy Letter included those to review the strategic funding of Long-term Care and the operation of the Scheme. A copy of the Resolutions appears at Appendix 1.

1.4. The Committee *for* Employment & Social Security was directed under the resolutions to investigate issues relating to the strategic funding of Long-term Care, in conjunction with the Policy & Resources Committee. In doing so it has investigated the implications of the principle that the LTCF should pay only for the cost of care and support, with the individual being responsible for their accommodation and daily living costs. Further it has investigated the implications for extending the scheme to provide benefits to pay for care in the community.

1.5. These are not simple issues to resolve. There are a number of challenges where action to tackle one issue worsens the position of others and the solutions require a balance between these competing aspects. The key challenges can be summarised as follows:

- **Challenge 1:** Increasing the minimum amount payable for a care bed to stabilise the market and encourage investment to meet demand requires either an increase in the minimum amount individuals must pay for themselves, which some people cannot afford, or an increase in the

benefit paid which makes the financial sustainability of the Scheme worse.

- **Challenge 2:** Increasing the co-payment so that individuals are responsible for meeting (in broad terms) their own living and accommodation costs has knock on effects on the income support system and transfers a portion of the saving made by the Scheme to general revenue.
- **Challenge 3:** Expanding the scheme to cover care in an individual's own home offers opportunities to improve patient choice but adds significantly to the financial challenges faced by the scheme. However, not extending the scope of the Long Term Care Scheme will not remove the need to provide these services. The increasing demand for community based care services needs to be addressed.
- **Challenge 4:** To resolve the financial challenge solely by increasing contributions places the most significant lifetime cost burden on the youngest in our community and is particularly disadvantageous to those who will not benefit from inheriting wealth from older relatives. However the alternative, to require those with significant income or assets to self-fund a limited portion of their own care costs, is publically and politically challenging and seen by some as incompatible with the original stated intentions of the Scheme.

1.6. Reaching a consensus agreement on how to address these challenges has been challenging for the Committee and has required compromise. It is evident, however, that change is required or the Scheme will fail before the majority of those currently contributing to it are likely to benefit and the States will be left with the even greater task of supporting Long-term Care solutions for an ageing population year by year.

1.7. This Policy Letter sets out a number of recommendations and proposals to address the issues identified. However, the proposals presented will affect different people in different ways, depending on their circumstances. Principles of fairness, particularly between generations, and the economic and social impact of the proposals must be considered as part of the decision making process.

1.8. The Committee, in its work to address the SLAWS resolutions, has also been concerned about access to so called 'States rates' care home beds. This is where the cost of the bed does not exceed the combined amount of the co-payment and the Long-term Care benefit. Currently there is no contractual arrangement between the States and care homes which benefit from the Long-term Care scheme, although the homes are subject to certain conditions under the Long-term Care Insurance (Guernsey) Law, 2002 and Regulations made under that Law. The Committee has examined the opportunities for

commissioning beds from the care home proprietors and, to date, has found very little appetite from the sector. The Committee will continue to work towards establishing contractual arrangements with some or all care home providers in order to provide certainty on the number of beds available at 'States rates'.

1.9. Based on evidence from the care homes' financial accounts, meetings with some of the care home owners or trustees and having witnessed the recent closure of two care homes the Committee is convinced that there should be an immediate increase in the income of the care homes to improve the viability and confidence of the sector.

1.10. It is for that reason that the Committee made a request of the Presiding Officer for an Ordinance continuing new rates of Long-term Care benefit to be attached to this Policy Letter. The Committee is grateful to the Presiding Officer for granting that request. The draft Ordinance appears at Appendix 2.

1.11. Some of the Committee's proposals are for immediate action, while others require further work and consideration.

1.12. The Committee's proposals for immediate action can be summarised as an increase to the minimum amount paid for the provision of care home beds, informed by a benchmarking analysis, by a combination of:

- increases in the levels of benefit paid by the LTCF, from 5th October 2020, and
- an increase in the 'co-payment' required of the person in care. The current rate of £209.37 per week would increase to £229.37 from 5th October 2020.

1.13. The additional costs to the LTCF will further impact the Fund's financial sustainability. It is estimated that the contribution rate necessary to ensure the sustainability of the Long-term Care Insurance Fund, adding the above measures to the existing inadequate funding, will require an increase in the contribution rate of 0.9%, taking it from 1.8% to 2.7% for people under pension age and from 1.9% to 2.8% for people above pension age. The Committee is not, in this Policy Letter, recommending the immediate application of such increases. Instead, the Committee, with the agreement of the Policy & Resources Committee, is recommending that the source of funding for the sustainability of the LTCF is addressed within the Review of Taxation.

1.14. The Committee's proposals for medium and longer-term action can be summarised as follows:

- Further increasing the co-payment over a two year period, to be £280 per week from January 2023.
- The addition of a higher rate of Long-term Care benefit payable for exceptional and complex cases, at a provisional rate of £1,112.00 per week, with the relevant criteria being determined by the end of 2020.
- Extending the provision of the Long-term Care Scheme to incorporate benefits payable towards care and support provided at home, thereby extending choice to the individual as to where they receive care.
- Investigating the formation of a States-run or supported scheme for deferred property loans to be made available to those seeking or receiving care, with appropriate protections for a spouse our partner or dependent relative residing in the property.
- Agreeing in principle to include property assets with a value in excess of £350,000 within the income support assessment for those needing assistance to meet the cost of the minimum personal contribution to care home fees (subject to the creation of a suitable deferred loan scheme). At present, the value of a person's former home is not taken into account in assessing whether they should be assisted by income support with the cost of the co-payment.
- Returning to the States by December 2021 with further options for moderating the increase in contributions which will otherwise be required, including a model based on the scheme in place in Jersey, which in Guernsey would include a requirement that an individual with assets above £350,000 (including their primary residence) should meet the first £35,000 of the costs otherwise covered by the Long-term care Insurance Scheme. The requirement for a couple would be £50,000.
- Directing the Policy & Resources Committee, as part of the Review of Taxation to identify a suitable source of funding to ensure the long term stability of the Long-Term Care Fund; and directing the Committee *for* Employment & Social Security, if the Review of Taxation does not identify such measures, to propose within its annual contributory benefit report an increase in the social security contribution rate of a maximum of 1.3% with effect from January 2022.
- Continuing to work, in co-operation with the Committee *for* Health & Social Care, towards establishing contractual arrangement with care home providers in order to provide certainty of income for the care home and certainty on the number of beds available at 'States rates'.
- Rescinding a resolution of the States that sets the standard charge for a long-stay bed provided by Committee *for* Health & Social Care at an amount equal to the co-payment.

1.15. All financial estimates provided within this Policy Letter are produced based on the best available information. However, when projecting costs into the future in this manner there is inevitably a wide degree of uncertainty. Even small changes in key assumptions can compound over a long projection time frame to significant differences. Such estimates are therefore always subject to revision but are non-the less an important tool for long term planning.

1.16. Estimates provided for the cost implications for policy changes, such as the proposed change in the income support policy or the inclusion of home care services within the scope of the Long-term Care Scheme, are also based on a range of assumptions about how these policies will be implemented. These are therefore also subject to change as the details of how they might be implemented evolves.

1.17. Further, the financial projections were performed before the outbreak of COVID-19. It should therefore be acknowledged that the disruption to contribution revenues and investment returns, may have impacted the accuracy of the projections contained in this Policy Letter. There is insufficient evidence available at this time to determine how significant this impact might be in the medium to long-term.

2. Strategic context of the proposals

2.1. The Supported Living and Ageing Well Strategy (SLAWS) was debated and approved by the States in 2016[1]. The SLAWS Working Party had been established on behalf of the then Policy Council in late 2013 to review the provision of Long-term Care and support services provided to adults over 18 years of age in both Guernsey and Alderney. The Strategy covered all areas of Long-term Care and undertook extensive research on Long-term Care and support services including wide ranging public engagement.

2.2. The key findings of the Working Party report set out four key changes considered as necessary:

- A better resourced and developed strategic planning function;
- The addressing of social attitudes towards care, disability and ageing;
- The reconfiguring of health and social care services to provide a greater emphasis on community-based, person-centred services (including those provided to carers);
- A radical overhaul of the funding of Long-term Care services and the operation of the Long-term Care Insurance Scheme in particular.

[1] Supported Living and Ageing Well Strategy (Billet d'État III of 2016, Volume II, Article XIV)

2.3. Having concluded that the current funding system is not sustainable and must change if it is to be fit for the future, the 2016 Policy Letter made recommendations for the strategic funding and development of Long-term Care benefit. It considered that increasing tax or contributions indefinitely was not an option and that the opportunity should be taken to restructure the provision of care and support services to make it more sustainable. As an interim step, to provide medium term stability for the LTCF in advance of more developed proposals it was recommended that the Long-term Care contribution rate should increase by 0.5% to 1.8% from January 2017.

3. Introduction

3.1. The Long-term Care Insurance Scheme was introduced in 2003 to assist with the cost of care in nursing and residential homes[2]. Prior to its introduction individuals who required care in a residential setting faced potentially huge costs associated with paying for care. There was also concern that the private and third sector care providers were not supplying enough beds to meet the level of demand.

3.2. The 2001 Long-term Care Policy Letter[3] set out proposals for a scheme of insurance that would pay a substantial part of their fees should they need care. Objectives set out in the Policy Letter included pooling the financial risk of needing care to protect individuals from a potentially large cost through an insurance based scheme, making the funding system fair and affordable and maintaining flexibility for changes that would be inevitable in a scheme expected to be in place for many years. At the same time the provision of the benefit was intended to promote stability and growth in the private care home market.

3.3. Eligibility for benefit was based on residency criteria, an individual being assessed as having Long-term Care needs by a Needs Assessment Panel[4], taking up a place in a registered nursing or residential home and making a set contribution (or co-payment) towards the care home fees.

3.4. The co-payment towards care home fees was to be a standard rate and would apply to all residents in both private and public long-term residential or nursing care. This, along with a grant from the Long-term Care Fund, would cover the fee payable to a private or third sector care home. Together these payments became known as the 'States rate' and would be increased each year in the course of the Committee's Policy Letter on contribution and

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2 See Appendix 2 for the background to the Long-term Care Scheme

3 Long-term Care Insurance Scheme for Guernsey and Alderney (Billet d'État No. III of 2001, Article VII)

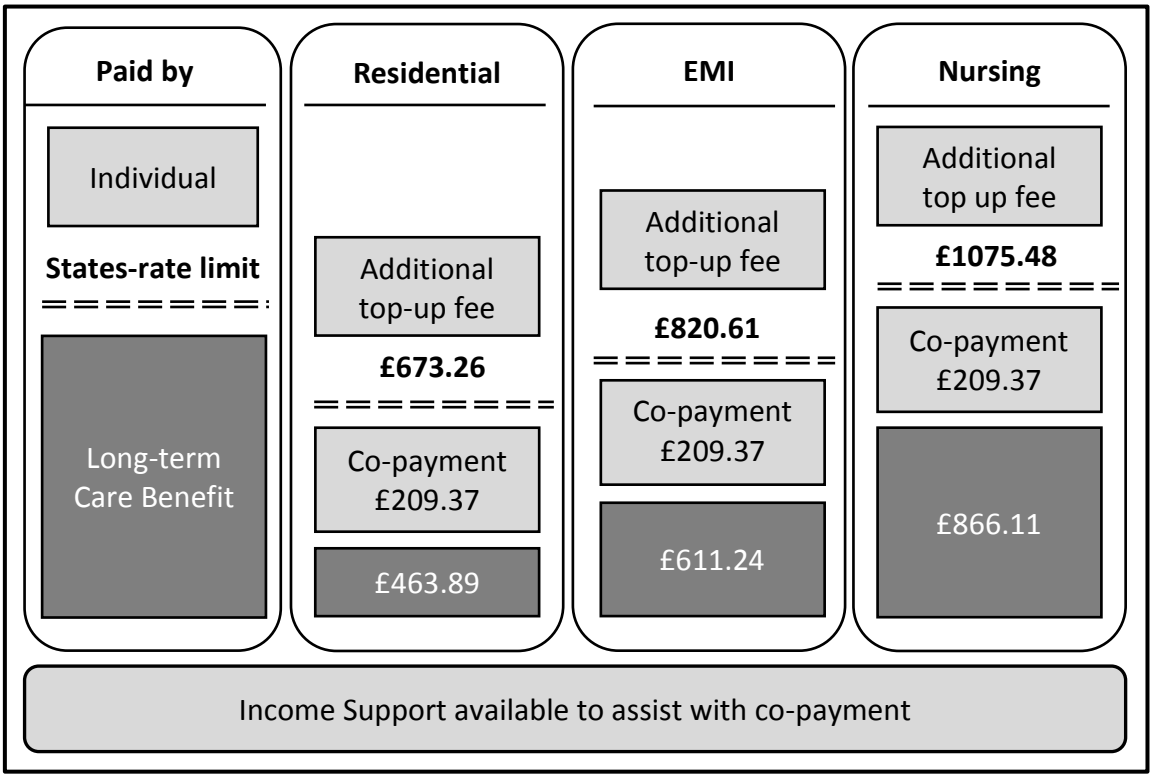
4 See Appendix 3 for further detail on the assessment and claim process.

benefit rates. Anyone who could not afford to pay the co-payment would be assisted by a means-tested supplementary benefit claim (now operated under Income Support) and the value of an individual's former residence would be excluded from their financial assessment.

3.5. At the time the scheme was introduced a small number of care homes had fees which exceeded the States Rate. Any fees above the States Rate, would be paid by the individual resident in addition to the co-payment.

3.6. It was acknowledged at its inception that the scheme would not be financially sustainable in the long run at the initial rate of contributions. The original contribution rates (1.4% for employed and self-employed individuals) were expected to be maintained for at least 15 years, provided that there was no fundamental change in provision.

Figure 3.1 – Responsibility for care home fees – 2020 rates



3.7. The Long-term Care Insurance (Guernsey) Law (2002) describes 'a person in need of Long-term Care' as a person who:

a. by reason of bodily or mental disability, or a combination of bodily or mental disability, is so disabled that he may suffer harm whilst undertaking the normal activities of daily life without substantial assistance or attention from another person, or

b. is not so disabled, but in respect of whom there is good reason to believe that he would suffer such harm without such assistance or attention.

3.8. Since the introduction of Long-term Care benefit in 2003 much has changed in society and in health and social care. Person centred care is promoted with the aim that individuals should have choice over the services they receive and where they receive them. Much is being done to support people to remain in their own homes which helps to reduce urgent hospital admissions and delay the need to move into residential or nursing homes. The SLAWS report recognised the need to further develop community services to support people to remain in their own homes and proposed the LTCF should be extended to pay for care in the community.

3.9. The States approved the SLAWS recommendations in full and directed the Committee *for* Employment & Social Security, in conjunction with the Policy & Resources Committee, to investigate the implications of the LTCF paying only for the cost of providing care services and support. Individuals would be expected to pay for their accommodation and daily living costs. As a second phase, the Committee was also directed, in conjunction with the Policy & Resources Committee, to investigate the implications for extending Long-term Care benefits to pay for care for people living in their own home. Through the course of this political term, during which these difficult matters of policy have been investigated and developed, the Committee has engaged with the Committee *for* Health & Social Care and the Policy & Resources Committee to report its progress and to invite input and comment.

3.10. Care costs, current care provision and future care requirements for Guernsey and Alderney were explored as part of the investigation. The Committee, concerned about the supply of beds available at the basic rate[5], sought to ensure the supply of affordable care home beds as part of the future policy development. It is likely that some increase in the number of 'States rate' beds available may result from increasing the States rate value in order to providing greater stability to the market. There would be more certainty in this area if effective commissioning arrangements with the homes could be achieved. Discussions with the care home owners and trustees have shown little or no interest in such arrangements from their behalf. The Committee will continue to keep this issue live and to pursue mutually beneficial arrangements.

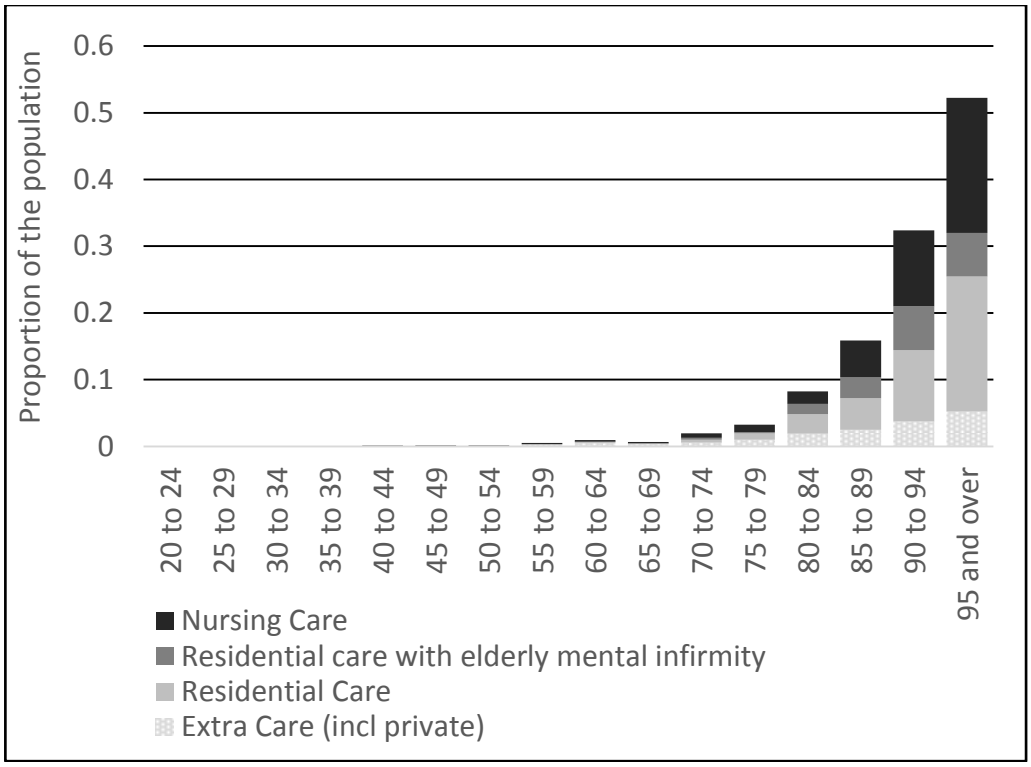
[5] Commonly referred to as the "States-rate" and is the appropriate long-term care benefit rate plus the minimum co-payment rate set by the States

4. The Issues

Issue 1: Current and future demand for Long-term Care is increasing

4.1. The population is ageing in Guernsey and most of the developed world. This is a well-established fact and it is driving an increasing demand for health and care services.

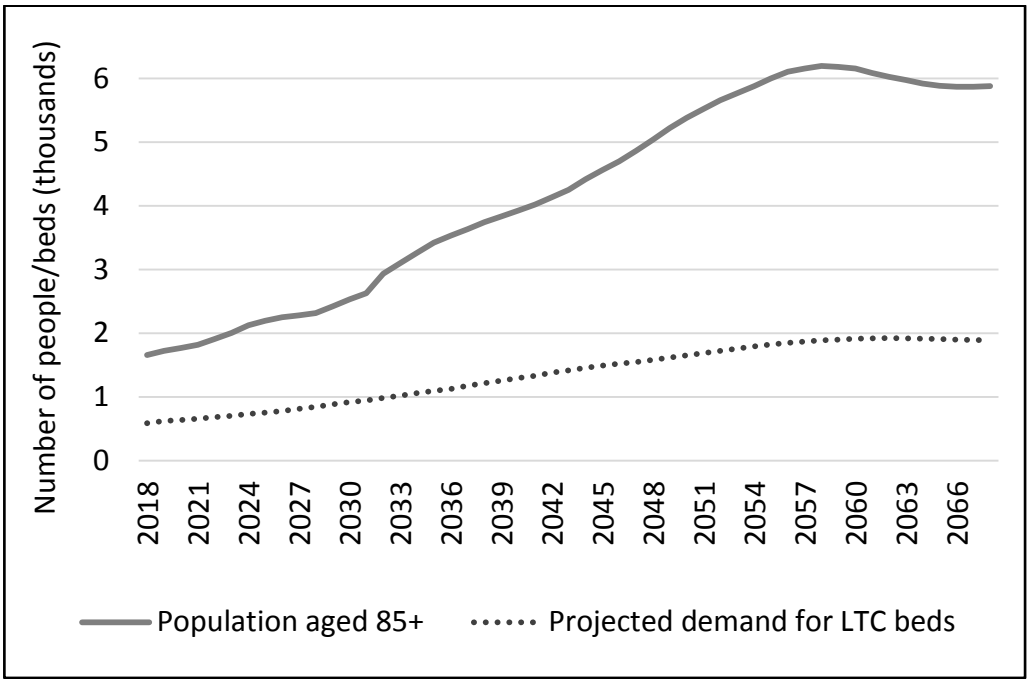
Figure 4.1 – Service user profile for residential, nursing and extra care



4.2. Figure 4.1 provides an estimate of the proportion of the population who are in receipt of Long-term Care Benefit or living in extra care housing by age. While these benefits and services are available to anyone over 18 who meets the assessment criteria, it is the oldest in the community who are the largest users. These services are just a small part of the care being provided to older people in the Bailiwick. These age groups are also the largest users of health and social care services in general.

4.3. As can be seen in Figure 4.2 overleaf, the number of highly dependent adults is projected to increase significantly over the next 40 years and this drives a significant increase in the projected demand for care beds.

Figure 4.2 – Projections of the population aged 85+ and total number of care beds



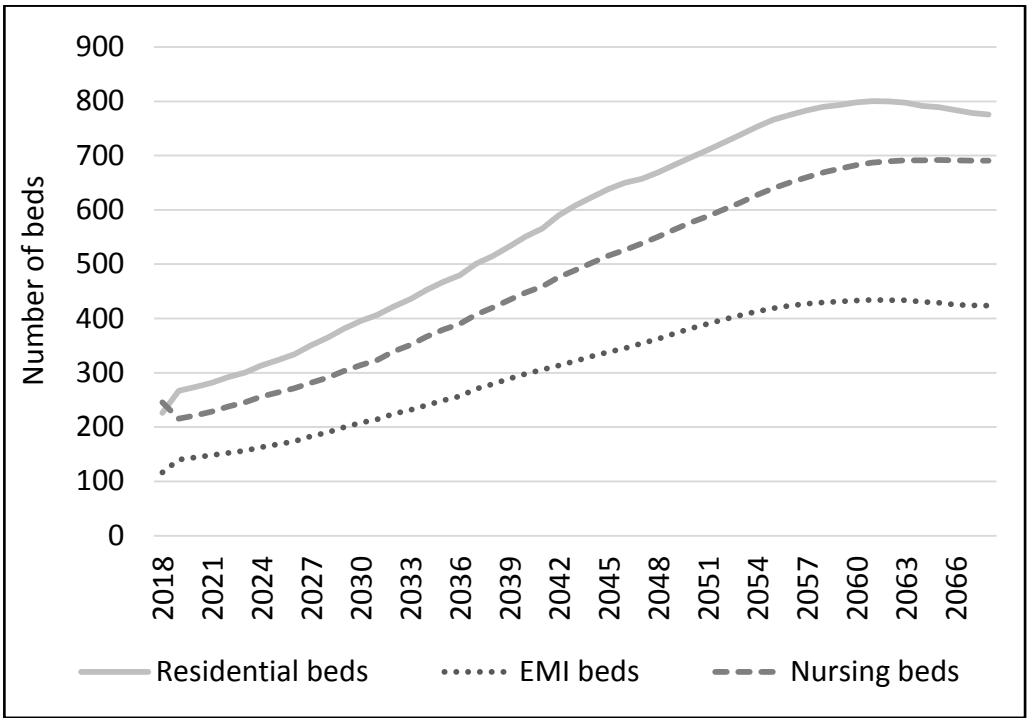
4.4. The modelling reveals that demand for residential, EMI (dementia care) and nursing beds may increase by more than 40% by 2030, double by 2040 and triple by 2060 (see Figure 4.3 overleaf). Even if the modelling assumptions are relaxed and home care services are assumed to meet some of this demand, it is evident that there is a need to plan for the provision of substantially more care beds than the current profile of homes provide.

4.5. In addition, statistical information shows that while life expectancy is increasing the amount of time spent in poor health and needing care has also increased[6]. This will put further pressure on the funding of Long-term Care. Overall, the working person will be supporting an increasing number of non-working people for longer.

4.6. These projections are central to the planning of Long-term Care services. Future policy must support both the need to maintain a financially sustainable system and to promote the supply of care services needed to meet the long term demand. Any policy which might disrupt or discourage supply would come with a significant long term risk.

[6] Public Health England's Health profile for England: 2018 states *"Since the period 2009 to 2011, the life expectancy at birth has increased more than healthy life expectancy and therefore the number of years lived in poor health has increased slightly, as has the proportion of life spent in poor health"*.

Figure 4.3 – Projected increase in demand for care beds by type



Issue 2: The minimum amount paid for a care bed in the current scheme is too low to sustain the market

4.7. Detailed analysis was conducted on the cost breakdown of the provision of care beds using a recognised tool known as the LaingBuisson Benchmark. The benchmark is constructed assuming homes need to make a market return on their investment in order for provision to be sustainable in the long term and for there to be an incentive for providers to invest in the market.

4.8. The Benchmark provides a floor rate and a ceiling rate, which will meet the ongoing cost of investment in full (see Appendix 5). The Committee has assumed that, in order for the market to be sustainable the 'States rate' should as a minimum cover the benchmark floor to sustain the market as it is and should cover the mid-point between the floor and ceiling in order to facilitate on-going investment. It is assumed that homes will continue to charge top-up fees for some beds in order to meet the remaining investment cost.

4.9. Analysis of 2018 accounting data shows that the current 'States rate' (the benefit plus the minimum co-payment) was insufficient to meet the mid-point benchmark on all bed types (see Figures 4.4 to 4.6 overleaf).

Figure 4.4 – 2018 Costs of care – Residential beds

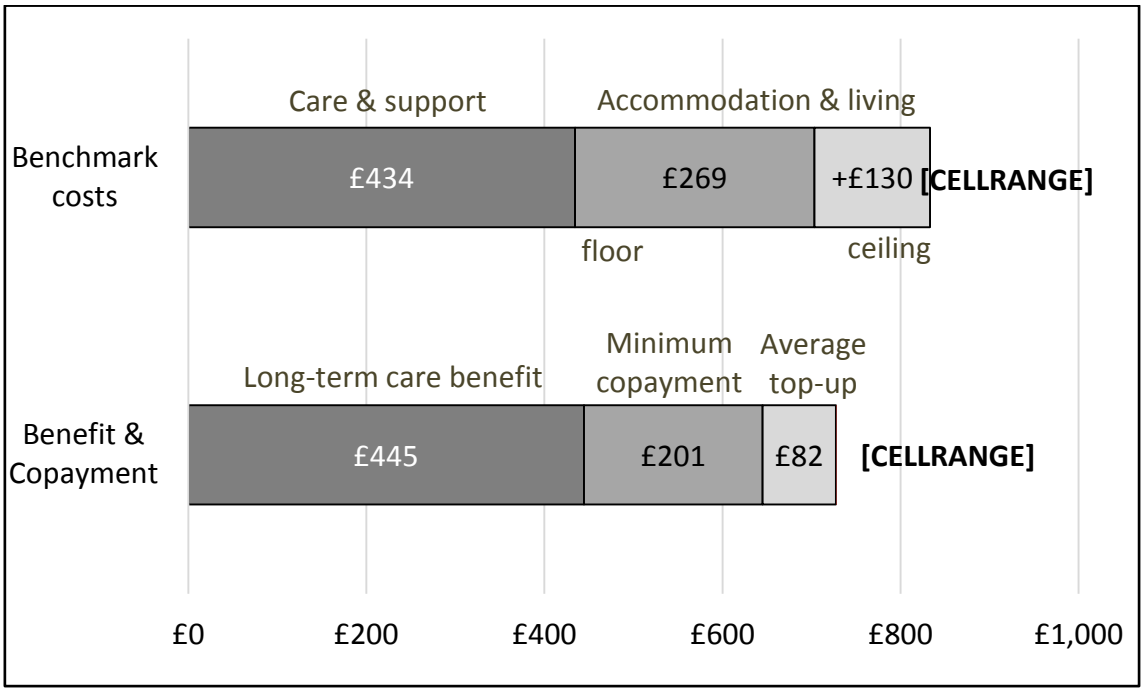


Figure 4.5 – 2018 Costs of care – Nursing beds

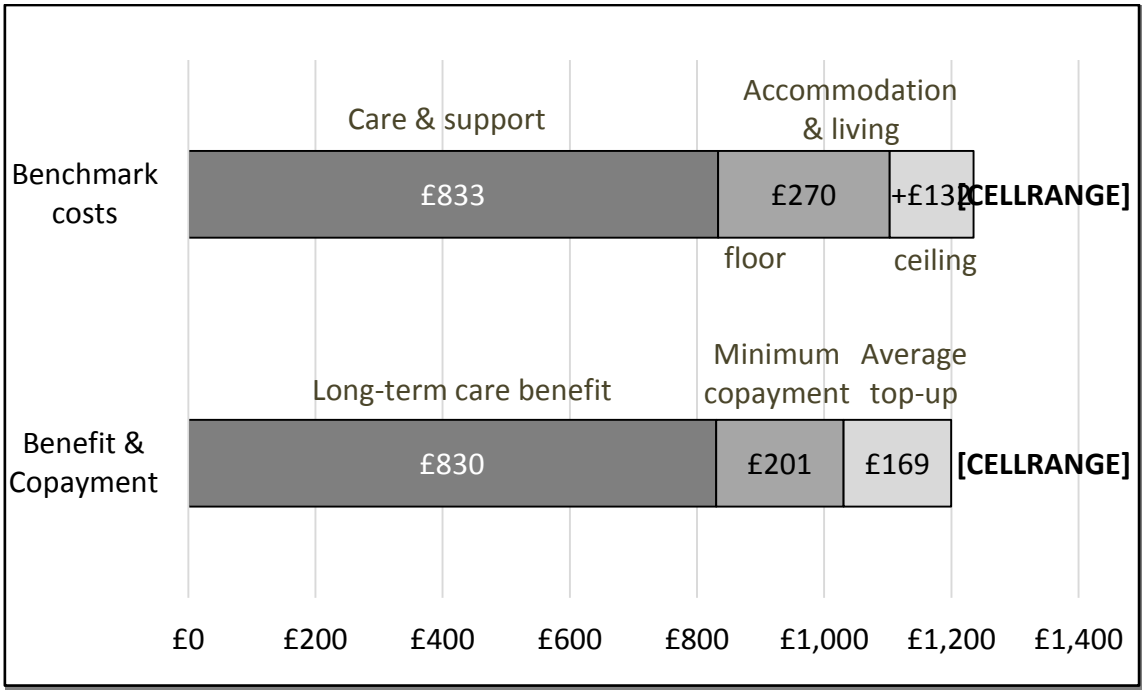
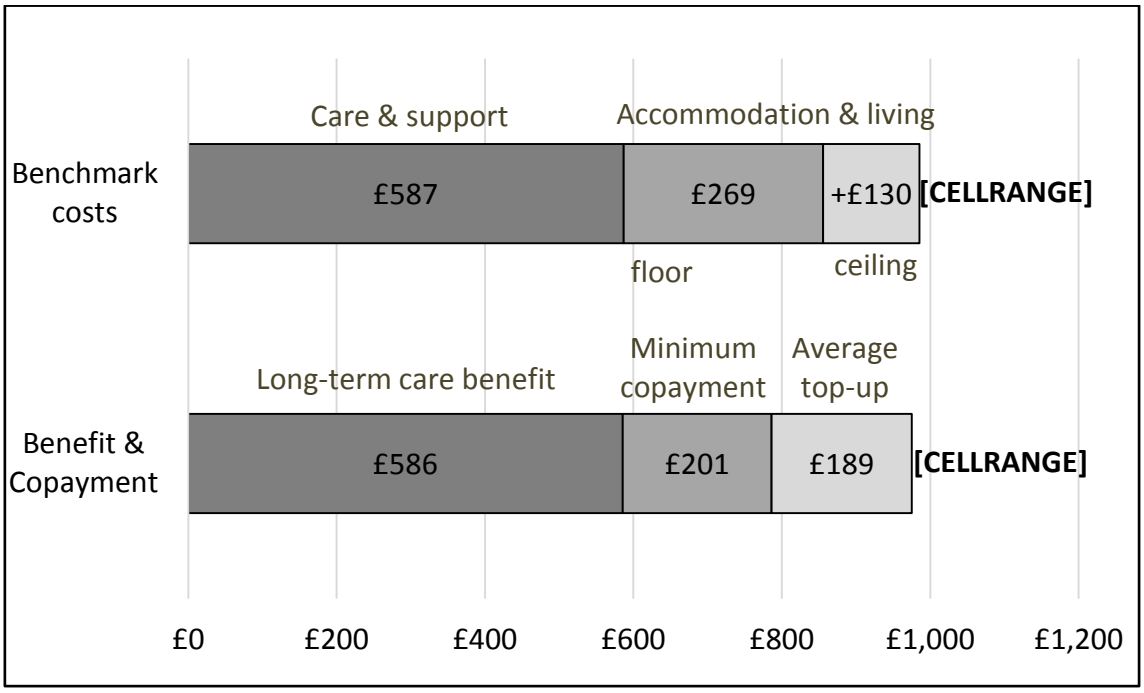


Figure 4.6 – Costs of care – EMI (dementia care) beds



4.10. This has manifested itself in different ways in different areas of the market. Residential care homes and not-for–profit homes, in general, show a weak financial position, with profits too low to provide for on-going investment and a limited number of homes are running at a financial loss. Smaller residential homes seem particularly vulnerable, and a number of these have closed in recent years.

4.11. Financially, private homes with a mix of beds or which offer exclusively dementia care or nursing beds appear to be in a better position, but the average level of top-up charged is substantially higher. In some cases, it is likely that States- Rate beds are being cross subsidised by top-ups charged on other beds.

4.12. As things stand the current level of provision could be considered insecure and there is little incentive for providers to invest in additional provision. Lack of provision also creates delays in discharging patients from hospital if they have to wait for a suitable bed to become available. Finding an appropriate bed is further complicated if the individual has particularly complex needs or if they need a States Rates bed because they are unable to afford top-up fees.

Issue 3: The current co-payment is insufficient to meet the cost of providing for an individual's accommodation and daily living costs.

4.13. In response to the 2016 Policy Letter the States resolved in principle that individuals should be responsible for meeting their own accommodation and

daily living costs. The analysis presented in Figures 4.4 to 4.6 shows that the minimum co-payment (£201 in the Figures, £209 in 2020) is insufficient to meet the minimum estimated cost of providing accommodation and living costs in a care home setting. That cost would be £280 per week if inflated to 2020 values.

Issue 4: The current scheme does not cover care provided in an individual's own home.

4.14. The States agreed in principle, following the 2016 Policy Letter, that the Long-term Care Insurance Scheme should be extended to cover care and support costs for people living in their own homes. Under the current scheme assistance is only given with the cost of care and support provided in a residential setting and care in an individual's own home is provided, in the majority of cases, by the Committee *for* Health & Social Care. There may be cases where individuals do not receive services to meet all their needs through Health *&* Social Care Community Services (typically because the Community Care Team and other operation units involved in delivery lack sufficient capacity to deliver the level of care required) and are unable to afford to buy in additional care from private providers.

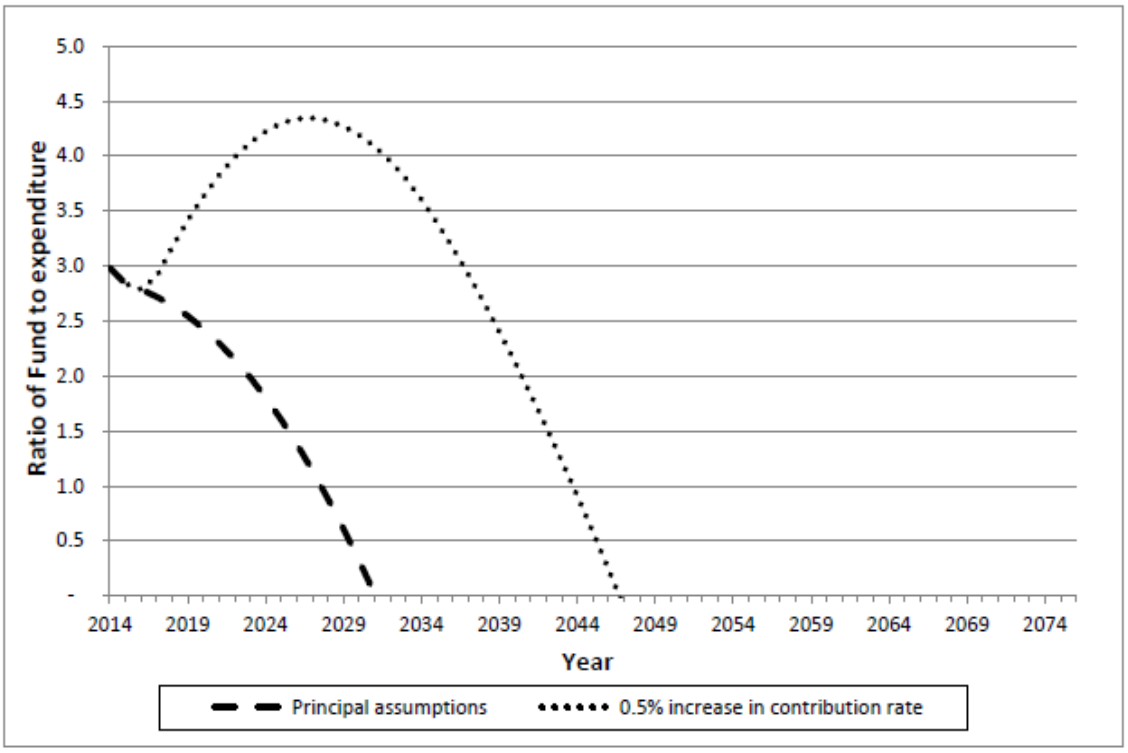
4.15. In such cases the division of care between the two separate systems may influence care choices for both medical and care professionals when they are assessing their client's care needs[7]. It may also influence the choices of the individual. As a result, recommendations for residential or nursing home care may be made where, with the right care package in place, the individual might have been able to remain in their own home.

Issue 5: The Long-Term Care Fund is not financially sustainable

4.16. The 2014 Actuarial Review projected that the LTCF would decline rapidly from 2014 and be exhausted by 2031. Subsequently, following approval of SLAWS and in accordance with the resolutions, contributions were increased by 0.5% from 1 January 2017 to bring the Long-term Care element of the contribution up to 1.8%. This was a first step in securing the sustainability of the Fund. The impact of the additional 0.5% has been to extend the projected life of the LTCF by 15 years (See Figure 4.7 overleaf).

[7] In the 2014 Initial Report for the Supported Living and Aging Well Strategy (SLAWS) Working Party member Melinda Philips wrote "the long-term care insurance while admirable in conception, only offers payments to people moving into private nursing and residential homes. It does not provide help to people who wish and are able to stay in their own homes or live in supported housing, even if they have the same needs. This has resulted in moves to residential and nursing care before it is needed."

Figure 4.7: Projected progress of the Long Term Care Fund (UK Government Actuary's Department 2014 Review)



4.17. However, this was only an interim measure to provide sufficient time for larger reforms to be developed. Even after the 0.5% increase in contributions in 2017 it is projected that the Long Term Care Fund will be exhausted by 2047 if no further changes are made to the scheme.

4.18. The latest internal analysis estimates that an increase in the contribution rates to 2.45% (an increase of 0.65% or additional revenues of approximately £11m-£12m a year) would be required to provide financial stability to the scheme in its current form. Actions to resolve issues 2 and 3 increase the level of additional revenues required.

5. The challenges in resolving the issues

5.1. Finding an acceptable solution to the whole suite of issues is complex. Action to resolve one issue can complicate or limit the solutions available to others. Other choices raise fundamental questions about what represents a fair and equitable distribution of the cost burden across the community and between generations.

5.2. The Committee has struggled to resolve these challenges and the dilemmas they present are outlined here to facilitate debate on this issue.

Challenge 1

5.3. Increasing the minimum amount payable for a care bed to stabilise the market and encourage investment to meet demand requires either an increase in the minimum amount individuals must pay for themselves, which some people cannot afford, or an increase in the benefit paid which makes the financial sustainability of the scheme worse.

5.4. To stabilise the market the Committee considers it necessary to increase the total value of the States rate to the mid-point benchmark indicated by the LaingBuisson benchmarking analysis. This should improve the financial position of those providers whose financial position is not sustainable, promote investment in the market to meet the longer term demand and potentially reduce the level and prevalence of top-ups in the market.

5.5. There are two possible approaches to this. The first is to increase the benefit rates by the full amount required to bring the total to the required amount. However this places an increased financial demand on a Fund which is already unsustainable. As described previously, the scheme as it stands would require an increase in social security contributions of 0.65% (or approximately £11m-£12m p.a. of additional revenue) to become financially sustainable. If the benefit rates are increased to this extent (and nothing else is changed) the level of additional contributions required would increase to 0.95% (or £17m-18m p.a.).

5.6. However, at present the minimum co-payment (£209 per week) does not cover the minimum estimated cost of an individual's accommodation and living costs, which is calculated at £280 per week. Following the debate on the 2016 SLAWS Policy Letter, the States resolved to agree in principle that the Fund should be used to meet the costs of care and support only and that individuals should pay for their accommodation and daily living costs. The Committee is therefore recommending an increase in the co-payment to £280 per week over two years (Proposition 6)

5.7. If part of the increase is met by increasing the co-payment to this level over 2 years, the required increase in the contribution rate could be reduced from 0.95% to 0.80% (or £14m-£15m p.a. of additional revenue). If the mid-point estimate of accommodation and daily living costs indicated by the LaingBuisson analysis is used the co-payment would be increased to £350 (broadly the same as the level of co-payment applied in Jersey). This would enable a slight reduction in the benefit level while still increasing the total value of the States Rate. As a result it would reduce the contribution increase required to stabilise the Fund further to 0.60% (or £10m-£11m p.a. of additional revenue).

5.8. The Committee recommends a position where part of the cost of stabilising the market is met by an increase in the benefit rate and part by an increase in the co-payment to the minimum accommodation and daily living cost indicated by the LaingBuisson Benchmark (Propositions 2, 3, 6 and 7).

5.9. There are also issues with finding suitable placements for individuals with very complex care needs, where the level of care required may exceed that which private and third sector providers can meet within their standard charging framework. At present, such individuals are usually cared for in the States- run 'Lighthouse' wards (see Section 8) at considerable additional cost. While the most extreme complex cases are likely to remain in publically provided facilities, the analysis suggests that if greater provision for more challenging cases can be made in the private sector there is the opportunity for savings. Further work is required on this complex case rate and the criteria under which it is to apply. The provisional rate of the benefit is £1,112 per week in 2020 terms.

5.10. The Committee recommends in-principle approval of an exceptional or complex need rate to assist in the placement of individuals whose needs exceed that which would be covered by the standard provision (Proposition 9).

Challenge 2

5.11. Increasing the co-payment so that individuals are responsible for meeting (in broad terms) their own living and accommodation cost has knock-on effects on the income support system and transfers a portion of the 'saving' made by the Long-Term Care Fund to general revenue.

5.12. At present approximately 30% of individuals in receipt of the Long-term Care benefit also receive income support to help them meet the cost of their minimum co-payment at an estimated annual cost to general revenue of £0.6m.

5.13. As described above, the Committee is proposing an increase in the minimum co-payment to £280 over 2 years. If the co-payment is increased to this level the estimated percentage of pensioners who would qualify for income support to assist with the payment of their minimum co-payment is expected to increase from 30% to between 40% and 45%.

Table 5.1 Estimated percentage of LTC benefit claimants entitled to income support to assist with co-payment costs at different levels

	Minimum co-payment £209 (2020 level)	**Minimum co-payment £280**	**Minimum co-payment £350**
Without inclusion of property assets in IS assessment	Approx. 30%	40%-45%	45%-50%
With property assets in excess of £350,000 included in IS assessment	15% - 20%	20% to 25%	20%-25%

5.14. The means that an increase in the co-payment would result in an increase in the cost of providing income support. Increasing the minimum co-payment from £209 to £280 a week would reduce the Fund expenditure in 2022 by an estimated £1.8m[8] a year but could increase the cost of providing income support by between £0.7m and £1.1m[9]. The total net reduction in States expenditure is therefore reduced to between £0.7m and £1.1m a year (at 2020 prices) (see Table 5.2).

5.15. The available data shows that approximately 75% of pensioners own their own property. The majority of these will be unencumbered since mortgage lenders do not routinely allow people to extend their mortgages beyond the state pension age and equity release in retirement is rare in Guernsey. It is estimated that the mean average value of assets owned (or co-owned) by pensioners in Guernsey is approximately £620,000.

5.16. It has been a fundamental part of the Scheme since its design and implementation, that the capital value of the property which a person vacates immediately prior to moving to a care home is ignored where that person claims assistance from income support to assist with the co-payment.

5.17. The requirement rate under Income Support legislation for a person living in a residential or nursing home is the sum of the co-payment and the personal allowance. Those amounts in 2020 are £209.37 per week and £36.00 per week respectively, giving a total of £245.37 per week. This combined total is more than the full rate of States pension, which is £222.58 per week. This means that a person with a full rate pension, but no other income or capital other than the value of the home that they had vacated, would be eligible for

[8] The total spend from the LTCF in 2019 was £20.4m

[9] These are broad estimates based on the income distribution of households aged over 65

income support when going into a care home, without any value being attached to the former home.

5.18. The Committee takes the view that this level of protection of the former home is no longer justifiable. Rather than switching to a position of fully valuing the former home, the Committee believes that there is a compromise position where the value of the former home in excess of £350,000 should be taken into account in the assessment of eligibility for income support. The Committee acknowledges that there is a need to protect the position of a spouse, partner or dependant relative who may still be resident in the property. The Committee also notes that a person who vacated a house valued at, say, £400,000 while no longer being eligible for income support may not readily be able to access some of that capital. The Committee, therefore will not seek to implement this proposed new rule until such time as a deferred property loan scheme is available. The Committee believes that there are advantages in such a loans scheme being States-run or supported, so that interest rates are kept at a reasonable rate and that unnecessarily large loans are not initially required.

5.19. The Committee recommends, in principle, changing the income support rules so that, for those in receipt of Long-term Care benefit, the value of their residence in excess of £350,000 is included in their assessment for income support to meet the cost of their co-payment (proposition 16).

5.20. As shown in the Table 5.2 this could make significant cost savings for income support but the application of this recommendation should be dependent on the introduction of a suitable deferred loan scheme to support people who may need to release value from their properties (proposition 15).

5.21. Income support for those in receipt of Long-term Care benefit and deferred loans schemes are covered in more detail in Sections 11 and 12.

Table 5.2 – Estimated net saving to the Long Term Care Fund from an increase in the minimum co-payment from £209pw to £280pw (presented at 2020 prices).

		2022	2032	2042	2052	2062
	Annual change in expenditure of the Long Term Care Fund	(£1.8m)	(£2.8m)	(£4.1m)	(£5.3m)	(£6.4m)
Without a change in IS policy	Annual change in IS costs	£0.7m-£1.1m	£1.0m-£1.7m	£1.5m-£2.5m	£1.9m-£3.2m	£2.3m-£3.8m
	Net change in **total** States Expenditure	(£0.7m-£1.2m)	(£1.1m-£1.8m)	(£1.7m-£2.7m)	(£2.2m-£3.5m)	(£2.6m-£4.1m)
With property assets in excess of £350,000 included in IS assessment	Annual increase in IS costs	£0.2m-£0.3m	£0.3m-£0.5m	£0.4m-£0.7m	£0.6m-£1.0m	£0.7m-£1.0m
	Net change in **total** States Expenditure	(£1.5m-£1.7m)	(£2.3m-£2.3m)	(£3.5m-£3.7m)	(£4.5m-£4.9m)	(£5.4m-£5.5m)

Challenge 3

5.22. Expanding the scheme to cover care in an individual's own home offers opportunities to improve patient choice but adds significantly to the financial challenges faced by the scheme. However, not extending the scope of the Long Term Care Scheme will not remove the need to provide these services and the increasing demand for community based care services will need to be addressed in some other form if it is not incorporated within the recommendations of this Policy Letter.

5.23. The projected exhaustion of the Fund in 2047 by the UK Government Actuary's Department was based on Long-term Care benefits providing assistance with residential, EMI and nursing care in care homes only, but a substantial amount of Long-term Care is provided in peoples own homes.

5.24. The Health & Social Care Community Care Team currently provide most of the formal community care in the island free of charge to the user. A small number of private care agencies also provide additional nursing and personal care and support at the users cost. Care is provided in users own homes, in extra-care housing and in residential care settings when more specialist nursing support is needed.

5.25. The care delivered covers long-term nursing, social care, home help and sitting services and cost approximately £5m in 201910. The demand for these services is expected to rise significantly as the population ages and the projected cost of delivery is expected to rise with it.

5.26. The States agreed in principle in 2016 to extend the scope of the scheme to cover care in an individual's own home, which means an additional cost to the scheme which is already financially unsustainable. Table 5.3 below provides estimates of the projected cost to the Fund of incorporating these services within its scope.

Table 5.3 – Projected cost of providing care at home

	2022	**2032**	**2042**	**2052**	**2060**
Estimated cost of care at home within the scope of the LTCF	£6m	£8m	£11m	£14m	£15m

5.27. The Committee recommends continuing the in-principle decision to expand the scope of the scheme to cover care in an individual's own home and recommends developing detailed plans for implementing these recommendations (proposition 11). This adds an additional 0.4% (£9m - £10m revenue income p.a.) to the contribution rate increase required to stabilise the LTCF over the long term.

5.28. Whether or not the States choose to accept the Committee's recommendation to formally bring these services into the scope of the Fund, the need for greater provision of community based care services will need to be met. If this is not done through the LTCF the responsibility is likely to fall on the Committee for Health & Social Care to develop an alternative solution and for the increasing costs to be met from general revenue.

5.29. Depending on how the implementation is structured, this could transfer a significant amount of expenditure from general revenue to the LTCF. Part of the financial solution may be to use the net saving to general revenue to establish a 'revenue grant' to the LTCF to meet part of the on-going cost. While this would run counter to recent moves to remove general revenue grants from the Social Security Funds, the Committee would none-the-less wish to see this considered as an option as part of the funding solution within the forthcoming tax review (Proposition 18).

[10] This incorporates both Long-term Care packages and some acute and rehabilitation service which would not be covered by the LTCF and these are excluded from the modelling. Estimates also include an allowance for an under provision of long term home care services in the current model

Challenge 4

5.30. To resolve the financial challenge solely by increasing contributions places the most significant lifetime cost burden on the youngest in our community and is particularly disadvantageous to those who may not benefit from inheriting wealth from older relatives. It also raises the overall level of taxation in Guernsey. However the alternative, to require those with significant income or assets to self-fund a limited portion of their own care costs, is publically and politically challenging and seen by some as incompatible with the original stated intentions of the scheme.

5.31. As the system currently stands, if no changes are made, the LTCF will be exhausted by 2047. This means almost no one in our community currently aged under 50 will benefit from the scheme in its current form, despite having paid contributions towards the scheme since 2003.

5.32. The proposed solution to the previous challenges described only adds to this problem. If the States approves propositions X to X the net result will be to bring forward the point of exhaustion of the Fund from 2047 to 2034 and the contribution rate increase required to avoid such exhaustion and to stabilise the Fund will rise from an estimated 0.65% (or £11m-£12m additional revenue per year) to 1.30% (or £24m-25m additional revenue per year).

5.33. To meet this challenge solely by increasing the contribution rate places the largest burden on the younger members of our community who will in effect, be meeting part of the underfunding of the cost of providing care for their parents and grandparents as well as their own over the course of their lifetime.

5.34. Considered over a single year, the structure of the contributions system means that increases in contribution rates sit most heavily with those of working age (see Table 5.4). Pensioners for example are charged contributions against all their income, rather than just their earned income, but get an allowance of £8,460 per annum, which is not available to employed or self-employed people. Pensioners also do not pay contributions at all if their income is less than £18,720 a year. As a result, increases in contributions tend to affect those of pension age less than those of working age when considered as a percentage of their total income.

Table 5.4 – Estimated average impact of increasing contributions by 1.3% on household income

Household composition	Change in total amount of contributions paid as a % of gross income	Change in contributions liability (£)
One adult (16-64)	1.0%	£494
One adult (16-64) with child(ren)	0.8%	£398
One adult (65 or over)	0.4%	£166
Three and four adults (16-64)	1.1%	£1,335
Two adults (16-64)	1.1%	£1,007
Two adults (16-64) with child(ren)	1.1%	£1,167
Two adults (65 or over)	0.5%	£370
Two adults (one 16-64, one 65 or over)	0.8%	£572
Average across households	0.9%	£724

5.35. Considered across the course of a lifetime the difference is even greater. Someone aged 20 in 2020 with an income at median earnings might be expected to pay between £30,000 and £35,000 towards Long-term Care over the course of their lifetime at the current rates. If contribution rates are increased by 1.3% they might expect to pay a further £25,000. The life time contribution of someone with a similar lifetime income aged 65 in 2020 would be approximately £13,000 at the current rates and they would pay an additional £2,500 if the rates were increased by 1.3%.

5.36. This situation is particularly disadvantageous for those who do not stand to benefit from inheriting property from older relative and therefore do not benefit from the protection of their relatives principal residence.

5.37. It is estimated that between 50% and 70% of individuals will require Long-term Care services in some form during their lifetime. The average cost of these services for those who do require support is estimated at between £60,000 and £80,000. On a risk adjusted basis the average person could therefore spend around £42,000 on Long-term Care cost11.

5.38. Without making any consideration of long-term investment returns on contributions held in the LTCF, a young person beginning work today earning median earnings would therefore be expected to pay £15,000 more in to the LTCF than they would be expected to claim from it across the course of their lifetime if the financial issue is solved solely by increasing contributions. For

[11] Assumes likelihood of needing care of 60% and an average claim cost of £70,000.

the 50% of the population who will have earnings above the median, the level of lifetime overpayment will be even higher. This over-payment will serve to subsidise the care of their parents and grandparents, who will not have paid enough in to the Fund to meet the full cost of their care because they will have made fewer contributions during their lifetime (contributions to the Fund began in 2003 at a lower rate).

5.39. The alternative is to ask those with greater resources to pay more towards the cost of their own care if and when they receive it. Both Jersey and the UK apply such systems. In England an individual is expected to use almost the entire value their assets (only £14,250 is fully protected) before local councils are expected to meet an individual's care costs in full. In Jersey, a scheme was introduced in 2014 which required those with significant income, a primary residence valued at more than £419,000 or other assets in excess of £25,000, to fund up to the first £57,590 of their care costs (or £86,390 for a couple). More detail is provided in Section 14.

5.40. Guernsey's current scheme is substantially more generous than that of England or Jersey. It operates universally and takes no consideration of people's income or assets when assessing their entitlement for LTC benefit. Everyone who meets the residence criteria and has an appropriate Needs Assessment Certificate is entitled to claim the full level of LTC benefit. Only if they need income support to assist in meeting the cost of their co-payment are they subject to financial assessment and at present this financial assessment specifically excludes the value of their primary residence.

5.41. The residence requirement for eligibility to Long-term Care Benefit, is that the individual has been ordinarily resident in Guersney for a minimum of 5 years continuously at any time and has been ordinarily resident for at least one year immediately before benefit is claimed. The Committee has considered whether there is merit in increasing the 5 year test to a longer duration. However, examination of claims has shown that the great majority of people receiving long-term care benefit have lived in Guernsey considerably longer than the test period. The Committee is not persuaded, therefore, that there is a need to extend the qualification period.

5.42. Changing the scheme to require those with more wealth to pay a limited additional amount toward the cost of their care and support is the most effective way of reducing the need to increase contributions. Some will feel that it is inconsistent with the original insurance principles of the Scheme and the way in which it was presented to the general public at its inception. The Committee acknowledges this view. However, it considers that, given the scale of the financial challenge, it is important to question whether the principle that the Fund, and by inference contributions paid by the whole community, should protect the entire value of people's property assets and

inheritance from the potential cost of providing them with Long Term Care Services is still valid and sustainable.

5.43. An equitable solution for both those needing Long-term Care and the working age population who are contributing more for their longer working lives is essential. The Committee presents an example of how such a scheme might be applied in Guernsey.

Options

- To devise a scheme similar to that applied in Jersey where an individual assessed as having the means to do so is expected to meet a maximum of the first £35,000 (or £50,000 for a couple) of the costs that would otherwise be met by Long-term Care benefit (referred to as 'care costs').
- Such a scheme would include financial assessment of an individual's income and the value of any assets, including their primary residence, above the value of £350,000[12].
- Once an individual's care cost liability had been met they would be entitled to receive Long-term Care benefit in full.
- Where resident in a care home, individuals would continue to pay their co-payment, considered to represent the cost of their accommodation and daily living expenses, after their care cost has been met, together with any additional fees that may be agreed with their care provider.
- The scheme would need to be supported with a suitable deferred loan scheme, although the experience in Jersey suggests that a limited number of households choose this route to finance their care costs.
- A scheme of this nature would reduce the contribution increase required to stabilize the fund from 1.3% (£24m - £25m additional revenue per year) to 0.9% (£16m to £17m).

5.44. More detail on how this or other options might work and summaries of the schemes operating in England and Jersey appear in Section 11. The Committee notes that if these sort of measures are introduced to the Long-term Care Insurance scheme, their design will have to include consideration as to whether they should apply to people already in care and receiving benefit as well as new entrants. Transitional provisions may be necessary .

[12] Individuals would be able to opt out of the assessment process and opt to pay the care cost contribution without assessment if their assets were above this limit

6. Establishing the appropriate benefit and co-payment levels

The LaingBuisson Benchmark analysis

6.1. The analysis of what the appropriate levels of benefit and co-payment should be was approached by undertaking a comprehensive analysis of the yearly accounts submitted by the care homes and using a benchmarking toolkit[13] which had been devised by health and community care analysts LaingBuisson[14] in conjunction with the Joseph Rowntree Foundation. The aim was to provide a transparent and robust means of calculating the reasonable operating costs of efficient care homes. The toolkit is adaptable and the benchmark model was extensively adapted to reflect the economics of operating in Guernsey[15]. This enabled a more granular view of care home costs than the published accounts alone, and provided an independent, market-based expectation of profitability. The costs from the benchmark model were mapped to either care and support, accommodation or day to day living.

6.2. The LaingBuisson benchmark model acknowledges that in order to be sustainable, homes need to make reasonable profits. The benchmark included provision for profits at the same level as the UK benchmark requirement, which is the sum of a 6% return on the expected capital costs of a care home property plus a 10% return on operating costs. This benchmark return on capital is intended to be sufficient to fund a new purpose-built home. In practice many homes are older with lower capital values. For this reason the benchmark profits, and therefore fees, have been stated as a range. The lower limit, the 'Floor' is for older homes, and the upper limit, the 'Ceiling' is for new, purpose built homes.

6.3. The analysis establishes the following benchmark for the provision of care beds across the three bed types (see Table 6.1). The total benchmark rate covers the cost of care and living and accommodation costs.

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13 The LaingBuisson toolkit it is a market standard toolkit for calculating a fair market price for care.

14 LaingBuisson a leading healthcare business intelligence provider and is the chosen provider of independent sector health care market data to the UK government's Office for National Statistics. In 2018 was awarded the contract by the Department of Health and Social Care to review the NHS-Funded Nursing Care Rate in England.

15 All the care homes in the Bailiwick were invited to complete a questionnaire based on the toolkit and this was followed up with individual interviews. Responses were received from the majority of homes

Table 6.1 – Benchmarks for the provision for residential EMI (dementia) and nursing care beds.

		Residential care	EMI Care	Nursing care
At 2018 prices	**Benchmark floor**	£703.00	£833.00	£1,103.00
	Mid-point	£768.00	£921.00	£1,169.00
	Benchmark ceiling	£833.00	£986.00	£1,235.00
At 2020 prices	**Benchmark floor**	£734.00	£893.00	£1,151.00
	Mid-point	£801.00	£961.00	£1,220.00
	Benchmark ceiling	£869.00	£1,029.00	£1,289.00
2020 States rate value (Co-payment plus LTC benefit)		£673.00	£821.00	£1,075.00

6.4. As demonstrated above the current States rate is insufficient to meet even the floor of the calculated benchmark on all bed types. This means that the amount the States pays for a bed is insufficient to cover the cost of its provision with a reasonable return, even in an older home. This has manifested itself in instability in the private and third sector provision of care beds, the charging of top-ups on the majority of beds and low profits or financial losses in some areas.

6.5. The position is different in different sectors of the market and a summary of the financial position of the various care home types based on their 2018 accounts is provided below:

<u>For residential homes</u>

- Costs in Guernsey commercial residential homes generally compared well to the Guernsey benchmark but tended to exceed the benchmark in smaller homes[16]
- The basic States Rate was below the bottom of the range anticipated by the benchmark for residential beds
- Actual rates charged, inclusive of top ups were reasonable or low compared to benchmark
- Profits appear low
- Residential homes providing EMI (dementia) care attract a higher basic States Rate and profits are reasonable

[16] The LaingBuisson view is that homes with fewer than 25 beds are likely to make inefficient use of care staff.

For nursing homes

- Costs in Guernsey nursing homes appear slightly high compared to the benchmark
- The basic States Rate was below the bottom of the range anticipated by the benchmark for nursing beds
- However, Top Ups are generally high for these homes, and the average fee rate including Top Ups was at the top end of the range anticipated by the Guernsey benchmark.
- Profits in nursing homes and mixed nursing and residential homes appear reasonable or high. They vary considerably between homes, but on average are in the top half of the range anticipated by the benchmark. In three cases profits exceeded the upper limit of the benchmark range, suggesting that in these cases Top Ups could be reduced, or more beds offered at States Rates, while maintaining good profits.

Not for profit homes

- Costs are much higher in 'not for profit' homes than commercial homes and high compared to the benchmark. On average, these homes have higher care hours per bed, pay their staff more and incur higher non-staff costs.
- In 2018, none of the six 'not for profit' homes achieved a reasonable operating surplus, and four of them incurred a material operating deficit after rent payments. In two of these four cases, this deficit appeared to be structural and enduring. Deficits are substantially funded by charitable income, though it was not clear from the review how sustainable this was.

6.6. This analysis was also performed three years earlier, using 2015 accounts and 2016 questionnaire responses. A comparison shows that over the three years 2015 to 2018 the average profitability of both residential and nursing homes has deteriorated, when compared with the benchmark expectation of reasonable profits.

6.7. The Committee considers that, in order to ensure stability in the care home market and encourage investment, the total States rate should reflect the mid-point of the benchmark derived above. The Committee would seek to achieve this over a two year period by increasing both the benefit level and the co-payment. Given the current pressure facing care homes and the real risk to some not-for-profit homes in particular, the Committee is seeking an immediate increase in the benefit rates in October 2020 to the level outlined in Table 6.2 overleaf.

Table 6.2 – Proposed Long-term Care benefit rates from 5th October 2020

Residential Long-term Care benefit	£521.00	(current rate £463.89)
Residential care respite care benefit	£750.37	(current rate £673.26)
Residential EMI Long-term Care benefit	£681.00	(current rate £611.24)
Residential EMI respite care benefit	£910.37	(current rate £820.61)
Nursing Care Long-term Care benefit	£940.00	(current rate £866.11)
Nursing Care respite care benefit	£1,169.37	(current rate £1,075.45)

6.8. The Committee is grateful to the Presiding Officer for allowing the ordinance necessary to give effect to these new rates to be considered by the States at the same time as this Policy Letter.

6.9. An increase in the co-payment to £280 will be phased in over 2 years. The first increase of £20 will be applied in October 2020 and will be enacted if the Ordinance at Appendix 2 is approved. Combined, these measures will bring the States rate above the benchmark floor in October 2020 and transition this to the benchmark mid-point by January 2023.

6.10. The Committee recommends that a review of the adequacy of benefit rates should be conducted in conjunction with each actuarial review of the Long Term Care Fund to ensure that benefit rates remain appropriate. Additional or interim reviews should be conducted by the Committee for Employment & Social Security if there is evidence of significant pressure on the cost of delivering Long-term Care services. Such pressure could include a significant upward pressure on staff costs in order to maintain competitive rates of pay in response to increases in the pay of public sector nurses and carers.

<u>Separating the cost of care and support from the cost of accommodation and daily living expenses</u>

6.11. The benchmark analysis also separated the cost of beds between the provision of care and accommodation and living costs. This analysis showed that the level of the co-payment was lower than it should be if the SLAWs principle that individuals should be responsible for their accommodation and daily living expenses is adopted[17]. The co-payment would need to rise to between £270 and £400 a week at 2018 prices (£280 and £415 a week adjusted to 2020 prices) to reflect the true accommodation and daily living expenses incurred in a residential or nursing home.

6.12. The States of Jersey co-payment in 2020 is £345.80, whereas the minimum co-payment in Guernsey is £209.37.

[17] See Appendix 5 for the results of the benchmarking of care home costs

6.13. The SLAWS Working Party considered that while it would be possible to increase tax or social security contributions to cover rising costs, there was a limit to the extent that this was desirable, particularly in the knowledge that the ageing population would create cost pressure in other areas of government such as healthcare and pensions[18]. The extent of these costs has become clearer in the intervening years and was discussed in the January 2020 Policy Letter titled 'The Review of the Fiscal Policy Framework and Fiscal Pressures'[19].

6.14. As a result, the balance between the amount that the States pays and the amount that the individual pays needs to be considered. Using earlier work carried out by the Funding of Long-term Care Working Party it was acknowledged that the charges for residential accommodation could be broken down into three separate components:

- day to day living expenses (e.g. food, clothes)
- accommodation costs (e.g. rent, service charge)
- care and support costs (e.g. the wages of a professional carer)

6.15. The results of the SLAWS public consultation question on 'Where people can afford to pay, should the States or the individual bear more responsibility?' found that the majority (60%) of respondents supported the individual being all or largely responsible for funding living cost. There was a majority (56%) expectation that the States should cover all or most of care costs (Article XIV of Billet D'État No. III of 2016, Volume II p 734).

6.16. Public opinion was divided on accommodation costs. However, it was argued that 'Living and accommodation costs are common to everyone in the Islands, so it was arguably inequitable that those people who receive care and support in residential or nursing homes have some of the costs met by the States via tax funding, when tax payers more generally may be struggling with these costs and many of those receiving care are in a position to cover these expenses. Care costs, on the other hand, are hard for individuals to predict or plan for, and may be best met by the States.' Further, if the scheme is to be extended to include care provided in an individual's own home it would be inconsistent to expect those receiving benefit for community care based services to meet their own living and accommodation costs in full while the benefit rates for those receiving care in a care home included an implicit partial subsidy on their living and accommodation costs.

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[18] The Supported Living and Ageing Well Strategy (Billet D'Etat III of 2016, Volume II, Article 14, page 605)

[19] The Review of the Fiscal Policy Framework and Fiscal Pressures (Billet d'État No. I of 2020, Article V).

6.17. It was recommended, therefore, that the States should 'seek to continue to pay all or most of the care and support costs across all care settings (if possible), individuals could be asked to contribute more to cover their living and accommodation costs where these are being subsidised presently.'

6.18. This concept is not unique. Many countries around the world have schemes to assist with care costs, some requiring a contribution towards the cost of care, but day-to-day living costs remain the responsibility of the individual; means tested assistance being provided for those who have limited resources.

6.19. Scotland introduced free personal care for people of over 65 years in 2002. While personal care would be free both in a residential setting and a person's own home the accommodation and day to day living costs would remain the responsibility of the person receiving care in either setting.

6.20. In 2011 the Commission on the Funding of Care and Support, chaired by Andrew Dilnot published its report, Fairer Care Funding. Its key finding was that the system for funding Long-term Care in England was not fit for purpose and needed urgent reform. Among its other recommendations the Commission supported the expectation for individuals in residential accommodation to make a contribution towards their general living costs, just as they would be expected to meet the costs of living at home.

6.21. The SLAWS Policy letter recommended that individuals should be responsible for the daily living and accommodation charges that they might incur while receiving Long-term Care, but the LTCF should be used to meet the costs of care and support. The rationale for this change was to ensure parity of treatment for those receiving Long-term Care in a residential or nursing home and those who remain in their own homes who would be responsible for their accommodation costs such as rent, mortgage, utilities and daily living expenses such as food and toiletries. The States agreed in principle to this recommendation.[20]

6.22. The Committee for Employment & Social Security supports this principle, particularly in the light of analysis that suggests that the current minimum level of payment towards the cost of a private or third sector care bed is insufficient to support on-going investment or to guarantee the stability of the market as it currently stands. Increasing the minimum personal contribution to align with the assessed living and accommodation costs would offer an opportunity to share the cost burden of stabilising the market between the States and those benefiting from care provision.

[20] See resolution 1c) on the 2016 SLAWS Policy Letter (Billet d'État III of 2016, Volume II, Article 14). The Resolutions following that Policy Letter are set out in Appendix 1.

6.23. However, the Committee is aware that this represents a significant cost increase for claimants and, at this time, proposes an increase in the minimum personal contribution to the minimum cost of living and accommodation cost indicated by the analysis (adjusted for inflation in the intervening years) and are recommending an increase in the minimum personal contribution to £280 over two years as described previously.

6.24. This change has a potentially significant impact on the cost of providing income support in respect of those also in receipt of Long-term Care benefit. The relationship between Long-term Care benefit and income support is described in Section 7 below.

7. Long-term Care Benefit and Income Support

How does it work now?

7.1. Long-term care benefits are based on an insurance principle with eligibility being determined on residency requirements, a Needs Assessment and taking up a bed in residential accommodation.

7.2. There is no financial assessment except where an individual cannot afford the co-payment (currently £209 per week) and to have the availability of a personal allowance (currently £39 per week). In this case a means tested income support claim may be able to assist. Although a property not being lived in would usually be treated as an asset in an income support claim this is not the case when the claimant is living in a nursing or residential home and have vacated their former home. The value of the property is ignored in calculating a person's entitlement to income support. This was a deliberate provision when the scheme was first designed and approved by the States in 2001.

7.3. The individual may be cash poor but asset rich, and, under current arrangements, the tax payer would be financially supporting the co-payment element of the Long-term Care place while the individual owned their former home of significant value. It is not unknown for non-dependent family members to be living in the family home rent free or paying a rent well below market value while a family member in care is in receipt of income support to meet the cost of their co-payment. While any rent paid for the family home would be treated as income in an income support claim, there is no assumption that the property should be let if it is empty, or about the level of rent it would receive if it is occupied by a tenant or non-dependent relative.

7.4. In 2019, it was estimated that providing income support to assist with the cost of co-payments for people in receipt of Long-term Care was £0.6m.

7.5. The Committee is recommending an increase in the minimum co-payment to the minimum cost of living and accommodation cost indicated by the analysis (adjusted for inflation in the intervening years) increasing the co-payment from £209.37 to £280 per week over two years, starting with an increase of £20 per week from 5th October 2020. Work has been undertaken to identify how affordable the level of increase in the user co-payment would be.

7.6. At present approximately 30% of individuals in receipt Long- term care benefit also receive income support to help meet the cost of their minimum co-payment at an estimated annual cost of £0.6m. If the co-payment is increased to £280 a week as recommended the estimated percentage of people who would qualify for income support to assist with the payment of their minimum co-payment would increase from 30% to between 40% and 45%21. If this is increased to the mid-point of estimates of living and accommodation costs (£350) this number would increase further to 45% to 50%.

7.7. This has a significant impact on the cost of providing income support in respect of those also in receipt of Long-term Care benefit. Both the amount of support existing claimants would need and the number of people needing some assistance with meeting their co-payment would increase. Without a change in income support policy and legislation, the increase in the co-payment could save the LTCF £1.8m in 2022, but it would cost an additional £0.7m to £1.1m to provide income support to people claiming Long-term care benefit.

7.8. This reduces the net cost saving to the States by 40% to 60% by transferring costs from the Long-term Care Fund to general revenue. Both the value of the expenditure reduction to the Fund and the increase in the cost of income support will increase over time as demand for these services increases.

7.9. To mitigate this the Committee is therefore also recommending in principle a change in the income support policy and legislation which would bring a person's principal residence with a value in excess of £350,000 into the assessment for means tested benefits for claimants in receipt of Long-term Care benefit to meet the cost of their co-payment and person allowance. This recommendation is subject to the development of a suitable deferred loan scheme which would enable people to unlock some of the capital tied up in their homes.

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21 These estimates are drawn from analysis of 7,830 'pensioner only' households in which there were one or two people aged 65 years or over. The analysis uses data drawn from the Rolling Electronic Census for 2015 and extrapolates estimates of households' income (excluding means tested benefits and rent rebates) their capital assets from data sourced from income tax and cadastre systems.

7.10. It should also be noted that because income support claims across the wider population are assessed on net income, any increase in the contribution rate to improve the financial sustainability of the Fund will also affect the cost of income support payments. The structure of the system is such that the benefit paid to anyone in receipt of income support will automatically be adjusted to compensate for an increase in their social security contributions. It is estimated that each 0.1% increase in the contribution rate adds approximately £50,000 to the cost of providing income support. Section 14 details the contribution, general revenue and other implications of the propositions at various stages.

<u>What does the proposed change in income support rules mean and how might it work?</u>

7.11. The data shows that approximately 75% of pensioners own their own property. The majority of these will be unencumbered since mortgage lenders do not routinely allow people to extend their mortgages beyond the state pension age and equity release products cannot yet be offered in Guernsey. In addition, an estimated 40% of individuals list some form of asset return (bank interest or investment return) which would suggest that many have non-property assets of more than £20,000.

7.12. Under the current income support legislation, the total value of an individual's primary residence and any saving of less than £13,000 (for a single person) are disregarded in calculating a person's resources for the purposes of their financial assessment for assistance with paying their co-payment. In some cases this results in a position where the States are providing means-tested income support to individuals who own a house of a very significant value.

7.13. The cost to general revenue of providing income support to help meet the costs of the co-payment could be significantly reduced if the value of the primary residence was included in the assessment. The Committee proposes that the value of the primary residence in excess of £350,000 (the approximate average value of a two bedroom property in Guernsey) be included in the financial assessment for income support for those claimants also in receipt of Long-term Care benefit. Under such a scheme the value of smaller or less valuable properties will be excluded from assessment entirely, but those owning larger or more valuable properties would no-longer be eligible to claim income support to help meet the cost of their co-payment.

Table 7.1 – Estimated percentage of LTC benefit claimants entitled to Income support to assist with co-payment costs

	Minimum co-payment £209 (Actual 2020 level)	**Minimum co-payment £280**	**Minimum co-payment £350**
Without inclusion of property assets in income support assessment	Approx. 30%	40%-45%	45%-50%
With property assets in excess of £350,000 included in Income Support assessment	15% - 20%	20% to 25%	20%-25%

7.14. A change in income policy and legislation of this nature could reduce the current cost of providing income support to those in receipt of Long-term Care benefit (£600,000) by between £240,000 and £360,000 per annum. Applied in conjunction with an increase in the value of the minimum co-payment, it significantly reduces the transfer of costs from the Long-term Care Fund to general revenue, increasing the total net reduction in States expenditure. The financial benefit of the change in policy would grow over time (see Table 7.2).

Table 7.2 – Estimated net saving to the Long-term Care Insurance Fund and to total States' expenditure from an increase in the minimum co-payment from £209pw to £280pw (presented at 2020 prices).

		2022	**2032**	**2042**	**2052**	**2062**
	Annual change in expenditure of Long-term Care Fund	(£1.8m)	(£2.8m)	(£4.1m)	(£5.3m)	(£6.4m)
Without a change in IS policy	Annual change in Income support costs	£0.7m-£1.1m	£1.0m-£1.7m	£1.5m-£2.5m	£1.9m-£3.2m	£2.3m-£3.8m
	Net change in total States Expenditure	**(£0.7m-£1.2m)**	**(£1.1m-£1.8m)**	**(£1.7m-£2.7m)**	**(£2.2m-£3.5m)**	**(£2.6m-£4.1m)**
With property assets in excess of £350,000 included in the assessment for Income Support claimants receiving LTCB	Annual increase in Income support costs	£0.2m-£0.3m	£0.3m-£0.5m	£0.4m-£0.7m	£0.6m-£1.0m	£0.7m-£1.0m
	Net change in total States Expenditure	**(£1.5m-£1.7m)**	**(£2.3m-£2.3m)**	**(£3.5m-£3.7m)**	**(£4.5m-£4.9m)**	**(£5.4m-£5.5m)**

7.15. Application of a policy of this nature will require a mechanism by which home owners can release value from their home if it is needed. The Committee is therefore proposing that a deferred loan scheme be established to facilitate this (see section 12). Consideration will need to be given as to whether the current income support provisions allowing the value of assets to be taken into account, in calculating a claim, where persons have deliberately deprived themselves of them would need to be strengthened or amended if a deferred loan scheme is introduced.

7.16. In exploring the treatment of personal assets in assessing an income support claim the Committee has been concerned that there should be financial security for couples where one is resident in a care home and their partner or dependent relative remains at home in their main residence. The current income support legislation allows for partners to be assessed separately for income support claims unless, when assessing their resources, it is considered just and equitable for the requirements and resources to be aggregated. It is proposed that this should not change and that while the partner or dependent relative remains at home the value of the property should be ignored in full in any income support claim.

8. Care at home and other public sector care provision

Care at Home services

8.1. Under the current Long-term Care Insurance scheme, assistance is only given with the cost of care provided in a private sector or third sector care home. The majority of care provided in an individual's own home is provided free at the point of use by the Committee for Health & Social Care[22]. The provision of these services is financed from the General Revenue Budget.

8.2. The States' Adult Community Services provide care and support to people from the age of 18 years in their own homes. The services are made up of a number of professional specialties including social work, physiotherapy and occupational therapy as well as nursing and social care provision. The services cover the full spectrum of acute to long-term and palliative care.

8.3. The SLAWS Report identified a number of problems with existing services, for example with the transition between moving from a hospital bed to a person's own home and the lack of capacity to meet demand with the available services, particularly at peak times and at weekends. Respondents to their consultation reported having no control or certainty over what time they would be visited by a member of the Community Services Team.

8.4. The Report considered that community services remained under-developed and this, combined with poor information provision, meant that Islanders may be less aware of what community services were available. This reinforced the historic reliance on residential homes as the service of choice when significant care and support needs arose. The consequence of this was that more individuals may move into more costly, high dependency care settings earlier than is necessary or cost effective.

8.5. In cases where capacity is not available for the Adult Community Services team to meet all an individual's needs and where they are unable to afford additional private care in their own home, this may influence care choices for both medical and care professionals when they are assessing their client's care needs[23] and the individual. This may result in recommendations for residential or nursing home care where, with the right care package in place,

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22 Users of the Home Help Service are charged for the service

23 In the 2014 Initial Report for the Supported Living and Aging Well Strategy (SLAWS) Working Party, Melinda Philips wrote "the long-term care insurance while admirable in conception, only offers payments to people moving into private nursing and residential homes. It does not provide help to people who wish and are able to stay in their own homes or live in supported housing, even if they have the same needs. This has resulted in moves to residential and nursing care before it is needed."

the individual might have been able to remain in their own home. This may, but will not always, cost the States less than paying for a residential care bed.

8.6. There has since been considerable development and expansion of community services including increased capacity and the piloting of a Reablement Service to work alongside the Rapid Response Service. However, as the aim to keep people in their homes for as long as possible and demographics take effect, an increasing number of people are being referred for support. There is also a largely unquantifiable amount of unmet need within the community. Some need is at a level too low to meet the criteria for formal support but some is due to a lack of resources and still more is unknowable; some individuals may be unaware that help is available while others choose to manage alone rather than accept help which they feel they cannot control or afford.

8.7. At home care is provided by Health & Social Care following an assessment carried out by a healthcare professional or social worker using a needs assessment framework. The care is delivered by trained nurses in the Community Team and carers and home help staff in the Social Care Team. The teams respond to the assessed needs of individuals. Care packages may range from a relatively small amount of assistance from a carer or home help assistant, in some cases as little as one hour per week, to 20 or more hours per week with two carers needed for each visit plus additional input and support from a trained nurse.

8.8. The cost of these services currently stands at approximately £5m[24] in 2019, funded through General Revenue. This provides for both acute treatment, recovery and Long-term Care and support at no cost to individuals living in their own homes. The extension of Long-term Care benefit to cover care in the community would mean that where care becomes long-term, and an individual living at home is assessed as needing care services, they would be funded through Long-term Care benefit rather than the Health & Social Care General Revenue budget. The Health & Social Care budget would continue to be responsible for acute and therapeutic community services relating to short-term medical treatment, recovery, rehabilitation and palliative care.

8.9. There are a small number of private care agencies who provide services in people's homes. For the most part they provide social care and support. On occasion they will provide a care package with qualified nursing care but this is infrequent and not readily promoted due to the difficulties of recruiting and employing trained nurses.

[24] This covers Community Nursing, the Social Care Team, the Sitting Service and Community Teams

8.10. The services provided by the care agencies include mainly personal care such as assistance with getting up in the morning, personal hygiene, putting to bed, medication administration, shopping, meal preparation and light housekeeping. They also provide assistance for appointments, chaperoning and companionship. The care packages vary from low level to high dependency with 24 hour full time care on occasion. The agencies have a minimum time requirement per episode of care. At the time the information was provided one agency required visits of not less than one hour duration with a charge of £25 per hour; three agencies had a minimum requirement of two hours per visit charging between £17.50 to £20.80 per hour with higher rates for weekends, Bank Holidays and nights. Shorter visits were considered uneconomical, the business less viable and recruitment of staff more problematic.

8.11. The information provided by the local care agencies indicates the number of people using their services is relatively small with their clients' care packages of varying hours. They report that some people enquire about their services but do not always take them up; sometimes it is due to cost, though not always. Some who do take up care services give them up after a short time, in some cases it is when they realise how much the care services cost. One agency said it was apparent that some individuals, particularly the elderly, refuse care even when their children are struggling to help them and are paying for the services.

Extra-care housing

8.12. When the Long-term Care scheme was being developed there was some debate as to whether sheltered housing should be included in the scheme. It was recognised that as sheltered housing costs were broken down into accommodation, services and care, it could be argued that the latter could be covered by the scheme. At the time there was a significant shortfall of sheltered housing units and the consensus was that Long-term Care benefit should not be extended to cover these forms of provision.

8.13. Since 2001, in keeping with the aim to keep people independent and in their own homes, a considerable programme of building to provide additional supportive housing in the form of extra-care units began. In the intervening period 248 extra-care units have been developed, 85 at Rosaire Court, 73 at La Nouvelle Maraitaine and 90 at Le Grand Courtil.

8.14. Extra-care housing developments comprise self-contained homes that are designed and built with disability-friendly features that enable people to self-care and live independently but at the same time receive an element of care and support services as part of the package. Residents pay rent to the provider and fund their own daily living costs. The care element is provided by

Health & Social Care through General Revenue at no additional charge to the individual and would be included in the Adult Community Services described above.

8.15. The SLAWS report considered extra-care housing to be an alternative to residential or community care services and recommended care delivered in this setting should be funded through the Long-term Care scheme. The States resolved in principle that residents should continue to pay rent to the provider and fund their own daily living costs, only the cost of their care provision would be funded through the Long-term Care scheme.

Lighthouse Wards

8.16. The Lighthouse Wards (Corbiere, Roustel and Brehon) are on the Princess Elizabeth Hospital site and provide specialist residential and nursing placements for people primarily with a diagnosis of dementia who present with behaviours that are challenging or have complex physical health needs. The services are not age-specific but are needs-led however individuals must be in possession of a Needs Assessment Panel Certificate to be considered for admission.

8.17. Roustel ward is specifically focused on complex behaviours associated with mental health conditions (primarily dementia). Brehon ward is for people with both complex behaviours and complex physical health needs. Corbiere ward is a residential facility which deals with individuals who do not have complex nursing needs but have behaviours that are challenging.

8.18. The current capacity across the three wards is 54, inclusive of 2 short-break care beds which provide prearranged short term respite for families and carers. Average occupancy is high with the service usually running at or near capacity. Residents pay a fee equivalent to the Long-term Care Insurance co-payment and are required to pay for GP visits and chiropody etc. In addition, charges are made for continence products. All psychiatric input is free at the point of contact.

The relative cost of care provided in different settings

8.19. The type of care delivered by the Health & Social Care Community Care team has been analysed and broken down into nursing, social care and sitting services at a cost of £5m a year. Analysis of the episodes of care provided by Health & Social Care has also been undertaken to confirm numbers, age of care recipients and length of episodes of care. Some information has also been sought from private care providers to begin to understand the extent and costs of their services as well as an indication of some of the unmet need in the island.

8.20. An analysis of the cost of publically provided social care was undertaken in 2018. This included the Social Care Team, a share of the Community Nurses costs representing care staff in the Nights and Twilights team and a share of administrative staff in the Community team. The result of the analysis indicated a cost of face-to-face social care of £33 per hour in 2018. Inflated to 2020 prices this represents an estimated cost of £35 per hour. This figure was used to calculate low, medium and high home care 'per user' costs using detailed information on service volumes as shown in Table 8.1 below[25].

Table 8.1 – Low, medium and high homecare costs per user

	Number of hours	**Cost per week (at 2018 values of £33 an hour)**	**Cost per week (at 2020 values of £35 an hour)**
Homecare low user	1.8	£59	£63
Homecare medium user	5.6	£185	£196
Homecare high user	11.8	£389	£413

8.21. Generally, the overall cost of providing moderate amounts of care in a home setting is less costly to the government than supporting someone in a care home setting. However there is a tipping point (currently at about 14 hours a week) at which it is more cost effective to provide care in a care home setting. There are a small number of cases where patients are receiving exceptionally high levels of care (more than 30 care hours a week) in their own home.

8.22. The costs of providing an Extra Care housing service to individuals are primarily for care services provided by the Committee *for* Health & Social Care and the provision of the flats (individuals are responsible for their own rent and living costs). The analysis indicated that on average those housed within the Extra Care setting receive between 5 and 8 hours of care a week at an average cost of £212 per week (or £225 at 2020 prices). £197 of that was for the provision of on-site care staff.

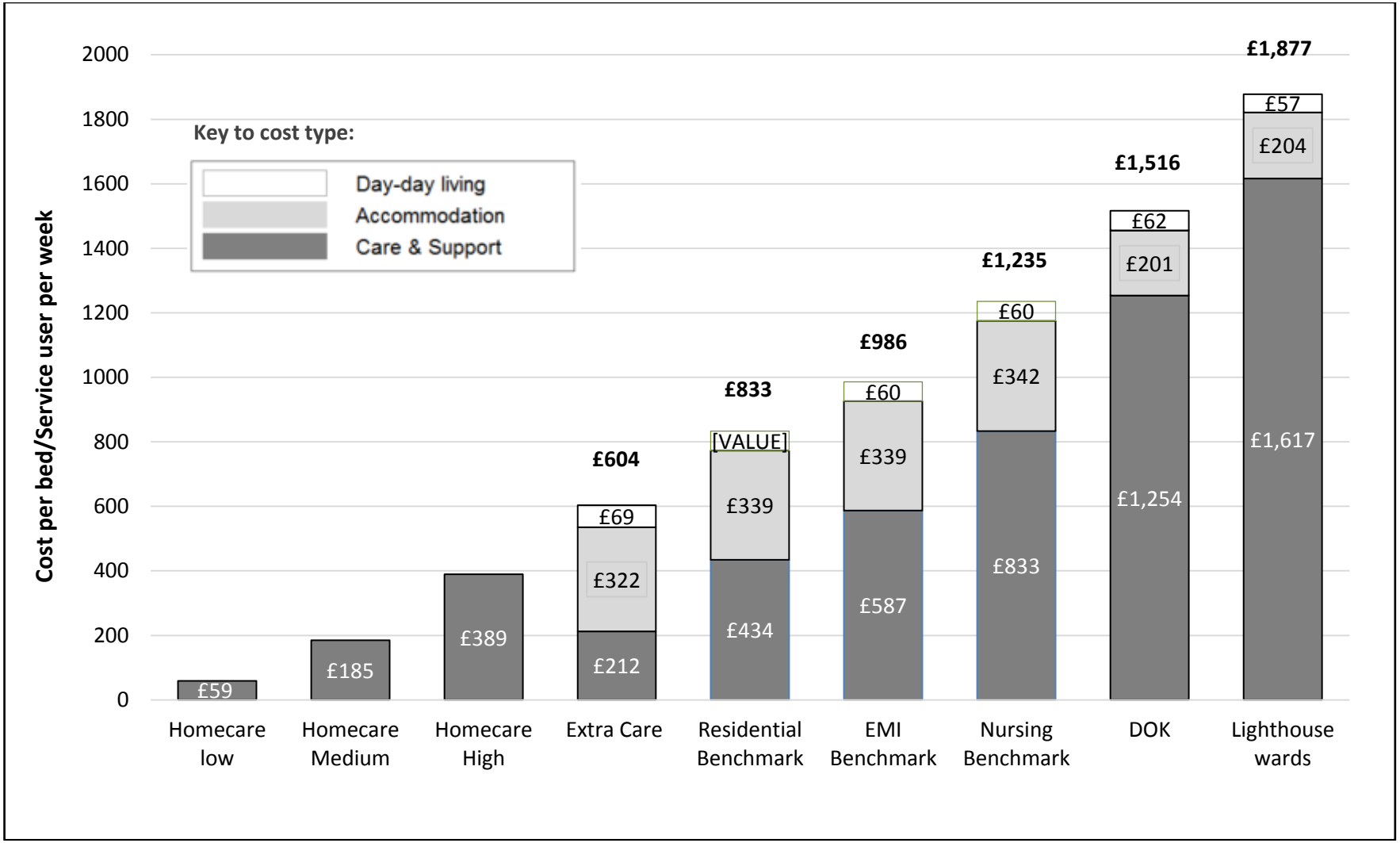
8.23. This exercise was expanded to cover the cost of providing residential care in the Duchess of Kent[26] residential home and the two Lighthouse wards in operation at the time the analysis was undertaken. Adjustments were made to improve comparability with alternate care models which include full accommodation costs.

[25] See Appendix 6 for further details of these calculations

[26] The Duchess of Kent residential services have moved to the third Lighthouse ward in 2019

8.24. In Figure 8.2 overleaf, the costs of these public care models has also been compared to the fees for commercial residential and nursing homes stated at their 2018 Guernsey benchmark ceiling levels.

Figure 8.2 – Costs of care – comparison of public care models with commercial care home benchmarks



8.25. The provision of care in these States operated settings is substantially more expensive than the benchmark level established for private and third sector nursing care. Care costs ranged from £1,254 per week for the Duchess of Kent to £1,617 for the Lighthouse wards. Total costs, which included accommodation and day to day living costs, were £1,516 and £1,877 per week respectively.

8.26. The higher level of costs incurred by providing care in States-operated facilities reflects, to some extent, the level of complexity of cases managed in these facilities. Typically, residents in the Lighthouse wards are those with the most complex care requirements for whom it is difficult to find places in private sector homes. It may also reflect a cost margin associated with public sector provision of services verses private and third sector provision. There are approximately 10 cases where the Committee *for* Health & Social Care make additional payments to care homes, in addition to the standard benefit met by the Long Term Care Fund in order to secure places for people with more complex needs in private sector homes, because this is more cost effective than providing care in the Lighthouse wards.

9. Expanding the provision of the Fund

Complex cases

9.1. It is likely that States-operated facilities will always need to provide care for the most complex cases. However the analysis suggests that, if some of those currently cared for in States-operated facilities at high costs could be accommodated within the private sector, it may be possible to reduce the overall cost of providing more complex care. This may also help in long term planning to ensure that the island as a whole has sufficient capacity to manage a growing number of complex cases.

9.2. The Committee is therefore suggesting that an additional benefit rate be established for complex cases at a rate between the suggested benefit rate for nursing care and the estimated cost of providing care in the Duchess of Kent setting. Provisionally the Committee suggest that this rate be set at £1,112 per week. Work will need to be undertaken in conjunction with the Committee *for* Health & Social Care to establish suitable assessment criteria for the additional rate. Amendments to the benefit rates in legislation would also be required.

Care at Home

9.3. The extension of the benefit to cover community-based care services is intended to provide greater consistency regarding the way in which Long-term Care services are financed. It also provides an opportunity to expand the

provision of services to meet the known (but unmeasured) unmet demand by allowing service users to use private sector providers to deliver their care needs without additional cost to the user.

9.4. The expansion has been modelled on the assumption that this will capture care needs at a lower level than is currently supported by the Long-term Care scheme. The scheme has been modelled with the introductions of two new rates of benefits set below the current level of benefit available for residential care, representing approximately 5 or 10 hours of care per week respectively.

9.5. The expansion of the available support, while it has a cost to the Fund, has the potential to:

- Bring consistency to the funding and assessment of Long-term Care provided in the home and care in residential and nursing homes
- Reduce the number of individuals requiring residential care service
- Reduce the number of emergency hospital admissions among older people due to factors such as preventable falls. The Kings Fund identified access and supply of community care services as a contributing factor to the number of emergency hospital admissions although this is difficult to quantify. The models built by the Kings Fund[27] to assess the potential impact of changes to the UK Social Care system include assumptions of reduction in non-elective admissions for non-surgical patients of between 5% and 20% and a reduction in bed days for these patients by between 14% and 42%.
- Increase the supply capacity of private sector care services and reduce delayed discharges from hospital due to lack of adequate care provision. With assumed savings of between £60 and £200 a bed day, ensuring adequate supply and access to this suggests that delivering a robust Social Care system, including adequate access to home care services, could result in savings for the Committee *for* Health & Social Care.
- Promote greater patient choice in how care is provided. At present Long-term Care benefit is only available to those receiving care in a care home. Expanding the scope of the Fund to incorporate at home care presents the opportunity to let people choose whether they wish to receive care at home or in a residential or nursing home. If, for example, they are assessed as needing a level of care equivalent to the current residential care rate, they could choose to use their benefit towards the cost of providing care in their home. If an individual or their family

[27] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/community-services-nigel-edwards-feb14.pdf

wished to engage a more expensive method of care they would be expected to pay the additional cost themselves.

9.6. The financial modelling assumes that approximately 10% of the cost of services currently provided by the Committee *for* Health & Social Care relate to the provision of short term or rehabilitation care which would not be included within the scope of the Long-term Care Fund. There is also evidence that the demand for home care services currently outstrips the level of supply. Modelling therefore assumes that once the scheme is introduced the market will expand to meet the excess demand for home care services and that this will increase costs above the current level. Given that unmet demand is largely unquantified there is a large degree of uncertainty around these figures.

9.7. Expanding the scheme to incorporate care at home is projected to add £5.6m to the expenditure of the Fund by 2022 and this will increase significantly as the population ages. It is estimated that the inclusion of home care services within the scope of the Long-term Care scheme adds £10m a year to the revenue required to stabilise the Fund, equivalent to an increase in contribution rates of approximately 0.5%.

Table 9.1 – Estimated cost of extending the Long-term Care Scheme to incorporate care at home

	2022	2032	2042	2052	2060
Estimated cost of including Care at home within the scope of the LTCF	£6m	£8m	£11m	£14m	£15m

9.8. While this represents a new cost to the Fund it should be noted that if the States choose not to support the proposition to incorporate home care within the scope of the Fund, the Committee *for* Health & Social Care will continue to support the majority of the costs associated with its provision and the escalating costs of that provision as the population ages. An alternative solution to ensuring the long-term sustainable provision of care at home will be required in some other form.

9.9. The Committee recommend that the expansion of the scope of the Long Term Care Fund to cover care at home should be progressed as resolved in 2016 and are recommending developing a detailed implementation plan in conjunction with the Committee *for* Health & Social Care. These plans should include:

- A minimum care need threshold to be eligible for subsidised care from the Long Term Care Fund

- Lower rates of benefit to support those with care needs below that currently required to meet the threshold for residential care. Provisionally the Committee recommends two lower rates of benefit:

  Home care of up to 5 hours a week: £175
  Home care of up to 10 hours a week: £350

- A scheme whereby claimants receiving a subsidy towards residential or nursing care could in the future have the option of using this subsidy towards care in their own home.
- Criteria for establishing long term need (for example care requirements likely to persist for at least six months or until end of life) which would qualify for a claim from the Long Term Care Fund
- A suitable assessment process capable of establishing eligibility for benefit for those requiring care at home in a time and cost efficient manner.
- A register of approved care providers who are able to provide the subsidised care services.

9.10. Key to these investigations will be identifying what type of care should be covered by the scheme and the time at which a person would become eligible for Long-term Care benefit.

9.11. The experience in Jersey also suggests that ongoing efforts to introduce care regulation should be progressed in anticipation of an increase in the number of private sector providers. This work is currently being undertaken by the Committee *for* Health & Social Care. The main focus is on the establishment of a new regulatory regime for health and care and a review of standards, particularly those that regulate practitioners, care homes and private carers. While care homes are already required to be registered under current legislation and may be inspected by a person authorised by the Committee *for* Health & Social Care, additional regulation under the new proposed legislation would provide more protection for the public in general and especially for elderly and vulnerable users of care services in the community.

9.12. Based on the research conducted to date the Committee makes the following recommendations concerning care at home.

<u>Care at Home services covered within the scope of Long-term Care benefit should cover Activities of Daily Living (ADL) which comprise the basic requirements for daily self-care such as bathing, dressing and eating.</u>

9.13. The provision of care under Long-term Care schemes around the world were explored along with services being provided by the Committee *for* Health and Social Care and private providers in Guernsey. Most schemes around the

world provide support with Activities of Daily Living (ADL) which comprise the basic requirements for daily self-care such as bathing, dressing and eating. Some schemes also provide additional support for activities that are not fundamental to functioning but assist with independent living, known as Instrumental Activities of Daily Living (IALD)[28]. The latter are usually provided in countries with comprehensive Long-term Care coverage such as the Nordic countries[29]. The cost of such schemes is significant and it is notable that in recent years these countries have been making changes to address the sustainability of their schemes. The solutions are principally to reduce benefits or target higher levels of need by increasing eligibility requirements.

9.14. The Committee considers the community care to be funded under the Long-term Care scheme should reflect as far as possible the services currently being provided through the Health & Social Care Community Care Teams and the personal care being delivered by private providers. Funding would cover assistance with self-care, both nursing and personal care needs (ADLs) where it was assessed as being a long-term need. Housekeeping and domestic services (IADLs) would not be covered. These latter services are generally excluded from all but the most comprehensive (and expensive) Long-term Care schemes as a measure to control costs and manage sustainability. It should be noted that users of Health & Social Care Home-help Services are currently charged for this service[30].

9.15. Health & Social Care provide a range of specialist services which also deliver care in the community. These services include:

- Older Adult Mental Health Services
- Adult Mental Health Services
- Disability Services – includes physical and learning disabilities and group homes
- Condition related services including palliative care

9.16. These services are funded under the Health & Social Care General Revenue budget and are not within scope for funding under the Long-term Care scheme.

28 See Appendix 7 for further information on social care provision

29 Help wanted; long-term care financing arrangements in OECD countries

30 This charge is not applied to users in receipt of income support.

Long term care should be defined as care estimated to last at least six months or where there is no potential for further recovery or improvement.

9.17. The Long-term Care Insurance (Guernsey) Law, 2002 sets out persons entitled to benefit under the Law, the categories of benefit payable and defines a 'person in need of Long-term Care' as a person who may suffer harm whilst doing the normal activities of daily life without substantial assistance or attention from another person. These provisions would require review in order to amend the Law to provide for entitlement to benefit relating to care in the community. The review would include a consideration of whether or not to give greater clarity to what is meant by 'long-term' care. Appendix 8 sets out definitions of this term in a care setting. The review will assist in ensuring that the eligibility rules are clear and unambiguous for the general public and professionals alike.

9.18. No time limit for Long-term Care was specified in the SLAWS report. However, the Working Party agreed that Long-term Care 'is distinguishable from acute care as it is provided to individuals with enduring needs, including chronic, disabling conditions or impairments, who need help on a permanent basis'. The terms 'enduring needs' and 'need help on a permanent basis' are key and support the intention of Long-term Care benefits being provided for continuing care and support needs over an extended period of time or permanently rather than for short or medium term interventions or needs.

9.19. The current relatively simple eligibility criteria for the Long-term Care scheme which covers permanent or respite care in residential accommodation, will be inadequate when benefits are extended to pay for care in the community. A time requirement for benefit would not be without precedent; severe disability benefit has a three-month qualifying period with exceptions for certain specified circumstances such as terminal illness. The Committee proposes to review the provisions of the Long-term Care legislation so that entitlement to benefit is primarily focussed on those who need care estimated to last at least six months or where it is unlikely that there will be further recovery or improvement, but with some flexibility for borderline cases. This would differentiate the care from acute and intermediate care provided by the Committee *for* Health & Social Care, funded through general revenue.

Revised rate structure and choice of care setting

9.20. If the recommendations in this Policy Letter are approved, the Long-term Care benefit could be restructured into 6 levels.

- Two lower levels corresponding to low and moderate levels of care need which would generally be expected to be delivered in a patient's own home

- Three levels of benefit which correspond to the existing benefit levels (increased to stabilise the care market), which patients would be able to choose to put towards care either in their own home or in a care home.
- A higher level of benefit for complex cases. It is not anticipated that individuals requiring this level of care would remain in their own home

9.21. Table 9.2 overleaf details how this structure might look.

Table 9.2: Current and proposed weekly rates of Long-term Care Benefit

Benefit level	Description	2020 Grant	2020 minimum co-payment	2020 total minimum bed rate	Proposed Grant	Proposed minimum co-payment (payable in care home only)	Proposed total minimum bed rate
1	Home care (up to 5 hours)	N/a	N/a	N/a	£175 (provisional)	N/a	£175 (provisional)
2	Home care (up to 10 hours)	N/a	N/a	N/a	£350 (provisional)	N/a	£350 (provisional)
3	Residential care	£463.89	£209.37	£673.26	£521.00	£280.00	£801.00
4	EMI care	£611.24	£209.37	£820.61	£681.00	£280.00	£961.00
5	Nursing care	£866.11	£209.37	£1,075.48	£940.00	£280.00	£1,220.00
6	Exceptional and complex cases	N/a	N/a	N/a	£1,112.00 (provisional)	£280.00	£1,392.00

10. Restructuring the scheme so that those with means pay more towards the cost of their care

10.1. If reforms to the system are progressed to the point described in section 9, the policy will have:

- addressed the issues of market stability and the financial incentives for the market to increase supply to meet the level of projected demand
- addressed the in-principle decision taken by the States in 2016 to make individuals responsible for their living and accommodation costs
- sought to mitigate the impact that this might have on the cost of providing income support
- progressed the extant resolution to extend the scope of the scheme to cover care at home to the next stage

10.2. However, it will not address the financial stability of the Fund. If propositions 2 to 9 are approved by the States it would be necessary to increase the revenue of the fund by £15m- £16m a year (equivalent to an increase in the contribution rate of 0.9%) in order to make the fund sustainable over a 50 year horizon.

10.3. If the States also approve proposition 11, extending the scope of Long-term Care benefit to cover care in people's own homes, it would be necessary to increase the revenue of the fund by a further £6m a year (equivalent to a further increase in the contribution rate of 0.4% and a combined total of 1.3%) in order to make the fund sustainable over a 50 year horizon.

10.4. Both scenarios represent a substantial increase in overall taxation at a time when there are many other increasing demands on the public purse. The 2016 SLAWS report states that 'increasing tax or contributions indefinitely is not an option'. With secondary pensions imminent and other potential increases to social insurance contributions the Committee agrees that a contribution increase alone is not the appropriate way to address the sustainability of the Long-term Care Insurance Fund.

10.5. As well as the issues of intergenerational fairness described in Section 5, meeting the whole of the cost of making the Fund financially sustainable through an increase in contributions will make it more difficult for the States to operate within the limits placed on it by the Fiscal Policy Framework to keep aggregate States revenues below 24% of GDP in the long term. Members should be aware that if they choose to opt for a 'contributions only' approach that it may place restrictions on initiatives the States might support or

increase the risk that the States may breach the Fiscal Policy Framework in the long term.

10.6. The Committee acknowledges that LTC benefit was introduced on the premise that individuals would not need to sell their family home to access residential care and that provision was made within the Supplementary Benefit (now Income Support) legislation to protect the main home of individuals needing means-tested assistance. However, times and society have moved on since the LTC benefit was introduced. The 'increasingly unknowable' future referred to in the 2001 Long-term Care Policy Letter has proved to be the case. Changes must be made to secure Long-term Care benefits well into the future, even if those changes may be unpalatable.

10.7. Following extensive investigation and modelling the Committee concurs with the SLAWS findings and accepts that individuals will need to increase the direct payment that they make towards their care and accommodation costs. Taking a realistic and equitable approach this does mean that personal assets must contribute to a greater degree than they do currently.

10.8. The Committee remains committed to the principle that a person should not have to sell their main residence to pay for care (as is typically the case in England and Wales) and recommends that a level of protection for such assets should be built into any changes in income support rules. The level of protection recommended and used for modelling purposes is £350,000, on the basis of that being around the value of a two bedroomed property. This amount would be ignored in an income support claim. An equity release scheme will need to be available to ensure that the property would not need to be sold in order for the owner to have the availability of any equity above £350,000.

10.9. The Committee has identified three principal options to assist with financial sustainability of the Long-term Care Insurance Fund. In the first two options, the co-payment is increased to cover the minimum estimated value of accommodation and living costs and those with a certain level of means would be asked to pay a limited amount towards their care (the portion of the cost otherwise covered by Long-term Care benefit). In the third option, no additional contribution is required and the Fund would need to be stabilised by a larger increase in contributions (or revenue in some other form):

<u>Option 1</u>

10.10. To apply a scheme where those with significant income and/or assets with a value in excess of £350,000 would contribute the first £35,000 (or £50,000 for a couple) of their care cost. This would reduce the revenue required to make the scheme sustainable to £15m-£16m (or a 0.9% increase in contributions).

Option 2

10.11. To apply a scheme where those with significant income and/or assets with a value in excess of £350,000 receive a reduced level of benefit for a period of up to 3 years and must meet a proportion of their care costs themselves during this period. The Scheme could be designed to cap an individual's maximum contribution at £35,000 (or £50,000 for a couple). Two options for how this could be applied are set out below:

- A scheme where individuals with this level of means paid the equivalent of the first 5 hours of care a week (est. £175) in addition to their co-payment (£280) for the first 3 years would reduce the revenue required to make the scheme sustainable to £16m-£17m (or a 1.0% increase in contributions)
- A scheme where individuals with this level of means paid the equivalent of the first 10 hours of care a week (est. £350) in addition to their co-payment (£280) for the first 2 years would reduce the revenue required to make the scheme sustainable to £15m-£16m (or a 0.9% increase in contributions)

Option 3:

10.12. Not to progress development of a scheme which would require additional care contributions. This would require an estimated increase in revenues of £21m-£23m (or an increase in contributions of 1.3%) to make the scheme financially sustainable.

11. What happens in Guernsey now?

11.1. Eligibility for long-term care benefits is determined on meting residency requirements, a Needs Assessment, taking up a bed in residential accommodation and making a co-payment. There is no financial assessment except where an individual cannot afford the co-payment.

11.2. This means that, regardless of the level of income or assets an individual holds they will be entitled to the full level of Long-term Care benefit as long as they require care, provided they meet the residency and need requirements.

11.3. The schemes applied in Jersey, England and Wales are less generous, with means tested elements which require claimants to contribute a limited part (in Jersey) or almost all (in England and Wales) the value of their assets towards the cost of their care.

11.4. A comparison between the Guernsey Scheme and the English and Jersey schemes is provided in Table 11.1 on page 60.

11.5. England and Wales have made attempts to reform the structure of their Long-term Care provision over the years. In 2011, the Commission on the Funding of Care and Support, chaired by Andrew Dilnot published its report, Fairer Care Funding. Its key finding was that the system for funding Long-term Care in England was not fit for purpose and needed urgent reform. It did establish, however, that 'Most people are realistic about the need for individuals to make some contribution to the costs of care in late life, but they want a fairer way of sharing costs and responsibility between the state and individuals'.

11.6. The Commission believed that a capped cost model would be the best way to achieve these aims. This approach would mean that individuals would take responsibility for their own costs up to a certain point but, after that, the state would pay. This was seen as a type of social insurance policy with a significant 'excess' that people would need to cover themselves. The Commission also supported the expectation for individuals in residential accommodation to make a contribution towards their general living costs, just as they would be expected to meet the costs of living at home.

11.7. The Dilnot report was the cornerstone of the scheme introduced in Jersey in 2014. Before this point the treatment of care costs in Jersey were much closer to the position in England and Wales, i.e. individuals were largely responsible for all their care costs until their resources were exhausted, with costs for those requiring care over a very lengthy period potentially running to hundreds of thousands of pounds.

Table 11.1 Main elements of Long-term Care funding in Guernsey, Jersey and England 2020

	Guernsey	Jersey	England
Residence conditions	Lived in Guernsey for 5 years immediately before claiming benefit. Or 5 years at any time in the past BUT 1 year immediately before claiming benefit	Lived in Jersey continuously as an adult for 10 years before applying; or lived in Jersey for 10 years continuously as an adult in the past and for another year immediately before applying; or if under 28 years of age the test is to have lived in Jersey continuously for a period of 10 years at any age	Ordinarily resident or present in the local area. Can fund care in certain circumstances for residents of other areas. Exception rules apply for provision of certain health services or people subject to immigration control.
Benefits	**Long-term care in care home only** Nursing - £866.11 Residential - £463.89 EMI - £611.24 Income support if unable to meet co-payment/ personal allowance Respite care funded in full.	**Residential and home care** Covers standard care costs with 4 rates payable dependent on level of need L1- £390.39 L2 - £595.70 L3 - £861.07 L4 - £1082.55	**Residential and home care and assistance with equipment** Personal budget to meet the assessed care and support needs including relevant equipment up to a value of £1,000. NHS continuing Services for health related condition. Needs assessment required. NHS funded nursing care in a care home. It is a flat rate contribution of £156.25 per week.
Personal contribution	Co-payment - £209.37	Co-payment - £345.80 for residential care	Daily living costs for residential care
Needs assessment	Yes	Yes	Yes
Financial conditions	No	Yes for means tested elements	Yes – fully means tested

	Guernsey	Jersey	England
Means test capital limit	N/A	£419,000 for family home + £25,000 of other assets	**Above** £23,250 – pay in full **Between** £14,250 and £23,250 part contribution to care costs **Below** £14,250 no contribution to care cost
Care cap	No	£57,590 single person, £86,390 for a couple	Provision in the Care Act but not yet introduced
Deferred payments	No	Yes – States deferred payment scheme	Yes
Treatment of top-ups	Top-up charges are the responsibility of the individual-no assistance from income support. Ignored in an income support claim if paid by a third party.	Additional costs are the responsibility of the individual or their family. Assistance may be given through the deferred loan scheme up to agreed limits.	Local Authorities may have to pay higher fees if unable to source an appropriate commissioned place in a care home Top-ups can be paid by a third party.

11.8. The scheme applied in Jersey has some key elements:

- The Jersey scheme is available to cover both care in an individual's own home or in a care home. They can choose to put their benefit towards care in either setting. However, if the care route they choose is more expensive than that which can be met from their benefit (which based on their assessed need) they are responsible for any additional costs.[41]
- Recipients are responsible for their living and accommodation costs via a co-payment (£345.80 a week in 2020)
- The scheme is partially means tested with those with a family home valued at more than £419,000 or other assets in excess of £25,000 required to contribute the first £57,590 (single person) of their care costs.

[41] For example an individual assessed as needing a level of need that would correspond to that delivered in a nursing home, they could choose to receive this care at home but, if the cost of this exceeded their benefit level they would need to pay the extra themselves.

- Once this contribution is deemed to be met based on their assessed level of need, they are entitled to claim benefit in full, (if their remaining asset value falls to the threshold value means tested assistance would be available)
- An individual who has met their care cost contribution is still required to continue meeting their co-payment if they are in a care home as representing their accommodation and living costs
- The scheme is supported by an in-house deferred loan scheme

11.9. Options 1 and 2, presented previously, seek to move in this direction, requiring a care cost contribution from those with greater wealth. Both options would seek to protect assets below a value of £350,000 and both would seek to limit the maximum contribution of an individual to their care cost to no more than £35,000 for a single individual or £50,000 for a couple.

11.10. Within option 1 this would mean that and individual needing to make an additional contribution, because they had assets over £350,000, would have to meet the first £35,000 of the cost of their care in full (in addition to their co-payment and any top-ups charged).

11.11. Within option 2 this would mean that those needing to make an additional contribution, because they had assets over £350,000, would have to meet part of the cost of their care (in addition to their co-payment and any top-ups charged) for up to three years and of a total cost of no more than £35,000.

11.12. The proposed contribution limit of £35,000 for an individual in Guernsey, is lower than that in applied Jersey. This reflects the different starting point for consideration of such a scheme in Guernsey. The asset threshold proposed, £350,000 which is the approximate value of a two bed property, is also significantly lower, reflecting the lower property prices in Guernsey.

11.13. The complicating factor in this decision is that this is being considered from the position of a scheme that is, at present, substantially more generous than that applied in Jersey. Rightly or wrongly, there is also a perception among a large proportion of the public that the scheme will protect their property assets in full if they need care.

11.14. Continuing the existing policy could mean placing the cost of stabilising the Fund on contributions. This places the largest financial burden on the young, who will be paying additional contributions for more years. For those who stand to inherit a local property, there may be some compensation for this approach, but it is particularly disadvantageous for those who do not stand to inherit.

11.15. Adding a means tested element to the scheme which requires those who have means to make an additional contribution to their care, if they need it (published estimates for the proportion of people who will require Long-term Care in some form in their lifetime range from 50% to 70%), shares some of the cost burden of providing it between the generations. At the same time those requiring care are still protected from the risk that they will be in care for a long period and incur very substantial expense as a result.

11.16. Balancing the issue of intergenerational equity in this context is not straightforward, and the Committee has not presented a preferred option among those presented. The States are instead requested to provide direction on how they would wish to tackle this issue in debate.

11.17. Examples of how a care cost cap could work in the cases of a low income home owner and higher income home owner are shown at Appendix 9.

11.18. Any move in this direction will also need to consider applying divestment rules, to limit evasion of the charge. This means calculating contributions to care taking into account assets transferred to others, including the family home, for a period before a person applies for benefit. In Jersey, the scheme includes assets given away in the last 10 years[42] in any financial assessment if disposed of for less than the market value. This does not apply if the person can demonstrate that the main purpose of the disposal was not to obtain or increase access to Long-term Care benefit.

11.19. Under current income support legislation if a person deprives themself of any resources by neglecting to claim or abandoning any right to a benefit or assets, including property, and by doing so is able to secure income support or an increase in the benefit paid, the resources can be taken into account as if they were still that person's. In fact very few people would behave in this way, but occasionally it may become evident that someone has not claimed a pension to which they are entitled or in the recent past has passed property to a third party for a negligible amount. In such cases the Administrator, in assessing the claim, is able to take the value of the assets foregone into account if it seems appropriate. Such decisions are rare.

11.20. The inclusion of a person's main home in calculating their resources when considering an income support claim to support Long-term Care costs, or the introduction of a means tested element to the payment of Long-term Care benefits, raises the question of whether this may encourage divestment of property to avoid having to make a higher contribution to benefit. There may

[42] The value of a person's home can be taken into account at any time prior to a person becoming eligible for benefit if the person retains certain rights over the property e.g. right to receive rental income.

be an expectation of such behaviour, although it is hoped that by ensuring there is substantial protection for capital assets, the majority of people will be reasonable and not attempt to circumvent the legislation. It is anticipated that an income support claim or other financial assessment would pick up evidence of potential divestment for this purpose and, as already happens in respect of income support claims, the circumstances would be investigated.

11.21. Currently, a decision to take into account assets which a person has deprived themselves of or neglected to claim, is based on all the circumstances of the case rather than a specific time-frame or value. However, it is possible that for the purpose of an income support claim to assist with Long-term Care costs a time-frame could be built into the legislation. This is the case in Jersey where, in certain circumstances, property disposed of up to 10 years before a claim can be taken into account.

12. Deferred Loan Schemes

12.1. This Policy Letter sets out high level principles for the future sustainability and purpose of the Long-term Care Insurance Fund. The issues raised are multifaceted and complex and must be linked with a number of associated issues when reaching a decision.

12.2. There are two elements of this Policy Letter which are contingent on the availability of a mechanism for people to be able to release value from their property:

- The in-principle recommendation reflected in proposition 16 that would change the income support rules so that those with property assets (including their primary residence) with a value in excess of £350,000 should not be entitled to income support to assist in meeting the cost of the co-payment payable in respect of care beds under the Long Term Care Scheme.
- The recommended direction to the Committee and the Policy & Resources Committee, reflected in proposition 17, to report on options to moderate future increases in contributions by requiring those with assets in excess of £350,000 (including their primary residence) to meet the first £35,000 of the costs otherwise covered by the Long-term Care Insurance scheme.

12.3. The Committee considers the provision of a deferred loan or equity release scheme is a vital component of these proposals. Such products have generally not been available in Guernsey as there are certain rules of Guernsey customary law which mean that equity release mortgages cannot currently be

offered in Guernsey[43]. The States have already directed the drafting of legislation to amend customary law to enable such products to be offered[44]. Further details of the policy were set out in paragraphs 6.89 to 6.92 of the 2020 Budget Report[45].

12.4. However, the Policy & Resources Committee stated in the Budget Report that they did not intend to bring forward the legislation to amend the customary law until after there were appropriate consumer safeguards in place as there had been incidences of inappropriate selling of equity release products in other jurisdictions. The Budget Report stated that a Policy Letter would be submitted by the Policy & Resources Committee and the Committee *for* Economic Development so that a licence from the Guernsey Financial Services Commission would be required for such lending. This would also require legislation, subject to States approval of the policy.

12.5. The reputation of commercial equity release and deferred loan scheme in the UK has not always been positive but better regulation of the industry has largely resolved the problems. Mindful of the financial risk to individuals who require Long-term Care for extended periods and the length of time commercial products may take to set up, the Committee has a preference for a States run equity release scheme such as the Property Loan Scheme operated in Jersey as part of their Long-term Care scheme. Consideration has also been given to the possibility of structuring the scheme as a partnership arrangement with a private sector provider where the States could negotiate standardised terms and conditions for those wishing to make use of such a scheme.

12.6. Any scheme should include:

- Standardised terms and conditions which are fair and equitable for potential claimants
- Conditions to protect the interests of any surviving partner or dependent relative forming part of the same household and resident in the claimant's primary residence.

12.7. Consideration should also be given, as part of the investigation, to:

- providing access to the scheme for those who need to make modification to their home or buy equipment in order to facilitate care in their own home

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43 These rules relate to acknowledgement of debt, bonds, saise (the procedures by which realty/land assets of a person can be distributed to creditors) and prescription (which provides for extinction of rights to bring an action after certain periods).

44 See Resolution 28 of 8 November 2019 on the 2020 Budget Report.

45 The States of Guernsey Annual Budget for 2020 (Billet d'État XXI of 2019, Article I).

- supporting any direction provided by the States which might require a greater contribution towards the cost of care for those with significant income or assets

12.8. To be effective in the context of contributing towards long-term care costs, there will be a need for the property loan scheme to issue its loans speedily. Otherwise, it is likely that hospital discharges to long-term care provision will be delayed while property valuations take place and the associated contractual documentation is agreed and funds released.

12.9. It should be noted that not everyone needing to make additional co-payments or meet their personal care cost contribution will need or want to make use of a deferred property loans scheme. Some may have income savings or other assets they could use to meet these costs. Others may be in a position where their family decide that it is more cost effective to find another means to support the payment, allowing the property to be passed to the heirs unencumbered on their relative's death.

12.10. One consideration in such decisions is likely to be the accrual of interest on a deferred loan scheme. The system in Jersey operates under a mechanism that the loan is accrued as it is needed. That is, the scheme allows costs to be added to the loan amount on a weekly or monthly basis as needed rather than requiring the maximum amount to be borrowed at once. This means that there is much greater flexibility and that interest accrues more slowly. Nonetheless, over time the interest can add significantly to the loan amount.

12.11. The examples in Tables 12.1-12.3 below demonstrate how a loan and rolled up interest could accrue on a loan assuming an interest rate of 3.5% per annum. It should also be noted that commercial providers also often charge arrangement fees for setting up a loan agreement.

Table 12.1 – Example 1 of how interest could accrue on a loan at an interest rate of 3.5% per annum

Example 1			
Loan meets part payment of co-payment	£100 per week		
Care cost contribution not required	£0		
Claim length	3 years		
Assumed interest rate applied monthly	**3.5%**	**3.85%**	**4.50%**
Assumed property value	£400,000		
Total amount borrowed for co-payment	£15,429		
Total amount borrowed for care cost contribution	£0		
Total interest accrued	£862	£951	£1,119
Total repayment value	£16,290	£16,380	£16,547
Property value remaining	£383,710	£383,621	£383,453

Table 12.2 – Example 2 of how interest could accrue on a loan at an interest rate of 3.5% per annum

Example 2			
Individual pays co-payment in full from income	£0 per week		
Loan meets payment of EMI care costs for 51 weeks until care cost cap met	£681 per week		
Claim length	3 years		
Assumed interest rate applied monthly	**3.50%**	**3.85%**	**4.50%**
Assumed property value	£400,000		
Total amount borrowed for co-payment	£0		
Total amount borrowed for care cost contribution	£35,000		
Total interest accrued	£3,266	£3,607	£4,248
Total repayment value	£38,266	£38,607	£39,248
Property value remaining	£361,734	£361,393	£360,752

Table 12.3 – Example 3 of how interest could accrue on a loan at an interest rate of 3.5% per annum

Example 3			
Loan meets part payment of co-payment for approx. 120 weeks until remaining equity falls below £350,000	£100 per week		
Loan meets payment of EMI care costs for 51 weeks until care cost cap met	£681 per week		
Claim length	3 years		
Assumed interest rate applied monthly	**3.50%**	**3.85%**	**4.50%**
Assumed property value	£400,000		
Total amount borrowed for co-payment	£12,000		
Total amount borrowed for care cost contribution	£35,000		
Total interest accrued	£4,082	£4,508	£5,309
Total repayment value	£50,921	£51,331	£52,101
Property value remaining	**£349,079**	**£348,669**	**£347,899**

13. Care home bed affordability and a commissioning approach

13.1. As work has progressed to address the SLAWS resolutions the Committee has expressed concern that individuals may not always be able to access a care home bed when they need it. This may be because there is no basic rate bed available in the home of their choice, or they are unable to afford the additional top-up fees that some homes charge.

13.2. There has been political concern over the additional top-up charges being charged by the majority of homes. This has been particularly the case for individuals who do not have the resources to pay the extra charges in addition to their required co-payment. The concerns are that there are too few basic rate beds available.

13.3. The current arrangement is that homes receive a standard rate of Long-term Care benefit linked to the assessed need of the resident. This, combined with the standard co-payment is the full cost of a basic rate bed and is often referred to as the 'States-rate'. When the scheme started in 2003, around 70% of beds were available at this basic rate. From the outset some homes were charging fees in excess of this, but over time an increasing number of beds have been subject to fees above the basic rate. More recently a number of homes, particularly those in the charitable sector who use charitable donations to support their services, have needed to introduce additional 'top-up' fees to remain viable.

13.4. There is evidence that a lack of supply of beds in general, and beds without top-up fees (States rates beds) in particular can result in delays in discharging patients from the hospital. Although patients are expected to meet the cost of their co-payment if they are in hospital under delayed discharge waiting for a bed to become available, the cost of providing a hospital bed is still substantially higher than the grant paid towards beds in private or third sector care homes. As a result, additional costs are incurred by the States and additional pressure placed on the resources of the hospital.

13.5. In other cases there are people declining more expensive beds and making do without the care they need or relying on family, friends or charities to help pay the top-up fee.

13.6. The Committee *for* Health & Social Care is able to charge the standard Long-term Care co-payment for a patient occupying a hospital bed while waiting for a suitable bed to become available in a care home. The same rate also applies to long stay beds in the Lighthouse Wards on the hospital site. This policy, provided for in the resolutions following the 2001 Long-term Care Policy Letter[46] was intended to remove the incentive for people to remain in hospital in order to avoid the co-payment payable on private and third sector care beds. It presumed that most people in Long-term Care in the private sector would be paying no more than the standard co-payment and therefore also achieved a level playing field. However, as the number of private care homes applying or increasing top-up fees has increased over time, an incentive to remain in public Long-term Care has returned. This is being seen

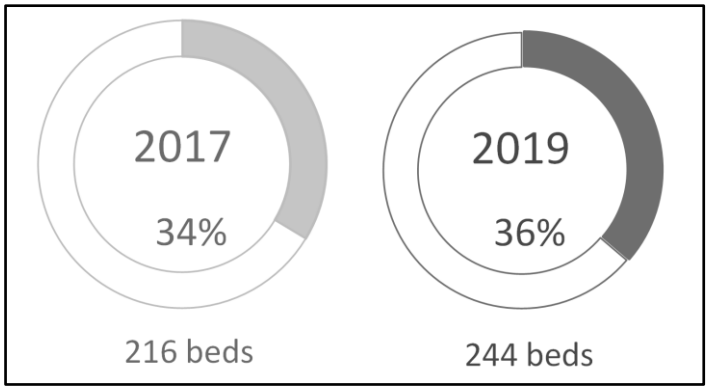
[46] Long-term Care Insurance Scheme for Guernsey and Alderney (Billet d'Etat III of 2001, Article VII)

in an increasing number of delayed discharges at the Princess Elizabeth Hospital.

13.7. The Committee, having consulted with the Committee *for* Health & Social Care, will recommend that the 2001 Resolution requiring the latter Committee to limit its charges to the standard co-payment be rescinded. This will allow the Committee *for* Health & Social Care the discretion to set the fees for its long-stay beds at rates appropriate for the effective management of that Committee's resources.

13.8. As part of the recent analysis of care costs it was established that in the first half of 2019 36% of beds across Guernsey and Alderney were offered at the basic rate. This means that close to two-thirds of residential and nursing home beds have an additional top-up fee being charged. Although it is a benefit entitlement due to the individual, Long-term Care benefit is for convenience nearly always paid directly to the care home by Social Security and the resident is responsible for paying the co-payment and any additional top-up charge to the home. Figure 13.1 below shows the proportion of the beds available without a top-up fee in 2017 and 2019.

Figure 13.1 – Proportion of Long-term Care beds available without payment of a top-up fee



13.9. Top-up fees range from £25 to £550 per week depending on the care home and the level of service they provide. Top-up fees on Nursing and EMI specialist dementia care beds tend to be higher than those on Residential beds. The charts in Appendix 5 illustrate this, and show that, in 2019, residents in beds incurring top-up fees paid on average £182 per week more than the Basic Rate for Nursing beds, and £206 more for Residential EMI beds. There was better availability of Residential care beds with a low top up, and on average these users paid £107 more than the Basic Rate.

13.10. The Committee is aware from the analysis of care home costs that although some homes have levels of profit above the benchmark others have lower than benchmark profits. Some third sector homes have had to use charitable

funds or find other financial support to maintain their services. The 2019 review of care home costs found evidence of changes in the care home market since 2017. The review identified a downward trend in profitability and it is apparent that additional top-up fees are, in effect, subsidising basic rate beds. Furthermore, two care homes have closed since 2017, though it is not clear that these closures were the result of factors affecting care homes profitability more generally.

13.11. It is perhaps likely that the steps proposed to improve the sustainability of the market will reduce the need for homes to charge top-ups and increase the number of States rate beds available. However, the Committee would wish to move towards a position where the number of States rates beds on offer is significantly higher than it is currently and to gain some certainty about the number of beds on offer under the three classifications. A number of alternatives have been explored with the commissioning of beds being considered the most suitable way to address this issue.

13.12. Currently, while the care homes are required to meet certain conditions in order to be eligible to receive payment of Long-term care benefit paid on behalf of the residents they care for, they are not subject to formal contractual arrangements. The care homes have complete discretion as to how many of their beds they offer at a basic rate and for how many of their beds they charge top-up fees for. The homes also determine the mix of their residential or nursing beds provided they are operating within the terms of their statutory registration. There is currently no formal contract between individual care homes and the States of Guernsey. This means that homes can change the registration of their bed between care types or introduce top-ups on States-rate beds at any time.

13.13. This can cause significant issues. In 2017 for example one of the larger care homes reregistered all its nursing beds to residential, requiring the relocation of a significant number of residents to alternative homes. In other instances homes, particularly not-for-profit-homes, have found it necessary to make significant increases in top-ups in order to remain viable, thereby reducing the number of States rates beds available.

13.14. The Committee supports a move to enter into a more formal agreement with care providers, particularly given that the intended extension of the benefit to cover care in an individual's own home could mean a significant increase in the number of providers eligible to receive payment from the Fund on behalf of their client. Given the work undertaken by the Committee *for* Health & Social Care to develop the Partnership of Purpose there is an opportunity to extend this approach to the relationship between the States and private care providers.

13.15. In the context of reaching a contractual arrangement with care providers, a number of cost control measures have been explored including establishing a quota for States rates bed or commissioning services. The concept of commissioning most closely meets the policy requirements of the Committee. This concept is not new. Although it was not included in the Long-term care Insurance Law, the 2001 Long-term Care Policy Letter proposed the ability to form a commissioning body as a future provision to be included in legislation[47].

13.16. The term 'commissioning' is often used interchangeably with 'purchasing'[48]. However, commissioning is more than just buying a product. There are numerous models of commissioning. They all put outcomes for users at the heart of the strategic planning process while getting the best possible services that deliver value for money. NHS England describe commissioning as 'the continual process of planning, agreeing and monitoring services'.

13.17. A potential commissioning approach for the procurement of standard rate beds has been explored (Appendix 10). This approach could be adapted to commission care in the community. Regular reviews of care and daily living costs would be built into the process to ensure future benefits remain fair and linked to the actual cost of care.

14. Meeting the remaining funding requirements

14.1. There will be a need to raise more revenues to support the Long-term Care Insurance Fund if it is to be available to the younger members of our community when they might need it. How much this will cost will depend on the decisions made in response to this Policy Letter and the progression of implementing the measures it recommends. Table 14.1, at paragraph 14.5, summarises the estimated financial impact of the propositions to stabilise the Fund (maintaining at least 2 years of expenditure in reserve at the end of the projected period in accordance with the principles of the Fiscal Policy Framework).

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47 Long-term Care Insurance Scheme for Guernsey and Alderney (Billet d'État III of 2001, Article VII – see paragraphs 63-64)

48 John Bolton Outcome based commissioning paper April 2015 - Definitions are taken from the book "Commissioning for Health and Social Care" published by SAGE and IPC (Oxford Brookes University) in 2014: **Commissioning** is the processes which include assessing the needs of people in an area, designing and then achieving appropriate outcomes. The service may be delivered by the public, private or civil society sectors. **Procurement** or purchasing refers to the process of finding and deciding on a provider and buying a service from them. **Outcomes** are the perceived benefits to a person from the services they have received.

14.2. Included in the table is an estimate of the impact the propositions may have on the cost to general revenue and a summary of the progress the propositions will make to address the issues outlined. These costs cover only the costs to income support resulting from increases in the co-payment and increases in contribution rates. They do not include any estimates of the administrative costs of changing the income support rules to incorporate an assessment of an individual's primary residence if they are in receipt of Long-term Care benefit or the on-going management of a scheme that requires additional care contributions from those with greater means.

14.3. As a result, the additional revenue that would be required is still unclear. In January 2020 the States resolved to commence a review of taxation. The objective of this review is to investigate the most appropriate way to meet the long term revenue requirements within the boundaries of the fiscal framework in the face of rising demand across a variety of service areas, of which Long-term Care is one of the largest.

14.4. The fiscal challenges have subsequently been significantly compounded by the economic impacts of the COVID-19 crisis.

14.5. The Committee *for* Employment & Social Security has agreed with the Policy & Resources Committee that, having broadly established the amount of additional funding required with this Policy Letter, finding the most appropriate source of revenues to meet these requirements will fall within the scope of the review. This may include an increase in contributions, but it may include revenues from other sources. The Policy and Resources Committee and the Committee *for* Employment & Social Security will work together on this matter.

Table 14.1 – Financial impact analysis of propositions

Approval of propositions	Exhaustion point with no additional revenue	Estimated revenue required to stabilise fund		Annual cost to general revenue	Impact summary
		Expressed as contribution increase	Expressed in annual monetary terms (2020)		
Status quo: Maintains the scheme as it stands; no extension to home care, no market stabilisation.	2047	0.65%	£10m-£11m	£0.3m	• Market continues unsustainable. • Existing supply may be lost. Medium term demand likely to exceed supply of beds. • Sustainable provision of care in an individual's own home is unresolved and will need to be addressed and financed in another way. • Financial sustainability not addressed (unless by increasing contributions only).
Propositions 2-8: Value of a minimum 'States rate' bed increased via an increase in the benefit and an increase in the minimum co-payment to a level representative of the minimum cost of accommodation and living costs (£280 per week) phased over 2 years.	2043	0.80%	£14m-£15m	£1.1m-£1.5m	• Market stability improved and investment in supply encouraged. • Increase in co-payment may transfer a significant portion of the cost 'saving' to the LTCF to income support. • Sustainable provision of care in an individual's own home is unresolved and will need to be addressed and financed in another way. • Financial sustainability not addressed (unless by increasing contributions only).

Approval of propositions	Exhaustion point with no additional revenue	Estimated revenue required to stabilise fund		Annual cost to general revenue	Impact summary
		Expressed as contribution increase	Expressed in annual monetary terms (2020)		
Propositions 2-9 • Value of a minimum 'States rate' bed increased through an uplift in benefit and co-payment to £280, phased over 2 years. • Add a higher rate of benefit for complex cases.	2042	0.90%	£15m-£16m	£1.1m-£1.5m	• Market stability improved and investment in supply encouraged. • Increase in the co-payment may transfer a significant portion of the cost 'saving' to the LTCF to income support. • Sustainable provision of care in an individual's own home is unresolved and will need to be addressed and financed in another way. • Financial sustainability not addressed (unless by increasing contributions only)
Propositions 2-9 and 16 • Value of a minimum 'States rate' bed increased through an uplift in benefit and co-payment to £280, phased over 2 years. • Add a higher rate of benefit for complex cases. • Change income support rules for LTC benefit claimants to include the value of their residence that is in excess of £350,000.	2042	0.90%	£15m-£16m	£0.6m-£0.7m	• Market stability improved and investment in supply encouraged. • Increase in the co-payment may transfer a significant portion of the cost 'saving' to the LTCF to income support. • Sustainable provision of care in an individual's own home is unresolved and will need to be addressed and financed in another way. • Financial sustainability not addressed (unless by increasing contributions only)

Approval of propositions	Exhaustion point with no additional revenue	Estimated revenue required to stabilise fund		Annual cost to general revenue	Impact summary
		Expressed as contribution increase	Expressed in annual monetary terms (2020)		
Propositions 2-9, 11 and 16 • Value of a minimum 'States rate' bed increased through an uplift in benefit and co-payment to £280, phased over 2 years. • Add a higher rate of benefit for complex cases. • Change Income support rules for LTC benefit claimant to include the value of their residence in excess of £350,000. • Extend the scope of the scheme to cover care provided at home.	2034	1.30%	£21m-£22m	£0.9m-£1.1m Less revenue savings of up to £5m	• Market stability improved and investment in supply encouraged. • Cost transfer to General Revenue from increased co-payment reduced by change in income support rules. • Sustainable provision of care in an individual's own home resolved by opening up private sector provision • Financial sustainability not addressed (unless by increasing contributions only)

Approval of propositions	Exhaustion point with no additional revenue	Estimated revenue required to stabilise fund		Annual cost to general revenue	Impact summary
		Expressed as contribution increase	Expressed in annual monetary terms (2020)		
Propositions 2-9, 11, 16 and 17 • Value of a minimum 'States rate' bed increased through an uplift in benefit and co-payment to £280, phased over 2 years. • Add a higher rate of benefit for complex cases. • Change Income support rules for LTC benefit claimant to include the value of their residence in excess of £350,000. • Extend the scope of the scheme to cover care provided at home. • Fund will be stabilised by a combination of individuals with greater means paying up to the first £35,000 of care costs and an increase in contributions (or other revenues).	2043	0.90%	£15m-£16m	£0.7m-£0.8m Less revenue savings of up to £5m	• Market stability improved and investment in supply encouraged. • Cost transfer to General Revenue from increased co-payment reduced by change in income support rules. • Sustainable provision of care in an individual's own home resolved by opening up private sector provision • Financial sustainability addressed by a combination of increases in fund revenue and requiring a care cost contribution from those with greater means, sharing a portion of the cost between generations.

Approval of propositions	Exhaustion point with no additional revenue	Estimated revenue required to stabilise fund		Annual cost to general revenue	Impact summary
		Expressed as contribution increase	Expressed in annual monetary terms (2020)		
Propositions 2-9, 11, and 16 • Value of a minimum 'States rate' bed increased through an uplift in benefit and co-payment to £280, phased over 2 years. • Add a higher rate of benefit for complex cases. • Change Income support rules for LTC benefit claimant to include the value of their residence in excess of £350,000. • Extend the scope of the scheme to cover care provided at home. • Fund will be stabilised by a combination of individuals with greater means receiving a reduced benefit towards the cost of their care for two to three years and an increase in contributions (or other revenue).	2039	1.0%	£16m-£17m	£0.7m-£0.8m Less revenue savings of up to £5m	• Market stability improved and investment in supply encouraged. • Cost transfer to General Revenue from increased co-payment reduced by change in income support rules. • Sustainable provision of care in an individual's own home resolved by opening up private sector provision • Financial sustainability addressed by a combination of increases in contributions and a care cost contribution from those with greater means, sharing a portion of the cost between generations.

Approval of propositions	Exhaustion point with no additional revenue	Estimated revenue required to stabilise fund		Annual cost to general revenue	Impact summary
		Expressed as contribution increase	Expressed in annual monetary terms (2020)		
Propositions 2-9, 11, and 16 • Value of a minimum 'States rate' bed increased through an uplift in benefit and co-payment to £280, phased over 2 years. • Add a higher rate of benefit for complex cases. • Change Income support rules for LTC benefit claimant to include the value of their residence in excess of £350,000. • Extend the scope of the scheme to cover care provided at home. • Fund will be stabilised with contributions (or other revenues) only.	2034	1.3%	£21m-£22m	£0.9m-£1.1m Less revenue savings of up to £5m	• Market stability improved and investment in supply encouraged. • Cost transfer to General Revenue from increased co-payment reduced by change in income support rules. • Sustainable provision of care in an individual's own home resolved by opening up private sector provision • Financial sustainability addressed by increases in contributions only, placing a greater proposition of the cost burden on younger members of the community.

15. Other considerations

Fund governance and investment return assumptions

15.1. The Committee *for* Employment & Social Security and the Policy & Resources Committee are currently engaged in a review of the investment governance of the States investment assets with a view to unifying the governance structures and investment policies.

15.2. The level of investment return achieved on the LTCF contributes to the Fund's long-term sustainability and is a variable used by the Government Actuary's Department in making projections of income and expenditure of the Fund.

15.3. The investment return in the actuarial assumptions is currently RPIX +2.5%. On advice from the Committee's investment adviser, taking into account the Committee's risk tolerance of 10 to12% Value at Risk (at 95% confidence level) the investment portfolio is allocated to achieve an expected return of 3.5% above 6 month LIBOR. This suggests that the assumption for the actuarial projection of RPIX +2.5% is perhaps a little on the high side, but reasonable.

15.4. However, if the investment return could be increased to RPIX +3.5%, the necessary increase in the contribution rate to secure financial sustainability, without taking the possible moderating measures described in this Policy Letter, would reduce from 1.3% to 1.15%.

15.5. It is evident that improving the investment performance is not a panacea, but could contribute to the eventual solution.

Economic, population and earnings growth

15.6. The LTCF is sensitive to economic conditions. The Fund is reliant on contributions charged against earnings or income, which means that the revenues of the Fund are dependent on:

- The size of the population and the population in work in particular
- The long-term average level of earnings growth.

15.7. Modelling suggests that the rate of long-term earnings growth is particularly important. The modelling assumes a long-term increase in earnings of RPIX+ 1% each year. This is slightly higher than the growth rate achieved in the last 5 years (average RPIX +0.5%) but close to the rate achieved in the last year (RPIX +1.1%). Increasing this assumption to 1.5% reduces the long term revenue requirement of the Fund by an estimated £4m-£5m (reducing the contribution requirement by 0.2%-0.3%). Reducing it to 0.5% increases the

long term revenue requirement of the Fund by an estimated £3m-£4m (estimated 0.2% of contributions).

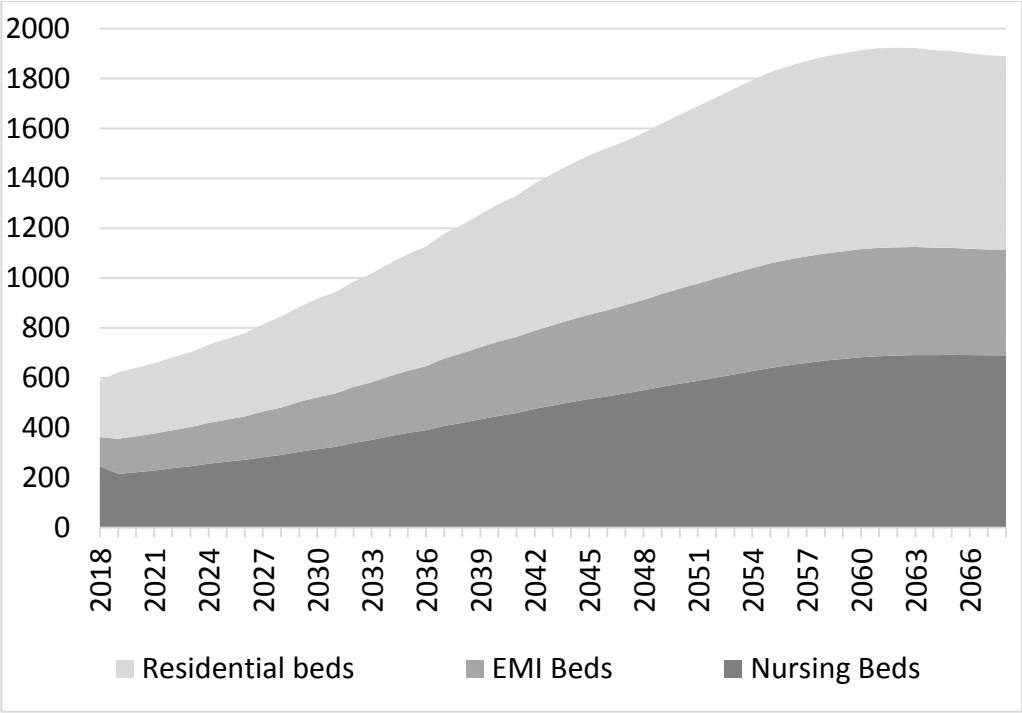
15.8. Maintaining a successful economy and a skilled and well paid workforce is important to the long term stability of this Fund.

15.9. Raising the overall level of revenue extracted from the economy by increasing Social Security contributions has potential implications for economic growth. These propositions would require an additional £26m of additional annual funding. This would mean increasing overall taxation by approximately 0.8% of GDP. This would suppress consumption and, while in the long term this money would return to the economy, it will create a medium term suppression of economic growth.

Long term market supply capacity

15.10. As described previously there is a substantial increase in the projected demand for care beds in Guernsey as the population ages. While this work stream seeks to ensure that there is a financial incentive to invest in the market, the States also has a role to play in ensuring that its policies support the physical provision of care beds.

Figure 15.1 – Projected demand for care beds



15.11. Acknowledging this, projections have been shared with officers working on the Review of the Island Development Plan and progressing the Elderly Tenures Strategy (part of the Future Housing Strategy).

16. Implementation

16.1. Implementation of the States decisions on the propositions set out in this Policy Letter will, for the most part, require detailed design and project management. Various elements will require differing levels of planning, resources, legislative changes and project management depending on the choices made by the States and are likely to take at least two years to implement depending on the extent of the changes required.

16.2. Increasing the benefit levels and co-payments over two years

- This can be implemented via ordinance and the process can begin almost immediately. With the States approval the intention is that the first stage of this process be implemented as early as October 2020.

16.3. Extending Long-term Care benefits to pay for care in the community will require:

- The development and implementation of suitable assessment criteria with the Committee *for* Health & Social Care;
- Increased capacity for assessment of care needs which would require changes to the Needs Assessment Panel and assessment process;
- Increased capacity to manage the increased number of claims;
- The development of payment processes and increased financial capacity for payment of accounts;
- The development, if necessary of processes by which the Committee *for* Health & Social Care can invoice for services either to the Long-term Care Fund or to individuals depending on the model pursued;
- The development of eligibility criteria for private sector providers who might wish to offer care services in people's homes
- The implementation of regulation of care services to be in place;
- Increased availability of care in the community either through Health & Social Care or the development of a private community care market; and
- Changes to legislation.

16.4. Technology solutions will be a vital component in reducing the number of additional staff required.

16.5. Increasing the level of co-payment and/or introducing a care cost cap will require:

- Increased capacity to undertake means-tested income support claims;

- Developing procedures for assessing the value of an individual's property assets; and
- Provision of an equity release scheme.

16.6. Increasing the formality of the relationship with care providers and periodic review of care costs will require:

- Negotiation and development of contracts with care providers
- Resources to procure and manage contracts
- Resources to undertake periodic review of care costs and benchmarking.

17. Consultation

17.1. Officers have undertaken to keep communication with care home stakeholders as open as possible throughout the development of proposals and have been regular attenders at the Care Home Association Managers Meetings[49] to update on progress and listen to concerns. Unsurprisingly, there has been much apprehension about the work being undertaken and the nature of proposals being developed. More recently Committee members have met with a number of care home owners, trustees and managers. Officer level meetings have taken place with homecare providers.

17.2. Over the course of the SLAWS work the care home sector has experienced more challenging trading conditions. Reports of this have been supported by evidence arising from the analysis undertaken to separate care costs from accommodation and daily living costs. In addition to the meetings that Committee Members have had with care home stakeholders, more recently there has been a joint meeting including those stakeholders and Members from both the Committee *for* Employment & Social Security and the Committee *for* Health & Social Care.

18. Conclusion

18.1. In Guernsey and Alderney, the demographic changes which had long been forecast are beginning to have increasing effect. In addition to the ageing of the post-war baby boomers, medical, societal and technological advances have contributed to the increase in life expectancy with some individuals living longer with multiple chronic conditions. There has also been a greater shift to individualised, person- centred care. This latter principle underpins the move towards individuals being supported to remain at home for as long as possible. In 2017, the Policy Letter 'A Partnership of Purpose: Transforming

[49] The Care Home Managers Association does not represent all care homes in the Bailiwick.

Bailiwick Health and Care'[50] had key aims of user centred care and effective community care.

18.2. Key priority outcomes in the SLAWS report were that there should be financial sustainability and affordability of care and support in the medium and long-term and that all people with care and support needs in community life should be included. These principles have been at the centre of the investigation, analysis and policy options presented in this Policy Letter.

18.3. Much has changed since the Long-term Care Insurance Scheme was introduced in 2003. At the outset, the scheme was seen as essential to reduce the risk to individuals needing residential Long-term Care of having to use all their assets to fund it. It replaced multiple charging and financial assessment systems, which were generally seen as very unsatisfactory. The new scheme was welcomed and, among other things, it was seen as a way to enhance the provision of the private care market which was recognised as not meeting the level of demand. By introducing an insurance-based scheme the risk for funding such care was to be shared by the general population. Protection of the family home was viewed a key requirement of the scheme. (See Appendix 3 for the background to the Long-term Care Insurance Scheme.)

18.4. It is clear that the scheme has been successful and met its main objectives. Those currently benefiting from the scheme do so at substantially reduced costs and the private provision of care beds has expanded beyond what was offered when the scheme started. However, the Committee has been convinced by financial evidence that profitability and indeed viability of the care home sector has deteriorated in recent years. This has led to some home closures and more could follow unless their income is increased. The Committee is recommending an immediate increase in the rate of the co-payment from the individual and an immediate increase in benefit rates in order to improve the financial viability of the sector.

18.5. In the 2001 Policy Letter, it was reported that there was '…some confidence in the financial projections for the following 10 to 15 years, but thereafter the future is increasingly unknowable'. The current position, 17 years after its introduction, is that unless further action is taken to make it sustainable, the LTCF will be depleted by 2047 at the latest.

18.6. The States will need to decide whether it wishes to extend the system of financing, based primarily on contributions. If that is the case, the rates will have to increase by a minimum of 0.9% for the current scope of the scheme, with the recommended increase in co-payment and benefit rates. If the scope

[50] A Partnership of Purpose: Transforming Bailiwick Health and Care (Billet d'État XXIV, Article XII).

of the scheme is to be extended to include Long-term Care provided in the community, the contribution rates will have to increase by a further 0.4%, making 1.3% in total. While, numerically, this may appear a modest amount, it would be an increase of approximately 70% on the payments that people currently make under the exiting rates of 1.8% for people under pension age and 1.9% for people over pension age.

18.7. The alternatives to relying wholly on increases in the contribution rate include requiring more from the person receiving care. This can be achieved through increasing the co-payment and, to a limited extent, the Committee recommends that approach in this Policy Letter. It can also be achieved by taking account, to a greater of lesser extent, of an individual's capital assets. This could apply in particular to the former principle residence (family home) of the person needing Long-term Care. Protection of the former family home was a fundamental part of the original design of the Long-term Care Insurance Scheme, but it is necessary to re-examine that aspect of policy and legislation.

18.8. The Committee believes that, in the case of people needing the assistance of income support to meet the cost of their co-payment and personal allowance (pocket money) it is no longer tenable to disregard totally the value of the former family home. The Committee acknowledges that protections would have to be built in for a spouse or partner, or adult dependant still living in the home. The Committee also believes that a substantial capital disregard should still apply and proposes that £350,000 should remain disregarded.

18.9. The Committee recognises that a change to the system, as described in the previous paragraph, would first require the facility for people to access part of the capital value of their former home. The Committee believes that the development of a deferred loan is a prerequisite and that this should be States-run or supported. Subject to a suitable deferred loan scheme being in place, the Committee also believes that the option of a 'care cost cap' should be investigated. This would be a system, similar to that which is applied in Jersey, which would require the payment by the person needing Long-term Care of the first £35,000 of costs that would otherwise be covered by the Long-term Care Insurance Scheme.

18.10. The Policy & Resources Committee has advised the Committee that there should be no increases in contribution rates until the Policy & Resources Committee has reported back to the States on the Review of Taxation. That Review is intended to return to the States in June 2021. While agreeing not to recommend any increase in contribution rates in this Policy Letter, the Committee is concerned by the risk of the necessary, although unpalatable, financing decisions for the Long-term Care Insurance Fund being indefinitely postponed. The Committee is therefore proposing that, subject to the outcome of States' decisions on the Review of Taxation, it should include

proposals in its uprating report for contribution rates for 2022, for an increase in contribution rates to the Long-term Care Insurance Fund of up to 1.3%.

19. Compliance with Rule 4 of the Rules of Procedure

19.1. Rule 4 of the Rules of Procedure of the States of Deliberation and their Committees sets out the information which must be included in, or appended to, motions laid before the States.

19.2. In accordance with Rule 4(3), this Policy Letter includes estimates of the financial implications to the States of carrying the proposals into effect. This includes the costs to the Long-term care Insurance Fund by way of increased benefit payments and costs to General Revenue in respect of income support assistance with the higher level of co-payment. Details are provided in Table 14.1.

19.3. In accordance with Rule 4(4) of the Rules of Procedure of the States of Deliberation and their Committees, it is confirmed that the Propositions 1, 2, 5, 6 and 8 to 19 have the unanimous support of the Committee. Propositions 3, 4 and 7 have the majority support of the Committee, with Deputy Langlois dissenting.

19.4. In accordance with Rule 4(5), the Propositions relate to the purpose of the Committee 'To foster a compassionate, cohesive and aspirational society in which responsibility is encouraged and individuals and families are supported through schemes of social protection…'. It is a responsibility of the Committee to advise the States on matters including Long-term Care insurance.

Yours faithfully

M K Le Clerc
President

S L Langlois
Vice-President

J A B Gollop
E A McSwiggan
P J Roffey

M J Brown
Non-States Member

A R Le Lièvre
Non-States Member

APPENDIX 1

Resolutions of the Supported Living and Ageing Well Strategy, 2016

THE SUPPORTED LIVING AND AGEING WELL STRATEGY

XIV. After consideration of the Policy Letter dated 7th December, 2015, of the Policy Council:-

1. To endorse all of the recommendations to progress the Supported Living and Ageing Well Strategy, as set out in the Working Party's research report and reproduced in Appendix III of that Policy Letter, with the exception of those reproduced under '7. Address strategic funding issues (Section 7 of the research report)'; and:

    a. To direct the Committee for Employment & Social Security to increase contribution rates to the Long-term Care Insurance Fund for employed, self- employed and non-employed persons by no less than 0.5% from 1st January 2017;

    b. To agree, in principle, that wherever care and support is received, for accounting and charging purposes, the costs associated with the provision of long-term care services should be separated into three distinct areas: accommodation; day- to- day living expenses; and care and support;

    c. To agree, in principle, that the Long-term Care Insurance Fund should be used to meet the costs of care and support only, with payments for accommodation costs and living expenses being the responsibility of the individual receiving care and support.

    d. To agree, in principle, that where an individual receiving long-term care was unable to meet their accommodation and living costs in full, they would be eligible for means-tested assistance via Supplementary Benefit.

    e. To direct the Committee for Employment & Social Security, in conjunction with the Policy and Resources Committee, to investigate in detail the implications for contributors, individuals and for the States of the application of the principle that the Long-term Care Insurance Fund should cover care and support costs only, and to report to the States with its findings and recommendations no later than October 2017.

    f. To agree that investigation of this principle shall be limited, in the first stage, to the implications related to care and support provided to individuals in public and private sector residential and nursing homes.

g. To note that any costs associated with the investigation of this principle will be met from the Long-term Care Insurance Fund.

h. To agree, in principle, that the Long-term Care Insurance Scheme should be extended to cover care and support costs for people living in their own homes (including those accommodated in their own homes in sheltered and extra care housing).

i. To direct the Committee for Employment & Social Security, in conjunction with the Policy and Resources Committee, to investigate in detail the implications for contributors, individuals and for the States of the application of the principle that the Long-term Care Insurance Scheme should be extended to cover the cost of care and support at home, and to report to the States with its findings and recommendations no later than October 2018.

j. To agree that the investigation of this principle should include:

- a review of the role of related benefits such as Severe Disability Benefit and Carer's Allowance; and
- detailed investigation into the possibility of introducing personal budgets, including, if appropriate, the establishment of a pilot project to inform the research.

k. To note that any costs associated with the investigation of this principle will be met from the Long-term Care Insurance Fund.

l. To direct the Committee for Employment & Social Security to keep under review whether there is a strategic, long-term financial need to introduce: (i) the inclusion of capital assets in any means-testing of benefits associated with the provision of long-term care; and (ii) the capping of care costs to set out the respective funding liabilities for individuals and for the States.'.

2. To direct that, until alternative arrangements are agreed, the Policy Council, and thereafter the Policy & Resources Committee, shall be responsible for ensuring that the Supported Living and Ageing Well Strategy continues to be taken forward.

3. To direct the Policy & Resources Committee, as part of its finalisation of the Policy and Resource Plan, to report to the States of Deliberation, no later than June 2017, on the arrangements by which political direction and oversight will be provided to enable the Working Party's recommendations to be progressed and implemented, having first consulted with the Committees for Health & Social Care, Employment & Social Security, and Environment and Infrastructure, together with the States of Alderney and appropriate third sector groups.

4. To approve, in principle, the implementation plan and timescales associated with taking forward the various elements of the Supported Living and Ageing Well Strategy, as shown in Appendix II of that Policy Letter, but to ask the Policy & Resources Committee to bring forward firm proposals as part of the aforementioned Policy and Resource Plan, including identification of the resources required.

5. To acknowledge that to bring about the level of transformational change identified by the investigations undertaken to date will require significant further research and other implementation activities, which can only be undertaken successfully by applying to them programme and project management disciplines, and by assigning to them the right level of appropriately skilled resources.

6. To make the nine strategic commitments required to bring about the significant transformational change necessary to deliver the Supported Living and Ageing Well Strategy.

7. To direct that progress on implementing the actions in the Supported Living and Ageing Well Strategy form part of the annual reporting on the Policy and Resource Plan that will commence in June 2018.

APPENDIX 2

The Long-term Care Insurance (Guernsey) (Rates) Ordinance, 2020

THE STATES, in pursuance of their Resolutions of the ** 2020[a], and in exercise of the powers conferred on them by sections 5 and 31 of the Long-term Care Insurance (Guernsey) Law, 2002[b] and all other powers enabling them in that behalf, hereby order:-

Rates of benefit.

1. (1) The maximum weekly rates of care benefit shall be -

(a) for persons resident in a residential home -

(i) £521.00, or

(ii) where also receiving EMI care, £681.00, and

(b) for persons resident in a nursing home or the Guernsey Cheshire Home, £940.00.

(2) The maximum weekly rates of respite care benefit shall be -

(a) for persons receiving respite care in a residential home-

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[a] Article ** of Billet d'État No. ** of 2020.

[b] Order in Council No. XXIII of 2002; amended by No. IV of 2014; Ordinance No. XXXIII of 2003; Ordinance No. XLII of 2007 ; and Ordinance No. IX of 2016.

(i) £750.37 or

(ii) where also receiving EMI care, £910.37, and

(b) for persons receiving respite care in a nursing home or the Guernsey Cheshire Home, £1,169.37.

Co-payment by way of contribution.

2. The weekly co-payment which a claimant shall make by way of contribution towards or for the cost of that claimant's care -

(a) as a condition of the right to care benefit, and

(b) which shall be taken into account for the purposes of determining the rate of care benefit,

shall be £229.37.

Interpretation.

3. In this Ordinance, unless the context requires otherwise -

'**EMI care**' means care which, in the opinion of the Administrator, is necessary to meet the needs of a person who is assessed by the Panel as having the characteristics of an elderly and mentally infirm person, and

'**nursing home**' and '**residential home**' have the meanings given by section 18(1) of the Nursing Homes and Residential Homes (Guernsey) Law,

1976[c].

Repeal.

4. The Long-term Care Insurance (Guernsey) (Rates) Ordinance, 2019[d] is repealed.

Citation.

5. This Ordinance may be cited as the Long-term Care Insurance (Guernsey) (Rates) Ordinance, 2020.

Extent.

6. This Ordinance shall have effect in the Islands of Guernsey, Alderney, Herm and Jethou.

Commencement.

7. This Ordinance shall come into force on the 5th October, 2020.

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c Ordres en Conseil Vol. XXVI, p. 71; amended by Ordres en Conseil Vol. XXXI, p. 278; Order in Council No. VI of 2007; Ordinance No. XXXIII of 2003; and Ordinance No. IX of 2016.

d Ordinance No. XXXI of 2019.

APPENDIX 3

Background to the Long-term Care Insurance Scheme

1. In the 1990s there was much concern surrounding the funding of Long-term Care. Analysis indicated that over the next 40 years the number of people over 65 years of age would increase substantially while the number of working age people would remain fairly static. This growth had obvious implications for the provision and funding of health and social care and raised questions as to who would provide beds for the increase in elderly people and who and how would they be paid for. It was recognised that the arrangements for funding Long-term Care at the time were unsatisfactory and did not offer an adequate model to cope with the future demand.

2. Persons needing long-term residential or nursing care at that time faced potentially huge costs resulting in their lifetime savings including the capital value of their home disappearing rapidly to pay their fees. For those unable to meet their fees in Guernsey there were three different means tested funding schemes depending on the type of accommodation they occupied. The Board of Health and the States Housing Authority administered schemes for public sector accommodation and the Social Security Authority administered the scheme in respect of private sector residential and nursing homes. The States of Alderney operated a fourth scheme.

3. All the schemes were funded through general revenue but had developed piecemeal over time. They were considered inadequate and unfair. The main difference between the schemes was how the capital and resources were treated and this was the main source of unfairness. In particular, the Board of Health assessment ignored the capital value of property owned but not lived in while the Social Security assessment treated property in the same way as money in the bank with a notional income attached to the capital value. The Housing Authority means-test also took account of the capital value of a person's house but applied a very high assumed notional income from the asset. While the Board of Health assessment was most favourable to the individual, it was the most costly for the taxpayer. It created an incentive for individuals with capital to enter Board of Health accommodation and caused bed blocking on wards as people resisted being moved to private sector homes. It was a commonly held belief at the time that 'if you go into care the States will take your house'. This was not true but people in Board of Health accommodation were at much less risk of losing their life savings than individuals in other types of residential care. This situation remained unchanged despite a States resolution in 1988 for one uniform assessment for fees.

4. In 1988 the Social Security Authority was directed by States resolution, to report back on ways to implement a standard means-tested assessment based on the provisions of the Supplementary Benefit (Guernsey) Law, 1971 to replace the Board of Heath and Housing Authority schemes[55]. Other policy matters took precedence over this piece of work and, with the passage of time, it was evident that dealing solely with the problem of conflicting assessments, would not address the broader issues of future funding and provision of services for an ageing population. A working party was set up to look at public and private sector services in Guernsey and Alderney for both long and short–term care. It also considered the balance between institutional and community care services and the expansion of sheltered housing and how these services would need to expand and be funded over the next twenty years.

5. Following the working party investigation the Social Security Authority believed that although supplementary benefit was a possible solution, a Long-term Care insurance scheme broadly similar to the specialist health insurance scheme, would be a better option. An insurance scheme, would spread the costs of Long-term Care across the community and should avoid the need for the capitalisation of assets, including property, to pay for a residential or nursing care bed. In a 1999 Policy Letter[56], the Social Security Authority recommended to the States:

   a. That development of the means-tested supplementary benefit based model as the approach to assessment of fees for Long-term Care should be discontinued;

   b. That the preferred approach to funding Long-term Care should be an insurance based scheme.

6. The States approved these recommendations in-principle. The working party continued to work to address the questions that had been raised during the debate. Particular attention was given to how to control demand and cost, and how to ensure provision and quality.

7. In 2001, the Social Security Authority presented their Policy Letter[57] with the developed proposals (Appendix 3), which were approved and legislation prepared. The Long-term Care Insurance (Guernsey) Law, 2002 came into effect in 2003 with an initial contribution rate of 1.4% being charged from

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55 Benefit payable to persons residing in a hospital or home (Billet d'État XX of 1988, Article XX)

56 Long-term Care Insurance Scheme for Guenrsey and Alderney (Billet d'État XIX of 1999, Article XVI)

57 Long-term Care Insurance Scheme for Guernsey and Alderney (Billet d'État III of 2001, Article VII)

January 2003 and paid to the Long-term Care Insurance Fund. Benefit payments commenced in April 2003.

8. The main eligibility requirements were simple; the beneficiary would need to be aged 18 years or over and have been ordinarily resident in Guernsey for five years immediately before claiming benefit or for five years at any time in the past, but resident for one year immediately before claiming benefit. They would also need to have been assessed as needing Long-term Care in residential accommodation by the Needs Assessment Panel, taken up a place in a nursing or residential home and make a contribution towards the fees. The benefit rate was set to cover the agreed care home fees minus the beneficiary's contribution, known as the co-payment; the co-payment was linked to the full Guernsey Old Age Pension minus a pocket money allowance. Where the beneficiary had insufficient income to pay the co-payment, assistance would be available through means tested supplementary benefit.

9. When introduced Long-term Care Benefit was paid at two rates, a lower rate for residential homes and a higher rate for nursing homes. In 2009 following the opening of a specialist unit for the elderly mentally infirm a third, intermediate, rate of benefit was introduced reflecting the additional needs and care required for people with dementia.

10. Although the benefit rate plus co-payment, commonly now referred to as the 'States-rate', was designed to meet the cost of care home fees in full some homes have from the outset set their fees above this level. These additional top-up fees are generally charged for larger rooms, rooms with additional features or facilities that are considered as added extras. However, there are an increasing number of homes starting to charge additional top-ups or increasing the rates of top-up being charged, some needing to do so to remain financially viable. In 2017 analysis indicated the additional top-ups being charged ranged from £12 to £575 per week.

11. Table A3.1 overleaf shows the current benefit rates payable per week, which were implemented on 1st January 2020.

Table A3.1 – Current benefit rates payable per week from 1st January 2020

	Long-term care benefit	**Respite care benefit**	**Paid by**
Private residential home	£463.89	£673.26	Long-term Care Fund
Private residential home and also receiving EMI care	£611.24	£820.61	Long-term Care Fund
Private nursing home	£866.11	£1,075.48	Long-term Care Fund
Co-payment	£209.37	Co-payment is included in the fee	Resident or through income support claim
Additional top-up from 2019 analysis	Wide range of top-up fees charged, ranging from £25 per week to a maximum of £550 a week. *a small number of double rooms are offered for single occupancy and incur higher charges Average top-up fee: Residential - £107 EMI - £206 Nursing - £182		Resident or their family

12. Since it was introduced the Long-term Care Scheme has provided valuable support and financial protection for individuals who have needed residential care. It has also been successful in stimulating growth in the private residential care sector; around 136 nursing and 67 residential beds have been created offsetting the reduction of 89 nursing and 165 residential beds in the public sector. Of note, the original research for the Scheme indicated there was an oversupply of 140 residential beds and undersupply of supported living accommodation.

APPENDIX 4

Eligibility and the needs assessment process

An assessment of care needs must be undertaken by the Needs Assessment Panel (NAP) to determine eligibility for Long-term Care benefit. The Panel, the appointment of its members by the Committee for Health & Social Care and their responsibilities are set out in the Long-term Care Insurance (Guernsey) Law.

The Needs Assessment Panel is responsible for issuing a written assessment of the Long-term Care needs on behalf of a person applying for Long-term Care benefit.

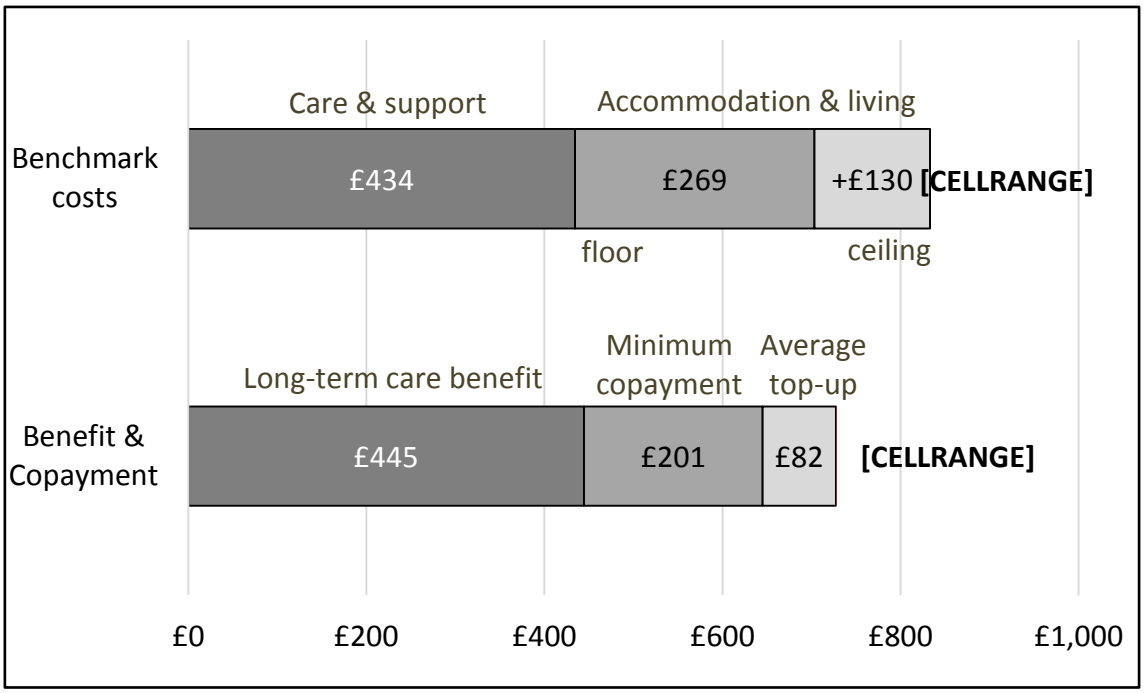
- The process begins with a person who is thought to need residential Long-term Care being assessed by an appropriate health professional who then presents the findings to the NAP
- The Panel considers the information and decides whether the person is in need of care and whether it should be residential, nursing, respite, extra-care or hospital care
- A certificate specifying the appropriate level of care required is issued
- The certificate is submitted to Social Security and a copy sent to the person who has been assessed
- It is the responsibility of the person and their family to find and agree a place in a home of their choice
- Once a place has been agreed the home will usually support the individual or their family with the application for Long-term Care benefit and will submit the claim and relevant paperwork to Social Security
- When these have been received, the NAP certificate is linked to the claim and used to confirm the level of care and benefit needed
- The claim is put into payment once the person has taken up the place in the home
- If the person's condition changes the home can ask for a review of the care needs assessment, and, where the review shows there has been a change, the NAP will issue a new certificate appropriate to their changed condition and benefit will be paid accordingly.

APPENDIX 5

Benchmarking results from analysis of care home costs

This Appendix sets out the benchmarking results from the analysis of care home costs for residential, nursing and EMI beds and the distribution of top up fees.

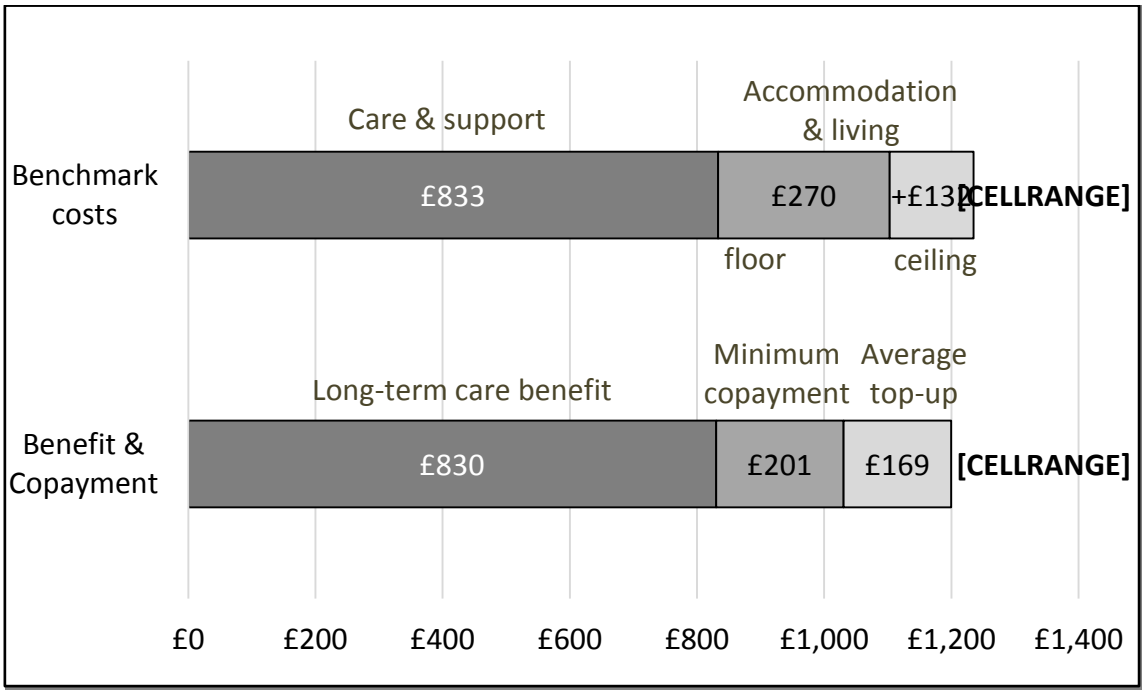
Figure A5.1 – 2018 Costs of care – Residential beds



The 2018 benchmark cost of care and support for residential beds was £434, close to the Long Term Care benefit rate for these beds.

The benchmark cost of accommodation and living costs was between £269 ('*floor rate*') and £399 ('*ceiling rate*'), depending on the quality of accommodation. The upper limit corresponds to a newly built care home that meets the latest specifications for best practice, whilst the lower limit corresponds to an older home, with a lower property value. Even at the floor rate, the benchmark cost for accommodation and living is substantially above the minimum co-payment of £201.

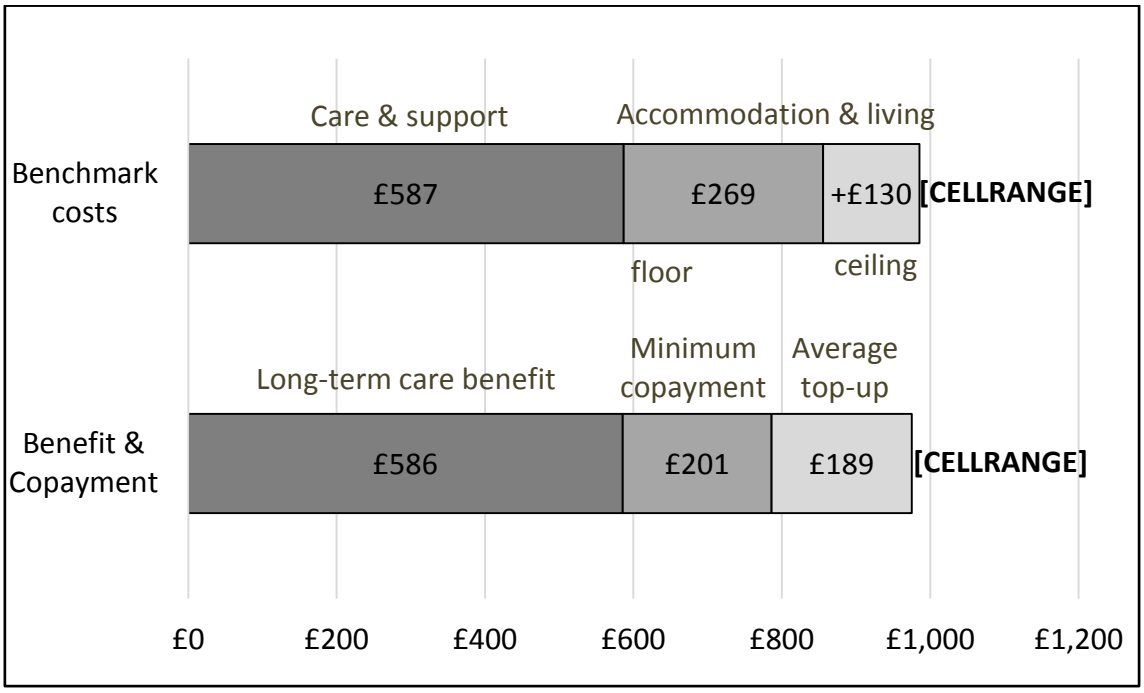
Figure A5.2 – 2018 Costs of care – Nursing beds



The 2018 benchmark cost of care and support for nursing beds was £833, close to the Long Term Care Benefit rate of £830 for these beds.

However, the benchmark cost of accommodation and living costs was between £270 (floor) and £402 (ceiling). Even at the lower floor rate, this benchmark cost is above the minimum co-payment of £209.

Figure A5.3 – Costs of care – EMI (dementia care) beds



The 2018 benchmark cost of care and support for EMI beds was £587, close to the Long Term Care Benefit rate of £586 for these beds.

However, similar to Residential and Nursing beds, the benchmark cost of accommodation and living costs was substantially above the co-payment. Benchmark costs were £269 (floor) and £399 (ceiling). Even at the lower floor rate, this benchmark cost is above the minimum co-payment of £201.

This analysis shows that for all three bed types, the States Rate is below the fee that we would expect a home to need to charge to achieve reasonable profits, even for older homes represented by the 'floor' benchmark. Table A5.1 overleaf summarises the difference between the benchmark fee at its mid-point, and the States Rate for each bed type. Figures are shown at their 2018 values and indexed to 2020.

Table A5.1 – Summary of the difference between the benchmark fee at its midpoint and the States rate for each bed type

Bed type	Benchmark Fees					2018 States rate			Benchmark mid-point vs States rate		
	Care costs	Accommodation & living costs			Total mid-point	Benefit	Co-payment	Total	Care	Accommodation	Total
		Min	Max addition	Mid-point							
Residential (2018)	£434	£269	£130	£334	£768	£445	£201	£645	-£11	+£133	+£123
Nursing (2018)	£833	£270	£132	£336	£1,169	£830	£201	£1,031	+£3	+£135	+£138
EMI (2018)	£587	£269	£130	£334	£921	£586	£201	£786	+£1	+£133	+£135
Residential (2020)	£453	£281	£136	£349	£801	£464	£209	£673	-£11	+£139	+£128
Nursing (2020)	£869	£282	£138	£351	£1,220	£866	£209	£1,075	+£3	+£141	+£144
EMI (2020)	£613	£281	£136	£349	£961	£611	£209	£821	+£1	+£139	+£140

Long-term care homes: distribution of top-up fees by class of bed (2019)

The distribution of the top-up fees charged for different types of bed is shown in Figures A5.4-A5.6. and Table A5.2 below.

Figure A5.4 – top up fees for residential beds

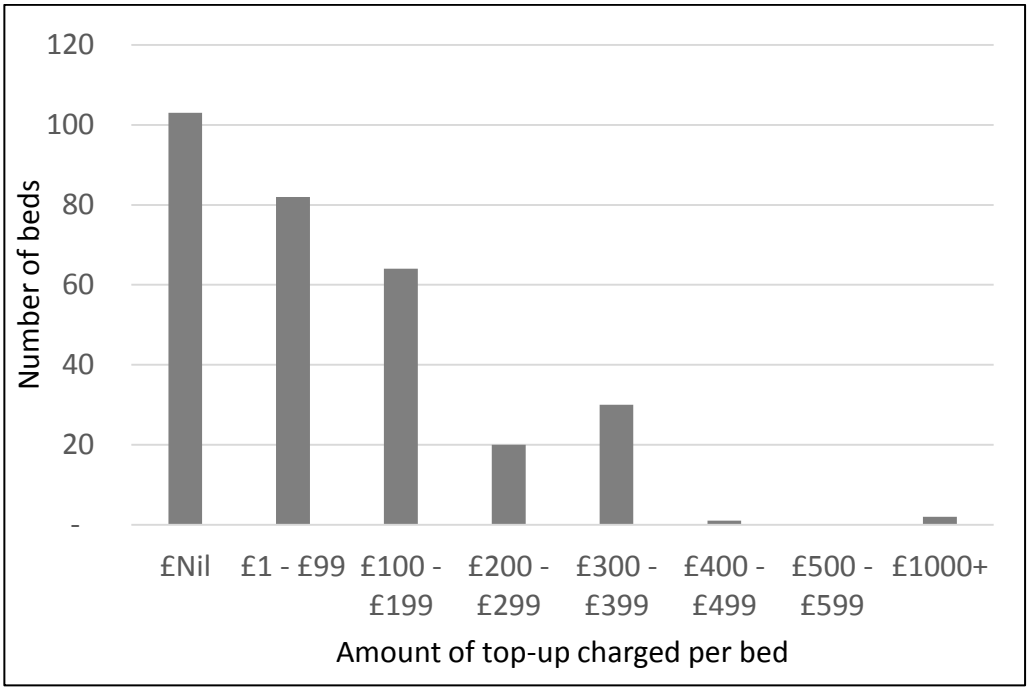


Figure A5.5 – Top-up fees for nursing beds

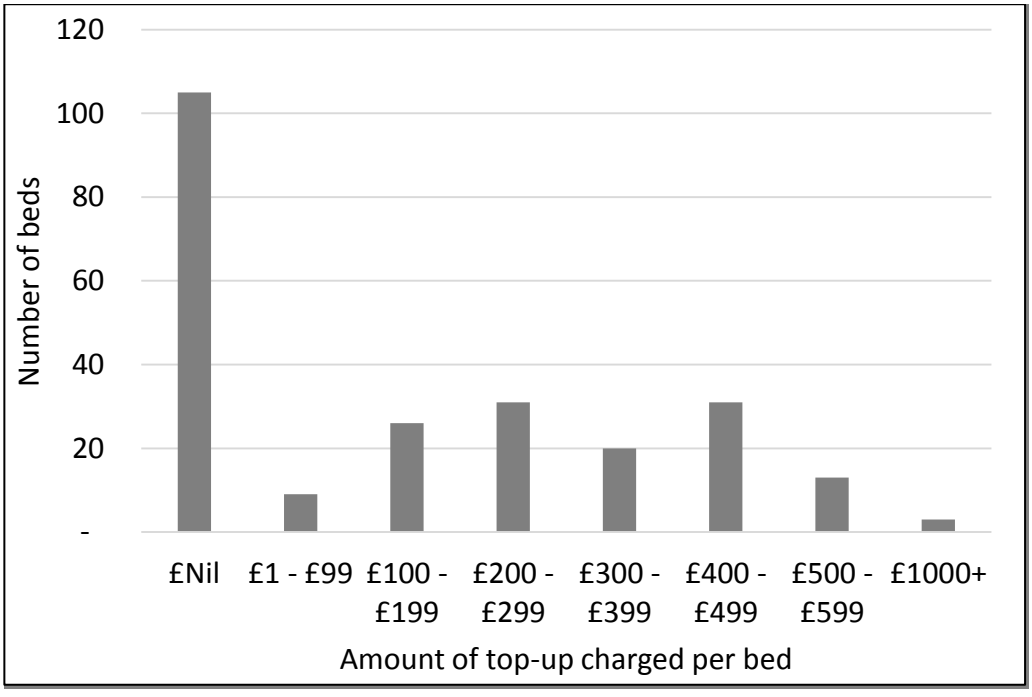


Figure A5.6 – Top-up fees for EMI beds

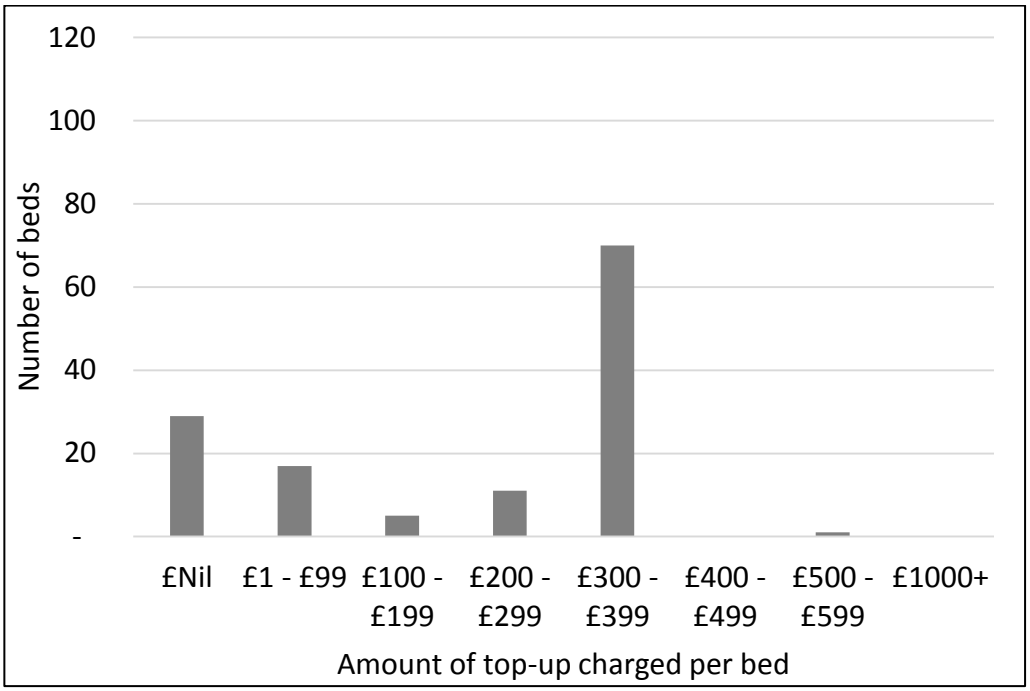


Table A5.2 below summarises the number of beds available at each class, the percentage that are available at the States rate, and the average top up for each class of bed.

Table A5.2 – Summary of the distribution of top-up fees by class of bed

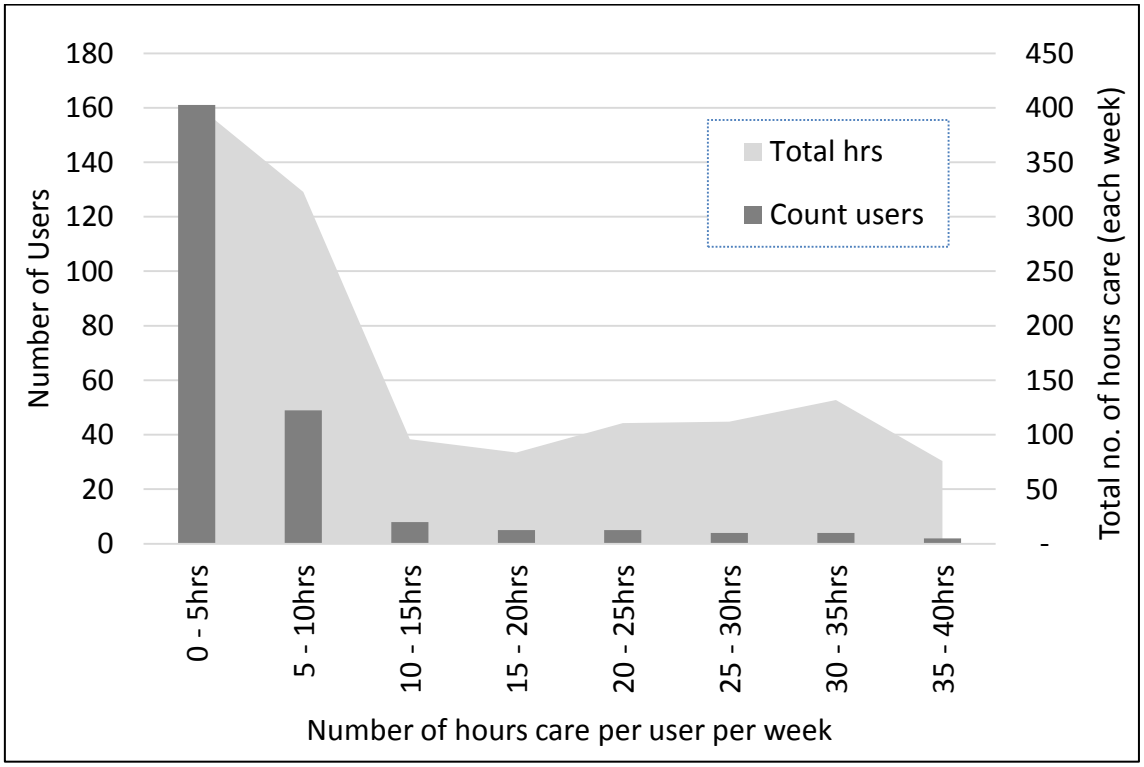
Type of bed	Number of beds available	Percentage of beds at States rate	Average top-up per bed
Residential	302	36%	+£107
Nursing	238	44%	+£182
EMI	133	22%	+£206

Health & Social Care Homecare costs

The 'per user' costs of homecare was based on 3 stages of review, which are set out below.

Stage 1: A summary of service volumes was prepared based on detailed information provided by the Community Social Care Team. This showed the number of service users to be 238, with a mean 'face to face' social care time of 5.6 hours per week. There was however a wide distribution of care hours, with the least demanding 25% of users receiving 1.8 hours or less, and the top 10% of users with the most complex needs receiving 12 hours or more per week. This latter group, although small in number receives nearly 50% of all care time delivered. Figure A6.1 below illustrates this distribution of users and service hours.

Figure A6.1 – Homecare hours per user per week



Stage 2: The cost per hour of social care was calculated 'bottom up' in terms of the hourly pay to social care staff, adjusted for holidays, travel time and departmental administration overheads. This gave an hourly cost of £31.

Stage 3: A top down review of total costs incurred in Health & Social Care Community care cost codes was performed, based on the actual forecast costs for 2018. Cost

centre totals were allocated across the range of services provided by the Community Care Team to arrive at the total annual cost for each service.

The total annual cost of Social care was £2,275,000 including the Social Care Team, care staff in the Nights and Twilights team and a share of administrative staff in the Community team. This implies an effective cost per hour of face to face social care of £33, close to the rate of £31 calculated bottom up. The difference is attributed to simplifications in the bottom up calculation, which assumed for example, that all care staff were on PSD pay scale D. This higher figure was used to calculate low, medium and high home care 'per user' costs as follows:

- Homecare low user: 1.8 hours at £33 per hour = £59
- Homecare medium user: 5.6 hours at £33 per hour = £185
- Homecare high user: 11.8 hours at £33 per hour = £389

Extra care

The costs of providing Extra Care housing service to individuals are primarily the provision of the on-site care staff and the provision of the flats.

Care costs of £212 per user include primarily the cost to Health & Social Care of £197 per week for providing on-site care staff. Health & Social Care costs were calculated top down in terms of the known 2017 actual spend on staff in each location per SAP, and the number of residents benefitting from care. This calculation was performed for each site, and gave an average care cost per user of £10,300 per annum equivalent to £197 per week:

Table A6.1 – Care costs in extra care

Health & Social Care facility	FTE (indicative)	2017 actual cost	Number of cared flats	Cost per flat
Rosaire Court	12	£493k	60	£8.2k
Le Grand Courtil	20	£855k	87	£9.8k
Nouvelle Maraitaine	23	£911k	73	£12.5k
Total	**55**	**£2,258k**	**220**	**£10.3k**

Accommodation costs of £322 per week include a rental value for the Extra Care flat, plus a service charge which includes utilities, as shown in Table A6.2 on the following page.

Table A6.2 – Accommodation costs in extra care

Charge	Cost
Equivalent weekly rental	£267
Plus – GHA Service charge (incl. utilities)	£42
Other	£14
Total weekly cost	**£322**

Rental values, capital, build and maintenance costs were factored into the analysis. The equivalent weekly rental figure is based on the economic cost of building and maintaining the apartments, and is not the same as the actual rent charged.

Duchess of Kent and Lighthouse wards

The cost to Health & Social Care for providing residential care in the Duchess of Kent[58] residential home and the two Lighthouse wards was taken from an earlier exercise undertaken as part of the wider service costing review. Costs were based on actual spend, including an apportionment of centrally incurred Princess Elizabeth Hospital costs for shared services. In addition, a notional rent cost was added to reflect the economic cost of providing the buildings, in order to improve comparability with alternate care models which include full accommodation costs. See Table A6.3 below.

Table A6.3 – Cost of providing accommodation and care in Duchess of Kent and Lighthouse wards

	Lighthouse wards			DOK
	Hanois	**Fougere**	**average**	
Average occupancy (2015)	14	14		24
Total bed-weeks (2015)	752	750		1,253
Total spend				
HSC revenue cost	£1,275k	£1,338k		£1,727k
Notional building rental cost	£104k	£104k		£173k
Total 2015 cost	£1,379k	£1,441k		£1,899k
Cost per bed week				
Care costs	£1,571	£1,662	£1,617	£1,254
Accommodation costs	£205	£204	£204	£201
day-day living	£57	£56	£57	£62
Total	£1,833	£1,922	£1,877	£1,516

[58] The Duchess of Kent residential services have moved to the third Lighthouse ward in 2019

Note that the lighthouse wards were rebranded in late 2017:

- Hanois was renamed Corbiere
- Fougere was renamed Roustel
- Casquets was renamed Brehon

APPENDIX 7

Further information on types of social care provision

Most schemes around the world provide support with Activities of Daily Living (ADL) which comprise the basic requirements for daily self-care. Some schemes also provide additional support for activities that are not fundamental to functioning but assist with independent living, known as Instrumental Activities of Daily Living (IADL). The latter are usually provided in countries with comprehensive Long-term Care coverage such as the Nordic countries. The cost of such schemes is significant and it is notable that in recent years these countries have been making changes to address the sustainability of their schemes. The solutions are principally to reduce benefits or target higher levels of need by increasing eligibility requirements.

Table A7.1 – Examples of ADLs and IADLs

Activities of Daily Living (ADLs)	Independent Activities of Daily Living (IADLs)
Having a bath or shower	
Using the toilet	
Getting up and down stairs	Doing routine housework or laundry
Getting around indoors	Shopping for food
Dressing and undressing	Getting out of the house
Getting in and out of bed	Doing paperwork or paying bills
Washing face and hands	Use of the telephone
Eating, including cutting up food	
Taking medicine	

In Guernsey

The Health & Social Care Community Care Team provide most of the formal community care in the island. Care is provided in users own homes, in extra-care housing and in residential care settings when more specialist nursing support is needed. The type of care delivered by the Health & Social Care Community Care team consists of nursing and social care, home help and sitting services provided by registered and qualified nurses in the Community Team and carers and home helps in the Community Social Care Team.

The type of care being delivered by each team is as shown in Tables A7.2 and A7.3 on the following page.

Table A7.2 – Care delivered by the Community team

Registered nurse	VQ qualified nurses
Assessment Complex dressings Drug administration Syringe drivers Palliative care End of life care (imminent)	Insulin administration Blood tests Minor dressings Catheter care Palliative care PEG feeds (percutaneous endoscopic gastrostomy)

Table A7.3 – Care delivered by the Community Social Care team

Home help	Carers
Domestic assistance (but not general household cleaning that a cleaner would do) Shopping Empty commodes Change soiled beds and deal with laundry Dealing with hoarding	Provide care and support, includes personal care such as washing, dressing, toileting, stockings Assist with medication, eye drops Assist with food preparation and eating May do multiple visits in the day, may be two staff per visit

APPENDIX 8

Definitions related to Long-term Care

Definitions of Long-term and Long-term Care

Long-term - For OECD financial account and mapping purposes, the notion of long-term in the context of nursing care services usually refers to services delivered over a sustained period of time, sometimes defined as lasting at least six months. As a rule of thumb is suggested to consider patients as long-term dependent when their impairment is expected to last at least six month or for the rest of their lives without expectation of full recovery

Long-term care - A range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL). This 'personal care' component is frequently provided in combination with help with basic medical services such as 'nursing care' (help with wound dressing, pain management, medication, health monitoring), as well as prevention, rehabilitation or services of palliative care. Long-term care services can also be combined with lower-level care related to 'domestic help' or with instrumental activities of daily living (IADL).

Acute care - A World Health Organization (WHO) Bulletin (Bull World Health Organ 2013,91:368-388) proposes a definition of acute care which is that it:

> 'Includes the health system components, or care delivery platforms, used to treat sudden, often unexpected, urgent or emergent episodes of injury and illness that can lead to death or disability without rapid intervention. The term acute care encompasses a range of clinical healthcare functions, including emergency medicine, trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care and short-term inpatient stabilization.'

Put simply acute care is services whose primary purpose is to promote, restore and/or maintain health. Such health services are aimed at contributing to improved health or to the diagnosis, treatment and rehabilitation of sick people and include health promotion and prevention, cure, rehabilitation and palliation efforts.'

APPENDIX 9

Worked examples

The two examples below show worked examples of application with and without a change in income support rules and a care cost contribution

Example 1 – Low income couple with existing income support claim receiving care at home

Mr and Mrs D

- Live in their own home valued at £450,000
- Weekly income Mr D £222.58 (OAP) + £89.07* (Joint IS claim)
- Mr D needs help with personal care
- Assessed by NAP as Level 2 LTCB - £344.00/week

* plus rates and insurance

Current income support rules with proposed new level and rates of benefit.	Valuing property in an income support claim with a long-term care claim – first £350,000 discounted.
Mr D receives care in his own home receiving care up to a value of £344/wk Income - £222.58 **Income support determination** Joint couple householder claim Requirement - £311.65 Calculation £222.56-£311.65 = £89.07* **Income support paid £89.07 (joint)** **Long-term Care Benefit paid - £344** * Plus rates and insurance	**Mr D** receives care in his own home receiving care up to a value of £344/wk Income £222.58 **Income support determination** Joint couple householder claim Requirement - £311.65 Calculation £222.56-£311.65 = £89.07* **Income support paid £89.07(joint)** **Means testing determination for LTC** £100,000 capital (in excess of £350,000) **Mr D liable for up to £35,000 of care contributions or until capital reduces to under £350,000** Assistance available from deferred loan scheme *Plus rates and insurance
Mr D is cared for at home for two years. Income support paid - £9,263.28. Long-term care benefit - £35,776	Mr D is cared for at home for 2 years Income support paid - £9,263.28 Care fees paid by Mr D - £35,000 Long-term care benefit paid - £776

Example 2: Higher income couple with existing income support claim receiving care at home

Mr and Mrs E

- Live in their own home valued at £450,000
- Weekly income Mr E £222.58 (OAP) + £200 (Occupational pension)
- Mr E needs help with personal care
- Assessed by NAP as Level 2 LTCB - £344.00/week
- Care cost cap of £35,000

Current rules with proposed new level and rates of benefit	Care cost cap of £35,000 + valuing property in an income support claim with a long-term care claim – first £350,000 discounted
Mr E receives care in his own home receiving care up to a value of £344/wk Income - £422.58 **Long-term Care Benefit paid - £344**	**Mr E** receives care in his own home receiving care up to a value of £344/wk Income £422.58 **No income support payable** **Means testing determination for LTC** £100,000 capital (in excess of £350,000) **Mr E liable for up to £35,000 of care contributions or until capital reduces to under £350,000** **Mr E reaches the care cost cap of £35,000 in 102 weeks** (£35,000÷£344 = 102 weeks) Assistance available from deferred loan scheme
Mr E is cared for at home for 4 years Long-term care benefit paid - £71,552	Mr E is cared for at home for 4 years Income support paid - £0 Care fees paid by Mr D - £35,000 Long-term care benefit paid - £36,552

APPENDIX 10

A commissioning model

The main objectives of the model are:

- For the States to maximise the provision of affordable beds at a basic rate through an arm's length tendering process.
- To improve transparency of care home bed rates and bed availability. The aim here is to increase price competition for non-basic rate beds, as well as simplify the process for users of finding a bed.
- For the States to take on the responsibility of contracting with care homes, and negotiating terms. This addresses concerns that individuals may be in a weak negotiating position, and the State is better placed to negotiate good terms with the care homes.

The benefits of this model to the States and users are:

- All users of commissioned beds would be offered a standard contract, with the reassurance that it has been robustly negotiated and includes terms covering uprating policy and core service specification.
- The tendering process, combined with the benefit of appearing on a preferred supplier list should encourage more beds to be offered at States rates. Furthermore, the improvements in transparency of bed availability and price for non-commissioned beds should promote price competition.
- The block booking process will give certainty of the numbers of beds available at States rates, and will tie homes into providing States rates beds over the contract term.

There are also a number of benefits to homes:

- The increased security of income offered by pre-bookings, combined with the assurance that States rates will be calculated to provide a market return on investment, should provide an environment in which homes feel more comfortable investing in new capacity.
- This model meets the need to encourage the provision of beds at basic rates in a way that recognises the differences between homes. Premium homes would be free to choose not to participate if they wish.

In time, these benefits to homes should benefit all users, through increases in supply.

<u>Commissioning: The key process points from this model</u>

The States would calculate an updated basic rate for each class of bed, using LaingBuisson methodology or similar. Importantly, this method ensures the basic rate

is sufficient to cover reasonable Guernsey adjusted costs, for users with typical care needs in each class. In addition, the rate provides for a profit, at market rates, comprising an operating profit and a return on investment capital.

Basic rates are currently separately set for residential, residential EMI and nursing beds. An additional rate would be introduced for complex nursing beds.

A standard service contract (the Framework agreement) would be negotiated, setting out the terms under which homes provide commissioned beds to users. The contract would cover terms such as a standard service specification, conditions under which additional charges could apply, and the policy for annual uprating of fees.

Homes would be invited to enter into a contract to pre-book beds with the States, at basic rates and under the terms of the Framework Agreement. This would be arranged through a formal periodic tendering process. Homes would be free to offer as many, or as few beds as they wish, or to choose not to bid at all. The States would offer these fixed rate contracts for fixed terms of (say) 2 or 3 years.

All homes would be required to publish their bed rates and maintain a current list of vacancies using a fixed format template. This is for all beds, both commissioned and non-commissioned. In time this could evolve into an on-line portal that homes update directly, and that provides users with a one-stop shop for comparing prices and availability. (There is a UK precedent for something similar to this, though it is limited to publishing vacant beds).

Any vacant States rates beds that have been pre-booked under this commissioning process would appear in a ‘preferred supplier’ bed shortlist, made available to eligible new users. Users would be directed to choose from this preferred supplier list. We anticipate minimal vacancies in these commissioned beds, but do not propose guaranteeing payments for vacant beds.

THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE *FOR* EMPLOYMENT & SOCIAL SECURITY

SUPPORTED LIVING AND AGEING WELL STRATEGY: EXTENDING THE LIFE OF THE LONG-TERM CARE INSURANCE SCHEME

The President
Policy & Resources Committee
Sir Charles Frossard House
La Charroterie
St Peter Port
GY1 1FH

29th June 2020

Dear Sir

Preferred date for consideration by the States of Deliberation

In accordance with Rule 4(2) of the Rules of Procedure of the States of Deliberation and their Committees, the Committee *for* Employment & Social Security requests that 'Support Living and Ageing Well Strategy: Extending the life of the Long-term Care Insurance Scheme' be considered at the States' Meeting to be held on 19th August 2020.

The Committee requests that the aforementioned Policy Letter is considered at the earliest opportunity because the Committees involved in developing the proposals are convinced, following close engagement with a number of care home owners, that the sector is financially vulnerable. Two care homes have closed recently and the Committee believes that others are at risk of closure unless there is an increase in their income, principally through an increase in the long-term care benefit rates. To mitigate this risk, the Committee is recommending an early uprating of the long-term care benefit rates, to commence on 5th October 2020. Further, with the likelihood of the General Election being held in October, the Committee requests that this Policy Letter is considered by the current Assembly, so as not to further delay the provision of financial support to the care home sector.

Yours faithfully

Michelle Le Clerc
President

Shane Langlois
Vice President

John Gollop, Emilie McSwiggan, Peter Roffey

Mike Brown, Andrew Le Lievre
Non-States Members