Department
of Health

# The Care Act 2014

## Consultation on draft regulations and guidance for implementation of Part 1 of the Act in 2015/16

June 2014

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# The Care Act 2014

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The Department of Health

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# Ministerial foreword

## The Care Act is an historic piece of legislation that will make a difference to some of the most vulnerable people in society for many years to come. It places care and support law into a single, clear modern statute for the first time and enshrines the principle of individual wellbeing as the driving force behind it.

The principle of personalisation is at the core of these reforms. Rather than the state deciding what people need, people themselves will be able to shape their care and support around what *they* want, to achieve the outcomes that matter to *them*. To help them do this, the Act ensures that people will have clearer information and advice to help them navigate the system, and a more diverse, high quality range of support to choose from to meet their needs. The Act places more emphasis than ever before on prevention – shifting from a system which manages crises to one which focuses on people's strengths and capabilities and supports them to live independently for as long as possible.

The Care Act will make the care and support system clearer and fairer for those who need it. We will set a national minimum eligibility threshold to help people better understand whether they are eligible for local authority support. This also paves the way to allow older people and those with disabilities to move from one area to another with less fear of having their care and support interrupted. Crucially the Act is also a landmark moment for carers. For the first time, they will be put on the same legal footing as the people they care for, with extended rights to assessment, and new entitlements to support to meet their eligible needs.

The Care Act also marks an overdue reform to the way that care is paid for. After almost two decades of debate with little progress, I am proud that we are finally bringing forward reforms to how people pay for care so they get more financial support from the state, and are protected from crippling costs if they develop conditions like dementia. The universal deferred payment scheme will ensure that people are not forced to sell their home during their lifetime to pay for care.

I am proud of the uniquely collaborative approach taken to developing this legislation. From the Law Commission's report, through to the public consultation on the draft Care and Support Bill, to the pre-legislative scrutiny and debates during the Bill's passage through parliament, the Government has listened and improved the legislation at every stage of the process.

This consultation continues our collaborative approach. We want to hear from people with experience of care and support, from those with needs for care and support and their carers to the dedicated professionals who are responsible for delivering care and support. We are holding a consultation on the draft regulations and guidance which will make a reality of these reforms.

This consultation provides an important opportunity to influence the documents which will inform *how* local authorities go about delivering these reforms.

I hope that local authorities, people who use and provide of care and support, the voluntary sector and everyone with interest or expertise will once again contribute. By sharing your views and experience you can help us to ensure that the regulations and guidance deliver these crucial reforms.

*Norman Lamb MP*
*Minister of State for Care and Support*

# 1. Introduction

## What are the draft regulations and guidance?

1.1. The Care Act contains the core legal duties and powers relating to adult social care. The Care Act also contains regulation making powers. These allow the Government to make secondary legislation (regulations) that provide more detail. The regulations will be laid before Parliament, and some of them will be debated in both Houses of Parliament.

1.2. The statutory guidance is intended to provide local authorities with the information they need about how they should meet the legal obligations placed on them by the Act and the regulations. Local authorities are required to act under the guidance, which means that they must follow it, unless they can demonstrate legally sound reasons for not doing so. The guidance will be used by local authority officers to plan care and support at a local authority level, as well as by practitioners. The guidance will also be used by people using care and support, their families, the voluntary sector and providers of care and support to help them understand the new system, and by courts in deciding whether a local authority has acted within the law.

1.3. All of this points to the importance of getting the regulations and guidance absolutely right. In order to achieve this, we will continue to use the same collaborative approach we have used throughout the process of developing this legislation. This will continue to draw on the expertise and experience of the care and support sector to make sure that the guidance and regulations realise the ambitions of the Care Act.

1.4. The draft regulations and guidance have been developed in collaboration with a number of expert reference groups comprising users of care and support, local authority staff, voluntary sector organisations, social workers, and national representative bodies including those drawn from local government.

1.5. In order to support delivery of this significant programme of reform we have established a joint programme office, in partnership between the Department of Health, the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS). This unprecedented step demonstrates our absolute commitment to deliver these reforms in partnership with local government.

1.6. The draft regulations and guidance published relate to the care and support reforms and provisions in the Care Act which will come into effect in April 2015. The guidance describes how the care and support system should operate in 2015/16. Regulations and updated guidance to support implementation of the additional reforms which come into effect in April 2016 (for example, the cap on

care costs), will be subject to a separate consultation, to be published later this year.

## What will happen to the existing legislation?

1.7. When the Care Act comes into force in April 2015, it will replace various pieces of existing legislation. These pieces of legislation will be disapplied or repealed, so they will no longer have force in relation to England. The Act and its supporting regulations and guidance will also replace a number of existing regulations, directions and guidance. A list of some of the key pieces of legislation to be repealed is provided for reference at Annex E. We will also make consequential amendments to other pieces of legislation that refer back to legislation that is no longer relevant and amend them to refer to the Care Act.

## About this consultation

1.8. This document should be read alongside the draft regulations and guidance. It sets out a high level summary of the policies to which the regulations and guidance relate and the questions on which we would particularly welcome views and evidence.

1.9. Respondents should not feel limited to the questions included here. We welcome views about anything included in (or omitted from) the regulations and guidance, and we invite respondents to share their views about the approach we have taken to each section of the guidance and each of the regulations.

1.10. In considering and responding to the draft regulations in particular, respondents should look in parallel at the provisions in the Care Act, which set out the limits on how regulations can be used in particular circumstances.

1.11. We also invite respondents to let us know of any examples of best practice or tools that they think would be particularly helpful to local authorities to deliver the policies in the Act.

1.12. We will be accepting written submissions to the consultation until 15 August 2014. Please submit your comments to: careactconsultation@dh.gsi.gov.uk , online at www.careandsupportregs.dh.gov.uk or, alternatively to:

Care and Support consultation team
Department of Health
Room 313B, Richmond House
79 Whitehall
London
SW1A 2NS

1.13. Following this consultation, we intend to publish the final documents in October 2014 to allow local authorities six months to finalise preparations before the Act comes into force. The draft regulations will be laid before Parliament at the same time.

# 2. General duties and universal services

## Wellbeing

2.1. Local authorities must promote wellbeing when carrying out any of their care and support functions in respect of an individual. This “wellbeing principle” enshrines people’s needs and desired outcomes as the heart of the care and support system. The Act sets out the areas that wellbeing relates to, as well as further matters that local authorities should consider in promoting wellbeing (such as starting from the assumption that an individual is best-placed to judge their own wellbeing). These areas focus on the most relevant outcomes that people want to achieve.

2.2. The Act also signifies a shift from existing duties on local authorities to provide particular services, to the duty to ‘meet needs’. This is the core legal entitlement for adults to public care and support. It establishes one clear and consistent duty for all people who need care and support, and an equivalent duty for carers. The concept of ‘meeting needs’ recognises that everyone’s needs are different and personal to them, and local authorities will have to consider how to meet each person’s specific needs rather than simply considering what service they will fit into.

2.3. The draft guidance covers:

- the definition of wellbeing;
- the principles which underpin the focus on wellbeing; and,
- how the concept of wellbeing is reinforced throughout the provisions in the Act.

**Questions for consultation**

1. Does the draft guidance provide local authorities with the information they need to embed wellbeing into the way that they work?
2. Can you suggest some examples to illustrate how the wellbeing principle could be applied?

## Preventing, reducing and delaying needs

2.4. The Act requires local authorities to ensure the provision or arrangement of services, facilities or resources to help prevent, delay or reduce the development of needs for care and support. The prevention duty extends to all people in a local authority's area, including carers, regardless of whether they have needs for care and support, or whether someone has had a needs or carer's assessment.

2.5. The draft guidance covers:

- the definition of "prevention" and different approaches to preventing needs;
- how local authorities should go about developing local approaches to preventing, reducing and delaying need;
- identifying those who may benefit from specific preventative services; and,
- rules on charging for preventative services.

### Questions for consultation

2.6. The draft guidance describes prevention in order to illustrate the provisions in section 2 of the Care Act which refer to preventing, reducing or delaying the needs for care and support. The intention of this approach is not to narrow a local authority's vision for prevention or the scope of its prevention services, rather it is intended to provide clarity about the range of preventative interventions, the people who may benefit and the circumstances in which a person may benefit.

3. Is the description of prevention as primary, secondary or tertiary, a helpful illustration of who may benefit from preventative interventions, when and what those interventions may be?

2.7. A key element of the preventative approach envisaged by the Act is for the local authority to support the person to make the most of the resources available to them in their community – for instance, local support networks or voluntary services – as well as to build and develop their own strengths and capabilities. This should apply whatever needs the person has.

2.8. The Act creates a legal basis for a wide range of preventative approaches, which are referred to as 'services, facilities or resources'. There is flexibility about how a local authority carries out its duty on prevention and the draft guidance lists a number of services, facilities or resources. The list is not exhaustive.

4. Is the list of examples of preventative 'services, facilities or resources' helpful? What else should be included?

## Information and advice

2.9. The Act requires local authorities to establish and maintain an information and advice service in their area. The information and advice service must cover the needs of all its population, not just those who are in receipt of care or support which is arranged or funded by the local authority. Information and advice is fundamental to enabling people, carers and families to take control of and make well-informed choices about their care and support. Not only does information and advice help to promote people's wellbeing by increasing their ability to exercise choice and control, it is also a vital component of preventing or delaying people's need for care and support.

2.10. The draft guidance covers:

- ensuring the availability of information and advice services for all people;
- who in particular might benefit from information and advice;
- the local authority role with respect to financial information and advice;
- the accessibility and proportionality of information and advice; and,
- the development of plans/strategies to meet local needs.

### Questions for consultation

2.11. Local authorities, working with partners must use the wider opportunities to provide targeted information and advice at key points in people's contact with the care and support, health and other local services.

5. Views are invited about how local authorities should co-ordinate and target information to those who have specific health and care and support needs.

2.12. The new funding arrangements introduced by the Act, access to deferred payments from 2015 and the cap on care costs from 2016, have all increased the importance of people's access to financial information and advice that is independent of the local authority. The guidance seeks to make clear the local authority's role in actively identifying and supporting people who would benefit from financial information and advice. It recognises that finance is an integral part of a person's consideration of care and support options and in supporting them to make the best and most appropriate individual choices. Local authorities must be able to describe the general benefits of financial information and advice and be able to explain the benefits to an individual. While authorities may not wish to make a direct referral to an individual independent financial adviser, they should actively help and direct a person to a choice of adviser.

6. Does the guidance provide sufficient clarity about the active role that the local authority should play to support people's access to financial information and advice that is independent of the local authority, including regulated financial advisors?

2.13. At the Budget, the Government announced plans to give people greater flexibility and choice over their retirement options. The proposals, including plans to provide financial information and support at retirement (the 'guidance guarantee' will be a free, impartial and face-to-face offering that explains an individual's range of options to help them make informed choices about taking their pension pot) and beyond, are currently open for consultation[1].

2.14. We see retirement as a key point at which people should be considering and planning for future care and support needs and as such recognise the importance of ensuring these two policies are complementary. The Department of Health will work with HM Treasury to ensure that this guidance for local authorities reflects the outcome of the consultation.

[1] https://www.gov.uk/government/consultations/freedom-and-choice-in-pensions

## Market shaping and commissioning

2.15. The Act introduces new duties on local authorities to facilitate a vibrant, diverse and sustainable market for high quality care and support in their area, for the benefit of their whole local population (regardless of how the services are funded). The local authority's own commissioning and procurement practices should take account of these wider 'market shaping' duties.

2.16. The draft guidance covers:

- the principles which should underpin market-shaping and commissioning activity, including:
    - focusing on outcomes and wellbeing;
    - promoting quality services, including through workforce development and remuneration and ensuring appropriately resourced care and support; and,
    - supporting sustainability, and ensuring choice;
- the steps which local authorities should take to develop and implement local approaches to market-shaping and commissioning, including:
    - designing strategies that meet local needs;
    - engaging with providers and local communities;
    - understanding and facilitating the development of the market; and,
    - securing supply in the market and assuring its quality through contracting.

### Questions for consultation

7. Does the statutory guidance provide a framework to support local authorities and their partners to take new approaches to commissioning and shaping their local market?

8. Are there any further suggestions of case studies or tools that can assist local authorities in carrying out their market shaping and commissioning activities?

## Managing provider failure and other service interruptions

2.17. The Care Act places a duty on the Care Quality Commission (CQC) to assess the financial sustainability of those providers local authorities would find difficult to replace should they fail financially. CQC will take measures to ensure that a provider who is in financial difficulty is working to return to financial sustainability, warn local authorities of imminent provider failure, and work with the local authorities affected to coordinate a response.

2.18. The CQC will consult on its detailed proposals for the design and operation of the new regime in autumn 2014. The draft regulations published for consultation here set out the legal framework for the regime, including criteria for those providers which are to be included.

2.19. The draft guidance relates to local authorities' responsibilities for dealing with cases of business failure and other service interruptions, in parallel with the CQC regime. It covers:

- local authorities' roles and responsibilities in the event of business failure;
- the meaning of "business failure";
- service interruptions other than business failure;
- the link with local authorities' duties in respect of market shaping; and,
- contingency planning to prepare for managing business failure and other service interruptions.

2.20. The draft Care and Support (Market Oversight Information) Regulations 2014, cover:

- CQC's power to require information so that it can fully assess the financial sustainability of providers.[2]

2.21. The draft Care and Support (Business Failure) (England and Wales and Northern Ireland) Regulations 2014, cover:

- situations that will constitute business failure which, if it leads to the provider's inability to carry on, will trigger the temporary duty on local authorities or equivalents in Wales and Northern Ireland.

2.22. The draft Care and Support (Cross-border Placements) (Scotland) Regulations 2014:

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[2] See Annex A for further considerations made by the Department when developing the regulations with stakeholders

- ensure provision for provider failure duties on Scottish local authorities under the Social Care (Scotland) Act 1968 in the case of cross-border placements in Scotland.

2.23. The draft Care and Support (Market Oversight Criteria) Regulations 2014, cover:

- the criteria for providers to be included in the CQC market oversight regime.

2.24. The draft regulations specify the entry criteria for the CQC's regime. In setting the criteria, the Act provides that regard must be had to size, geographical concentration and the extent to which a provider specialises in the delivery of a particular type of care.

2.25. The entry criteria for residential care providers[3] capture those large providers that operate nationally, alongside those providers who are smaller but who provide services across much of the country and those who have a significant share of the market in a small number of areas.  The justification for choosing these three factors – size, geographical coverage and market concentration – is that were such providers to fail financially, there would be significant challenges in managing that failure both locally and nationally.

2.26. It may be that a less complex calculation would be equally effective in identifying providers that are "difficult to replace", and would give providers greater clarity on whether they qualified for the regime.

### Questions for consultation

9. We invite views on the entry criteria to the market oversight regime, and whether and how they could be made simpler for residential care providers.

2.27. The Act also requires the regulations to define the meaning of "business failure". We have done this by referencing different types of insolvency in the regulations, for example the appointment of an administrator. These insolvency 'situations' will act as trigger for local authorities in England and Wales4, and

[3] See Annex A for further considerations related to non-residential and specialist providers

[4] Provider failure duties on local authorities in Wales under section 50 of the Care Act are not intended to be commenced until 2016 at which time the relevant provisions of the Social Services and Well-being (Wales) Act 2014 will also be commenced.

equivalent in Northern Ireland to temporarily meet care and support needs where insolvency causes a care provider to become unable to do so.

2.28. In defining business failure for this purpose, we have attempted to balance the importance of the local authority taking action to ensure people's needs are met when their provider ceases to operate, with not inadvertently creating a situation where the local authority precipitates the failure by taking action too soon, or detracting from the core responsibility of the provider itself for arranging care and support services for those people for whom it cares.

2.29. In Scotland there are duties on local authorities under the Social Work (Scotland) Act 1968 to meet needs of people whose needs were being met in their areas under arrangements made by an authority from another UK country, where a care provider operating in Scotland can no longer do so because of business failure.

## Questions for consultation

10. We invite views on the approach to defining business failure by reference to insolvency situations.
11. We also invite views on the insolvency situations listed, e.g. are they appropriate and clear. Should other situations be covered?
12. In particular, are the listed insolvency situations appropriate and relevant to the various legal forms registered care providers can take (including providers registered in respect of establishments or agencies under the relevant legislation in/Wales and Northern Ireland)?

# 3. First contact and identifying needs

## Needs assessments and carer's assessments

3.1. The assessment process is one of the most important elements of the care and support system. It is the first contact many people have with the system, and this must be a collaborative process that involves the person concerned. The assessment must consider their needs and desired outcomes and how care and support could improve the wellbeing of the person.

3.2. In order to build a more consistent and supportive system, the Act imposes a duty for local authorities to carry out a needs assessment or carer's assessment wherever it appears that an adult has needs for care and support, or a carer has needs for support (regardless of the authority's view of the level of those needs or of the person's financial resources).

3.3. The draft guidance, together with the draft Care and Support (Assessment) Regulations 2014, cover:

- the purpose of needs and carers' assessments;
- approaches to conducting appropriate and proportionate assessments;
- what should be done to consider the impact of fluctuating needs, as well as the impact of needs on the whole family of the person being assessed;
- approaches to supported self- assessment, where the person themselves leads on aspects of the assessment process;
- the required training, knowledge and experience of assessors, including where specialist assessors are required; and,
- the relationship with the eligibility framework.

### Questions for consultation

3.4. The regulations require all assessors to be appropriately trained. In addition, where the assessor is asked to carry out an assessment of an adult with a condition they have no experience in, they must consult a person with expertise in that condition. Due to the complexities in assessing an adult who is deafblind, regulations require that a specialist assessor must carry out these assessments.

13. What further circumstances are there in which a person undergoing assessment would require a specialist assessor? Please describe why a specialist assessor is needed, and what additional training is required above the requirement for the assessor to be appropriately trained to carry out the assessment in question.

## Eligibility

3.5. The current care and support system has often been said to be complicated and unfair, because local authorities are able to set their eligibility thresholds at different levels. Even where local authorities set their criteria at the same level these can be interpreted differently. As a result, people often feel unsure about whether they are eligible for care and support, and fear that a local change in the threshold will mean losing the care they need. To make access to local authority care and support clearer and more equal across England, and to ensure a minimum level of need which must always be met, we are introducing a national minimum eligibility threshold. The draft eligibility regulations have already been subject to considerable consultation, which is detailed at annex B.

3.6. The draft guidance, together with Care and Support (Eligibility Criteria) Regulations 2014, cover:

- the national minimum threshold, which describes needs which meet the eligibility criteria for adults with care and support needs and carers;
- how to interpret the eligibility criteria; and,
- considering the impact of needs on the person's wellbeing.

### Questions for consultation

3.7. The eligibility regulations are intended to allow local authorities to maintain existing access to care and support, in the vast majority of cases.

14. Do the draft eligibility regulations, together with powers to meet other needs at local discretion, describe the national eligibility threshold at a level that will allow local authorities to maintain their existing level of access to care and support in April 2015? If you believe they don't please explain your reasons for this.

3.8. The eligibility regulations have been revised following engagement to date, to focus on outcomes and reflect how the new system will ensure a personalised approach to care and support. Some stakeholders have continued to ask whether the regulations could go further to reflect the person's outcomes, while maintaining the threshold at the level of having a significant impact on the person's wellbeing.

3.9. To make the wording more outcomes-focused we have in particular looked at the definition of the adult's "basic care activities", which are the essential care tasks that a person carries out as part of normal daily life. The question is whether these could be described as outcomes rather than activities. The draft regulations define these activities as eating and drinking, maintaining personal hygiene, toileting, getting up and dressed, getting around one's home, preparing meals, and cleaning and maintenance of one's home. As currently described, these activities define needs which are widely understood, and are used to inform the discussion about what outcomes the person wants to achieve. However, using a list of activities or tasks in this way risks undermining the focus on outcomes which is espoused by the Act in other areas, and we would like to consider alternative approaches during consultation.

3.10. If we were to redefine these basic care activities as outcomes, the following might be an example of the sorts of concepts that could be used:

a. Managing/maintaining nutrition for good health;

b. Maintaining personal hygiene and everyday appearance;

c. Living comfortably and safely at home;

d. Cleaning and maintaining one's home.

15. Do you think that the eligibility regulations give the right balance of being outcome- focused and set a threshold that can be easily understood, or would defining "basic care activities" as "outcomes" make this clearer?

16. Do the current definitions of "basic care activities" include all the essential care tasks you would expect? If not, what would you add?

3.11. Section 21 of the National Assistance Act 1948 requires local authorities to provide residential accommodation in certain cases. Under the new framework, the eligibility criteria will apply to the provision of all types of care and support including residential accommodation.

17. Are you content that the eligibility regulations will cover any cases currently provided for by section 21 of the National Assistance Act 1948?

3.12. The assessment and eligibility guidance sets out what local authorities should be doing when assessing an adult or carer and determining whether they have eligible needs.

18. Does the guidance adequately describe what local authorities should take into consideration during the assessment and eligibility process? If not, what further advice or examples would be helpful?

## Independent advocacy

3.13. The Act requires local authorities to involve people in assessments, care and support planning, and reviews. In order to facilitate the involvement of people who would otherwise have difficulty, it introduces a new requirement to arrange independent advocacy for people who either have substantial difficulty in being involved in these processes or in being fully involved in these processes, and there is no one available to act on the person's behalf. There is also a separate requirement to arrange independent advocacy in connection with safeguarding enquiries and reviews.

3.14. The draft guidance covers:

- matters which a local authority must consider in deciding whether an individual would experience substantial difficulty in engaging with certain aspects of the care and support process;
- circumstances in which a local authority must arrange for an advocate during the care and support planning process; and,
- the role of independent advocates and how they are to carry out their functions.

3.15. The draft Care and Support (Independent Advocacy) Regulations 2014, cover:

- requirements for a person to be an independent advocate;
- deciding whether someone has substantial difficulty;

- when independent advocacy must be provided, even if there is someone available to represent and support someone; and,
- the manner in which independent advocates are to carry out their role.

## Questions for consultation

3.16. In certain specified circumstances, regulations state that the local authority must provide independent advocacy to an individual who would experience substantial difficulty being 'involved', even if there is an appropriate person to act on their behalf. The specified circumstances relate to where the assessment, planning or review might result in NHS-funded provision in a hospital for a period exceeding four weeks or in a care home for a period exceeding eight weeks; and where there is a disagreement between the local authority and the appropriate person relating to the individual.

3.17. During production of the regulations, stakeholders have suggested that these circumstances should also include people undergoing an assessment or planning which results in joint provision by social care and the NHS, due to the complexity of these processes.

19. We would welcome views on further specific circumstances where the advocacy duty should apply. In particular, we welcome views on the potential benefits and disadvantages of providing independent advocacy for people for people receiving care jointly from adult social care and the NHS.

# 4. Charging and financial assessment

## Charging for care and support

4.1. Where a local authority arranges care and support to meet a person's needs, it may choose to charge the person for this, except in a small number of cases where regulations specify that it must be free. The revised framework does not represent a major change to the current system and does not extend the ability to charge from the current position. However, this is a complex part of the system and one that is not often well understood, so we are taking the opportunity to clarify the framework that will be in place for 2015/16 in new guidance.

4.2. Where a local authority chooses to charge a person, it must undertake a financial assessment of that person to assess what they can afford to contribute to the cost of meeting their care needs. If this "means test" shows that a person cannot afford the full costs of meeting their eligible needs, they will only be charged the amount they can afford, and the local authority will be responsible for the remainder. Where someone's assets and income are below minimum thresholds, the local authority will meet the full cost of their care and support.

4.3. Further reforms to be implemented from 2016/17, including the introduction of the cap on care costs and the extension to the financial limits which determine who receives financial support from the local authority, will be consulted on later this year.

4.4. The draft guidance covers:

- the principles which should underpin approaches to charging;
- financial assessments, including the treatment of capital and income;
- the persons' right to a choice of accommodation when in residential care, and in certain circumstances, their right to make an additional payment;
- the treatment of temporary residents;
- deprivation of assets; and,
- recovery of debts.

4.5. The draft Care and Support (Charging and Assessment of Resources) Regulations 2014 cover:

- limitations on the local authority power to charge – when certain services must be provided free;
- the process for assessment of financial resources;
- the financial limits which determine the financial support people may receive from the local authority;
- the assessment of capital and income;
- calculating tariff Income;

- particular sums to be disregarded during the assessment; and,
- “light touch” financial assessments.

### Questions for consultation

4.6. The aim of the draft regulations and guidance is to broadly re-create the current rules, whilst taking the opportunity to update and clarify the rules. We would therefore welcome views on the following questions:

20. Do the regulations and guidance provide a clear modern framework for charging that will enable local authorities to maintain existing flexibilities in how people contribute to the cost of meeting their care needs? Are there any particular areas that are not clear?

21. Is there anything from the current rules that has not been re-created that you feel should have been? If so, please list along with a brief explanation of why.

## 12-week property disregard

4.7. The “12-week property disregard” means that the value of a person’s property is not taken into account in the financial assessment, for the first 12 weeks from when a person enters a care home. The purpose of the 12-week property disregard for those entering a care home is to prevent people from being forced to sell their home at a time of crisis. At present this means people benefit when they first enter a care home, or when they have run down their other non-housing assets to the level of the upper capital limit set out in regulations.

4.8. This disregard provides much needed protection and we intend to retain it. However, we are aware that it does not always work as well as it might and that given the intention that people will be able to better plan and prepare for the risk of declining assets, we would like to take the opportunity to better target this support at those who most need it.

4.9. We are therefore proposing that the 12 week property disregard should apply in the following circumstances:

- When someone first enters a care home. During this period they would be assessed on the basis of their non-housing assets with an upper capital limit of £23,250 in 2015/16 (rising to £27,000 from 2016/17);
- When a person’s home unexpectedly loses an alternative disregard, for example due to the death or the moving into care of a qualifying relative; **This is an extension to the current policy; and**
- Provide local authorities the flexibility to apply the disregard in other circumstances where there is a sudden or unexpected change in a person’s financial circumstances.

4.10. To provide for the proposed extension above, we will remove the disregard for those who are already in residential care and have run down their assets. They will be able to plan and prepare for this well in advance; whereas the 12-week disregard is designed to protect people from unexpected changes in circumstance. Based on the data available, we believe this adjustment would be cost neutral. Further detail is set out in the impact assessment.

22. Do you agree that we should adjust the operation of the 12 week property disregard to better support those most at risk?

23. Would you prefer to see the current approach retained?

24. Do you agree that this proposal is cost neutral for local authorities? If it is not, please provide evidence.

## Other disregards

4.11. In 2010, we consulted on whether the disregard for products such as Investment Bonds should be removed given it potentially created a perverse incentive, particularly where they included a very small amount of life insurance. Most respondents agreed with this proposal.

4.12. We also consulted on whether pre-paid funeral plans should be disregarded for the purposes of the financial assessment. Most respondents agreed, although a number expressed some concern around the detail, for example how much should a pre-paid funeral plan be worth for the purposes of a disregard and felt that this should be limited to around £3,000 - £4,000.

4.13. These were not implemented at the time as the announcement was made that the recommendations of the Commission on Funding Reform for Care and Support would be introduced and therefore the current system would be

maintained. Given it is sometime since we consulted on these questions, we would welcome views on we should introduce this for 2015.

25. Do you think these bonds should be taken account of in the financial assessment? What are the risks and costs to local authorities and individuals?

26. Should pre-paid funeral plans be disregarded and if so should there be a limit to the size of plan that can be disregarded? If so, how much?

## Choice of accommodation and additional payments

4.14. Where a local authority is meeting a person's needs for care and support and the planning process has determined that a person needs to live in a specific type of accommodation in order to receive care, the person must have a right to choose between different providers of that type of accommodation, subject to certain conditions. In some cases a person will choose a setting that is more expensive than the amount identified in someone's personal budget. In these circumstances, an arrangement can be made for a willing and able third party to meet this additional cost.

4.15. The drafts take the current directions and guidance and move them on to a firmer statutory footing, and expand the provision to cover certain other types of care that may also include an accommodation element.

4.16. The draft guidance covers:

- the principles underpinning choice and the making of additional cost payments;
- the conditions that must be applied in exercising choice;
- how an additional cost payment may be agreed;

4.17. specific circumstances when a person may make an additional cost payment themselves;

- how additional cost payments should be managed; and
- the responsibilities and liabilities for additional cost payments if there is any breakdown in the arrangement.

4.18. The draft *Care and Support and Aftercare (Choice of Accommodation) Regulations 2014* cover:

- the right to a choice of accommodation;
- conditions for the provision of preferred accommodation;
- the application of choice to accommodation provided for mental health aftercare;
- the additional cost condition (top-up fees); and,
- the types of accommodation the regulations apply to.

4.19. The current provisions only apply to care homes. The draft regulations also cover other types of provision such as Shared Lives and Extra Care Housing. We understand that contractual arrangements for these types of provision can vary, particular if housing and social care responsibilities are split.

27. Does the guidance need to particularly cover these types of accommodation? If so, what would it be helpful to discuss?

4.20. From April 2016, the additional cost provisions will be expanded to enable a person to meet these costs themselves in more circumstances. This is being introduced to further support choice. Local authorities and the person involved will need to assure themselves of the affordability and sustainability of any such arrangements. We would therefore particularly welcome views on the following:

28. What are the risks of the expansion of the additional cost provisions so that the person can meet this cost themselves (to both local authorities and the person)? How can any risks be mitigated by regulations and guidance?

## Pension reform

4.21. In the Budget statement in March, the Chancellor announced a number of changes to defined contribution pensions that will introduce far greater choice for how people are able to fund later life. This means that from April 2105 a person with a defined contribution pension, whatever its size, will be able to take it how they wish, subject to their marginal rate of income tax. A person will still be able to take their pension fund to purchase an annuity should they wish, but it will also give them the flexibility to access their money and invest or spend it as they wish. Details of the proposed reforms can be found at https://www.gov.uk/government/consultations/freedom-and-choice-in-pensions and the consultation is open until 11 June 2014.

4.22. Charging for care and support needs is dependent on a financial assessment of a person's capital and income. Currently any funds invested in an annuity or a capped or flexible drawdown pension are disregarded and only the income drawn from those products is taken into account in the financial assessment.

4.23. The Government is considering whether the current charging rules for care and support need to be updated, in light of the recently announced changes to the private pension system, to ensure they are fair, appropriate and sustainable. Views would be welcome on how the means test can appropriately take account of the new private pensions system.

29. What do you think the impact of the increased pension flexibilities might be for social care charging for people and local authorities? How can any risks be mitigated via regulations and guidance?

## Deferred payment agreements

4.24. The establishment of the universal deferred payment scheme will mean that people should not be forced to sell their home in their lifetime to pay for their care. By taking out a deferred payment agreement, a person can 'defer' or delay paying the costs of their care and support until a later date, so they do not have to sell their home at a point of crisis.

4.25. The draft guidance covers:

- who to offer a deferred payment to;
- the provision of information and advice before making a deferred payment agreement;
- how much can be deferred, and security for the agreement;
- the interest rate for the deferral and administrative charges; and,
- making the agreement, responsibilities while the agreement is in place and termination of the agreement.

4.26. The draft Care and Support (Deferred Payment) Regulations 2014, cover:

- when a local authority must enter into a deferred payment agreement;
- when a local authority may enter into a deferred payment agreement; and,
- conditions relating to deferred payment agreements.

### Questions for consultation

*Who to offer deferred payments to*

4.27. In the 2013 Caring for our future: implementing funding reform consultation[5], a number of respondents suggested that the eligibility criteria for deferred payment agreements should extend to people in extra care housing and supported living. There are circumstances where, during the care planning process, it is agreed between the local authority and a person that the best way to meet their needs would be in these types of accommodation. In principle we agree that deferred payment agreements should enable these people to access the care they need without having to sell their home. We need further evidence of how many people may fall into this category to understand better the likely scale and costs of this extension.

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[5] https://www.gov.uk/government/consultations/caring-for-our-future-implementing-funding-reform

30. Should the eligibility criteria for deferred payment agreements be extended to include people in extra care housing or supported living arrangements? Do you have evidence of the likely demand for deferred payment agreements from people whose needs are met in these types of accommodation?

4.28. During the legislative passage of the Act we added in a new section 36 to allow deferred payment agreements to be offered in a manner that would make them compliant with Sharia law. There were mixed views in response to the consultation as to whether it was necessary to enact this or not and as such we have decided not to enact it for April 2015. We will keep under review whether a Sharia compliant scheme may be needed in future; and would welcome further views now that the detail of the scheme has been developed.

31. Do you think we should seek to introduce a scheme which is compliant with Sharia law at a later date?

*How much can be deferred?*

4.29. When agreeing how much a person can defer they, with the local authority, need to consider the maximum amount that can be deferred – the 'upper limit'. We have suggested that this is usually a maximum percentage of the value of someone's home, a loan-to-value (LTV) ratio. Drawing on similar situations where debts are secured against a property, such as mortgages and equity release, we have suggested that this should be between 70 and 80% of the value of the property. Further sensitivity analysis needs to be conducted to assure the final value.

4.30. In combination, the maximum amount deferred, the interest rate and the security required will govern how much financial risk local authorities are exposed to and so all three need to be balanced against each other. As well as providing security against risk, these three factors will also have a key role in determining how generous the scheme is to people within it. For example, choosing a lower LTV ratio would likely mean that the interest rate could be lower and therefore cheaper for people but it would also reduce the amount that each person could defer as a maximum.

4.31. Sometimes people may want or need to defer more of their fees than they would be able to if the LTV was rigidly applied, for example where they have a low value home or they have a very low income. Local authorities will have the discretion to allow people to defer more than the maximum LTV and up to the full sale value of the home minus the lower capital limit (currently this is £14,250). This will help to prolong the deferred payments scheme for as long as possible where people need it for longer than normal.

32. Do you agree that the maximum LTV for deferred payment agreements should fall between 70 and 80%? Do you have any evidence to support a particular amount within that range?

4.32. Currently the deferred payment scheme offers very little incentive for people to rent, and as a consequence scheme rental rates are low. This increases the risk that the scheme will lead to more empty homes, which we are keen to mitigate as far as possible. We therefore want to incentivise people with a deferred payment agreement to rent out their home. As well as the economic benefits, this will have several benefits to the people involved: it will mean increased income for the owner of the home and could also decrease the cost of insuring it; it is likely to mean that the home is routinely maintained to high standards and so ensure the property maintains its value; for local authorities, they will be able to collect council tax from the tenants.

4.33. A way to incentivise a greater number of people with a DPA to rent out their property would be to allow them to keep a proportion of their rental income on top of their disposable income allowance. This would not alter the amount that a person would be charged for their care – and under the charging framework, the additional income would be taken into account. The proposal is that within the deferred payment scheme, a person would be able to defer more rental income than other income and so keep more income, giving them greater flexibility over their assets.

33. Do you agree that people should be able to keep a proportion of any rental income they earn on a property they have secured a deferred payment agreement on? Are there other ways people could be incentivised to rent out their houses?
34. Do you have any views or evidence to suggest how much rental income people should be able to keep to incentivise them to rent their property out?

*Obtaining security*

4.34. Local authorities are required to obtain adequate security when entering into a deferred payment agreement. This is to ensure they are not exposed to undue financial risk. Where local authorities are required to enter into a deferred payment agreement they must accept a legal charge on a property as adequate security. We have proposed that to maintain the generosity of offer, local authorities must be prepared to accept any charge on a property, not just a first charge. First charges would be more secure, however it would mean that people with outstanding mortgages who otherwise meet the criteria would not be entitled to a deferred payment agreement. This felt unnecessarily restrictive.

35. Do you agree that local authorities should be required to accept any legal charge on a property as security for a deferred payment agreement when they are required to enter into one and not just a first charge?

*Interest rate and administration charge*

4.35. From April 2015, local authorities will have a new power to charge interest on deferred payment agreements. This is designed to be affordable to people within the scheme and not a means for local authorities to generate profit. It is designed to cover the risks to the local authority, for example of default, and to cover the cost of lending.

4.36. The final interest rate will need to reflect final decisions on the LTV rate and the security that is required and the actual cost of borrowing at that time. Subject to these decisions, based on current basis, we have suggested that the interest rate is likely to be between 3.5% and 5%.

36. In line with the recommendations of the Independent Commission on Funding of Care and Support, do you agree that the interest rate should be set so that it is reasonable for people, cost neutral to local authorities and as such that it does not create incentives for people to apply for deferred payments when they are not needed?

4.37. The risks and possible costs to local authorities will differ between those deferrals that a local authority is required to offer and those deferrals that a local authority has a discretionary power to offer. In order to keep the interest rate low for people in the mandatory scheme, regulations could specify a different interest rate for the two types of deferred payment agreement. If this were the case, local authorities could be given the discretion to decide what the interest rate for a discretionary deferral should be locally and so better reflect individual risk. A maximum interest rate above which they could not charge would still be specified in regulations; this would likely be higher than that specified for the mandatory scheme.

37. Do you agree that there should be a different interest rate for deferred payment agreements made at the local authority's discretion? If so, what should the maximum rate be?

# 5. Person-centred care and support planning

5.1. The care and support planning process is there to help agree the best way to meet the person's needs. It considers a number of different things, such as what needs the person has, what they want to achieve, what they can do by themselves or with the support they already have, and what types of care and support might be available to help them.

## Care and support plans

5.2. The local authority must prepare a care and support plan (or a support plan, in the case of a carer) that sets out the detail of how the person's needs will be met. The plan will detail the needs to be met and how they will be met, and will link back to the outcomes that the adult wishes to achieve in day-to-day life as identified in the assessment process. This should reflect the individual's wishes, their needs and aspirations, and what is important to and for them. This process is central to the provision of person-centred care and support that provides people with choice and control over how to meet their needs. The local authority must take all steps to agree to the plan with the person concerned, and must involve them (and anyone else they ask to be involved) in the production of the plan. The local authority has a legal responsibility to review the plan to make sure that the adult's needs and outcomes continue to be met over time.

5.3. The draft guidance covers:

- the production of the plan;
- involving the person in producing the plan;
- approaches to planning for people who lack capacity; and,
- combining plans for different individuals, or integrating plans with those provided to meet other needs such as health needs.

**Questions for consultation**

38. Does the guidance on personalisation fully support and promote a care and support system that has personalisation at its heart?

39. Does the guidance on personalisation support integration of health and care (and any other state support)?

40. Does the guidance support care and support workers to do their job effectively?

## Personal budgets

5.4. As part of the planning process, the local authority will tell the person about their personal budget. This is the amount of money that the local authority has worked out it will cost to meet the needs which the local authority is going to meet. The purpose of the personal budget is to allow people to make informed choices about how they want their needs to be met, including via a direct payment, by seeing upfront the costs of doing so. Where the person is going to pay towards some or all of those costs (as determined by the financial assessment), the personal budget will also set out the costs to be met by the person themselves and the local authority.

5.5. The draft guidance covers:

- the different required elements of the personal budget;
- principles to follow in calculating the personal budget;
- agreeing the final budget; and,
- use of the personal budget.

5.6. *The draft Care and Support (Personal Budget Exclusion of Costs) Regulations 2014*, cover:

- excluding the cost of intermediate care/reablement from personal budgets, where it is provided to meet needs, rather than as a universal preventative service.

### Questions for consultation

5.7. The regulations state that that the costs of intermediate care/reablement should not be included in the personal budget where it is provided free of charge . The regulations define intermediate care/reablement support. In setting out this definition we are keen to end previous confusion around the meaning of these terms, but also to avoid any unintended consequences related to excluding such provision from personal budgets.

41. Is this definition clear and does it conform to your understanding of intermediate care and reablement? Is there any way it can be improved?

42. Does excluding the cost of reablement/intermediate care from the personal budget as defined above:

    - Create inconsistencies with the way that reablement/intermediate care is provided in NHS personal health budgets?
    - Affect the provision of reablement/intermediate care for people with mental health problems?

43. Are the ways in which different Personal Budgets can be combined sufficiently clear?

## Direct payments

5.8. Using the information from the personal budget, people can ask the local authority for a direct payment. This is a cash payment to the individual by the local authority, to give the person control over how money is spent to meet their needs. The local authority must provide it to someone who meets the conditions, unless the Act or regulations state otherwise. Direct payments provide independence, choice and control by enabling people to commission their own care and support in order to meet their eligible needs.

5.9. The draft guidance, together with the draft *Care and Support (Direct Payments) Regulations 2014,* cover:

- making direct payments available, and circumstances in which the local authority may not make direct payments;

- steps following a request to receive direct payments, and specific steps for people who lack mental capacity;
- administering direct payments, and conditions which apply to making the payments;
- using the direct payment;
- reviewing direct payment; and,
- how to discontinue direct payments.

### Questions for consultation

5.10. We have proposed relaxing the existing exclusion around paying family members for managing a direct payment on behalf of the person with care and support needs. This means people will be able to pay a family member living in the same household for management/administration of the direct payment. This should not increase the size of the personal budget, but instead allow for some of this amount to be spent in this way. This is intended to help people manage direct payments, especially in large packages of care and support. It may increase take-up of direct payments by incentivising family members who were previously put off by complex administration tasks, as these may now be recognised financially.

44. Will the easing of the restriction to pay family members living in the same household for administration/management of the direct payment increase uptake of direct payments? Will this create implementation issues for local authorities?

5.11. We also have proposed reducing the mandatory review of direct payments from 12 months to 6 months. This was because we heard that many local authorities conduct this review early to ensure that the person is managing the payment appropriately. Additionally, we felt that it was important to reduce this timeframe if more people would be using direct payments in future due to easing the family member restriction.

45. The draft direct payment regulations decreases the time period to conduct a review of the direct payment from 12 months to 6 months – is this workable?

5.12. We have also made clear in the regulations that a person should not be subjected to excessive monitoring of the payment by the local authority, and the local authority must not dictate that the direct payment should be used with a particular provider. This freedom of choice has always been a policy intention, and we have now taken the opportunity to make this clear in regulations.

46. The draft regulations seek to ensure choice is not stifled and the direct payment is not monitored excessively – is it strong enough to encourage greater direct payment use, but workable for local authorities to show effective use of public monies?

# 6. Integration and partnership working

## Integration, co-operation and partnerships

6.1. For people to receive high quality health and care and support, local services need to work in a more joined-up way to eliminate the disjointed care that can be a source of frustration, and which often results in poor care and a negative impact on health and wellbeing. Our vision is for integrated, person-centred care and support. As part of a wider suite of reforms that will enable this vision to become a reality, the Care Act requires greater integration and co-operation between health, care and support, and the wider determinants of health such as housing.

6.2. The philosophy underpinning the government's approach to care and support is that it is person-centred, with the needs of the individual driving how care is designed and delivered by local services. For this to become a reality, local authorities and their partners need to work together to integrate services wherever possible so that the services people receive are properly joined-up. It will also require local partners to work in co-operation when designing and delivering services for their populations and for specific individuals.

6.3. The draft guidance covers:

- strategic planning at the local level between partner organisations;
- integrating service provision and combining and aligning processes;
- the requirements of the general duty to cooperate;
- ensuring cooperation between the different functions within local authorities; and,
- the process for requiring cooperation of a partner in specific cases.

### Questions for consultation

47. Does the draft statutory guidance provide a framework that will support local authorities and their partners to make integration a reality locally?
48. Are there any ways the guidance can better support cooperation locally**?**

## The boundary with the NHS

6.4. In meeting an adult's needs for care and support, or a carer's needs for support, a local authority may not provide healthcare services which are the responsibility of the NHS. The Act sets out the limits on what a local authority may provide by way of healthcare and so, in effect, sets the boundary between the responsibilities of local authorities for the provision of care and support, and those of the NHS for the provision of health care, and so also reflects the policy on the provision of NHS Continuing Healthcare. The Act is not intended, in effect, to change the current boundary between what the local authority may provide and what it is for the NHS to provide.

6.5. The draft guidance covers:

- the boundary between local authority care and support and NHS healthcare.

6.6. The draft Care and Support (Provision of Health Services) Regulations 2014; cover:

- identifying the CCG from which a local authority must seek consent before it makes any arrangements that involve the provision of registered nursing care.
- local authority cooperation with NHS bodies in carrying out NHS continuing healthcare assessments; and,
- dispute resolution procedures about whether something should be provided by the NHS.

### Questions for consultation

49. Is the description in the guidance of exceptions to provision of healthcare (which effectively sets out the boundary between NHS and local authority responsibilities) sufficiently clear and does it maintain the current position on the boundary?

50. Is there any danger that the legal barrier could be interpreted as a barrier to integration? Are there specific examples where it would be helpful to clarify?

## Delayed transfers of care

6.7. The draft regulations and guidance focus on those NHS hospital patients who have been receiving acute care and whose discharge from hospital is unlikely to be safe without some care and support input. Of course, good and safe discharge planning applies to all patients, as do broader legal duties to ensure this happens; however the statutory provisions relating to reimbursement apply specifically to transfer of care from NHS hospitals to local authority care of patients with care and support needs, which can be measured in a fair way and which has historically been an issue.

6.8. The regulations set out the details of the notices which the NHS body responsible for the patient must contain to ensure the local authority complies with its requirements to undertake assessments and put in place any arrangements necessary for meeting any of the patient's care and support needs. This means that if the local authorities do not comply with the requirements set out in the regulations and a delay occurs to the patient's discharge, then the local authority may become potentially liable to pay a reimbursement to the relevant NHS body for such a period and at such an amount as set out in the draft regulations.

6.9. The draft guidance and draft Care and Support (Discharge of Hospital Patients) Regulations 2014, cover:

- processes and requirements relating to delayed discharges from hospital for NHS acute care patients with care and support needs; and,
- the period and amounts of any delayed discharge payment.

### Questions for consultation

6.10. We have largely carried forward the effect of the existing Delayed Discharge regulations in these new regulations. However, there are areas where we have amended current provisions. The key changes are shown below.

6.11. For those delays, which are recorded as being attributable to the local authority, the NHS is no longer obliged to seek reimbursement. This is intended to reinforce the need to focus on joint working at a local level as a way of reducing those days attributable to the local authority, with the expectation that reimbursement generally would only be asked for by the NHS as a last resort.

6.12. In keeping with the expectations that both the NHS and the local authority should be operating on the basis of a 7-day model, the regulations remove weekends and bank holidays as being exempt from reimbursement.

6.13. To reflect that there has been no increase in the reimbursement rates since 2003, the updated regulations increase the proposed discretionary reimbursement rates by the Consumer Price Index measure of inflation since

2003. This means an increase for local authorities outside London from £100 to £130 and for London authorities from £120 to £155. The purpose of making this increase was to reflect the fact that there has been no increase since 2003, without increasing the amount to a level that would encourage an increased use of reimbursement. We have reduced the scope of those local authorities covered by the higher rate to only London authorities to reflect the acknowledged increased cost base that there is in comparison to other areas of the country.

6.14. The updated regulations require that the Assessment and Discharge notices include the patient's NHS number. In addition, to facilitate an effective joint working relationship between the NHS organisation and the local authority, the contact details (i.e. email address or telephone number) of the person at the hospital who will be responsible for liaising with the local authority will also be required for these notices. This is intended to address concern that the 2003 regulations only require the name of the person, and there are concerns that this means in some cases locating where that person is can or how to contact that person can cause a delay.

51. Will any of these changes affect the working of delayed discharge processes in ways not discussed in the guidance?
52. Can you provide any best practice examples or guidance relating to hospital discharge for people with care and support needs**?**

## Working with housing authorities and providers

6.15. The Care Act is clear that the provision of suitable accommodation can be an integral part of care and support, and provides flexibility for local authorities to arrange different types of accommodation to meet a person's care and support needs. The Act is clear on the legal boundary between care and support and general housing responsibilities, to ensure that there is no overlap or confusion with the role of the local housing authority. The Act is not intended to change the current boundary between what the local authority may provide under housing provisions and what it required to provide under care and support provision.

6.16. The draft guidance covers:

- the place of housing in health and care and support system;

- integration of health, care and support and housing;
- ensuring cooperation with housing providers;
- integrating information and advice on housing; and,
- housing services which may not be provided to meet care and support needs.

**Questions for consultation**

53. Could local authorities' duties in relation to housing be described more clearly in the guidance?
54. Are the links to prevention, integration, co-operation, information and advice, market shaping and assessments adequate?
55. How could guidance on the legal boundary between care and support and general housing responsibilities be improved?

## Working with employment and welfare services

6.17. Local Authorities and local offices of the Department of Work and Pensions (that is, JobCentre Plus as a "relevant partner") must co-operate when exercising functions which are relevant to care and support. When considering opportunities for fuller integration of commissioning, planning and delivery of local services, local authorities should consider the links between care and support, and employment and welfare. Furthermore, local authorities must consider education, training and employment at when working with people with care and support needs.

6.18. The draft guidance covers:

- considering employment at a local level; and,
- considering employment when working with people.

### Questions for consultation

56. Are there any good practice examples of local authorities working with their partners, including health, education, employment and housing?

## Transition to adult care and support

6.19. The Care Act allows for ‘transition assessments’ to take place under the adult statute in advance of a young person’s 18th birthday. The intention is to provide young people and their families with information and advice so that they know what to expect in the future and can prepare for adulthood. The Act also requires local authorities to continue children’s services until an adult needs or carer’s assessment has taken place, and a decision has been reached about the young person’s care and support. This ensures that there is no gap in provision of care and support when people move from children’s to adult social care.

6.20. The draft guidance covers:

- when a transition assessment must be carried out, for young people, young carers and carers of children;
- features of a transition assessment;
- the importance of cooperation between professionals and organisations;
- provision of age-appropriate local services and resources; and,
- what happens after the young person in question turns 18.

6.21. The draft Care and Support (Children’s Carers) Regulations 2014, cover:

- local authorities’ power to meet child’s carers’ needs.

### Questions for consultation

6.22. Instead of specifying an age, the Act states that the assessment must take place for young people who are likely to have needs for care and support after becoming 18, and when there is ‘*significant benefit*’ to the child in having an assessment. This recognises that circumstances are different for every young

person. There has been some concern that the term ‘significant benefit’ could be misinterpreted by local authorities to be in relation to the level of need, rather than the *timing* of the assessment. Through the guidance, we have sought to make as clear as possible that significant benefit is a reference to the timing of the assessment, and used a case study to further illustrate this.

57. Is the guidance clear enough that the term ‘significant benefit’ is about the timing of the assessment? Is the guidance precise enough to ensure that ‘significant benefit’ is not open to misinterpretation and that people who should be assessed are assessed at the right time for them?

58. Are the descriptions in the guidance of people’s rights to transition assessments and continuity of care beyond 18 sufficiently clear?

## Prisons, approved premises and bail accommodation

6.23. The Act establishes that the local authority in which a prison, approved premises or bail accommodation is based will be responsible for assessing and meeting the care and support needs of the offenders residing there. The provision of care and support for those in custodial settings is based on the principle of equivalence to provision in the community. The Act clarifies the application of Part 1 for people in custodial settings, including aspects which do not apply, because the current law is not clear on responsibilities in this area.

6.24. The draft guidance covers:

- setting the context of care and support in custodial settings;
- the application of specific care and support functions in custodial settings; and,
- complaints, investigations and inspections.

### Questions for consultation

6.25. There are a number of aspects of providing “equivalent” care and support in prisons where the custodial setting may mean that the handling of steps in the process of assessment and commissioning of care and support could be improved by consideration of experience or good practice.

59. We would welcome views and transferable good practice examples about the application of care and support to custodial settings, in particular about information and advice, advocacy, financial assessment, personal budgets, the sharing of information between agencies, and joint commissioning arrangements between custodial establishments, local authorities and health services.

6.26. There is a high prevalence of mental ill health, substance misuse and learning disability in the custodial population.

60. When delivering care and support in custodial settings, how should local authorities go about reflecting the high prevalence of mental ill health, substance misuse and learning disabilities?

6.27. The provision by local authorities of care and support in custodial settings raises questions of equivalence with other residential settings about responsibility for provision of reasonable adjustments, aids, adaptations and equipment, ranging from fixtures and fittings (such as adapted bathrooms) to items specific to meet the individual's needs.

61. How might these be best provided in custodial settings and how might responsibility for provision best be identified?

6.28. We know that prisoners move prison relatively frequently (compared to people in the community) and it therefore seems disproportionate to require local authorities to conduct a full re-assessment every time a prisoner moves area. In addition, prisoners may spend a very short time in some prisons, particularly at the beginning of their sentence. An assessment at the beginning of their sentence which can be shared, reviewed as necessary and used to inform their care and support plan in subsequent prisons would enable the second and subsequent local authorities to plan to meet the same needs that the first authority was meeting and when carrying out the new assessment to carry it

out in a proportionate manner. For example, where the person is only staying in the prison for a short period the local authority should focus on the person's identified eligible needs and how the change in environment might impact on these.

6.29. This frequent movement means that it is important to ensure that a prisoner is referred for assessment in their first prison where they are likely to have some care and support needs on which the LA can advise, even if they do not have eligible needs. However, referral processes must be proportionate and avoid placing an undue assessment burden on local authorities.

62. How could the initial assessment of a prisoner's care and support needs be best constructed to be useful in supporting proportionate reassessment and planning to meet any eligible care and support needs in subsequent custodial settings throughout the person's sentence? Are there triggers, particularly which might be identified in the health assessment which all prisoners receive on entering prison, which could help prison staff and/or health care partners to identify when it would be appropriate to refer a prisoner for a care needs assessment?

## Delegation of local authority functions

6.30. The Act introduces a new power to local authorities to delegate certain of their functions under the Act to an external organisation. This is intended to allow maximum flexibility for local authorities to design innovative models in how they exercise their functions and improve the quality of care and support for its population. When delegating their functions, local authorities retain ultimate responsibility for how they are carried out. As such, people using care and support will always have a means of redress against the local authority.

6.31. The draft guidance covers:

- overview of the approach to delegation;
- the importance of contracts;
- which functions may not be delegated;
- the difference between legal delegation and outsourcing or commissioning activities; and,
- identifying and avoiding conflicts of interest.

### Questions for consultation

6.32. When local authorities delegate care and support activities to another party, the contract between the two will govern how the activity is carried out. Contracts should include stipulations which ensure that the activities are carried out in a way that is compatible with all of the local authority's legal obligations, for example, its obligations under the Human Rights Act. The local authority will retain responsibility to users of care and support for how its functions are carried out and the contract will be the means by which the local authority holds the contractor to account for how they exercise the function. The strength of the contracts is therefore of vital importance.

63. Are there any core principles or requirements that local authorities should always place on contractors when delegating care and support functions?

64. Some stakeholders have mentioned that a 'model contract' would be helpful. What would be included in a model contract? Can you give any examples of a good model contract when delegating statutory care and support functions?

# 7. Adult safeguarding

7.1. The Act sets out the local authority's responsibility for protecting adults with care and support needs from abuse or neglect for the first time in primary legislation. This is vital to ensure clear accountability, roles and responsibilities for helping and protecting adults with care and support needs who are experiencing, or at risk of, abuse or neglect as a result of those needs. Local authorities are given a lead role in coordinating local safeguarding activity.

7.2. The draft guidance covers:

- the principles of safeguarding which should underpin all work to protect people from abuse and neglect;
- types of abuse and neglect;
- local authorities' responsibilities to carry out safeguarding enquiries where it is suspected that someone is suffering or at risk of abuse or neglect;
- creating Safeguarding Adults Boards (SABs) in every area to bring together the key local partners to focus on safeguarding strategy and practice;
- conducting Safeguarding Adults Reviews where there is a cause for concern about a particular case, to learn lessons for the future;
- sharing information between local and national organisations to support reviews and enquiries; and,
- providing independent advocates to enable some people who would otherwise have difficulty to take part in an enquiry or review.

### Questions for consultation

7.3. The Care Act does not list every type of abuse and neglect. It explicitly refers to financial abuse, not because it has priority status but because most definitions of abuse do not ordinarily include this type of abuse. We want to leave no doubt that financial abuse comes within the scope of adult safeguarding planning and activity. The guidance includes fuller descriptions of abuse and neglect. We do not expect this to be exhaustive but it does give the practitioner a helpful framework when looking at allegations of abuse or neglect.

65. Are there any other types of behaviour that should be explicitly stated in the guidance? Are there any that should be removed?

7.4. The guidance focuses on the function, roles and responsibilities of SABs, rather than concentrating on process issues such as how often the SAB meets, whether or not the Chair is independent from SAB members and how it constitutes itself (e.g. whether it has sub-committees feeding in or time-limited task and finish groups). This allows maximum local flexibility within the statutory framework. SABs work within very different areas and will need to reflect this in their ways of working.

66. Are there additional possible members of SABs that we should add?
67. Are there additional aspects of the SAB's work that we should highlight?
68. Would it be useful to append a draft template for the strategic plan for SABs to use if they wish?

7.5. The guidance concentrates on the positive learning aspects of Safeguarding Adults Reviews because these offer a real opportunity to improve practice if managed properly.

69. Is there anything we could add to improve how managers and practitioners view and participate in Safeguarding Adults Reviews?

7.6. The guidance recognises the tensions for professionals in the sharing of information and notes the revised Caldicott principles and the new Information Governance Alliance guidance.

70. Are there other areas of information sharing that need to be spelt out in this section?

# 8. Moving between areas: inter-local authority and cross-border issues

## Ordinary residence

8.1. The Act seeks to provide clarity about which local authority has responsibility for a person's care and support. "Ordinary residence" plays a central role in deciding which individuals – whether adults with care and support needs or carers – are entitled to care and support from a local authority. Whether the person is 'ordinarily resident' in the area of the local authority (or for carers, whether the person they care for is ordinarily resident) is a key test in determining whether the duty to meet eligible needs arises.

8.2. The draft guidance covers:

- how ordinary residence affects the legal framework in the Care Act;
- how to determine ordinary residence;
- determining ordinary residence when a person moves into certain types of accommodation in another local authority area;
- disputes between authorities, and the process for seeking a determination by the Secretary of State for Health;
- financial adjustments between local authorities; and,
- further information where ordinary residence may apply, relevant scenarios and other legislation under which ordinary residence determinations can be made.

8.3. The draft Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014, cover:

- the types of accommodation to which the ordinary residence principle applies when arranging care and support in another local authority area.

8.4. The draft Care and Support (Ordinary Residence Disputes, etc.) Regulations 2014 cover:

- the process when disputes around ordinary residence arise.

### Questions for consultation

8.5. The specified accommodation regulations detail the types of accommodation to which the ordinary residence "deeming" provision applies, explicitly setting out three types of accommodation: care homes; supported living/extra care housing; and shared lives/adult placement schemes. The regulations include definitions of these types of accommodation.

71. Are the definitions of the types of accommodation as cited in the regulations too wide? Are they workable and clear?

72. Do the guidance and regulations about ordinary residence disputes provide enough clarity to settle ordinary residence disputes between two or more local authorities? Are there other scenarios that it would be helpful for the guidance to consider?

73. Which authority should be responsible for meeting the needs of an adult or carer when two authorities in dispute, or another authority cannot come to an agreement on who should be the lead authority? Do you agree with the regulations as currently set out in the regulations?

## Continuity of care

8.6. The continuity of care provisions in the Act mean that people with care and support needs who wish to move from one local authority area to another, will be able to do so with confidence about what care and support they are likely to receive in the new authority, and with assurance that there will be no gap in their care and support when they move. The new provisions mean that people will be supported throughout the period of their move until the new local authority has completed a new assessment and put in place care and support to meet their needs in the new area.

8.7. The draft guidance covers:

- making informed decisions to move; confirming the intention to move; supporting people to be fully involved in the process;
- what to take into account when planning the move; and,

- how to ensure continuity of the person’s care if the second local authority has not carried out an assessment ahead of the day of the move.

8.8. The draft Care and Support (Continuity of Care) Regulations 2014, cover:

- what local authorities must have regard to when they have not completed an assessment on the day of the move.

#### Questions for consultation

74. What further circumstances should be considered when carers and people with care and support needs want to move?

## Cross-border placements

8.9. People in care homes may wish to move to a different territory of the UK from that in which they reside, for example, to be near their friends and family. The Act sets out certain principles which seek to support the notion of residential care placements by ensuring that, generally, where a local authority (or equivalent in Northern Ireland) places someone in a care home cross-border within the UK, it does not result in transfer of the authority’s responsibility for the individual concerned.

8.10. The draft guidance covers:

- principles which apply to cross-border residential placements;
- steps to take when making a cross-border care home placement; and,
- how to manage disputes between authorities.

8.11. The draft Care and Support (Cross-border Placements and Provider Failure: Temporary Duty) (Dispute Resolution) Regulations 2014, cover:

- process for resolution of cross-border disputes that may arise between authorities about the general principles of non-transfer of responsibility; and,
- process for resolution of cross-border disputes that may arise between authorities in relation to temporary duties to meet needs in the provider failure context.

### Questions for consultation

75. Do the regulations provide for an effective dispute resolution procedure?

76. In particular, in setting out the process for local authorities to follow when making a cross-border residential care placement, are there any gaps or omissions in the guidance in terms of key issues that need to be addressed before a placement can successfully take place?

77. With regard to the arrangements for managing a placement once it has commenced, can you envisage issues other than those identified? Specifically, what are these and how should they be addressed?

78. Would it be helpful for the guidance to be supplemented by best practice guidance? If so, what issues and scenarios will it be important for best practice guidance on these placements to cover?

# 9. Other areas

## Registers

9.1. Local authorities must keep a register of adults who are severely sight impaired and sight impaired in their local areas. This can facilitate people with sight impairment to get access to the care and support they need. Local authorities may also maintain registers of other people with disabilities or who may need care and support now or in the future.

9.2. The draft guidance covers:

- registration, certification and making contact with people who are sight impaired;
- rehabilitation and care planning for those individuals; and,
- the use of other registers.

9.3. The draft Care and Support (Registers) Regulations 2014 cover:

- who should be treated as sight-impaired or severely sight-impaired.

### Questions for consultation

9.4. The draft regulations state that only a consultant ophthalmologist may certify a person as sight impaired or severely sight impaired. It has been suggested that other senior ophthalmologists (associate specialist or senior speciality doctor in ophthalmology; and senior doctors in training within six months of the Certificate of Completion of Training) should be able to give a Certificate of Visual Impairment (CVI), as well as consultant ophthalmologists. The intention of this would be to expedite patients being able to access the benefits of certification.

79. Should certification of CVIs be extended senior ophthalmologists, or should this continue to be carried out by consultant ophthalmologists as is currently the case?

*Patient consent for the Royal National Institute of Blind (RNIB) to have access to contact details from the Certificate of Vision Impairment (CVI)*

9.5. People who are registered with the local authority will have received confirmation of being sight impaired or severely sight impaired through the CVI. The NHS is required to keep the completed certificate, signed by the consultant

and the patient, for their records. Currently a copy of the Certificate is also sent to the relevant local authority, the GP, the Certifications Office at Moorfield's Eye Hospital and the patient.

9.6. We are seeking views about whether patients should be asked if they would agree to have their contact details shared with the RNIB. This will enable the RNIB to make contact with patients and direct them to the correct avenues for further advice and support quickly.

80. Should we seek the patient's consent to pass their contact details to RNIB, as well as to the local authority, as part of the CVI process in order for RNIB to offer advice and support?

## The transition to the new legal framework

9.7. The chapter on transition to the new legal framework covers key considerations for local authorities in advance of many elements of the Care Act coming into force in April 2015, and looks ahead to preparing for funding reform from April 2016.

9.8. The draft guidance covers:

- transition to the new statute in 2015/16 for people receiving care and support, and carers:
  - the status of previous assessments and eligibility determinations under the Care Act; and,
  - the role of care planning and review in implementation.
- preparing for funding reforms in 2016/17:
  - understanding the likely demand;
  - awareness raising;
  - approaches to carrying out early assessments and managing capacity; and,
  - other systems implications.

### Questions for consultation

9.9. The guidance details key considerations around previous assessments, financial assessments, eligibility determinations and care plans – and how they should be treated under the Care Act.

> 81. Are there other considerations around preparation for implementation of the April 2015 elements of the Care Act on which national guidance would be helpful?

### Funding reform

9.10. The guidance also sets out actions for local authorities in preparing for the funding reform elements of the Care Act that come into force from April 2016, including assessing demand, raising awareness, early assessments and ICT and workforce capacity.

### Question for consultation

> 82. Are there other considerations around preparation for implementation of the April 2016 elements of the Care Act on which national guidance would be helpful?

### Appealing decisions

9.11. It is important to ensure that there are effective arrangements in place for people with care and support needs and their carers to challenge decisions that impact on their ability to access care and support. Current complaints provision for care and support is set out in regulations[6]. The provisions of the regulations mean that anyone who is dissatisfied with a decision made by the local authority would be able to make a complaint about that decision and have that complaint handled by the local authority. The local authority must make its own arrangements for dealing with complaints in accordance with the 2009 regulations.

9.12. We recognise that, as result of the reforms in the Care Act, more people will be brought into contact with the local authority. Given these changes, it is vital that

[6] Local Authority Social Services and NHS Complaints Regulations 2009, made under powers in Sections 113 to 115 of the Health and Social Care (Community Health and Standards Act) 2003.

individuals have confidence in the system, and that they are able to challenge decisions without having to resort to judicial review. That is why we held a wide-ranging consultation during the second half of last year to seek opinions on how best we could ensure this.

9.13. Following this consultation, we recognised the need for change in this area, and the Act provides a power to establish an appeals system. The appeals system would come into force from April 2016, in line with wider reform of adult social care funding. Our intention with a new system is to provide for the establishment of a bespoke appeals mechanism that has an element of independence from the local authority, although with some local authority representation. This would mirror arrangements for other areas of public sector decision-making, such as for decisions relating to NHS Continuing Healthcare funding and schools admissions. There are a range of approaches to resolving complaints and providing redress. We believe that it is advantageous to have a flexible system that works well and efficiently at a local level and in a manner that is proportionate to the type of complaint. Our current assumption is that a formal tribunal process would be likely to slow down the process of resolving complaints and add significant costs, introducing a further burden on the system.

9.14. We will develop detailed proposals for a system of reviewing local authority decisions which will be set out in regulations. These proposals will be developed in conjunction with stakeholders, and working closely with local government, in keeping with the spirit of co-production that has characterised work on other areas of the Care Act and associated regulations and guidance. We will then hold a public consultation on these more detailed proposals later in 2014.

# ANNEX A: Market oversight and business failure

## Entry criteria to the market oversight regime for **non-residential and specialist** providers

The entry criteria for non-residential care providers capture those providers that deliver significant levels of care to a large number of people, and medium size providers who deliver care and support to people with more complex needs in their homes. Were those providers to fail financially, local authorities would face significant logistical challenges to temporarily meet the needs of those affected.

We have discussed this with relevant stakeholders and the feedback has been that local non-residential care markets are usually relatively competitive, and the failure of one smaller provider with a large market share in a single local authority area (i.e. not captured in the criteria due to its size) would very likely be manageable. Stakeholders have pointed to the entry criteria regarding intensity of care provided (measured in hours of care per week) as being more important, as these providers would be difficult to replace even if they represent a relatively small portion of the local market.

The regulations do not set the entry criteria for “specialist” providers. This is because there is a wide range of services which could be considered “specialist” and we have found difficulty in developing a single, quantitative and objective measure applicable to all specialist care. There is no accepted definition of “specialist” services and no current data collection by CQC or other organisation that could assist us with developing this measurement. Instead, we are considering whether a panel, made up of experts in commissioning or providing specialist care from local government and the care provider sector, could assist us with identifying providers, not already included in the regime, where the specialised nature of their services would make them difficult to replace in the event of business failure. We have not therefore proposed entry criteria for specialist providers. If the specialist panel recommended the inclusion of further providers, the Secretary of State has the power in primary legislation to co-opt those providers into the regime.

## Excluding providers from the CQC regime

The Act gives the Secretary of State a power to exclude providers from CQC’s regime, irrespective of whether the provider would otherwise qualify. Having considered this, we do not feel that it is necessary to exercise this power at this time.

Where a provider is subject to a comparable regulatory regime is one particular circumstance where the Secretary of State has the power to exclude providers, for example, organisations who are regulated by the Homes and Communities Agency (HCA). However, it has been concluded that while there may be some overlap, the CQC's and HCA's regimes cannot be considered 'comparable'. For instance, the HCA's regulatory regime will focus on the financial health of the housing element of the business rather than the care element, whereas the CQC would do the opposite. We have decided not to make regulations to exempt providers which are subject to the HCA's regime. However, while it is for CQC to determine and consult on its approach to monitoring those organisations, it is expected that they will take a proportionate approach to regulating providers that are also regulated by HCA.

## CQC power to gather information to assess financial health of providers

The regulations enable the CQC, where a provider qualifies for its regime, to require information from entities within that care provider's group in order to fully assess the financial sustainability of that provider. An example is a care company that is a subsidiary of a larger group company with other interests. The regulations ensure CQC is able to obtain financial information from the whole group to gain the full picture of the care company's financial health.

The Act also allows for regulations to make provision for how providers should be financially assessed and the circumstances in which the CQC may be satisfied that they are likely to fail. We have decided not to exercise the power to make regulations on these issues. It has been decided that it should be for CQC to determine and consult on a proportionate approach to assessing the financial health and likelihood of failure of providers in the regime.

# ANNEX B: Monitor licensing regime and social care organisations

*This is not draft guidance issued under the Care Act. It is included because it concerns related matters.*

## Proposals on the extension of licence exemption of nursing care

Providers of care and support are currently not regulated by Monitor and do not require a licence to provide care and support services. Under Regulation 6 of the National Health Service (Licence Exemptions, etc.) Regulations 2013, providers of NHS Continuing Healthcare[7] and NHS-funded nursing care[8] services are exempt from the requirement to hold a licence until 1 April 2015.

We are consulting on the following two options:

- To allow the current nursing care licence exemption to expire. This would require providers of nursing care whose total NHS turnover exceeds the de minimis threshold to hold a Monitor licence from 1 April 2015.
- To continue with licence exemption for provider organisations that provide NHS Continuing Healthcare and NHS-funded nursing care. Most care and support providers that provide these services will continue to be exempt. These services will also be exempt from being designated as a Commissioner Requested Service[9]. This option would allow CQC to have sole and focussed financial oversight over these providers, liaising with Monitor where necessary.

### Questions for consultation

83. Do you think that providers of NHS Continuing Healthcare and NHS-funded nursing care should continue to be exempt from the requirement to hold a licence from Monitor?

84. Should providers NHS Continuing Healthcare and NHS-funded nursing care services be subject to those services being designated CRS?

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7 NHS Continuing Healthcare means a package of care arranged and funded solely through by the NHS where the individual has been assessed as having a 'primary health need'.  Such care is provided to an individual aged 18 or over, to meet physical or mental health needs which have arisen as a result of disability, accident or illness.

8 NHS funded care is the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse.  'Nursing care by a registered nurse' has the same meaning as in section 49(2) of the Health and Social Care Act 2001.

9 Commissioner Requested Services are services that will be considered by the commissioner for protection should the provider fail.

# ANNEX C: Consultation to date on the draft eligibility regulations

The level of the national eligibility criteria was announced last summer by the Chancellor as part of the spending round for 2015/16. These criteria, together with other provisions in the Act and funding announced for 2015/16, are intended to allow for local authorities to maintain the same level of access to care and support, when moving from the current to the new system in April 2015. The national minimum eligibility threshold is designed to reflect the level adopted by the vast majority of current local authorities, and will allow people whose needs have "a significant impact on their wellbeing" to access to care and support. As this is a minimum threshold, authorities who want to meet needs that are not eligible needs can continue to do so.

A first draft of the eligibility regulations was published for discussion in the summer of 2013. An extensive engagement process was carried out, including:

- engaging with over 100 local authorities in eight discussion workshops held between September and November 2013;
- receiving 68 written submissions from individuals and organisations;
- working with the Care and Support Alliance to survey nearly 400 people receiving care services and carers.

The findings of this engagement process were split. Some stakeholders said that the draft regulations would make more people eligible for care and support as compared with the current arrangements, while other stakeholders thought the threshold too high, and called for it to be set at a level similar to "moderate" as described by the current guidance[10].

During the engagement process, we also commissioned the Personal Social Services Research Unit at the London School of Economics to evaluate the draft regulations against the current eligibility framework, using a series of simple "vignette" case studies to test how care managers would interpret eligibility. The evaluation found that the majority of respondents agreed that the regulations were easy to understand;

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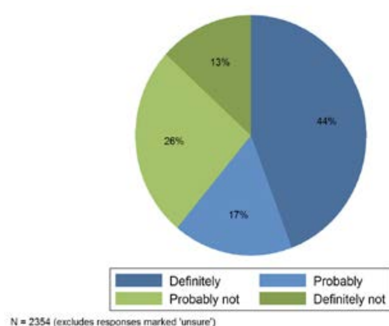
[10] **Prioritising need in the context of *Putting People First*: A whole system approach to eligibility for social care** *Guidance on Eligibility Criteria for Adult Social Care, England 2010.* Department of Health. February 2010.

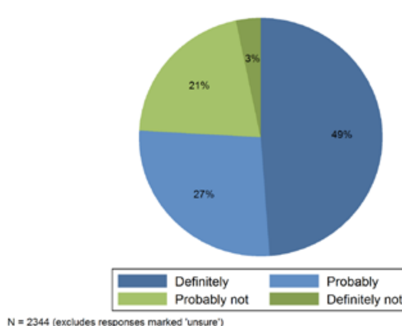
cover the right circumstances; were easy to apply; and were flexible enough to allow professional judgement. It also identified that care managers were better able to assess the likely care packages using the eligibility regulations than the current guidance.

Importantly, the evaluation also found that the first draft of the eligibility regulations would "definitely" or "probably" increase the number of adults eligible for care and support. The following graphs demonstrate the findings for older people. The study also considered younger adults with physical disabilities, learning disabilities, mental health needs, and carers. A similar pattern was observed across these groups.

***Estimated eligibility under FACS – older people, all vignettes***




***Estimated eligibility under national eligibility – older people, all vignettes***




Comments received from all sources were analysed and considered through the Assessment and Eligibility Task and Finish Group, a group comprising a number of stakeholders, including local authorities, voluntary organisations, providers and people who use care and support.

## What has changed as a result of the initial consultation?

The intention remains that the draft regulations will describe the same level of access to care and support as exists in the current system. The version of the regulations on which we are now consulting reflects many of the comments we received through the engagement and looks to address the concern that they will leave more people into the system than currently is the case. They aim to do this through:

- Making clear the tests to be considered when determining whether a person has eligible needs – these are now more clearly set out in regulation 2(1);
- Modifying how the definitions of "basic care activities" and "basic household activities" work together to ensure they are focusing on the outcomes the adult wants to achieve rather than the tasks of meeting those needs;
- Requiring that an adult must require support to achieve some or all basic care activities to become eligible rather than one in the earlier draft;

- That the list of “basic care activities” includes the adult’s ability to getting up and dressed and moving around their house;
- Clarified the wording of the carer’s eligibility criteria so it is clear which relate to them being able to continue caring, and which refer to their wellbeing and how they can continue with other elements of their lives;
- Removed references to making carer’s eligible for support where they are currently not carrying out a caring role, and in circumstances where they do not want to carry out certain caring duties, as this should be considered in the adult needing care eligibility determination;
- Introduced a requirement to consider whether the carer or the person they care for has fluctuating needs, and that these are considered during the determination.

It is important that the eligibility regulations are considered in conjunction with the guidance. For example, many submissions called for a definition of ‘significant impact on wellbeing.’ However, as wellbeing is not the same for everyone, in our subsequent discussions with stakeholders we concluded that it would not be meaningful to define this.  Instead, we have set out case examples in the draft guidance to show what is meant by ‘significance’ and wellbeing.

The guidance also sets out what local authorities should take into account when considering the adult’s “basic care activities”.  For example, a number of stakeholders asked that the eligibility criteria refer to an adult’s ability to communicate.  The guidance clarifies that local authorities must consider the person’s needs and one of the contributing factors to why the person is unable to carry out that activity is their inability to communicate.

# ANNEX D: List of consultation questions

1. Does the draft guidance provide local authorities with the information they need to embed wellbeing into the way that they work?

2. Can you suggest some examples to illustrate how the wellbeing principle could be applied?

3. Is the description of prevention as primary, secondary or tertiary, a helpful illustration of who may benefit from preventative interventions, when and what those interventions may be?

4. Is the list of examples of preventative 'services, facilities or resources' helpful? What else should be included?

5. Views are invited about how local authorities should co-ordinate and target information to those who have specific health and care and support needs.

6. Does the guidance provide sufficient clarity about the active role that the local authority must play to support people's access to independent financial advice, including regulated financial advisors?

7. Does the statutory guidance provide a framework to support local authorities and their partners to take new approaches to commissioning and shape their local market?

8. Are there any further suggestions of case studies or tools that can assist local authorities in carrying out their market shaping and commissioning activities?

9. We invite views on the entry criteria to the market oversight regime, and whether and how they should be made simpler for residential care providers.

10. We invite views on the approach to defining business failure by reference to insolvency situations.

11. We also invite views on the insolvency situations listed, e.g. are they appropriate and clear. Should other situations be covered?

12. In particular, are the listed insolvency situations appropriate and relevant to the various legal forms registered care provider can take (including providers registered in respect of establishments or agencies under the relevant legislation in/Wales and Northern Ireland)?

13. What further circumstances are there in which a person undergoing assessment would require a specialist assessor? Please describe why a specialist assessor is needed, and what additional training is required above the requirement for the assessor to be appropriately trained to carry out the assessment in question.

14. Do the draft eligibility regulations describe the national eligibility threshold at a level that will allow local authorities to maintain their existing level of access to care and support in April 2015? If you believe they don't please explain your reasons for this.

15. Do you think that the eligibility regulations give the right balance of being outcome- focused and set a threshold that can be easily understood or would defining "basic care activities" as "outcomes" make this clearer?

16. Do the current definitions of "basic care activities" include all the essential care tasks you would expect? If not, what would you add?

17. Are you content that the eligibility regulations will cover any cases currently provided for by section 21 of the National Assistance Act 1948?

18. Does the guidance adequately describe what local authorities should take into consideration during the assessment and eligibility process? If not, what further advice or examples would be helpful?

19. We would welcome views on further specific circumstances where the advocacy duty should apply. In particular, we welcome views on the potential benefits and disadvantages of providing independent advocacy to people for people receiving care jointly from adult social care and NHS continuing health care.

20. Do the regulations and guidance provide a clear modern framework for charging that will enable local authorities to maintain existing flexibilities in how people contribute to the cost of meeting their care needs? Are there any particular areas that are not clear?

21. Is there anything from the current rules that has not been re-created that you feel should have been? If so, please list along with a brief explanation of why.

22. Do you agree that we should adjust the operation of the 12 week property disregard to better support those most at risk?

23. Would you prefer to see the current approach retained?

24. Do you agree that this proposal is cost neutral for local authorities? If it is not, please provide evidence.

25. Do you think these bonds should be taken account of in the financial assessment? What are the risks and costs to local authorities and Individuals?

26. Should pre-paid funeral plans be disregarded and if so should there be a limit to the size of plan that can be disregarded? If so, how much?

27. Does the guidance need to particularly cover these types of accommodation? If so, what would it be helpful to discuss?

28. What are the risks of the expansion of the additional cost provisions so that the person can meet this cost themselves (to both local authorities and the person)? How can any risks be mitigated by regulations and guidance?

29. What do you think the impact of the increased pension flexibilities might be for social care charging for people and local authorities? How can any risks be mitigated via regulations and guidance?

30. Should the eligibility criteria for deferred payment agreements be extended to include people in extra care and very sheltered housing? Do you have evidence of the likely demand for deferred payment agreements from people whose needs are met in extra care or very sheltered housing?

31. Do you think we should seek to introduce a scheme which is compliant with Sharia law at a later date?

32. Do you agree that the maximum LTV for deferred payment agreements should fall between 70 and 80%? Do you have any evidence to support a particular amount within that range?

33. Do you agree that people should be able to keep a proportion of any rental income they earn on a property they have secured a deferred payment agreement on? Are there other ways people could be incentivised to rent out their houses?

34. Do you have any views or evidence to suggest how much rental income people should be able to keep to incentivise them to rent their property out?

35. Do you agree that local authorities should be required to accept any legal charge on a property as security for a deferred payment agreement when they are required to enter into one and not just a first charge?

36. In line with the recommendations of the Independent Commission on Funding of Care and Support, do you agree that the interest rate should be set so that it is

reasonable for people, cost neutral to local authorities and as such that it does not create incentives for people to apply for deferred payments when they are not needed?

37. Do you agree that there should be a different interest rate for deferred payment agreements made at the local authority's discretion? If so, what should the maximum rate be?

38. Does the guidance on personalisation fully support and promote a care and support system that has personalisation at its heart?

39. Does the guidance on personalisation support integration of health and care (and any other state support)?

40. Does the guidance support care and support workers to do their job effectively?

41. Is this definition clear and does it conform to your understanding of intermediate care and reablement? Is there any way it can be improved?

42. Does excluding the cost of reablement/intermediate care from the personal budget as defined above:
    - Create inconsistencies with the way that reablement/intermediate care is provided in NHS personal health budgets?
    - Affect the provision of reablement/intermediate care for people with mental health problems?

43. Are the ways in which different Personal Budgets can be combined sufficiently clear?

44. Will the easing of the restriction to pay family members living in the same household for administration/management of the direct payment increase uptake of direct payments? Will this create implementation issues for local authorities?

45. The draft direct payment regulations decreases the time period to conduct a review of the direct payment from 12 months to 6 months – is this workable?

46. The draft regulations seek to ensure choice is not stifled, and the direct payment is not monitored excessively – is this strong enough to encourage greater direct payment use, but workable for local authorities to show effective use of public monies?

47. Does the draft statutory guidance provide a framework that will support local authorities and their partners to make integration a reality locally?

48. Are there any ways the guidance can better support cooperation locally?

49. Is the description in the guidance of exceptions to provision of healthcare (which effectively sets out the boundary between NHS and local authority responsibilities) sufficiently clear and does it maintain the current position on the boundary?

50. Is there any danger that the legal barrier could be interpreted as a barrier to integration? Are there specific examples where it would be helpful to clarify?

51. Will any of these changes affect the working of delayed discharge processes in ways not discussed in the guidance?

52. Can you provide any best practice examples or guidance relating to hospital discharge for people with care and support needs?

53. Could local authorities' duties in relation to housing be described more clearly in the guidance?

54. Are the links to prevention, integration, co-operation, information and advice, market shaping and assessments adequate?

55. How could guidance on the legal boundary between care and support and general housing responsibilities be improved?

56. Are there any good practice examples of local authorities working with their partners, including health, education, employment and housing?

57. Is the guidance clear enough that the term 'significant benefit' is about the timing of the assessment? Is the guidance precise enough to ensure that 'significant benefit' is not open to misinterpretation and that people who should be assessed are assessed at the right time for them?

58. Are the descriptions in the guidance of people's rights to transition assessments and continuity of care beyond 18 sufficiently clear?

59. We would welcome views and transferable good practice examples about the application of care and support to custodial settings. In particular about information and advice, advocacy, financial assessment, personal budgets, the sharing of information between agencies, and joint commissioning arrangements between custodial establishments, local authorities and health services.

60. When delivering care and support in custodial settings, how should local authorities go about reflecting the high prevalence of mental ill health, substance misuse and learning disabilities?

61. How might these be best provided in custodial settings and how might responsibility for provision best be identified?

62. How could the initial assessment of a prisoner's care and support needs be best constructed to be useful in supporting proportionate reassessment and planning to meet any eligible care and support needs in subsequent custodial settings throughout the person's sentence? Are there triggers, particularly which might be identified in the health assessment which all prisoners receive on entering prison,, which could help prison staff and/or health care partners to identify when it would be appropriate to refer a prisoner for a care needs assessment?

63. Are there any core principles or requirements that local authorities should always place on contractors when delegating care and support functions?

64. Some stakeholders have mentioned that a 'model contract' would be helpful. What would be included in a model contract? Can you give any examples of a good model contract when outsourcing statutory functions?

65. Are there any other types of behaviour that should be explicitly stated in the guidance? Are there any that should be removed?

66. Are there additional possible members of SABs that we should add?

67. Are there additional aspects of the SAB's work that we should highlight?

68. Would it be useful to append a draft template for the strategic plan for SABs to use if they wish?

69. Is there anything we could add to improve how managers and practitioners view and participate in Safeguarding Adults Reviews?

70. Are there other areas of information sharing that need to be spelt out in this section?

71. Are the definitions of the types of accommodation as cited in the regulations too wide? Are they workable and clear?

72. Do the guidance and regulations about ordinary residence disputes provide enough clarity to settle ordinary residence disputes between two or more local authorities? Are there other scenarios that it would be helpful for the guidance to consider?

73. Which authority should be responsible for meeting the needs of an adult or carer when two authorities in dispute, or another authority cannot come to an agreement on who should be the lead authority? Do you agree with the regulations as currently set out in the regulations?

74. What further circumstances should be considered when carers and people with care and support needs want to move?

75. Do the regulations provide for an effective dispute resolution procedure?

76. In particular, in setting out the process for local authorities to follow when making a cross-border residential care placement, are there any gaps or omissions in the guidance in terms of key issues that need to be addressed before a placement can successfully take place?

77. With regard to the arrangements for managing a placement once it has commenced, can you envisage issues other than those identified? Specifically, what are these and how should they be addressed?

78. Would it be helpful for the guidance to be supplemented by best practice guidance? If so, what issues and scenarios will it be important for best practice guidance on these placements to cover?

79. Should certification of CVIs be extended senior ophthalmologists, or should this continue to be carried out by consultant ophthalmologists as is currently the case?

80. Should we seek the patient's consent to pass their contact details to RNIB, as well as to the local authority, as part of the CVI process in order for them to offer advice and support?

81. Are there other considerations around preparation for implementation of the April 2016 elements of the Care Act on which national guidance would be helpful?

82. Are there other considerations around preparation for implementation of the April 2015 elements of the Care Act on which national guidance would be helpful?

83. Do you think that providers of NHS Continuing Healthcare and NHS-funded nursing care should continue to be exempt from the requirement to hold a licence from Monitor?

84. Should providers NHS Continuing Healthcare and NHS-funded nursing care services be subject to those services being designated CRS?

# ANNEX E: Legislation and guidance to be replaced

The following lists summarise some of the key legal provisions and existing statutory guidance which are to be replaced by the Care Act 2014 and the associated regulations and guidance.

Where existing provisions relate to jurisdictions other than England, the provisions will be disapplied so that they no longer relate to English local authorities. Where provisions relate to children as well as adults, they will be disapplied in relation to adults, but will remain in force in relation to children.

The repeals and revocations required will be provided for by Orders under the Care Act. The final detail of which precise provisions are to be replaced is to be confirmed during the consultation process. The tables below are not therefore a final position, but intended to given an indication of the scope of the Act, and the key existing provisions which are to be affected.

## Primary legislation to be repealed or disapplied

*Title of legislation to be repealed, in whole or in part*

- National Assistance Act 1948
- Health Services and Public Health Act 1968
- Local Authority Social Services Act 1970
- Chronically Sick and Disabled Persons Act 1970
- Health and Social Services and Social Security Adjudications Act 1983
- Disabled Persons (Services, Consultation and Representation) Act 1986
- National Health Service and Community Care Act 1990
- Carers (Recognition and Services) Act 1995
- Carers and Disabled Children Act 2000
- Health and Social Care Act 2001
- Community Care (Delayed Discharges etc.) Act 2003
- Carers (Equal Opportunities) Act 2004
- National Health Service Act 2006

## Secondary legislation to be revoked

*Title of instruments to be revoked, in whole or in part*

- Approvals and directions under S.21(1) NAA 1948 (LAC (93)10)
- National Assistance (Assessment of Resources) Regulations 1992
- National Assistance Act 1948 (Choice of Accommodation) Directions 1992
- National Assistance (Residential Accommodation) (Relevant Contributions) Regulations 2001
- National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) Regulations 2001
- Delayed Discharges (Mental Health Care) (England) Order 2003
- Delayed Discharges (England) Regulations 2003
- National Assistance (Sums for Personal Requirements) Regulations 2003
- Community Care (Delayed Discharges etc.) Act (Qualifying Services) Regulations 2003
- Community Care Assessment Directions 2004
- Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009
- NHS Continuing Healthcare (Responsibilities) Directions 2009
- Ordinary Residence Disputes (National Assistance Act 1948) Directions 2010

## Statutory guidance to be cancelled

*Title of guidance to be cancelled*

- Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care (2010)
- Fairer Charging Policies for Home Care and other non-residential Social Services (2013) and LAC (2001)32
- Charging for residential accommodation guidance (CRAG) (2014)

- Guidance on direct payments for community care, services for carers and children's services (2009)
- The Personal Care at Home Act 2010 and Charging for Reablement (LAC (2010)6)
- Charging for residential accommodation guidance (CRAG) (2014)
- Identifying the ordinary residence of people in need of community care services (2013)
- Transforming Adult Social Care (LAC (2009)1)
- Guidance on National Assistance Act 1948 (Choice of Accommodation) Directions 1992 and National Assistance (Residential Accommodation) (Additional Payments) Regulations 2001 (LAC (2004)20)
- The Community Care (Delayed Discharges etc.) Act 2003 guidance for implementation (LAC (2003)21)
- Fair Access to Care Services (FACS): Guidance on eligibility criteria for adult social care (2002)
- Carers and people with parental responsibility for disabled children (2001)
- No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (2000)
- Caring for people: community care in the next decade and beyond (1990)