



Department  
of Health

# Response to the consultation on draft regulations and guidance for implementation of Part 1 of the Care Act 2014



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Presented to Parliament  
by the Secretary of State for Health  
by Command of Her Majesty

October 2014



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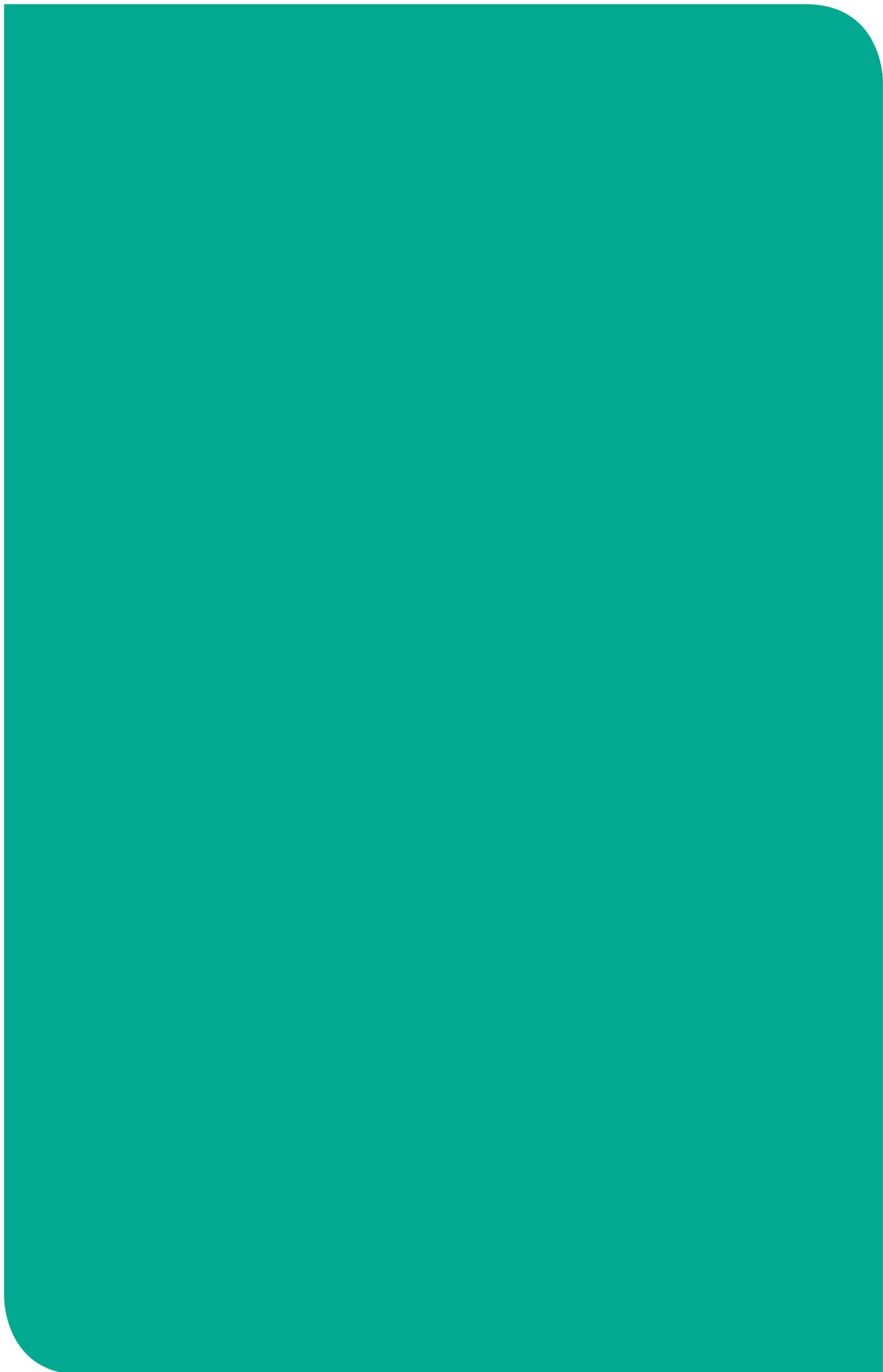
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# Contents

About the consultation, engagement process and analysis of responses	1
Summary of consultation responses, and next steps	5
General duties and universal provision	11
First contact and identifying needs	19
Charging and financial assessment	25
Person-centred care and support planning	31
Integration and partnership working	35
Safeguarding	41
Moving between areas: inter-local authority and cross-border issues	43
Other areas	47
Annex A: List of consultation responses	49



# About the consultation, engagement process and analysis of responses

## The consultation

The Care Act is a bold and historic piece of legislation that for the first time places adult care and support law into a single clear statute. The Act introduces wide-reaching reforms to adult social care in England, and enshrines the principle of individual wellbeing at the core of the system. It will ensure that people themselves will be able to shape their care and support, focusing on what they want to achieve and the outcomes that matter to them, and will support them to maintain their wellbeing and independence for longer.

In order to deliver the key changes to the system to enable this vision to be realised, the guidance and regulations underpinning the Act must be fit for purpose – to help ensure local authorities fully comprehend and apply the core legal duties and powers, and to support people in understanding their rights and responsibilities.

That is why we were keen to ensure a comprehensive consultation on how local authorities and partners can deliver the care and support reforms. The objective of this process was to engage with all people who have experience and views on the adult social care system and give them the opportunity to influence the documents which will inform how local authorities go about delivering the reforms in years to come.

To assist this process, we published a consultation document setting out a high-level summary of the policies to which the regulations and guidance relate. We included in the document questions on specific issues, but also invited respondents to share their views about the overall approach to each section of the guidance and each of set of regulations, as well as asking them to share with us any examples of good practice or tools which they thought would be particularly helpful.

The consultation was published on 5 June 2014, and ran for ten weeks to 15 August.

The second phase of the reforms under the Care Act will be the implementation of the cap on care costs, the extended means test, and a new appeals system from April 2016. A second consultation will be launched by the end of the year. This will consult on draft guidance and regulations on the cap on care costs, extended means test, and policy proposals for the appeals system.

## Engagement process

In order to reach a comprehensive and varied pool of experience and expertise, the consultation contained a mix of digital and face-to-face meetings and events with the full spectrum of stakeholders, including:

- people receiving care and support and their carers;
- social workers and other frontline practitioners;
- local authority finance managers, commissioners and elected members;

- voluntary and private social care providers;
- national representative groups and other charities and trusts; and
- NHS agencies, housing departments, DWP Job Centre Plus and other key partners involved in the reforms.

The Department of Health hosted or attended a large number of consultation events, the majority co-hosted in partnership with stakeholders, which covered the Act, regulations and guidance as a whole, as well as more specific events on individual themes or topics. The consultation encompassed 57 formal consultation events and a large number of smaller meetings and virtual discussions. These events spanned all regions in England, including nine regional events organised jointly with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), a number of “deep dives” on specific topics arranged jointly with the Care and Support Alliance, as well as other events hosted with specific stakeholders. The Department is grateful to all those who contributed their time to arranging, running and attending the consultation events.

The Department also set up an accessible online platform as the online hub for all Care Act and consultation information. This site allowed for easy online access to the draft regulations and guidance documents and most importantly was a key tool for gathering stakeholder feedback, as it allowed users to respond with their comments and suggestions on various parts of the Act. The consultation also utilised channels such as gov.uk, social care news and the LGA-hosted care and support reform website, as well as social media and other communications, to spread awareness of the consultation period and encourage input. In addition, Welsh, Northern Irish and Scottish Governments each launched parallel consultations on the regulations and guidance affecting local authorities and HSC Trusts in those countries. A wide range of responses were received from independent community organisations, independent regulatory bodies, local authorities, HSC Trusts and voluntary sector organisations.

### Overview of response

In total, the consultation drew over 4,000 responses from many different sources. Of these, the consultation website received 1,175 comments in response to the 84 questions we asked through the consultation document.

We also received 551 direct emails to the consultation mailbox. To add to this, officials from the Department also captured feedback collected at the various stakeholder engagement events noted above to ensure this information was fed into the final response document.

The consultation responses were received from many different types of respondent, including individuals, people with care and support needs, carers, local authorities, provider organisations, voluntary organisations, representative groups, user-led organisations, NHS and other public bodies and legal advisors.

A full list of the consultation respondents can be found in Annex A. This variety in responses has allowed us to undertake a comprehensive review of the draft guidance and regulations and to make appropriate adjustments and clarifications, based on the feedback received.

## This document

This document sets out our response to the consultation process, and summarises changes to the regulations and guidance as a result.

For each of the chapters of the guidance, the main points and issues raised through the consultation process have been summarised, major changes highlighted, and where relevant we have set out how we intend to implement those changes. We have also summarised other key themes or emerging issues that are not directly related to any one of the areas in the guidance.

We have included in each summary the questions we originally asked relating to specific chapters of the guidance.

Regulations which are subject to negative procedure will be laid in Parliament shortly and the proposed final versions, revised in light of the consultation, are annexed to this document.

Regulations that are subject to affirmative procedure, which means that they will be debated in Parliament, are also annexed to this document in the proposed final form.



# Summary of consultation responses, and next steps

## General issues

Most of the consultation responses took the opportunity to make more general points regarding the implementation of the Care Act, and the associated benefits and risks. A number of the most frequently cited issues are noted below.

### Supporting the ambition

Almost all consultation responses recognised the opportunity provided by the Care Act, and were supportive of the ambition and principles espoused within the Act, regulations and guidance.

*“CCN strongly supports the ambition and policy context of the Care Act, particularly its focus on personalisation, prevention and early intervention.”* [County Councils Network]

### Financial concerns

Many consultation responses, in particular those from local government, highlighted concerns about adequate funding for social care, and for the specific reforms in the Care Act, as their primary issue. As stated in the joint response from the Local Government Association and the Association of Directors of Adult Social Services:

*“Adequate funding for the reforms... is essential given the significant overall pressures on local authority budgets. It is also essential for realising the aspirations of the Act and, ultimately, supporting the people the legislation is aimed at.”*

The Department recognises the scale of these concerns. It is critical to the successful implementation of the Care Act that local authorities are both able to plan effectively for the changes required, and that funds be made available to deliver those changes within a constrained financial environment.

In the 2013 Spending Review settlement, the Government announced a total of £470m for 2015/16 to support implementation of the care and support reforms in this first year. This includes £135m of revenue and £50m capital funding which was incorporated within the Better Care Fund, in order to release additional benefits through integrating plans with the NHS, and £285m in additional local government grants. This total provides funding for the costs arising from new duties in the Care Act in the 2015/16 year, as set out in the impact assessment which accompanies this document, and further funding in relation to preparation for the second phase of reforms in 2016/17.

The Department has continued to work closely with local government and others to refine cost estimates and improve our understanding of the risks involved. In partnership with LGA, ADASS and council networks, the Department coordinated a nationwide cost modelling exercise, providing support and tools to allow councils to undertake their own costings for key

policies being implemented in 2015/16. This exercise was intended to increase understanding and improve the evidence base on the new burdens on local government from implementing the Act in 2015/16, and to support local planning and budget setting, responding to feedback received during the consultation that several local authorities had difficulty in producing estimates to determine likely demand. Over 120 local authorities provided information for this work.

As a result of this exercise, and supported by other feedback during the consultation, we have made significant changes to the cost estimates in our impact assessment. Responding to particular concerns about the potential demand from carers to access new rights in 2015/16, we have revised our assumptions to reflect a larger number of potential recipients, and show additional costs in the first year and beyond – rising to an additional £100m per year. In order to ensure that funding is targeted most appropriately to meet this extra need, we will create a new grant to be paid to local authorities for carers and Care Act implementation in 2015/16. These new costs are balanced by reductions in other areas, where the evidence has shown that the impact is not likely to be as great as previously assessed. Overall, we believe that this presents the likely costs more accurately, and means that the new burdens in the Care Act can be met in 2015/16. We will work with local government to develop plans to monitor costs in the highest risk areas during the year.

Managing risks associated with new costs is not a matter of additional funding alone, but also requires that local authorities adopt efficient practices in delivering the Act. As set out below in response to this and broader implementation issues, we are committed to delivering a national support offer for local authorities which will help them address such risks. This will include guidance on how to implement key provisions in the Act in the most efficient way.

### **Other implementation issues**

Many consultation respondents considered other issues which would affect or support implementation of the Care Act by local authorities.

Some respondents questioned the ability of local authorities to implement the Act, and suggested that the timetable was itself a risk and implementation should be delayed beyond April 2015 in order to provide more time for preparation.

We do not underestimate the challenge of implementing the Care Act from April 2015. This is a major reform programme. But it is also an overdue one; and we must not delay change to improve the outcomes for people who need care and support, their carers and families. Feedback from local authorities has consistently demonstrated confidence that the reforms will be implemented in 2015/16 on a local level. In the most recent national stocktake survey of all local authorities conducted by the LGA, 97% of authorities said that they were “fairly” or “very” confident of delivering the reforms.

Notwithstanding this positive response, we recognise the need to further support local authorities, many of whom are in a different starting place, to plan and prepare for the requirements of the Act. We have already committed funding of £25.7m to local authorities and regional networks to invest in programme management capacity to ensure that local plans are robust, and will continue to consider the case for further targeted support.

We have also designed a public awareness campaign. This will address those people with an existing care need, as well as their carers and families, and will help explain what the reforms mean for them. A toolkit to support local authorities and trusted partners to communicate these changes is in development, and products will be available from October.

A large proportion of respondents pointed to the need for additional support or practical tools to help local authorities deliver the Act effectively. The suggestions for such support were numerous, relating to all areas of the Act and including, for example, practical guidance, model approaches and multimedia toolkits. Others noted the critical importance of training, learning and development for the workforce delivering care and support.

We agree that the regulations and guidance alone may not provide sufficient detail in all areas to ensure successful implementation. Statutory guidance is by its nature high-level, and does not seek to describe the fine detail of process or operating models which are for local determination. We have therefore worked with local government and other partners to better understand the particular areas in which more detailed practical advice, guidance or training would be of most value.

As a result of this work, we have developed a detailed implementation support offer for local government – a list of different support materials which cover the breadth of the functions in the Act, based on the feedback received about the areas of most importance or concern; namely those key areas which enable local change programmes to succeed: workforce, informatics and IT, funding and communications. Since June, we have worked to develop the specification of each product to support the final guidance and regulations. The full list has been published on the LGA's care and support reform website.<sup>1</sup> A number of specific areas are referenced in relation to the relevant topic in the sections of this document which follow.

### **Possible impact on the provider market**

A number of consultation responses demonstrated some confusion about how the duty to meet needs set out in sections 18 and 20 replaces the various current duties to provide specific services to specific people. Others raised questions as to how the duty to meet needs could be met, the balances to be struck between choices about commissioning or providing particular services, and the potential overlap between a duty to meet care and support needs and duties to provide other public services. We have accordingly added a new section of guidance explaining these issues more explicitly, within the chapter on care and support planning.

This new section also responds in part to further concerns raised by several consultees, in particular from local government and provider organisations, about the possible impact on the provider market arising from the ability for people who pay for their own care (“self-funders”) to seek local authority assistance in arranging their care. The concern arises from the duty in Section 18(3) which allows for people with financial means above the financial limit (i.e. those who are judged to be able to pay for their own care) to ask the local authority to meet their needs. As the County Councils Network wrote in their response:

*“there remains considerable concern and uncertainty over the precise impact of Section 18(3) of the Care Act will have on the provider market (erosion of cost-differential & legal challenge) and additional demand for local authority services, particularly in areas with high levels of self-funders.”*

This individual right in Section 18(3) is not new in most cases – it is already the case that people receiving any form of non-residential care are entitled to such support based on the level of their needs, and their finances are not relevant. Section 18(3) extends this principle to

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<sup>1</sup> <http://www.local.gov.uk/care-support-reform>

care homes, building on current practice in many local authorities, so that people who may lack the skills or confidence to navigate the market and find their own care home – but who have financial means to pay for their care – are able to access this support when they need it.

We recognise the concerns from some stakeholders as to the perceived risks attached to this provision. However, consultation has demonstrated that there is little consensus on the size of this risk, how and where this may impact, or the extent to which it could be mitigated by local practices and robust information and advice. This was also balanced by the views of other respondents to the consultation, who noted the benefits to the individual of more transparency around care costs, as well as the protection afforded by Section 18(3) for people who may have some financial means, but nonetheless be vulnerable and in need of support to access care.

Added to this lack of consensus is the difficulty of predicting how this change will influence people's care choices, and significant lack of empirical evidence to support our understanding of the issue. Whilst some data exist which demonstrate the difference in prices paid by local authorities and individuals in some cases, this is not sufficiently robust to determine whether or how such risks may manifest, or to quantify accurately any impact on local authorities or providers.

We also note that there is strong evidence, supported by views from the consultation, that any impact would be significantly less in 2015/16 than 2016/17, when self-funders with eligible needs may be given an independent personal budget which will indicate the amount that the local authority considers it would pay in order to meet their needs, and thus there will be additional incentives for self-funding people to come forward to the local authority.

We have put in place a program of work to assess the risks put forward in consultation. It is important that such further work is taken forward in order to properly ascertain the potential scale of any impact, and to determine how any risks could be managed. Given the nature of the concerns arising in the consultation, and recognising the need for further evidence, we have decided to delay the implementation of this provision for one year, until April 2016, insofar as it relates to people whose needs are to be met in care homes. This additional time will allow for further analysis and a better common understanding of the issues, to identify risks to the care and support system and to individuals, and to develop strategies for implementing this most effectively. In order to do so, the Department intends to work closely with local authorities, providers and other stakeholders to carry out this work and has commissioned the Office of Public Management to undertake detailed research looking at the potential scope and scale of any impact.

Section 18(3) will continue to be implemented in 2015/16 in relation to all other types of care and support, to ensure that no one should lose an entitlement to care and support that they have currently. The delay only relates to where people are to move into care homes. Local authorities will, however, retain the ability to arrange care homes for self-funders, in line with existing best practice, where the person needs support to find the care they need. The guidance has been amended to make clear that local authorities have this discretion, and should consider it where the person may struggle to access care independently. We remain committed to implementing this provision in full from April 2016, and will work with the sector to determine if further mitigation is required, including through the revised regulations and guidance for the second phase of reforms in 2016/17.

## Carers

Respondents were broadly supportive of the approach of “mainstreaming” guidance relating to carers throughout the guidance to ensure that consideration of carers is embedded throughout the reformed system. However, respondents also pointed out that this approach meant that local carers leads, carers organisations, carers themselves, and other interested parties did not have a single document setting out in one place what the regulations and guidance mean for carers. We have listened to this and, while maintaining the individual carer sections throughout the document, we will also produce an “at a glance” document that draws together in one place what the Care Act, the regulations, and the guidance mean for carers. This will form part of the best practice guidance on effective and efficient interventions for carers to be published in November.

Responding to concerns from a number of consultation respondents, we have also set out more fully the economic case for local authorities to avoid excessive charging of carers. Carers voluntarily provide a huge amount of care and support. Supporting carers to continue to do so is extremely likely to be cost-effective when compared with the cost of directly meeting the eligible needs of even a small fraction of the people carers support, which would be inevitable where carers no longer felt able to continue caring due to lack of support. Excessive charging creates a risk that some carers choose not to move forward with support following an assessment, and it will almost certainly prove a false economy for local authorities.

We have clarified that, although in some cases universal services aimed at prevention or providing information and advice can be a way of meeting a carer’s eligible needs (or indeed those of the people they care for), systematically using such services to attempt to meet all carers’ eligible needs is very unlikely to be compliant with the requirements of the Care Act. This responds to concern among some respondents that there was some confusion about this point.

We have also clarified how the new statutory framework for safeguarding applies to carers, setting out the different ways it is possible for carers to be involved in safeguarding issues. The guidance sets the clear expectation that carers are listened to where they speak up about abuse and neglect.

### Use of language in the statutory guidance

A number of responses questioned the use of the words “must” and “should” in the guidance document, often with a desire to use more directive language in setting requirements for local authorities.

The use of these words is deliberate, and reflects the legal status of each of the matters considered. Where “must” is used, this is because the point ties directly to a legal duty – either in the Act itself or in regulations. This language cannot be used where there is no statutory duty. Where “should” is used, this is intended to set a clear expectation, but not to create a legal requirement. The status of the guidance is set out in the introduction, which states that “local authorities must follow it, unless they can demonstrate legally sound reasons for not doing so”.

Others commented similarly on the use of case studies or examples and the status of these. Case studies do not form part of the guidance itself, but are intended as an illustration of

the principles or examples of how organisations have gone about implementing them in real circumstances. It is not expected that case studies will be followed in the same way. This has been further clarified in the introduction to the guidance.

# General duties and universal provision

## Promoting wellbeing

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

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

The wellbeing principle was widely seen as a clear and positive description of the values of modern care and support. As one respondent said:

*“The descriptions of wellbeing are clear and positive. I like the fact that wellbeing is not specifically/concretely defined but relates to what matters to the individual”.*

However, some respondents did worry that the principle was, *“too abstract to be effective”*. As the draft guidance made clear, the wellbeing principle is designed to set out the overarching purpose of care and support into which specific duties (such as to carry out needs assessments) fit, rather than require a local authority to undertake any particular action in and of itself. As such the principle is intentionally broad in order to capture all of the different matters which wellbeing can mean to people in the context of the care and support.

Many respondents felt that case studies would be helpful to show the wellbeing principle being applied in real life scenarios. We have accordingly made more explicit links to the promotion of wellbeing in case studies throughout the guidance, to both respond to these requests and further demonstrate how the wellbeing principle functions throughout the Act and guidance.

## Preventing, reducing and delaying needs

**Question 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?*

**Question 4:** *Is the list of examples of preventative ‘services, facilities or resources’ helpful? What else should be included?*

We received a generally very positive response to the prevention duty in the Care Act and the supporting guidance. Respondents recognised that the Care Act acknowledges that a modern and sustainable care and support system should include a focus on prevention and move away from crisis management. One typical response said:

*“We strongly welcome the Local Authority’s new responsibility to arrange for services, facilities and resources which would prevent reduce or delay the needs for care and support”.*

Most respondents welcomed the clarity that the guidance provided in defining prevention, with the majority finding the description of the approaches to prevention helpful in providing a framework. However, a number of respondents were concerned that the guidance could be strengthened to clarify that prevention is not a one-off activity done at the start of the care journey or only after an assessment, and that prevention services may change following a change in circumstance. This feedback is welcomed and drafting changes to the guidance have been made to emphasise this more strongly.

Most respondents found the examples of preventative services facilities and resources helpful, however some groups raised concerns that examples were listed under a particular approach (e.g. primary prevention) when they were perhaps better examples of a different level of preventative activity (e.g. secondary prevention). Where a number of respondents made the same observation the guidance has been changed, and the guidance now also makes it clear that the examples provided under each heading are for illustrative purposes and are not to be seen as limited to that approach.

Many respondents welcomed the tone of the guidance and the balance struck in locating prevention in the context of personalisation and community resilience, recognising the role that family, friends and the community can provide but also recognising the needs of carers and that the prevention duty extends to preventing or reducing the needs of carers.

We also received feedback about the role the wider community infrastructure and other council services play in prevention and we have reflected this in changes to the guidance on developing a local approach to preventative support.

Some respondents said that they would welcome best practice examples and further evidence of what works in the area of prevention, particularly given that it is a broad concept. We agree, and have already begun work to develop a prevention library populated with evidence, evaluated practice examples and good practice, which is intended to supplement the guidance. This library will be available from early 2015.

## Information and advice

**Question 5:** *Views are invited about how local authorities should coordinate and target information to those who have specific health and care and support needs.*

**Question 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?*

The vast majority of responses to the consultation was supportive of the fact that information and advice was the subject of statutory guidance for the first time, and was largely positive both about the description of the duty on local authorities and the description of the need to work with and use partner organisations in the community, voluntary, private and statutory sectors.

*"The Alliance welcomes the provision in the Care Act for local authorities to establish and maintain an information and advice service. We believe that access to free, independent advice from trusted sources enables people to make informed choices about many aspects of their lives, preventing as well as solving the problems people face at different points in their lives. This is particularly important when people are vulnerable through reasons of age, disability or illness." [Advice Services Alliance UK]*

*“We believe that housing forms a crucial part of the choices about services that many people will need to make when considering their social care needs, and are pleased to see this identified in this section of the guidance.” [The National Housing Federation]*

Responses from both local authorities and the voluntary sector expressed concerns that the additional work necessary to put the described information and advice services into place was not reflected in the accompanying Impact Assessment. Whilst we believe that the legal requirements in the Act do not constitute a new requirement for local authorities and are intended to codify existing good practice, we have previously recognised that need for some additional investment in information and advice to improve the local offer. The Department initially set out the general plans and funding for improved information, advice and advocacy in the Caring for our future White Paper and the related impact assessment, and around £24m of funding has already been made available since the White Paper to support the policy. In addition to this, the programme to support the local implementation of the information and advice services includes national work to provide a greater level of consistent, generic text, information, explanation, tools and web-based resources that local authorities and other information and advice providers can utilise at no cost.

In regards to question 5, respondents confirmed the relevance and importance of addressing this area within an information and advice service. To support their view, many gave examples of current practice. These examples will be used in the ongoing work to support local implementation of services, the spread of good practice and consistency, while providing a range of options on what might work best in different areas or circumstances. The important role that the Department could play in providing nationally agreed resources that could be ‘localised’ was also covered.

In regards to question 6, this question drew a significant amount of comment, but views varied across interest groups. Views expressed ranged from the guidance being very clear on this point and achievable, to specific concerns about the potential legal implications for local authorities should a person be unsatisfied with the outcome of a financial decision on which they took independent financial advice from a person or organisation whose details were provided by the local authority. There were mixed views about the framing of the role of local authorities in actively helping and directing people (particularly those who arrange and pay for their own care) to regulated financial advice, with some stakeholder groups seeking stronger wording of the duty and others seeking more detail about how this may work in practice, for example identifying triggers for considering a person’s need for financial information and advice.

*“Overall we are supportive of the guidance as regards local authorities’ duties to support people’s access to independent financial advice, including regulated financial advisers. However in a number of places we believe the guidance could be strengthened, for example by using the word “must” rather than “should”” [The Association of Professional Financial Advisers]*

*“It is vital local authorities facilitate access to independent information and advice. Adults with care needs and their carers often need impartial information and advice, particularly where a person is seeking to understand their rights or wishes to challenge a local authority’s decision.” [Independent Age]*

*“Facilitation of access to independent financial advice is potentially the most problematic aspect of the Guidance on information and advice and an area of concern... It is critically important that this advice is also independent of any provider of financial products, or their subsidiary or linked organisations, and complies with financial services legislation.” [LGA/ADASS]*

We have made some amendments to the guidance to clarify some of the points raised in relation to roles and responsibilities, and will supplement this with further implementation support materials to help local authorities in delivering this function.

There were many specific and detailed comments on the text both in terms of amendment and additional examples, such as making reference to the Guidance Guarantee (GG) supporting the changing pension arrangement offered to people approaching retirement, which was introduced in the Budget 2014.

The responses have not led to any major, directional changes but have more broadly pointed to the need for additional text to help explanations and understanding. The section on ‘accessibility’ drew both comment and some useful suggestions for revision and reordering. These have been used to amend the guidance to make it clearer.

### **Market shaping and commissioning**

**Question 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?*

**Question 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?*

Respondents were broadly supportive of the draft statutory guidance, in particular welcoming the focus on wellbeing and outcomes. In the main, they wanted further clarification and additional information. The majority of amendments to the guidance therefore have taken the form of small additions to the text and extensions to existing paragraphs to add clarity.

Many representative groups and third sector organisations were pleased that issues are addressed where Government had committed to including clarification and examples raised during the passage of the Care Act through Parliament, for example, clarity that:

- local authorities should have evidence that their contracting does not compromise a provider’s ability to pay the national minimum wage;
- very short home care visits are not normally appropriate; and
- the definition of quality includes that services should be appropriate for an individual.

As requested, respondents provided examples and links of where market shaping and commissioning practices were in place and considered to be effective. Where relevant, these have been included in the guidance, noting that they are not directions to consider them, but that they may be helpful in designing local approaches.

A number of respondents felt that local authorities, providers and other stakeholders would benefit from additional guidance and help, for example:

- help for local authorities to collect, analyse and articulate information on likely trends,

- specifically, help to understand and measure supply and demand for services paid for by 'self-funders'; and,
- help for smaller providers to engage more productively with local authorities and others around market-shaping.

In response, the Department is actively working to develop support projects to help smooth the implementation of the Care Act, and is considering how to embed and extend guidance recently developed to promote market shaping (through the Developing Care Markets for Quality and Choice Programme)<sup>2</sup> to address these issues. These would include, for example, a toolkit for small providers to help them engage with market shaping.

A number of respondents suggested being clearer about the links between care and housing and related services, and the guidance has been improved to reflect these concerns.

### Managing provider failure and other service interruptions

**Question 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.*

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

**Question 11:** *We also invite views on the insolvency situations listed, for example, are they appropriate and clear. Should other situations be covered?*

**Question 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)?*

In relation to the draft guidance, most responses to the consultation were seeking further information or clarification and very few went into the detail of the guidance. Having carefully considered all the responses we have decided to make no changes to the policy described in the guidance. The issues raised in the responses have been addressed through amendments and extensions to the text of the guidance.

The most common comment was that local authorities needed more help and support to fulfil the temporary duty to ensure continuity of care if a local provider were to experience business failure. Two issues were prominent: what information do local authorities need to be sure of the financial "health" of local providers, and what is the best practice in developing contingency plans for use should a care and support service be interrupted. For example, Salford City Council said:

*"The Act and Guidance do not cover sufficiently the approach to medium sized providers. It leaves an uncertain middle ground relating to the failure of medium size providers. This represents a risk for CQC and Local Government for the future. Some further development about roles and duty to support is required."*

In response, the Department is considering whether to commission advice and support materials on these two issues to be made available to local authorities.

Many of the responses from local authorities mentioned the need to know more about how the Care Quality Commission (CQC) will work with authorities in the exercise of its function to

<sup>2</sup> <http://ipc.brookes.ac.uk/dcmqc.html>

oversee the most “difficult to replace” providers. Those issues are beyond the scope of this guidance, but will be passed to CQC to help it develop the guidance on the operation of the oversight regime that it plans to issue early in 2015.

A few respondents argued that CQC should have formal oversight of the financial sustainability of all providers, rather than the suggested subset. Ministers do not consider that an option because the resource implications would be well out of balance with the risk posed. A few respondents questioned the fact that authorities are responsible for meeting all needs for all local people in a failure situation rather than just eligible needs for those for whom the authority had commissioned services. Those provisions are in the Care Act and so have been subject to Parliamentary agreement. They reflect the vulnerability of local people generally in provider failure situations. Of course, a local authority will not have to meet needs longer than it considers necessary to ensure continuity of care.

Several respondents suggested the guidance should be expanded in places, for example, clarifying when the duty on authorities applies. Wherever appropriate, we have made the suggested changes. Some providers felt the guidance was unbalanced in painting provider failure and service closure as a universally bad event. They pointed out that failure is rare and that most failures do not impact on those receiving services. We have strived to achieve a better balance in the final guidance by prefacing the discussion of business failure with some contextual comments.

In regards to the draft regulations a number of respondents felt that the regulations describing the entry criteria for CQC’s market oversight scheme should be changed so that, in addition to residential care providers that are large and spread across the country, those who were relatively small in size but retain a large market share in a single or small number of local authority areas should be overseen by CQC.

We considered this issue carefully but decided not to include providers solely on the basis that they retain a large local market share, as local residential care markets typically run with some spare capacity and the failure of one smaller provider with a significant market share would very likely be manageable by the relevant authorities who should, as part of standard contingency planning, be aware of alternative providers in their local area that have spare capacity and have developed relationships with those providers. As described above, the Department will be making available advice to supplement existing work by local authorities in respect of contingency planning and in light of these responses, will consider what further work is needed to assist them in this area.

Defining business failure in the regulations by reference to different insolvency situations was generally seen as a practical and proportionate approach that “*consolidates current practice and arrangements*”. Some local authorities argued that continuity of care would be at risk should an organisation enter a voluntary arrangement with its creditors as this was a clear indicator that an organisation was in financial difficulty. The regulations have therefore been amended to make provision for Company Voluntary Arrangements (CVAs) and Individual Voluntary Arrangements (IVAs).

Some contributors felt that the meaning of business failure should be “*widened*” so that, in addition to insolvency, the temporary duty on local authorities is triggered when the business ceases to operate because of failure to meet CQC’s fundamental standards or other quality standards. Whilst we recognise that it is important for local authorities to have

a clear understanding of their role in this type of situation, we have decided not to adopt this approach as it could detract from the core responsibility of the provider itself for arranging care and support services for those people for whom it cares. In addition, where a business was arranging alternative care services, for example, by placing individuals at another of its care homes in line with contractual liabilities, the effect may be to undermine an otherwise solvent business and interrupt the smooth transition of care services. Moreover, this would detract from the policy to limit the provider failure duties to situations where there is an element of loss of control over events on the part of the provider.

Local authorities have powers under the Care Act to intervene to meet needs where it deems those needs to be urgent. Those powers are available to authorities if the urgent needs arise from quality failings. We have therefore made clear in the statutory guidance described above that failure to meet quality standards may be one particular scenario where a local authority may want to consider stepping in to meet urgent needs using this power.



# First contact and identifying needs

## Needs assessment and carer's assessment

**Question 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.*

The majority of responses focused on statutory guidance, rather than the regulations. They sought clarification of processes and concepts including what a “proportionate” assessment is, where safeguarding should fit into the assessment process, and how integrated assessments can be supported. These sections have been updated accordingly.

Some respondents raised concerns about the requirement for local authorities to provide carers carrying out a supported self-assessment with information about the person they care for. We have therefore added a regulation that requires the consent of the person being cared for before any information about them is shared.

Other respondents raised concerns that a large number of carers that will come forward for assessment in 2015/16, and questioned whether this would be manageable.

To support local authorities in handling higher volumes of assessments for carers, we are providing an extra £22m per annum from 2015/16, rising to £27.5m from 2017/18 onwards, and are working with local government to refine cost modelling and share assumptions on likely demand. We are also developing implementation tools with the Social Care Institute for Excellence to share good practice and to support local authorities in finding efficient solutions for providing assessments. This includes tools that support proportionate assessments and efficiencies around first contact, as well as working with local authorities to refine practice around self-assessment. Further to this, we are working with Skills for Care to develop training materials for managers and practitioners. These materials are all being developed with key stakeholders, and will begin to be available from October.

Question 13 on assessment asked whether regulations should require local authorities to provide specialist assessors for those with particular conditions or circumstances. Some third sector organisations proposed new requirements for specialist assessors, particularly for those with sensory impairments and with autism or learning disabilities. Local authorities and practitioners, however, argued that requiring specialist assessors for specific conditions would be restrictive and encourage a ‘tick-box’ approach. They also pointed out that Regulation 5 on training already requires all assessors to have the skills, knowledge and competence to carry out the assessment in question. It also requires local authorities to consult an expert where necessary.

*“Every assessment needs to be carried out by someone with the knowledge, experience and skills-set necessary for the purpose... This is not about being ‘specialist’, but about having an empathetic understanding...” [LGA/ADASS]*

We believe that as Regulation 5 already lays down requirements around training, knowledge and expertise that apply to all assessments, a requirement for specific specialist assessors for a longer list of conditions or circumstances is not necessary. Such a requirement would add to local authorities’ burdens, and could be restrictive. We do not recommend any further requirements for specialist assessors.

## **Eligibility**

**Question 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.*

**Question 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?*

**Question 16:** *Does the current definitions of ‘basic care activities’ include all the essential care tasks you would expect? If not, what would you add?*

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

**Question 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?*

Government policy is to introduce a national minimum threshold for eligible needs that enables local authorities to maintain current levels of access to care and support when the regulations come into effect in April 2015. Recognising the criticality of getting the regulations and guidance right to achieve this aim, engagement on draft regulations began in June 2013, in parallel with debate on the primary legislation in Parliament. The latest version of those draft regulations was published in this consultation, and was amongst the most debated of areas, attracting over 900 comments and responses through the different channels used.

Consultation respondents were widely in favour of having a national threshold, saying the proposed regulations were comprehensive and easy to understand by comparison to the existing approach.

The key themes in the consultation responses revolved around the level of the threshold. A majority of local authorities felt the draft regulations would make more people eligible than is currently the case, and thus increase costs associated with meeting needs. From the point of view of local authorities, the most frequently cited issue with the proposed outcomes listed in the draft regulations was the reference to “a clean home”, which was thought to set an entitlement for support which would not ordinarily be provided to all people at present, except as an ancillary part of a broader package of care. This language has been changed in order to address these concerns and to take a more outcomes focused approach.

Conversely, a majority of other organisations, in particular voluntary organisations, argued that the relative level described in the eligibility regulations was too high, and would lead to a large number of people not receiving the care and support they need, with likely future cost implications.

Opinions were divided over whether outcomes-focused language would be preferable to describe the “basic care activities” in the regulations (Question 15). Those who preferred the use of outcomes generally reflected on the positive nature of such concepts, the clear consistency with the broader aims of the Act (and the wellbeing principle itself), and the possible benefits in terms of supporting other objectives, such as outcomes-based commissioning.

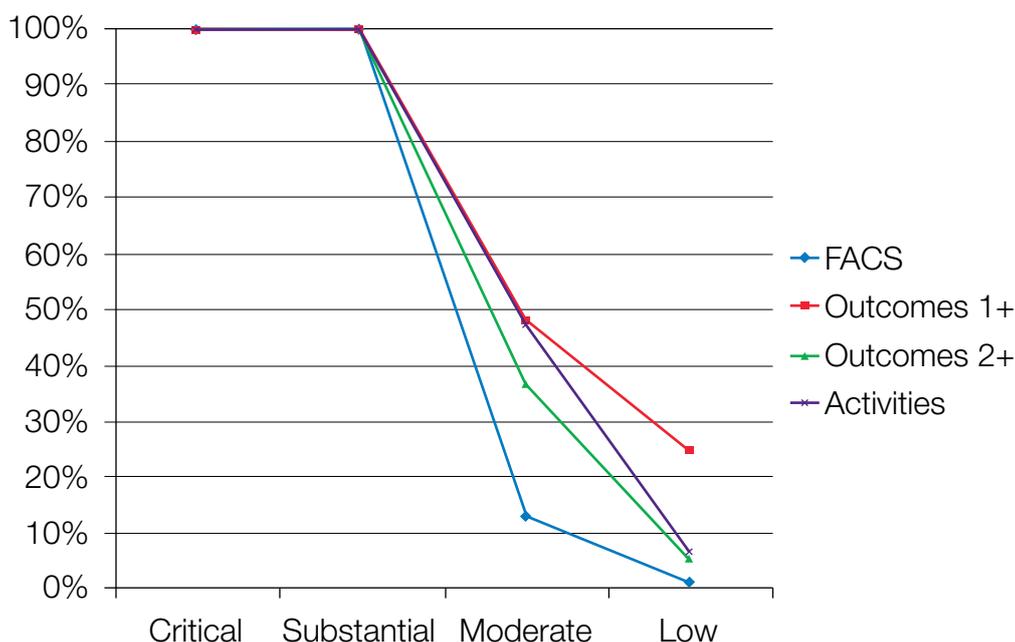
*“We feel that defining basic activities as outcomes would make the system more transparent by setting a clear set of expectations in relation to what the client should be able to do.” [Home Group]*

On the contrary, others thought activities inherently easier to understand and therefore measure, and likely to form the basis for a more robust criterion.

In order to assess the appropriateness of the use of outcomes-focused language, the Department commissioned Personal Social Services Research Unit (PSSRU) at the London School of Economics to evaluate three versions of the regulations. In addition to the version published for consultation, the Department created two more outcome-focused versions, which attempted to redefine the “basic care activities” in terms of the outcomes which are intended to be achieved. The two versions differed only in the number of such outcomes required to be achieved in order to meet eligibility, with one requiring two or more outcomes, and the other only one.

To carry out this research, PSSRU worked with 27 local authorities in order to test out the different versions of the regulations, by asking social workers and other professionals to apply the regulations to recent real cases, and record the likely outcome. In total, 1,865 cases were reviewed by 245 professionals.

PSSRU’s research findings are illustrated in the graph below, which compares the impact of the three versions with the existing approach (FACS – *Fair Access to Care Services*), which had already been applied to all the cases used and so was able to be used for direct comparison. The graph shows the likelihood of people with needs at each of the four existing levels being determined to be eligible, based on one of the approaches. It shows how all the research versions of the regulations capture the current “critical” and “substantial” level needs, but that all led to some possible increase in the number of people with “moderate” needs being eligible, and one also created an increase for those with “low” needs. In all cases, the potential increase at the “moderate” level was shown to be far smaller than in previous versions of the regulations, showing that engagement and development has improved the outcome.



One of the research questions the Department asked PSSRU to answer was whether outcomes-focused or activities-based language came closer to allowing local authorities to maintain their current level of access to care and support. Measured against the *Fair Access to Care Services* framework, PSSRU concluded that the version that was outcomes-focussed and set the minimum level at two or more outcomes was the version that came closest to current practice. The Department has therefore chosen to proceed with this version. This is also the version that best reflects the outcomes language used in the Care Act as a whole.

The research found that the best version of the regulations might still result in a small increase in the number of people with moderate needs who would be eligible. In order to address this gap, we have made further amendments to the threshold to strengthen the threshold, and now outline a single, long list of outcomes and require that needs are eligible if they prevent a person from achieving two or more of the listed outcomes.

Regarding wider comments, there was strong support to include “protection from abuse and neglect” as an outcome in the eligibility criteria from some stakeholders. Local authorities, however, almost unanimously supported the Department’s policy to keep safeguarding separate to the eligibility decision, ensuring that there is a quick and appropriate response when an adult is at risk. We have therefore retained the separation of safeguarding from other needs and strengthened the guidance on both assessment and safeguarding in response to the comments received.

A large number of campaign responses said the draft eligibility regulations did not adequately address social isolation. The Department has accordingly redrafted one of the outcomes in the criteria, so that this now includes support to “develop”, as well as to “maintain” personal relationships.

Many of the comments the Department received revolved around the difficulty of interpreting “some or all” outcomes and a “significant impact on wellbeing”. The Department has therefore amended the regulations, so it is now clear that a person is eligible where they need support to achieve “two or more” outcomes. In addition, we have added further guidance to draw out

the descriptions behind these concepts, and intend to supplement this with more practical materials on making eligibility determinations, including case studies, to be made available from November.

We have also made changes to the carers' eligibility criteria, following feedback from consultation events that these regulations were confusing. The consultation version included two parallel routes to eligibility for carers: one made carers eligible if they would otherwise be unable to continue caring, and the other, like eligibility for adults, made carers eligible if their caring role resulted in a significant impact on their wellbeing. As we believe that a carer might not continue caring if doing so would have a significant impact on their wellbeing, we have chosen to combine the two and to focus on the criteria which, similarly to eligibility for adults, make carers eligible if as a result of caring there is a significant impact on their wellbeing. We have also made a number of changes to the constituent outcomes to promote parity with the criteria for those they care for.

The Department has worked to ensure that what is meant by "significant impact on wellbeing" is illustrated better in the guidance. The concept of wellbeing has been retained in the regulations because it is an important part of the eligibility consideration. It links eligibility with the obligation set out in the Care Act to promote the wellbeing of the person and is intended to work with the specified outcomes to provide a more personal perspective on what is important to the individual. Going forward, the Department will be supporting the development of tools to aid implementation of the eligibility criteria, including developing further case studies and materials which will be available in the autumn.

Finally, the Department asked the public if they were satisfied that the eligibility regulations could also cover cases currently provided for under section 21 of the National Assistance Act 1948. The majority of respondents to this question were local authorities, who said they felt confident that the new regulations together with the powers in section 19 of the Care Act would mean people who currently have access to care and support would continue to be supported when the regulations and guidance take effect in April 2015.

### **Independent advocacy**

**Question 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 receiving care jointly from adult social care and the NHS.*

Almost all respondents were very positive about the new entitlements to independent advocacy included in the Care Act.

*"We believe that the Care Act provides a major step forward for people who require social care and carers by strengthening the legal entitlement to advocacy. There is also a great deal to commend in the Draft Regulations on advocacy as well as the Draft Guidance, including the emphasis on supported decision making and provisions to ensure that people in greatest need of support to be involved in their own life-decisions receive that assistance."* [Voiceability]

Two specific areas were picked out by respondents in which they considered that there were particular difficulties in people being supported to be involved in what often include complex considerations:

- i. A large number of respondents considered that the exemption from having an 'appropriate person', a carer, relative or friend available to support the person's involvement in NHS Continuing Healthcare (CHC) assessments which the local authority was party to regarding care and support needs and planning. This was seen as intuitively the right thing to do given the complexity and people's lack of understanding of the processes involved. However, a number of the responses looked further at the practicalities and potential consequences of doing this. Issues were raised about the legal aspects of addressing NHS responsibilities within social care legislation, aspects of implementation that may produce inequalities in practice. The regulations have therefore not been amended to include this exemption, but guidance has been redrafted to address this aspect in more detail. The relevance of the advocacy duty to those whose care and support needs are being considered by the local authority in these situations has been reinforced and the benefits from providing independent advice and/or advocacy through this complex process and inviting authorities to make local arrangements with CCGs on improved access to advocacy that could cover both health and care and support. A recent, independent report based on information from a FOI request, on NHS CHC arrangements indicates that there are local opportunities in the availability of advocacy to support patients understanding and involvement.<sup>3</sup>
- ii. The other area respondents drew attention to related to those people who require aftercare under Section 117 of the Mental Health Act 1983. The guidance has been amended to include an explanation of how the duty to consider access to advocacy under the Care Act should be applied.

There were also consistent views on the content and connectivity to the chapter on safeguarding enquiries and safeguarding adult reviews. This aspect has been incorporated into the independent advocacy chapter and references increased. Other commented on the relevance and content of some of the case studies, and amendments and additions made.

Otherwise, the responses provided some very detailed comments and views on the text and practicality. Many of these focused on practicality and how the duty should be implemented. These will be built into the detailed plans for national work to support local authority implementation.

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<sup>3</sup> [<http://www.sallykeeble.org.uk/dementiacare>]

# Charging and financial assessment

## Charging for care and support

**Question 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?*

**Question 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.*

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

**Question 23:** *Would you prefer to see the current approach retained?*

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

**Question 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?*

**Question 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?*

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

**Question 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?*

**Question 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?*

The aim of the new charging regulations and guidance was to broadly re-create the current provisions, in order to provide continuity for local authorities in 2015/16 ahead of the funding reforms that will come into effect from April 2016.

On the whole, the new regulations and guidance were generally welcomed as achieving these aims, however stakeholders helpfully added value by picking up a number of unintended changes such as around housing-related expenditure and additional sources of income that should be disregarded in the guidance as well as the regulations. These have now been addressed.

A significant area of concern that was raised was in relation to local authorities' new powers to recover debts. There was a strong view that the draft guidance was too light touch and

insufficient to support good practice, and in particular did not address questions around lack of mental capacity or provide detail on how the County Court system works or what alternatives might be appropriate. As a result, this section (Annex D to the guidance) has undergone significant re-drafting and now addresses these points.

The new regulations and guidance on choice of accommodation were felt to be a welcome improvement. Some comments were raised about points of detail such as how often 'top-up' arrangements should be reviewed and the guidance has now been amended to include a best practice approach.

The consultation proposed a number of minor changes to the approach to charging to make it better able to deliver its aims (questions 22 to 26). In relation to proposals on the operation of the 12-week property disregard, this was broadly welcomed with most agreeing this would be cost neutral. However, there were some wider issues raised such as the treatment of personal injury compensation payments. No change is planned at this time.

Responses to questions on the treatment of investment bonds with an element of life insurance and the possibility of disregards for pre-paid funeral plans both received mixed responses. This is a change from the views expressed to the Department prior to the announcement of funding reform. As a result, further work will be undertaken on both these areas to understand the concerns raised in greater detail.

The consultation also asked a question in relation to the impact of pension reform. Budget 2014 announced a number of reforms to defined contribution pensions to give people greater choice over how they fund later life. This means that from April 2015, a person with a defined contribution pension, whatever its size, will be able to take it as they wish, subject to their marginal rate of tax. The consultation sought views on how the reforms might impact on charging for care and support for both the person and the local authority. The responses did not show a significant level of concern for either, but asked that the approach be clearly set out in the guidance. In parallel, the consultation on the reforms by HMT has closed. The guidance therefore now confirms that resources should be treated according to where they are invested at the time of assessment and where someone has not accessed their pension or is drawing a notional amount, that a local authority can apply notional income to the equivalent of the maximum available under an annuity.

### Deferred payment agreements

**Question 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?*

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

**Question 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?*

**Question 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?*

**Question 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?*

**Question 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?*

**Question 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?*

**Question 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?*

Around half of all responses received provided comments on deferred payments. The majority of respondents were highly supportive of the overall intention to extend the deferred payments scheme. The Care and Support Alliance stated:

*"The Care and Support Alliance supports the extension of Deferred Payment Agreements so that more people can access them. Whilst they may not be suitable for everyone they broaden the options for paying for care and can mean that someone does not have to sell a property during their lifetime"*

This view was also reaffirmed by Independent Age who quoted:

*"We welcome the extension of the deferred payment scheme and the government's commitment to ensuring that the scheme is affordable to those who may benefit from it. It is crucial that the scheme is implemented sensibly so as to protect both individuals and local authorities from overreaching themselves financially."*

A minority of respondents provided general comments on the scheme; which tended to focus on three themes. Firstly, some respondents suggested that the guidance needed to provide further clarity around how to manage issues associated with lack of mental capacity. There were concerns about people entering into deferred payment agreements (DPAs) inappropriately when they lacked capacity, and what might happen if people lost capacity whilst in DPAs. The Alzheimer's Society commented:

*"It should be made clear to local authorities that a deferred payment cannot be entered into by people who lack capacity, and a valid Lasting Power of Attorney (Property and Finance) or a valid Deputyship of the Court of Protection would be required for someone to enter into this on their behalf."*

We have accordingly strengthened the guidance to ensure local authorities are clear on how best to manage cases where someone lacks, or may come to lack, mental capacity; and have included references to the amended debt recovery guidance which discusses the issue in more detail.

A number of consultees also pointed out that, given that DPAs may be relatively brief in length, people should be provided with statements of the amount deferred at more frequent intervals, and should be able to request statements as and when they were needed. These changes have also been made.

Some respondents also suggested that the guidance should be clearer that local authorities should signpost people to independent financial advice (including regulated financial advice) when considering taking out a DPA. This has also been included in the guidance.

In regards to question 30, consultees were highly supportive of the principle to extend DPAs to extra care settings, recognising that this was a helpful flexibility and might be needed in specific situations. Some individuals suggested that they would have taken up this offer had it been available. Consequently the guidance and regulations have been amended to give local authorities discretion to provide DPAs to people who want to retain their own property and rent an extra care property.

For question 31 there were mixed responses of whether to develop a Sharia law-compliant deferred payment scheme in future years. A number of responses voiced concerns over fairness and equity, fearing that the Sharia scheme might be more generous than the core scheme. Others questioned the place of Sharia law in the British legal system, while others still pointed out that there might be other products available for those wishing to pay for care in a Sharia-compliant way. Those supportive of introducing a Sharia-compliant scheme in the future largely highlighted the desirability of offering the same protection from having to sell one's home to pay for care to everyone.

No responses gave an indication of the likely demand for a Sharia-compliant scheme, so we intend to conduct further targeted research with the Muslim community to assess whether there is demand for a scheme and will take a decision informed by this research subsequently.

Whilst consultation responses for question 32 were broadly supportive of the approach of having an equity limit, a number of consultees pointed out that there was the potential for confusion with the proposal set out in draft regulations and guidance (whereby local authorities were required to defer up to a limit of 70-80% of the property's value, but had discretion to defer beyond it). Consultees observed that the lower 70-80% limit either added an unnecessary layer of confusion (assuming most authorities would exercise their discretion, it would be largely irrelevant) or it would risk some people being forced to sell their homes to pay for their care (if local authorities did not exercise their discretion, people would have too much equity left in their property to qualify for local authority support, but might still have no way to fund their care aside from selling their property).

Some consultees suggested implementing a single equity limit, taking advantage of flexibilities in charging guidelines to set the limit at a lower level:

*“We would welcome a replication of the measures in CRAG [Charging for Residential Accommodation Guidance] for 10% of the value of the property to be protected in order to pay for sales costs before the remaining capital is assessed to pay for future care.”*

We have consequently amended the equity limit to simplify it and draw on the additional flexibilities offered by charging guidelines to allow people to retain more equity in their property, providing greater security to local authorities.

For questions 34 and 35, the majority of respondents were supportive of the suggestion to incentivise rental by allowing people to retain a proportion of any income they generated from letting their property.

However, consultees were divided on how this incentive should work. Some were supportive of the approach proposed whereby local authorities would have discretion to set a percentage figure of rental income for individuals to retain, whilst others advocated a system where the individual was only allowed to retain the costs associated with renting the property (the net rental income being absorbed by the authority to reduce the amount being deferred). The latter 'net income' proposal would be challenging to administer, as it would require local authorities to be able to assess the total costs of rental and subtract this from the total income; the fixed percentage of income approach set out in the consultation has been adopted.

In regards to question 35, the consultation also sought views on whether, when a local authority is required to offer a deferred payment to someone meeting eligibility criteria, they should accept only a first legal mortgage charge as adequate security; or instead any legal charge they could secure. Consultees' responses to this question were mixed, but the majority were opposed to local authorities being required to accept *any* legal charge, and in favour of authorities only being required to accept a first charge. This response was not limited to local authorities, and included providers, the professional services sector, and representative groups and voluntary organisations (indeed more of the latter category were opposed than were in favour). The main concern was the risk to local authorities of being forced to accept non-first charges – though there was recognition that discretionary powers would be helpful to allow authorities to assess levels of risk in individual cases and offer DPAs accordingly. The final regulations and guidance consequently make clear that LAs are only required to accept a first legal charge, but have discretion to accept other legal charges as well.

The vast majority of respondents were supportive of the proposals set out in questions 36 and 37 to govern the interest rate, however consultees were strongly opposed to having differential rates for DPAs formed under 'discretionary' and 'mandatory' powers. Their objections were primarily on the grounds of the complexity and confusion faced by both local authorities and people with care and support needs when administering a scheme with two rates. The criteria governing whether a DPA is mandatory or discretionary are fairly technical, and it is likely that individuals (or indeed local authorities) might inadvertently end up being charged the wrong rate for a fixed period of time, precipitating challenges or appeals. The final regulations and guidance make clear that only one interest rate will apply to the entire scheme.



# Person-centred care and support planning

## Meeting needs

A number of consultation responses demonstrated some confusion about how the duty to meet needs set out in sections 18 and 20 replaces the various current duties to provide specific services to specific people. Others raised questions as to how the duty to meet needs could be met, the balances to be struck between choices about commissioning or providing particular services, and the potential overlap between a duty to meet care and support needs and duties to provide other public services. We have accordingly added a new section of guidance explaining these issues more explicitly, within the chapter on care and support planning.

## Care and support plans

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

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

**Question 40:** *Does the guidance support care and support workers to do their job effectively?*

There was general consensus from respondents that the guidance effectively promotes a care and support system that has personalisation at its core.

However, a proportion of respondents asked for clarification in the guidance with more case studies and examples to illustrate the policy intentions throughout. We have therefore added a greater number of examples to accompany the guidance.

We also received many responses suggesting specific changes to passages of text, or paragraphs within the guidance. It is not possible to reflect on each of these, but wherever appropriate these changes have been incorporated as part of the wider effort to ensure the guidance is clarified and provides sufficient detail to aid local implementation.

## Personal budgets

**Question 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?*

**Question 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?*

**Question 43:** *Are the ways in which different personal budgets can be combined sufficiently clear?*

There was consensus between the respondents that this section of the guidance was clear. However, like the responses we received for the questions on care and support planning, the proportion of respondents also asked for clarification in the guidance with more case studies and examples. We have since added more examples of use of personal budgets in practice to accompany the guidance. Cheshire West and Chester Council commented that:

*“The consolidation and clarification of the legislation and new guidance is long overdue. Personalisation has been a core theme for some years now and we need to ensure that the focus is accelerating the move from concept to practical and tangible outcomes”*

## Direct payments

**Question 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?*

**Question 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?*

**Question 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?*

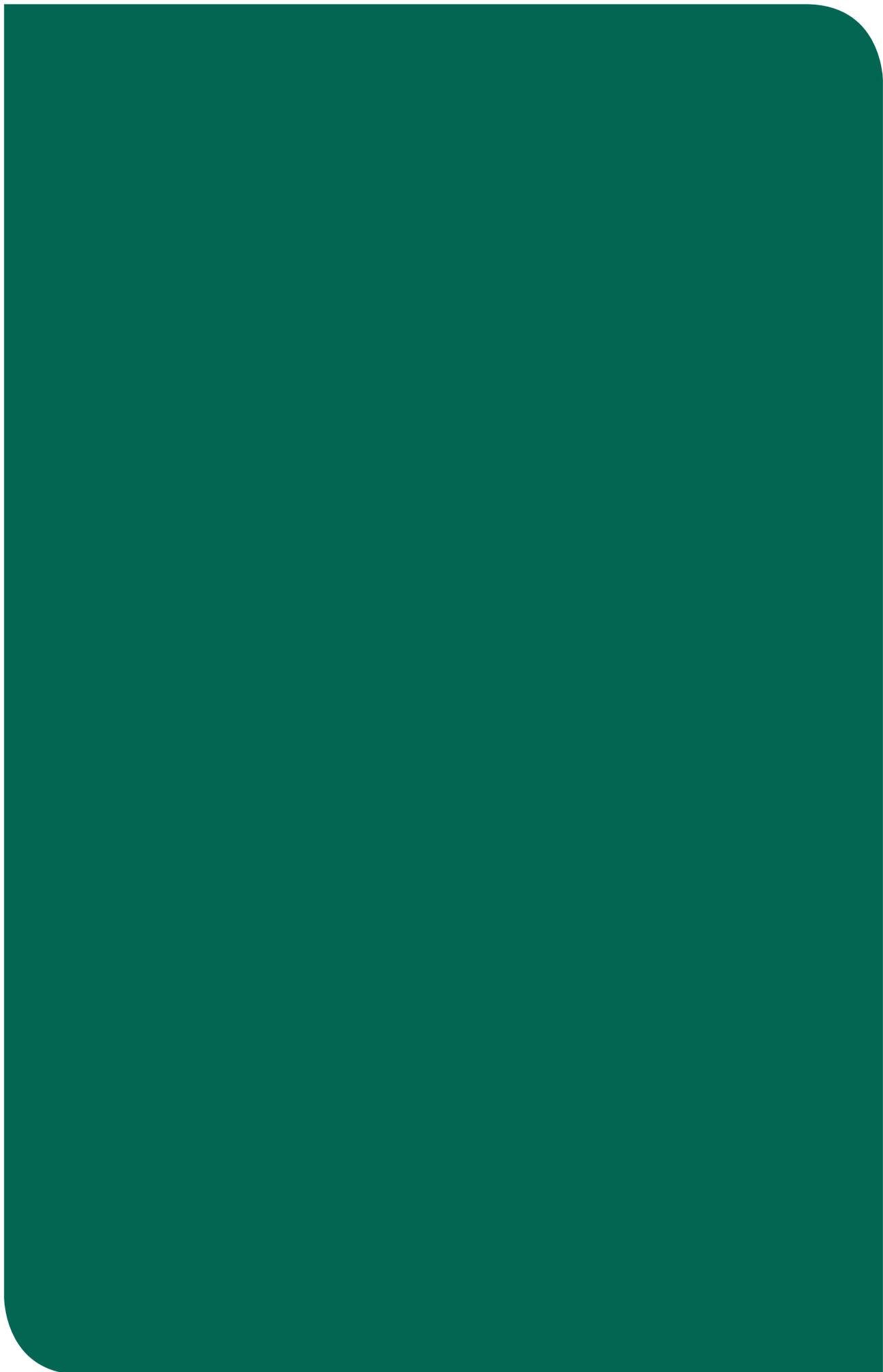
There was significant interest in the question regarding allowing direct payments to be used to pay close family members to provide administration and management support. Responses were split almost equally between whether this policy option would increase uptake of direct payments, or pose implementation issues for local authorities. Some respondents agreed that it would make direct payments more attractive to people, provide people with greater flexibility and recognise the role that carers play in supporting people. However, there was greater concern, even from respondents that agreed it may increase uptake, about safeguarding issues, and wider concerns from many respondents that additional monitoring and accountability processes would need to be in place which could undermine the policy intention to ensure these arrangements are kept light touch and proportionate.

We have therefore amended the regulation to allow this payment for administrative support in cases where the local authority determines it ‘necessary to do so’, rather than ‘giving prior consent’. We feel this strengthening of the regulatory power achieves the right balance in addressing the concerns we received, whilst still making this a viable option available for individuals in some circumstances. The guidance has been updated to include examples of where this option could work in practice.

We received many comments relating to the proposal to amend the review of the direct payment from 12 months to 6 months, with many of these commenting on extra pressure or the associated burden in complying with this change.

It is important to clarify that the proposed change is only relevant for the first review after the making of the direct payment, and thus would only apply to new direct payments. After that point the review period is set at every 12 months, with guidance suggesting that local authorities align this with the review of the care and support plan, or support plan. Furthermore, the guidance stresses that local authorities may wish to perform the initial 6 month review of the direct payment as part of the light-touch review of the care plan 8 weeks or so after sign off. We accept that the consultation document may not have made

this distinction clear, and we heard many local authorities already conduct light-touch reviews as best practice. We therefore do not view this change as an additional burden, and do not propose any change to the consultation version of the direct payment regulations.



# Integration and partnership working

## Integration, cooperation and partnerships

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

**Question 48:** *Are there any ways the guidance can better support cooperation locally?*

Stakeholders were broadly supportive of integration and cooperation chapter. For example, MacMillan Cancer support welcomed the section (15.10) that:

*“encourages Clinical Commissioning Groups and local authorities to work together to identify and plan to meet the care and support needs of the population through the use of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies”.*

Views differed over the extent to which the guidance would help achieve the Government’s ambition. Some felt it was a good basis, others felt it should be more prescriptive or explicit in telling local areas what they should do. Other stakeholders welcomed the flexibility built into the guidance, recognising that there is no one single model that should be imposed on local areas.

Representing the former view, the Alzheimer’s Society welcomed the guidance on integration but felt that:

*“more needs to be done if integration is to be a reality in the majority of local authority areas”.*

Similarly the Royal College of Nursing (as well as some of the comments received via the website) felt a more detailed framework for integration could be provided.

Most consultation comments (especially those received via the website) reflected on the challenges of making integration and cooperation happen, rather than recommending drafting changes to the guidance. Many of these related to barriers to integration that are recognised by the Department and for which we, with our partners, are seeking to address, such as:

- Workforce issues: different cultures, terms and conditions;
- How to improve progress towards integration: suggestions included a greater scrutiny role for HealthWatch, greater role for Health and Wellbeing Boards to oversee and take responsibility for integration. Other suggestions relate to performance measurements, e.g. publishing lists of best performers, rewarding innovation and good practice;
- Comments about the problems due to different performance and outcome framework against which different organisations (e.g. CCGs, Councils and Trusts) are measured.

While we recognise the issues raised and some of the proposed solutions (for example Health and Wellbeing Boards have a key responsibility with regard to integration through their

leadership of joint strategies as well as Better Care Fund plans), our view is that most of the suggestions are too prescriptive and not in line with the Government's approach to encourage greater integration and cooperation through the implementation of the Care Act and wider integration policy (including the Better Care Fund and the Integration Pioneers programme).

Some changes have been made to the guidance to respond to a desire for greater clarity on the links with the other chapters of the guidance, and more explicit references to related legislation, particular the flexibilities enabled by section 75 of the NHS Act 2006.

Responding to a call from some respondents for further practical examples, a new case study on integrated care has also been included.

### The boundary with the NHS

**Question 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?*

**Question 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?*

The Care Act and supporting guidance does not seek to alter the boundary of responsibilities of local authorities and the NHS, or change the threshold for NHS Continuing Healthcare (NHS CHC) that has been in place for some time.

A number of respondents to the consultation asked for clarification in paragraph 6.68 as to the boundary of responsibilities between the NHS and local authority. Some thought that the guidance lacked transparency as to what the local authority is responsible for and what can be classed as "incidental and ancillary" services. We welcome this feedback and have amended this paragraph on the basis of feedback we received.

Some groups suggested that the guidance could be more explicit in defining what is meant by a "primary health need", for example, asking whether the guidance could include specific examples. We feel that the term "primary health need" is covered adequately in the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* through its development over several years. There is a risk that in attempting to provide specific examples or definitive lists of what constitutes a "primary health need" we may confuse rather than clarify the position for professionals involved in the assessment and decision-making process.

Similar feedback was received about the terms "incidental and ancillary" needs and again, we feel that this is covered adequately within the National Framework.

We received feedback from a number of interested parties who welcomed the fact that the Care Act does not change the boundary of responsibilities, and was consistent with the National Framework. Consultation feedback confirmed that this section of the Care Act does not act as a barrier to integration, with one particular local authority stating:

*"It provides clarity that will support future integration negotiations which could otherwise start with one partner suggesting something was already the other one's responsibility."*

### Delayed transfers of care

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

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

The regulations and guidance on delayed transfers of care consolidate the existing requirements for the NHS to notify the relevant local authority when a patient is planned to be discharged from hospital and an assessment of their care and support needs is required. It continues but makes optional the current provision for the NHS to claim reimbursement for any delays attributed to the local authority.

The majority of comments arising from the consultation indicated that, whilst formal notices and reimbursement may have role to play in terms of the interface between the NHS and local authorities, by themselves they would not improve the objective of safe, effective and timely discharge. There was some concern that the regulations and guidance could potentially be an unhelpful distraction as they relate to only those patients where there is a care and support need on discharge.

The landscape of working across the NHS/local government boundary is changing. With the promotion of integration between health and social care and the development of mechanisms such as the Better Care Fund to achieve this, these provisions were viewed by some as being out of step with the collaborative working that is needed.

Whilst we recognise the reality of the increased focus on integration, our view remains that these provisions are likely to continue to have benefit for those local partners that currently use them, and to remove them may jeopardise such local arrangements. The framework for delayed transfers of care is intended to be permissive, to be used where it is a helpful support to local partnership working rather than on a strict compliance basis. We have sought to address this with more emphasis on the need to look at these regulations and guidance as part of the broader integration agenda and the duties to co-operate with partners.

### **Working with housing authorities and providers**

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

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

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

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

Respondents replied to these questions by making specific comments to chapters where housing is referenced (for example information and advice) and also specifically chapter 15 on integration, cooperation and partnerships.

Overall, respondents welcomed the prominent role that housing is given throughout the Care Act and the important role for housing in a number of areas covered by the Act, for example, wellbeing, prevention, information and advice, market shaping, integration, cooperation and partnerships.

Of those responses relating to chapter 15, a number were concerned that housing was referred to primarily in terms of the built environment, for example a "safe and secure place"

and that housing-related services include services provided within and around the home. Changes have been made to the guidance to ensure consistency and that recognise that housing services have a broader meaning than just the physical environment and can encompass other types of housing related support.

Feedback was also received that the guidance could be clearer about two tier authorities and councils' responsibilities for care and support and housing. The guidance has been amended to provide more clarity in this regard.

### Transition to adult care and support

**Question 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?*

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

Respondents on the whole were welcoming to the guidance put forward for the transition to adult care and support. However, concern was raised in the main regarding the definitions and terminology used in the guidance to describe certain individuals and processes. Substantial attention was given to the definition of "significant benefit" and how lack of clarity in the guidance regarding this term may cause misinterpretation and thus affect the quality and approach of local authorities when conducting transition assessments.

The guidance has been revised to include a definitions table at the beginning of the chapter outlining the meaning of some of the key terms used throughout the chapter. The intention behind including this new section is to make it easier for those being assessed, their families and carers and for the local authority to fully understand their rights and responsibilities in relation to the timing of a transition assessment and beyond.

Another area that respondents noted as requiring greater clarification was how local authorities should consider how to identify young people who are not receiving children's services who are likely to have care and support needs as an adult. We have included a list of key examples to aid local authorities on this issue.

Additional clarification was also requested to ensure that adult carers would not be charged for any service provided to the young person being cared for, even if it is provided to meet the needs of the carer, and around a local authority's need to establish a young person's competence using the test of 'Gillick competence' (whether they are able to understand a proposed treatment or procedure). Further information on these issues has since been added to the guidance.

### Prisons, approved premises and bail accommodation

**Question 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 and joint commissioning arrangements between custodial establishments, local authorities and health services.*

**Question 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?*

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

**Question 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?*

Those who commented on the prisons and approved premises chapter were in broad agreement with the underlying principles outlined in the chapter and the clarity it provides on the respective responsibilities of local authorities and prisons in supporting prisoners and people residing in approved premises who have care and support needs.

As one respondent said:

*"We are especially pleased that the policy basis for the Care Act (2014) and subsequent guidance is that 'all adults in custody, as well as offenders and defendants in the community, should expect the same level of care and support as the rest of the population.' This is essential and has a valuable role to play in addressing the high level of health and social care inequalities experienced by people in contact with the Criminal Justice System (CJS)".*

A number of respondents wanted further detail or clarification on specific issues. One such issue was the provision of equipment, aids and adaptations in prison, with some citing that the guidance was vague on who would be responsible for providing what types of equipment and adaptations in prisons. We have revised the guidance to advise that, as aids for individuals, as defined in the Care and Support (Preventing Needs for Care and Support) Regulations 2014, are the responsibility of the local authority, whilst more significant adaptations would be the responsibility of the custodial establishment, and that clear agreements are needed between local authority, the custodial establishment and the healthcare provider. The comments received highlighted the potential need for local agreements, which clarify who is responsible for different types of equipment. We will address this in developing further tools and guidance to support implementation of the Act.

Some respondents said that the section on continuity of care and ordinary residence, when an individual moves to another custodial setting or is released back into the community, was ambiguous. We have amended the guidance accordingly to make this clearer. Similarly, some respondents also said that the guidance on safeguarding was not clear and was open to interpretation so we have amended this section accordingly.

Whilst not directly relevant to the guidance, a significant number of comments highlighted concerns that local authorities may not receive sufficient funding to support the new responsibilities, because the distribution of prison populations in England does not follow usual patterns for local authority funding based on need. Responding to this concern, the

Department has already announced that it will allocate funding to those local authorities which have prisons within their boundaries using a bespoke allocation formula, in order for them to meet their responsibilities under the Act. A consultation,<sup>4</sup> which closed on 9 October, sought views on the proposal for how this funding should be allocated, and a separate response will be confirmed in December.

### Delegation of local authority functions

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

**Question 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?*

Most respondents were positive about the ability of councils to delegate functions, seeing it as an important aspect of care and support and setting out some innovative ideas for operating models making use of the expanded delegation powers.

Some respondents did express concern that delegation would lead to fragmentation of functions and thus prove a barrier to integration. We understand this concern – it is expressly to address this that the duty to promote integration is one of the areas that cannot be delegated, and why the guidance states explicitly that local authorities should take steps to ensure that authorised parties co-operate with other partners and work in a way which supports integration.

Some respondents also expressed confusion about whether NHS, police or other bodies could lead on a safeguarding enquiry – given that it is one of the functions that cannot be delegated. To clarify, the enquiry duty is for local authorities to make enquiries or cause them to be made, so a local authority can still have arrangements whereby NHS or others are asked to undertake the enquiries where necessary. So while a local authority can ask others to carry out an actual enquiry, it cannot delegate its responsibility for ensuring that this happens and ensuring that, where necessary, any appropriate action is taken. We have made this distinction clearer in the guidance.

Lastly, the vast majority of respondents agreed that model contracts would be helpful and accordingly we will ensure that these are developed and provided to local authorities as part of the package of materials to support implementation of the Act.

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<sup>4</sup> <https://www.gov.uk/government/consultations/care-act-2014-funding-allocations-for-new-adult-social-care-duties>

# Safeguarding

## Adult safeguarding

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

**Question 66:** *Are there additional possible members of Safeguarding Adults Boards that we should add?*

**Question 67:** *Are there additional aspects of the Safeguarding Adults Board's work that we should highlight?*

**Question 68:** *Would it be useful to append a draft template for the strategic plan for Safeguarding Adult Boards to use if they wish?*

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

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

Overall, the consultation demonstrated wide and positive support for the Act and putting adult safeguarding on a statutory footing for the first time, recognising how important this new legislation will be in terms of the impact on people's lives when they are in extremely difficult circumstances – either experiencing or at a risk of abuse and neglect.

Whilst all welcomed the principles and focus on safeguarding, it was clear from several responses that the guidance was not sufficiently clear in describing the roles and responsibilities of different agencies. The chapter has been reworked at length to focus more clearly on the scope of safeguarding, and the responsibilities of local authorities and other partners.

Some comments demonstrated this confusion with questions about the scope or definition of safeguarding. The guidance has been redrafted to consider what safeguarding is, and is not, describing types and patterns of abuse and neglect and how to identify the signs.

The Act makes clear that the definition of abuse includes financial abuse. Respondents wanted the guidance to be more explicit about how to identify signs of this type of abuse which are likely to present differently from other, more physical types of abuse. To this end we have included more detail in the role of the Office of the Public Guardian who often has a crucial role in investigating allegations of financial abuse where attorneys or deputies are implicated. Age UK highlighted this in their response by saying:

*"There are several gaps in the guidance on financial abuse, including on how to respond where the abuser is someone who is authorised to manage a person's money."*

Considering the process for safeguarding enquiries and subsequent actions, some respondents felt that this section was incomplete and needed clearer expectations as to the options following the enquiry, for example ongoing plans, particularly where an adult had fluctuating capacity. The Care and Support Alliance built on this by stating:

*“[The outcome] following such an enquiry might be a safeguarding plan. This must set out a range of things, including: the provision of any support, treatment or therapy including advocacy... which is necessary to help assure their safety in the future.”*

Additionally, there was wide support for the production of a ‘decision-making tree’ or process flow chart that has appropriate pauses for reflection, consideration and professional judgement and reflects the different routes and actions that might be taken. These comments have been taken on board in the amendments made to the guidance.

With regard to safeguarding carers, some called for recognition of carers and their support needs particularly within the context of their well-being and prevention of abuse and neglect. We believe this point was implicit in the guidance before, but this has now been made explicit.

We are providing additional clarity about the interface with safeguarding arrangements in prisons and approved premises as some felt that this was not sufficiently clear.

The guidance also now recognises that safeguarding partnerships can be a positive means of addressing issues of self-neglect, and that the SAB is a multi-agency group that is the appropriate forum for strategic discussions about often complex and challenging situations for practitioners and managers as well as communities more broadly.

Respondents were critical of some of the case studies cited in the guidance suggesting that they did not always represent good social work or that they were at times muddled in their narrative. We have taken steps to improve and replace many of the case studies throughout the chapter.

Feedback suggested that it was confusing having a chapter on advocacy and then including advocacy requirements in the safeguarding chapter also. Some of the messages were found to duplicate and sometimes contradict. This has now been rationalised by moving all relevant content into the advocacy chapter.

In regards to protection of property, respondents felt confused by guidance on this being in the safeguarding chapter. This has now been transferred to the care planning chapter.

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

## Ordinary residence

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

**Question 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?*

**Question 73:** *Which authority should be responsible for meeting the needs of an adult or carer when two authorities are 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?*

There were many and varied consultation responses in the area of ordinary residence, mainly from local councils and voluntary organisations. The proposals on disputes in relation to ordinary residence were broadly welcomed:

*“We find the guidance and regulations round ordinary residence disputes to be clear and comprehensive”*

The most significant area of comment was with regard to the regulations and guidance specifying additional types of accommodation to which the existing provision would be applied that if a local authority arranges that type of care in another area, it retains responsibility for meeting those needs. Although it was clear that overwhelmingly the responses supported the widening of the definition of types of accommodation and the extension of this principle, it was strongly felt that the guidance and regulations could be made clearer. For example, Scope said:

*“Scope warmly welcomes the expansion of the categories of ‘specified accommodation’ beyond residential care. However, we believe that these categories are still not broad enough to reflect diverse patterns of care which are likely to develop over the ‘life’ of the Act. For example, the market shaping provisions in the Act are designed to promote innovation and development of new types of care provision to meet people’s evolving needs and aspirations. It is crucial that the regulations and guidance on ordinary residence are not at odds with other parts of the Act.”*

Many of the respondents focused on the detail of the definitions in the regulations, and questioned whether certain definitions may be more restrictive than is intended, with possible unintended consequences. As a result of comments like these, we have strengthened the guidance and have amended the definitions used in the regulations to better reflect the policy intent and capture the broad range of types of accommodation related to care and support needs.

Other respondents were unclear as to the application of the ordinary residence rules in cases where a person is, or has been, arranging and funding their own care. The ordinary residence rules apply where a local authority is meeting a person's needs, and the guidance has been revised to make this clearer.

Some responses asked for further clarification in regard to difficult situations involving carers, for example where one carer is caring for more than one adult in two local authority areas. As a consequence we have supplemented the guidance to provide examples of how to respond to such situations.

### Continuity of care

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

The continuity of care process was widely seen as aligning with good current practice. The Department asked whether there were further circumstances to which a local authority should have regard when they plan for continuity of care. The majority of respondents replied that the regulations and guidance were comprehensive and useful.

Some respondents commented on the level of detail provided in the guidance around providing equipment when a person is moving. The Department has reflected these comments in the re-drafted guidance.

Other stakeholders reflected on the need to specify timescales. Recognising that a single timeframe would not be appropriate to all cases, the Department has amended the guidance around the importance of timely actions and collaboration of the local authorities with the person who is moving.

Lastly, many respondents felt continuity of support for carers should reflect other chapters of the guidance better. The Department has accordingly corrected the guidance so carers who will continue to care for the adult when they move also have continuity of support as necessary.

### Cross-border residential care placements

**Question 75:** *Do the regulations provide for an effective dispute resolution procedure?*

**Question 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?*

**Question 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?*

**Question 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?*

A small number of written responses were received regarding Schedule 1 (that provides a legal framework to support the principle of cross-border placements between England, Scotland, Wales and Northern Ireland). In addition, verbal comments were received during a dedicated consultation event for stakeholders.

The response from the Alzheimer's Society was typical:

*"We are also pleased to see a legal framework which will allow people to move between the different nations in the UK if they wish to. We strongly support the underlying rationale should be to improve well-being of the person and are pleased to see this reflected in a process which puts the individual at its heart".*

Comments were received regarding clarification of a few issues contained within the guidance, for example, the potential benefit of a lead person in each local authority who can advise on the arrangements for a cross border placement.

Many comments highlighted points that would be helpfully explored in practice guidance (but which are not suitable for statutory guidance). A number of stakeholders expressed support for practice guidance, including potential case studies and the Department is actively considering this.

Given the UK-wide implications, the UK Government has worked closely with counterparts in the devolved administrations. All three devolved administrations have conducted parallel consultations specifically on "The Care and Support (Cross-Border Placements and Business Failure: Temporary Duty) (Dispute Resolution) Regulations 2014" that are made under Schedule 1. Consultation responses were supportive of the proposed regulations and usefully highlighted a couple of clarification points for example, a need to be clear if the regulations apply retrospectively for disputes that pre-date the introduction of Schedule 1. The regulations will not be retrospective; this has been made clear in the guidance.



## Other areas

### Registers

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

**Question 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?*

Local authorities' continuing responsibility for maintaining registers of sight impaired and severely sight impaired people resident in their area was seen as positive by most of those who responded. These registers enable local authorities to plan services and enable people to access certain benefits.

The consultation questions sought views about (i) whether other senior ophthalmologists should be able to certify people severely sight impaired and sight impaired and (ii) whether the patient's consent should be sought 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 majority of the views were in support of other senior ophthalmologists being able to certify people as severely sight impaired and sight impaired provided they are trained to the required criteria. As one respondent said:

*"It is therefore important that the ophthalmologist who completes the CVI has the experience and skills firstly to verify that the patient has a visual impairment which meets the legal definition of sight impairment or severe sight impairment, and secondly to diagnose the cause of the patient's visual impairment accurately, ensuring that no treatable cause has been overlooked".*

In light of these responses, policy officials will be considering further whether and how we might make this change in future in conjunction with the relevant professional and patient groups and ensuring consistency with other legislation.

However, most responses had concerns about allowing the RNIB to have access to patient contact details from the Certificates of Visual Impairment (CVI) forms as it is a national charity and one that provides a valuable service, but it may not be best placed to advise the patient on local services. We are exploring with the RNIB and other local services how to ensure the CVI process enables people to have contact with appropriate non-statutory advice and support.

### Transition to a new legal framework

**Question 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?*

**Question 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?*

There were few direct responses in relation to the final chapter of the guidance, which considers issues relating to the transition to the new legal framework.

Several stakeholders brought to our attention their concerns regarding the handling of transfer of the Independent Living Fund to local authorities by July 2015.

The ILF already has in place a Transfer Review and Support Programme to engage local authorities and people who receive funding ahead of transfer in July 2015. However, it was suggested that guidance on ILF transfer within the Care Act statutory guidance would support this process and guide local authorities in making use of this existing structure of engagement.

We have consulted ILF users, ADASS, third sector representatives, DWP colleagues and the ILF, to draft guidance on managing ILF Transfer and have included a new section in the chapter so that local authorities can consult this information when considering how to 'passport' people over to the new system after April 2015.

# Annex A:

## List of consultation responses

### List of respondents to consultation on part one of the Care Act 2014

- ADASS
- ABI
- Action on Elder Abuse
- Action on Hearing Loss
- ADASS Continuing Health Care Reference Group
- ADKC Centre
- Age UK
- Age UK Bury
- Age UK Cheshire East
- Age UK East London
- Age UK Lancashire
- Age UK London
- Age UK Oxfordshire
- Age UK Redbridge
- Age UK Shropshire Telford & Wrekin and Shropshire Seniors & SOPA
- Age UK Surrey
- Age UK Wiltshire
- Allied Healthcare
- Alzheimer's Society
- Anchor Trust
- Antony Collins LLP
- ARCO
- Arthritis Research UK
- Aspire
- Associated Retirement Community Operators
- Atlantic Customer Solutions
- Autism Alliance

- B&NES
- Barchester Health Care
- Barnardos
- Barnsley MBC
- Berkshire Council Legal Team
- Birmingham City Council
- Borough of Poole
- Bournemouth Borough Council
- Bracknell Forest Council
- Breakthrough UK
- Brighton and Hove City Council
- British Association of Social Workers
- British Red Cross
- Bristol Disability
- Buckinghamshire County council
- BUPA
- Bury Council
- Camden Borough Council
- Campaign to end Loneliness
- Camphill Families and Friends
- Care and Repair England
- Care and Support Alliance
- Care England
- Care UK
- Care Quality Commission
- Care & Support Alliance
- Carers Action Worcestershire
- Carers Advisory Group – East Riding of Yorkshire Council
- Carers Network
- Carers Northumberland
- Carers Support Centre –South West network
- Carers Trust
- Central Manchester University Hospitals
- Centre for Health & Social Care Law – Cardiff Law School

- County Councils Network
- Chartered Institute of Housing
- Cheshire East Council
- Cheshire West Council
- Children's Society
- City and County Healthcare Group
- Clinks
- College of Occupational Therapists
- College of Social Work
- Combined Response - Help the Hospices, Macmillan Cancer Support, Marie Curie Cancer Care, the Motor Neurone Disease Association, the National Council for Palliative Care (NCPC) and Sue Ryder
- Combined Response – HFT Family Carer Support Service, the National Family Carer Network and the National Valuing Families Forum
- Combined Response – Leeds Advocacy, Choice Advocacy, Advonet, Cloverleaf Advocacy and Bradford and Airedale Mental Health Advocacy Group
- Combined Response – Local Government Association and ADASS
- Comet Group
- Corelogic Ltd
- Cornwall Council
- Cornwall Carers Partnership Board
- Croydon Council
- CSW
- Cumbria Council
- Darlington Association on Disability
- Darlington Borough Council
- Deafblind UK
- Derby City Council
- Derbyshire County Council
- Devon County Council
- Devon Senior Voice
- Disability Rights UK
- District Councils Network
- Doncaster Council
- Dorset County Council

- DSA
- Dudley Metropolitan Borough Council
- Durham County Council
- East London Branch – ADASS
- East London Vision
- East Midlands Branch - ADASS
- East Riding of Yorkshire Council
- East Sussex County Council
- East Sussex Disability Association
- Effective Practice
- Empowerment Matters
- Enfield Council
- Erosh
- Essex County Council
- Flash
- Foundations UK
- Gateshead Council
- Gloucester County Council
- GMB
- Guide Dogs for the Blind
- Habinteg Housing Association
- Halton Borough Council
- Havering Vision Strategy Group
- Healthwatch East Sussex
- Healthwatch Knowsley
- Healthwatch Islington
- Healthwatch Reading
- Healthwatch Richmond
- Healthwatch Staffordshire
- Healthwatch Stoke on Trent
- Healthwatch Worcestershire
- HERIB
- Herefordshire Council
- Hertfordshire County Council

- Home Group Network
- Homeless Link
- Housing and Care 21
- Howard League for Penal Reform
- Huntingdon Disease Association
- Ideal Care Homes
- Institute and Faculty of Actuaries
- Independent Living Fund
- Inclusion London
- Inclusive Change Partnership
- Independent Age
- Isle of Wight Council
- Jewish Care
- Just Retirement
- JustRights
- Kent County Council
- Kirklees Council
- Knowsley MBC
- Lancashire County Council
- Law Society
- Leicester City Council
- Leonard Cheshire
- Lesbian and Gay Foundation
- Lincolnshire Health and Wellbeing Board
- Liverpool City Council
- London Branch - ADASS
- London Borough of Bexley
- London Borough of Havering
- London Borough of Newham
- London Borough of Redbridge
- London Borough of Richmond
- London Borough of Sutton
- London Councils
- London Voluntary Services Council

- Loughborough University
- Luton Carers
- Live
- Liverpool Victoria
- Making Every Adult Matter
- Manchester City Council
- MENCAP
- Mental health Nursing Association
- Middlesbrough Council
- Midland Heart Ltd
- Mind
- Monitor
- Motor Neuron Disease Association
- MS Society
- Narco
- National Association of Financial Assessment Officers
- National AIDS Trust
- National Housing Federation
- National LGB&T Partnership
- National Pensioners Convention
- National Star College
- National Care Forum
- Newcastle Forum for Voluntary Services
- Newcastle City Council
- No Recourse to Public Funds
- Norfolk Carers
- Norfolk County council
- North East Councils Association
- North East Lincolnshire Council
- North Somerset Council
- North Tyneside Council
- North West ADASS Task and Finish Group
- North Yorkshire County Council
- Northamptonshire County Council

- Northumberland County Council
- Nottingham North and East Clinical Commissioning Group
- Nottinghamshire County Council
- NRAS
- Oldham Council
- Oxfordshire County Council
- Papworth Trust
- Parkingsons UK
- Partnership
- Peterborough Council
- Plymouth City Council
- Pohwer
- Priory Social Care
- Real Life Options
- Reading Borough Council
- Real
- Recruitment and Employment Confederation
- Rehabilitation and Low Vision Group
- Richmond User and Care Group
- RNIB
- Rochdale Council
- Royal Association of Deaf People
- Royal Borough of Kensington and Chelsea
- Royal Borough of Windsor and Maidenhead
- Royal College of General Practitioners
- Royal College of Nursing
- Saga and Allied Healthcare
- Sandwell MBC
- Salford City Council
- Sanctuary Group
- SBC
- Scope
- Scott-Moncrieff & Associates
- Sense

- SHAP
- Shared Lives
- Sheffield City Council
- Sheffield Young Carers
- SHIP Group (Southampton City, Hampshire Council, Isle of Wight and Portsmouth Councils)
- Shropshire Partners in Care
- Sitra
- Slough Borough Council
- Society of Local Authority Chief Executives and Senior Managers
- Solihull MBC
- Solihull Care Forum and SWICDA
- South East Strategic Leaders - Hampshire County Council
- South Gloucestershire Council
- South Tyneside Council
- Southend-on-Sea Borough Council
- Southern Healthcare
- Spinal Injuries Association
- St Helens Council
- Staffordshire County Council
- Stoke on Trent City Council
- Suffolk County Council
- Sue Ryder
- Sunderland City Council
- Surry County Council
- Sustainable Housing Action Partnership
- Swiss Re
- Telford & Wrekin Council
- The April Centre
- The Carers Resource
- The Disabilities Trust
- The Information Commissioner
- The Lesbian and Gay Foundation
- The Priory Group

- The Rehabilitation and Low Vision Group
- Think Local Act Personal
- Together All are Able
- Together for Short Lives
- Torbay Council
- Tower Hamlets
- Tri-Borough Councils
- Transform Housing
- Trafford Council
- United Kingdom Homecare Associations
- UNISON
- User Voice
- VoiceAbility
- Voluntary Organisations Disability Group
- Wakefield Metropolitan District Council
- Warwickshire County Council
- Weightmans LLP
- West Sussex County Council
- Wigan Council
- Wiltshire Council
- Wirral Council
- Wokingham Borough Council
- Worcestershire Association of Carers
- Worcestershire County Council
- Yorkshire and Humber ADASS

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