Department of Health

Care and Support Statutory Guidance

Issued under the Care Act 2014

June 2014

Contents

Introduction 3

General responsibilities and universal services

1. Promoting wellbeing 5
2. Preventing, reducing or delaying needs 13
3. Information and advice 25
4. Market shaping and commissioning of adult care and support 41
5. Managing provider failure and other service interruptions 59

First contact and identifying needs

6. Assessment and eligibility 67
7. Independent advocacy 93

Charging and financial assessment

8. Charging and financial assessment 107
9. Deferred payment agreements 119

Person-centred care and support planning

10. Care and support planning 135
11. Personal budgets 151
12. Direct payments 163
13. Review of care and support plans 181

Adult safeguarding

14. Safeguarding 189

Integration and partnership working

15. Integration, cooperation and partnerships 225
16. Transition to adult care and support 245
17. Prisons, approved premises and bail accommodation 261
18. Delegation of local authority functions 273

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

19. Ordinary residence 279
20. Continuity of care 295
21. Cross-border placements 305

Other areas

22. Sight registers 317
23. Transition to the new legal framework 325

Annexes

Annex A: Choice of accommodation and additional payments 335
Annex B: Treatment of capital 347
Annex C: Treatment of income 363
Annex D: Recovery of debts 373
Annex E: Deprivation of assets 375
Annex F: Temporary residents in care homes 379
Annex G: The process for managing transfers of care from hospital 383
Annex H: Continuity of care: equipment and adaptations 395
Annex J: Ordinary residence 397
Annex K: Repeals and revocations 423
Glossary 427

Introduction

Purpose and legal status of the guidance

This is draft guidance for consultation. When published in its final form the statutory guidance is intended to provide local authorities with the information they need about how they should meet the legal obligations placed on them by the Act and the regulations. Local authorities are required to act under the guidance, which means that they must follow it, unless they can demonstrate legally sound reasons for not doing so.

The guidance will be used by local authority officers to plan care and support at a local authority level, as well as by practitioners. The guidance will also be used by people using care and support, their families, the voluntary sector and providers of care and support to help them understand the new system, and by courts in deciding whether a local authority has acted within the law.

Presentation of this guidance

Throughout this guidance, the Care Act 2014 is referred to as "the Act". Where there is reference to provisions of other legislation, the relevant legislation is clearly indicated. Where the Guidance refers to "the regulations", it means regulations made under the Act.

A list of relevant material is also provided at the end of each chapter, where appropriate. These references do not form part of the Guidance and do not attract the same legal status. The information is provided for assistance only.

Case studies and scenarios

In a number of the chapters of the guidance, scenarios or case studies have been included which are intended to illustrate the way in which the guidance might be applied to decisions which people have to take under the Act. The scenarios and case studies are illustrative.

General responsibilities and universal services

1. Promoting wellbeing

This chapter provides guidance on section 1 of the Care Act 2014.

This chapter covers:

- Definition of wellbeing;
- Promoting wellbeing;
- Wellbeing throughout the Care Act.

1.1. The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. Throughout this guidance document, the different chapters set out how a local authority should go about performing its care and support responsibilities. Underpinning all of these individual "care and support functions" (that is, any process, activity or broader responsibility that the local authority performs) is the need to ensure that doing so focuses on the needs and goals of the person concerned.

1.2. Local authorities **must** promote wellbeing when carrying out any of their care and support functions in respect of a person. This may sometimes be referred to as "the wellbeing principle" because it is a guiding principle that puts wellbeing at the heart of care and support.

1.3. The wellbeing principle applies in all cases where a local authority is carrying out a care and support function, or making a decision, in relation to a person. For this reason it is referred to throughout this guidance. It applies equally to adults with care and support needs and their carers. In some specific circumstances, it also applies to children, their carers and to young carers when they are subject to transition assessments (see chapter 16 on transition to adult care and support).

Definition of wellbeing

1.4. "Wellbeing" is a broad concept, and it is described as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional wellbeing;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support provided and the way it is provided);
- participation in work, education, training or recreation;
- social and economic wellbeing;
- domestic, family and personal relationships;

- suitability of living accommodation;
- the individual's contribution to society.

1.5. The individual aspects of wellbeing or outcomes above are those which are set out in the Care Act, and are most relevant to people with care and support needs and carers. There is no hierarchy, and all should be considered of equal importance when considering "wellbeing" in the round.

Promoting wellbeing

1.6. Promoting wellbeing means actively seeking improvements in the aspects of wellbeing set out above when carrying out a care and support function in relation to an individual at any stage of the process from the provision of information and advice to reviewing a care and support plan. Wellbeing covers an intentionally broad range of the aspects of a person's life and will encompass a wide variety of specific considerations depending on the individual.

1.7. A local authority can promote a person's wellbeing in many ways. How this happens will depend on the circumstances, including the person's needs, goals and wishes, and how these impact on their wellbeing. There is no set approach – a local authority should consider each case on its own merits, consider what the person wants to achieve, and how the action which the local authority is taking may affect the wellbeing of the individual.

1.8. The Act therefore signifies a shift from existing duties on local authorities to provide particular services, to the concept of 'meeting needs' (set out in sections 8 and 18-20 of the Act). This is the core legal entitlement for adults to care and support, establishing one clear and consistent set of duties and power for all people who need care and support.

1.9. The concept of 'meeting needs' recognises that everyone's needs are different and personal to them. Local authorities must consider how to meet each person's specific needs rather than simply considering what service they will fit into. The concept of meeting needs also recognises that modern care and support can be provided in any number of ways, with new models emerging all the time, rather than the existing legislation which focuses primarily on traditional models of residential and domiciliary care.

1.10. Whenever a local authority carries out any care and support functions relating to an individual, it must act to promote wellbeing – and it should consider all of the aspects above in looking at how to meet a person's needs and support them to achieve their desired outcomes. However, in individual cases, it is likely that some aspects of wellbeing will be more relevant to the person than others. For example, for some people the ability to engage in work or education will be a more important outcome than for others, and in these cases "promoting their wellbeing" effectively may mean taking particular consideration of this aspect. Local authorities should adopt a flexible approach that allows for a focus on which aspects of wellbeing matter most to the individual concerned.

1.11. The principle of promoting wellbeing should be embedded through the local authority care and support system, but how the local authority promotes wellbeing in practice will depend on the particular function being performed. During the assessment process, for instance, the local authority should explicitly consider the most relevant aspects of wellbeing to the individual concerned, and assess how their needs impact on them. Taking this approach will allow for the assessment to identify how care and support, or other services or resources in the local community, could help the person

to achieve their outcomes. During care and support planning, when agreeing how needs are to be met, promoting the person's wellbeing may mean making decisions about particular types or locations of care (for instance, to be closer to family).

1.12. The wellbeing principle applies equally to those who do not have eligible needs but come into contact with the system in some other way (for example, via an assessment that does not lead to ongoing care and support) as it does to those who go on to receive care and support, and have an ongoing relationship with the local authority. It should inform the delivery of universal services which are provided to all people in the local population, as well as being considered when meeting eligible needs. Although the wellbeing principle applies specifically when the local authority performs an activity or task, or makes a decision, in relation to a person, the principle should also be considered by the local authority when it undertakes broader, strategic functions, such as planning, which are not in relation to one individual. As such, "wellbeing" should be seen as the common theme around which care and support is built at local and national level.

1.13. In addition to the general principle of promoting wellbeing, there are a number of other key principles and standards which local authorities must have regard to when carrying out the same activities or functions:

(a) **the importance of beginning with the assumption that the individual is best-placed to judge the individual's wellbeing.** Building on the principles of the Mental Capacity Act, the local authority should assume that the person themselves knows best their own outcomes, goals and wellbeing. Local authorities should not make assumptions as to what matters most to the person;

(b) **the individual's views, wishes, feelings and beliefs.** Considering the person's views and wishes is critical to a person-centred system. Local authorities should not ignore or downplay the importance of a person's own opinions in relation to their life and their care. Where particular views, feelings or beliefs (including religious beliefs) impact on the choices that a person may wish to make about their care, these should be taken into account. This is especially important where a person has expressed views in the past, but no longer has capacity to make decisions themselves;

(c) **the importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist.** At every interaction with a person, a local authority should consider whether or how the person's needs could be reduced or other needs could be delayed from arising. Effective interventions at the right time can stop needs from escalating, and help people maintain their independence for longer (see chapter 2 on prevention);

(d) **the need to ensure that decisions are made having regard to all the individual's circumstances** (and are not based only on their age or appearance, any condition they have, or any aspect of their behaviour which might lead others to make unjustified assumptions about their wellbeing). Local authorities should not make judgments based on preconceptions about the person's circumstances, but should in every case work to understand their individual needs and goals;

(e) **the importance of the individual participating as fully as possible** in decisions about them and being provided with the information and support

necessary to enable the individual to participate. Care and support should be personal, and local authorities should not make decisions from which the person is excluded;

(f) **the importance of achieving a balance between the individual's wellbeing and that of any friends or relatives who are involved in caring for the individual.** People should be considered in the context of their families and support networks, not just as isolated individuals with needs. Local authorities should take into account the impact of an individual's need on those who support them, and take steps to help others access information or support;

(g) **the need to protect people from abuse and neglect.** In any activity which a local authority undertakes, it should consider how to ensure that the person is and remains protected from abuse or neglect. This is not confined only to safeguarding issues, but should be a general principle applied in every case;

(h) **the need to ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary** for achieving the purpose for which the function is being exercised. Where the local authority has to take actions which restrict rights or freedoms, they should ensure that the course followed is the least restrictive necessary.

1.14. All of the matters listed above must be considered in relation to every individual, when a local authority carries out a function as described in this guidance. Considering these matters should lead to an approach that looks at a person's life holistically, considering their needs in the context of their skills, ambitions, and priorities – as well as the other people in their life and how they can support the person in meeting the outcomes they want to achieve. The focus should be on supporting people to live as independently as possible for as long as possible.

1.15. As with promoting wellbeing, the factors above will vary in their relevance and application to individuals. For some people, spiritual or religious beliefs will be of great significance, and should be taken into particular account. For others, this will not be the case. Local authorities should consider how to apply these further principles on a case-by-case basis. This reflects the fact that every person is different and the matters of most importance to them will accordingly vary widely.

1.16. Neither these principles, nor the requirement to promote wellbeing, require the local authority to undertake any particular action. The steps a local authority should take will depend entirely on the circumstances. The principles as a whole are not intended to specify the activities which should take place. Instead, their purpose is to set common expectations for how local authorities should approach and engage with people.

"Independent living"

1.17. Although not mentioned specifically in the way that "wellbeing" is defined, the concept of "independent living" is a core part of the wellbeing principle. Section 1 of the Care Act includes matters such as individual's control of their day-to-day life, suitability of living accommodation, contribution to society – and crucially, requires local authorities to consider each person's views, wishes, feelings and beliefs.

1.18. The wellbeing principle is intended to cover the key components of independent living, as expressed in the UN Convention

on the Rights of People with Disabilities.[1] Supporting people to live as independently as possible, for as long as possible, is a guiding principle of the Care Act. The language used in the Act is intended to be clearer, and focus on the outcomes that truly matter to people, rather than using the relatively abstract term "independent living".

Wellbeing throughout the Care Act

1.19. Wellbeing cannot be achieved simply through crisis management; it must include a focus on delaying and preventing care and support needs, and supporting people to live as independently as possible for as long as possible. (See chapter 2 for more detail on approaches to prevention).

1.20. Promoting wellbeing does not mean simply looking at a need that corresponds to a particular service. At the heart of the reformed system will be an assessment and planning process that is a genuine conversation about people's needs for care and support and how meeting these can help them achieve the outcomes most important to them. Where someone lacks the capacity to fully participate in these conversations and has no one to help them, local authorities will provide an independent advocate. Chapters 6 (Assessment and eligibility), 10 (Care and support planning), and 7 (Independent advocacy) discuss this in more detail.

1.21. In order to ensure these conversations look at people holistically, local authorities and their partners must focus on joining up around an individual, making the person the starting point for planning, rather than what services are provided by what particular agency. Chapter 15 (integration and cooperation) sets this out in more detail.

1.22. Promoting wellbeing is not always about local authorities meeting needs directly. It will be just as important for them to put in place a system where people have the information they need to take control of their care and support and choose the options that are right for them. People will have an opportunity to request their local authority support in the form of a direct payment that they can then use to buy their own care and support using this information. Chapters 3 (Information and advice) and 12 (Direct payments) explain this in more detail.

1.23. Control also means the ability to move from one area to another or from children's services to the adult system without fear of suddenly losing care and support. The Care Act ensures that people will be able to move to a different area without suddenly losing their care and support and provides clarity about who will be responsible for care and support in different situations. It also includes measures to help young people move to the adult care and support system, ensuring that no one finds themselves suddenly without care on turning 18. Chapters 20 (Continuity of care), 19 (Ordinary residence) and 16 (Transition to adult care and support set this out in more detail.

1.24. It is not possible to promote wellbeing without establishing a basic foundation where people are safe and their care and support is on a secure footing. The Care Act puts in place a new framework for adult safeguarding and includes measures to guard against provider failure to ensure this is managed without disruption to services. Chapters 14 (Safeguarding), and 5 (Managing provider failure) set this out in more detail.

[1] http://www.un.org/disabilities/default.asp?id=279

2. Preventing, reducing or delaying needs

This chapter provides guidance on section 2 of the Care Act 2014.

This chapter covers:

- Defining "prevention";
  - Primary prevention/promoting wellbeing;
  - Secondary prevention/early intervention;
  - Tertiary prevention/intermediate care and reablement;
- The focus of prevention;
- Developing local approaches to prevention;
  - Working with others to focus on prevention;
- Identifying those who may benefit from prevention;
- Enabling access to preventative support;
- Charging for preventative services.

2.1. It is critical to the vision in the Care Act that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point. To meet the challenges of the future, it will be vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence, and prevents need or delays deterioration wherever possible.

2.2. There are many ways in which a local authority can achieve these aims whilst promoting wellbeing and independence and reducing dependency. This guidance sets out how local authorities should go about fulfilling their responsibilities, both individually and in partnership with other local organisations, communities, and people themselves.

2.3. The local authority's responsibilities for prevention apply to all adults, including:

- people who do not have any current needs for care and support;
- adults with needs for care and support, whether their needs are eligible and/or met by the local authority or not (see chapter 6);
- carers, including those who may be about to take on a caring role or who do not currently have any needs for support, and those with needs for support which may not be being met by the local authority or other organisation.

2.4. The term "prevention" or "preventative" measures can cover many different types of support, services, facilities or other resources. There is no one definition for what constitutes preventative activity and this can range from wide-scale whole-population measures aimed at promoting health, to more targeted, individual interventions aimed at improving skills or functioning for one person or a particular group or lessening the impact of caring on a carer's health and wellbeing. In considering how to give effect to their responsibilities, local authorities **should** consider the range of options available, and how those different approaches could support the needs of their local communities.

2.5. "Prevention" is often broken down into three general approaches – primary, secondary and tertiary prevention – which are described in more detail below.

Prevent: primary prevention/ promoting wellbeing

2.6. These are aimed at individuals who have no current particular health or care and support needs. These are services, facilities or resources provided or arranged that may help an individual avoid developing needs for care and support, or help a carer avoid developing support needs by maintaining independence and good health and promoting wellbeing. They are generally universal (i.e. available to all) services, which may include, but are not limited to interventions and advice that:

- provide universal access to good quality information;
- support safer neighbourhoods;
- promote healthy and active lifestyles (e.g. exercise classes);
- reduce isolation (e.g. befriending schemes); or,
- encourage early discussions in families or groups about potential changes in the future, e.g. conversations about potential care arrangements or suitable accommodation should a family member become ill or disabled.

Reduce: secondary prevention/ early intervention

2.7. These are more targeted interventions aimed at individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration or prevent other needs from developing. In order to identify those individuals most likely to benefit from such targeted services, local authorities may undertake screening or case-finding, for instance to identify individuals at risk of developing specific health conditions or experiencing certain events (such as strokes, or falls), or those that have needs for care and support which are not currently met by the local authority. Targeted interventions **should** also include approaches to identifying carers, including those who are taking on new caring responsibilities. Early intervention could include a fall prevention clinic, minor adaptions to housing which improve accessibility or provide greater assistance for those at risk of a fall, or telecare services. Carers can also benefit from support to help them develop the knowledge and skills to care effectively and look after their own health and wellbeing.

Delay: tertiary prevention

2.8. These are interventions aimed at minimising the effect of disability or deterioration for people with established health conditions, complex care and support needs or caring responsibilities, including

supporting people to regain skills and reduce need where possible. Local authorities **must** provide or arrange services, resources or facilities that maximise independence for those already with such needs, for example, interventions such as rehabilitation/ reablement services (discussed below) and joint case-management of people with complex needs, e.g. community equipment service, handyman services. This could also include helping carers to continue to care, enabling them to have a life of their own alongside caring, to have breaks from their caring responsibilities, develop mechanisms to cope with stress associated with caring and awareness of their own physical and mental health needs, e.g. emotional support or stress management classes. Social Workers and Occupational Therapists are well placed to be the lead professional to undertake assessment or review of an individual or their carer with complex care and support needs.

Intermediate care and reablement

2.9. "Intermediate care" is a structured programme of care provided for a limited period of time, to assist a person to maintain or regain the ability to live independently at home. "Reablement" is a particular type of intermediate care, which has a stronger focus on helping the person to regain skills and capabilities to reduce their needs, in particular through the use of therapy or minor adaptations.

2.10. There is a tendency for the terms "reablement", "rehabilitation" and "intermediate care" to be used interchangeably. The National Audit of Intermediate Care[2] categorises four types of intermediate care: **crisis response** – services providing short-term care (up to 48 hours); **home-based intermediate care** – services provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists; **bed-based intermediate care** – services delivered away from home, for example, in a community hospital; and **reablement** – services to help people live independently which are provided in the person's own home by a team of mainly care and support professionals.

2.11. Three of the four types of intermediate care have historically been clinician-led and provided by health staff, with reablement being provided by local authorities. However, these are not concrete, mutually-exclusive categories – and, furthermore, with greater integration and co-operation between health and local authorities, there should be greater use of qualified staff from health and social care working together to provide intermediate care.

Carers and prevention

2.12. There may be specific interventions for carers that prevent, reduce or delay the needs for support. These interventions may differ from those for people without caring responsibilities. Examples of services, facilities or resources that could contribute to preventing, delaying or reducing the needs of carers may include interventions, information or advice that help carers to:

- care effectively and safely – both for themselves and the person they are supporting, e.g. timely interventions or advice on moving and handling safely or avoiding falls in the home, or training for carers to feel confident performing basic health care tasks;

[2] http://www.nhsbenchmarking.nhs.uk/projects/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php

- look after their own physical and mental health and wellbeing, including developing coping mechanisms;
- make use of IT and assistive technology;
- make choices about their own lives, for example managing care and paid employment;
- find support and services available in their area;
- access the advice, information and support they need including information and advice on welfare benefits and other financial information and about entitlement to carers' assessments (see chapter 6).

The focus of prevention

Promoting wellbeing

2.13. Local authorities must have regard to promoting wellbeing and the principles set out in chapter 1. Local authorities should look at an individual's life holistically. This will mean considering any care and support needs in the context of the person's skills, ambitions, and priorities. This **should** include consideration of the role a person's family or friends can play in helping the person to meet their goals, not creating or adding to their caring role but including them in an approach supporting the person to live as independently as possible for as long as possible. In regard to carers, the local authority should consider how they can be supported to look after their own health and wellbeing and to have a life of their own alongside caring.

An older man lives alone with some support from his daughter who works full time. He needs occasional personal care to remain living independently with dignity, and it is likely that these needs will increase. He has lost contact with family and friends following his wife's death and rarely goes out without support from his daughter who is restricted to taking him out at weekends because of work commitments.

An assessment would consider all of his needs, including those currently being met by his daughter, along with the outcomes he wishes to achieve. A separate carer's assessment offered to his daughter (or a combined assessment if both father and daughter agreed) would establish the daughter's willingness and ability to care and continue to care and the outcomes she wishes to achieve. This joint assessment would look at issues such as the possible impact on the daughter of supporting her father while in full-time employment as well as the man's isolation, ability to connect with others or be an active citizen.

Community groups, voluntary organisations, and buddying services could support the man to maximise opportunities to look after his own health and wellbeing and participate in local community activities. This, in turn, could lessen the impact of caring on his daughter and enable her to continue to support her father effectively alongside paid employment Such support can be identified/suggested alongside other, perhaps more formal services to meet personal care needs.

Developing resilience and promoting individual strength

2.14. In developing and delivering preventative approaches to care and support, local authorities should ensure that individuals are not seen as passive recipients of support services, but are able to design care and support based around achievement of their goals. Local authorities should, where possible, actively promote participation in providing interventions that are co-produced with individuals, families, friends, carers and the community. "Co-production" is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered. Such interventions can contribute to developing individual resilience and help promote self-reliance and independence, as well as ensuring that services reflect what the people who use them want.

Case Study

http://www.thinklocalactpersonal.org.uk/Browse/SDSandpersonalbudgets/Reducing_Process/CaseStudies/Resource/?cid=9598

2.15. Through the assessment process, an individual will have direct contact with a local authority. A good starting point for a discussion that helps develop resilience and promotes independence would be to ask "what does a good life look like for you and your family and how can we work together to achieve it?" Giving people choice and control over the support they may need and access to the right information enables people to stay as well as possible, maintain independence and caring roles for longer.

2.16. Social workers, Occupational Therapists, other professionals, service providers and commissioners who are effective at preventing, reducing, or delaying needs for care and support are likely to have an holistic picture of the individuals and families receiving support. This will include consideration of a person's strengths and their informal support networks as well as their needs and the risks they face. This approach recognises the value in the resources of voluntary and community groups and the other resources of the local area.

Developing a local approach to preventative support

2.17. A local authority **must** provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers. Local authorities **should** develop a clear, local approach to prevention which sets out how they plan to fulfil this responsibility, taking into account the different types and focus of preventative support as described above.

2.18. Whilst local authorities may choose to provide some types of preventative support themselves, others may be more effectively provided in partnership with other local partners (e.g. rehabilitation or falls clinics provided jointly with the local NHS), and further types may be best provided by other organisations e.g. specialist housing providers or some carers' services. A local authority's commissioning strategy for prevention **should** consider the different routes available, and the benefits presented by each.

2.19. In developing a local approach to prevention, the local authority **must** take steps to identify and understand both the current and future *demand* for preventative

support, and the supply in terms of services, facilities and other resources available.

2.20. Local authorities **must** consider the importance of identifying the services, facilities and resources that are already available in their area, which could support people to prevent, reduce or delay needs, and which could form part of the overall local approach to preventative activity. Understanding the breadth of available local resources will help the local authority to consider what gaps may remain, and what further steps it should itself take to promote the market or to put in place its own services.

2.21. Where the local authority does not provide such types of preventative support itself, it **should** have mechanisms in place for identifying existing and new services, maintaining contact with providers over time, and helping people to access them. Local approaches to prevention should be built on the resources of the local community, including local support networks and facilities provided by other partners and voluntary organisations.

2.22. Local authorities **must** promote diversity and quality in provision of care and support services, and ensure that a person has a variety of providers to choose from (see chapter 4). Considering the services, facilities and resources which contribute towards preventing or delaying the development of needs for care and support is a core element of fulfilling this responsibility. A local authority **should** engage local providers of care and support in all aspects of delivery and encourage providers to innovate and respond flexibly to develop interventions that contribute to preventing needs for care and support.

2.23. Local authorities **should** consider the number of people in its area with existing needs for care and support, as well as those at risk of developing needs in the future, and what can be done to prevent, delay or reduce those needs now and in the future. In doing so, a local authority should draw on existing analyses such as the Joint Strategic Needs Assessment, and work with other local partners such as the NHS to develop a broader, shared understanding of current and future needs, and support integrated approaches to prevention.

2.24. In particular, local authorities **must** consider how to identify "unmet need" – i.e. those people with needs which are not currently being met, whether by the local authority or anyone else. Understanding unmet need will be crucial to developing a longer-term approach to prevention that reflects the true needs of the local population. This assessment should also be shared with local partners, including through the health and wellbeing board, to contribute to wider intelligence for local strategies. Preventative services, facilities or resources are often most effective when brought about through partnerships between different parts of the local authority and between other agencies and the community. Local authorities **should** consider how they can work with different partners to identify unmet needs for different groups, for example working with the NHS to identify carers, and how to coordinate shared approaches to preventing or reducing such needs.

Working with other partners to focus on prevention

2.25. In developing and delivering local approaches to prevention, the local authority **should** consider how to align or integrate its approach with that of other local partners. Preventing needs will often be most effective when action is undertaken at a locality level, with different organisations working together to understand how the actions of each may

impact on the other. Within the local authority, prevention of care and support needs is closely aligned to other local authority responsibilities in relation to public health, children's services, and housing, for example. Across the local landscape, the role of other bodies including the local NHS, welfare and benefits, Jobcentre Plus, the police, service providers and others will also be important in developing a comprehensive approach.

2.26. Local authorities **must** ensure the integration of care and support provision, including prevention with health and health-related services, which includes housing (see chapter 15). This responsibility includes in particular a focus on integrating with partners to prevent, reduce or delay needs for care and support.

2.27. A local authority **must** cooperate with each of its relevant partners and the partners must cooperate with the local authority (see chapter 15 on cooperation and details of specific relevant partners), for example, in relation to the provision of preventative services and the identification of carers a local authority must cooperate with NHS bodies.

2.28. A local authority **must** also set up arrangements between its relevant partners and individual departments in relation to its care and support functions, which includes prevention. Relevant partners and individual departments include, but are not limited to, housing departments where, for example, housing services or officers can provide support through early identification of people with dementia and their carers, provide housing related support and or in partnership with others, home from hospital services or "step up step down" provision.

Identifying those who may benefit from preventative support

2.29. Local authorities **should** put in place arrangements to identify and target those individuals who may benefit from particular types of preventative support. Helping people to access such types of support when they need it is likely to have a significant impact on their longer-term health and wellbeing, as well as potentially reducing or delaying the need for ongoing care and support from the local authority.

2.30. In developing such approaches, local authorities **should** consider the different opportunities for coming into contact with those people who may benefit, including where the first contact may be with another professional outside the local authority. There are a number of interactions and access points that could bring a person into contact with the local authority or a partner organisation and act as a trigger point for the local authority to consider whether the provision of a preventative service, or some other step is appropriate. These might include, for instance:

- initial contact through a customer services centre, whether by the person concerned or someone acting on their behalf;
- contact with a GP, community nurses, housing officers or other professionals which leads to a referral to the local authority;
- an assessment of needs or a carer's assessment (see chapter 6 on assessment), which identifies that the person would benefit from a preventative service or other type of support available locally.

2.31. Prevention **should** be a consistent focus for local authorities in undertaking their care and support functions. However, there may be key points in a person's life or in the care and support process where a preventative intervention may be particularly appropriate or of benefit to the person. Approaches to identifying those people who may benefit from preventative support **should** consider how to locate people in such circumstances, for example:

- bereavement;
- hospital admission and or discharge;
- application for benefits such as Attendance Allowance, or Carer's Allowance;
- contact with/use of local support groups;
- contact with/use of private care and support;
- changes in housing.

2.32. A local authority **must** establish and maintain a service for providing people with information and advice relating to care and support (see chapter 3). In addition to any more targeted approaches to communicating with individuals who may benefit from preventative support, this service should include information and advice about preventative services, facilities or resources, so that anyone can find out about the types of support available locally that may meet their individual needs and circumstances, and how to access them.

Helping people access preventative support

2.33. Many different kinds of service, facility or resource can be preventative and can help individuals live well and maintain their independence or caring roles for longer. Local authorities should be innovative and develop an approach to prevention that meets the needs of their local population. A preventative approach requires a broad range of interventions, as one size will not fit all.

2.34. Where a local authority has put in place mechanisms for identifying people who may benefit from a type of preventative support, it **should** take steps to ensure that the person concerned understands the need for the particular measure, and is provided with further information and advice as necessary.

2.35. Contact with a person who is identified as being able to benefit from preventative support may lead to the local authority becoming aware that the person appears to have needs for care and support, including support as a carer. This appearance of need is likely to trigger the requirement to carry out a needs assessment (in the case of an adult with needs for care and support), or a carer's assessment (see paragraphs 2.38-2.42 below). However, where a local authority is not required to carry out such an assessment under the Care Act, it **should** nonetheless take steps to establish whether the person identified will benefit from the type of preventative support proposed.

2.36. Where a person is provided with any type of service, or supported to access any facility or resource as a preventative measure, the local authority **should** also provide the person with information in relation to the measure undertaken. The local authority is not required to provide a care and support plan or a carer's support plan where it only take steps under section 2 of the Care Act; however, it **should** consider which aspects of a plan should be provided in these circumstances, and **should** provide such information as is necessary to enable the person to understand:

- what needs the person has or may develop, and why the intervention or other action is proposed in their regard;

- the expected outcomes for the action proposed, and any relevant timescale in which those outcomes are expected; and
- what is proposed to take place at the end of the measure (for instance, whether an assessment of need or a carer's assessment will be carried out at that point).

2.37. The person concerned must agree to the provision of any service or other step proposed by the local authority. Where the person refuses, but continues to appear to have needs for care and support (or for support, in the case of a carer), then the local authority **must** proceed to offer the individual an assessment.

Assessment of adults' and carers' needs

2.38. In assessing the needs of either an adult with care and support needs or a carer, the local authority **must** consider whether the person concerned would benefit from the preventative services, facilities or resources provided by the local authority or which might be available in the community. This is to ensure that as part of the assessment process, the local authority considers the capacity of the person to manage their needs or achieve the outcomes which matter to them, and allows for access to preventative support before a decision is made on whether the person has eligible needs (see chapter 6 on assessment for more information).

2.39. As part of this process, the local authority **should** also take into account the person's own capabilities, and the potential for improving their skills, as well as the role of any support from family, friends or others that could help them to achieve what they wish for from day-to-day life. This should not assume that others are willing or able to take up caring roles, and where necessary a carer's assessment **should** always be offered. Children should not undertake inappropriate or excessive caring roles that have an impact on their development. However, considering the support from family, friends or others is important in taking a holistic approach to see the person in the context of their support networks and understanding how needs may be prevented, reduced or delayed by others within the community, rather than by more formal services (also see chapter 6, paragraph 6.43 to 6.50 about the whole family approach to assessment).

2.40. If a person is provided with care and support or support as a carer by the local authority, the authority is also required to provide them with information about what can be done to prevent, delay, or reduce their needs as part of their care and support plan or carer's support plan. This **should** also include consideration of the person's strengths and the support from other members of the family, friends or the community (see chapter 10 on care and support planning).

2.41. If a person's needs are not to be met by the local authority, the authority must in any case provide in writing, information about what can be done to prevent, delay, or reduce their needs. This is to ensure that all people, whatever their level of need, are provided with targeted, personalised information that can support them to take steps to prevent or reduce their needs, connect more effectively with their local community, and delay the onset of greater needs to maximise their independence and quality of life. Where a person has some needs that are eligible, and also has some other needs that are not deemed to be eligible, the local authority must consider similarly what information and advice would contribute to preventing, reducing or delaying

the needs for care and support or support as a carer which are not eligible, and this **should** be aligned with the care and support plan or carer's support plan.

2.42. It is important that people receive information in a timely manner about the services or interventions that can help or contribute to preventing an escalation in needs for care and support. Supporting people's access to the right information at the right time is a key element of a local authority's responsibilities for prevention.

Charging for preventative support

2.43. Preventative services, like other forms of care and support, are not always provided free, and charging for some services is vital to ensure affordability. The Care and Support (Charging and Assessment of Resources) Regulations 2014 continue to allow local authorities to make a charge for the provision of certain preventative services, facilities or resources. The regulations also provide that some other specified services **must** be provided free of charge.

2.44. Where a local authority chooses to charge for a particular service, it **should** consider how to balance the affordability and viability of the measure with the likely impact of charging on uptake by individuals. Whilst some charging may act as an incentive for people to use a service or facility (for example, upfront charges for certain activities may make people more likely to attend), others may have the opposite effect. Charging may also make a preventative service viable or keep a service running.

2.45. When charging for any type of preventative support, local authorities **should** always take steps to ensure that any charge is affordable to the person concerned. This does not need to follow the method of the financial assessment used for mainstream charging purposes; and the use of such a process is likely to be disproportionate. However, local authorities **should** consider adopting more proportionate or "light-touch" processes which ensure that charges are only paid by those who can afford to do so and would not in any case leave someone below the national minimum level of income (see chapter 8 on charging and financial assessment). In any event, a local authority **must not** charge more than it costs to provide or arrange for the particular type of support.

2.46. The regulations require that intermediate care and reablement provided up to six weeks, and minor aids and adaptations provided up to the value of £1,000 **must** always be provided free of charge.

2.47. Where local authorities provide intermediate care or reablement to those who require it, this **must** be provided free of charge for a period of up to six weeks. This is for all adults, irrespective of whether they have eligible needs for ongoing care and support. Although such types of support will usually be provided as a preventative measure under section 2 of the Act, they may also be provided as part of a package of care and support to meet eligible needs. In these cases, regulations also provide that intermediate care or reablement cannot be charged for in the first six weeks, to ensure consistency.

2.48. Whilst they are both time-limited interventions, neither intermediate care nor reablement should have a strict time limit, since the period of time for which the support is provided should depend on the needs and outcomes of the individual. In some cases, for instance a period of reablement for a person who has recently become sight-impaired, the support may be expected to last longer than six weeks. Whilst the local authority does have the power to charge for such types

of support where it is provided beyond six weeks, local authorities **should consider** continuing to provide it free of charge beyond six weeks in such circumstances, in view of the clear preventative benefits to the individual and, in many cases, the reduced risk of hospital admissions.

Case study:

Mr A is a 91 year old man who lives alone with his dog in his house. He is usually independent, is a passionate cook and enjoys socialising. He drives a car. Whilst out walking his dog he suffered a stroke, he fell, causing a fractured neck of femur. He was admitted to hospital and underwent surgery for a hip replacement which meant he had to follow hip precautions for 6 weeks.

The stroke had left him with slight left sided weakness and problems with concentration, sequencing and attention. He was transferred to a Community Hospital for rehabilitation where the Physiotherapists (PTs) and Occupational Therapists (OTs) worked on mobility, transfers, personal care following hip precautions, stair climbing and kitchen tasks. Cognitive screens were completed and the OT's targeted their input on helping improve concentration, sequencing and attention.

Mr A was discharged, independently mobile using a frame, independent transferring using equipment and stair climbing with supervision. He was discharged home with 4 calls per day from BEST plus (Bradford Enablement Support Team). Joint sessions between the PT and OT and BEST plus were completed to work on the following:

- Practising walking safely indoors using 2 walking sticks.
- Increase hip strength through exercises.
- To be safe and independent washing and dressing.
- To be safe and independent preparing hot drinks and simple snacks and transport safely using trolley.
- The above goals were achieved and new goals were set in consultation with Mr A:
- To be safe and independent walking outdoors using 2 sticks.
- To be safe and independent bathing using bath lift.
- To be safe and independent preparing hot meals from scratch.
- To be safe and independent completing shopping using Access bus.
- To be safe and independent walking dog short distances using 4 wheeled walker.

After 6 weeks of continued BEST plus input in Mr A's home, he was able to achieve all of his goals and all Social Services input was withdrawn.

3. Information and advice

This chapter provides guidance on section 4 of the Care Act 2014.

This chapter covers:

- The duty placed on local authorities to ensure the availability of information and advice services for all people in its area;
- The broad audience for the information and advice service;
- The local authority role with respect to financial information and advice;
- The accessibility and proportionality of information and advice;
- The development of plans/strategies to meet local needs.

3.1. Information and advice is fundamental to enabling people, carers and families to take control of, and make well-informed choices about, their care and support and how they fund it. Not only does information and advice help to promote people's wellbeing by increasing their ability to exercise choice and control, it is also a vital component of preventing or delaying people's need for care and support.

3.2. Local authorities **must**: *"establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers"*.

3.3. The local authority has a critical role in the provision of information and advice and **must** take an active role. The duty extends beyond the direct provision of information and advice by the local authority, though this is clearly important, to ensuring the coherence, sufficiency and availability of information and advice across the local authority area and facilitating access to it. Importantly, the duty relates to the whole population of the local authority area, not just those with care and support needs or in some other way already known to the system.

3.4. The local authority **must** ensure that information and advice services established cover more than just basic information about care and support. The service **should** also address, prevention of care and support needs, finances, health, housing, employment, what to do in cases of abuse or neglect of an adult and other areas where required. In fulfilling this duty, local authorities **should** consider the people they are communicating with on a case by case basis, and seek to actively encourage them towards the types of information and/or advice that may be particularly relevant to them.

3.5. Local authorities **must** also have regard to identifying people that contact them who may benefit from financial information and advice independent of the

local authority and actively facilitate those people to access to it (see paragraph 3.46). Additionally, local authorities **must** provide independent advocacy to facilitate the person's involvement in the care and support assessment, planning and review processes where an individual would experience substantial difficulty in understanding, retaining or using information given, or in communicating their views, wishes or feelings and where there is nobody else appropriate.

3.6. The availability and provision of information and advice, whether more general information about the way the system operates in the local authority area or more personalised information on a person's specific needs, are essential building blocks to all of the reforms and many of the specific duties the Act introduces. This chapter of guidance **should** therefore be read in conjunction with guidance throughout this document, including:

- Promoting individual wellbeing (Chapter 1).
- Prevention of needs for care and support (Chapter 2).
- Integration of care and support with health and housing related services (Chapter 15).
- Promoting diverse and high quality services (Chapter 5).
- Assessment and eligibility (Chapter 6).
- Personal budgets, personal care and support planning and direct payments (Chapters 10-13).
- Deferred payment agreements (Chapter 9).
- Continuity of care (Chapter 20).
- Safeguarding (Chapter 14).
- Transition to adult care and support (Chapter 16).
- Independent advocacy (Chapter 7).

Terminology

3.7. In this section of guidance, the term 'information' means the communication of knowledge and facts regarding care and support. 'Advice' means helping a person to identify choices and/or providing an opinion or recommendation regarding a course of action in relation to care and support.

3.8. This section of guidance also uses the term 'advocacy' to mean supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need.

3.9. This guidance talks about 'financial information and advice' which includes a broad spectrum of services whose purpose is to help people plan, prepare and pay for their care costs. In places it talks of 'independent' financial information or advice which in this document means services independent of the local authority. This guidance also refers to 'regulated' financial advice which means advice from an organisation regulated by the Financial Conduct Authority[3] (FCA) which can extend to individual recommendations about specific financial products. Local authorities should ensure that people are able to access all of these types of financial information and advice which help people plan and pay for their care.

The duty to establish and maintain a service

3.10. Local authorities **must** establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers. In doing so local authorities **should** take account of the services currently in

[3] http://www.fca.org.uk/

place and actions already taken and plans with partner organisations resulting from Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.[4] The information and advice service **must** cover the needs of all its population, not just those who are in receipt of local authority funded care or support. For example, people may often require information and advice before they need to access care or support services, to consider what actions they may take now to prevent or delay any need for care, or how they might plan to meet the cost of future care needs.

3.11. People need information and advice across many areas to support them to make informed choices about their care and support (see paragraph 3.23).

3.12. In establishing and maintaining an information and advice service, local authorities **should** ensure that they engage widely with people with care and support needs, carers, the wider public and local providers of information and advice and other types of care and support, to identify what is available and exactly what is needed locally, and how and where it should best be provided.

3.13. It is important to recognise that while local authorities **must** establish and maintain a service, it does not require they *provide* all elements of this service. Rather, under this duty local authorities are expected to understand, co-ordinate and make effective use of other statutory, voluntary and/or private sector information and advice resources available to people within their areas. This may also include provision of a service or parts of a service in conjunction with one or more local authorities, health services, children's services,[5] or reuse of information from other local or national sources. When a local need for additional information and advice services is identified, local authorities **should** consider carefully whether such a service **should** be provided by the local authority directly or by another agency, including independent providers.

The audiences for the information and advice service

3.14. Local authorities are responsible for ensuring that all adults in their area with a need for information and advice about care and support are able to access it. This is a very broad group, extending much further than people who have an immediate need for care or support. It will only be achieved through working in partnership with wider public and local advice and information providers.

3.15. People who are likely to need information and advice include, but are not restricted to:

- people wanting to plan for their future care and support needs;
- people who may develop care and support needs, or whose current care and support needs may become greater. Under the duty of prevention in Clause 2 of the Act, local authorities are expected to take action to prevent, delay and/or reduce the care and support needs for these people (see chapter 2 on prevention);
- people who have not presented to local authorities for assessment but are likely to be in need of care and support. Local authorities are expected to take steps to identify such people and encourage them

[4] https://www.gov.uk/government/publications/joint-strategic-needs-assessment-and-joint-health-and-wellbeing-strategies-explained

[5] Children and Families Act and SEN Code of Practice (to be published)

to come forward for an assessment of their needs (see chapter 2 on prevention);

- people who become known to the local authority (through referral, including self-referral), at first contact where an assessment of needs is being considered (see chapter 6 on assessments);
- people who are assessed by local authorities as currently being in need of care and support. Advice and information **must** be offered to these people irrespective of whether they have been assessed as having eligible needs which the local authority must meet (see chapter 6 on assessments);
- people whose eligible needs for care and support the local authority is currently meeting (whether the local authority is paying for some, all or none of the costs of meeting those needs) (see chapter 10 on care and support planning);
- people whose care and support or support plans are being reviewed (see chapter 13 on reviews of care and support plans);
- family members and carers of adults with care and support needs, (or those who are likely to develop care and support needs). Under Sections 2 and 20 of the Act, local authorities are expected to identify carers and take action to reduce their needs for support (see chapter 6 on assessments);
- adults who are subject to adult safeguarding concerns (see chapter 16 on safeguarding);
- people who may benefit from financial information and advice on matters concerning care and support. Local authorities must have regard to identifying these people, to help them understand the financial costs of their care and support and access independent financial information and advice including from regulated financial advisers (see paragraph 3.46).

3.16. In providing information and advice, local authorities **must** recognise and respond to the specific requirements that carers have for both general and personal information and advice. A carer's need for information and advice may be separate and distinct from information and advice for the person they are caring for. These distinct needs may be covered together, in a similar manner to the local authority combining an assessment of a person needing care and support with a carer's assessment (where both the individuals concerned agree) (see chapter 6 on assessments), but may be more appropriately addressed separately. This may include information and advice on:

- Breaks from caring
- The health and wellbeing of carers themselves
- Caring and advice on wider family relationships
- Carers' financial and legal issues
- Caring and employment
- A carer's need for advocacy

Accessibility of information and advice

3.17. The local authority **must** ensure that there is an accessible information and advice service that meets the needs of its population. Information and advice **must** be open to everyone who would benefit from it. People access information and advice from a wide variety of sources. The authority **should**

take account of information standards[6] published by the Information Standards Board for Health and Social Care under the provisions of the Health and Social Care Act 2012.

3.18. As required under the Equality Act 2010,[7] reasonable adjustments should be made to ensure that disabled people have equal access to information and advice services. Reasonable adjustments could include the provision of information in accessible formats or with communication support.

3.19. Advice and information content **should**, where possible, be provided in the manner preferred by the person and will therefore often need to be available in a number of different formats. The duty in the Care Act will not be met through the use of digital channels alone, and information and advice channels are likely to include all of the following:

- face-to-face contact;
- use of peer-to-peer contacts;
- telephone;
- mass communications, and targeted use of leaflets, posters etc. (e.g. in GP surgeries);
- use of 'free' media such as newspaper, local radio stations, social media;
- local authority's own and other appropriate internet websites, including support for the self-assessment of needs;
- third party internet content and applications;
- email.

6 For example, the developing Standard, ISB 1605, on Accessibility http://www.isb.nhs.uk/documents/isb-1605/amd-08-2013/index_html

7 https://www.gov.uk/equality-act-2010-guidance#public-sector-equality-duty

3.20. Some groups in need of information and advice about care and support may have particular requirements. Local authorities **must** ensure that their information and advice service has due regard to the needs of these people. These include, but are not limited to:

- people with sensory impairments;
- people who do not have English as a first language;
- people who are socially isolated;
- people whose disabilities limit their physical mobility;
- people with learning disabilities;
- people with mental health problems.

3.21. Some people may require an independent advocate to access or avail themselves of necessary information and advice. Any such need for advocacy to facilitate access to this universal information and advice needs to be considered in planning for delivery of the service. From the point of first contact with or referral to the authority consideration of the duty to provide for independent advocacy to support involvement in assessment, planning and reviews **should** be made (see chapter 7 on independent advocacy).

What should be provided – information and advice content

3.22. In discharging this duty, local authorities **must** ensure that information and advice is provided on:

- ***the care and support system locally*** – about how the system works. An outline of what the 'process' may entail and the judgements that may need to be made. Including specific information on what the assessment process, eligibility, and review stage is, what they involve and

when independent advocacy should be provided and be widely available. This also includes wider information and advice to support individual wellbeing (see paragraph 3.25); the charging arrangements for care and support costs (utilising current and developing national resources (see paragraphs 3.63-3.64); how a person might plan for their future care and support needs and how to pay for them, including provision for the possibility that they may not have capacity to make decisions for themselves in the future;

- ***how to access the care and support available locally*** – where/who and how to make contact, including information on how and where to request an assessment of needs, a review or to complain or appeal against a decision;[8]
- ***the choice of types of care and support, and the choice of care providers available in the local authority's area*** – including prevention and reablement services and wider services that support wellbeing. Where possible this **should** include the likely costs to the person of the care and support services available to them. This **should** also include information on different types of service or support that allow people personal control over their care and support for example, details of Independent Service Funds, and direct payments (see chapter 4 on market shaping and commissioning);
- ***how to access independent financial advice on matters relating to care and support*** – about the extent of their personal responsibilities to pay for care and support, their rights to statutory financial and other support, locally and nationally, so that they understand what care and support they are entitled to from the local authority or other statutory providers. Including what information and advice people may wish to consider when making financial decisions about care so that they can make best use of their financial resources and are able to plan for their personal costs of care whether immediately or in the future. (See paragraphs 3.34-3.45.);
- ***how to raise concerns about the safety or wellbeing of an adult with care and support needs*** (see paragraphs 3.47-3.48).

3.23. The breadth of the circumstances under which information and advice **must** be provided, and the overall duty to promote individual wellbeing, means that local authorities **must** ensure that the areas covered by their information and advice service go much further than a narrow definition of care and support. Depending on local circumstances, the service **should** therefore include, but not be limited to, information and advice on:

- available housing and housing-related support options for those with care and support needs;
- effective treatment and support for health conditions;
- availability and quality of health services;
- availability of services that may help people remain independent for longer such as handyman or maintenance services;
- availability of befriending services and other services to prevent social isolation;
- availability of intermediate care entitlements such as aids and adaptations;

[8] Link to Consultation document section on appeals

- eligibility and applying for disability benefits and other types of benefits;
- availability of employment support for disabled adults;
- children's social care services and transition;
- availability of carers' services and benefits;
- sources of independent information, advice and advocacy;
- raise awareness of the need to plan for future care costs;
- practical help with planning to meet future or current care costs.

When information should be provided

3.24. Local authorities have a number of direct opportunities to provide – or signpost to – advice and information when people in need of care and support come into contact with them. These include:

- at first point of contact with the local authority;
- as part of a needs or carer's assessment;
- during a period of reablement;
- around and following financial assessment;
- when considering a financial commitment such as a deferred payment agreement or top-up agreement;
- during or following an adult safeguarding enquiry;
- when considering take up of a personal budget and/or Direct Payment;
- during the care and support planning process;
- during the review of a person's care and support plan;
- when a person may be considering a move to another local authority area;
- at points in transition, for example when people needing care or carers under 18 become adults and the systems for support may change.

3.25. Local authorities, working with its partners **must** use the wider opportunities to provide targeted information and advice at key points in people's contact with the care and support, health and other local services. These include, but are not limited to, known 'trigger points' during a person's life such as:

- contact with other local authority services;
- bereavement;
- hospital entry and/or discharge;
- diagnosis of health conditions – such as dementia, stroke or an acquired impairment for example;
- take-up of power of attorney;
- applications to Court of Protection;
- application for disability benefits such as Attendance Allowance and Personal Independence Payments, and for Carers Allowance;
- access to work interviews;
- contact with local support groups/ charities/User Led Organisations including carers' groups and disabled person's organisations;
- contact with/use of private care and support services;
- change or loss of housing;
- contact with the criminal justice system;
- release from prison;
- retirement.

Accessibility

3.26. The local authority **should** ensure that products and materials (in all formats) are as accessible as possible for all potential users. Websites **should** meet specific standards such as the Web Content Accessibility Guidelines,[9] printed products **should** be produced to appropriate guidelines with important materials available in easy read, and telephone services should also be available to those with hearing impairments. Local authorities should particularly be aware of the needs of individuals with complex but relatively rare conditions, such as deaf-blindness.[10]

3.27. Local authorities **should** ensure that information supplied is clear.[11,12] Information and advice **should** only be judged as clear if it is understood and able to be acted upon by the individual receiving it. Local authorities will need to take steps to evaluate and ensure that information and advice is understood and able to be acted upon.

3.28. Information and advice provided within the service **should** be accurate, up-to-date and consistent with other sources of information and advice. Staff providing information and advice within a local authority and other frontline staff **should** be aware of accessibility issues and be appropriately trained.

3.29. All reasonable efforts **should** be taken to ensure that information and advice provided meets the individual's requirements, is comprehensive and is given at an early stage. Local authorities **must** seek to ensure that all relevant information is available to people for them to make the best informed decision in their particular circumstances, and omission or the withholding of information would be at odds with the duty as set out in the Act.

3.30. There are some circumstances where it is particularly important for information and advice to be impartially provided. Local authorities **should** consider when this might most effectively be provided by an independent source rather than by the local authority itself. This is particularly likely to be the case when people need advice about how and whether to question or challenge the decisions of the local authority or other statutory body.

Proportionality of information and advice

3.31. The type, extent and timing of information and advice provided **should** be appropriate to the needs of the person. More complex issues may require more intensive and more personalised information and advice, helping people to understand the choices available to them, while general enquiries may require a less intensive approach. It is also important that the right level of information and advice is provided at the right time, recognising that a person's need for information or advice may vary depending on the circumstance. For example, providing a person with too much information,

9 http://www.w3.org/TR/WCAG20/

10 Social care for deafblind adults and children LAC(DH)(2009)6 [*under review*] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/DH_101114

11 Crystal mark for plain English http://www.plainenglish.co.uk/services/crystal-mark.html

12 The information Standard – The Information Standard is a certification scheme for health and social care information. It has been established by the Department of Health to help patients and the public make informed choices about their lifestyle, their condition and their options for treatment and care. http://www.theinformationstandard.org/

more than they can take in, perhaps at a time of crisis, can be counter-productive.

3.32. To help ensure that information and advice is proportionate to the needs of those for whom it is provided, a local authority **should** enable those providing information and advice to people contacting the local authority to have access to the support of registered social work advice when it is required. This can help ensure that the potential for complexity is recognised early on and the person receives help to access non-statutory services and/or initial statutory sector support proportionate to their needs.

3.33. In providing an information and advice service, local authorities **must** be providing more than just leaflets and web-based materials. The focus should be on enabling people to access what they need through a tailored range of services that assists people to navigate all points and aspects of their journey through care and support. In doing this, local authorities **should** think about how they are reaching out and joining up with other providers of information and advice to ensure the coherence of the overall "offer" (see chapter 14 on integration and cooperation).

Financial information and advice

3.34. Financial information and advice is fundamental to enabling people to make well-informed choices about how they pay for their care. It is integral to a person's consideration of how best to meet care and support needs, immediately or in the future. People with good and impartial financial information and advice have a better understanding of how their available resources can be used more flexibly to fund a wider range of care options.

3.35. Financial information and advice is considered in a separate section due to the sometimes specialist and complex nature of what can be needed. This section should be read in the context of the overarching chapter and all requirements set out in this chapter, for example on accessibility and proportionality, **must** also be applied to financial information and advice. As set out at the start of the chapter, when this section refers to 'independent financial information and advice' it means services independent of the local authority. Where it refers to 'regulated' financial advice it means advice from an organisation regulated by the Financial Conduct Authority which can extend to individual recommendations about specific financial products.

3.36. The service that local authorities are required to establish and maintain **must** include financial information and advice on matters relevant to care. It **should** provide some of this information directly to people in its community. However, the local authority **should** have an important role in facilitating access to independent financial information and advice, where it would not be appropriate for a local authority to provide it directly. Care decisions are often made quickly and at a time of crisis, and they can often involve family and friends in the process. The local authority **must** have regard to the importance of identifying those who may benefit from independent financial advice or information as early as possible. This should be complemented by broader awareness raising about how care and support is funded. Local authorities may also include how care and support costs interact with retirement decisions. Actions taken by a local authority to do this **should** include:

- working with partners to get the right message to people in the authority's area: those who develop care and support needs, their carers, families and friends;

- working with partners to communicate messages about the benefits of financial information and advice for example with the voluntary sector, through hospitals, GPs, or even solicitors who may be advising on wills or power of attorney; and
- considering a person's need for financial information and advice when they make first contact with the authority and throughout the assessment, care and support planning and review processes.

3.37. When making financial plans about how to pay for care and support, a person needs to have confidence in what to do in the present, a view ahead to the future and a plan for what to do if/when circumstances change. This long-term outlook means that people will want to access financial information and advice at different points in their journey to enable them to make sustainable plans to pay for their care. The local authority **should** provide a service that covers this breadth and that facilitates access to the full spectrum of financial information and advice – from basic budgeting tips to regulated advice – to ensure that people within its area who would benefit can access it. They **should** also be aware and provide for the fact that some people will be less able to protect themselves from theft, fraud and financial exploitations.

3.38. The local authority service **should** include the following aspects of financial information and advice:

- understanding care charges;
- ways to pay;
- money management;
- making informed financial decisions; and
- facilitating access to independent financial information and advice.

Understanding care charges

3.39. The local authority **must** provide information to help people understand what they may have to pay, when and why and how it relates to people's individual circumstances. This **must** include the charging framework for care and support, how contributions are calculated (from both assets and income) and the means tested support available; top-ups (see chapter 8 on charging); and how care and support choices may affect costs. In the case of top-ups, local authority **should** ensure that sure someone is willing and able to pay for them – this information will be fundamental in helping with this. From April 2016, it will also need to include the capped costs system. The local authority **should** use the knowledge it has of the local care market – types of care and local providers of information and advice – to complement and develop the overarching narrative on how care funding works at the national level. This would include both domiciliary and residential care.

Ways to pay

3.40. The local authority **must** provide people with information on the availability of different ways to pay for care including through income and assets (e.g. pension or housing wealth), a deferred payment agreement (see chapter 9 on deferred payment agreements), a financial product or a combination of these things. Local authorities **should** seek to give information that would be particularly pertinent to a person's individual circumstances and facilitate access to an independent source of information or advice where relevant.

Money management

3.41. Different people will need different levels of support from the local authority and other providers of information and advice depending on their financial capability, their care needs and the amount they are expected to contribute. At the lower end of the spectrum, people may just need some basic information and support to help them rebalance their finances in light of their changing circumstances. Topics may include welfare benefits, advice on good money management, help with basic budgeting and possibly on debt management. The local authority may be able to provide some of this information itself, for example of welfare benefits, but where it cannot, it should help people access it.

Making informed financial decisions

3.42. The local authority **must** support people to make informed, affordable and sustainable financial decisions about their care throughout all stages of their life. In many situations the role of the local authority will be to understand the circumstances of the person, understand their preferences and help them to access the tailored information and advice that they need to make well-informed decisions.

3.43. The local authority **must** offer to consider a person's specific circumstances and discuss with them which methods of paying for their care may be available to them. The local authority may consider the timing and context of any retirement decisions a person might be making and how this interacts with paying for their care and support. They **should** advise people of the ways to pay that others in similar circumstances would usually consider and the range of information and advice they should be considering to help make their decision.

3.44. To help people access the information and advice they need, the local authority **should** have a clear view of the information and advice services available locally and what they provide. The local authority **should** have a role in joining up information and advice organisations locally so they can work collaboratively. The local authority **should** help providers and people to understand the role of each information and advice provider and be widely available so people can access the right provider at the right time and not be sent round in circles. Local authorities **should** provide and publicise links and information on access to wider sources of information and advice, including those available nationally.

3.45. Staff within a local authority and other frontline staff **should** have the knowledge to direct people to the financial information and advice they need. Local authorities should ensure frontline staff are able to **support** and guide people to make good financial decisions.

Facilitating access to independent financial information and advice

3.46. A key role for local authorities is to facilitate access to financial information and advice which is independent of a local authority. This should include free and fee-based advice as well as covering regulated forms of financial advice. 'Access' may include making people aware of specific sources of information and advice that are available and giving directions about how to use them. Local authorities **should** make people aware that some independent services may charge for the information and advice they provide. Local authorities should be able to actively describe the general

benefits of independent information and advice and be able to explain the benefits to an individual. Local authorities may not wish to make a direct referral to an individual independent financial adviser, but they **should** actively help and direct a person to a choice of adviser.

Information and advice on adult safeguarding

3.47. The Government expects local authorities and others to help people with care and support needs, who may be at risk of abuse or neglect as a result of those needs, keep safe. But this must not mean preventing them making their own choices and having control over their lives. Everyone in the community should understand the importance of safeguarding and help keep people safe.

3.48. The local authority **must** provide information and advice on how to raise concerns about the safety or wellbeing of an adult who has needs for care and support and **should** support public knowledge and awareness of different types of abuse and neglect, how to keep yourself physically, sexually, financially and emotionally safe, and how to support people to keep safe. The information and advice provided **should** also cover who to tell when there are concerns about abuse or neglect and what will happen when such concerns are raised, including information on how the local Safeguarding Board works.

Complaints

3.49. Current complaints provision for care and support is set out in regulations.[13] The provisions of the regulations mean that anyone who is dissatisfied with a decision made by the local authority would be able to make a complaint about that decision and have that complaint handled by the local authority. The local authority **must** make its own arrangements for dealing with complaints in accordance with the 2009 regulations. As an essential part of how the whole system operates, the local authority **must** provide information and advice on its own local arrangements for receiving and dealing with complaints and what independent support is available to people to do so.

Reviewing and developing a plan or strategy

3.50. Local differences and different starting points will mean that each local authority will need to develop and implement a plan regarding their information and advice services that matches their circumstances and meets the needs of its population. The information and advice service **should** be aligned with wider local authority strategies such as market shaping and commissioning, and with joint area strategies with health. The development of such plans **should** have regard to some common principles, including:

- involving people who use services and carers, interested organisations and service providers in determining what is needed and how it is provided;

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

- being available at the right time for people who need it, in a range of formats and through a range of channels;
- meeting the needs of all groups;
- being clear, comprehensive and impartial;
- be consistent, accurate and up-to-date;
- meeting quality standards;
- being based on a detailed analysis of the needs of the local population served by the council;
- being commissioned in tandem with other relevant support and independent advocacy services;
- avoiding reinventing the wheel/ unnecessary duplication;
- directing/signposting people to sources of further information;
- be used to inform future planning;
- ensuring appropriate quality assurance and review, including customer feedback to make sure that the service leans from experience and continuously improves.

3.51. The plan **should** build on local and national best practice and make best use of national resources. These national resources[14] include guidance on principles for local information and advice strategies, case studies and practice examples.

3.52. The local authority **must** exercise its functions under the Care Act, including the duty to provide an information and advice service, with a view to integrating care and support provision with health and health-related issues (including housing). It **must** also co-operate more generally with each of its relevant partners taking account of their respective functions (see chapter 15 on integration and cooperation).

[14] Available at: http://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/

3.53. The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012), provides that local authorities are under a duty to work with their local CCGs, and other partners through the Health and Wellbeing Board to undertake Joint Strategic Needs Assessments for their areas and to develop Joint Health and Wellbeing Strategies. Statutory Guidance[15] published in March 2013 makes clear that the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies **must** be published, and have specific regard to "what health and social care information the community needs, including how they access it and what support they may need to understand it".

3.54. The development and implementation of a wider plan or strategy on the provision of information and advice on care and support **should** be led by the local authority, acting as the coordinator and where appropriate the commissioners of information and advice services.

3.55. The development of information and advice plans and their implementation **should** be an ongoing and dynamic process, involving all relevant stakeholders, rather than a one off occurrence. The plan and the resulting service **should** adapt to changing needs and as a result of feedback and learning on what works best. The plan **should** be reviewed at agreed intervals. As a minimum, the process of developing a local plan **should** include:

- engagement with people, carers and family members, to understand what is working and not working for them, their preferences and how their information,

[15] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277012/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf

advice and advocacy needs can best be met;

- adopting a 'co-production' approach to their plan, involving user groups and people themselves, other appropriate statutory, commercial and voluntary sector service providers, and make public the plan once finalised;
- mapping to understand the range of information, advice and advocacy services, including independent financial advice and different providers available;
- coordination with other statutory bodies with an interest in care and support, including local Clinical Commissioning Groups, Health and Wellbeing Boards, local Healthwatch and neighbouring local authorities;
- building into the plan opportunities to record, measure and assess the impact of information and advice services rather than simply service outputs.

3.56. In deciding the types of information and advice services to be provided, each local authority will need to analyse and understand the specific needs of its population. Some of the factors and circumstances that local authorities **should** consider in doing this will often be identified in Joint Strategic Needs Assessments. These factors may include, but are not limited to:

- the ethnic composition of the local area, including languages used;
- the identity and nature of hard to reach groups;
- the split between those whose care and support is (or is likely to be) arranged or funded by the person and the state;
- demographic trends relating to health and care needs, age and disability;
- how people access information and advice at the moment and the quality of information and advice services;
- an appropriate balance between the needs of its local population for information and the needs people will have for access to advice;
- the current sufficiency of supply and the range of information and advice providers from different sectors (including their prospects for growth).

3.57. Local authorities **should** review and publish information about the effectiveness of the information and advice service locally, including customer satisfaction and may wish to build these into the local Joint Health and Wellbeing Strategies.

3.58. These actions will support local authorities to meet their duties for understanding and promoting the efficient and effective market of services for meeting care and support needs in its area (see chapter 4 on market shaping and commissioning).

3.59. As part of their plans, local authorities **should** consider the persons and/or places most likely to come into contact with people in need of information and advice at these and other critical points in the person's care and support journey. This may be another statutory party, such as a GP or other NHS professional, other professionals, such as a solicitor or funeral director, or a local group, user-led or charitable organisation, rather than the local authority itself. Local authorities **should** consider whether independent sources of information and advice may in some circumstances be more trusted – and therefore more effective – than the local authority itself.

3.60. In addition or instead of direct provision, local authorities **should** consider

whether it is in a person's best interests that they be signposted, directed or referred to independent sources of information and advice. In particular, people **should** be signposted to appropriate independent information and advice when they are entering into a legal agreement with a local authority or other third party, such as a deferred payment agreement or committing to a top-up, or they wish to question, challenge or appeal a decision of the local authority or other statutory body.

3.61. People often come into contact with care and support services and need to make important decisions at a time of crisis. A local authority plan **should** therefore allow for the urgent provision of information and advice when necessary. Local authorities **should** work with health organisations and other partners to provide targeted information and advice to people in these critical situations and where people have long-term health conditions such as dementia (see paragraph 3.25).

3.62. In their information and advice plan, local authorities will need to weigh up the likely demand and effectiveness of these different channels of communication, some of which will incur substantially higher costs than others. A plan that relies disproportionately on provision of information and advice through the authority's website, or third party websites, is unlikely to meet the authority's duty under the Act to provide information and advice on care and support.

3.63. Local authorities will need to consider in their information and advice planning the appropriate interface and balance between local and national sources of information and advice. Where appropriate, local authorities **should** signpost or refer people to national sources of information and advice where these are recognised as the most useful source. Examples might include:

- the NHS Choices website, which contains online quality profiles of registered care providers in local areas. Local authorities are encouraged to add local sources of information and advice to the online profiles and make sure their local registered care providers add information on the services and support they offer. http://www.nhs.uk/CarersDirect/Pages/CarersDirectHome.aspx
- the NHS Choices website. Health A to Z, detailed information on specific health conditions and how/where to access health services http://www.nhs.uk/Pages/HomePage.aspx
- Carers Direct – national telephone helpline: Tel 0300 123 1053
- Money Advice Service https://www.moneyadviceservice.org.uk/
- the Care Quality Commission website http://www.cqc.org.uk/
- the Local Government Ombudsman www.lgo.org.uk
- consumer websites providing people with information and advice, including on managing their finances well, for example http://www.which.co.uk/elderly-care
- national charities and/or advice services supporting people with disabilities or older people and those with expert knowledge of specific conditions (e.g. deaf blind). For example, http://www.alzheimers.org.uk/ and http://www.sense.org.uk/
- national charities and advice services for carers, for example http://www.carersuk.org/ or http://www.ageuk.org.uk/
- national resources related to housing, accommodation and housing related support, for example http://www.firststopcareadvice.org.uk/

3.64. Some national providers, for example the Money Advice Service and NHS choices, may also offer free access to tools, resources and information content that can be integrated into local authority websites or delivered in paper formats. Local authorities are encouraged to explore how they can make the most of cost-effective partnership opportunities with national providers. Referral or signposting to national sources **should** only occur where this is deemed to be in the best interests of the person and their circumstances and should not take the place of local services necessary for local authorities to discharge their duty under the Act. Local authorities will need to find the appropriate balance between local and national provision to cost-effectively meet their local need.

3.65. Information and advice provided, whether directly by a local authority or by third parties as part of the information and advice service that the local authority provides and maintains, **should** be of a good standard and, where appropriate, delivered by trained or suitably qualified individuals.

4. Market shaping and commissioning of adult care and support

This chapter provides guidance on section 5 of the Care Act 2014.

This chapter covers:

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

4.1. High-quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers. The role of the local authority is critical to achieving this, both through the actions it takes to directly commission services to meet needs, and the broader understanding and interactions it facilitates with the wider market, for the benefit of all local people and communities.

4.2. The Care Act places new duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways. The ambition is for local authorities to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support providers, continuously improving quality

and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support.

4.3. Local authorities **should** review the way they commission services, as this is a prime way to achieve effective market shaping and directly affects services for those whose needs are met by the local authority, including where funded wholly or partly by the state.

4.4. At a time of increasing pressure on public funds, changing patterns of needs, and increasing aspirations of citizens, together with momentum for integrated services, joint commissioning, and choice for individuals, it is suggested that fundamental changes to the way care and support services are arranged may be needed, driven through a transformation of the way services are considered and arranged. Commissioning and market shaping are key levers for local authorities in designing and facilitating a healthy market of quality services.

Definitions

4.5. **Market shaping** means the local authority collaborating closely with other relevant partners, including people with care and support needs, carers and families, to facilitate the whole market in its area for care, support and related services. This includes services arranged and paid for by the state through the authority itself, those services paid by the state through direct payments, and those services arranged and paid for by individuals from whatever sources (sometimes called 'self-funders'), and services paid for by a combination of these sources. Market shaping activity should stimulate a diverse range of appropriate high quality services (both in terms of the types, volumes and quality of services and the types of provider organisation), and ensure the market as a whole remains vibrant and sustainable.

4.6. The core activities of market shaping are to engage with stakeholders to develop understanding of supply and demand and articulate likely trends that reflect people's evolving needs and aspirations, and based on evidence, to signal to the market the types of services needed now and in the future to meet them, encourage innovation, investment and continuous improvement. It also includes working to ensure that those who purchase their own services are empowered to be effective consumers, for example by providing information and advice. A local authority's own commissioning practices are likely to have a significant influence on the market to achieve the desired outcomes, but other interventions may be needed, for example, incentivising innovation by third sector providers, possibly through grant funding.

4.7. **Commissioning** is the local authority's cyclical activity to assess the needs of its local population for care and support services that will be arranged by the authority, then designing, delivering, monitoring and evaluating those services to ensure appropriate outcomes. From the 1990s onwards care services have been increasingly procured from the independent sector (i.e. not directly provided by an authority itself) and covered all services that the authority arranged for people receiving state funding. Since 2007 when personalisation became a mainstream policy, commissioning has also covered activity to ensure that sufficient and appropriate services are available to meet the needs of growing numbers of people with personal budgets and direct payments. This has changed the commissioning role, as purchasing decisions have been increasingly devolved to individuals and families and direct procurement using block contracts has reduced. Commissioning has come to be shaped more by the outcomes commissioners

and individuals identify, rather than volumes of activity expected and commissioners have sought to facilitate flexible arrangements with providers for other forms of service to support choice and control, such as Individual Service Funds (ISFs).

4.8. **Procurement** is the specific functions carried out by the local authority to buy or acquire the services which the local authority has duties to arrange to meet people's needs who are funded by the state, to agreed quality standards so as to provide effective value for money to the public purse and deliver its commissioning strategy.

4.9. **Contracting** is the means by which that process is made legally binding. Contract management is the process that then ensures that the services continue to be delivered to the agreed quality standards. Commissioning encompasses procurement but includes the wider set of strategic activities.

4.10. This statutory guidance describes at a high level the themes and issues that local authorities should have regard to when carrying out duties to shape their local markets and commission services. Market shaping, commissioning, procurement and contracting are inter-related activities and the themes of this guidance will apply to each to a greater or lesser extent depending on the specific activity.

Principles of market-shaping and commissioning

Focusing on outcomes

4.11. Local authorities **must** ensure that the promotion of the wellbeing of individuals who need care and support, and the wellbeing of carers, and the outcomes they require, are central to all activities relating to care and support, emphasising the importance of enabling people to stay independent for as long as possible.

4.12. To meet this overarching duty when exercising market-shaping and commissioning functions, local authorities will need to understand the outcomes which matter most to people in their area, and demonstrate that these outcomes are at the heart of their local strategies and approaches.

4.13. Local authorities **should** consider the Adult Social Care Outcomes Framework (ASCOF),[16] in addition to any locally-collected information on outcomes and experiences (for example, from local consumer research), when framing outcomes for their locality and groups of people with care and support needs. Local authorities **should** have regard to guidance from the Think Local Act Personal (TLAP) partnership when framing outcomes for individuals, groups and their local population, in particular the Making It Real "I" statements, which set out what good personalised care and support should look like from the perspective of people with care and support needs, carers and family members.[17] Outcomes should be considered both in terms of outcomes for individuals and outcomes for groups of people and populations.

4.14. Local authorities **should** consider analysing and presenting local needs for services in terms of outcomes required. Local authorities **should** ensure that achieving better outcomes is central to its commissioning strategy and practices, and **should** be able to demonstrate that they are moving to contracting in a way that has an outcome basis at its heart. Local authorities **should** consider emerging best practice on outcomes-based commissioning.

16 https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014

17 http://www.thinklocalactpersonal.org.uk/

4.15. **Outcomes-based services** mean developing service arrangements that are defined on the basis of an agreed set of outcomes either for an individual or a group of people. Moving more to an outcomes-based approach therefore means changing the way services are bought: from units of provision to meet a specified need (for example, hours of care provided) to what is required to ensure specified outcomes for people are met. The approach should emphasise prevention, enablement, ways of reducing social isolation and promotion of independence as ways of achieving and exceeding desired outcomes, as well as choice in how people's needs are met. Outcomes should be used as a principal measure for quality assurance of services.

4.16. In encouraging outcomes-based services, consideration should be given to how services are paid for. Local authorities **should consider** incorporating elements of "payments-for-outcomes" mechanisms, where practical, to emphasise and embed this commissioning approach which is based on specifying the outcomes to be achieved, rather than the service outputs to be delivered.[18] Whilst payments by outcomes may be theoretically the most appropriate approach for outcomes-based services, it is recognised that proxies for outcomes may be required to make the approach practical. The design of any mechanism should, however, be introduced in cooperation with stakeholders and partners to ensure it is sustainable and ensure that innovation, and individual choice and control are not undermined. Any move to payments by outcomes should be achieved such that smaller, specialist, voluntary sector and community-based providers are not excluded from markets or disadvantaged.

4.17. Local authorities should have regard to Section 2 of the Care Act that outlines local authorities' role in preventing, reducing or delaying the need for care and support. This includes how the authority facilitates and commissions services and how it works with other local organisations to build community capital and make the most of the skills and resources already available in the area. Local authorities **should consider** working not just with traditional public sector partners like health, but also with a range of other partners to engage with communities to understand how to prevent problems from arising.[19]

Promoting quality

4.18. Local authorities **must** facilitate markets to offer continuously improving, high-quality, appropriate and innovative services, including fostering a workforce which underpins the market. The quality of services provided directly affect the wellbeing of people receiving care and support, and that of carers, and it is important to establish agreed understandable criteria and to ensure they are met.

4.19. When considering the quality of services, local authorities should be mindful of the capacity, capability, timeliness, continuity, reliability and flexibility of services delivered to support well-being, using the definitions that underpin the CQC's fundamental standards of care as a minimum, and having regard to the ASCOF framework of population outcomes. High quality services should enable people who need care and

[18] Insert link to examples of outcome-based commissioning and relevant studies on cost-effectiveness – The Commissioning Standards work should identify these – expected by October 2014.

[19] An example of local authority commissioning preventative services effectively, taken from the Leeds Market Position Statement on Leeds Community Equipment Service, Telecare and Care Ring Services, can be found at: http://www.leeds.gov.uk/docs/LeedsAdultsMPS2012.pdf

support to meet appropriate personal outcome measures.

4.20. Local authorities should also consider other relevant national standards including those that are aspirational, for example, any developed by the National Institute of Health and Care Excellence (NICE).

4.21. Local authorities **should** encourage a wide range of service provision to ensure that people have a choice of appropriate services; appropriateness is a fundamental part of quality. For example, a working age person should be able to choose care and support tailored for their situation, and not be faced with only a choice of facilities designed for older people, as this is unlikely to be appropriate to their situation, regardless of how high quality the facilities may be in their own contexts.

4.22. When arranging services themselves, local authorities **must** ensure their commissioning practices and the services delivered on their behalf comply with the requirements of the Equality Act 2010, and do not discriminate against people with protected characteristics. When shaping markets for services, local authorities **should** work to ensure compliance with this Act for services provided in their area that are not arranged and/or paid for by them.[20]

4.23. Local authorities **should** encourage services that respond to the fluctuations and changes in people's care and support needs and support the transition of services throughout the stages of their lives to ensure the services provided remain appropriate. This is particularly important, for example, for young people with care and support needs and young carers transitioning to adulthood.

For example: Ensuring provision of appropriate services

When young people move from children's to adult care and support or providing support for situations where young carers become adults. For instance, many young people with learning disabilities leave full-time education at around this age and require new forms of care and support to live independently thereafter. Ensuring that services are made available to meet those needs is better for the quality of life of the young person in question. This could include things such as job training, developing friendships or advice on housing options. It is equally important to think about ways of supporting carers at this time: some parent carers sometimes have to give up paid work after their child leaves full time education. Loss of paid employment can have a significant impact on the carer's wellbeing and self-esteem as well as a significant impact on the family's financial circumstances. Similar issues can affect young carers. Taking a whole family approach to care and support planning that sets out a "five-day offer" for a young person and support for a carer to manage an increased caring role (that ideally allows them to stay in paid work if they wish to do so) can help families manage the transition and save money by avoiding unwanted out-of-county placements.

4.24. Local authorities **should** commission services having regard to the cost-effectiveness and value for money that the services offer for public funds. The Local Government Association Adult Social Care Efficiency Programme has advice on these issues.[21]

[20] https://www.gov.uk/equality-act-2010-guidance http://www.scie.org.uk/publications/ataglance/ataglance41.asp

[21] See: http://www.local.gov.uk/productivity/-/journal_content/56/10180/3371097/ARTICLE

4.25. People working in the care sector play a central role in providing high quality services. Local authorities **must consider** how to help foster and enhance this vital workforce to underpin effective, high quality services.[22]

4.26. Local authorities **should consider**, in particular, how to encourage training and development for the care and support workforce through, for example, standards recommended by Skills for Care, and the National Skills Academy for Social Care,[23] and have regard to funding available through grants to support the training of care workers in the independent sector.[24]

4.27. When commissioning services, local authorities **should** assure themselves and have evidence that service providers deliver services through staff remunerated so as to retain an effective workforce. Remuneration should be *at least* sufficient to comply with the national minimum wage legislation for hourly pay or equivalent salary. This will include appropriate remuneration for any time spent travelling between appointments. Guidance on these issues can be found at the HMRC website.[25]

4.28. When commissioning services, local authorities **should** assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care, that will not undermine the wellbeing of people who receive care and support, or compromise the service provider's ability to meet the statutory obligations to pay at least minimum wages and provide effective training and development of staff. Local authorities should have regard to guidance on minimum fee levels necessary to provide this assurance.[26,27,28]

4.29. Local authorities **should** ensure that they themselves have functions to fulfil duties on market shaping and commissioning that are fit for purpose, with sufficient capacity and capability of trained and qualified staff to meet the requirements set out in the Care Act and this statutory guidance. In particular, local authorities should encourage relevant staff to be trained or developed to meet the National Skills Academy standards and programmes of training for care and support commissioners 'Commissioning Now', or equivalent.[29]

Supporting sustainability

4.30. Local authorities **must** work to develop markets for care and support that – whilst recognising that individual providers may exit the market from time to time – ensure the overall provision of services remains healthy in terms of the adequate provision of high

22 How to commission the adult social care workforce – North-West Joint Improvement Programme: http://ipc.brookes.ac.uk/publications/pdf/How_to_Commission_the_Adult_Social_Care_Workforce.pdf

23 http://www.skillsforcare.org.uk/Home.aspx; https://www.nsasocialcare.co.uk/

24 An example of collaborative training by Surrey, East Sussex & Brighton & Hove can be found at: http://www.eastsussex.gov.uk/nr/rdonlyres/07194ab7-15a9-44b4-9f74-91c39fa479c5/0/esccmicroproviderguidedocupdatejan2013.pdf

25 http://www.hmrc.gov.uk/payerti/payroll/pay-and-deductions/nmw.htm

26 UKHCA Minimum Price for Homecare tool: http://www.ukhca.co.uk/pdfs/AMinimumPriceforHomecareVersion1020140202.pdf

27 Laing and Buisson toolkit to understand fair price for residential care: https://www.laingbuisson.co.uk/portals/1/media_packs/Fact_Sheets/Fair_Price_ThrdEd_2008.pdf

28 ADASS paying for care calculator: http://www.adass.org.uk/Paying-for-care-calculator/

29 See https://www.nsasocialcare.co.uk/programmes/commissioning-now

quality care and support needed to meet expected needs. This will ensure that there are a range of appropriate and high quality providers and services for people to choose from.

4.31. Local authorities **should** understand the business environment of the providers offering services in their area and seek to help providers facing challenges and understand their risks. Where needed, based on expected trends, local authorities should consider encouraging service providers to adjust the extent and types of service provision. This could include signalling to the market as a whole the likely need to extend or expand services, encourage new entrants to the market in their area, or if appropriate, signal likely decrease in needs – for example, drawing attention to a possible reduction in residential care needs, and changes in demand resulting from increasing uptake of direct payments. The process of developing and articulating a Market Position Statement or equivalent should be central to this process.

4.32. Local authorities **should** consider the impact of their own activities on the market as a whole, in particular the potential impact of their commissioning decisions and where they may also be a supplier of care and support. The local authority may be the most significant purchaser of care and support in an area, and therefore its approach to commissioning will have an impact beyond those services which it contracts. Local authorities **should not** undertake any actions which may threaten the sustainability of the market as a whole – for example, setting standard fee levels below an amount which is sustainable for providers in the long-term.

4.33. Local authorities **should** have effective communications and relationships with providers in their area that should minimise risks of unexpected closures and failures, and have effective interaction and communication with the Care Quality Commission (CQC) about the larger and most difficult to replace providers that CQC will provide financial oversight for. Where it is apparent to a local authority that a provider is likely to fail financially, either through its own intelligence or through information from the CQC, the authority **must** prepare to step in to ensure continuity of care and support for people who have their care and support provided by that provider (see chapter 5 on managing provider failure).

Ensuring choice

4.34. Local authorities **must** encourage a variety of different providers and different types of services. This is important in order to facilitate an effective open market, driving quality and cost-effectiveness so as to provide genuine choice to meet the needs of local people who need care and support services.

4.35. Local authorities **must** encourage a range of different types of service provider organisations to ensure people have a genuine choice of different types of service. This will include independent private providers, third sector and voluntary and community based organisations, including user-led organisations, mutual and small businesses; recognising that the different underpinning philosophies and style of service of these organisations may be more suited to some people with care and support needs. Local authorities **should consider** supporting providers or directly intervening to promote an appropriate balance of provision between types of provider.

4.36. Where a local authority develops approved lists and frameworks that are used to limit the number of providers they work with, for example within a specific geographical

area or for a particular service type, the local authority must have regard to ensuring that a there is still a reasonable choice for people who need care and support.

4.37. Local authorities **should** encourage a genuine choice of service type, not only a selection of providers offering similar services, encouraging, for example, a variety of different living options such as shared lives and live-in domiciliary care as alternatives to residential care, and low volume and specialist services for people with less common needs.

4.38. Choice for people who need care and support and carers should be interpreted widely. Local authorities **should** encourage choice over the way services are delivered, examples would include: developing arrangements so that care can be shared between an unpaid carer or relative and a paid care worker, a choice over when a service is delivered, choice over who is a person's key care worker, arranging for providers to collaborate to ensure the right provision is available, for example, a private provider and a voluntary organisation working together, choice over when a service is delivered.[30]

4.39. Local authorities **must** have regard to ensuring a sufficiency of provision – in terms of both capacity and capability – to meet anticipated needs for all people in their area needing care and support – regardless of how they are funded. This will include regularly reviewing trends in needs – including multiple and complex needs, outcomes sought and achieved, and trends in supply, anticipating the effects and trends in prevention and community-based assets, and through understanding and encouraging changes in the supply of services and providers' business and investment decisions.

4.40. When considering the sufficiency and diversity of service provision, local authorities **should** consider all types of service that are required to provide care and support for the local authority's population, including, for example, domiciliary (home) care, residential care, nursing care, live-in care services, specialist care, support for carers, sheltered accommodation and supported living, shared lives services, community support, counselling, social work, information, advocacy and advice services, and support services and universal and community services that promote prevention. This will include keeping up to date with innovations and developments in services, networking through for example, the Association of Directors of Adult Social Services (ADASS), TLAP, and the Local Government Association (LGA) etc.

4.41. Local authorities **should** facilitate the personalisation of care and support services, encouraging services (including more traditional services as well as small, local, specialised and personal assistant services that are highly tailored), to enable people to make meaningful choices and to take control of their support arrangements, regardless of service setting or how their personal budget is managed. Personalised care and support services should be flexible so as to ensure people have choices over what they are supported with, when and how their support is provided and wherever possible, by whom. The mechanism of Individual Service Funds by service providers, which are applicable to many different service types, can help to secure these kinds of flexibilities for people and providers.[31]

[30] Shared Lives Plus/Community Catalyst guidance on commissioning for provider diversity. An example of a commissioning intervention to encourage diversity: http://sharedlivesplus.invisionzone.com/index.php?/files/file/184-commissioning-for-provider-diversity/

[31] http://www.thinklocalactpersonal.org.uk/Browse/commissioning/servicefunds/

4.42. Local authorities **should** help people who fund their own services or receive direct payments, to 'micro-commission' care and support services and/or to pool their budgets, and should ensure a supporting infrastructure is available to help with these activities.[32] Many local authorities, for example, are utilising web-based systems such as e-Marketplaces for people who are funding their own care or are receiving direct payments to be able to search for, consider and buy care and support services on-line, consider joint purchases with others, offering information and advice about, for example, the costs and quality of services and information to support safeguarding.[33] This activity should support people to become more effective consumers, helping to match people's wider needs with services.

4.43. Local authorities **must** facilitate information and advice to support people's choices for care and support.[34] This **should** include where appropriate through services to help people with care and support needs understand and access the systems and processes involved and to make effective choices. This is a key aspect of the new duty to establish and maintain a universal information and advice service locally as set out in Section 4 of the Care Act. Information and advice services should be reviewed for effectiveness using people's experiences and feedback; this feedback forms part of the overall information a
local authority considers about people's needs and aspirations.

4.44. Local authorities **should** encourage preventative, enablement and support services, including support for carers to make caring more sustainable, such as interpreters, signers and communicator guides, and other support services such as 'telecare', home maintenance and gardening that may assist people achieve more independence and supports the outcomes they want.

4.45. Local authorities **should** encourage flexible services to be developed and made available that support people who need care and support, and carers who need support, to take part in work, education or training.[35] Services **should** be encouraged that allow carers who live in one local authority area but care for someone in another local authority area to access services easily, bearing in mind guidance on ordinary residence.

Co-production with stakeholders

4.46. Local authorities **should** pursue the principle that market shaping and commissioning should be shared endeavours, with commissioners working alongside providers and people with care and support needs, carers, family members and the public to find shared and agreed solutions. This should be in line with the Building Capacity and Partnership in Care Agreement.[36]

Developing local strategies

4.47. Commissioning and market shaping should be fundamental means for local authorities to facilitate effective services in their area and it is important that authorities develop local strategies for how they exercise these functions, and align these with wider

32 http://ipc.brookes.ac.uk/publications/pdf/Safeguarding_Vulnerable_Adults_through_better_commissioning.pdf

33 http://www.hertsdirect.org/services/emarketplace/

34 http://www.pssru.ac.uk/pdf/dp2713.pdf

35 FOOTNOTE TEXT MISSING

36 http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006241

corporate planning based on evidence. Local authorities **should** have in place published strategies that include plans that show how their legislative duties, corporate plans, analysis of local needs and requirements (integrated with the Joint Strategic Needs Assessment), thorough engagement with people, carers and families, market and supply analysis, market structuring and interventions, resource allocations and procurement and contract management activities translate (now and in future) into appropriate high quality services that deliver identified outcomes for the people in their area and address any identified gaps.[37]

4.48. Since 2007 there has been a duty on local authorities and clinical commissioning groups, through health and wellbeing boards, to undertake Joint Strategic Needs Assessments (JSNA). JSNA is a process that assesses and maps the needs and demand for health and care and support, supports the development of joint Health and Wellbeing Strategies to address needs, understands community assets and informs commissioning of local health and care and support services that together with community assets meet needs. Therefore, market shaping and commissioning intentions **should** be cross-referenced to JSNA, and should be informed by an understanding of the needs and aspirations of the population and how services will adapt to meet them. Strategies **should** be informed and emphasise preventative services that encourage independence and wellbeing, delaying or preventing the need for acute interventions. Statutory guidance on JSNA and Joint Health and Wellbeing Strategies was published in March 2013.[38] The ambition is for commissioning to be an integral part of understanding and delivering the whole health and care economy.

4.49. Plans at all levels to deliver this strategy should be developed by local authorities in partnership and collaboration with stakeholders, in particular: provider organisations, people needing care and support themselves (through for example, consumer research), carers, health professionals, care and support managers and social workers (and representative organisations for these groups), independent advocates, and wider citizens to reflect the range and diversity of communities and people with specific needs. A fully co-produced approach will stress the value of meaningful engagement with people at all stages, through design, delivery and evaluation, rather than simply as 'feedback'. Local authorities **should** publish and make available their local strategies for market shaping and commissioning, to support local accountability and engagement with the provider market and the public.

4.50. It is suggested that a local authority can best commence its duties under Sections 5 (market shaping and commissioning) and 48-57 (market oversight and provider failure) of the Care Act on by developing with providers and stakeholders a published Market Position Statement.[39]

4.51. Local authorities **should** review strategies related to care and support together with stakeholders to ensure they remain fit for purpose, learn lessons, and

37 Examples of local authority strategies, development with stakeholders, links to JSNA, review processes, roles & responsibilities: http://www.hscic.gov.uk/jsna http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/Personalisation_advice/298683_Uses_of_Resources.pdf

38 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

39 http://ipc.brookes.ac.uk/dcmqc.html

adapt to incorporate emerging best practice, noting that peer review has a strong track record in driving improvement. It is suggested that reporting against strategies for care and support should form part of the local authority's Local Account.[40]

4.52. Many public sector bodies, including local authorities, have radically transformed services by reconsidering commissioning in a strategic context. The Government's Commissioning Academy[41] is working to promote such transformational approaches and local authorities should have regard to the emerging best practice it is producing.

4.53. Developing a diverse market in care and support services can boost employment and create opportunities for local economic growth, through for example, increasing employment opportunities for working-age people receiving care and carers, and developing the capacity of the care workforce. Local authorities **should** consider how their strategies related to care and support can be embedded in wider local growth strategies, for example, engaging care providers in local enterprise partnerships, as in Poole.[42]

4.54. Recognising that changes to adult care and support are taking place at a time of the need to deliver services from constrained resources, local authorities **should** have regard to best practice on efficiency and value for money, in particular the Local Government Association Adult Social Care Efficiency Programme.[43]

4.55. Local authority strategies **should** adhere to general standards, relevant laws and guidance, including the Committee of Standards in Public Life principles of accountability, regularity and ensuring value for money alongside quality,[44] and the HM Treasury guidance on Managing Public Money.

4.56. Local authorities **should** develop standards on transparency and accountability to ensure citizens are able to contribute to and understand policy and review delivery. Standards should be in line with the codes of practice drawn up by the Department of Communities and Local Government.[45]

Engaging with providers and local communities

4.57. Local authorities **should** engage with a wide range of stakeholders and citizens in order to develop effective approaches to care and support, including through developing the JSNA and a Market Position Statement or equivalent document. While the duties under section 5 of the Care Act fall upon local authorities, successful market shaping is a shared endeavour that requires a range of coordinated action by commissioners and providers, working together with the citizen at the centre. Local authorities **should** engage and cooperate with stakeholders, in particular: provider organisations, people

40 https://www.gov.uk/government/policies/making-local-councils-more-transparent-and-accountable-to-local-people

41 https://www.gov.uk/the-commissioning-academy-information

42 http://www.boroughofpoole.com/business/business-support-and-advice/locating-to-poole/dorset-local-enterprise-partnership/

43 http://www.local.gov.uk/productivity/journal_content/56/10180/3371097/ARTICLE

44 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228884/8519.pdf https://www.gov.uk/government/publications/managing-public-money

45 https://www.gov.uk/government/policies/making-local-councils-more-transparent-and-accountable-to-local-people

needing care and support themselves and their representative organisations, carers and their representative organisations, health professionals, social care managers and social workers, independent advocates, and wider citizens to reflect the range and diversity of communities and people with specific needs. Local authorities **should** arrange engagement to include hard-to-reach individuals and groups, including those who have communication issues and involving representatives of those who lack mental capacity.

4.58. Engagement with people needing care and support, people likely to need care and support, carers, independent advocates, families and friends, **should** emphasise understanding the needs of individuals and specific communities, what aspirations people have, what outcomes they would like to achieve, their views on existing services and how they would like services to be delivered in the future.[46] It **should** also seek to identify the types of support and resources or facilities available in the local community which may be relevant for meeting care and support needs, to help understand and build community capacity to reinforce the more formal, regulated provider market. In determining an approach to engagement, local authorities **should** consider methods that enable people to contribute meaningfully to:

- setting the strategic direction for market shaping and commissioning;
- engaging in planning – using methods that support people to identify the problem and the solution, rather than relying on "downstream" consultation;
- identifying outcomes and set priorities for specific services;
- setting measures of success and monitor on-going service delivery;
- playing a leading role throughout tendering and procurement processes, from developing specifications to evaluating bids and selecting preferred providers;
- contributing to reviews of services and strategies that relate to decommissioning decisions and areas for new investment.

4.59. Engagement with service providers **should** emphasise an understanding of the organisation's strategies, risks, plans, and encourage building trusting relationships and fostering improvement and innovation to better meet the needs of people in the area.

4.60. Local authorities **should** ensure that active engagement and consultation with local people is built into the development and review of their strategies for market shaping and commissioning, and is demonstrated to support local accountability (for example, via the Local Account).

4.61. Local authorities **should** exercise care in engaging with provider organisations to ensure fair play and necessary confidentiality. The Think Local Act Personal (TLAP) partnership has produced specific guidance that may assist in the process – Stronger Partnerships for Better Outcomes.[47]

4.62. Local authorities **should** make available to providers available routes to register concerns or complaints about engagement and commissioning activities.

[46] Example of engagement with people using care and support: Warwickshire transformation assembly http://www.warwickshire.gov.uk/transformationassembly

[47] http://www.thinklocalactpersonal.org.uk/_library/NMDF/StrongerPartnerships_final.pdf

Understanding the market

4.63. Local authorities **must** understand local markets and develop knowledge of current and future needs for care and support services, and understand providers' businesses.[48] This is important so that authorities can articulate likely trends in needs and signal to the market the likely future demand for different types of services for their market as a whole, and understand the local needs and business environment to support effective commissioning.

4.64. Local authorities (through an engagement process, in concert with commissioners for other services where appropriate) **should** understand and articulate the characteristics of current and future needs for services with underpinning demographics, drivers and trends, the aspirations, priorities and preferences of those who will need care and support, their families and carers, and the care and support needs of people as they progress through their lives. This **should** include an understanding of people with existing care needs drawn from assessment records, new care and support needs, those whose care and support needs will transition from young people's services to adult services, those transitioning from working-age adults to services for older people, people whose care and support needs may fluctuate, people moving to higher needs and specialised care and support, and those that will no longer need care and support. It should include information and analysis of multiple and complex conditions.

4.65. Local authorities **should** have in place robust methods to collect, analyse and extrapolate this information about care and support needs, including multiple and complex needs, and providers' intentions to deliver support, with a view over an appropriate timescale – likely to be at least 5 years into the future, with alignment to other strategic timeframes. Data collection **should** include information on the quality of services provided in order to support local authority duties to foster continuous improvement, including feedback from people who receive care, their families and carers.

4.66. Local authorities **should** include in their engagement and analysis, services and support provided by voluntary, community services and other groups that make up 'community assets' and plan strategically to encourage, make best use of and grow these essential activities to integrate them with formal care and support services.

4.67. Local authorities **should** also seek to understand trends and changes to the levels of support that come from the invaluable unpaid work of carers, and seek to develop support for and encourage carers.

4.68. The assessment of needs **should** include an understanding of people who are or are likely to be wholly or partly state funded, people who are or are likely to be self-funding, and an analysis of those self-funding people who are likely to move to state funding in the future. This will also support preparation for implementation of funding reforms from 2016/17, as such individuals will be 'metered' towards and reach the cap on care costs. It **should** also include an understanding of the likely demand for state-funded services that the local authority will need to commission directly, and state-funded services likely to be provided through direct payments and require individuals to 'micro-commission' services. Local authorities **should also** consider the extent to which people receiving services

[48] http://ipc.brookes.ac.uk/services/documents/DCMQC_MPS_example.pdf
Request for consultation: are there other examples of how to gather market information

funded by the state may wish to 'top up' their provision to receive extra services or premium services – that is, the assessment of likely demand should be for services that people are likely to need and be prepared to pay through top ups.

4.69. The assessment of needs **should** be integrated with the process of developing, refining and articulating a local authority's Joint Strategic Needs Assessment. Where appropriate, needs should be articulated on an outcomes basis.

4.70. In order to gather the necessary information to shape its market, local authorities **should** engage with providers (including the local authority itself if it directly provides services) to seek to understand and model current and future levels of service provision supply, the potential for change in supply, and opportunities for change in the types of services provided and innovation possible to deliver better quality services and greater value for money. Local authorities **should** understand the characteristics of providers' businesses, their business models, market concentration, investment plans etc. Information about both supply and expected demand for services should be made available publicly to help facilitate the market and empower communities and citizens when considering care and support.

4.71. Assessment of supply and potential demand **should** include an awareness and understanding of current and future service provision and potential demand from outside the local authority area where this is appropriate, for example in considering services to meet highly specialised and complex needs, care and support may not be available in the local authority area, but only from a small number of specialised providers in the country.

Facilitating the development of the market

4.72. Local authorities **should** collaborate with stakeholders and providers to bring together information about needs and demands for care and support together with that about future supply, to understand for their whole market the implications for service delivery. This will include understanding and signalling to the market as a whole the need for the market to change to meet expected trends in needs, adapt to enhance diversity, stability and sustainability, and consider geographic challenges for particular areas. To this picture, local authorities should add their own commissioning strategy and future likely resourcing for people receiving state-funding.

4.73. Local authorities **should** consider how to support and empower effective purchasing decisions by people who self-fund care or purchase services through direct payments, recognising that this can help deliver a more effective and responsive local market.

4.74. Local authorities **should** ensure that the market has sufficient signals, intelligence and understanding to react effectively and meet demand, a process often referred to as market structuring or signalling. Local authorities **should** publish, be transparent and engage with providers and stakeholders about the needs and supply analysis to assist this signalling. It is suggested that this is best achieved through a document like a Market Position Statement that clearly provides evidence and analysis and states the local authority's intent. A Market Position Statement or equivalent is intended to encourage a continuing dialogue between a local authority, stakeholders and providers where that dialogue and resulting enhanced understanding by all parties is an important element of signalling to the market.

4.75. A Market Position Statement or equivalent document **should** contain information on: the local authority's direction of travel and policy intent, key information and statistics on needs, demand and trends, (including for specialised services, personalisation, integration, housing, community services, information services and advocacy, and carers' services), information from consumer research and other sources about people's needs and wants, information to put the authority's needs in a national context, an indication of current and future authority resourcing, a summary of supply and demand, the authority's ambitions for quality improvements and new types of services and innovations, and details or cross-references to the local authority's own commissioning strategies and practices.

4.76. Developing and then making publicly available a Market Position Statement[49,50] is one way a local authority can meet its duties to make available information about the local market, and demonstrates activity to meet the other parts of Section 5 of the Act.

4.77. As part of developing and publishing a document like a Market Position Statement, local authorities **should** engage with stakeholders and partners to structure their markets. This could include: discussions with potential providers, actively promoting best practice and models of care and support, understanding the business planning cycles of providers, aligning interactions and supporting the provider's business planning, identifying and addressing barriers to market entry for new providers, facilitating entry to the market through advice and information, streamlining the authority's own procurement processes, promoting diversification of provider organisations, working with providers on an 'open-book accounting' approach to cost current and future services and ensure provider sustainability, supporting providers through wider local authority activity – planning, business support and regeneration.

4.78. Local authorities may consider that market structuring activity – signalling to the market and providing assistance – is not achieving the strategic aims as quickly or as effectively as needed, and may wish to consider more direct interventions in the market. Market interventions may also be planned as part of the market shaping and commissioning strategies where there is an immediate need for intervention.

4.79. Market interventions could for example include: refocusing local authority business support initiatives onto the care and support sector, exploring how local care and support projects could attract capital investments and support and what guarantees may be needed, encouraging and supporting social enterprises, micro-enterprises, Community Interest Companies, and User-Led Organisations, exploring planning barriers and using planning law, offering access to training and development opportunities.

---

49 DCMQC web pages http://ipc.brookes.ac.uk/dcmqc.html

50 Examples of MPSs and associated guidance:
https://www.n-somerset.gov.uk/Your_Council/Policies_plans_and_strategies/Documents/social%20care%20market%20position%20statement%20(pdf).pdf
http://www.bury.gov.uk/index.aspx?articleid=7890
http://www.warwickshire.gov.uk/wp-content/uploads/2011/10/Adults-MPS-FINAL-DESIGNED.pdf
http://www.telford.gov.uk/downloads/file/6164/domiciliary_care_market_position_statement
http://www.coventry.gov.uk/info/200050/help_for_adults/2120/market_position_statement_for_adult_social_care
http://www.nottinghamcity.gov.uk/article/25285/Market-Position-Statements
http://www.towerhamlets.gov.uk/lgsl/701-750/730_longer-term_support_and_pe/information_for_providers.aspx

Promoting integration with local partners

4.80. The Health and Social Care Act 2012 sets out specific obligations for the health system and its relationship with care and support services. It gives a duty to NHS England, clinical commissioning groups, Monitor and Health and Wellbeing Boards to make it easier for health and social care services to work together to improve outcomes for people. Section 3 of the Care Act places a corresponding duty on local authorities to carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services, such as housing. Local authorities **should** also consider working with appropriate partners to develop integration with services related to care and support such as housing, employment services, benefits and leisure services. Local authorities should prioritise integration activity in areas where there is evidence that effective integration of services materially improves people's wellbeing, for example, end of life care, and be in line with the priorities of the Better Care Fund, for example, reducing the length of stays in hospitals.

4.81. Local authorities should work towards providing integrated care and support, providing services that work together to provide better outcomes for individuals who need care and support and enhancing their wellbeing. Local authorities **must** have regard to guidance[51] that has been co-produced that sets out how local areas can use existing structures for integrating care and support, encouraging health and care organisations to work together to meet people's needs.

4.82. Local authorities **should** consider with partners, the enabling activities, functions and processes that may facilitate effective integrated services.[52] These will include consideration of: joint commissioning strategies, joint funding, pooled budgets, lead commissioning, and collaborative commissioning.

Securing supply in the market and assuring its quality and value for money through contracting

4.83. Local authorities **should** consider best practice on commissioning services, for example the NAO guidance[53] to ensure they deliver quality services with value for money.

4.84. Decommissioning and replacing services represents a particular challenge and should be carried out so as to maintain quality and service delivery that supports the wellbeing of people who need care and support and carers, and guards against the risk of a discontinuity of care and support for those receiving services.[54,55] For example, multiple contracts terminating around the same time may destabilise local markets if established providers lose significant business rapidly and staff do not transfer smoothly to new providers.

4.85. A local authority's own commissioning **should** be delivered through a professional

[51] https://www.gov.uk/government/publications/integrated-care

[52] Example of Bexley LA and CCG joint commissioning of preventative services: http://www.local.gov.uk/web/guest/health/-/journal_content/56/10180/4060433/ARTICLE http://www.bexley.gov.uk/CHttpHandler.ashx?id=12085&p=0

[53] http://www.nao.org.uk/successful-commissioning/

[54] http://www.nao.org.uk/decommissioning/

[55] http://ipc.brookes.ac.uk/publications/pdf/Decommissioning_and_reconfiguring_services.pdf

and effective procurement, tendering and contract management, evaluation and decommissioning process that must be focussed on providing appropriate high quality services to individuals to support their wellbeing and supporting the strategies for market shaping and commissioning, including all the themes set out in this guidance.

4.86. Local authorities **should** ensure that they understand relevant procurement legislation, and that their procurement arrangements are consistent with such legislation and best practice. Local authorities should be aware that there is significant flexibility in procurement practices to support effective engagement with provider organisations and support innovation in service delivery, potentially reducing risks and leading to cost-savings. The Office of Fair Trading has produced guidance[56] to help public purchasers understand the flexibilities so as to support service transformations through better commissioning.

4.87. Local authorities **should** ensure that their procurement and contract management systems provide direct and effective links to care service managers and social workers to ensure the outcomes of service delivery matches individual's care and support needs.

4.88. Local authorities **should** ensure that where they arrange services, the assessed needs of a person with eligible care and support needs is translated into effective, appropriate commissioned services that are adequately resourced. For example, short home-care visits of 15 minutes or less would not routinely be appropriate for people with intimate care needs, though such visits may be appropriate for services like checking whether medicine has been taken, or where specifically requested by people receiving care.

4.89. When commissioning services, local authorities **should** undertake due diligence about the effectiveness of potential providers to deliver services to agreed criteria for quality, and should assure themselves that any recent breaches of regulatory standards or relevant legislation by a potential provider have been corrected before considering them during tendering processes. For example, where a provider has previously been in breach of national minimum wage legislation, a local authority **should** consider every legal means of excluding them from the tendering process.

4.90. Contracts **should** incentivise value for money, sustainability, innovation and continuous improvement in quality and actively reward improvement and added social value. Contracts and contract management must manage and eliminate poor performance and quality by providers and recognise excellence.

4.91. Local authorities are under a duty to consider added social value when letting contracts through the Public Services (Social Value) Act 2012 and are required to consider how the services they procure, above relevant financial thresholds, might improve the economic, social and environmental well-being of the area.[57] Local authorities should consider using these duties to promote added value in care and support both when letting contracts to deliver care and support, and for wider goods and services. This should include considering whether integrated services, voluntary and community services and 'community capital' could be enhanced.

4.92. All services delivered **should** adhere to national quality standards, with procedures in place to assure quality, safeguarding,

[56] http://www.oft.gov.uk/OFTwork/competition-act-and-cartels/guidance-public-bodies/

[57] http://www.socialenterprise.org.uk/uploads/files/2012/03/public_services_act_2012_a_brief_guide_web_version_final.pdf

consider complaints and commendations, and continuing value for money, referencing the CQC standards for quality and CQC quality ratings.

4.93. Local authorities may consider delegating some forms of contracting to brokers and people who use care and support to support personal choice for people taking direct payments, with appropriate systems in place to underpin the delivery of safe, effective appropriate high quality services through such routes.[58] Local authorities should also consider providing support to people who wish to use direct payments to help them make effective decisions.

4.94. Local authority procurement and contract management activities should seek to minimise burdens on provider organisations and reduce duplications, where appropriate, using and sharing information, with for example the Care Quality Commission.

4.95. Recognising that procurement is taking place against a backdrop of significant demand on commissioners to achieve improved value for money and make efficiencies, local authorities should consider emerging practice on achieving efficiencies without undermining the quality of care.[59]

Further information/best practice

4.96. The Department of Health funded a programme in 2013/14 to support local authorities prepare for market shaping duties; further information is available at the website for the Developing Care Markets for Quality & Choice programme website.[60] The Department is also funding a project to develop commissioning standards for local authorities that will deliver guidance and standards by December 2014.

4.97. Both the Developing Care Markets programme and the commissioning standards and guidance will develop the themes presented in this statutory guidance and will themselves reference case studies of best practice and support tools that demonstrate how these themes have been introduced and delivered effectively.

58 http://www.surreycc.gov.uk/__data/assets/pdf_file/0009/278640/Factsheet-7-Brokerage-v2-Nov11.pdf

59 http://www.local.gov.uk/productivity/-/journal_content/56/10180/3371097/ARTICLE

60 http://ipc.brookes.ac.uk/dcmqc.html

5. Managing provider failure and other service interruptions

This chapter provides guidance on:

- *Sections 19 and 48 to 57 of the Care Act 2014;*
- *The Care and Support (Business Failure) (England and Wales and Northern Ireland) Regulations 2014;*
- *The Care and Support (Market Oversight Criteria) Regulations 2014;*
- *The Care and Support (Market Oversight Information) Regulations 2014.*

This chapter covers:

- Service interruptions because of business failure. This chapter explains what local authorities must do if a provider is unable to carry on because of business failure;
- Business failure involving a provider in the Care Quality Commission's (CQC) market oversight regime. This section explains CQC's role if business failure occurs and the link with local authorities;
- Business failure involving a provider not in the CQC market oversight regime. This section explains what local authorities must do if the business failure involves a provider not in the CQC regime;
- Administration and other insolvency procedures. This section explains the relationship between local authorities and persons such as an Administrator appointed in insolvency proceedings;
- Service interruptions other than business failure. This section explains local authorities' powers where a service is interrupted for other reasons;
- The link with local authorities' duties in respect of market shaping and commissioning. This section explains how local authorities' market shaping activities can play a part in effectively addressing service interruptions;
- The need for contingency planning. This section explains how local authorities should consider having contingency plans in advance to address the service interruptions that pose the greatest risk locally.

5.1. The possibility of interruptions to care and support services causes uncertainty and anxiety for the person receiving services, their carers, family and friends. This guidance explains how the Care Act makes provision to ensure that, in such circumstances, the care and support needs of those receiving the service continue to be met. It describes local authorities' powers and duties when services are at risk of interruption in general and, in particular, when the interruption is because a provider's business has failed. It provides guidance to local authorities on the exercise of those powers and the discharge of those duties.

5.2. Potential interruptions can arise from a number of different causes. An example is when a provider of services faces commercial difficulties that put the continuation of their business under threat. In 2011, Southern Cross Healthcare, then the biggest provider of residential care services in the United Kingdom, ran into financial difficulties and it was possible the business would have to close down, putting services to residents at risk. While Southern Cross was a provider of services in all parts of the country, smaller local providers can also encounter commercial issues which cause uncertainty for people receiving care and support. Local authorities have an important role in situations where a provider is unable to continue to supply services because of business failure.

5.3. There are numerous other situations that can cause care and support services to be disrupted. Some may impact on the whole business – e.g. a provider puts the business up for sale – while others impact on a particular service – e.g. a meningitis outbreak at a care home. Local authorities should use their powers to act in such cases, as set out below.

Definitions

5.4. "Business failure" is defined in the Care and Support (Business failure) (England and Wales and Northern Ireland) Regulations 2014. These Regulations define what is meant by "business failure" and explain the circumstances in which a person is to be treated as being unable to do something because of business failure. Business failure is defined by a list of different events such as the appointment of an administrator, the appointment of a receiver or an administrative receiver; or the appointment of a liquidator (the full list appears in the Regulations). Service interruption because of "business failure" relates to the whole of the regulated activity and not to parts of it.

5.5. "Temporary duty" or "duty" means the duty on local authorities to meet needs in the case of business failure. "Temporary" means the duty continues for as long as the local authority considers it necessary. The temporary duty applies regardless of whether a person is ordinarily resident in the authority's area. The duty applies from the moment the authority becomes aware of the business failure. A local authority's duty to meet needs does not extend to doing particular things – the actions to be taken will depend on the circumstances, and may range from providing information on alternate providers, to arranging care and support itself.

Service interruptions because of business failure

5.6. Local authorities are under a temporary duty to meet people's needs when a provider is unable to continue to carry on the relevant activity in question because of business failure. The duty applies when a service can no longer be provided and the reason for

that is that the provider's business has failed. If the provider's business has failed but the service continues to be provided then the duty is not triggered. This may happen in insolvency situations where an Administrator is appointed and continues to run the service.

5.7. The needs that must be met are those being met by the provider immediately before the provider became unable to carry on the activity. Local authorities **must** ensure the needs are met but how that is done is for the local authority to decide, and there is significant flexibility in determining how to do so, as set out in section 8 of the Care Act. It is not necessary to meet those needs through exactly the same combination of services that were previously supplied. However, when deciding how needs will be met, local authorities **must** involve the person concerned, any carer that the person has, or anyone whom the person asks the authority to involve (see chapter 10 on care and support planning). Where the person lacks capacity to ask the authority to do that, the local authority must involve anyone who appears to the authority to be interested in the person's welfare. Where a carer's service is involved, local authorities must involve the carer and anyone the carer asks the authority to involve. The authority must take all reasonable steps to agree how needs should be met with the person concerned.

5.8. An authority has the power, where it considers this necessary to discharge the temporary duty, to request the provider, or anyone involved in the provider's business as it thinks appropriate, to supply it with information that it wishes to have. This may involve, for example, up to date records of the individuals who are receiving services from that provider, to assist the local authority to identify those who may require its support.

5.9. The authority **should** act promptly to meet individuals' needs. The lack of a needs' or carer's assessment or a financial assessment for a person must not be a barrier to action. Neither is it necessary to complete those assessments before or whilst taking action. Similarly, authorities **must** meet needs irrespective of whether those needs would meet the eligibility criteria. All people receiving services in the local authority's area are to be treated the same. In particular, how someone pays for the costs of meeting their needs – for example, in full by the person themselves – must have no influence on whether the authority fulfils the duty. However, an authority may charge the person for the costs of meeting their needs, and it may also charge another local authority which was previously meeting those needs, if it temporarily meets the needs of a person who is not ordinarily resident in its area. The charge must cover only the cost incurred by the authority in meeting the needs. No charge must be made for the provision of information and advice to the person.

5.10. In fulfilling this function, authorities **must** follow the general duties to cooperate (see chapter 15). Where a person is not ordinarily resident in an authority's area, that authority must cooperate with the authority which was arranging for the needs to be met previously (i.e. before the provider became unable to carry on because of business failure). The duty of cooperation applies equally where the needs being met previously were paid for (in full or in part) by another authority through a direct payment to the person concerned.

5.11. Authorities that disagree on whether and/or how the law (i.e. section 48) applies in these circumstances may apply to the Secretary of State for a determination of a dispute under the procedure that applies to disputes over ordinary residence or continuity of care (see chapters 19 and 20).

5.12. All of the duties on local authorities described above apply equally if the person whose needs the authority must meet were, at the time the provider became unable to carry on because of business failure, being met under arrangements made by local authorities in Wales, Scotland or Northern Ireland under the legislation that applies in those countries. English local authorities may recover from their counterparts in Wales, Scotland and Northern Ireland the costs incurred in meeting the person's needs. If applicable, English authorities can also recover costs from the person themselves (other than the costs of needs being met or funded by the authorities mentioned above).

5.13. Disputes between authorities in England, Wales, Scotland or Northern Ireland about whether or how the temporary duty applies in cross-border situations are to be resolved under the legislation governing cross-border placements in Schedule 1 and the relevant Regulations (see chapter 22).

Business failure involving a provider in the CQC oversight regime

5.14. From April 2015, the financial "health" of certain care and support providers will become subject to monitoring by CQC. The Care and Support (Market Oversight Criteria) Regulations 2014 set out the entry criteria for a provider to fall within the regime. These are intended to be providers which, because of their size, geographic concentration or other factors, would be difficult for one or more local authorities to replace, and therefore where additional national oversight is required. CQC will determine which providers satisfy the criteria.

5.15. CQC must then assess the financial sustainability of the provider's business. If it assesses there is a significant risk to the financial sustainability of the provider's business, there are certain actions CQC may take with that provider (none of which involve local authorities).

5.16. Where CQC is satisfied that a provider in the regime is likely to become unable to continue with their activity because of business failure, it is required to tell the local authorities which it thinks will be required to carry out the temporary duty, so that they can prepare for the local consequences of the business failure. CQC's trigger to contact authorities is that it believes the whole of the regulated activity in respect of which the provider is registered is likely to fail, not parts of it. It is not required to make contact with authorities if, say, a single home owned by the provider in the regime is likely to fail because it is unprofitable and the CQC is not satisfied that this will lead to the whole of the provider's regulated activity becoming unable to continue. When and how to involve local authorities is a decision for CQC in the light of what it considers is the best course of action to maintain continuity of care for those receiving services.

5.17. Where CQC considers it necessary to do so to help a local authority to carry out the temporary duty, it may request the provider to provide it with information and CQC must then give the information, and any further relevant information it holds, to the local authorities affected.

5.18. If the CQC is of the view that a provider is likely to become unable to continue with their activity because of business failure, the CQC may work closely together with the affected local authorities to help them fulfil their temporary duty. Local authorities should consider the guidance which CQC will publish in Autumn 2014 on its operation of the market oversight function and how it will work with authorities in such situations.

Business failure involving a provider not in the CQC oversight regime

5.19. Regulations set out the entry criteria into the CQC regime. It will be for CQC to apply those regulations and decide which providers are included. There are many thousands of providers in England and only a relatively small number of providers will fall in the regime. The providers outside the regime will in the main be those with small and medium size businesses.

5.20. The temporary duty on local authorities applies regardless of whether the provider is in the market oversight regime. Despite the CQC having a market oversight responsibility, local authorities **must** ensure continuity of care in respect of business failure of all providers.

Administration and other insolvency procedures

5.21. Business failure (as defined) will usually involve an official being appointed e.g. an Administrator to oversee the insolvency proceedings. An Administrator represents the interests of the creditors of the provider that has failed and will try to rescue the company as a going concern. In these circumstances, the service will usually continue to be provided, and the exercise of local authorities' temporary duties may not be called for. It is not for local authorities to become involved in the commercial aspects of the insolvency, but they **should** cooperate with the Administrator if requested. Local authorities **should**, insofar as it does not adversely affect people's wellbeing, support efforts to maintain service provision (by, for example, not prematurely withdrawing people from the service that is affected, or ceasing commissioning arrangements).

Service interruptions other than business failure

5.22. Sections 18 and 20 of the Care Act set out when a local authority must meet a person's eligible needs. They place duties on the local authority. If the circumstances described in the sections apply and the needs are eligible, the local authority **must** meet the needs in question. These duties apply whether or not business failure is at issue. The temporary duty only applies in so far as the local authority is not already required to meet needs.

5.23. Section 19 of the Care Act covers the circumstances where care and support needs may be met, i.e. circumstances where no duties arise under section 18 but the local authority may nevertheless meet an adult's needs. In particular, section 19(3) permits a local authority to meet needs which appear to it to be urgent. This is likely to be the case in many situations where services are interrupted but business failure is not the cause. The power in section 19(3) can be exercised in order to meet urgent needs without having first conducted a needs assessment, financial assessment or eligibility criteria determination. The local authority may meet urgent needs regardless of whether the adult is ordinary resident in its area. This means the local authority can act quickly if circumstances warrant.

5.24. This section gives local authorities a power to act to meet needs, but it does not require that authorities must act. Whether or not to act is a decision for the authority itself but authorities should consider the examples which follow.

5.25. In relation to service interruption, circumstances that might lead to the exercise of the power include where the continued provision of care and support to those receiving services is in imminent jeopardy and there is no likelihood of returning to a "business as usual" situation in the immediate future, leading to urgent needs. Not all situations where a service has been interrupted or closed will merit local authority involvement because not all cases will result in adults having urgent needs. For example, if a care home closes and residents have agreed to the provider's plans to move the residents to a nearby care home that the provider also owns, local authorities will not necessarily have to become actively involved as urgent needs might not arise. On the other hand, the local authority might wish to be satisfied that the alternative home can adequately meet the urgent needs. Whether to act under this power is a judgement for the local authority to make in the first instance.

5.26. If a provider has not failed, it is primarily the provider's responsibility to meet the needs of individuals receiving care in accordance with its contractual liabilities. The local authority may wish to be involved to help with this. The power provides an ultimate backstop for use where the provider cannot or will not meet its responsibilities, and where the authority judges that the needs of individuals are urgent (and where the local authority is not already under a duty to meet the adult's needs, e.g. under section 18).

5.27. A service closure may be temporary (e.g. unforeseen absence of qualified staff) or permanent (e.g. the home is to be sold on for residential use). Similarly, an emergency closure or planned closure may be involved. What matters in deciding whether to meet needs is whether the needs of the people affected appear to be urgent.

5.28. Where the local authority does get involved in ensuring needs continue to be met, that involvement might be short-lived (e.g. the giving of advice) or enduring over some months (e.g. overseeing the movement of residents following the closure of several homes owned by the same provider). Acts of God (e.g. flooding) or complications with suppliers (e.g. a nurses agency refuses to continue to provide qualified staff) should not in themselves automatically be considered to trigger the use of the power. In all cases, the test is whether the local authority considers there is an urgent need to be met.

5.29. When considering action in relation to service interruption or closure, there is a balance to be struck. On the one hand, if local authorities know there is a serious risk to the continued provision of a service, they may consider not using that service temporarily or reassigning people using that service to an alternative service. On the other hand, it may be possible and justifiable for the local authority to act in a way that maximises the provider's chances of continuing to provide the service and avoiding a business failure. Local authorities **should** weigh the consequences of their actions before deciding how to respond, in particular, how their actions might impact on the likelihood of the service continuing.

5.30. In summary, each service interruption **should** be considered on its facts and assessed by the local authority. It is for the local authority to decide if it will act to meet a person's needs for care and support which appear to it to be urgent. In exercising this judgement the local authority **must** act lawfully, including taking decisions that are reasonable.

The link with local authorities' duties in respect of market shaping

5.31. Section 5 and the associated guidance sets out authorities' duties to promote the efficient and effective operation of the local market in care and support services (see chapter 4). Central to this function is the need to ensure that the authority has, and makes available, information about the providers of care and support services in its area and the types of services they provide. This gathering of market intelligence is equally relevant to authorities' responses to business failure and other service interruptions. Where alternative services are to be put in place, an effective response requires a thorough knowledge of the market, which providers provide which services, the quality of each provider's services and where there is spare capacity in service provision. In anticipating potential service interruptions, there is also a need to know the vulnerabilities in the operation of the market. For example, is there only one local provider of a particular service and no alternatives exist locally, or does one provider cater for a substantial part of the local market and alternative capacity could not be found easily? Service interruptions involving such providers are likely to be more difficult to address. Local authorities **should** have knowledge of market vulnerabilities such as this in order to respond effectively to service interruptions.

5.32. Local authorities **should** understand how providers in their area are coping with the current trading conditions through discussions with the providers themselves. Authorities can achieve this without the collection of detailed financial metrics, accounts and business plans that CQC might utilise in respect of the major corporate providers in the regime. The business failure of providers outside the CQC regime will be on a smaller scale, usually with lesser impact, and local authorities **should** take a proportionate approach to anticipating or getting early warning of business failure.

The need for contingency planning

5.33. Most service interruptions are on a small scale and are easily managed. But service interruptions on a large scale pose far greater problems. This was very evident in 2011 when Southern Cross Healthcare ran into financial difficulty and there was the prospect of 750 care homes, caring for 30,000 people, having to close. Southern Cross provided more than 30% of the beds in some local authority areas. A major learning point from this activity was that few local authorities could respond effectively on their own. Where Southern Cross held a market share of 30% or more, there was no prospect of finding sufficient replacement beds within the authority's boundaries. Local authorities **should** consider how they would respond to different service interruptions and, where the involvement of neighbouring authorities would be essential, ensure effective liaison and information sharing arrangements are set up in advance.

5.34. A second learning point was the need for an effective media strategy to manage the anxieties of residents, carers and families. Some authorities were uncertain whether that was Government's job, or the Care Quality Commission's, or Southern Cross's, or their own. The conclusion was that such communications are best managed locally, leaving strategic communication to Government. Local authorities **should** have the capacity to react quickly to the media consequences of service interruptions,

whether large scale or small, if uncertainty and anxiety are to be minimised.

5.35. Local authorities **should** consider how to undertake contingency planning most effectively at a local level, to ensure preparedness for possible business failures in the future. By their nature, service interruptions are often unforeseen and require rapid response. Local authorities should review which service interruptions pose the greatest risk in their locality and consider developing contingency plans in advance, in conjunction with local partners. This may also include regional activity with other local authorities in the same area, where risks are better shared between a number of neighbouring authorities.

First contact and identifying needs

6. Assessment and eligibility

This chapter provides guidance on:

- *Sections 9 to 13 of the Care Act 2014;*
- *The Care and Support (Assessment) Regulations 2014;*
- *The Care and Support (Eligibility Criteria) Regulations 2014.*

This chapter covers:

- The purpose of needs and carers' assessments; refusal of assessment; first contact; supporting the person's involvement in the assessment; taking a preventative approach and looking at a person's strengths;
- The importance of appropriate and proportionate assessment, including supporting the person through the process, enabling supported self-assessment, combining assessments and referring to NHS Continuing Healthcare where appropriate;
- Taking into account the wider picture by considering fluctuating needs and the impact on the whole family;
- The importance of having assessors appropriately trained and with the experience and knowledge necessary to carry out the assessment;
- Carrying out integrated assessment where a person has other needs, for example where the person also has health as well as care and support needs;
- The eligibility framework to ensure that there is clarity and consistency around local authority determinations on eligibility.

6.1. The assessment and eligibility process is one of the most important elements of the care and support system. The assessment is the key interaction between the local authority and an individual, whether an adult needing care or a carer. It should not just be seen as a gateway to care and support, but should be a critical intervention in its own right, which can help people to understand their situation and the needs they have, to reduce or delay the onset of greater needs, and to access support when they require it.

6.2. People will approach a local authority for an assessment, or be referred by a third party, for a number of reasons. The "assessment" which they receive must follow the core statutory obligations, but the process is flexible and can be adapted to best fit with the person's needs, wishes and goals. The nature of the assessment will not always be the same for all people, and depending on the circumstances, it could range from an initial contact which helps a person with lower needs to access support

in their local community, to a more intensive, ongoing process which requires the input of a number of professionals over a longer period of time.

6.3. The aim of the assessment is to identify what needs the adult with needs for care and support or carer may have and what outcomes they are looking to achieve to maintain or improve their wellbeing. The outcome of the assessment is to provide a full picture of the individual's needs so that a local authority can provide an appropriate response at the right time to meet the level of the person's needs. This might range from offering guidance and information to arranging for services to meet those needs. The assessment may be the only contact the local authority has with the individual at that point in time, so it is critical that the most is made of this opportunity.

6.4. The assessment and eligibility process provides a framework to identify any level of need for care and support so that local authorities can consider how to provide a proportionate response based on the individual's needs. For example, prevention and early intervention are placed at the heart of the care and support system, and even if a person has needs that are not eligible at that time, the local authority **must** consider providing information and advice or other preventative services. Local authorities **should** consider the person's own strengths or if any other support might be available in the community to meet those needs. The assessment and eligibility framework provides for ongoing engagement with the person so where they have eligible needs they are involved in the arrangements put in place to deliver the outcomes they want to achieve.

6.5. To provide a comprehensive assessment, the assessor must be appropriately trained. Registered social workers are uniquely placed to be involved in complex assessments which indicate a wide range of needs, risks and strengths that may require a co-ordinated response from a variety of statutory and community services.

Assessment

The purpose of a needs assessment

6.6. Local authorities **must** undertake an assessment for any adult who appears to have any level of needs for care and support, regardless of whether or not the local authority thinks the individual has eligible needs.

6.7. The purpose of a needs assessment is to identify the needs and outcomes that an adult wishes to achieve in their day-to-day life, whether those needs are eligible for care and support from the local authority, and how the provision of care and support may assist the adult in achieving their desired outcomes. An assessment **must** be person centred, involving the individual and any carer that the adult has, or any other person they might want involved. An adult with care needs could for example ask for their GP or a district nurse to be contacted to provide information relevant to their needs.

6.8. An assessment **must** seek to establish the total extent of needs before the local authority considers the person's eligibility for care and support and what types of care and support can help to meet those needs. This **must** include looking at the impact of the adult's needs on their wellbeing and whether meeting these needs will help the adult achieve their desired outcomes.

6.9. Wherever an individual expresses a need, or any challenges and difficulties they face because of their condition(s), the local authority **should** ensure that it has established the impact of that on the

individual's day-to-day life. The local authority must also consider whether the individual's needs impact upon their wellbeing beyond the ways identified by the individual. For example where an adult expresses a need regarding their physical condition and mobility, the local authority **must** establish the impact of this on the adult's desired outcomes; and **must** also consider whether their need(s) have further consequences on their wider wellbeing such as on their personal health or the suitability of their living accommodation.

6.10. An individual may lack capacity to request an assessment or lack capacity to express their needs. The local authority **must** in these situations carry out supported decision making, supporting the adult to be as involved as possible in the assessment, and **must** carry out a capacity assessment and take "best interests" decisions. The requirements of the Mental Capacity Act and access to an Independent Mental Capacity Advocate apply for all those who may lack capacity.[61]

6.11. During the assessment local authorities **must** consider all of the adult's care and support needs, regardless of any support being provided by a carer. Where the adult has a carer, any care that they are providing **must not** be considered until after it has been determined that the adult has eligible needs, during the care and support planning stage. The local authority is not required to meet any needs which are being met by a carer who is willing and able to do so, but it should record where that is the case. This ensures that the entirety of the adult's needs are identified and the local authority can respond appropriately if the carer feels unable or unwilling to carry out some or all of the caring they were previously providing.

6.12. Decisions about whether an adult or carer has eligible needs **should** be made after the assessment. Likewise, an assessment of the individual's financial situation **should** come after the assessment and **must not** affect the local authority's decision to carry out an assessment. Local authorities **should** inform individuals that a financial assessment will determine whether or not they pay towards their care and support, but this **must** have no bearing on the needs assessment process itself.

The purpose of a carer's assessment

6.13. Where an individual provides or intends to provide care for another adult, local authorities **must** consider whether to carry out a carer's assessment if it appears that the carer may have any level of needs for support. Where an adult provides care under contract or as part of voluntary work, they **should not** normally be regarded as a carer. There may be circumstances where the adult providing care, either under contract or through voluntary work, is also providing care for the adult outside of that. In such a circumstance, the local authority **may** consider whether to carry out a carer's assessment for that part of the care they are not providing on a contractual or voluntary basis.

6.14. Carers' assessments **must** seek to establish not only the carer's needs for support, but the sustainability of the caring role itself, which includes both practical and emotional support the carer provides to the adult. Therefore where the local authority is carrying out a carer's assessment it **must** include in its assessment a consideration of the carer's potential future needs for care

[61] https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice http://www.legislation.gov.uk/ukpga/2005/9/contents

and support. Factored into this **must** be a consideration of whether the carer is currently able, and whether the carer will continue to be able to care for the adult needing care. The consideration of sustainability **must** also involve a consideration of whether the carer is willing, and likely to continue to be willing, to provide care. This will allow local authorities to make a realistic evaluation of the carer's present and future needs for support and whether the caring relationship is sustainable. Where appropriate these views may be sought in a separate conversation independent from the adult's needs assessment.

6.15. The carer's assessment **must** also consider the carer's activities beyond their caring responsibilities, and the impact of caring upon those activities. This includes considering the impact of caring responsibilities on a carer's desire and ability to work, to partake in education, training or recreational activities, such as having time to themselves. This impact **should** be considered in both a short-term immediate sense but also the impact of caring responsibilities over a longer term cumulative sense.

Refusal of assessment

6.16. An adult with possible care and support needs or a carer may choose to refuse to have an assessment. The person may choose not to have an assessment because they do not feel that they need care or they may not want local authority support. In such circumstances local authorities are not required to carry out an assessment. However, where the local authority identifies that an adult lacks mental capacity and that carrying out a needs assessment would be in the adult's best interests, the local authority is required to do so. The same applies where the local authorities identifies that an adult is experiencing, or is at risk of experiencing, any abuse or neglect.

6.17. In instances where an individual has refused a needs or carers assessment but at a later time requests that an assessment is carried out, the local authority **must** do so. Additionally, where an individual previously refused an assessment and the local authority establishes that the adult or carer's needs or circumstances have changed, the local authority **must** consider whether it is required to offer an assessment, unless the person continues to refuse.

First contact with the authority

6.18. From their very first contact with the local authority, an adult with an appearance of need for care and support – or a carer with an appearance of need for support – **should** be given as much information as possible about the assessment process, prior to assessment wherever practicable. Local authorities **must** ensure that this information is in an accessible format for those to whom it is provided. This **should** include detail of what can be expected during the assessment process and allow them to be as involved in the process as possible. From this early stage local authorities **should** consider whether the individual would have substantial difficulty in being involved in the assessment process and if so consider the need for independent advocacy.

6.19. Getting the initial response right can save time and costs on assessment later. Some local authorities have found that putting in place a single access point for all new requests and people currently receiving care can speed up and simplify the process for people approaching the authority; and can also free up time for professional staff to focus on more complex cases.

6.20. Local authorities **should** not, however, remove people from the process too early. Early or targeted interventions such as universal services, a period of reablement and providing equipment or minor household adaptions can delay an adult's needs from progressing. The first contact with the authority, which triggers the requirement to assess, may lead to a pause in the assessment process to allow such interventions to take place and for any benefit to the adult to be determined. Local authorities **must** ensure that their staff are sufficiently trained and equipped to make the appropriate judgements needed to steer individuals seeking support towards either preventative services or a more detailed care and support assessment. They must also be able to identify a person who may lack mental capacity and to act accordingly.

6.21. Where an individual with urgent needs approaches or is referred to the local authority, the local authority **should** provide an immediate response and meet the individual's care and support needs. For example, where an individual's condition deteriorates rapidly, they will need a fast-track response to ensure their needs are met. Following this initial response, the individual **should** be informed that a more detailed needs assessment, and any subsequent processes, will follow. Once the local authority has ensured these urgent needs are met, it can then consider details such as the person's ordinary residence and finances. The Care Act contains powers for local authorities to meet needs urgently without having first carried out an assessment, where that is necessary.[62]

6.22. Staff who are involved in this first contact should have the benefit of access to professional support from social workers or occupational therapists as appropriate, to support the identification of any underlying conditions or that complex needs are identified early and that people are signposted appropriately.

6.23. Local authorities **must** ensure that every adult with an appearance of care and support needs, and every carer with an appearance of need for support, receives a proportionate assessment which identifies their level of needs. In cases where an individual's needs are easily recognisable an assessment **may** be carried out over the phone or online. However, local authorities **should** be aware of the risks attached with such an approach. For example, where assessments are carried out by telephone, local authorities should ensure that staff have training and experience in recognising issues around mental capacity and further underlying needs. Where an individual may lack capacity – for example those with early dementia, learning disabilities or mental health needs – a face-to-face assessment **must** be arranged. Local authorities have a duty of care to carry out an assessment in a way that enables them to recognise the needs of those who may not be able to put these into words.

6.24. An assessment **should** be carried out over an appropriate and reasonable timescale taking into account the urgency of needs and a consideration of any fluctuation in those needs. Local authorities **should** inform the individual of an indicative timescale over which their assessment will be conducted and keep the person informed throughout the assessment process.

Safeguarding

6.25. When carrying out an assessment local authorities may identify that the person is at risk of abuse or neglect. Where they suspect that the person is at risk they must carry

[62] See section 19 of the Care Act which provides powers to meet urgent needs.

out an enquiry to consider if the person is experiencing abuse or neglect and decide what action is necessary (see Chapter 14). The action taken should reflect the risk to the person and is not subject to the national eligibility criteria. This enquiry should not disrupt the assessment of the person's care and support needs and the determination of whether those needs are eligible for care and support.

Supporting the person's involvement in the assessment

6.26. Putting the person at the heart of the assessment process is crucial to understanding the person's needs and outcomes, and delivering better care and support. The local authority **must** involve the person being assessed in the process. In the case of an adult with care and support needs, the local authority **must** also involve any carer the person has (which may be more than one carer), and in all cases, the authority **must** also involve any other person requested. The local authority **should** have processes in place, and suitably trained staff, to ensure the involvement of these parties, so that their perspective and experience supports a better understanding of the needs and circumstances.

6.27. At the point of first contact, request or referral (including self-referral), local authorities **should** recognise the importance of whether an individual is able to be involved in their assessment and local authorities **must** therefore consider whether the individual has substantial difficulty in doing so. Local authorities **must** consider whether the adult would experience substantial difficulty in any of these four areas: understanding the information provided; retaining the information; using or weighing up the information as part of the process of being involved; and communicating the person's views, wishes or feelings. Where a person has substantial difficulty in any of these four areas, then they need assistance.

6.28. If they do have significant difficulty, the local authority **must** find someone appropriate and independent to support and represent the person, for the purpose of facilitating their involvement. This **should** be done as early as possible in the assessment process so that the individual can be supported throughout the process. Individuals may require help to understand information provided, assistance in weighing up the information, and support in communicating their wishes and preferences. Where there is a family member or friend who is willing and able to facilitate the person's involvement effectively, and who is acceptable to the individual and deemed appropriate by the local authority, they may be asked to support the individual in the assessment process. Where there is no one thought to be appropriate for this role – either because there is no family member or friend willing and available, or if the individual does not want them to be a part of the assessment – the local authority **must** appoint an independent advocate.

6.29. Where the local authority identifies that an adult is unable to effectively engage in the assessment process independently, it **should** seek to involve somebody who can assist the adult in engaging with the process and helping them to articulate their preferred outcomes and needs. Some people with mental impairments will nevertheless have capacity to engage in the assessment alongside the local authority. They may require assistance whereby the local authority provides an assessment, tailored to their circumstances, their needs and their ability to engage. These people with capacity **should** be supported in understanding the

assessment process and assisted to make decisions wherever possible.

6.30. Where a person has a mental impairment such as dementia, acquired brain injury or learning disabilities, the local authority **must** consider whether the person **should** have an assessment of capacity and **should** be assisted under the Mental Capacity Act. They may need extra support to identify their needs and make any subsequent decisions. The more serious the needs, the more support people may need to identify their impact and the consequences. Professional qualified staff, such as social workers, can advise and support assessors when they are carrying out an assessment with a person who may lack capacity.

Focusing on preventing needs

6.31. The assessment and eligibility framework should be a key element of any prevention strategies authorities put in place. It is during the assessment where local authorities can identify needs that could be reduced, or where escalation could be delayed, and help people improve their wellbeing by providing specific preventive services, or information and advice on other universal services available locally. Early interventions can prevent or delay a person's needs from progressing.

6.32. Local authorities **should** consider the benefits of approaches which delay or prevent the development of needs in individuals who would otherwise require care and support in the future. This could include signposting people to universal services such as community support groups which ensure that people feel supported, including an ability to participate in their local community. Local authorities **may** also seek to promote access to appropriate employment which can be an effective way of maintaining independence. Such interventions at an early stage will help to sustain the independence and wellbeing of people. More detail is available in chapter 2 on prevention and chapter 3 on information and advice.

Considering the person's strengths and capabilities

6.33. At the same time as carrying out the assessment, the local authority **must** consider what else other than the provision of care and support that might assist the

Considering a person's strengths and capabilities: case study

Sally is 40 and has a physical disability. She can manage her personal care needs but spends a lot of time alone at home and has never worked. Sally's sister refers her for a needs assessment because she fears that Sally is in danger of isolation and depression.

The assessor asks Sally what outcomes she is looking for in day-to-day life and Sally says she would like to work but has never had the confidence to do so. They discuss what she would feel comfortable doing; the assessor finds out that Sally has an understanding of basic accounting from managing her own finances. She might well be an asset to a local shop looking for help.

The assessor puts Sally in touch with a local charity shop that is short-staffed, and asks a neighbour if they would be happy assisting her in getting to work each morning.

person in meeting the outcomes they want to achieve. In considering what else might help, authorities **should** consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help. Any suggestion that support could be available from family and friends should be considered in light of their willingness and ability to provide any additional support and the impact on them of doing so.

Appropriate and proportionate assessments

6.34. The assessment **must** be person-centred throughout. Local authorities **must** find out whether the person being assessed wishes to co-produce the assessment and **should** as far as is practicable do so, as the person is the expert on their own condition(s).

6.35. An assessment **should** be a collaborative process and it is therefore essential that the process is transparent and understandable so that the individual is able to:

- develop an understanding of the assessment process;
- develop an understanding of the implications of the assessment process on their condition(s) and situation;
- understand their own needs and outcomes they want to achieve to allow them to engage effectively with the assessment process;
- start to identify the options that are available to them to meet those outcomes and to support their independence and wellbeing;
- understand the basis on which decisions are reached.

6.36. To support co-production, the local authority **should** establish the individual's communication needs and seek to adapt the assessment process accordingly. In doing so local authorities **must** provide information about the assessment process in an accessible format.

6.37. To help the adult with needs for care and support, or the carer, prepare for the assessment the local authority **should** provide in advance, and in accessible format, the list of questions to be covered in the assessment. This will help the individual or carer prepare for their assessment and think through what their needs are and the outcomes they want to achieve.

6.38. Some people being assessed may have severe communication needs, such as people who are deafblind. Such individuals may require the support of a specialist interpreter to help them to communicate and engage in the assessment.

6.39. Local authorities **should** also consider the impact of the assessment process itself on the individual's condition(s). People may feel uncertain and worried about what an assessment involves and may find the process itself to be strenuous. Local authorities **should** therefore give consideration to the preferences of the individual with regards to the timing, location and medium of the assessment.

6.40. The assessment **should** be designed to reflect the wishes of the person being assessed, taking into account their presenting need and their circumstances. An assessment process which benefits an individual in one instance may not necessarily be as effective for another. Local authorities **should** recognise this and in order to maintain a person centred approach, local authorities **must** ensure that assessments are flexible to each individual case.

6.41. In carrying out a proportionate assessment local authorities **must** have regard to;

- the person's wishes and preferences and desired outcomes. For example, an individual who pays for their own care may wish to receive local authority support with accessing a particular service, but may not want the same interaction with the authority as someone who wants greater support;
- the severity and overall extent of the person's needs. For example, an individual with more complex needs will require a more detailed assessment, potentially involving a number of professionals. A person with lower needs may require a less intensive response;
- the potential fluctuation of a person's needs. For example, where the local authority is aware that an adult's needs fluctuate over time, the assessment carried out at a particular moment may take into account the adult's history to get a complete picture of the person's needs.

6.42. Each local authority **may** decide to use an assessment tool to help collect information about the adult or carer and details of their wishes and feeling and their desired outcomes and needs. Where a local authority has decided that a person does not need a more detailed assessment, it **should** consider which elements of the assessment tool it **should** use and which are not necessary. When carrying out a proportionate assessment the assessor **should** continue to look for the appearance of further needs which may be the result of an underlying condition. Where the assessor believes that the person's presenting needs may be as a result of or a part of wider needs then the local authority **should** undertake a more detailed assessment and refer the person to other services such as housing or the NHS if necessary.

Whole-family approach

6.43. The intention of the whole family approach is for local authorities to take a holistic view of the person's needs, in the context of their wider support network. The approach **must** consider both how the adult or their support network or the wider community can contribute towards meeting the outcomes they want to achieve (see above), and whether or how the adult's needs for care and support impacts on family members or others in their support network.

6.44. During the assessment the local authority **must** consider the impact of the person's needs for care and support on family members or other people the authority may feel appropriate. This will require the authority to identify anyone who may be part of the person's wider network of care and support.

6.45. In considering the impact of the person's needs on those around them, the local authority **must** consider whether or not the provision of any information and advice would be beneficial to those people they have identified. For example, this **may** include signposting to any support services in the local community.

6.46. The local authority **must** also identify any children who are involved in providing care. The authority may become aware that the child is carrying out a caring role through the assessment or informed through family members or a school. Identification of a young carer in the family **should** result in an offer of a needs assessment for the adult requiring care and support and, where appropriate, the local authority **must** consider whether to undertake a young carer's assessment or a child's assessment.

6.47. When carrying out an adult's or carer's assessment, if it appears that a child is involved in providing care the local authority **must** consider:

- the impact of the person's needs on the young carer's wellbeing, welfare, education and development;
- whether any of the caring responsibilities the young carer is undertaking are inappropriate.

6.48. An adult's needs assessment **should** take into account the parenting responsibilities of the adult as well as the impact of the adult's needs for care and support on the young carer. Local authorities **should** consider how supporting the adult with needs for care and support can prevent the young carer from undertaking excessive or inappropriate care and support responsibilities. A young carer becomes vulnerable when their caring role risks impacting upon their emotional or physical wellbeing and their prospects in education and life. This might include:

- preventing the young carer from accessing education, for example because the adults needs for care and support result in the young carer's regular absence from school or impacts upon their learning;
- preventing the young carer from building relationships and friendships;
- impacting upon any other aspect of the young carer's wellbeing.

6.49. Inappropriate caring responsibilities **should** be considered as anything which is likely to have an impact on the child's health, wellbeing or education, or which can be considered unsuitable in light of the child's circumstances and may include:

- personal care such as bathing and toileting;
- carrying out strenuous physical tasks such as lifting;
- administering medication;
- maintaining the family budget;
- emotional support to the adult.

6.50. The local authority **must** consider whether the child or young carer **should** be referred for a young carer's assessment or a needs assessment under the Children Act 1989,[63] or a young carer's assessment under section 63 of the Care Act. Local authorities **should** ensure that protocols are in place for such referrals and that adult and children's social care services work together to ensure the assessment is effective.

Supported self-assessment

6.51. Local authorities can offer individuals a supported self-assessment. The local authority **must** offer the individual the choice of a supported self-assessment if the adult or carer is able and willing to undertake it. If the adult with an appearance of needs for care and support does not wish to self-assess, then the local authority **must** offer an assessment following the processes outlined above.

6.52. A supported self-assessment is an assessment carried out jointly by the adult with care and support needs or carer and the local authority. It places the individual in control of the assessment process to a point where they themselves complete their assessment. The person **should** be asked to complete the same assessment

[63] https://www.gov.uk/government/publications/children-act-1989-transition-to-adulthood-for-care-leavers http://www.legislation.gov.uk/ukpga/1989/41/contents.

questionnaire that the authority uses in their needs or carers assessments.

6.53. Before offering a supported self-assessment local authorities must ensure that the individual has capacity to fully assess and reflect their own needs. Local authorities **must** establish the individual's mental capacity in accordance with the Mental Capacity Act 2005.[64]

6.54. Where local authorities have established that the adult has capacity to undertake a self-assessment but experiences substantial difficulty in understanding, retaining and using the relevant information in relation to their self-assessment, they may wish to involve their carer or any other member of their family or support network in their self-assessment. Where the adult does not have the support required from a carer or family member the local authority must provide an independent advocate to assist them in their self-assessment.

6.55. The local authority **must** assure itself that the person's self-assessment is an accurate and complete reflection of their needs. When assuring itself that a self-assessment is comprehensive a local authority **should not** look to repeat the full assessment process again. In assuring self-assessments local authorities **may** consider it useful to seek the views of those who are in regular contact with the person self-assessing, such as their carer(s), any professional involved in providing care, a GP, a treating clinician, or a district nurse. This **may** be helpful in allowing local authorities to build an understanding of the individual's needs.

6.56. When a person who would otherwise receive a specialist assessment (for example, someone who is deafblind) chooses to undertake a self-assessment, the local authority **must** involve a person who has specific training and expertise when assuring that the person's assessment taken as a whole reflects the overall needs of the individual concerned.

6.57. Local authorities **should** ensure that self-assessments are completed in suitable time periods. If there is a delay in the person returning the self-assessment form the authority **should** assure itself that this is not because the person's condition(s) have deteriorated and is unable to complete the self-assessment.

6.58. Where the local authority is satisfied that the individual's self-assessment has accurately captured their needs the local authority **must** come to a view on the person's eligibility for care and support, and where appropriate this **may** include taking into account the person's own view.

6.59. Although the local authority and the individual are working jointly to ascertain needs and eligibility, the final decision regarding eligibility will rest with the local authority. In all cases, the authority **must** inform the person of their eligibility judgement and why the local authority has reached the eligibility determination that it has. It **must** also discuss what needs are eligible and discuss how these might be met. Where the authority determines that the person does not have any eligible needs it **must** provide advice and information on what services are available in the community that can support the person in meeting the needs that are not eligible.

Fluctuating needs

6.60. As the condition(s) of the individual on the day of the assessment may not be entirely indicative of their needs more generally, local authorities **should** consider whether the individual's current level of need

[64] http://www.legislation.gov.uk/ukpga/2005/9/contents.

is likely to fluctuate and what their on-going needs for care and support are likely to be. In establishing the on-going level of need local authorities **must** consider the person's care and support history over a suitable period of time, both the frequency and degree of fluctuation. The local authority may also take into account at this point what fluctuations in need can be reasonably expected based on experience of others with a similar condition. It is important to recognise the benefit of adopting this comprehensive approach to assessment as the consideration of an individual's wider wellbeing may allow local authorities to provide types of care and support, or information and advice which delay or prevent the development of further needs in the future.

6.61. The assessment **should** also include a consideration of the individual's wider care and health needs. This may include types of care and support the individual has received in the past and their general medical history, which may be indicative of their current care and support needs.

Integrated assessments

6.62. Adults and carers may require services from different professionals such as adult care and support, children's services, housing, health or mental health professionals. All of the agencies involved **should** work closely together to prevent that person having to undergo a number of assessments at different times, which can be distressing and confusing.

6.63. Where a person has both health and care and support needs, local authorities and the NHS **should** work together effectively to deliver a high quality, coordinated assessment. To achieve this, local authorities should:

- ensure healthcare professionals' views and expertise are taken into account when assessing the care and support services people require; and,
- work with healthcare professionals to ensure people's health and care services are aligned and set out in a single care and support plan, in particular where people are enrolled on the Proactive Care Programme, which was introduced through the Avoiding Unplanned Emergency Admissions Enhanced Service in the 2014/15 GP Contract.[65]

6.64. Where an assessment involves a body from outside of the local authority, the local authority **should** provide any resources or facilities which may be required to carry out the assessment. Sharing resources may include the provision of facilities or relative information relating to the person being assessed.

Combining assessments

6.65. Local authorities **may** combine an assessment of an adult needing care and support with a carer's assessment and an assessment relating to a child (including a young carer) where both the individual and carer agree, and the consent condition is met in relation to the child. It will also avoid the authority from carrying out two separate assessments. If either of the individuals concerned do not agree to a combined assessment, then these **must** be carried out separately.

6.66. The local authority **may** carry out the care and support assessment jointly with any other assessment that the individual or carer

[65] http://www.nhsemployers.org/~/media/Employers/Publications/ PCC/GMS/ Avoiding 20unplanned20 admissions20guidance 20201415.pdf

is having with another body, where the adult or carer agrees. The local authority can also undertake the other assessment on behalf of the other body, where this is agreed.

NHS Continuing Healthcare

6.67. Where it appears that a person may be eligible for NHS Continuing Healthcare (NHS CHC), local authorities **must** notify the relevant body. NHS CHC is a package of on-going care that is arrange and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (November 2012) (Revised).[66] Such care is provided to individuals aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. Eligibility for NHS CHC places no limits on the settings in which the package of support can be offered or on the type of service delivery.

6.68. Whilst local authorities have a duty to carry out an assessment of needs where a person has an appearance of needs and a duty to meet eligible needs, local authorities cannot arrange services that are the responsibility of the NHS (e.g. care provided by registered nurses and services that the NHS has to provide because the individual is eligible for NHS CHC). However, the local authority may provide or arrange healthcare services where they are simply incidental or ancillary to doing something else to meet needs for care and support.

6.69. Individuals may require care and support provided by their local authority and/or services arranged by Clinical Commissioning Groups (CCGs). Local authorities and CCGs therefore have a responsibility to ensure that the assessment of eligibility for care and support and CHC respectively take place in a timely and consistent manner. If a person does not qualify for NHS CHC, the NHS may still have a responsibility to contribute to that person's health needs – either by directly commissioning services or by part-funding the package of support. Where a package of support is commissioned or funded by both an LA and a CCG, this is known as a 'joint package' of care. A joint package of care could include NHS-funded nursing care and other NHS services that are beyond the powers of a local authority to meet. The joint package could also involve the CCG and the local authority both contributing to the cost of the care package, or the CCG commissioning part of the package. Joint packages of care may be provided in a nursing or residential care home, or in a person's own home, and could be by way of joint personal budget.

6.70. Local authorities and CCGs in each local area **must** agree a local disputes resolution process to resolve cases where there is a dispute between them about eligibility for NHS CHC, about the apportionment of funding in joint funded care and support packages, or about the operation of refunds guidance. Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be provided pending resolution of the dispute. Where disputes relate to local authorities and CCGs in different geographical areas, the disputes resolution process of the responsible CCG should normally be used in order to ensure resolution in a robust and timely manner. This should include agreement on how funding will be provided during the dispute, and arrangements for reimbursement to the agencies involved once the dispute is resolved.

66 https://www.gov.uk/government/uploads/system/uploads/attachment_data/ file/213137/National-Framework -for-NHS-CHC-NHS-FNC-Nov- 2012.pdf

Record-keeping

6.71. Following their assessments individuals **must** be given a record of their needs or carer's assessment, including the views of the individual. A copy **must** also be shared with anybody else that the individual requests the local authority to share a copy with. Where an independent advocate is involved in supporting the individual, the local authority **should** keep the advocate informed so that they can support the person to understand the outcome of the assessment and its implications.

Roles and responsibilities for assessment

6.72. Assessments can be carried out by a range of professionals including registered social workers, occupational therapists, rehabilitation officers and those with relevant NVQs. Registered social workers and occupational therapists are considered to be two of the key professions in adult care and support. Local authorities **should** consider how adults who need care, carers, and assessors have access to registered social care practitioners, such as social workers or occupational therapists.

Training and expertise

6.73. It is essential that the assessment is carried out to the highest quality. The assessment **must**: identify the person's needs and outcomes; consider the person's strengths and capabilities; and consider what universal services might help the person improve their wellbeing. Local authorities must ensure that their staff have the required skills, knowledge and competence to undertake assessments and that this is maintained.

6.74. Local authorities **must** ensure assessors have received suitable and up to date training to carry out assessments. They must also have the skills and knowledge to carry out the assessment of the specific condition(s) that they are being asked to assess, for example when assessing an individual who has autism, learning disabilities, mental health problems or dementia. This training **must** be maintained throughout their career. As part of maintaining their registration, social workers and occupational therapists are required to evidence their Continuing Professional Development.

6.75. Some people who have particularly complex needs will require the support of an expert to carry out their assessment, to ensure that their needs are fully captured. Local authorities **should** consider whether additional relevant expertise is required on a case-by-case basis, taking into account the nature of the needs of the individual, and the skills of those carrying out the assessment.

6.76. Where the assessor does not have the knowledge in carrying out an assessment for a specific condition, they **must** consult someone who has experience of the condition. This is to ensure that the assessor can identify any underlying conditions and ask the right questions relating to the condition and interpret these appropriately. A person with relevant expertise can be considered as somebody who, either through training or experience, has acquired knowledge or skill of the particular condition. Such a person may be a doctor or health professional, but there is no obligation for the local authority to source an expert from an outside body if the expertise is available in house.

Assessment for people who are deafblind

6.77. Local authorities **must** ensure that an expert is involved in the assessment of adults who are deafblind. People are regarded as deafblind "if their combined sight and hearing impairment causes difficulties with communication, access to information and mobility. This includes people with a progressive sight and hearing loss" (Think Dual Sensory, Department of Health, 1995).

6.78. During an assessment the appearance of both sensory impairments, even if when taken separately each sensory impairment appears relatively mild, **must** trigger a specialist assessment. This specialist assessment **must** be carried out by an assessor or team that has specific training and expertise relating to individuals who are deafblind. Training and expertise **should** in particular include; communication, one-to-one human contact, social interaction and emotional wellbeing, support with mobility, assistive technology and rehabilitation. Local authorities should also recognise that deafblindness is a dual sensory condition which requires a knowledge and understanding of the two respective conditions in unison, which cannot be replicated by taking an individual approach to both senses.

6.79. The combined loss of sight and hearing can have significant impact upon the individual even where they are not profoundly deaf and totally blind, as it is the impact of one impairment upon the other which causes difficulties. Deafblindness can have significant impact on the adult's independence and their ability to achieve their desired outcomes. In particular deafblindness may have impact upon the adults:

- autonomy and ability to maintain choice and control;
- health and safety and daily routine;
- involvement in education, work, family and social life.

6.80. Local authorities **should** recognise that adults may not define themselves as deafblind. Instead they may describe their vision and hearing loss in terms which indicate that they have significant difficulty in their day-to-day lives. The assessment **should** therefore take the initiative to establish maximum possible communication with the adult to ensure that individuals are as fully engaged as possible and have the opportunity to express their wishes and desired outcomes. Whilst the person carrying out the assessment **must** have the suitable training and expertise, it may not be possible for them to carry out the assessment without an interpreter, for instance where the adult uses sign language. Therefore, where necessary a qualified interpreter with training appropriate for the deafblind adult's communication **should** be used. A trained interpreter may be able to draw more out from the assessment by framing questions in a particular manner allowing the adult to engage more effectively. It is not normally appropriate to use a family member or carer as an interpreter and this **should** be done only where there is no other option; for instance where the adult's communication is idiosyncratic or personal to them and would therefore be understood, only, by those close to them.

6.81. The assessment **should** take into account both the current and future needs of the person being assessed, particularly where the adult's deafblindness is at risk of deteriorating. In such cases the adult may benefit from learning alternative forms of communication before their condition has deteriorated to a point where their current or preferred form of communication is no longer suitable.

National eligibility criteria

6.82. The national eligibility criteria introduce a minimum threshold establishing what level of needs must be met by local authorities. All local authorities **must** comply with this national threshold. Authorities can also decide to meet needs that are not deemed to be eligible if they chose to do so.

6.83. The introduction of a national eligibility threshold will provide people with more clarity on what level of need is eligible. Local authorities **must** provide a written record of their determination about a person's eligibility and the reasons for coming to their decision. This will provide transparency on how and why decisions were made.

6.84. Where local authorities have determined that a person has any eligible needs, they **must** meet these needs, subject to meeting the financial criteria (see chapter 8: charging and financial assessment) and provided that the person meets the ordinary residence requirement (see chapter 19: ordinary residence), and the person agrees to the authority meeting their needs.

6.85. During the assessment local authorities **must** consider whether the person would benefit from some type of preventive service or intervention, or other service available locally, for example reablement services. When doing so, the local authority **may** decide to pause the process of the assessment to provide the adult with reablement or some other type of preventative service or intervention. This will mean that the determination of eligibility would be similarly paused until after the anticipated outcome of the preventive service is expected to be realised. Following this period of reablement, it may be possible that all of the adult's needs may have improved to the extent that they do not meet the national eligibility criteria. In such circumstances local authorities have addressed the adult's needs and are not required to arrange ongoing services, because there are no eligible needs at that time. They **should** however, keep a record in case the adult's condition deteriorates over time, or other circumstances change. Where the adult still has needs which meet the eligibility criteria after any period of reablement, the local authority must meet them as usual.

Interpreting the eligibility criteria

6.86. The eligibility threshold for adults with care and support needs and carers is set out in the Care and Support (Eligibility Criteria) Regulations 2014. The threshold is based on identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing.

6.87. In considering whether a person's needs are eligible for care and support, local authorities must consider whether:

(a) **The adult's needs are due to a physical or mental impairment or illness**. This includes conditions such as physical, mental, sensory, learning or cognitive disabilities or illnesses and brain injuries.

(b) **The effect of the adult's needs is that the adult is unable to achieve one or more of the following outcomes:**

- to carry out some of the following basic care activities, which are activities that the person carries out as part of normal daily life, such as eating and drinking, maintaining personal hygiene, toileting, getting up and dressed, getting around the home, preparing meals, and cleaning and maintaining of one's home. This is not an exhaustive list and local authorities

may consider other comparable care activities;

- to maintain their family or other significant personal relationships. This should focus on how needs impact on the ability to maintain those relationships (as part of the individual's support networks), which if were not maintained would have a significant impact on the adult's wellbeing;
- to access and engage in work, training, education or volunteering;
- to access necessary facilities or services in the local community including recreational facilities or services; or
- to carry out any caring responsibilities the adult has for a child.

When considering if an adult is "unable" to achieve these outcomes, local authorities must also be aware that the regulations provide that "being unable" to do so includes any of the following circumstances, where the adult:

- is unable to achieve the outcome without assistance. This would include where an adult would be unable to do so even when assistance is provided;
- is able to achieve the outcome without assistance but doing so causes the adult significant pain, distress or anxiety. For example, an elderly person with severe arthritis may be able to prepare a meal, but this leaves them in severe pain and unable to eat the meal;
- is able to achieve the outcome without assistance, but doing so endangers or is likely to endanger the health or safety of the adult, or of others. For example, if the health or safety of another member of the family, including any child could be endangered when an adult attempts to complete a task or an activity without relevant support;
- is able to achieve the outcome without assistance but takes significantly longer than would normally be expected. For example, a young adult with a physical disability is able to dress themselves in the morning, but it takes them a long time to do this and exhausted and taking the remainder of the morning to recover.

(c) **Finally, local authorities must consider whether, as a consequence of the person being unable to achieve one of the outcomes above there is, or is likely to be, a significant impact on the adult's wellbeing**. To do this, local authorities should consider how the adult's needs impact on the areas of wellbeing which are set out in Section 1 of the Care Act (see chapter 1). Local authorities should determine whether:

- the adult's needs impact on an area of wellbeing in a significant way; or,
- the cumulative effect of the impact on a number of the areas of wellbeing mean that they have a significant impact on the adult's overall wellbeing.

In making this judgement, the local authority should look to understand the adult's needs in the context of what is important to him or her. The impact of a given need may be different for different individuals, because what is important for the individual's wellbeing may be different. Circumstances which create a significant impact on the wellbeing of one individual may not have the same effect on another.

6.88. An adult's needs are only eligible where they meet all three of these conditions. In considering the type of needs an adult may have, the local authority **should** note that there is no hierarchy of needs or of the constituent parts of wellbeing as described

in chapter 1 of this guidance. The following case studies provide examples of how local authorities may judge whether there is a significant impact on the adult's wellbeing.

6.89. Where a person has fluctuating needs, local authorities **must** look at the adult's needs over a sufficient period of time to get a complete picture of those needs. This will

Case study 1: John Taylor

John is 32 and has been referred by his mother for an assessment, who is concerned for John and his future. John's mother is getting to an age where she has to face the possibility that she might not be able to carry out the same amount of work for her son that she has done so far. John lives with his mother, and she does all the housework for both of them. It is important to John that he is intellectually stimulated and that there are no or as few interruptions to his daily routines as possible. John also likes socialising. John would like to gain access to get employment that is a better match for his intellectual abilities. John is very good with numbers, but in his current job, he does not make the most of his skills. He attends a chess club once a week. John has no issues with personal care and is able to do household chores.

Category	Needs	Impact on Wellbeing	Decision
Adult on the autistic spectrum.	John struggles severely in social situations leading to difficulties accessing work and cooperating with other people. He only has transactional exchanges with others and avoids eye contact. John knows that others feel uneasy around him and spends a lot of his time alone.	John is not in ideal employment, but John has access to and is engaged in work and has access to a social life through his chess club. It emerges from conversations with John that he has access to those personal relationships that he considers essential. John is contributing to society, has contact with others, is in employment and is able to look after himself.	**Not Eligible** John has difficulties doing some of the things that many other people would think should be a natural part of daily living. Those aspects of his wellbeing that are affected by his shortcomings are not so significantly affected that John's overall wellbeing is at risk. The local authority decides that John's needs are not eligible, because they do not have a significant effect on his wellbeing despite his mother's concerns. **Next Action:** John's local authority should note that John's mother could well be the person who really needs support in this case. John's local authority is very proactive and contacts John's mother to suggest she consider having a carer's assessment.

allow them to take into consideration where an adult's needs fluctuate.

6.90. Individuals with fluctuating needs may have needs which are not apparent at the time of the assessment, but may have arisen in the past and are likely to arise again in the future. Therefore local authorities **must** consider an individual's need over an appropriate period of time to ensure that all of their needs have been accounted for and taken into account when eligibility is being determined. Where fluctuating needs are apparent, this **should** also be factored into the care planning process that details the

Case study 2: John Taylor

John is 32 and has been referred by his mother for an assessment, who is concerned for John and his future. John's mother is getting to an age where she has to face the possibility that she might not be able to carry out the same amount of work for her son that she has done so far. John lives with his mother, and she does all the housework for both of them. It is important to John that he is intellectually stimulated and that there are no or as few interruptions to his daily routines as possible. John also likes socialising. John would like to gain access to get employment that is a better match for his intellectual abilities. John is very good with numbers, but in his current job, he does not make the most of his skills. He attends a chess club once a week. John has no issues with personal care and is able to do household chores.

Category	Needs	Impact on Wellbeing	Decision
Adult on the autistic spectrum.	John has severe difficulties socialising leading to difficulties accessing work and cooperating with other people. He only has transactional exchanges with others and cannot make/maintain eye contact. John knows that others feel uneasy around him and spends a lot of his time alone.	John feels lonely almost all of the time and does not know what to do about it. Not knowing how to read others facial expressions and other communication problems means that John has not been able to get through job interviews.	**Eligible** John's local authority thinks John's needs are eligible. As a result of his communication problems, John says he feels lonely almost always and other aspects of his wellbeing appear to be significantly affected by his communication problems. **Next Action:** John's local authority thinks the most effective way of assisting John is to make sure he gets connected with an autism social group where he can practice his conversational skills. John's local authority should note that John's mother could well need support too. John's local authority is very proactive and contacts John's mother to let her know to consider having a carer's assessment.

steps the local authority will take to meet circumstances where needs fluctuate. For example, if an adult has had a mental health problem in the past and over the past 8 months this has been managed but that due to a specific issue in their life their condition starts to deteriorate, the local authority **must** consider their needs over the previous year to get a complete picture of their needs.

6.91. The eligibility determination **must** be made without consideration of whether the adult has a carer, or what needs may be being met by a carer at that time. The determination **must** be based solely on the adult's needs and if an adult does have a carer, the care they are providing will be taken into account when considering whether the needs must be met. Local authorities are not required to meet any eligible needs which are being met by a carer, but those needs should be recognised and recorded as eligible during the assessment process. This is to ensure that should there be a breakdown in the caring relationship, the needs are already identified as eligible, and therefore the local authority must take steps to meet them without a further assessment.

Carers' eligibility

6.92. Carers can be eligible for support in their own right. Carers' eligibility does not depend on whether the adult for whom they care has eligible needs.

6.93. There are two ways by which carers can be eligible for support. The first is in order to help them to maintain their caring role. The second is if their caring is having a significant impact on their wellbeing and is having an adverse effect on their lives. These two forms of carers' eligibility are explained below.

6.94. In considering a carer's eligibility for support to help them maintain their caring role, local authorities **must** consider if the carer is unable, or requires support to provide some of the necessary care to the adult needing care. In considering whether a carer is unable to carry out their caring role, local authorities **must** also take into account that this also applies if the carer:

- requires assistance to complete any task in relation to the provision of care;
- is able to provide the care without assistance but doing so:
    - causes or is likely to cause either the carer or the adult needing care significant pain, distress or anxiety; or
    - endangers or is likely to endanger the health or safety of the carer or the adult needing care.

6.95. When determining a carer's eligibility for support, authorities **must** consider if their caring role is having a significant impact on the carer's wellbeing in the following circumstances:

- the carer's physical or mental health is, or is at risk of deteriorating; or
- the carer is unable to achieve any of the following outcomes—
    - to carry out some or all basic household activities in the carer's home (whether or not this is also the home of the adult needing care). This would include household activities a carer carries out as a part of normal life such as preparing meals, and cleaning and maintenance of the their home;
    - to carry out any caring responsibilities the carer has for a child;
    - to provide care to other persons for whom the carer provides care;
    - to maintain family or other significant personal relationships;

- to engage in work, training, education or volunteering;
- to make use of necessary facilities or services in the local community; or
- to engage in recreational activities.

6.96. Local authorities **must** also consider a carer's support needs over a sufficient period of time to get a complete picture of any fluctuating needs. This could be because at specific times where they need more support than at others. For example, if they share responsibility for looking after their children with a former spouse, they may need more support in their caring role when they are also the primary care-giver to their children. The carer's support needs could also fluctuate based on the adult receiving care needs. For example, if the adult's needs fluctuate he or she might need additional care at different times of the year and this **must** be taken into consideration when determining the carer's eligibility.

Case study 3: Sarah Taylor, John's mother & carer

John's assessment revealed that his mother is coping a lot less well than her son. Sarah is 69 and is starting to think about how she is going to manage with John when she is older and will be less able to do as much for John as she does currently.

Caring for	Need	Impact	Result
Autistic son, whose needs are not eligible.	Sarah is very concerned for the welfare of her son because he spends so much time alone. John has a very rigid schedule, which Sarah complies with. She also does all of the housework. The chores and John's schedule affect every day of her life.	The responsibilities Sarah has taken upon herself mean she has very little capacity to live her own life. Sarah has good friends that have known her for a long time and that offer her good support, but she has not got the time to see them. As a result, Sarah does not get to talk to the people that care about her, and this makes her feel very alone and insecure.	**Eligible** Sarah is eligible because caring causes her a great deal of stress, anxiety and sacrifice in her own life. The root cause of her distress is a combination of all the work she does for her son and the worry about their future. Many other people deal similar adversity by talking to and spending time with friends and family. Sarah does not have the opportunity to help herself in this way without support from the council. **Next Action:** Sarah's local authority thinks that everyone will be better off if Sarah is connected with autism support groups, where she can get emotional support from people who are qualified for that and where she can learn how to develop new routines with John so Sarah does not have to do all the chores. The assessor talked to Sarah about who was at the chess club and between them they worked out that they could get a lift rota going that would mean Sarah only had to drop him off once a month so Sarah can have Thursday evenings to herself when John is at the chess club. By having a file on Sarah, the local authority can keep an eye on how her needs develop, which could have adverse effects on John.

Meeting needs that are not eligible

6.97. Local authorities can decide to meet needs that do not meet the eligibility criteria. Where they decide to do this, the same steps **must** be taken as would be if the person did have eligible needs (for example, the preparation of a care and support plan). Where local authorities choose to exercise this power to meet other needs, they must inform the person that they are doing so.

6.98. There may be cases where an adult has eligible needs that are being met by a carer, and also has other needs that are not considered eligible but the carer is unable or unwilling to meet these. In such circumstances local authorities **should** consider what preventative services or information and advice might delay the ineligible needs deteriorating.

Informing the individual of their eligibility determination

6.99. It is important to maintain the transparency of the assessment and eligibility process after the eligibility determination has been made. Therefore, having assessed the individual's needs and determined whether any of their needs meet the eligibility criteria, the local authority must produce a written record of their determination and the reasons for it, for the individual concerned or their advocate, if they have one.

6.100. Where the local authority has determined that the person has needs but which are not eligible, it **must** provide information and advice on what support might be available in the wider community or what preventative measures that might be taken to prevent or delay the condition progressing. Authorities can also discuss with the adult what they can do themselves or what support might be available from the adult's wider support network to help achieve their outcomes.

6.101. Where the local authority has determined that the individual has some eligible needs, it **must** consider what can be done to meet those needs and carry out a financial assessment if it proposes to make a charge for meeting those needs. Local authorities **should** also give consideration to whether needs which are not eligible can be met by any services in the community or through information and advice. Where the local authority determines that none of the adult's needs are eligible, it **must** provide them with written information and advice about what could be done to meet or reduce their needs, or to delay or prevent the development of further needs. For example, this may involve directing the person (or "signposting") to available services in the local community which are specific to their needs.

6.102. The local authority **must** also establish whether the individual wants to have their eligible needs met by the local authority. If the individual wishes to arrange their own care and support, the authority does not have to meet those needs. Local authorities must also establish whether the individual is ordinarily resident in the local authority area (or, in the case of a carer, that the adult for whom they care is ordinarily resident in the area). Where the local authority finds that the individual's ordinary residence is within another local authority, it **should** continue to meet their needs but **must** also refer their case to the local authority of their ordinary residence (see chapter 10 on care and support planning and 11 on personal budgets.

Appeals/complaints

6.103. It is important that individuals have confidence in the assessment process and the wider care and support system. Therefore

any individual should be able to make a complaint and challenge decisions where they believe a wrong decision has been made in their case. Current complaints provision for care and support is set out in regulations.[67] The provisions of the regulations mean that anyone who is dissatisfied with a decision made by the local authority would be able to make a complaint about that decision and have that complaint handled by the local authority. The local authority must make its own arrangements for dealing with complaints in accordance with the 2009 Regulations. As an essential part of how the whole system operates in its own area, the local authority must provide information and advice on its own local arrangements for receiving and dealing with complaints.

Further information

6.104. The Brain Injury Rehabilitation Trust has created a Brain Injury Needs Indicator to support local authorities in carrying out assessments for people with brain injuries. It provides information on how to evidence brain injury and will reflect the information local authorities require in assessing a person with a brain injury: www.birt.co.uk/bini

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

7. Independent advocacy

This chapter provides guidance on:

- *Sections 67 and 68 of the Care Act 2014;*
- *The Care and Support (Independent Advocacy) Regulations 2014.*

This chapter covers:

- Local authorities' responsibilities to provide independent advocacy;
- Matters which a local authority must consider in deciding whether an individual would experience substantial difficulty in engaging with care and support 'process';
- Circumstances in which an advocate must be provided;
- The role of the advocate and how independent advocates are to carry out their functions.

7.1. The purpose of this section of guidance is to ensure that local authorities fully understand their duties in relation to the provision of independent advocacy and to assist them in carrying out these duties effectively.

7.2. This duty applies to all adults, as part of their own assessment and care planning and care reviews, as well as to those in their role as carers. It also applies to children who are approaching the transition to adult care and support, when a child's needs assessment is carried out, and when a young carer's assessment is undertaken.

7.3. Local authorities **must** arrange an independent advocate to facilitate the involvement of a person in their assessment, in the preparation of their care and support plan and in the review of their care plan, if two conditions are met. The aim is to provide assistance; first, to people who have **substantial difficulty** in being fully involved in these processes and second, **where there is no one appropriate available to support** and represent the person's wishes. The role of the independent advocate is to support and represent the person, and to facilitate their involvement in the key processes and interactions with the local authority.

7.4. Everyone should have access to information and advice on care and support.[68] Prior to making contact with the local authority, there may be some people who require independent advocacy to access that information and advice. Local authorities will need to consider such needs in ensuring that the information and advice service is accessible. Subsequently, once a person

[68] See guidance on information and advice in chapter 3.

has contacted the local authority, they **must** be actively involved in identifying their needs through assessment, in developing their care and support plan, and in leading their care reviews, where relevant. The aim of the duty to provide advocacy is to enable people who have substantial difficulty in being involved in these processes to be supported in that involvement as fully as possible, and where necessary to be represented by an advocate who speaks on their behalf. The ultimate aim is for people's wishes, feelings and needs to be at the heart of the assessment, care planning and review processes.

Advocacy and the duty to involve

7.5. Local authorities **must** involve people in decisions made about them and their care and support. Involvement requires the local authority helping people to understand how they can be involved, how they can contribute and take part and sometimes lead or direct the process. People should be active partners in the key care and support processes of assessment, care and support planning and review. No matter how complex a person's needs, local authorities are required to involve people, to help them express their wishes and feelings, to support them to weigh up options, and to make their own decisions.

7.6. The duty to involve applies in all settings, including for those people living in the community, in care homes or in prisons, for example.

7.7. Local authorities **must** form a judgement about whether a person has substantial difficulty in being involved with these processes. If it is thought that they do, and that there is no person who would be appropriate to support and represent them, then the local authority **must** arrange for an independent advocate to support and represent the person.

7.8. Many of the people who qualify for advocacy under the Care Act will also qualify for advocacy under the Mental Capacity Act 2005. The same advocate can provide support as an advocate under the Care Act as under the Mental Capacity Act. This is to enable the person to receive seamless advocacy and not to have to repeat their story to different advocates.

Judging 'substantial difficulty' in being involved

7.9. Local authorities **must** consider for each person, whether they would have substantial difficulty in engaging with the local authority care and support processes. The Care Act defines four areas where a substantial difficulty might be found, which are set out below.

Understanding relevant information

7.10. The first area to consider is *'understanding relevant information'*. Many people can be supported to understand relevant information, if it is presented appropriately and if time is taken to explain it. Some people, however, will not be able to understand relevant information, for example if they have advanced dementia.

Retaining information

7.11. The second area to consider is *'retaining information'*. If a person is unable to retain information long enough to be able to weigh up options and make decisions, then they are likely to have substantial difficulty in engaging.

Using or weighing the information as part of engaging

7.12. The third area is *'using or weighing the information as part of engaging.'* A person must be able to weigh up information, in order to participate fully and express preferences for or choose between options. For example, they need to be able to weigh up the advantages and disadvantages of moving into a care home. If they are unable to do this, they will have substantial difficulty in engaging.

Communicating their views, wishes and feelings

7.13. The fourth area involves *'communicating their views, wishes and feelings'*. A person must be able to communicate their views, wishes and feelings to aid the decision process and to make priorities clear. If they are unable to do this, they will have substantial difficulty in engaging.

7.14. For example, a person with advanced dementia, significant learning disabilities, a brain injury or mental ill health may be considered to have substantial difficulty in communicating their views, wishes and feelings. But equally a person with Asperger's may be so considered, as may a frail older person who does not have a diagnosis but is confused as a result of an infection, or a person who is near the end of their life and appears disengaged from involvement and decision-making.

7.15. Both the Care Act and the Mental Capacity Act recognise the same areas of difficulty, and both require a person with these difficulties to be supported and represented, either by family or friends, or by an advocate in order to communicate their views, wishes and feelings.

Case study

Stephen sustained a brain injury in a fall as a result of a seizure. He has completed six months in an intensive residential rehabilitation setting; the next step is a local authority assessment for community discharge.

The social worker is aware that Stephen has little family support and asks him if he would like the support of an independent advocate. He declines and during the assessment Stephen reports that he is fine, has made a good recovery and is ready to return home. He sounds plausible, can engage well in conversation and looks physically fine. The social worker agrees a gradual discharge with extended periods at home.

On his first return to the service Stephen is clearly malnourished, his mood is low and his body odour is over-powering. This self-neglect, malnutrition and dehydration also seems to have increased the frequency of his epileptic seizures and he has had several in short succession. The social worker telephones Stephen's treating clinician who confirms that Stephen is unable to acknowledge the effect his brain injury has had on his current ability to live independently; hence why he declined the support of an advocate.

The social worker carries out a second needs assessment, employing the support of an independent advocate with brain injury training following a 'best interests decision' as once again Stephen declines the need for support during the assessment. A care package for Stephen to re-learn the skills of daily living and personal hygiene as well as assistance to reintegrate into the community with support workers trained in brain injury is agreed. This will then be reviewed with Stephen and his advocate in a further eight weeks.

When the duty to provide independent advocacy applies

Assessment of needs

7.16. From the point of first contact, request or referral (including self-referral) for an assessment, the local authority must involve the person. They must initially consider the best way of involving the person in the assessment processes, which is proportionate to the person's needs and circumstances. In some cases this may be relatively brief, in others it may consist of a series of interviews, in the person's own home, over a period of time.

7.17. At the start of the assessment process, if it appears to the local authority that a person has care and support needs, and throughout any subsequent part of the process, the local authority must judge whether a person has *substantial difficulty in involvement* with the assessment, the care and support planning or review processes. The identification of a potential need for advocacy may arise through the process, from the person themselves, carers or family. Where an authority has outsourced or commissioned all or some of this process, the authority will maintain overall responsibility for this judgement.

7.18. Where the local authority considers that a person has substantial difficulty in engaging with the assessment process, then they must consider whether *there is anyone appropriate who can help the person be fully involved*. This might for example be a family member or friend. If there is no one appropriate, then the local authority must arrange for an independent advocate. The advocate must support and represent the person in the assessment, in the care and support planning, and the review. This applies to the following:

- a needs assessment under section 9 of the Care Act;
- a carer's assessment under section 10;
- the preparation of a care and support plan or support plan under section 25;
- a review of care and support plan or support plan under section 27;
- a child's needs assessment under section 60;
- a child's carer's assessment under section 62;
- a young carer's assessment under section 65.

7.19. As part of the assessment and the care and support plan, the local authority must have regard to the need to help protect people from abuse and neglect. They should assist the person to identify any risks and ways to manage them. They should also assist the person to decide how much risk they can manage. The local authority must also have regard to ensuring that any restriction on the person's rights or freedom of action is kept to the minimum necessary. Restrictions should be carefully considered and frequently reviewed. Any potential deprivation of liberty must be authorised, either by a Deprivation of Liberty Authorisation by the local authority or the Court of Protection under the Deprivation of Liberty Safeguards in the Mental Capacity Act.

Continuity of care and ordinary residence

7.20. The local authority which is carrying out the assessment or review of the person is responsible for considering whether an

advocate is required. In the case of a person who is receiving care and support from one local authority and decides to move and live in another authority, the responsibility will be with the authority the person is moving to as their ordinary residence will be in the new authority.[69] For a person whose care and support is being provided out of area (in a type of accommodation set out in the section on Ordinary Residence (see chapter 19)) it will be the authority in which the person is ordinarily resident. Understanding of local communities may be an important consideration, so the advocacy/advocate should wherever possible be from the area where the person is resident at the time of the assessment, care plan etc.

Consequences for local authorities

The local authority **should** have local policies to clarify the appointing of advocates:

- from advocacy services out of their area that they may not have a direct commissioning relationship with (as it currently is with Independent Mental Capacity Advocacy (IMCA));
- for people placed out of area temporarily;
- for people who move from one area to another following an assessment and care and support planning in which an advocate is involved (the same advocate **should** be involved wherever practicable).

Reviews

7.21. The local authority **must** involve the person, their carer and any other individual that the person wants to be involved in any review of their care and support plan, and take all reasonable steps to agree any changes.[70]

7.22. Local authorities **must consider** whether an advocate is required to facilitate the person's involvement in the review of a care and support plan and, if appropriate, appoint an advocate. This applies regardless of whether an advocate was involved at an earlier stage. For example because:

- The person's ability to be involved in the process without an advocate has changed.
- The circumstances have changed (e.g. the person's involvement was previously facilitated by a relative who is no longer able to perform that role).
- An advocate should have been involved at the care and support planning stage and was not.
- The requirement to involve an advocate at the care and support planning stage did not exist at that time.

Judgements made by the local authority

An appropriate individual to facilitate the person's involvement

7.23. Local authorities **must consider** whether there is an appropriate individual (or individuals) who can facilitate a person's involvement in the assessment, planning or review processes, and this includes three specific considerations.

7.24. First, it cannot be someone who is already providing the person with care or treatment in a professional capacity or on a paid basis (regardless of who employs or

69 See chapter 20 on Continuity of Care

70 See chapter 13 on Reviews

pays for them). That means it cannot be, for example, a GP, or a nurse, a key worker or care and support worker.

Case study

If a person receives support to live in their own home from a domiciliary care worker who has known them for many years, it would be good practice to seek that care worker's views if the individual wishes this to happen – and this is a requirement which flows from the Mental Capacity Act. The care worker's involvement would not displace the local authority's duty to provide an independent advocate in the right circumstances. It would be the role of the advocate rather than the care worker to represent and support the individual for the purpose of facilitating the individual's involvement.

7.25. Second, the person who is to be supported must agree to the particular individual supporting them, if the person has the capacity to make this decision. Where a person does not wish to be supported by a relative, for example, perhaps because they wish to be moving towards independence from their family, then the local authority cannot consider the relative appropriate. The person's wish not to be supported by that individual should be respected regardless of whether the person is assessed to have or lack capacity. The person **must** agree to the appropriateness of the individual who is proposed to support them. If the person lacks the capacity to make a decision, then the local authority **must** be satisfied that it is in a person's best interests to be supported and represented by the individual.

Case study

If the person already has an advocate, who is acting outside of the requirements of the Care Act, who is able and willing to facilitate their involvement in the assessment, planning, and review processes then they may be an appropriate person/facilitator to support the individual's involvement and represent them.

7.26. Third, the appropriate individual is expected to support and represent the person and to facilitate their involvement in the processes. It is unlikely that some people will be able to fulfil this role easily, for instance a family member who lives at a distance and who only has occasional contact with the person, a spouse who also finds it difficult to understand the local authority processes, a friend who expresses strong opinions of her own prior to finding out those of the individual concerned, or a housebound elderly parent. It is not sufficient to know the person well or to love them deeply; the role of the advocate is to support the person's active *involvement with the local authority processes*.[71]

Case study

Jacinta is 26 and lives with her mother and father. She has 2 siblings aged 28 and 23 who have left the family home. Jacinta would also like to move to living more independently. Jacinta has moderate learning disabilities and finds it hard to retain information. Jacinta's parents are very worried that she won't be able to cope living in her own home and are against her doing so. In these circumstances Jacinta's parents would not be 'an appropriate person' who could effectively represent and support her interests.

[71] [link para (9) of V4 Assessment Chapter]

Case Study

Brian is 84 and has advanced dementia. He lives alone in the house he owns. Brian has very limited mobility, has frequent falls and has difficulty in remembering to take medication and to eat. Brian says he feels very lonely. Social services are already providing some domiciliary care for which Brian is charged. The local authority is reviewing Brian's care plan. Brian's daughter and son in law who will inherit the house say he can cope at home and does not need to go into residential care. In these circumstances there would be a conflict of interests and Brian's relatives would not be 'an appropriate person'.

7.27. Sometimes the local authority will not know at the point of first contact or at an early stage of the assessment whether there is someone appropriate to assist the person in engaging. They may need to appoint an advocate, and find later that there is an appropriate person in the person's own network. The advocate can at that stage 'hand over' to the appropriate person. Alternatively, the local authority may agree with the individual, the appropriate person and the advocate that it would be beneficial for the advocate to continue their role, though this is not a specific requirement under the legislation. Equally, it is possible that the local authority will consider someone appropriate who may then turn out to have difficulties in supporting the person to engage and be involved in the process. The local authority **must** at that point arrange for an advocate.

7.28. There may also be some cases where the local authority considers that a person needs the support of both a family member and an advocate; perhaps because the family member can provide a lot of information but not enough support, or because while there is a close relationship, there may be a conflict of interest with the relative, for example in relation to inheritance of the home.

7.29. If the local authority decides that they are required to appoint an independent advocate as the person does not have friends or family who can facilitate their involvement, the local authority **should** usually still consult with those friends or family members when appropriate.

7.30. It is the local authority's decision as to whether a family member or friend can act as an appropriate person to facilitate the individual's involvement. It is the local authority's responsibility to communicate this decision to the individual's friends and family where this may have been in question and whenever appropriate. The overall aim should be for people who need advocacy to be identified and when relevant, receive consistent support as early as possible and throughout the assessment, the care and support planning and the review processes.

7.31. The local authority may be carrying out assessments of two people in the same household. If both people agree to have the same advocate, and if the advocate and the local authority both consider there is no conflict of interest, then the same advocate may support and represent the two people. For example, if they both wish to be supported to live together in their own home, then it may make sense for one advocate to support both. But where for example one wishes for the other to be moved away, there may be a conflict of interest and two advocates will be needed. If any of the people – the people being assessed or taking part in care planning, the assessor or the advocate – consider that it would be better to have different advocates, then separate advocates should be provided.

The exceptions: provision of an advocate even where they have family or others who can facilitate the person's involvement

7.32. In general, a person who has substantial difficulty in being involved in their assessment, plan and review, will only become eligible for an advocate where there is no one appropriate to support their involvement. The exceptions are:

- where the exercising of the assessment or planning function might result in placement in NHS-funded provision in either a hospital for a period exceeding four weeks or in a care home for a period of eight weeks or more and the local authority believes that it would be in the best interests of the individual to arrange an advocate;
- where there is a disagreement, relating to the individual, between the local authority and the appropriate person whose role it would be to facilitate the individual's involvement, and the local authority and the appropriate person agree that the involvement of an independent advocate would be beneficial to the individual.

7.33. But there is one further important exception. The exception is where a deprivation of liberty[72] may be the result of the proposed care and support plan. The Supreme Court has clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances: the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. Where a proposed care and support plan may involve restricting a person's liberty to the extent that they may be deprived of their liberty, in any setting, an advocate must be involved. For example where:

- a family member strongly opposes a care and support plan that involves moving a person who lacks capacity into a care or nursing home;
- a person is objecting to leaving their home in the community;
- a care and support plan is so restrictive that paid staff make all the day-to-day decisions about a person's life;
- a care and support plan involves serious restraint, such as placing a person in seclusion, or physical restraint which is distressing to the person;
- a care and support plan involves serious restrictions on freedom to associate with family and friends;
- a care and support plan makes no provision for the person to be able to 'go out of' the place they live in, i.e. for leisure or social activities;
- a care and support plan makes a person entirely dependent for everything on paid staff, and there are no family or friends involved.

7.34. In any of these kinds of scenarios, an advocate **must**:

- actively apply the provisions of the Mental Capacity Act, particularly the five principles and specifically the "least restrictive" principle;
- when supporting and representing people in the development of new care and treatment plans for individuals lacking capacity, be alert to and identify any restrictions and restraint which may be of a degree or intensity that mean an individual

[72] https://www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards

is being, or is likely to be, deprived of their liberty (following the revised test supplied by the Supreme Court)[73];

- where a potential deprivation of liberty is identified, a full exploration of the alternative ways of providing the care and/or treatment **should** be undertaken with those responsible for care planning, in order to identify any less restrictive ways of providing that care which will avoid a deprivation of liberty;
- where the care/treatment plan for an individual lacking capacity will unavoidably result in a deprivation of liberty judged to be in that person's best interests, advocates must ensure that those responsible for the care plan know that this **must** be referred for authorisation.

Who can act as an advocate?

7.35. Advocates **must** have:

- a *suitable level of experience:* this may, for example, be in advocacy or in working with those groups of people who may have substantial difficulty in engaging with assessments and care and support planning.
- *appropriate training:* this may, for example, initially be training in advocacy or dementia, or working with people with learning disabilities. Once appointed, all independent advocates should be expected to work towards the National Qualification in Independent Advocacy (level 3) within a year of being appointed, and to achieve it in a reasonable amount of time.
- *competency in the task:* this will require the advocacy organisation assuring itself that the advocates who work for it are all competent and have regular training and assessments.
- *integrity and good character:* this might be assessed through: interview and selection processes; seeking and scrutinising references prior to employment and on-going DBS checks.
- *the ability to work independently of the local authority:* this would include the ability to make a judgement about what a person is communicating and what is in a person's best interests, as opposed to in a local authority's best interests, and to act accordingly to represent this.
- *arrangements for regular supervision:* this will require that the person meets regularly and sufficiently frequently with a person with a good understanding of independent advocacy who is able to guide their practice and develop their competence.

7.36. The third updated version on the Advocacy Quality Performance Mark (QPM)[74] was published on 3 April 2014 by the National Development Team for Inclusion (NDTi). The QPM is a tool for providers of independent advocacy to show their commitment and ability to provide high quality advocacy services – essential for people to have their voices heard, to exercise choice and control and to live independently.

7.37. The advocate **must not** be working for the local authority, or for an organisation that is commissioned to carry out assessments, care and support plans or reviews for the local authority. Nor can an advocate be appointed if they are providing care or

[73] Department of Health letter to local authority MCA and DoLS leads, 28 March 2014. https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-supreme-court-judgments

[74] Available at http://www.ndti.org.uk/major-projects/current/advocacy-quality-performance-mark/ and at. www.qualityadvocacy.org.uk

treatment to the individual in a professional or a paid capacity.

The role of the independent advocate

7.38. The regulations intend that advocates will decide the best way of supporting and representing the person they are advocating for, always with regard to the wellbeing and interest (including their views, beliefs and wishes) of the person concerned.

7.39. In addition, where practicable, they are expected to meet the person in private. Where a person has capacity, the advocate **should** ask their consent to look at their records and to talk to their family, friends, paid carers and others who can provide information about their needs and wishes, their beliefs and values. Where a person does not have capacity to decide whether an advocate should look at their notes or talk to their family and friends, then the Care Act requires the advocate to consult both the records and the family and others, but consulting the family and others only where the advocate considers this is appropriate and in the person's best interests. The Care Act allows advocates ability to access and to copy records where the person is unable to decide whether to give ability themselves. This mirrors the powers of an Independent Mental Capacity Advocate.

7.40. Acting as an advocate for a person who has substantial difficulty in engaging with care and support processes is a responsible position. It includes:

- Assisting a person to understand the assessment, care and support planning and review processes. This requires advocates to understand local authority policies and processes, the available assessment tools, the planning options, and the options available at the review of a care or support plan. It may involve advocates spending considerable time with the individual, considering their communications needs, their wishes and feelings and their life story, and using all this to assist the person to be involved and where possible to make decisions.
- Assisting a person to communicate their views, wishes and feelings to the staff who are carrying out an assessment or developing a care or support plan or reviewing an existing plan.
- Assisting a person to understand how their needs can be met by the local authority or otherwise – understanding for example how a plan can be personalised, how it can be tailored to meet specific needs, how it can be creative, inclusive, and how it can be used to promote a person's rights to liberty and to family life.
- Assisting the person to make decisions about their care and support arrangements – assisting them to weigh up various care and support options and to choose the ones that best meet the person's needs and wishes.
- Assisting the person to understand their rights under the Care Act – for an assessment which considers their wishes and feelings and which considers the views of other people; their right to have their eligible needs met, and to have a care or support plan that reflects their needs and their preferences. Also assisting the person to understand their wider rights, including their rights to liberty and family life. A person's rights are complemented by the local authority's duties, for example to involve the person, to meet needs in a way that is least restrictive of a person's rights.

- Assisting a person to challenge a decision made by the local authority; and where a person cannot challenge the decision even with assistance, then to challenge it on their behalf.

Representing

7.41. There will be times when an advocate will have concerns about how the local authority has acted or what decision has been made or what outcome is proposed. The advocate **must** write a report outlining their concerns for the local authority. The local authority **should** convene a meeting with the advocate to consider the concerns and to provide a written response to the advocate following the meeting.

7.42. Where the individual does not have capacity, or is not otherwise able, to challenge a decision, the advocate **must** challenge any decision where they believe the decision is inconsistent with the local authority's duty to promote the individual's wellbeing.

7.43. Where a person has been assisted and supported and nevertheless remains unable to make their own representations or their own decisions, the independent advocate **must** use what information they have collected and found, and make the representations on behalf of the person. They **must** 'advocate' on their behalf, to put their case, to scrutinise the options, to question the plans if they do not appear to meet all eligible needs or do not meet them in a way that fits with the person's wishes and feelings, or are not the least restrictive of people's lives, and to challenge local authority decisions where necessary. The ultimate goal of this representation is to secure a person's rights and ensure that their wishes are taken fully into account.

7.44. The local authority is expected to recognise that an advocate's duty is to support and represent a person who has substantial difficulty in engaging with the local authority processes. The local authority **must** take into account any representations made by an advocate. The local authority must provide a written response to a report from an advocate which outlines concerns about how the local authority has acted or what decision has been made or what outcome is proposed. The local authority should understand that the advocate's role incorporates 'challenge' on behalf of the individual.

7.45. The local authority is responsible for ensuring that the relevant people who work for the authority are aware of the advocacy service and the authority's duty to provide such services. It may engage with the advocates to support this awareness raising.

7.46. The local authority **should** consider including the identification and referral of those people likely to benefit from independent advocacy (during assessment, care and support planning and review) through the care and support services they may commission.

7.47. The local authority **should** take reasonable steps to assist the advocate in carrying out their role. For example, they should let other agencies know that an advocate is supporting a person, facilitating access to the person and to the records, they should propose a reasonable timetable for the assessment and the care and support plan (taking into consideration the needs of the person), and where the advocate wishes to consult family, friends or paid staff, the timetable should allow this. They should keep the advocate informed of any developments and of the outcome of the assessment and the care and support plan.

7.48. The local authority may make reasonable requests of the advocate for information or for meetings both in relation to particular individuals and in relation to the advocate's work more generally, and the independent advocate should comply with these.

7.49. The local authority **must** meet its duties in relation to working with an Independent Mental Capacity Advocate (IMCA) provided under the Mental Capacity Act as well as those in relation to an advocate under the Care Act when the advocate is acting in both roles. These duties have been closely aligned so as to facilitate this.

Availability of advocacy services to people in the area

7.50. All local authorities **must** ensure that there is sufficient provision of independent advocacy to meet their obligations under the Care Act. There should be sufficient independent advocates available for all people who qualify, and it will be unlawful not to provide someone who qualifies with an advocate.[75]

7.51. Advocacy **should** be seamless for people who qualify, so that they can benefit from the support of one advocate for their whole experience of care. It rarely makes sense to have one advocate for assessment and another for care and support planning; the two are interrelated, and people who have substantial difficulty in engaging should not be expected to have to tell their story repeatedly to different advocates.

7.52. The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012), provides that local authorities are under a duty to work with their local CCGs, and other partners through the Health and Wellbeing Board to undertake Joint Strategic Needs Assessments for their areas and to develop Joint Health and wellbeing Strategies. Statutory Guidance[76] published in March 2013 makes clear that the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies must be published, and have specific regard to "what health and social care information the community needs, including how they access it and what support they may need to understand it".

7.53. Local authorities **should** be aware of and build on the current availability of independent advocacy services in its local area.

7.54. Independent advocacy under the duty flowing from the Care Act is similar in many ways to independent advocacy under the Mental Capacity Act (MCA). Regulations have been designed to enable independent advocates to be able to carry out both roles. For both:

- the independent advocate's role is to support and represent people;
- the independent advocate's role is primarily to work with people who do not have anyone appropriate to support and represent them;
- the independent advocates require a similar skill set;
- regulations about the appointment and training of advocates are similar;
- local authorities are under a duty to consider representations made by both independent advocates;
- independent advocates will need to be well known and accessible;

75 See also chapter 4 on Commissioning.

76 https://www.gov.uk/government/publications/joint-strategic-needs-assessment-and-joint-health-and-wellbeing-strategies-explained

- independent advocates may challenge local authority decisions;
- people who qualify for an Independent Mental Capacity Advocate (an IMCA) in relation to the care planning and care review will (in nearly all cases) also qualify for independent advocacy under the Care Act.

7.55. However, the duty to provide independent advocacy under the Care Act is broader and provides support to:

- people who have capacity but who have substantial difficulty in being involved in the care and support 'processes';
- people in relation to their assessment and/or care and support planning regardless of whether a change of accommodation is being considered for the person;
- people in relation to the review of a care and/or support plan;
- people in relation to safeguarding processes (though IMCAs are involved if protective measures are being proposed for a person who lacks capacity);
- carers who have substantial difficulty in engaging – whether or not they have capacity);
- people for whom there is someone who is appropriate to consult for the purpose of best interests decisions under the Mental Capacity Act, but who is not able and/or willing to facilitate the person's involvement in the local authority process.

7.56. Frequently a person will be entitled to an advocate under the Care Act and then, as the process continues it will be identified that there is a duty to provide an advocate (IMCA) under the Mental Capacity Act.[77] This will occur for example when during the process of assessment or care and support planning it is identified that a decision needs to be taken about the person's long-term accommodation. It would be unhelpful to the individual and to the local authority for a new advocate to be appointed at that stage. It would be better that the advocate who is appointed in the first instance is qualified to act under the Mental Capacity Act (as IMCAs) and the Care Act and that the commissioning arrangements enable this to occur.

7.57. Local authorities do not have to commission one organisation to provide both types of advocacy. But there may be advantages of one organisation providing both:

- it is better for the person receiving the support;
- it is easier for those carrying out assessment and care planning to work with one advocate per individual rather than two; and
- it is easier for the local authority to manage and monitor one contract rather than two.

7.58. For assessment, care planning and/or reviews, there are two groups of people who will now qualify for advocacy:

- People with capacity who nevertheless have substantial difficulty in being involved with the processes of assessment, planning and reviews. This group of people receives statutory advocacy for the first time under the Care Act.
- People who lack capacity and have substantial difficulty in engaging. People within this second group are already entitled to advocacy under the

[77] See chapter 10 of the *Mental Capacity Act 2005: Code of Practice on the functions of IMCAs*

Mental Capacity Act, including for care planning when this involves a change in accommodation decision. The Local Authority also has the power to appoint an independent advocate for care reviews.

Charging and financial assessment

8. Charging and financial assessment

This chapter provides guidance on sections 14, 17 and 69-70 of the Care Act 2014, the Care and Support (Charging and Assessment of Resources) Regulations 2014, and the Care and Support and Aftercare (Choice of Accommodation) Regulations 2014.

This chapter covers:

- Common issues for charging;
- Charging for care and support in a care home;
- Choice of accommodation when arranging care in a residential setting;
- Making additional payments for preferred accommodation;
- Charging for home care and support in a person's own home;
- Charging for support to carers;
- Requesting local authority support to meet eligible needs.

This chapter must be read in conjunction with Annexes A to F, which provide further technical and detailed information.

8.1. The Care Act 2014 provides a single legal framework for charging for care and support. It enables a local authority to decide whether or not to charge a person when it is arranging to meet a person's care and support needs or a carer's support needs.

8.2. Where a local authority arranges care and support to meet a person's needs, it **may** charge the adult, except where the local authority is required to arrange care and support free of charge. The new framework is intended to make charging fairer and more clearly understood by everyone. The overarching principle is that people should only be required to pay what they can afford. People will be entitled to financial support based on a means-test and some will be entitled to free care. The framework is therefore based on the following principles that local authorities **should** take into account when making decisions on charging. The principles are that the approach to charging for care and support needs should:

- Ensure that people are not charged more than it is reasonably practicable for them to pay;
- Be comprehensive, to reduce variation in the way people are assessed and charged;
- Be clear and transparent, so people know what they will be charged;

- Promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control;
- Support carers to look after their own health and wellbeing and to care effectively and safely;
- Be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs;
- Apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings;
- Encourage and enable those who wish to stay in or take up employment, education or training or plan for the future costs of meeting their needs to do so;
- Be sustainable for local authorities in the long-term.

Common issues for charging

8.3. Local authorities have a duty to arrange care and support for those with eligible needs, and a power to meet both eligible and non-eligible needs. In both cases, a local authority has the discretion to choose whether or not to charge. Where it decides to charge, it must follow the regulations and have regard to the guidance. The detail of how to charge is different depending on whether someone is receiving care in a care home or their own home or another setting. However, they share some common elements, which are set out in the following section.

8.4. The different approaches exist to reflect that the delivery model for care homes is relatively uniform across the country and it is therefore sensible to provide a single model for charging purposes. However, other models of care generally see a greater variety of approaches and innovation that we wish to continue.

8.5. Where a local authority chooses to charge, regulations determine the maximum amount a local authority can charge a person.

8.6. Only in care homes where a financial assessment identifies that a person's resources exceed the capital limits is a local authority precluded from paying towards the costs. Therefore local authorities **should** develop and maintain a policy setting out how they will charge people in settings other than care homes. In deciding what it is reasonable to charge, local authorities **must** ensure that they do not charge more than is permitted under these regulations and as set out in this guidance.

8.7. The subsequent guidance and the supporting Annexes assume that the appropriate assessment of needs has been carried out and the local authority has chosen to charge. It therefore provides detail on how to conduct the financial assessment for that person. The local authority has no power to assess couples or civil partners according to their joint resources. Each person must therefore be treated individually. For further guidance on assessment of needs see Chapter 6.

Capital limits

8.8. The financial limit, known as the "upper capital limit" exists for the purposes of the financial assessment. This sets out at what point a person is entitled to access local authority support. Full detail is set out in Annex B, and the local authority must read that guidance before undertaking a financial assessment.

8.9. The upper capital limit is currently set at £23,250. Below this level, a person can seek means-tested support from the local authority. This means that the local authority will undertake a financial assessment of the person's assets and will make a charge based on what the person can afford to pay. Where a person's resources are below the lower capital limit – currently set at £14,250 – they will not need to contribute to the cost of their care and support from their capital.

8.10. A person with more in capital than the upper capital limit can ask their local authority to arrange their care and support for them. However, these people are not entitled to receive any financial assistance from their local authority and may pay the full cost of their care and support until their capital falls below the upper capital limit.

8.11. The local authority **must not** charge for certain types of care and support which **must** be arranged free. These are:

- Intermediate care including reablement (for up to six weeks).
- Community equipment (aids and minor adaptations). Aids must be provided free of charge whether provided to meet or prevent/delay needs. A minor adaptation is one costing £1,000 or less.
- Care and support provided to people with Creutzfeldt-Jacob Disease.
- After-care services/support provided under section 117 of the Mental Health Act 1983.
- Any service or part of service which the NHS is under a duty to provide. This includes Continuing Health Care and the NHS contribution to Registered Nursing Care.
- More broadly, any services which a local authority is under a duty to provide through other legislation may not be charged for under the Care Act 2014.

Carrying out a financial assessment

8.12. The legal framework for charging is set out in Sections 14 and 17 of the Care Act 2014. When choosing to charge, a local authority **must not** charge more than the cost that it incurs in meeting the assessed needs of the person. It cannot recover any administration fee relating to arranging that care and support. The only exception is in the case of a person with eligible needs and assets above the upper capital limit who has asked the local authority to arrange their care and support on their behalf. In such cases, the local authority **may** apply an administration fee to cover its costs. However this **must not** be higher than the cost the local authority has incurred in arranging that care and support.

8.13. Where a local authority has decided to charge, it **must** carry out a financial assessment of what the person can afford to pay and, once complete, it **must** give a written record of that assessment to the person. This could be provided alongside a person's care and support plan or via online means. It **should** explain how the assessment has been carried out, what the charge will be and how often it will be made, and if there is any fluctuation in charges, the reason.

8.14. In carrying out the assessment, the local authority **must** have regard to the detailed guidance set out in Annexes B and C that set out how both capital and income should be treated. A local authority **must** regularly reassess a person's ability to meet the cost of any charges to take account of any changes to their resources.

8.15. At the time of the assessment of care and support needs, the local authority **should** establish whether the person has the capacity to take part in the care plan

and financial assessment. If the person lacks capacity, the local authority **must** find out if the person has any of the following as they will need to be consulted:

- Enduring Power of Attorney (EPA);
- Lasting Power of Attorney (LPA) for Property and Affairs;
- Lasting Power of Attorney (LPA) for Health and Welfare;
- Property and Affairs Deputyship under the Court of Protection; or
- Any other person dealing with that person's affairs (e.g. someone who has been given appointee-ship by the Department for Work and Pensions (DWP) for the purpose of benefits payments).

8.16. In the financial assessment, the person's capital is taken into account unless it is subject to one of the disregards set out in Schedule 2 to the regulations and described in Annex B. The main examples of capital are property and savings. Where the person receiving care and support has capital at or below the upper capital limit (currently £23,250), but more than the lower capital limit (currently £14,250), they may be charged £1 per week for every £250 in capital between the two amounts. This is called "tariff income". For example, if a person has £4,000 above the lower capital limit, they are charged a tariff income of £16 per week.

8.17. In assessing what a person can afford to pay, a local authority **must** take into account their income. However, to help encourage people to remain in or take up employment, with the benefits this has for a person's well-being, earnings from current employment **must** be disregarded when working out how much they can pay. There are different approaches to how income is treated depending on whether a person is in residential care or receiving care and support in their own home. Full details are set out in Annex C on the treatment of income in residential care and non-residential care.

"Light-touch" financial assessments

8.18. In some circumstances, a local authority **may** choose to treat a person as if a financial assessment had been carried out. In order to do so, the local authority **must** be satisfied on the basis of evidence provided by the person that they can afford, and will continue to be able to afford, any charges due. This is known as a "light-touch" financial assessment.

8.19. The main circumstances in which a local authority **may** consider carrying out a light-touch financial assessment are:

(a) Where a person has significant financial resources, and does not wish to undergo a full financial assessment for personal reasons, but wishes nonetheless to access local authority support in arranging their care. In these situations the local authority may accept other evidence in lieu of carrying out the financial assessment and consider the person to have financial resources above the upper limit.

(b) Where the local authority charges a small or nominal amount for a particular service (e.g. for subsidised services) which a person is clearly able to meet and carrying out a financial assessment would be disproportionate.

(c) When an individual is in receipt of benefits which demonstrate that they would not be able to contribute towards their care and support costs. This might include income from jobseekers allowance.

8.20. Ways a local authority may be satisfied that a person is able to afford any charges due might include evidence that a person has:

(a) property clearly worth more than the upper capital limit;

(b) savings clearly worth more than the upper capital limit; or,

(c) sufficient income left following the charge due. This is likely to only be the case for small or nominal charges.

8.21. Where the local authority is going to meet the person's needs, and it proposes to undertake a light-touch financial assessment, and on that basis to charge the person it **should** take steps to assure itself that the person concerned is willing, and will continue to be willing, to pay all charges due.

8.22. When deciding whether or not to undertake a light-touch financial assessment, a local authority **should** consider both the level of the charge it proposes to make, as well as the evidence or other certification the person is able to provide. They **must** also inform the person when a light-touch assessment has taken place and make clear that the person has the right to request a full financial assessment should they so wish.

Deprivation and debts

8.23. People with care and support needs are free to spend their income and assets as they see fit including making gifts to friends and family. This is important for promoting their wellbeing and enabling them to live fulfilling independent lives. However, it is also important that people pay their fair contribution towards their care and support costs.

8.24. There are some cases where a person may have tried to deliberately avoid care and support costs through depriving themselves of assets – either capital or income. Where a local authority believes this may be the case, it **must** read Annex E concerning the deprivation of assets. In such cases, the local authority **may** either charge the person as if they still possessed the asset or, if the asset has been transferred to someone else, seek to recover the lost income from charges from that person. However, the local authority cannot recover more than the person gained from the transfer.

8.25. Where a person has accrued a debt, the local authority **may** use its powers under the Care Act 2014 to recover that debt. In deciding how to proceed, the local authority **should** consider the circumstances of the case before deciding a course of action. For example, a local authority should consider whether this was a deliberate avoidance of payment or due to circumstances beyond the person's control.

8.26. Ultimately, the local authority may institute County Court proceedings to recover the debt. However they should only use this power after other reasonable alternatives for recovering the debt have been exhausted. Further details on how to pursue debts are set out in Annex D.

Charging for care and support in a care home

8.27. This section **must** be read in conjunction with Annex B on the treatment of capital and Annex C on the treatment of income in residential care.

8.28. Where a local authority has decided to charge and undertaken the financial assessment, it **should** support the person to identify options of how best to pay any charge. This **may** include offering the person a deferred payment agreement. In such

cases, chapter 9 of the guidance **must** be considered.

8.29. Except where a local authority is arranging care and support at the request of a person who has resources above the financial limit (under Section 18(3) of the Care Act 2014), it **should** normally hold responsibility for contracting with the provider, unless all parties agree to a different approach. It **should** also hold responsibility for paying the full amount, particularly where a 'top-up' fee is being paid. However, it **may** choose to allow the person to pay the provider directly for the 'top-up' where this is permitted. Local authorities should ensure they read the guidance at Annex A on the use of 'top-up' fees.

8.30. Where a person is temporarily resident in a care home, a local authority **may** choose to charge based on its charging policies outside of a care home. For example, where a person is resident in order to receive respite care, for the first 8 weeks a local authority **may** choose to charge based on its approach to charging for those receiving care and support in other setting or in their own home.

8.31. People in a care home will contribute most of their income, excluding their earnings, towards the cost of their care and support. However, a local authority **must** leave the person with a specified amount of their own income so that the person has money to spend on personal items such as clothes and other items that are not part of their care. This is known as the personal expenses allowance (PEA). This is in addition to any income the person receives from earnings. Ministers have the power to adjust the PEA and have done so annually to ensure it maintains its value. These changes are communicated by Local Authority Circular and are binding. Local authorities have discretion to apply a higher income allowance in individual cases, for example where the person needs to contribute towards the cost of maintaining their former home. Further detail is set out in Annex C.

Choice of accommodation

8.32. Where the care planning process has determined that a person's needs are best met in a care home the local authority **must** provide for the person's preferred choice of accommodation, subject to certain conditions. This also extends to shared lives, supported living and extra care housing settings. Determining the appropriate type of accommodation should be made with the adult as part of the care planning process, therefore this choice only applies between providers of the same type.

8.33. The local authority **must** offer at least one option that is affordable within a person's personal budget. However, a person **must** also be able to choose alternative options, including a more expensive setting, where *a third party or in certain circumstances the resident is willing and able to pay the additional cost ('top-up')*. However, an additional payment must always be optional. Detailed guidance is set out in Annex A which a local authority **must** have regard to.

Charging for care and support in other care settings including a person's own home

8.34. This **section** should be read in conjunction with the regulations and Annex B on the treatment of capital and Annex C on the treatment of income in non-residential care.

8.35. These charging arrangements cover any setting for meeting care and support needs outside of a care home. For example, care and support received in a person's own home, in extra care housing, supported

living accommodation or shared lives arrangements.

8.36. The intent of the regulations and guidance is to support local authorities to assess what a person can afford to contribute towards their care costs. Local authorities **should** also consider how to use their discretion to support the objectives of care and support charging.

8.37. This guidance does not make any presumption that local authorities will charge for care and support provided outside care homes, but enables them to continue to allow discretion.

8.38. Because a person who receives care and support outside a care home will need to pay their daily living costs such as rent, food and utilities, the charging rules must ensure they have enough money to meet these costs. After charging, a person must be left with at least the basic level of Income Support plus a buffer of 25%. In addition, where a person receives benefits to meet their disability needs that do not meet the eligibility criteria for local authority care and support, the charging arrangements should ensure that they keep enough money to cover the cost of meeting these disability-related costs.

8.39. Additionally the financial assessment of their capital **must** exclude the value of the property which they occupy as their main or only home. Beyond this, the rules on what capital must be disregarded are the same for all types of care and support. However local authorities have flexibility within this framework for example, they **may** choose to disregard additional sources of income, set maximum charges or charge a person a percentage of their disposable income. This will help support local authorities to take account of local circumstances and promote integration and innovation.

8.40. Although local authorities have this discretion, this **should** not lead to two people with similar needs, and receiving similar types of care and support, being charged differently.

8.41. Local authorities **should** develop and maintain a policy on how they wish to apply this discretion locally. In designing this policy local authorities should consider the objectives of care and support charging and how it can;

- Ensure that people are not charged more than it is reasonably practicable for them to pay;
- Be comprehensive, to reduce variation in the way people are assessed and charged;
- Be clear and transparent, so people know what they will be charged;
- Promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control;
- Support carers to look after their own health and wellbeing and to care effectively and safely;
- Be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs;
- Apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings;
- Encourage and enable those who wish to stay in or take up employment, education or training or plan for the future costs of meeting their needs to do so;
- Be sustainable for local authorities in the long-term.

8.42. Local authorities **should** consult people with care and support needs when deciding how to exercise this discretion.

8.43. In doing this local authorities **should** consider how to protect a person's income. The government considers that it is inconsistent with promoting independent living to assume, without further consideration, that all of a person's income above basic levels of Income Support or the Guarantee Credit element of Pension Credit plus 25% is available to be taken in charges.

8.44. Local authorities **should** therefore consider whether it is appropriate to set a maximum percentage of disposable income (over and above the guaranteed minimum income) which may be taken into account in charges.

8.45. Local authorities **should** also consider whether it is appropriate to set a maximum charge, for example these might be set as a maximum percentage of residential charges in a local area. This could help ensure that people are encouraged to remain in in their own homes, promoting individual wellbeing and independence.

Charging for support to carers

8.46. Where a carer has eligible support needs of their own, the local authority has a duty, or in some cases a power, to arrange support to meet their needs. When it meets a carer's support needs, the local authority has the power to charge the carer. However, a local authority **must not** charge a carer for care and support provided directly to the person they care for under any circumstances.

8.47. Local authorities are not required to charge a carer for support. When deciding whether to charge, and in determining what an appropriate charge is, a local authority **should** consider how it wishes to express the way it values carers within its local community as partners in care, and recognise the significant contribution carers make. Carers help to maintain the health and wellbeing of the person they care for, support this person's independence and enable them to stay in their own homes for longer. Local authorities **should** consider carefully the likely impact of any charges on carers, particularly in terms of their willingness and ability to continue their caring responsibilities. It may be that there are circumstances where a nominal charge may be appropriate, for example to ensure sufficient numbers participate in an activity specifically arranged for a group of carers, for example a relaxation class. Ultimately, a local authority **should** ensure that any charges do not negatively impact on a carer's ability to look after their own health and wellbeing and to care effectively and safely.

8.48. Where a local authority takes the decision to charge a carer, it **must** do so in accordance with the non-residential charging rules. In doing so, it **should** usually carry out a financial assessment to ensure that any charges are affordable. However, it may be more likely, in the case of a carer, that the carer and the local authority will agree that a full financial assessment would be disproportionate as carers often face significantly lower charges.

8.49. In such cases, a local authority **may** choose to treat a carer as if a financial assessment has been carried out. When deciding whether or not to undertake a light-touch financial assessment, a local authority **should** consider both the level of the charge it proposes to make as well as the evidence the person is able to provide that they will be able to afford the charge. They **must** also inform the person when a light-touch assessment has taken place and make clear

that the person has the right to request a full financial assessment should they so wish.

Requesting local authority support to meet eligible needs

8.50. Under the Care Act 2014, people with eligible needs and financial assets above the upper capital limit are able to ask the local authority to arrange their care and support on their behalf. This could be for a variety of reasons such as the person finding the system too difficult to navigate, or wishing to take advantage of the local authority's knowledge of the local market of care and support services.

8.51. Local authorities **must** therefore take steps to make people aware that they have the right to request the local authority to meet their needs, even when they have resources above the financial limits and would not be entitled to financial support with charges. Local authorities should also offer support to people in meeting their own needs and must provide information and advice on different options and may offer to arrange contracts with providers.

8.52. Where the person's resources are above the financial limit the person's entitlement to local authority support in meeting their needs may be dependent on the request having been made. Therefore it is important that the person, and any carer, advocate or other person they wish to involve, are aware of this ability and the consequences for their care and support. The local authority **should** make clear to the person that they may be liable to pay an arrangement fee in addition to the costs of meeting their needs to cover the costs of putting in place the care and support required.

8.53. The information provided to the person following a financial assessment should include information on the right to request the local authority to meet their needs – and how they would be charged – and the advice and support that is available to help people make arrangements to meet their own needs.

8.54. A local authority will be under a duty to meet a person's eligible needs when requested to do so. However, where the person has resources above the financial limits the local authority **may** charge the person for the full cost of their care and support. In such circumstances, the person remains responsible for paying for the cost of their care and support, but the local authority takes on the responsibility for meeting those needs. This means that the local authority **must** for example provide or arrange care and support, or make a direct payment, or some combination of these.

8.55. The local authority **must** assure itself that whilst the person remains responsible for paying for their own care, they have sufficient assets for the arrangements that it puts in place to remain both affordable and sustainable. The local authority **should** also take steps to avoid disputes and additional liabilities by securing a person's agreement in writing to pay the costs that they are responsible for in meeting their needs, including payments to providers. Local authorities **should** make similar arrangements with any third parties that agree to contribute towards these costs.

Complaints

8.56. A person may wish to make a complaint about any aspect of the financial assessment or how a local authority has chosen to charge. A local authority **must** make clear what its complaints procedure is and provide information and advice on how to lodge a complaint.

8.57. Complaints about the level of charge levied by a local authority are subject to the usual Care and Support complaints procedure as set out in The Local Authority Social Services and NHS Complaints Regulations 2009.

8.58. Where a local authority has established a special Panel or Fast track review processes to deal with financial assessment/charging issues, they **should** remind the person that they still have access to the statutory Complaints Procedure.

9. Deferred payment agreements

This chapter provides guidance on sections 34-36 of the Care Act 2014 and the Care and Support (Deferred Payment Agreements) Regulations 2014.

This chapter covers:

- Who to offer a deferred payment to;
- Provision of information and advice before making a deferred payment agreement;
- How much can be deferred, and security for the agreement;
- Interest rate for the deferral and administrative charges;
- Making the agreement, responsibilities while the agreement is in place and termination of the agreement.

Definitions

9.1. 'Care home costs' – all costs charged to a person by a care provider, including daily living costs, any top-ups and care costs.

Introduction

9.2. The establishment of the universal deferred payment scheme will mean that people should not be forced to sell their home in their lifetime to pay for their care. By taking out a deferred payment agreement, a person can 'defer' or delay paying the costs of their care and support until a later date. Deferring payment can help people to delay the need to sell their home, and provides peace of mind during a time that can be challenging (or even a crisis point) for them and their loved ones as they make the transition into residential care.

9.3. A deferred payment agreement provides flexibility for when and how someone pays for their care and support. It should be stressed from the outset that the payment for care and support is *deferred* and not 'written off' – the costs of provision of care and support will have to be repaid by the individual (or a third party on their behalf) at a later date.

9.4. The scheme will be universally available throughout England, and local authorities will be required to offer deferred payment agreements to people who meet certain criteria governing eligibility for the scheme. Local authorities will need to ensure that adequate security is in place for the amount being deferred, to be confident of the person's ability to pay back the amount deferred in the future. Local authorities are also encouraged to offer the scheme more widely to anyone they feel would benefit who does not fully meet the criteria.

9.5. A deferral can last until death, however many people choose to use a deferred payment agreement as a 'bridging loan' to give them time and flexibility to sell their home when they choose to do so. This is entirely up to the individual to decide. Further details on deferred payment agreements are set out in the sections below.

Who to offer deferred payments to

Criteria governing eligibility for deferred payment agreements

9.6. Deferred payment agreements are designed to prevent people from being forced to sell their home in their lifetime to meet the cost of their care. Local authorities **must** offer them to people who meet the criteria below and who are able to provide adequate security (see section entitled 'Obtaining Security' below). They **must** offer them to people who have local authority arranged care and support, and also people who arrange and pay for their own care, subject to these criteria. The regulations specify that someone is eligible for and so **must** be offered a deferred payment agreement if they meet all three of the following criteria at the point of applying for a deferred payment agreement:

(a) anyone whose needs are to be met by the provision of residential care. This is determined when someone is assessed as having eligible needs which the local authority decides should be met through residential care. This **should** comply with choice of accommodation regulations and care and support planning guidance and so take reasonable account of a person's preferences;

(b) who has less than £23,250 in assets excluding the value of their home (i.e. in savings and other non-housing assets); and

(c) whose home is not occupied by a spouse or dependent relative as defined in regulations on charging for care and support (i.e. someone whose home is taken into account in the local authority financial assessment and so might need to be sold).

9.7. Local authorities are, at their discretion, **permitted** to be more generous than these criteria and offer deferred payment agreements to people in residential care who do not meet the other criteria. As well as providing protection for people facing the prospect of having to sell their home to pay for care, deferred payment agreements can offer valuable flexibility, giving people greater choice over how they pay their care home charges. In deciding whether someone who does not meet all of the criteria above should still be offered a deferred payment, some considerations a local authority could take into account include (but are not limited to):

(a) whether meeting care home charges would leave someone with very few accessible assets (this might include assets which cannot quickly / easily be liquidated or converted to cash);

(b) if someone would like to use wealth tied up in their home to fund reasonable top-ups (see further guidance on 'How much can be deferred' below);

(c) whether someone has any other accessible means to help them meet the cost of their care and support; and / or

(d) if a person is narrowly not eligible for a deferred payment agreement given the criteria above, for example because they have slightly more than the £23,250 asset threshold. This **should** include people who are likely to meet the criteria in the near future.

Permission to refuse a deferred payment agreement

9.8. A local authority **must** offer a deferred payment to someone meeting the criteria governing eligibility for deferred payment agreements (DPAs) and who is able to provide adequate security for the debt (usually obtaining a land registry charge on their property, see 'Obtaining security' below); and **may** offer a deferred payment agreement to others who do not meet the criteria, at their discretion.

9.9. A local authority **may** refuse a request for a deferred payment agreement ('permission to refuse') in circumstances set out in regulations. This permission (or discretion) to refuse is intended to provide local authorities with a reasonable safeguard against default or non-repayment of debt. Regulations set out circumstances when a local authority's requirement to offer a deferred payment agreement is removed and consequently when a local authority can refuse a deferred payment agreement.

9.10. Circumstances where the local authority **may**, but is not compelled to, refuse a deferred payment agreement include:

(a) where a local authority is unable to secure a charge on the property;

(b) where someone wishes to defer a larger amount than they can provide security for. In these situations, a local authority **must** still offer a deferral but **should** be guided by principles in the section below (entitled 'how much to defer') to determine a maximum amount and agree a weekly deferral. The person can then choose whether they wish to agree; and/or

(c) where a person's property is uninsurable.

9.11. There are also circumstances where a local authority **may** refuse to defer any more charges for a person who has an active deferred payment agreement. Local authorities **cannot** demand repayment in these circumstances. Repayment is still subject to the usual terms of termination, as set out in the section entitled 'termination of the agreement' below. The local authority **should** provide 30 days advance notice that further deferrals will cease; and **should** provide the person with an indication of how their care costs will need to be met in future. Depending on their circumstances, the person may either receive local authority support in meeting the costs of their care, or may be required to meet their costs from their income and non-housing assets.

9.12. Circumstances in which a local authority may refuse to defer any more charges include:

(a) when a person has reached the 'upper limit' that they are allowed to defer (see 'how much can be deferred' below). This also applies when the value of the security has dropped and so the 'upper limit' has been reached earlier than expected;

(b) where a spouse or dependent relative (as defined in charging regulations) has moved into the property *after* the agreement has been made, thus meaning the person is eligible for local authority support in paying for care and no longer requires a deferred payment agreement;[78] and

(c) where a relative who was living in the property at the time of the agreement subsequently becomes a dependent relative (as defined in charging regulations). The local authority **may** cease further deferrals at this point.

[78] In this case, interest would continue to accrue on the amount deferred until the agreement was terminated (either by sale of the property, the person's death or by the LA being repaid separately; as set out in the 'Termination of the Agreement' section below).

Case study 1

Manju develops a need for residential care. She lives alone and is the sole owner of her home. Her home is valued at £100,000, and she has £15,000 in savings. Manju meets the criteria governing eligibility for a deferred payment.

Information and advice

9.13. Under the Care Act, local authorities have responsibilities to provide information and advice about people's care and support. These extend to deferred payment schemes as well.

9.14. In order to be able to make well-informed choices, it is essential that people access appropriate information and advice before taking out a deferred payment agreement (DPA). It is also important that people are kept informed about their DPA throughout the course of the agreement, and that they (and their estate where appropriate) receive the necessary information upon termination of the agreement.

9.15. Information and advice requirements prior to taking out a DPA are discussed in this section, requirements on local authorities while the DPA is in place are discussed in a separate section below (see 'the local authority's responsibilities whilst the agreement is in place'), and the section entitled *'termination of the agreement'* addresses the responsibilities on the local authority when the agreement is concluded. The requirements on local authorities to offer and facilitate access to financial information and advice on other options for paying for care are discussed in chapter 3.

9.16. Deferred payment agreements are often made during a time that is demanding for a person and their loved ones – a period when they are making a transition into residential care. People may need additional support during this period, and the local authority has a role in providing this support and facilitating their transition, particularly if their transition to care is made rapidly and/or at an unexpected point. The local authority **must** provide information in a way which is clear and easy to understand, and it **should** be designed to ease the process of transition for people, their carers and their families.

9.17. Carers and families often assist people in making decisions about their care and how they pay for it. Local authorities **should** as appropriate invite carers and/or families to participate in discussions, and **should** also provide them with all the information that would otherwise be given to the person they care for, subject (where required)[79] to the consent of the person with care and support needs (if they have capacity) or someone else with appropriate authorisation. In doing this, they **must** ensure compliance with mental capacity and data protection legislation.

9.18. As a deferred payment agreement can take some time to set up and agree, it is important that both the local authority and the individual consider any potential issues around loss of capacity. If, at the point a person applies for a deferred payment agreement, a local authority has concerns that a person either lacks or will soon come to lack capacity, the local authority **may** offer to provide the person with information and advice on options for deputyship, legal power of attorney and advocacy. If a local authority and the person do discuss the issue, the local authority **should** confirm what would happen were the person to lose capacity and not have made their own arrangements.

[79] Not all information about a person's care will necessarily be confidential – so local authorities will need to apply data protection legislation to consider where seeking consent is and is not required.

9.19. If a local authority identifies someone who may benefit from or be eligible for a DPA or a person approaches them for information, the local authority **must** tell them about the DPA scheme and how it works. This explanation **should**, at a minimum:

- Set out clearly that the fees are being deferred or delayed and must still be paid back at a later date, for example through the sale of the home (potentially after the individual's death);
- Explain the types of security that a local authority is prepared to accept (as set out by each local authority in a publicly-available policy; see the section entitled 'Obtaining Security' below for further details);
- Explain that if a home is used as security, the home may need to be sold at a later date to repay the amount due;
- Explain how the interest rate will be charged on any amount deferred;
- Explain which administrative charges they may be liable for;
- Explain what happens on termination of the agreement, how the loan becomes due and their options for repayment;
- Explain what happens if they do not repay the amount due;
- Set out the criteria governing eligibility for a DPA;
- Detail the requirements that must be adhered to during the course of the DPA;
- Explain the implications that a deferred payment agreement may have on their income, their benefit entitlements, and charging; and
- Provide an overview of some potential advantages and disadvantages of taking out a DPA, and explain that there are other options for paying for their care that they may wish to consider.

9.20. Local authorities **should** give easy to read information about how the scheme works. This **may** be in the form of a standardised information sheet.

9.21. Local authorities **must** provide this information and advice in formats that ensure compliance with the requirements of the Equality Act 2010 (in particular, they **must** ensure where appropriate that the information is accessible to the sensory impaired, people with learning disabilities, and people for whom English is not their first language).

9.22. Local authorities **should** provide information and advice on DPAs during the period of the 12-week disregard.[80] The local authorities **should** aim to ensure that people are able to make a smooth transition from the 12-week disregard to the DPA. This means ensuring as far as possible that a DPA is available by the first day of week 13.

9.23. Local authorities **should** advise people (where appropriate) that they will need to consider how they plan to use, maintain and insure their property if they take out a DPA; that is whether they wish to rent, to prepare for sale, or to leave it vacant for a period. The local authority **must** advise if it intends to place conditions on how the property is maintained whilst the DPA is in place (authorities will usually include requirements for people to maintain and insure their homes in the terms and conditions of a deferred payment agreement; see the section entitled 'Making the Agreement' for further details).

9.24. Local authorities **should** develop basic information and advice for homeowners on how they may choose to use their property

[80] This refers to the first twelve weeks after entering local authority supported residential care during which local authorities must disregard the value of a person's home.

when they enter residential care, for example information on how they may go about renting their property, and the potential impact on other people living in the property if a sale is required after their death. They **should** signpost people to more specialist organisations who can provide further advice on this issue.

Case study 2

Manju's son has been providing informal care and support to her, and has heard of the deferred payments scheme. When Manju decides she may benefit from residential care, her son suggests they approach her local authority together for information and advice about deferred payment agreements.

Her local authority provides them both with a printed information sheet setting out further details on the authority's deferred payment scheme, and also provides them with contact details of some national and local services who provide financial information and advice

Manju is interested in renting her property whilst in residential care. The local authority has an existing housing advice service, so signposts Manju to them for further advice on lettings. The local authority's standard information sheet also includes information on how her rental income may be used to pay for her care and support.

How much can be deferred?

9.25. In principle, a person eligible for a deferred payment should be able to defer the entirety of their care home costs; subject to any contribution the local authority requires from the person's income. The local authority will need to consider whether a person can provide adequate security for the deferred payment agreement (see next section entitled 'Obtaining Security' – usually this requirement for 'adequate security' will be fulfilled by securing their deferred payment agreement against their property), and whether the amount or size of the weekly deferral requested is sustainable given the equity obtained from their chosen form of security.

9.26. Prior to entering into the agreement, both parties **should** have discussed the amount to be deferred, and have considered the security of the deferred payment and the sustainability (in terms of how costs, given intended length of deferral, match up to equity available). Security and sustainability are discussed in sections below. The care home costs to be deferred **must** be agreed between the local authority and the person and set out clearly and unambiguously in the agreement.

9.27. When considering the *equity available*, local authorities **must** set an 'upper limit' for the total amount that can be deferred and seek to ensure that the amount deferred does not rise above this agreed upper limit. The upper limit will leave some equity remaining in the security used for the DPA – this will both act as a buffer to cover any subsequent interest payments, and will provide a small 'cushion' in case of small variations in value of the security. In the majority of cases a property will be used as security, so this will provide a cushion against changes in house prices. When calculating progress towards the upper limit, the local authority **must** also include any interest or fees to be deferred.

9.28. If the person intends to secure their deferred payment agreement with a property, local authorities **must** secure a valuation of the property. People **may** request an independent assessment of the property's value (in addition to the local authority's valuation).

9.29. Where a local authority is required to offer a deferred payment agreement, the upper limit **must** be set at a maximum loan-to-value (LTV) ratio of the security provided as set out in regulations. This LTV will be between 70% and 80% and means that the total amount deferred should be that percentage of the full sale value. This provides security to the local authorities against possible house price fluctuations and the risk that they may not be able to recoup the full amount owed. Local authorities **should**, when someone is approaching or hits the maximum loan-to-value ratio use this as a point at which the local authority and the person review the cost of care, any means tested support they are now receiving and whether a deferred payment agreement continues to be the best way for someone to meet these costs.

9.30. The local authority has the discretion to allow someone to defer more than the stated maximum loan-to-value. Local authorities **should** exercise this discretion if someone does not have sufficient income or other assets to meet their care costs without having to sell their home. Local authorities **should** also consider whether it would be best to allow the deferral to continue if it is likely to be for a short period of time. Where a local authority allows someone to defer more, they can allow up to the full sale value of the home minus the lower capital limit used in the charging framework (currently £14,250).

9.31. The following examples illustrate this principle. For illustrative purposes the maximum loan-to-value ratio has been set at 70%.

Case Study: Where maximum LTV is applied

Manju's house is worth **£100,000**

The amount of equity available given a loan-to-value ratio of 70% would be **£70,000.**

Therefore, her 'upper limit' for the total amount she could defer would consequently be **£70,000**, which would leave **£30,000 in equity** in her home.

Case Study: Where a local authority uses its discretion to defer more than the maximum LTV

William's house is also worth **£100,000**

The amount of equity available given a loan-to-value ratio of 70% would be **£70,000.** Therefore, his 'upper limit' is also **£70,000**.

William has been deferring his care costs and a top-up for 3 years and has now reached the upper limit of **£70,000**. At this point, William is suffering from the acute after-effects of pneumonia and his prognosis suggests he will not live beyond a month. In light of his condition the local authority decides to exercise its discretion to allow him to continue to defer his fees.

William dies 2 weeks later.

9.32. Local authorities **should not** allow additional amounts to be deferred beyond the upper limit,[81] and have permission to refuse deferring care home costs beyond this (see section above entitled 'permission to refuse').

[81] Though local authorities do have discretion to set the upper limit at up to the full sale value minus the lower capital limit (currently £14,250), as set out above.

However, interest can still accrue beyond this point.

9.33. Before considering in detail how much they will be deferring, a person and usually the local authority **should** have a rough idea of their *likely care home charges* as a result of the care planning process. Someone may wish to vary their care package (or any top-ups they may be considering) following consideration of what they could afford with a deferred payment agreement but should approach the process with an approximate idea of what their care home charges are likely to be.

9.34. A person could meet the costs of their care and support from a combination of any of four primary sources:

- income,[82] including pension income;
- savings or other assets they might have access to, this might include any contributions from a third party;
- a financial product designed to pay for long-term care; or
- a deferred payment agreement which enables them to pay for their care at a later date out of assets (usually their home).

9.35. The share of care and support costs that someone intends to defer will be determined based on considerations of the amount they will be paying from other sources.

9.36. Local authorities **may** require a contribution towards fees from a person's income, but **must not** leave the person with less than the disposable income allowance. A person may choose to keep less of their income than the disposable income allowance, contributing more from their income upfront, should they wish. The disposable income allowance that local authorities must allow a DPA holder to retain is £144 per week.

9.37. A person **may** also contribute from payments by a third party (including any contributions available from a financial product).

Case study 3

Manju identifies a residential care placement that meets her care and support needs, costing £540 per week. She has an income provided by her pension of £230 per week. Manju decides not to rent her home as she intends to sell it within the year.

Based on this provisional estimate of her care costs, Manju would contribute £86 (230 – 144) per week from her income, and her weekly deferral would be £454.

9.38. When deciding on the *amount to be deferred*, both parties **should** consider a range of factors to satisfy themselves that the arrangement is sustainable:

- likely period the person would want a DPA for (if known);
- equity available;
- the sustainability of a person's contributions from their savings;
- flexibility to meet future care needs; and
- the period of time a person would be able to defer their weekly care costs for.

9.39. Deferred payment agreements should prevent people from having to sell their home in their lifetime to pay for their care. Local authorities **should** discuss with the person the projected upper limit of what their equity could cover, given their projected care home charges, and how their care home charges might change over time. This may

[82] See chapter 8 for definition of income.

include when they reach any of the income thresholds and may begin to qualify for local authority support in paying for their care.

9.40. Local authorities and individuals **should** also consider the *length of time that a person's intended contribution to care home charges from savings would last*, if they intend to contribute to their care home charges from their savings.

9.41. An important factor in the sustainability of a deferred payment agreement will be any *future care and support needs* someone might face, and local authorities and people **should** consider allowing flexibility for changes in circumstance, including possible escalations of needs, when deciding how much someone should defer. Local authorities and people **should** factor any potential changes in circumstances into their considerations of sustainability.

9.42. The Department will develop a tool to aid local authorities in assessing sustainability. Local authorities **may** use this tool to aid discussions and decisions about the amount to be deferred, but local authorities retain final responsibility for (and have discretion over) decisions taken.

9.43. In principle, people should be able to defer their full care home costs including any top-ups. At a minimum, when local authorities are required to offer a deferred payment agreement they **must** allow someone to defer the care costs (and from April 2016 their daily living costs). To ensure sustainability of the deferral, local authorities will have discretion over the amount people are permitted to top-up. Local authorities **must** consider any request for top-ups, but retain discretion over whether or not to agree to a given top-up. Local authorities **should** accept any top-up deemed to be reasonable given considerations of affordability, sustainability and available equity. Where local authorities are exercising their discretion to enter into a deferred payment agreement the amount is any amount agreed between them and the person.

9.44. When agreement has been reached between a person and the local authority as to how much they want to defer, the local authority **must** ensure this is clearly and unambiguously set out in the deferred payment agreement. Further details on what happens once an amount has been agreed are set out in the section entitled 'making the agreement' below, alongside a model deferred payment agreement.

9.45. The amount being deferred **should** be reviewed on an annual basis (or more frequently if needs change) to ensure the deferred payment amount does not exceed the upper limit as discussed above. Further details of local authorities' responsibilities during the course of the DPA are set out in the relevant section below.

Case study 4

Manju discusses her care home fees with the local authority. Based on the equity available in her home (70% loan-to-value ratio * £100,000 = £70,000), Manju could afford her weekly deferral of £454 for just under three years. Given an average length of stay in residential care of 19.7 months (source: BUPA 2010, cited in Laing and Buisson 2012/13), the local authority deems her projected care costs to be sustainable.

Manju enquires as to the cost of a room with a garden view. This would increase her weekly deferral to £525 which she could afford for about two and a half years. The local authority deems this to be sustainable, so agrees to Manju's requested top-up.

Obtaining security

9.46. A local authority **must** have adequate security in place when entering into a deferred payment agreement. The regulations set out some forms of security that local authorities **must** accept. They also provide discretion for local authorities to accept other forms of security as they see fit. Local authorities **should** consider whether another type of security could be provided if a person cannot secure their deferred payment agreement with a charge on a property.

9.47. One form of 'adequate security' would be the local authority securing a legal mortgage charge on a property via the Land Registry. Local authorities **must** accept a legal mortgage charge as adequate security – and local authorities **must** offer a deferred payment to someone who meets the eligibility criteria for the scheme where the local authority is able to secure a legal mortgage charge on the property.

9.48. In cases where an agreement is to be secured with a jointly-owned property, local authorities **must** seek both owners' consent (and agreement) to a charge being placed on the property. Both owners will need to be signatories to the charge agreement and the deferred payment agreement, and the agreement will require the co-owner to agree to the sale of the property in the event of the death of the person receiving care (following the same procedure as in the case where an individual is the sole owner of a property).

9.49. Local authorities have discretion to decide what else may constitute 'adequate security' for a deferred payment agreement, in cases where a charge cannot be secured. A local authority's decision **should** be based on an explicit policy of what other types of security they are willing to consider in addition to a charge, but local authorities **may** consider the merits of each case individually.

Other forms of security a local authority **may** choose to consider include (but are not limited to):

- a third-party guarantor – subject to the guarantor having / offering an appropriate form of security;
- a solicitor's undertaking letter;
- a valuable object such as a painting or other piece of art; or
- an agreement to repay the amount deferred from the proceeds of a life insurance policy.

9.50. A local authority has full discretion in individual cases to refuse a deferred payment agreement if it is not satisfied that adequate security is in place even if someone otherwise meets the criteria. The exception to this is in the case of legal mortgage charges, which a local authority **must** accept as adequate security.

9.51. The security **should** also be revalued periodically to assess any potential change in the value if its value is likely to change (and consequently the person's 'upper limit' should be reassessed in turn). If there is any substantial change the local authority **should** review the amount being deferred as well, as set out in the section "how much can be deferred" above.

Interest rate and administration charge

9.52. The deferred payment agreement scheme is intended to be run on a cost-neutral basis, with local authorities able to recoup the costs they may incur in deferral of fees via an interest rate. Local authorities can also recoup the administrative costs associated with DPAs, including legal and ongoing running costs, via administration charges. Administration charges and interest

accrued will usually be added on to the total amount deferred as they are accrued although a person may request to pay these separately if they choose. The deferred payment agreement **must** clearly set out that all fees deferred, alongside any interest and administrative charges incurred, must be repaid by the person in full.

9.53. Local authorities will have the ability to charge interest on any amount deferred, including any administration charge deferred. This is to cover the cost of lending and the risks to local authorities associated with lending, for example of default. Where local authorities charge interest this **must not** exceed the maximum amount specified in regulations. This will be an amount between 3.5% and 5%. Local authorities **must** inform people before they make the agreement if interest will be charged and what this will be. This is to enable people to make well-informed decisions about whether a deferred payment agreement is the best way for them to meet the costs of their care.

9.54. Interest can accrue on the amount deferred even once someone has reached the 'upper limit' (see 'how much can be deferred' above). It can also accrue after someone has died up until the point at which the deferred amount is repaid to the local authority.

9.55. Local authorities **must** set their administration charge at a reasonable level, and this level **must** reflect actual costs incurred by the local authority in provision of the Universal Deferred Payment Scheme, as set out in regulations. Relevant costs may include (but are not limited to) the costs incurred by a local authority whilst:

- Registering a legal charge with the Land Registry against the title of the property, including Land Registry search charges and any identity checks required;
- Undertaking relevant postage, printing and telecommunications;
- Total employment costs of those providing the service, including training;
- Cost of valuation and re-valuation of the property;
- Costs for removal of charges against property;
- Overheads, including (shares of) payroll, audit, top management costs, legal service.

9.56. Local authorities **should** maintain a publicly-available list of administration charges that a person may be liable to pay. Any charges **should** be separated into a fixed set-up fee for deferred payment agreements, reflective of the costs incurred by the local authority in setting up and securing a typical deferred payment agreement, and other reasonable one-time fees during the course of the agreement (reflecting actual charges incurred in the course of the agreement).

Making the agreement

9.57. Where someone chooses to enter into a deferred payment agreement, local authorities **should** aim to have the agreement finalised and in place by the end of the 12-week disregard period (where applicable), or within 12 weeks of the person approaching the local authority regarding DPAs in other circumstances.

9.58. Decisions on a person's care and support package, the amount they intend to defer, the security they intend to use and the terms of the agreement **should** only be taken following discussion between the local authority and the individual. Once agreement in principle has been reached between the local authority and the person, it is the local authority's responsibility to transpose

the details agreed into a deferred payment agreement, taking the legal form of a contract between the local authority and the person.

9.59. The local authority **must** provide a hardcopy of the deferred payment agreement to the person, and they **should** be provided with reasonable time to read and consider the agreement, including time for the individual to query any clauses and discuss the agreement further with the local authority.

9.60. The agreement **must** clearly set out:

(a) What the interest rate will be and how interest will be calculated against the amount deferred;

(b) conditions for the termination of the agreement by someone, including a requirement on the person to notify the local authority if they intend to sell their property or repay from an alternative mechanism (see the section entitled 'terminating the agreement' below);

(c) circumstances in which the local authority could refuse to defer further fees (for example if the person has already deferred up to their 'upper limit', as set out in the 'how much can be deferred' and 'permission to refuse' sections above);

(d) that the local authority will secure their debt either by placing a legal (Land Registry) charge against the property, or by some other means specified;

(e) The means of redress if either party feels the other has broken the terms of the agreement;

(f) A clear explanation of the consequences of taking out a DPA for the person and their property, including anybody who may reside in the property; and

(g) What the deferred amount or loan can be spent on. This would usually be restricted to care or care home costs.

9.61. The agreement **should** also stipulate:

(a) the value of any accrued or possible administrative or legal charges, and where possible a breakdown of their calculation;

(b) The person's responsibilities regarding maintenance and insurance of their home; and their responsibility to notify the local authority in any change of circumstance to either their income, home or care and support;

(c) The equity 'upper limit' of their security (as discussed above in the section entitled 'how much can be deferred') and the scope for this to change upon revaluation of the security used for the DPA;

(d) The process for varying any part of the agreement; and

(e) The process by which the local authority can require a re-valuation of a person's chosen form of security.

9.62. The agreement **may** also stipulate:

(a) A requirement on the individual to nominate a third party who can help the local authority to reclaim DPA costs due in the event of their death (usually the identified executor of the person's will); and

(b) provisions indemnifying the local authority against circumstances when someone might gain a beneficial interest in the property after the agreement has been made, such as a term requiring the person to notify the local authority when someone might gain a beneficial interest in the property.

9.63. Local authorities **must** ensure at a minimum that people sign or clearly and verifiably affirm they have received adequate information on options for paying for their

care, that they understand how the DPA works and understand the agreement they are entering into; and that they have had the opportunity to ask questions about the contract.

9.64. The Consumer Credit Act 1974 is designed to provide protection to people when they are borrowing money or making credit agreements. Local authorities **should** have regard to the requirements on lenders set out in the Act in deciding how to offer and run their local deferred payment agreement schemes and inform their own practice.

9.65. Under Clause 78 of the Care Act, local authorities **may** delegate responsibility for deferred payment agreements to another body. This could potentially allow a number of local authorities to combine their collective resources and offer a regional solution tailored to the local conditions and the administrative burden they face. If a local authority chooses to exercise their powers for delegation, the local authority **must** satisfy itself that the body taking on responsibility for DPAs is complying with all appropriate regulations and guidance (including but not limited to that governing deferred payments). The local authority **should** also seek feedback from people entering into DPAs to satisfy themselves that the service being provided meets the standards expected of the local authority. In the case of delegation of responsibility, the local authority remains ultimately responsible for (and liable for) the DPA.

The local authority's responsibilities whilst the agreement is in place

9.66. Local authorities **must** at a minimum provide people with an annual written update of the amount of fees deferred, of interest and administrative charges accrued to date, and of the total amount due and the equity remaining in the home (the 'upper limit' discussed in the section entitled at 'how much can be deferred' above). Local authorities **may** provide updates on a more frequent basis at their discretion. The update **must** set out the amount deferred during the previous year, alongside the total amount deferred to date, and **must** also include a projection of how quickly someone would deplete all equity remaining in their chosen form of security up to their 'upper limit'.

9.67. Local authorities **should** reassess the value of the chosen form of security periodically after the agreement is made, and adjust the 'upper limit' and review the amount deferred if the value has changed.

9.68. Local authorities **may** offer people a way to check their statement at any point in the year via an online facility.

9.69. Local authorities **may** choose to develop advice and guidance around maintaining a home, renting, and income. Local authorities **may** also offer services/ products to help the person meet the requirements for maintenance and insurance, but **must not** compel a person to take on their product. Local authorities **must** accept reasonable alternative maintenance and insurance services.

Case Study 5: Note – for illustrative purposes we have used an interest rate of 4%

After a year, Manju receives her first statement. It confirms has deferred a total of £27,957, including £557 in interest and £100 in administration fees.

At this point, the local authority revalues her property, and finds its value has increased to £105,000. Based on the amount deferred and her care costs, her equity would afford her a further 18 months in care at this price.

Contractual responsibilities on the individual whilst the agreement is in place

9.70. The deferred payment agreement sets out various contractual requirements on the individual as well as on the local authority. These are set out briefly in sections above, but the person's consequent responsibilities are recapped in more detail in the paragraphs below.

9.71. The local authority **should** include in a contract provisions requiring someone to ensure that adequate arrangements are in place to maintain their home whilst they are in care. In particular, the contract **should** require that their home is maintained adequately, and require someone to have in place an arrangement for regular maintenance to take place. Local authorities **should** also require the person to have adequate insurance for their property. If their home is to be left empty for an extended period of time, the person will need to ensure their insurance covers this adequately and that any terms required by the insurer are met.

9.72. The local authority **may** include in a contract provisions requiring a person to nominate a third party who is aware of their deferred payment agreement and who should help the local authority to reclaim the amount deferred (in the case where an individual dies before terminating their agreement). This may be the nominated executor of their will or may be another third party; but the third party should stand ready to facilitate repayment of the local authority's outstanding debts from the person's estate.

9.73. The local authority **may** include in a contract provisions for circumstances when someone moves into the property after the agreement has been made. In these circumstances, the local authority **may** require written consent from the dependent which places the debt owed to the local authority above any beneficial interest they may accrue in the property.

Termination of agreement

9.74. A deferred payment agreement can be terminated in three ways:

(a) voluntarily by the individual, or someone acting on their behalf, repaying the full amount due (this can happen during a person's lifetime or when the agreement is terminated through the DPA holder's death);

(b) automatic termination on sale of the property (or form of security);[83] or

(c) automatic termination when the person dies.

[83] In the case that a DPA is agreed on the basis of a form of security other than property, local authorities will need to make provision in the agreement for conclusion of the DPA in the event that the given security is disposed of / comes to fruition.

9.75. All three scenarios for the termination of the agreement are discussed below, alongside the various options for repayment. On termination, the full amount due (including care home charges, any interest accrued and any administrative or legal fees charged) **must** be paid by the person to the local authority.

9.76. If *a person decides sell their home*, they **must** notify the local authority at an early stage during the sale process (as per the terms of their agreement). They will be required to pay the amount due to the local authority from the proceeds of the sale, and the local authority will be required to relinquish the charge on their property.

9.77. A person may decide *to repay the amount due to the local authority from another source*, or *a third party may elect to repay the amount due on behalf of the individual*. In either case, the local authority **must** be notified of the person's/the third party's intention in writing, and the local authority **must** relinquish the charge on the property on receipt of the full amount due.

9.78. If the deferred payment is *automatically terminated by a person's death*, the amount due to the local authority **must** be either paid out of the estate or paid by a third party. A person's family or a third party may wish to settle the debt to the local authority by other means of repayment (as may be the case if the family wanted to avoid having to sell the property or means of security), and the local authority **must** accept an alternative means of payment in this case, provided this payment covers the full amount due to the local authority.

9.79. The executor of the will or Administrator of the Estate can decide how the amount due is to be paid; either from the person's estate (usually via the sale of the house or potentially via a life insurance policy) or from a third party source.

9.80. A local authority **should** wait at least two weeks following the person's death before approaching the executor of their will with a full breakdown of the total amount deferred (but a family member or the executor can approach the local authority to resolve the outstanding amount due prior to this point).

9.81. Responsibility for arranging for repayment of the amount due (in the case of payment from the estate) falls to the executor of the will, who may have been named in the deferred payment agreement. The executor is required by the agreement to be taking steps to repay the deferral within 90 days of a person's death; this would usually mean that they have started sale proceedings.

9.82. Interest will continue to accrue on the amount owed to the local authority after the individual's death and until the amount due to the local authority is repaid in full.

9.83. If terminated through a person's death, the amount owed to a local authority under a deferred payment agreement falls due 90 days after the person has died. After this 90 day period, if a local authority concludes a person is not taking active steps to repay the debt, for example if the sale is not progressing and a local authority has actively sought to resolve the situation (or the local authority concludes the executor is wilfully obstructing sale of the property), the local authority **may** enter into legal proceedings to reclaim the amount due to it.

9.84. In whichever circumstance an agreement is terminated, the full amount due to the local authority **must** be repaid to cover all costs accrued under the agreement, and the person (and/or the third party where appropriate) **must** be provided with a full breakdown of how the amount due has been calculated. Once the amount has been paid, the local authority **should** provide the individual with confirmation that the

agreement has been concluded, and confirm (where appropriate) that the charge against the property has been removed.

Case Study 6

Manju dies after a year and a half in residential care. Her son contacts the local authority a week after her death for an estimate of how much is owed to the local authority from Manju's estate. At this point in time, the amount due is £42,301.

Manju's son puts her home on the market for sale. After 90 days the home has not been sold, but the local authority is satisfied progress is being made towards a sale and so does not start to actively pursue the debt through legal means.

Manju's son sells her home around four months after her death for £108,000. Manju's son pays the £51,832 due at this point to the local authority, and the remaining £56,168 is inherited by Manju's son.

Person-centred care and support planning

10. Care and support planning

This chapter provides guidance on sections 24 and 25 of the Care Act 2014.

This chapter covers:

- When to undertake care and support planning;
- How to undertake care and support planning, and support planning;
- Production of the plan;
- Involving the person;
- Authorising others (including the person) to prepare the plan;
- Care planning for people who lack capacity;
- Minimising and authorising a deprivation of liberty (DOL) for people who lack capacity;
- Combining plans;
- Sign-off and assurance.

10.1. Care and support **should** put people in control of their care, with the support that they need to enhance their wellbeing and improve their connections to family, friends and community. A vital part of this process for people with eligible ongoing needs is the care and support plan or support plan in the case of carers (henceforth referred to as 'the plan').

10.2. The person **must** be actively involved and influential throughout the planning process, and should be free to take ownership of the development of the plan if they wish. There should be a default assumption that the person, with support if necessary, will play a strong leadership role in planning. Indeed, it should be made clear that the plan 'belongs' to the person it is intended for.

10.3. The personal budget in the plan will give everyone clear information regarding the costs of their care and support and the amount that the local authority will make available, in order to help people to make better informed decisions. The ability to meet needs by taking a direct payment **must** be clearly explained to the person in a way that works best for them, so that they can make an informed decision about the level of choice and control they wish to take over their care and support. This **should** mean offering the choice more than once in the process and enabling that choice by providing examples of how others have used direct payments, including via direct peer support.

10.4. Some people will need assistance to make plans and decisions, and to be involved in the planning process. The modern care

and support system will routinely provide supported decision making, where options and choices are presented simply and clearly. Independent advocates **must** be instructed early in the assessment and planning process for those who have substantial difficulty in engaging with the care system, and have no other means of accessing appropriate support through friends or relatives to facilitate their involvement. If the person's substantial difficulty only becomes apparent during the process, an advocate **must** be instructed as soon as this becomes known.

10.5. Ultimately, the guiding principle in the development of the plan is that this process **should** be person-centred and person-led, in order to meet the needs and outcomes of the person intended in ways that work best for them as an individual or family. Both the process and the outcome should be built holistically around people's wishes and feelings, their needs, values and aspirations, irrespective of the extent to which they choose or are able to actively direct the process.

Definitions

10.6. This chapter applies to people in need of care and support and carers equally, unless specifically stated.

10.7. For the purposes of this chapter 'the plan' means either the care and support plan (in the case of adults with care and support needs) or the support plan (in the case of carers).

When to undertake care and support planning, and support planning

10.8. Following the needs and carer's assessment and determination of eligibility (see chapter 6)**,** a plan **must** be provided where a local authority is required to meet needs under section 18 or 20(1) of the Care Act, or decides to meet needs under section 19(1) or (2) and 20(6) of the Act.

10.9. Local authorities should have regard to how needs are met beyond the provision of services. For example, needs may be met by a willing carer or in an educational establishment rather than the allocation of local authority traditional services. However needs are to be met, the principles in the this chapter **must** be followed, such as ensuring the process is person-centred, and involving and agreeing the plan with the person.

10.10. Where, through the assessment and care and support planning process, it has been identified that a person's needs would be best met in a residential setting, local authorities **must** ensure they comply with the regulations on choice of accommodation (see chapter 8).

10.11. Where the local authority is not required to meet needs, and subsequently decides not to use its powers to meet non-eligible needs, it **must** give the person written explanation for taking this decision, and **should** give a copy to their advocate if the person requests. This explanation should also include information and advice on how the person can reduce or delay their needs in future. Where possible this should be personal and specific advice based on the person's needs assessment and not a generalised reference to prevention services or signpost to a general web-site. For example, this should involve consideration of alternative ways in which a person could reduce or delay their care and support needs, including signposting to support within the local community. Authorities may choose to provide this information after the eligibility determination, in which case this need not be repeated again. At whatever stage this is done, in all cases the person **must** be given a

written explanation of why their needs are not being met. The explanation provided to the person **must** be personal to and accessible for the person (see chapter 3).

10.12. Where a local authority is meeting some needs, but not others, a combination of the two approaches above **must** be followed. The person **must** receive a care and support plan for the needs the local authority is required, or decides to meet, and which includes a tailored package of information and advice on how to delay and/or prevent the needs the local authority is not meeting. This information **should** be given to the person in a format accessible to them so they are clear what needs are being met by the local authority.

How to undertake care and support planning, and support planning

10.13. The plan will detail the needs to be met and how the needs will be met, and will link back to the outcomes that the adult wishes to achieve in day-to-day life as identified in the assessment process. This **should** reflect the individual's wishes, their needs and aspirations, and what is important to and for them, where this is reasonable. This process is central to the provision of person-centred care and support that provides people with choice and control over how to meet their needs.

10.14. The guiding principle therefore is that the person be actively involved and has the opportunity to lead or strongly influence the planning and subsequent content of the plan in conjunction with the local authority, with support if needed. Joint planning does not mean a 50:50 split; the person can take a bigger share of the planning where this is appropriate and the person wishes to do so. A further principle is that planning should be proportionate. The person **should not** be required to go through lengthy processes which limit their ability to self-plan, unless there are very strong reasons to add in elements of process and decision-making. Wherever possible the person should be able to develop a plan, and change it if circumstances change with minimum process.

Production of the plan

10.15. The plan **should** be person-centred, with an emphasis on the individual having every opportunity to be involved in the planning to the extent that they choose and are able. This requires the local authority to ensure that information is available in a way that is meaningful to the person, and that they have support and time to consider their options. The choices offered should range from support for the person to develop the plan for themselves, with their family, friends or whoever they may wish to involve (this might include web-based resources, written information and peer support), through to one-to-one support from a paid professional, such as a social worker which may be the same person whom undertook the assessment.

10.16. Where the person has substantial difficulty in being actively involved with the planning process, and they have no family and friends who are able to facilitate the person's involvement in the plan, the local authority **must** provide an independent advocate to represent and support the person to facilitate their involvement (see chapter 7). Likewise, where a person with specific expertise or training in a particular condition (for example, deafblindness) has carried out the assessment, someone with similar knowledge (and preferably the same person to ensure continuity) **should** also be involved in production of the plan.

10.17. In ensuring that the process is person-centred, the local authority **should** ensure that any staff responsible for developing the plan with the person are appropriately trained in the Mental Capacity Act, familiar with best practice , and that there is sufficient local availability of independent advocacy and peer support, including access to social work advice.

10.18. When developing the plan, there are certain elements that **must** always be incorporated in the final plan, [unless excluded by the Care and Support (Personal Budget Exclusion of Costs) Regulations 2014]. These are:

- the needs identified by the assessment;
- whether, and to what extent, the needs meet the eligibility criteria;
- the needs that the authority is going to meet, and how it intends to do so;
- for a person needing care, for which of the desired outcomes care and support could be relevant;
- for a carer, the outcomes the carer wishes to achieve, and their wishes around providing care, work, education and recreation where support could be relevant;
- the personal budget (see chapter 11);
- information and advice on what can be done to reduce the needs in question, and to prevent or delay the development of needs in the future;
- where needs are being met via a direct payment (see chapter 12), the needs to be met via the direct payment and the amount and frequency of the payments.

10.19. These requirements **should not** encourage lengthy process where this is not necessary, or fixed decisions that cannot be changed easily if the person wishes to make adjustments. The maximum flexibility should be incorporated to allow adjustment and creativity.

10.20. Consideration of the needs to be met should take a holistic approach that covers aspects such as the person's wishes and aspirations in their daily and community life, rather than a narrow view purely designed to meet personal care needs.

10.21. In considering the person's needs and how they may be met, the local authority must take into consideration any needs that are being met by a carer. The person may have assessed eligible needs which are being met by a carer at the time of the plan – in these cases the carer **should** be involved in the planning process. Provided the carer remains willing and able to continue caring, the local authority is not required to meet those needs. However, the local authority should record where this is the case in the plan, so that the authority is able to respond to any changes in circumstances (for instance, a breakdown in the caring relationship) more effectively. Where the carer also has eligible needs, the local authority **should** consider combining the plans of the adult requiring care and the carer, if all parties agree.

10.22. Local authorities **should** have regard to how universal services and community-based and/or unpaid support could contribute to the factors in the plan, including support that promotes mental and emotional wellbeing and builds social connections and capital. This may require additional learning and development skills and competencies for social workers and care workers which local authorities should provide.

10.23. Authorities are free, and are indeed encouraged, to include additional elements in the plan where this is proportionate to the needs to be met and agreed with the person the plan is intended for. For example, some

people may value having an anticipated review date built into their plan in order for them to be aware of when the review will take place.

10.24. The plan **should** be proportionate to the needs to be met, and **should** reflect the person's wishes, preferences and aspirations. However, local authorities should be aware that a "proportionate" plan does not equate to a light-touch approach, as in many cases a proportionate plan will require a more detailed and thorough examination of needs, how these will be met and how this connects with the outcomes that the adult wishes to achieve in day-to-day life.

10.25. For example, the person may have fluctuating needs, in which case the plan **should** make comprehensive provisions to accommodate for this, as well as indicate what contingencies are in place in the event of a sudden change or emergency. This **should** be an integral part of the care and support planning process, and not something decided when someone reaches a crisis point.

10.26. In all cases, additional content to the plan **must** be agreed with the adult and any other person that the adult requests, and should be guided by the person the plan is intended for. There should also be no restriction or limit on the type of information that the plan contains, as long as this is relevant to the person's needs and/or outcomes. It should also be possible for the person to develop their plan in a format that makes sense to them, rather than this being dictated by the recording requirements of the local authority. Where a person has significant difficulty in being involved, then the plan **must** be also agreed with the independent advocate who is representing and supporting the person to facilitate their involvement. Where the person lacks capacity to agree a plan, there **should** be a best interests meeting.

Example – Fluctuating Needs

Miss S has Multiple Sclerosis and requires a frame or wheelchair for mobility. Miss S suffers badly with fatigue, but for the majority of the time she feels able to cope with daily life with a small amount of care and support. However, during relapses she has been unable to sit up, walk or transfer, has lost the use of an arm or lost her vision completely. This can last for a few weeks, and happens two or three times a year; requiring 24 hour support for all daily activities.

In the past, Miss S was hospitalised during relapses as she was unable to cope at home. However, for the past three years, she has received a care and support package that include direct payments which allows her to save up one month's worth of 24 hour care for when she needs it, and this is detailed in the care and support plan.

Miss S can now instantly access the extra support she needs without reassessment and has reassurance that she will be able to put plans in place to cope with any fluctuating needs. She has not been hospitalised since.

10.27. In developing the plan, the local authority **must** inform the person which, if any, of their needs may be met by a direct payment (see chapter 12). In addition to this, the local authority **should** provide the person (and/or their advocate, if relevant) with appropriate information and advice concerning the usage of direct payments and how they differ from traditional services. This should include advice concerning:

- the difference between purchasing regulated and unregulated services (for example regarding personal assistants);
- explanation of responsibilities that come with being an employer, managing the payment, and monitoring arrangements and how these can be managed locally without being a burden;
- signposting to direct payment support and support organisations available in the area (e.g. employment, payroll, admin support, personal assistants, peer support);
- that there is no curtailment of choice on how to use the direct payment (within reason), with the aim to encourage innovation;
- local examples and links to people successfully using direct payment in similar circumstances to the person;
- advice and information should not be provided at a single fixed point but at various points in the process to ensure people have the best opportunities possible to consider how direct payments may be of benefit to them;
- the option to have a mixed package of direct payments and other forms of personal budgets.

10.28. This information provided upfront should assist the person to decide whether they wish to request a direct payment to meet some or all of their needs. However the person chooses to have their needs met, whether by direct payment, authority or third-party provision or a mix of the three, there should be no constraint on *how* the needs are met as long as this is reasonable. The local authority has to satisfy itself that the decision is an appropriate and legal way to meet needs, and should take steps to avoid the decision being the views of the professional versus those of the person. Above all, the local authority should refrain from any action that could be seen to restrict choice and impede flexibility.

10.29. It is important that people are allowed to be very flexible to choose innovative forms of care and support, from a diverse range of sources, including quality providers but also "non-service" options such as Information and Communication Technologies (ICT) equipment, club membership, and massage. Lists of allowable purchases should be avoided as the range of possibilities should be very wide and will be beyond what the local authority is able to list at any point in time. While many authorities may choose to operate lists of quality accredited providers to help people choose (for example some authorities include trading standards-style "buy with confidence" approaches) the use of such lists should not be mandated as the only choice offer to people. Limited lists of 'prescribed providers' that are only offered to the person on a 'take it or leave it' basis do not fit with the Government's vision of personalised care and must be avoided.

Involving the person

10.30. In addition to taking all reasonable steps to agree how needs are to be met, the local authority **must** also take all reasonable steps to involve the person the plan is intended for, the carer (if there is one), any other person the adult requests to be involved, or, where the person lacks capacity to ask the authority to do that, any person who appears to the authority to be interested in welfare of the person. An independent advocate must be provided if section 67 of the Act applies (see chapter 7). The person, and their carers, will have the best understanding of how the needs identified fit

into the person's life as a whole and connect to their overall wellbeing (see chapter 1). They are well placed to consider and identify which care and support options would best fit into their lifestyle and help them to achieve the day to day outcomes they identified during the assessment process. In practice, local authorities **should** give consideration to include a prompt to the person during the initial stages of the planning process to ask whether there is anyone else that the person wishes to be involved.

10.31. The level of involvement **should** be agreed with the individual and any other party they wish to involve and should reflect their needs and preferences. This may entail local authorities involving the person through regular planning meetings, or there may be instances where remote involvement is just as effective, such as over the telephone, through video conferencing, or other means. In other circumstances, local authorities will need to seek the support of speech and language therapists or other specialists. Some people will need little help to be involved, others will need much more. Social workers or other relevant professionals should have a discussion with the person to get a sense of their confidence to take a lead in the process and what support they feel they need to be meaningfully involved.

10.32. The person **should** be supported to understand what is being discussed and what options are available for them. The local authority should make sure that a person's lack of confidence to take a lead in the process should not limit the extent to which they can play an active role, if they wish to do so. In all cases, people should be allowed to gain support from individuals who they choose to assist their involvement in the planning process. Where they have substantial difficulty in being actively involved in the process, then they should be assisted by a family member or friend. If the person already has an advocate, who is acting outside of the requirements of the Care Act, who is able and willing to facilitate their involvement in the planning, then they may be an appropriate person to support the individual's involvement and represent them.

10.33. However, the local authority **must** instruct an independent advocate if there is no one else in their informal network that can facilitate their involvement (see chapter 7). This duty arises if the person would, without the representation and support of an independent advocate, experience substantial difficulty in any of the following:

- Understanding relevant information;
- Retaining that information;
- Using or weighing that information as part of the process of being involved;
- Communicating their views, wishes or feelings (whether by talking, using sign language, or any other means).

10.34. For example, there may be cases where a person wishes to have a greater involvement in the care planning process, has no family or friend who can help, and therefore requires an independent advocate to understand the relevant information provided by the local authority, and to be able to use it to effectively plan for their care and support. This can be particularly important for people in certain circumstances, for example evidence suggests that isolated older people are not benefitting from personal budgets as well as other groups.

10.35. Genuine involvement will aid the development of the plan, increase the likelihood that the options selected will effectively support the adult in achieving the outcomes that matter to them, and may limit disputes as people involved will be fully aware and have agreed to decisions made.

Local authorities **should** ensure that staff have appropriate learning and development opportunities in order to be able to facilitate involvement in the development of the plan.

Authorising others (including the person) to prepare the plan

10.36. As stated earlier in this guidance, it is important that local authorities give people every opportunity to prepare their own plan in conjunction with the local authority if they wish.

10.37. Where a plan is being developed by the person, a third party, or an independent advocate, the local authority **should** ensure that relevant information is shared securely and promptly to allow the plan to be developed in a timely fashion. A partnership approach should be taken, where each partner knows their role and the parties supported to identify options and choose between them. For example, many people may need help to weigh up different service options; they need to understand what each involves and they should be able to choose the most appropriate and least restrictive option possible.

10.38. The local authority should also consider cases or circumstances where it may not be appropriate for a person or third party to develop the plan. For example, a person may not wish their family involved, or the authority may be aware that family members may have conflicting interests, or the person requested to help develop the plan lives too far away from the person such that the plan is unable to be developed in a timely fashion. The test for allowing the person and others to have a role in developing the plan should start with the presumption that the person at the heart of the care plan should give consent for others to be involved; and should also have safeguarding principles embedded to ensure that there is no conflict of interest between the person and the person or persons they wish to involve. Where a person lacks capacity and cannot consent to the involvement of others, the local authority must always act in the best interests of the person requiring care and support.

Planning for people who lack capacity

10.39. Good, person-centred care planning is particularly important for people with the most complex needs. Many people receiving care and support have mental impairments, such as dementia or learning disabilities, mental health needs or brain injuries. The principles of the Care Act apply equally to them, in addition to the principles and requirements of the Mental Capacity Act 2005.

10.40. The Mental Capacity Act 2005 (MCA) requires local authorities to assume that people have capacity and can make decisions for themselves, unless otherwise established. Every adult has the right to make his or her own decisions in respect of his or her care plan, and must be assumed to have capacity to do so unless it is proved otherwise. This means that local authorities cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

10.41. The local authority **must** support the person to understand and weigh up information, to offer choices and help people to exercise informed choice. A person must be given all practicable help to make the specific decision before being assessed as lacking capacity to make their own decisions.

10.42. Local authorities **must** understand that people have the right to make what others might regard as an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. People cannot be treated as lacking capacity for that reason. Sometimes the care and support plan may have unusual aspects; the question to explore is whether it will meet the assessed needs and lead to the desired outcomes.

10.43. If a local authority thinks a person may lack capacity to make a decision or a plan, even after they have offered them all practicable support, a social worker or other suitably qualified professional, needs to carry out a capacity assessment in relation to the specific decision to be made. For example the local authority may assess whether the person has the capacity to decide whether family members should be involved in their care planning or whether the person has the capacity to decide on whether a particular support option will meet their needs.

10.44. Where an individual has been assessed to lack capacity to make a particular decision, then the local authority **must** commence care planning under the 'best interests principle' within the meaning of the MCA. Furthermore the person making a decision to a plan on behalf of a person who lacks capacity **must consider** whether it is possible to make a decision or a plan in a way that would be less restrictive of the person's rights and freedoms of action. Any intervention must be proportionate to the particular needs of the individual.

10.45. The duty to involve the person remains throughout the process. If lack of capacity is established, it is still important that the person is involved as far as possible in making decisions. Planning **should** always be done with the person and not for them; should always start by the identification of their wishes, feelings, values and aspirations, not just their needs, and should always consider their wellbeing in the wider context of their rights to security, to liberty, and to family life.

10.46. Where a person lacks capacity to be fully involved in their care planning or lack capacity to agree and consent to the care plan, they should be supported by family members or friends. If a person has no family or friend who is able to facilitate the person's involvement available and willing to do so, then an independent advocate must be introduced to the person. A friend or family member is not appropriate to facilitate the person's involvement if the person has capacity to decide who they wish to support them and chooses not to be supported by that individual. If the person lacks such capacity, then the Local Authority must decide on the suitability of the friend or family member in the person's best interests. The role of the independent advocate is to: support and represent the person to facilitate their involvement in decision-making in the care planning process; assist the person in communicating their wishes, feelings, value and aspirations where possible; and to challenge the local authority's decisions if necessary to represent the person's wishes or to promote the person's wellbeing and rights to security, liberty and family life.

Minimising and authorising deprivation of liberty (DOL) for people who lack capacity

10.47. In line with the least restrictive principle in the MCA, local authorities and others drawing up plans **must** minimise planned restrictions and restraints on the person as much as possible. The MCA provides legal protection for acts of restraint only if the act is necessary to prevent harm

to the person, a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm, and in the person's best interests.[84] Planned restrictions and restraints must be documented and reported to a social worker to agree.

10.48. However, if the degree and intensity of restrictions and restraints are so significant that they amount to a deprivation of liberty, this **must** be authorised under the Deprivation of Liberty Safeguards (DOLS) under the MCA.

10.49. Developing effective person-centred processes for planning in line with the guidance and the Act in general will in most cases avoid circumstances where a deprivation of liberty will arise.

10.50. The difference between a deprivation of liberty and restraint is one of degree, intensity and duration, not necessarily nature or substance. The Supreme Court has clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances: the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to those arrangements.[85] The precise scope of the term "deprivation of liberty" is not fixed. It develops over time in accordance with case law.

10.51. In DOLS cases, the MCA/DOLS team and independent advocate **must** go through the following steps when conducting the care planning process:

- Familiarise themselves with the provisions of the MCA, particularly the five principles and specifically the "least restrictive" principle;
- When designing and implementing new care and support plans for people lacking capacity, be alert to any restrictions and restraint which may be a degree or intensity that means a person is being, or is likely to be, deprived of their liberty (following the revised text supplied by the Supreme Court);
- Where a potential deprivation of liberty is identified, a full exploration of the alternative ways of providing the care and/or treatment should be undertaken, in order to identify any less restrictive ways of providing that care which will avoid a deprivation of liberty;
- Where the plan for an individual lacking capacity will unavoidably result in a deprivation of liberty judged to be in the person's best interests, this **must** be authorised.

10.52. If the person will be accommodated in a hospital or care home, the local authority can issue a deprivation of liberty authorisation under Schedule 1A to the MCA (DOL authorisation). If the person will be accommodated in other settings, a Court of Protection Order under the MCA to authorise the deprivation of liberty is needed. If the independent advocate is concerned that there is a risk of deprivation of liberty which has not been authorised, the advocate should raise this with the local authority. The advocate may make an application to the Court of Protection (with the Court's permission) if they are dissatisfied with the local authority's response.

Combining plans

10.53. Local authorities **should not** develop plans in isolation from other plans (such as plans of carers or family members, or Education, Health and Care plans) and

84 Mental Capacity Act 2005, section 5 and 6.

85 *P v Cheshire West and Chester Council and another; P and Q v Surrey County Council [2014] UKSC 19*

should have regard to all of the person's needs and outcomes when developing a plan, rather than just their care and support needs.

10.54. The local authority **should** attempt to establish where other plans are present, or are being conducted and seek to combine plans, if appropriate. This should be considered early on in the planning process (at the same time as considering the person's needs and how they can be met in a holistic way) to ensure that the package of care and support is developed in a way that fits with what support is already being received or developed. For example, this may be where the plan can be combined with a plan being developed to meet other needs, or where a plan might usefully be combined with that of a carer, or family member. In all circumstances, the plan should only be combined if all parties to whom it is relevant agree. It is the responsibility of the local authority to obtain consent from all parties involved, and the combination of plans should be in the best interests of all involved.

10.55. Where one of the plans to be combined is for a child (below 18 years old), the child **must** have capacity to agree to the combination, or if lacking capacity, the local authority **must** be satisfied that the combination of plans would be in the child's best interests. Often it will be; but where there is a conflict of interest (for example a parent does not wish to support their adult daughter's wish for greater independence) it may not be (see chapter 16 on transition to adult care and support).

10.56. The local authority may be undertaking care and or support planning for two people in the same household who require independent advocacy to facilitate their involvement. If both people have the capacity to consent to having the same advocate, and the advocate and the local authority both consider there is no conflict of interest, then the same advocate may support and represent the two people. If either person lacks the capacity to consent to having the same advocate, the advocate and local authority must both consider that using the same advocate would not raise a conflict of interest and would be in the best interests of both persons (see chapter 7).

10.57. Consideration should also be given to how plans could be combined where budgets are pooled, either with people in the same household, or between members of a community with similar care needs (see chapter 11 on personal budgets).

10.58. Where it has been agreed to combine the plan with plans relating to other people, it is important that the individual aspects of each person's plan are not lost in the process of combining plans. The combined plan **should** reflect the individual needs and circumstance for each person involved, as well as any areas where a joint approach has been agreed to meet needs in a more effective way.

10.59. One key area where plans can be combined, are cases where the person is receiving both local authority care and support and NHS health care. An example would be a person with mental disorder who meets the criteria for care and support under the multi-agency Care Programme Approach.[86] The introduction of personal health budgets in health, similar to personal budgets in social care, provides a powerful tool to enable integrated health and care provision which focuses on what matters most to the person. Local authorities should

[86] See "Refocusing the Care Programme Approach – Policy and Positive Practice Guidance" Department of Health, March 2008 http://www.nmhdu.org.uk/silo/files/dh-2008-refocusing-the-care-programme-approach-policy-and-positive-practice-guidance.pdf

provide information to the person of the benefits of combining health and social care support, and seek to work with health colleagues to combine health and care plans wherever possible.

10.60. In combining plans, whether among people or organisations (such as health, education or housing), it is vital to avoid duplicating process or introducing multiple monitoring regimes. Information sharing **should** be rapid and seek to minimise bureaucracy. Local authorities **should** work alongside health and other professionals where plans are combined to establish a 'lead' organisation who undertakes monitoring and assurance of the combined plan. Particular consideration should be given to ensuring that health and care planning process are aligned, coherent and streamlined, to avoid confusing the person with two different systems (see chapter 14 on integration and cooperation).

Sign-off and assurance

10.61. The local authority **must** take all reasonable steps to agree with the person, how the plan details how needs will be met. Therefore, it **should not** introduce measures that place any undue burden on the person, especially where the person is developing the plan themselves or with a third party. The local authority should therefore avoid developing processes that undermine the self-development of plans, such as excessive quality control. For example, a local authority may have arrangements or contract with outside organisations/individuals to provide peer support for planning. An important part of this contract will be to agree, non-restrictive approaches that enhance the quality of plans and the local authority's trust in the detail as well as removing issues that can cause delay and problems.

10.62. The local authority's role where the person or third-party are undertaking the development of the plan should be to oversee and provide guidance for the completion of the plan, and ensuring that the plans to meet needs are appropriate and represent the best balance between value for money and maximisation of outcomes. In some cases, this may involve providing materials and approaches to support self-planning, producing the plan on behalf of the person, or authorising a third-party to do so. In these cases, the best interests of the person **should** be reflected throughout.

10.63. Sign-off should occur when the person, any third party and authority have agreed on the factors within the plan, including the final personal budget amount (which may have been subject to change during the planning process), and how the needs in question will be met. This agreement **should** be recorded and a copy placed within the plan.

10.64. While there is no defined timescale for the completion of the care and support planning process, the plan **should** be completed in a timely fashion, proportionate to the needs to be met. Local authorities **must** ensure that sufficient time is taken to ensure the plan is appropriate to meet the needs in question, and is agreed by the person the plan is intended for.

10.65. Due regard **should** be taken to the use of approval panels in both the timeliness and bureaucracy of the planning and sign-off process. In some cases panels may be an appropriate governance mechanism to sign-off large or unique personal budget allocations and/or plans. However, local authorities **should refrain** from creating or using panels that seek to amend planning decisions, micro-manage the planning process or are in place purely for financial reasons. Local authorities should consider

how to delegate responsibility to their staff to ensure sign-off takes place at the most appropriate level. In cases or circumstances where a panel is to be used, and where an expert assessor has been involved in the care and support journey, the same person or another person with similar expertise should be part of the panel to ensure decisions take into account complex or specialist issues.

10.66. In the event that the local authority decides that it cannot sign-off a care or support plan, or where a plan cannot be agreed with the person, or any other person involved, the local authority **should** state the reasons for this and the steps which must be taken to ensure that the plan is signed-off. This may require going back to earlier elements of the planning process. If a dispute still remains, and the local authority feels that it has taken all reasonable steps to address the situation, it should direct the person to the complaints procedure. However, by conducting person-centred planning and ensuring genuine involvement throughout, this situation should be avoided.

10.67. Upon completion of the plan, the local authority **must** give a copy of the final plan in a format that is accessible to the person for whom the plan is intended, any other person they request to receive a copy, and their independent advocate if they have one. This should not restrict local authorities from making the draft plan available throughout the planning process; indeed in cases where a person is self-planning, the plan should be in their possession. Consideration should also be given to sharing key points of the final plan with other professionals and supporters, with the person's consent (for example, as part of the person's health record).

Links to external resources

Care and Support Planning Guide, National Voices, March 2014: http://www.nationalvoices.org.uk/read-our-guide

7 essential criteria of support planning, In Control 2005: http://bit.ly/1etdihV

Good practice in support planning and brokerage, PPF, 2008: http://bit.ly/1b4tfdS

Peer support and personalisation, NCIL, 2008: http://bit.ly/1fWs7Yz

Planning together – peer support and self-directed support, PPF, 2009: http://bit.ly/1fxsMOi

Support planning and brokerage with older people and people with mental health difficulties, PPF, 2010: http://bit.ly/LB7lgt

Personalisation through person-centre planning, DH, 2010: http://bit.ly/1iv3SBG

Rethinking support planning – ideas for an alternative approach, TLAP, 2011: http://bit.ly/1b4tYff

Empower and enable – a people led approach to support planning, Groundswell, 2012: http://bit.ly/1kYs93T

Implementing effective care planning, PHB Toolkit, NHSE, 2012: http://bit.ly/1cYCNWJ

Principles of care and support planning, National Voices, 2013: http://bit.ly/IKqjp5

PA toolkit, http://www.skillsforcare.org.uk/Employing-your-own-care-and-support/Support-for-individual-employers/Employing-personal-assistants-toolkit.aspx

Employing Staff, http://www.skillsforcare.org.uk/Employing-your-own-care-and-support/Employing-your-own-care--support-staff.aspx

The Common Core Principles to Self Care, http://www.skillsforcare.org.uk/Skills/Self-care/Self-care.aspx

Personal budgets and mental health, http://www.ndti.org.uk/who-were-concerned-with/mental-health/paths-to-personalisation/

Carers' rights, http://www.skillsforcare.org.uk/Skills/Carers/Carers.aspx

11. Personal budgets

This chapter provides guidance on:

- *Section 26 of the Care Act 2014;*
- *The Care and Support (Personal Budget Exclusion of Costs) Regulations 2014.*

This chapter covers:

- The personal budget;
- Elements of the personal budget;
- Elements of care and support that are excluded from the personal budget;
- Calculating the personal budget;
- Agreeing the final budget;
- Use of the personal budget;
- Use of a carer's personal budget;
- Carers' personal budgets where the adult being cared for is not a personal budget holder;
- Appeals/disputes.

11.1. Personal budgets are a key part of the Government's aspirations for a person-centred care and support system. Independent research shows that where implemented well, personal budgets can improve outcomes and deliver better value for money.[87,88,89,90] The Act places personal budgets into law for the first time, making them the norm for people with care and support needs.

11.2. The personal budget is the mechanism that, in conjunction with the care and support plan, or support plan, enables the person, and their advocate if they have one, to exercise greater choice and take control over how their care and support needs are met. It means:

- knowing, before care and support planning begins, how much money is available to meet eligible, assessed needs and having clear information about the proportion the local authority will pay, and what amount (if any) the person will pay.

87 Glendinning, C. et al, *Evaluation of the Individual Budgets Pilot programme,* IBSEN, York , 2008.

88 Audit Commission, *Improving Value For Money in Adult Social Care,* 2011. Thirty-six per cent of councils cited personalisation as a driver of better value for money in 2009/10. This rises to 45 per cent for 2010/11. Better value came mostly from improved outcomes, not savings.

89 Audit Commission, *Financial Management of Personal Budgets*, 2010.

90 Ipsos Mori, *Users of Social Care Budgets,* July 2011.

- being able to choose from a range of options for how the money is managed, including direct payments, the local authority managing the budget and a provider or third party managing the budget on the individual's behalf (an individual service fund), or a combination of these approaches.
- having a choice of over who is involved in developing the care and support plan for how the personal budget will be spent, including from family or friends.
- having greater choice and control over the way the personal budget is used to purchase care and support, and from whom.

11.3. It is vital that the process used to establish the personal budget is transparent so that people are clear how their budget was calculated, and the method used is robust so that people have confidence that the personal budget allocation is correct and therefore sufficient to meet their care and support needs. The allocation of a clear upfront indicative (or 'ball-park') allocation at the start of the planning process will help people to develop the plan and make appropriate choices over how their needs are met.

11.4. The process of allocating the personal budget **should** be completed in a timely manner, proportionate to the needs to be met. At all times the person **should** be informed where they are in the care planning process, what will happen next and the likely timeframes.

11.5. This chapter applies to people in need of care and support and carers equally, unless specifically stated.

The personal budget

11.6. Everyone whose needs are met by the local authority, whether those needs are eligible, or if the authority has chosen to meet other needs, **must** receive a personal budget as part of the care and support plan, or support plan. The personal budget is an important tool that gives the person clear information regarding the money that has been allocated to meet the needs identified in the assessment and recorded in the plan. An indicative amount **should** be agreed with the person, and anybody else involved, at the start of care and support planning, with the final amount personal budget confirmed through this process. The detail of how the personal budget will be used is set out in the care and support plan, or support plan.

11.7. This allows the person, and anybody else the person wishes, to make informed decisions about how to meet their care and support needs. The person can choose for the personal budget allocation to remain with the local authority to arrange care and support on the person's behalf, and in line with their wishes. Alternatively, if available locally, it can be placed with a third-party provider on the same basis, often called an individual service fund. Where an ISF type arrangement is not available locally, the local authority should explore arrangements to develop this offer, and should be receptive to requests from personal budget recipients to create these arrangements with specified providers. The person may also request to take some or all of the budget as a direct payment, and the local authority must comply with this request, provided the relevant conditions in the Act are met (see chapter 12 on direct payments).

11.8. There may also be cases where a person prefers to use a mixed package of care and support. For example, this may be

a direct payment for some of their needs, with the remainder of the personal budget allocated via the local authority or a third-party, or any combination of the above. The method of allocating the personal budget should be decided and agreed during the care and support planning process (see chapter 10). It is important that these arrangements can be subsequently adjusted if the person wishes this, with the minimum of procedure. The process for allocating and agreeing the personal budget via the planning process **should** be as straightforward and as timely as possible so that the person can access the budget without significant delay.

Elements of the personal budget

11.9. The personal budget **must** always be an amount sufficient to meet the person's care and support needs, and **must** include the cost to the local authority of meeting the person's needs which the local authority is under a duty to meet, or has exercised its power to do so. This overall cost **must** then be broken down into the amount the person **must** pay, following the financial assessment, and the remainder of the budget that the authority will pay.

11.10. The personal budget may also set out other amounts of public money that the person is receiving, such as money provided through a personal health budget. Integrated health and care, and integration of other aspects of public support are the long-term vision of the Government. This will provide the individual with a seamless experience, and can help to remove unnecessary bureaucracy and duplication that may exist where a person's needs are met through money from multiple funding streams.

11.11. Local authorities should take a lead in driving the integration of support services for their population. For example, this may involve agreeing with partner organisations a lead organisation that agrees to oversee monitoring and assurance of all budgets the person is receiving.

11.12. Where a local authority is meeting the eligible needs of a person whose financial resources are above the financial limit, but who has requested the local authority meet their needs, the local authority **may** make a charge for putting in place the necessary arrangements to meet needs (a brokerage fee) (see chapter 8 on charging and financial assessment). Where this occurs, the local authority should consider how best to set this information out to the person, in a format accessible to them. This fee is not part of the personal budget, since it does not relate directly to meeting needs, but it may be presented alongside the budget to help the person understand the total charges to be paid. For example, a local authority **may** wish to specify this in both the plan and the personal budget for the person so all parties are clear on how costs are allocated.

11.13. Similarly, there will be cases where a person is making an additional payment (or a "top-up") in order to be able to secure the care and support of their choice, where this costs more than the local authority would normally pay for such a type of care. In these cases, the additional payment does not form part of the personal budget, since the budget must reflect the costs to the local authority of meeting the needs. However, the local authority **should** consider how best to present this information to the individual, so that the total amount of charges paid is clear, and the link to the personal budget amount is understood.

Elements of care and support that are excluded from the personal budget

11.14. Regulations set out the cases or circumstances where the costs of meeting the needs of care and support do not have to be incorporated into the personal budget. Because both the care and support plan and personal budget are mechanisms to enable people to have greater choice and control over their care and support, there are not many instances where this exclusion will apply.

11.15. The *Care and Support (Personal Budget Exclusion of Costs) Regulations 2014* set out that the provision of intermediate care and reablement to meet eligible needs, **must** be excluded from the personal budget. This will mean that where either intermediate care or reablement is being provided to meet eligible needs (i.e. needs under section 18, 19 or 20 of the Care Act) the cost of this **must not** be calculated in the personal budget. "Intermediate care" is a structured programme of care provided for a limited period of time, to assist a person to maintain or regain the ability to live independently at home. "Reablement" is a particular type of intermediate care, which has a stronger focus on helping the person to regain skills and capabilities to reduce their needs, in particular through the use of therapy.

11.16. There is a tendency for the terms "reablement", "rehabilitation" and "intermediate care" to be used interchangeably. The National Audit of Intermediate Care categorises four types of intermediate care: **crisis response** – services providing short-term care (up to 48 hours); **home-based intermediate care** – services provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists; **bed-based intermediate care** – services delivered away from home, for example, in a community hospital; and **reablement** – services to help people live independently provided in the person's own home by a team of mainly social care professionals.

11.17. Three of the four types of intermediate care have historically been clinician-led and provided by health staff, with reablement being provided by local authorities. However, these are not concrete, mutually-exclusive categories – and, furthermore, with greater integration and co-operation between health and local authorities, there should be greater use of qualified staff from health and social care working together to provide intermediate care.

11.18. Local authorities **should not** seek to include additional elements that would not normally be classified as intermediate care or reablement into this exclusion. Indeed, the Act restricts the regulations into specifying only care and support which the local authority cannot charge for, or chooses not to charge for. This ensures that long-term care and support will always be part of the personal budget, and in future, the cap on care costs.

11.19. Intermediate care/reablement **should** usually be provided as a free, universal service under section 2 of the Act, and therefore would not contribute to the personal budget amount (and in future to the cap on care costs). However, in some circumstances, a local authority **may** choose to combine either service with aspects of care and support to meet eligible or ongoing needs, which would require a personal budget to be developed. Removing the cost of provision of intermediate care/reablement from the personal budget in these scenarios ensures that the allocation of both services is applied

uniformly across all local authorities, and in future people progress towards the cap on care costs in a fair and consistent way.

11.20. In cases where intermediate care/reablement is provided to meet needs under section 18 or 20(1) or under section 19(1) or 20(6), either in isolation or combined with longer-term care and support, the plan should describe what the package consists of and how long it will last. This will help the person understand what is being provided to meet their needs. However, the person should not receive a personal budget, unless there are other forms of eligible care and support being provided. In these cases, the personal budget amount should not include the cost of intermediate care/reablement.

Calculating the personal budget

11.21. It is important to have a consistent method for calculating personal budgets that provides an early indication of the appropriate amount to meet the identified needs to be used at the beginning of the planning process. Local authorities **should** ensure that the method used for calculating the personal budget produces equitable outcomes to ensure fairness in care and support packages.

11.22. There are many variations of systems used to arrive at personal budget amounts, ranging from complex algorithmic-based resource allocation systems (RAS), to more 'ready-reckoner' approaches. Complex RAS models of allocation may not work for all client groups, especially where people have multiple complex needs, or where needs are comparatively costly to meet, such as deaf-blind people. It is important that these factors are taken into account, and that a 'one size fits all' approach to resource allocation is not taken. If a RAS model is being used, local authorities should consider alternative approaches where the process may be more suitable to particular client groups to ensure that the personal budget is an appropriate amount to meet needs.

11.23. Regardless of the process used, the most important principles in setting the personal budget are transparency, timeliness and sufficiency. This will ensure that the person, their carer, and their independent advocate if they have one, is fully aware of how their budget was calculated, that they know the amount at a stage which enables them to plan their care and support accordingly, and that they can have confidence that the amount includes all relevant costs that will be sufficient to meet their identified needs in the way set out in the plan. This should prevent disputes from arising, but it **must** also be possible for the person, carer or advocate to challenge the local authority on the sufficiency of the final amount.

- **Transparency:** Authorities **should** make their allocation processes publicly available as part of their general information offer, or provide this on a bespoke basis for each person the authority is supporting in a format accessible to them. This will ensure that people fully understand how the personal budget has been calculated, both in the indicative amount and the final personal budget allocation. Where a complex RAS process is used, local authorities should pay particular consideration to how they will meet this transparency principle, to ensure people are clear how the personal budget was derived.
- **Timeliness:** It is crucial when calculating the personal budget to arrive at an upfront allocation which can be used to inform the start of the care and support

planning process. This 'indicative allocation' will enable the person to plan how the needs are met. After refinement during the planning process, this indicative amount is then adjusted to be the amount that is sufficient to meet the needs which the local authority is required to meet under section 18 or 20(1), or decides to meet under section 19(1) or (2) or 20(6). This adjusted amount then forms the personal budget recorded in the care plan.

- **Sufficiency:** The amount that the local authority calculates the personal budget to be **must** be sufficient to meet the person's needs which the local authority is required to meet under section 18 or 20(1), or decides to meet under section 19(1) or (2) or 20(6) and **must** also take into account the reasonable preferences to meet needs as detailed in the care and support plan, or support plan.

11.24. The Act sets out that the personal budget **must** be an amount that reflects the cost to the local authority of meeting the person's needs. In establishing the 'cost to the local authority', consideration should be given to the cost of the service at an appropriate quality, through local provision to ensure that the personal budget reflects local market conditions. Consideration should also be given as to whether the personal budget is sufficient where needs will be met via direct payments, especially around any 'on-costs' that may be required to meet needs (see chapter 12). There may be concern that the 'cost to the local authority' results in the direct payment being a lesser amount than is required to purchase care and support on the local market due to local authority bulk purchasing and block contract arrangements. However, by basing the personal budget on the price of quality local provision, this concern should be allayed.

11.25. However, a request for needs to be met via a direct payment does not mean that there is no limit on the amount attributed to the personal budget. There may be cases where it is more appropriate to meet needs via directly-provided care and support, rather than by making a direct payment. For example, this may be where there is no local market for a particular kind of care and support that the person wishes to use the direct payment for, except for services provided by the local authority. It may also be the case where the costs of an alternate provider arranged via a direct payment would be substantially more than the local authority would be able to arrange the same support for, whilst achieving the same outcomes for the individual.

11.26. In all circumstances, consideration should be given to the expected outcomes of each potential delivery route. It may be that by raising the personal budget to allow a direct payment from a particular provider, it is expected to deliver much better outcomes than traditionally delivered care and support. Decisions **should** therefore be based on outcomes and value for money, rather than purely financially motivated.

11.27. In cases such as these, the care plan **should** be reviewed to ensure that it is accurate and that the personal budget allocation is correct. The authority should work with the person, their carer and independent advocate to agree on how best to meet their care and support needs. It may be that the person can take a mixture of direct payment and local authority arranged care and support, or the local authority can work with the person to discuss alternate uses for the personal budget. Essentially, these discussions will take place during the planning process and local authorities should ensure that their staff are appropriately trained to support personalised care and support.

Example – Costs of direct payments

Mr A has been assessed as requiring home care support for 5 hours each week. The local authority has a block contract with an agency which has been providing support to Mr A twice per week. Mr A is happy with the quality of support he receives but would like more flexibility in the times at which he receives support in order to better meet his needs. He therefore requests a direct payment so that he can make his own arrangements with the agency, which is happy to provide a much more flexible and personalised service. The cost to the local authority of the block contracted services is £12.50 per hour. However, the more flexible support purchased by an individual costs £17 per hour. The local authority therefore increases Mr A's direct payment from £62.50 to £85 per week to allow him to continue to receive the number of hours he requires. The solution through a direct payment delivers better outcomes for Mr A and therefore the additional cost is reasonable and seen as value for money. The local authority also agrees it is more efficient for Mr A to communicate the hours he wants to receive support and handle the invoicing himself.

Agreeing the final budget

11.28. The final budget **should** be agreed at the end of the care and support planning process. This ensures there is scope for the budget to increase (should the budget prove insufficient during support planning) or decrease (should the budget prove to be more than is required, for example where unpaid support or universal services have been identified as appropriate to meet some needs during the support planning process). Any process in place for agreeing the final budget and associated care and support plan should be transparent and proportionate to the budget involved and any risks identified. Some local authorities are devolving responsibility for agreeing budgets set at a low level to frontline staff and/or social work team managers so as to avoid unnecessary delays and minimise the use of panels.

11.29. Generally, the agreement of the final budget and support plan should not involve scrutiny of specific elements of the plan on the basis of their cost alone. Consideration **should** be given to the cost of meeting needs as part of a wider evaluation of other aspects such as value for money and anticipated outcomes. In many cases, as long as a plan is within the indicative budget (or justifiably above it) and the proposed use of the money is appropriate, legal and meets the needs identified in assessment, it should be "signed off."

Use of the personal budget

11.30. The person should have the maximum possible range of options for managing the personal budget, including how it is spent and how it is utilised. Directing spend is as important for those choosing the council-managed option or individual service fund as for direct payments. Evidence suggests that people using council-managed personal budgets are currently not achieving the same level of outcomes as those using direct payments, and in too many cases do not even know they have been allocated a personal budget.[91]

11.31. There are three main ways in which a personal budget can be deployed:

[91] InControl Personal Budget Outcomes Evaluation Tool: http://www.in-control.org.uk/media/154591/poetnationalreport.pdf

- As a managed account held by the local authority with support provided in line with the persons wishes;
- As a managed account held by a third party (often called an individual service fund or ISF) with support provided in line with the persons wishes;
- As a direct payment.

11.32. In addition, a person may choose a 'mixed package' that includes elements of some or all three of the approaches above. Local authorities **must** ensure that whatever way the personal budget is used, the decision is recorded in the plan and the person is given as much flexibility as is reasonably practicable in how their needs are met. The mixed package approach can be a useful option for people who are moving to direct payments for the first time. This allows a phased introduction of the direct payment, giving the person time to adapt to the direct payment arrangements.

11.33. Where ISF approaches to personal budget management are available locally, the local authority **should** provide people with information and advice on how the ISF arrangement works, how the provider(s) will manage the budget on behalf of the person, and advice on what to do if a dispute arises. Consideration should be given to using real local examples that illustrate how other people have used the ISF arrangement.

11.34. Where there are no ISF arrangements available locally, the local authority **should** consider establishing this as an offer for people. Additionally, the local authority **should** reasonably consider any request from a person for an ISF arrangement with a specified provider.

11.35. Local authorities **should** also give consideration to how choice could be increased by pooling budgets together. For example, this may include pooling budgets of people living in the same household such as an adult and carer, or pooling budgets of people within a community with similar care and support needs, or aspirations. Pooling budgets in circumstances such as this may deliver increased choice, especially where managed budgets are concerned.

11.36. Evidence suggests that in most cases people need to know the amount of their budget, be able to choose how it is managed, and have maximum flexibility in how it is used to achieve the best outcomes. This implies that the process and practice for personal budgets **must** follow the key principles of self-directed support.[92] Local authorities **should** aim to develop a range of means to enable anyone to make good use of direct payments and where people choose other options, **should** ensure local practice that maximises choice and control (for example use of Individual Service Funds). Local authorities **should** also take care not to inadvertently limit options and choices. For example "pre-paid cards" can be a good option for some people using direct payments, but **must** not be used to constrain choice or be only available for use with a restricted list of providers.

Use of a carer's personal budget

11.37. Specific consideration should be given to how a personal budget will be used by carers. The Act specifies that a carer's need for support can be met by providing care to the person they care for. However, decisions on for whom a particular service is to be provided may affect issues such as whether the service is chargeable, and who is liable to pay any charges. It is therefore important that it is clear to all individuals

92 http://www.in-control.org.uk/related-pages/seven-principles-of-self-directed-support.aspx

involved whose needs are intended to be met by a particular type of support, to whom the support will be provided directly, and therefore who may pay any charges due. Where a service is provided directly to the adult needing care, even though it is to meet the carer's needs, then that adult would be liable to pay any charge, and must agree to doing so.

11.38. Decisions on which services are provided to meet carer's needs, and which are provided to meet the needs of the adult for whom they care, will therefore impact on which individual's personal budget includes the costs of meeting those needs. Local authorities should make this decision as part of the care planning process, in discussion with the individuals concerned, and should consider whether joint plans (and therefore joint personal budgets) for the two individuals may be of benefit.

11.39. Local authorities **should** consider how to align personal budgets where they are meeting the needs of both the carer and the adult needing care concurrently. Where an adult has eligible needs for care and support, and has a personal budget and care and support plan in their own right, and the carer's needs can be met, in part or in full, by the provision of care and support to that person needing care, then this kind of provision should be incorporated into the plan and personal budget of the person with care needs, as well as being detailed in a care and support plan for the carer.

11.40. "Replacement care" may be needed to enable a carer to look after their own health and wellbeing alongside caring responsibilities, and to take a break from caring. For example, this may enable them to attend their own health appointments, or go shopping and pursue other recreational activities. It might be that regular replacement care overnight is needed so that the carer can catch up on their own sleep. In other circumstances, longer periods of replacement care may be needed, for example to enable carers to have a longer break from caring responsibilities or to balance caring with education or paid employment.

11.41. The carer's personal budget **must** be an amount that enables the carer to meet their needs to continue to fulfil their caring role, and takes into account the outcomes that the carer wishes to achieve in their day to day life. This includes their wishes and/or aspirations concerning paid employment, education, training or recreation if the provision of support can contribute to the achievement of those outcomes. The manner in which the personal budget will be used to meet the carer's needs **should** be agreed as part of the planning process.

11.42. Local authorities **must** have regard to the wellbeing principle of the Act as it may be the case that the carer needs a break from caring responsibilities to look after their own physical/mental health and emotional wellbeing, social and economic wellbeing and to spend time with other members of the family and personal relationships. Whether or not there is a need for replacement care, carers may need support to help them to look after their own wellbeing. This may be, for example, a course of relaxation classes, training on stress management, gym or leisure centre membership, adult learning, development of new work skills or refreshing existing skills (so they might be able to stay in paid employment alongside caring or take up return to paid work), pursuit of hobbies such as the purchase of a garden shed, or purchase of laptop so they can stay in touch with family and friends.

Example – Flexible use of a carer's personal budget

Connor has been caring for his wife, who is in a wheelchair with ME and arthritis, for the last nine years. He does all the cooking, driving and general household duties for her. Connor received a personal budget which he requested in the form of a direct payment from his local authority for a laptop to enable him to be in more regular contact through Skype with family in the US. This now enables Connor to stay connected with family he cannot afford to fly and see. This family support helps Connor with his ongoing caring role.

Divya has four young children and provides care for her father who is nearing the end of his life. Her father receives a direct payment, which he used to pay for a family member to come from India for a period of time to give his daughter a break from her caring role. Divya received a carers' direct payment, which she uses for her children to attend summer play schemes so that she get some free time to meet with friends and socialise when the Indian family member providers care to her father. This gives Divya regular breaks from caring which are important to the family unit.

Carers' personal budgets where the adult being cared for is not a personal budget holder

11.43. The Act makes clear that the local authority is able to meet the carer's needs by providing a service directly to the adult needing care. In these cases, the carer **must** still receive a support plan which covers their needs, and how they will be met. This would specify how the carer's needs are going to be met (for example, via replacement care to the adult needing care), and the personal budget would be for the costs of meeting the carer's needs.

11.44. The adult needing care would not get a personal budget or care plan, because no matter what the service is in practice, it is designed to meet the carer's needs. However, it is essential that the person requiring care is involved in the decision-making process and agrees with the intended course of action.

11.45. In situations such as these, the carer could request a direct payment, and use that to commission their own replacement care from an agency, rather than using an arranged service from the local authority or a third party. The local authority **should** take steps to ensure that the wishes of the adult requiring care are taken into account during these decisions. For example, the adult requiring care may not want to receive replacement care in this manner.

11.46. If such a type of replacement care is charged for (and it may not be), then it would be the adult needing care that would pay, not the carer, because they are the direct recipient of the service. This is in part why it is so important that the adult needing care agrees to receiving that type of care. The decisions taken by the carer and adult requiring care should be agreed and recorded in the support plan.

11.47. For the purposes of charging, the personal budget which the carer receives **must** specify the costs to the local authority and the costs to the adult, based on the charging guidance (see chapter 8). In this case, "the adult" refers to the carer, because they are the adult whose needs are being met. However, in instances where replacement care is being provided, the carer **should** not be charged; if charges are due to be paid then these have to be met by the

adult needing care. Any such charges would not be recorded in the personal budget, but should be set out clearly and agreed by those concerned.

Appeals/disputes

11.48. The local authority **should** take all reasonable steps to limit appeals or disputes regarding the personal budget allocation. This will include through effective care and support planning, and transparency in the personal budget allocation process. Additionally, many disputes may be avoided by informing people of the timescales that are likely to be involved in different stages of the process. Keeping people informed how their case is progressing may help limit the number of disputes.

11.49. Current complaints provision for care and support is set out in regulations.[93] The provisions of the regulations mean that anyone who is dissatisfied with a decision made by the local authority can make a complaint about that decision and have that complaint handled by the local authority. The local authority **must** make its own arrangements for dealing with complaints in accordance with the 2009 regulations.

Links to external resources

The seven steps to being in control of my support, In Control, 2005: http://bit.ly/1c7cgSX

Managing the money – resource deployment options for personal budgets, PPF, 2008: http://bit.ly/1azdgUx

Financial management of personal budgets, Audit Commission, 2010: http://bit.ly/1dsWWzE

Enabling risk, ensuring safety – self-directed support and personal budgets, SCIE, 2010: http://bit.ly/1btZcqK

Self-directed support process – what good looks like, ADASS SW, 2010: http://bit.ly/1cYOXPi

Making resource allocation work in a financial environment, PPF / ADASS, 2010: http://bit.ly/1cYQpBh

Adult social care minimum process framework, TLAP, 2011: http://bit.ly/LBJym0

Keeping personal budgets personal – learning from the experiences of older people, people with mental health problems and their carers, SCIE, 2011: http://bit.ly/1iwYsFO

Personal budgets – taking stock, moving forward, TLAP, 2011: http://bit.ly/LTFDC3

Integrating personal budgets – early learning, PHB Toolkit, NHSE, 2012: http://bit.ly/Mv2F1Z

Integrating personal budgets – myths and misconceptions, PHB Toolkit, NHSE, 2012: http://bit.ly/1eXXz5j

Progressing personalisation – a review of personal budgets and direct payments for carers, Carers Trust, 2012: http://bit.ly/N8VzBj

Making it real – making progress towards personalised, community based support, TLAP, 2012: http://bit.ly/1nX2V8J

Choice and control for all – the role of individual service funds in delivering personalised care and support, Groundswell, 2012: http://bit.ly/1dsYA4f

Personal health budgets – ways in which money can be held and managed, NHSE, 2012: http://bit.ly/1iv2Gyn

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

Improving personal budgets for older people, TLAP, 2013: http://bit.ly/1iuTGJq

Self-directed support: reducing process, increasing choice and control, TLAP, 2013: http://bit.ly/LBIqig

RAS Challenge information, In Control, 2013: http://bit.ly/1ndyaJe

Paths to personalisation in mental health, TLAP / NDTi, 2013: http://bit.ly/1b5mRmB

National personal budgets survey, TLAP, 2013: http://bit.ly/1crP3KG

Making it real for carers, TLAP, 2013: http://bit.ly/1ndEmkK

12. Direct payments

This chapter provides guidance on:

- *Sections 31, 32 and 33 of the Care Act 2014;*
- *The Care and Support (Direct Payments) Regulations 2014.*

This chapter covers:

- Making direct payments available;
- Considerations for adults with and without capacity;
- Administering, monitoring and reviewing direct payments;
- Using the direct payment;
- Paying family members;
- Short-term and long-term care in a care home;
- Becoming an employer;
- Direct payments and hospital stays;
- Direct payments for local authority services;
- Direct payments in the form of pre-payment cards;
- Harmonisation of direct payments;
- Terminating direct payments;

12.1. Direct payments are monetary payments made to individuals who request to receive one to meet some or all of their eligible care and support needs. The legislative context for direct payments is set out in the Care Act, Section 117(2C) of the Mental Health Act 1983 (the 1983 Act) and the *Care and Support (Direct Payments) Regulations 2014*.

12.2. This guidance supersedes the 2009 guidance on direct payments, and reflects the new legislative framework.

12.3. Direct payments have been in use in adult care and support since the mid-1990s and they remain the Government's preferred mechanism for personalised care and support. They provide independence, choice and control by enabling people to

commission their own care and support in order to meet their eligible needs.[94]

12.4. Direct payments, along with personal budgets and personalised care planning, mandated for the first time in the Care Act, provide the platform with which to deliver a modern care and support system. People should be encouraged to take ownership of their care planning, and be free to choose how their needs are met, whether through local authority or third-party provision, by direct payments, or a combination of the three approaches.

12.5. For direct payments to have the maximum impact, the processes involved in administering and monitoring the payment should incorporate the minimal elements to allow the local authority to fulfil its statutory responsibilities. These processes **must not** restrict choice or stifle innovation, and **must not** place undue burdens on people to provide information to the local authority. An effective monitoring process **should** go beyond financial monitoring, and include aspects such as identifying wider risks and issues, for example non- payment of tax, and provision of employers' liability insurance.

12.6. The local authority also has a key role in ensuring that people are given relevant and timely information about direct payments, so that they can make a decision whether to request a payment, and, if doing so, are supported to use and manage the payment appropriately. The route to a direct payment is for a person to request one, but the local authority **should** support this request by providing the information and advice as detailed above. People must **not** be forced to take a direct payment against their will, but instead be informed of the choices available to them.

12.7. This chapter should be read in conjunction with the sections on care and support planning and personal budgets (see chapters 10 and 11), and applies to people in need of care and support and carers equally, unless specifically stated.

Making direct payments available

12.8. The availability of direct payments **should** be included in the universal information service that all local authorities are required to provide. This **should** set out:

- what direct payments are;
- how to request one including the use of nominated and authorised persons[95] to manage the payment;
- explanation of the direct payment agreement;
- the responsibilities involved in managing a direct payment and being an employer;
- making arrangements with social care providers;
- signposting to local organisations (such as user-led organisations and micro-enterprises)and the local authority's own internal support, who offer support to direct payment holders, and information on local providers;
- case studies and evidence on how direct payments can be used locally to innovatively meet needs.

94 In this guidance, references to care and support to meet an adult's eligible needs include care and support provided or commissioned by a local authority to discharge its duty under section 117 of the 1983 Act. References in this guidance to sections 31 and 32 of the Act also apply in respect of after-care services (as those sections are modified by Part 1 of Schedule 4 to the Act).

95 A nominated person is anyone who agrees to manage a direct payment on behalf of the person with care needs. An authorised person is someone who agrees to manage a direct payment for a person who lacks capacity according to the Mental Capacity Act 2005.

12.9. This will allow people to be fully aware what direct payments are and whether they are something that are of interest. In addition to this general information, authorities **must** also explain to people what needs could be met by direct payments during the care and support planning process.

12.10. Local authorities have a crucial role to play in promoting the use of direct payments, and enabling people to make requests to receive direct payments in an efficient way. However, the gateway to receiving a direct payment must always be through the request from the person. Local authorities **must not** force people to take a direct payment against their will, or allow people to be placed in a situation where the direct payment is the only way to receive personalised care and support. However, local authorities are encouraged to prompt people to consider direct payments and how they could be used to meet needs.

Steps following a request to receive direct payments

12.11. It is expected that most requests to receive direct payments will occur during the care planning stage as this is when authorities **must** inform the person of the needs that could be met via direct payments. However, local authorities **must** consider requests for direct payments made at any time, and have clear and swift processes in place to respond to the requests. For example, a person may request a direct payment before a scheduled or anticipated review. In these cases, the local authority **must** assess the request on the same basis as a request made during care planning. In practice, it may be convenient to consider the request at the same time as a review of the care plan. In these cases, the review **should** be brought forward so as not to delay the consideration of the direct payment request (see chapter 13 on reviews). The steps to follow after receiving a request for a direct payment will depend on whether the person has been assessed as having capacity to make a decision about direct payments or not, which should have taken place at the assessment of needs (see chapter 6).

Assessing capacity

The following considerations **should** be made when assessing capacity:

Does the person have a general understanding of what decisions they need to make and how they need to make them?

Does the person have a general understanding of the consequences of making, or not making the decision?

Is the person able to understand, retain, use and weigh up all relevant information to support the decision?

Can the person communicate the decision? (This **may** involve the use of a specialist or independent advocate)

Is there need to bring in additional expertise to aid the assessment?

12.12. Mental capacity is the ability to make a decision. Under the 2005 Mental Capacity Act, a person lacks capacity in relation to a matter if, at the material time, they are unable to make a decision in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

12.13. Assessments of capacity **must** always be made on a case-by-case basis, in relation to the specific decision to be made. Assumptions **should not** be made due to the existence of a particular condition, nor on whole groups of people.

12.14. Consideration **should** also be given to whether capacity is constant or likely to fluctuate. Where it is clear that fluctuating capacity is a known issue, or likely to be, this **should** be covered in the care plan which details the steps to take where capacity fluctuates. The *Care and Support (Direct Payments) Regulations 2014* allow for direct payments to continue to be made in cases of fluctuating capacity (see paragraphs 12.65-12.66 on terminating direct payments below).

Adults with capacity

12.15. Where the local authority is satisfied that the person has capacity to make a request for direct payments to cover some or all of their care needs, it **must** consider each of the four conditions in clause 31 of the Care Act.[96] These conditions need to be met in their entirety; a failure in one would result in the request to receive a direct payment being declined. The conditions are:

- the adult has capacity to make the request, and where there is a nominated person, that person agrees to receive the payments;
- the local authority is not prohibited by regulations under section 33 from meeting the adult's needs by making direct payments to the adult or nominated person, and if regulations under that section give the local authority discretion to decide not to meet the adult's needs by making direct payments to the adult or nominated person, it does not exercise that discretion;
- the local authority is satisfied that the adult or nominated person is capable of managing direct payments either by himself or herself, or with whatever help the authority thinks the adult or nominated person will be able to access;
- the local authority is satisfied that making direct payments to the adult or nominated person is an appropriate way to meet the needs in question.

12.16. The authority **must** clarify at the earliest stage possible where the request originates from. The Care Act provides a power to enable direct payments to be made to the person in need of care and support, or a nominated person acting on their behalf if agreed by the person with care needs. Where it is clear that the request is made from a nominated person, the authority **should** consider whether to involve the nominated person in any appropriate stages of the care planning journey, such as the development of the care plan. During this process, the nominated person **should** receive information regarding the local authorities direct payments processes, as well as information and advice on using and managing the direct payment, so that the nominated person understands their legal obligations as the direct payment recipient to act in the best interests of the person requiring care and support (see also *becoming an employer* below).

Adults lacking capacity

12.17. In cases where the person in need of care and support has been assessed as lacking capacity to request the direct payment, an authorised person can request the direct payment on the person's behalf. In these cases, the local authority **must** satisfy itself that the person meets the five conditions as set out in section 32 of the Care Act.[97] As with direct payments for people with

[96] In respect of after-care under section 117 of the Mental Health Act 1983, as modified by paragraph (1)-(4) of Part 1 of Schedule 4.

[97] In respect of after-care under section 117 of the Mental Health Act 1983, as modified by paragraph (5)-(9) of Part 1 of Schedule 4.

capacity, each of these conditions **must** be met in their entirety. Failure to meet any of the conditions would result in the request being declined. The conditions are:

- where the authorised person is not authorised under the Mental Capacity Act 2005 but there is at least one person who is so authorised, a person who is so authorised supports the authorised person's request;
- the local authority is not prohibited by regulations under section 33 from meeting the adult's needs by making direct payments to the authorised person, and if regulations under that section give the local authority discretion to decide not to meet the adult's needs by making direct payments to the authorised person, it does not exercise that discretion;
- the local authority is satisfied that the authorised person will act in the adult's best interests in arranging for the provision of the care and support for which the direct payments under this section would be used;
- the local authority is satisfied that the authorised person is capable of managing direct payment by himself or herself, or with whatever help the authority thinks the authorised person will be able to access;
- the local authority is satisfied that making direct payments to the authorised person is an appropriate way to meet the needs in question.

Consideration of the request

12.18. After considering the suitability of the person requesting the direct payment against the appropriate conditions in the Care Act, the local authority **must** make a determination whether to provide a direct payment. Where accepted, the decision **should** be recorded in the care plan, or support plan. Where refused, the person or person making the request **should** be provided with written reasons that explain the decision, and be made aware of how to appeal the decision through the local complaints process.

12.19. The Care Act defines one of the conditions to meet is that the direct payment is an appropriate way to meet the needs in question (or, in respect of after-care services, an appropriate way to discharge its duty under section 117 of the 1983 Act).[98] Local authorities **mus**t not use this condition to arbitrarily decline a request for a direct payment. Appropriateness is for local authorities to determine, although it is expected that in general, direct payments are an appropriate way to meet most care and support needs.

12.20. A further condition is that the local authority **must** be satisfied that the person is able to manage the direct payment by him or herself, or whatever help or support the person will be able to access. Local authorities **should** therefore take all reasonable steps to provide this support to people who may require it. To comply with this, many local authorities have contracts with voluntary or user-led organisations that provide support and advice to direct payment holders, or to people interested in receiving direct payments. This condition **should not** be used to deny a person from receiving a direct payment without consideration of support needs. Consideration **should** also be given to involving a specialist assessor in determination of support requirements, in particular if one was used earlier in the care and support process (such as assessment).

12.21. In all cases, the consideration of the request **should** be concluded in as timely a manner as possible.

98 See sections 31(7) and 32(9) of the Act as modified respectively by paragraph (4) and (9) of Part 1 of Schedule 4 to the Act.

Case study: Making direct payments support accessible

Abdul is a deafblind man; to communicate he prefers to use Braille, Deafblind Manual and email. He directly employs several staff through direct payments. He receives payroll support from his local direct payments support service. Abdul suggested ways to make direct payments management accessible to him. He communicates with the support service mainly via email but they also use Typetalk.[1]

At the end of the month, Abdul emails the support service with details of the hours that his staff have worked. The support service work out any deductions from pay (such as National Insurance and Income Tax) and email him to tell him how much he should pay the staff via cheque. They then send him pay slips to be given to staff. The envelope that the payslips are sent in has two staples in the corner so that he knows who the letter is from. The payslips themselves are labelled in Braille so that he knows which staff to give them to.

Each quarter, the support service tells him how much he needs to pay on behalf of his employees in National Insurance and Income Tax. The service also fills in quarterly Inland Revenue paperwork. At the end of the year, the support service sends relevant information to the council, so that they are aware of how the direct payments are being spent.

Abdul has taken on only some of the responsibilities of employing people; he has delegated some tasks to the support service. Control still remains with Abdul and confidentiality is maintained by using accessible labelling.

12.22. Where the decision has been declined, the person in need of care and support, and any other person involved in the request (i.e. nominated or authorised person) **should** receive the reasons in a format that is accessible to them. This **should** set out which of the conditions in the Care Act have not been met, and the reasons as to why they have not been met, and what the person **may** need to do in the future to obtain a positive decision. The consideration stage **should** be performed as quickly as is reasonably practicable, and the local authority **must** provide interim arrangements to meet care and support needs to cover the period in question.

12.23. Where the decision has been declined, the local authority **should** continue the care planning process so that it can agree with the person how best to meet the needs, without the use of direct payments (see chapter 10 on care and support planning).

Administering direct payments

12.24. The local authority **must** be satisfied that the direct payment is being used to meet eligible care and support needs, and **should** therefore have systems in place to monitor direct payment usage. The *Care and Support (Direct Payments) Regulations 2014* set out that the local authority must review the making of direct payments initially within six months, and thereafter every 12 months, but **must** not design systems that place a disproportionate reporting burden upon the individual. The reporting system **should not** clash with the policy intention of direct payments to encourage greater autonomy, flexibility and innovation. For example, people **should not** be requested to duplicate information or have onerous requirements placed upon them. Monitoring **should** also be proportionate to the needs to be met and the care package. Authorities **should** also have

regard to lowering monitoring requirements for people that have been managing direct payments without issues for a long period.

Example of reduced monitoring

Mrs. G has a stable condition and has been successfully managing their direct payment for over two years. The local authority therefore decides to monitor the payment by exception. Notwithstanding the required review in the Act and Regulations, Mrs. G is now considered to have the skills and experience to manage on his own unless the local authority request otherwise or information suggested otherwise comes to the attention of the local authority.

12.25. The amount of the direct payment is derived from the personal budget as set out in the care and support plan, or support plan, and thus **must** be an amount to meet the needs the local authority has a duty or power to meet. The direct payment amount will reflect whether the person is required to make any financial contributions, or is requesting a direct payment for only a part of their care and support requirements. Local authorities **cannot** require financial contributions for a direct payment for after-care services under the MHA; these must be provided without charge.

12.26. It is ultimately for authorities to decide whether payments are made on a gross or net basis,[99] in consultation with appropriate stakeholders. However, local authorities who operate systems of providing gross direct payments **should** consider the benefits of moving to net payments as these can reduce transaction and process costs for both the authority and the person receiving the direct payment.

12.27. The local authority **should** also have regard to whether the needs to be met via a direct payment will result in any 'on-costs' such as recruitment costs, employers National Insurance contributions, and any other costs associated with the payment. These costs **should** be incorporated into the personal budget amount where it is clear that the use of the direct payment to meet needs will incur these costs. Some local authorities include one-off payments within the direct payment to cover these factors. In addition, other authorities have commissioned support services such as brokerage, and payroll and employment advice.

12.28. Where a direct payment recipient is using their payment to employ a personal assistant (PA) or other staff, the local authority **should** ensure that there are clear plans in place of how needs will be met in the event of the PA being absent, for example due to sickness, maternity or holiday. Local authorities still have a duty to ensure needs are being met, even of the person makes their own arrangements via the direct payment, so contingencies may be needed. Where appropriate, these **should** be detailed in the care and support plan, or support plan.

12.29. Specific information **should** also be given to people about the requirements to have plans in place for redundancy payments due to circumstances such as moving home, a change in care and support needs, or the result of the death of the direct payment holder, or care recipient. If the person meets needs by directly employing someone, they will be responsible for all costs of employment including redundancy payments and this **should** be made clear to people as part of the information and advice process before a decision is made whether to request

[99] Gross payments are for the full direct payment amount, and the local authority then recovers any applicable charges from the person. A net direct payment is allocated after any appropriate charges have been subtracted, and is generally seen as the easiest way to administer direct payments.

direct payments. The local authority **must** ensure that the direct payment is sufficient to meet these costs. Normally, if someone dies any employment liabilities will be met by the person's estate, but local authorities and adults have freedom to develop their own arrangements for dealing with this issue. This could include using any unspent direct payment to contribute to any redundancy costs.

12.30. Whatever arrangements are made it is important that the local authority and direct payment holder are both clear as to their responsibilities in this regard to avoid any disputes at a sensitive time for family and carers.

12.31. Local authorities **should** also consider how to recover unspent direct payments if the recipient dies. For example, if someone wishes to pay an agency in advance for its services, the council **should** bear in mind that it may be difficult to recover money paid for services that were not in fact delivered. Councils **should** also consider, if the direct payment recipient does leave unspent funds to be recovered, that before their death the direct payment recipient may have incurred liabilities that **should** legitimately be paid for using the direct payments (for example, they received services for which payment had not been made at the time of death). Local authorities **may** need to consider any redundancy costs payable to personal assistants and be prepared to provide advice on how these might be met. As with other 'on-costs' the personal budget **must** be a sufficient amount to meet the person's needs, including the provision of any redundancy costs, if appropriate.

12.32. Local authorities **should** ensure all direct payment recipients are supported and given information in regards to having the correct insurance cover in place. Direct payments recipients **should** be given support to understand the benefits that insurance cover can provide.

12.33. The local authority **must** also have regard to where the direct payment can be integrated with other forms of public funding, such as personal health budget direct payments. Where this is apparent, the local authority **should** take steps to combine the payments, as long as the person and all parties agree. For example, the local authority could agree with the NHS that the social care and health direct payment are combined and that the monitoring is performed solely by the local authority, reporting to health professionals as appropriate. This will avoid the person having multiple bank accounts, and having to supply similar information to public bodies to account for direct payment spend.

Using the direct payment

Paying family members

12.34. The direct payment is designed to be used flexibly and innovatively and there **should** be no unreasonable restriction placed on the use of the payment, as long as it is being used to meet eligible care and support needs.

12.35. The previous 2009 Direct Payment Regulations excluded the payment from being used to pay for care from a close family member living in the same household,[100] except in exceptional circumstances. While the *Care and Support (Direct Payments) Regulations 2014* maintain this provision regarding paying a family member living in the

[100] This does not include family members that live elsewhere to the direct payment recipient (i.e. it is allowed to pay a family member to provide care, as long as that member does not live in the same household).

same household for care, they do allow local authority discretion to give prior consent to pay a close family member living in the same household to provide management and/or administrative support to the direct payment holder.

12.36. This is intended to reflect the fact that in some cases, especially where there are multiple complex needs, the direct payment amount may be substantial. The management and administration of a large payment, along with organising care and support can be a complex and time consuming task. This new discretion allows family members performing this task to be paid a proportion of the direct payment, similar to what many direct payment holders pay to third-party support organisations as long as the local authority allows this. The local authority should be satisfied that the request is reasonable and will only be used for administration and management of the payment. The circumstances and payment amount **should** be decided and agreed with the person requiring care and support, the family member, local authority and any other person (i.e. advocate), with the local authority taking steps to ensure all parties agree. These decisions **should** be recorded in the care plan and include the amount of the payments, their frequency and the activities that are covered. This arrangement **must** also be taken into account during allocation of the personal budget so that the amount remains sufficient to meet the person's needs.

12.37. Local authorities will need to have in place agreement between all parties about what steps to take in case of a dispute regarding the management of the payment by a household family member. This will be especially relevant where the person providing administrative and management is also the nominated or authorised direct payment recipient. In some cases, it may not be appropriate to allow the discretion where there is a risk that the direct payment may be abused, or there are other sensitivities such as safeguarding issues.

12.38. This new discretion is not intended to replace the normal family bonds associated with caring. Authorities will need to make this clear to people so that they are aware of the distinction between receiving an amount for providing administrative support and management of the direct payment, and the retained exclusion regarding family members in the same household being paid for providing care.

Short-term care in a care home

12.39. Direct payments cannot currently be used to pay for people to live in long-term residential care. They can be made to enable people to purchase for themselves a short stay in residential care, provided that the stay does not exceed a period of four consecutive weeks in any 12-month period. This could be used to provide a respite break for a carer, for example.

12.40. The Regulations specify that where the interim period between two stays in residential care is less than four weeks, then the two stays **should** be added together to make a cumulative total, which **should** also not exceed four weeks if it is to be paid for with direct payments. On the other hand, if two stays in residential care are more than four weeks apart then they are not added together.

12.41. Once a direct payment recipient has had four consecutive weeks in residential care, or two or more periods separated by less than four weeks which added together total four weeks, then they cannot use their direct payments to pay for any more residential care until 12 months have passed from the start of the four-week period. On the other hand, as long as each stay is less than

four weeks and there is an interim period of at least four weeks between two or more stays which added together exceed four weeks, then the service recipient may use their direct payments to pay for residential breaks throughout the year.

Example – Direct Payments for short-term residential care

Mrs. H has one week of residential care every six weeks. Because each week in residential care is more than four weeks apart, they are not added together. The cumulative total is only one week and the four-week limit is never reached.

Peter has three weeks in residential care, two weeks at home and then another week in residential care. The two episodes of residential care are less than four weeks apart and so they are added together making four weeks in total. Peter cannot use his direct payments to purchase any more residential care within a 12-month period.

12.42. People can receive additional weeks in a care home once they have reached the four-week maximum. They cannot purchase the stay using their direct payments, but if the local authority and the person agrees that a longer stay is needed, it can still arrange and fund stays for the person. There is no restriction on the length of time for which the council may arrange such accommodation for someone (see chapter 8 for guidance on choice of accommodation).

12.43. The time limit is imposed to promote people's independence and to encourage them to remain at home rather than moving into long-term residential care. Where a person is constantly using the direct payment to pay for short-term residential care stays, the local authority **should** consider whether to conduct a review to ensure that the care plan is still meeting needs.

Long-term residential care

12.44. People who are living in care homes may receive direct payments in relation to non-residential care services. For example, they may have temporary access to direct payments to try out independent living arrangements before making a commitment to moving out of their care home. Direct payments can also be used by people living in care homes to take part in day-time activities. This can be particularly empowering for young people in transition (see chapter 15).

12.45. Direct payments cannot currently be used to secure long-term residential care. However, the Government is currently testing the use of direct payments in residential care, with the aim of introducing this in 2016. The learning from the trailblazer programme will be used to develop additional statutory guidance for local authorities.

Becoming an employer

12.46. Local authorities **should** give people clear advice as to their responsibilities when managing direct payments, and whether the person in receipt of direct payments needs to register with HM Revenue & Customs (HMRC) as an employer. Becoming an employer carries with it certain responsibilities and obligations, in particular to HMRC.

12.47. The local authority **should**, as part of the monitoring of the direct payment arrangement, check to make sure any PAYE income tax and National Insurance contributions deducted from an employees' pay is in turn paid over to HMRC, and that employment payments conform to the national minimum wage. Where it is clear

that payments, or returns detailing employee information deductions, have not been made, or if the individual is failing to meet their obligations as an employer generally, the direct payment scheme **should** be reviewed and consideration given to whether alternative arrangements that result in the direct payment recipient no longer acting as the employer need to be made. Not doing so may result in the individual building up arrears of tax and National Insurance due to HMRC, which may then lead to enforcement action to recover any debt. This situation **should** be able to be avoided by effective monitoring, and by providing upfront information about the responsibilities of becoming an employer. Many local authorities have commissioned voluntary and charity organisations to provide support to direct payment holders.

12.48. Many people are interested in using the direct payment to become an employer, for example, directly employing a personal assistant (PA). In these instances, the local authority **should** ensure that the person is given appropriate information and advice that explains the difference between a regulated and unregulated provider to help the person make a fully informed decision on how best to meet their needs.

12.49. Where a person wishes to directly employ their own PA, the local authority **should** have regard to the guidance published by Skills for Care detailing minimum levels of support for individual employers and PAs. This guidance recommends local authorities should provide on-going support through access to training activities in a variety of ways and promote the Workforce Development Fund. It also proposes that local authorities promote apprenticeships for PAs.[101]

[101] Details of the advice note are available at: http://www.skillsforcare.org.uk/Document-library/Employing-your-own-care-and-support/ADASS-and-Skills-for-Care-advice-note-2013.pdf

Direct payments and hospital stays

12.50. There may often be occasions when direct payment holders require a stay in hospital. However, this **should** not mean that the direct payment **must** be suspended while the individual is in hospital. Where the direct payment recipient is also the person requiring care and support, consideration **should** be given to how the direct payment may be used in hospital. Suspending or even terminating the payment could result in the person having to break the employment contract with a trusted personal assistant, causing distress and a lack of continuity of care when discharged from hospital.

12.51. In these cases, the local authority **should** explore with the person, their carer and the NHS the options to ensure that both the health and care and support needs of the person are being fully met in the best way possible. For example, the person may prefer the personal assistant to visit hospital to help with personal care matters. This may be especially so where there has been a long relationship between the direct payment holder and the personal assistant. This **should** not interfere with the medical duties of hospital personnel, but be tailored to work alongside health provision.

12.52. In some cases, the nominated or authorised person managing the direct payment may require a hospital stay. In these cases, the authority **must** conduct an urgent review to ensure that the person continues to receive care and support to meet their needs. This may be through a temporary nominated/authorised person, or through short-term authority arranged care and support.

Example of using a direct payment whilst in hospital

Peter is deafblind and is required to stay in hospital for an operation. Whilst the hospital pays for an interpreter for the medical interventions, Peter needs additional support to be able to move around the ward, and to communicate informally with staff and his family. The local authority and the NHS Trust agree that Peter's communicator guide continues to support him in hospital, and is paid for via the direct payment, as it was when Peter was at home. Personal and medical care is provided by NHS staff but Peter's communicator guide is on hand to provide specialist communication and guiding support to make his hospital stay is as comfortable as possible.

Direct payments for local authority services

12.53. As a general rule, direct payments **should** not be used to pay for local authority-provided services from the 'home' local authority. Where a person wishes to receive care and support from their local authority, it should be easier and less burdensome to provide the service direct to the person. This will also avoid possible conflicts of interest where the local authority is providing the direct payment, but also promoting their services for people to purchase.

12.54. There may be cases where the local authority exercises discretion to provide care and support by receiving a direct payment amount, for example this could be where a person who is using direct payments wants to make a one-off purchase from the local authority such as a place in day care. In these cases, the local authority **should** take into account the wishes of the person requiring care and support when making a decision. In one off cases such as these, it may be less burdensome to accept the direct payment amount, rather than providing the service and then reducing the personal budget and direct payment accordingly.

Example of local authority provided service

Graham has a direct payment for the full amount of his personal budget allowance. He decides to use a local authority run day service on an infrequent basis and requests to pay for it with his direct payment so that he retains flexibility about when he attends. The local authority service is able to agree to this request and has systems already in place to take payments as self-funders often use the service.

The authority advise Graham that if he wishes to use the day service on a frequent basis (i.e. once a week) it would be better to provide the service to him direct, and to reduce the direct payment amount accordingly.

12.55. This does not preclude people from using their direct payment to purchase care and support from a different local authority. For example, a person may live close to authority boundaries and another local authority could provide a particular service that their 'home' authority does not provide.

Direct payments in the form of pre-paid or pre-payment cards

12.56. Many local authorities have been developing the use of pre-paid cards as a mechanism to allow direct payments without the need for a separate bank account, or to ease the financial management of the payment. Whilst the use of such cards can

be a useful step from managed services to 'cash' direct payments, they **should not** be provided as the only option to take a direct payment, the offer of a cash payment **should** always be available if this is what the person requests.

12.57. It is also important that where a pre-paid card system is used, the person is still free to exercise choice and control. For example, many local authorities operate blanket restrictions on cash withdrawals from pre-paid cards which could limit choice and control. The card **must not** be linked solely to an online market-place that only contains selected providers in which to choose from. Local authorities **should** therefore give consideration to how they develop card systems that encourage flexibility and innovation.

Harmonisation of direct payments

12.58. In circumstances where it is in the person's interest to combine the plan and budget with another form of state support (such as personal health budgets), and the person agrees that plans **should** be combined, the local authority **should** give consideration to whether the person is receiving direct payments from partner organisations, such as the NHS. If so, attempts **should** be made to harmonise the direct payments so that the person does not have multiple payments each with their own monitoring regime. For example, the local authority could work with the NHS partner to agree on a 'lead organisation' that oversees the overall budget and monitors the direct payments to ensure they are being to meet both health and care needs.

Reviewing direct payments

12.59. In addition to monitoring direct payments generally to ensure they are being used to meet care and support needs, the Regulations set out that local authorities **must** also review the making of the direct payment within the first six months of making the first payment.

12.60. This review is intended to be light-touch to ensure that the person is comfortable with using the direct payment, and experiencing no initial issues. It **should** be incorporated within the initial review of the care and support plan 6-8 weeks after sign-off and include elements such as managing and using the direct payment and a discussion to consider any long-term support arrangements that may be appropriate such as payroll, insurance cover and third party support. This review is **not** intended to be a full review of the person's care and support plan.

12.61. If the direct payment recipient is employing people, the local authority **should** within the first six months period or earlier if possible, check to ensure the individual is fulfilling their responsibilities as the employer, in particular that they are submitting PAYE returns to HMRC as well as paying tax and National Insurance deductions made to HMRC.

12.62. The Regulations also set out that following the six-month review, the local authority **must** then review the making of the direct payment no later than every 12 months. In practice, after the initial six-month review period, local authorities **may** wish to consider combining the annual review of the direct payment with the general review of the care plan. This will reduce bureaucracy and allow the local authority to review both at the same time.

12.63. Where a direct payment is being allocated to a nominated/authorised person, or where there may be a family carer being paid for administrative support, the review **should** incorporate all of these parties as well as the person in need of care and support. This will ensure that the local authority receives views from everyone involved in the direct payment, so that it can satisfy itself that there are no initial issues that require resolving.

12.64. The outcome of the review **should** be written down, and a copy given to all parties. Where there are issues that require resolving, the resolution method **should** be agreed with all parties involved, as far as is reasonably practicable. Where appropriate, local authorities **should** advise people of their rights to access the local authority complaints procedure.

Terminating direct payments

12.65. Direct payments **should** only be terminated as a last resort, or where there is clear and serious contradiction of the Regulations or where the conditions in the Act are no longer met (except in cases of fluctuating capacity – see below). Local authorities **should** take all reasonable steps to address any situations without the termination of the payment. Effective, but proportionate monitoring processes will help local authorities to spot any potential issues before a termination is necessary.

12.66. If terminating a direct payment, the local authority **must** ensure there is no gap in the provision of care support. Where a decision has been made to terminate a direct payment, the local authority **should** conduct a revision of the care and support plan, or support plan, to ensure that the plan is appropriate to meet the needs in question (see chapter 13 on reviews).

Reasons for discontinuing direct payments

12.67. A person to whom direct payments are made, whether to purchase support for themselves or on behalf of someone else, may decide at any time that they no longer wish to continue receiving direct payments. In these cases, the local authority should ensure there are no outstanding contractual liabilities, and conduct a review of needs to consider alternate arrangements to meet needs.

12.68. The Care Act also sets out that a local authority shall cease making direct payments if the person no longer appears to be capable of managing the direct payments or of managing them with whatever support is necessary.

12.69. Direct payments **should** be discontinued when a person no longer needs the support for which the direct payments are made. This might happen in situations where the direct payments are for short-term packages when leaving residential care or hospital. Direct payments for after-care services under section 117 of the Mental Health Act would also cease once clinical commissioning group and local authority are satisfied that the person concerned is no longer in need of such services.

12.70. There may be circumstances in which the local authority discontinues direct payments temporarily. An example might be when an individual does not require assistance for a short period because their condition improves and they do not require the care and support that the direct payments are intended to secure. The local authority will need to discuss with the person, their carer, and any other person how best to manage this. The person should be allowed to resume responsibility for their own care after the interruption, if that remains their wish, unless there has been a change of

circumstances which means that there is no duty on the council to make direct payments, or, in certain exceptional circumstances, the council decides not to exercise the power to make direct payments. In these situations the person's case should not be closed and they need not be reassessed at the resumption of care and support if all other issues remain the same. If there is a change of circumstances that affects the care plan/support plan the local authority **must** revise the plan to ensure that it is still meeting needs (see chapter 13).

12.71. The council might also discontinue payments if the person fails to comply with a condition imposed under regulations to which the direct payments are subject or if for some reason the council no longer believes it is appropriate to make the direct payments. For example, the council might discontinue the direct payment if it is apparent that they have not been used to achieve the outcomes of the care plan.

12.72. The 2009 Direct Payment regulations set out that direct payments **must** be discontinued under certain conditions, such as where the recipient is placed by the courts under a condition or requirement relating to a drug and/or alcohol dependency. The *Care and Support (Direct Payments) Regulations 2014* retain this universal restriction. The groups and conditions remain the same as the 2009 regulations and are set out in the schedule to the 2014 regulations.

12.73. Where direct payments are discontinued as a result of mental health or criminal justice legislative provisions, the local authority **should** make timely arrangements for services to be provided in lieu of the direct payments, to ensure continuity of support.

Discontinuing direct payments in the case of persons with capacity to consent

12.74. Where someone with capacity was receiving direct payments but then loses capacity to consent, the local authority **should** discontinue direct payments to that person and consider making payments to an authorised person instead. In the interim, the local authority should make alternative arrangements to ensure continuity of support for the person concerned.

12.75. If the local authority believes the loss of capacity to consent to be temporary, it may continue to make payments if there is someone else who is willing to manage payments on the person's behalf. This situation **should** be treated as strictly temporary and closely monitored to ensure that, once the person has regained capacity, they are able to exercise overall control over the direct payments as before. If the person's loss of capacity to consent becomes prolonged, then the local authority should consider making more formal arrangements for an authorised person to take over receipt of the direct payments on that person's behalf. The local authority should make clear that the arrangement is designed to be temporary, so that the person managing the direct payment does not enter into any long-term contractual arrangements.

Discontinuing direct payments in the case of persons lacking capacity to consent

12.76. Direct payments **must** be discontinued if the local authority is no longer satisfied for whatever reason that the authorised person is acting in the best interests of the beneficiary, within the

meaning of the 2005 Act. The local authority might also wish to discontinue the direct payments if it has sufficient reason to believe that the conditions imposed under regulations on the authorised person are not being met. The authority **may** wish to consider if someone else can act as an authorised person for the person lacking capacity, or whether it will have to arrange services for them in place of the direct payments.

12.77. Direct payments **must** be discontinued where the local authority has reason to believe that someone who had lacked capacity to consent to direct payments has now regained that capacity on a long-term or permanent basis. The authority **should not** terminate direct payments to the authorised person before beginning to make direct payments to the service recipient themselves or to arrange services for them, according to their wishes. If the local authority is satisfied that the regaining of capacity will only be temporary, then it can continue to make direct payments to the authorised person to the extent that he or she is capable, on the basis the beneficiary should control how the direct payments are used.

How to discontinue direct payments

12.78. In all cases, as soon as possible the local authority **should** discuss with individuals, their carers and any person managing the direct payments if it is considering discontinuing direct payments to them, in order to explore all available options before making the final decision to terminate the direct payments. For example, if ability to manage is an issue, the individual should be given an opportunity to demonstrate that they can continue to manage direct payments, albeit with greater support if appropriate. The local authority **should not** automatically assume when problems arise that the only solution is to discontinue or end direct payments.

12.79. If the local authority does decide to withdraw direct payments, it will need to arrange the relevant care and support provision instead, unless the withdrawal was following a review after which the local authority concluded that the services were no longer needed. A minimum period of notice should be established that will normally be given before direct payments are discontinued. This **should** be included in the information to be provided to people who are considering receiving direct payments.

12.80. It will be extremely unlikely that a local authority will discontinue direct payments without giving notice, although in serious cases this may be warranted (for example, the authorised person is not acting in the best interests of the person). Local authorities **should** explain to people, before they begin to receive direct payments, the exceptional circumstances in which this might occur and discuss with them the implications this has for the arrangements that individuals might make.

12.81. If direct payments are discontinued, some people may find themselves with ongoing contractual responsibilities or having to terminate contracts for services (including possibly making employees redundant). Local authorities **should** take reasonable steps to make people aware of the potential consequences if direct payments end, and any obligations they may have.

12.82. There may be circumstances where the person has lost the capacity to manage the direct payment and there is no-one else to manage the payment on their behalf, or where a person needs additional support to terminate arrangements. In these cases the local authority should have regard as to whether it needs to step in or provide support

to ensure that any contractual arrangements are appropriately terminated to ensure that additional costs are not incurred.

Links to external resources

Status – check to see if the person engaged is employee or self-employed. http://www.hmrc.gov.uk/payerti/employee-starting/status.htm

Does the direct payment recipient need to register as an employer? http://www.hmrc.gov.uk/payerti/getting-started/register.htm

Becoming a new employer http://www.hmrc.gov.uk/payerti/getting-started/new-employer.htm

Information on taking on a new employee http://www.hmrc.gov.uk/payerti/employee-starting/new-employee.htm

Best practice in direct payments support, TLAP, 2012: http://bit.ly/1fWbEDE

Direct payments in healthcare – a practical guide, HFMA, 2012: http://bit.ly/LBJym0

Increasing the uptake of direct payments, TLAP, 2013: http://bit.ly/LBlqig

PA toolkit, http://www.skillsforcare.org.uk/Employing-your-own-care-and-support/Support-for-individual-employers/Employing-personal-assistants-toolkit.aspx

13. Review of care and support plans

This chapter provides guidance on section 27 of the Care Act 2014.

This chapter covers:

- Review of the care and support plan, support plan;
- Keeping plans under review generally;
- Planned and unplanned review;
- Considering a request for a review of a care plan, support plan;
- Considering a review;
- Revision of the care and support plan, support plan;
- Timeliness and regularity of reviews.

13.1. Ensuring all people with a care and support plan, or support plan have the opportunity to reflect on what's working, what's not working and what might need to change is a an important part of the planning process. It ensures that plans are kept up to date and relevant to the person's needs and aspirations, will provide confidence in the system, and mitigate the risk of people entering a crisis situation.

13.2. The review process should be person-centred and outcomes focused, as well as accessible and proportionate to the needs to be met. The process **must** involve the person needing care and the carer where feasible, and consideration **must** be given whether to involve an independent advocate who local authorities are required to supply in the circumstances specified in the Act.

13.3. Reviewing intended outcomes detailed in the plan is the means by which the local authority complies with its ongoing responsibility towards people with care and support needs. The duty on the local authority therefore is to ensure that a review occurs, and if needed, a revision follows this. Consideration **should** also be given to authorising others to conduct a review – this could include the person themselves or carer, a third party (such as a provider) or another professional, with the local authority adopting an assurance and sign-off approach.

13.4. The review will help to identify if the person's needs have changed and can in such circumstances lead to a reassessment. The review **must** not be used as a mechanism to arbitrarily reduce the level of a person's personal budget.

13.5. In many cases, the review and revision of the plan should be intrinsically linked; it should not be possible to decide whether to revise a plan without a thorough review to

ascertain if a revision is necessary, and in the best interests of the person.

13.6. However, there are occasions when a change to a plan is required but there has been no change in the levels of need (for example, a carer **may** change the times when they are available to support). In addition, there can be small changes in need, at times temporary, which can be accommodated within the established personal budget. In these circumstances, it **may** not be appropriate for the person to go through a full review and revision of the plan. The local authority should respond to these 'light-touch' requests in a proportionate and reasonable way.

13.7. Where agreed local authority is satisfied that a revision is necessary, it **must** work through the assessment and care planning processes as detailed in sections 9-12 and 25 of the Act to the extent that it thinks appropriate (see chapter 6).

13.8. This chapter applies to people in need of care and support and carers equally, unless specifically stated. As many of the same principles apply to both care and support planning and reviews this chapter should be read in conjunction with the chapter on care and support planning.

Review of the care and support plan, support plan

Keeping plans under review generally

13.9. Keeping plans under review is an essential element of the planning process. Without a system of regular reviews, plans could become quickly out of date meaning that people are not obtaining the care and support required to meet their needs. Plans may also identify outcomes that the person wants to achieve which are progressive or time limited, so a periodic review is vital to ensure that the plan remains relevant to their goals and aspirations.

13.10. The Act specifies that plans **must** be kept under review generally. Therefore, local authorities **should** establish systems that allow the proportionate monitoring of both care and support plans and support plans to ensure that needs are continuing to be met. This system should also include cooperation with other health and care professionals who may be able to inform the authority of any concerns about the ability of the plan to meet needs (see chapter 14 on integration and cooperation).

13.11. The review **should** be a positive opportunity to take stock and consider if the plan is enabling the person to meet their needs and achieve their aspirations. The process **should not** be overly-complex or bureaucratic, and should cover these broad elements:

- have the person's circumstances and/or care and support or support needs changed?
- what is working in the plan, what is not working, and what might need to change?
- have the outcomes identified in the plan been achieved or not?
- does the person have new outcomes they want to meet?
- could improvements be made to achieve better outcomes?
- is the person's personal budget enabling them to meet their needs and the outcomes identified in their plan and is the current method of managing it still the best one for what they want to

achieve, e.g. should direct payments be considered?

- is the personal budget still meeting the sufficiency test?[102]
- are there any changes in the person's informal and community support networks which might impact negatively or positively on the plan?
- is the person, carer, independent advocate satisfied with the plan?

13.12. There are several different routes to reviewing a care and support or support plan including:

- **a planned review** (the date for which was set with the individual during care and support or support planning, or through general monitoring);
- **an unplanned review** (which results from a change in needs or circumstance that the local authority becomes aware of, e.g. a fall or hospital admission), and;
- **a requested review** (where the person with the care and support or support plan, or their carer, family member, advocate or other interested party makes a request that a review is conducted. This may also be as the result of a change in needs or circumstances).

Planned reviews

13.13. During the planning process, the person and their social worker, or relevant professional may have discussed when it might be useful to review the plan and therefore agree to record this date in the plan. This may be valuable to people in the care system so that they can anticipate when the review will take place, rather than the review being an unexpected experience. It also fits with the Government's view of personalised care and support, as the person may have a view as to a suitable time-frame for the review to occur. Additionally, setting out anticipated review dates may help authorities with future workload planning.

13.14. Even in cases with anticipated review dates, this **should not** reduce the requirement of the local authority to keep the plan under review generally. The first planned review **should** be an initial 'light-touch' review of the planning arrangements 6-8 weeks after sign-off of the personal budget and plan. Where relevant, this **should** also be combined with an initial review of direct payment arrangements. This will provide reassurance to all parties that the plan is working as intended, and will help to identify any teething problems. In addition, where plans are combined with other plans (for example education, health and care plans which are reviewed annually) the local authority should be aware of the review arrangements with these other plans and seek to align reviews together.

13.15. Local authorities **should** have regard to ensuring the planned review is proportionate to the circumstances, the value of the personal budget and any risks identified. In a similar way to care and support or support planning, there **should** be a range of review options available, which may include self-review, peer led review, reviews conducted remotely, or face-to-face reviews with a social worker. For example, where the person has a stable, longstanding support package with fixed or long term outcomes, they may wish to complete a self-review at the planned time, rather than have a face to face review with their social worker. This does not preclude their requesting a review at another time or a face to face review being

[102] Link personal budget.

needed if there is an unplanned change in needs or circumstances.

13.16. In all instances, the method of review **should** wherever reasonably possible be agreed with the person and all appropriate measures taken to ensure their involvement and the involvement of other people they may identify, including an independent advocate where this is required by the circumstances specified in the Act.

13.17. Furthermore, if a person is recorded as having a mental impairment and lacking capacity to make some decisions, then the local authority **should** consider carefully when it will be appropriate for the next review to take place. In these instances, making appropriate use of a social worker as the lead professional should be encouraged. Where conditions are progressive, and the person's health is deteriorating, reviews may need to be much more frequent. Similarly where a person has few or no family members or friends involved in supporting them, the risks are higher, and again reviews or monitoring may need to be more frequent. It may beneficial to put a 'duty to request a review' into commissioned services such as domiciliary care – domiciliary care workers **should** be required to ask for a review if they consider the person they are supporting is in need of one.

Unplanned reviews

13.18. If there is any information or evidence that suggests that circumstances have changed in a way that may affect the efficacy, appropriateness or content of the plan, then the local authority **should** immediately conduct a review to ascertain whether the plan requires revision. For example this could be where a carer is no longer able to provide the same level of care, there is evidence of a deterioration of the person's physical or mental wellbeing or the local authority receives a safeguarding alert. During the review process, the person the plan is intended for, or the person acting on their behalf **should** be kept fully involved and informed of what is occurring, the timescales involved and any likely consequences. This will help to alleviate anxiety at a time where things in the person's life **may** have changed substantially.

Considering a request for a review of a plan

13.19. In addition to the duty on local authorities to keep plans under review generally, the Act provides a duty on the local authority to conduct a review if a request for one is made by the adult or a person acting on the adult's behalf.[103] Local authorities **should** provide information and advice to people at the planning stage about how to make a request for a review. This process **should** be accessible and include multiple routes to make a request – phone, email, text for example. The information given to people **should** also set out what happens after a request is made, and the timescales involved in the process.

13.20. The request process **should** be accessible and streamlined. Consideration **should** also be given to the accessibility needs of the local population, for example this may include multiple language versions, and non-internet routes to request for people who may not have access to the internet, or in areas of digital exclusion. Local authorities should also consider the role that local

[103] A similar provision exists in the Children's & Family Act, where those with Education, health and care (EHC) plans have a right to request a review of their EHC plan (as can others on their behalf). This will include any adult care components set out in the plan.

community and voluntary organisations can play to help people log requests.

13.21. The right to request a review applies not just to the person receiving the care, but to others supporting them or interested in their wellbeing. For example a person with advanced dementia may not be able to request a review, but a relative or a neighbour may want to draw a deterioration in the person's condition to the attention of the local authority. The local authority **should** consider the request even if it is not made by the adult or their carer.

Considering a review

13.22. Upon receipt of a request to conduct a review, the local authority **must** consider this and judge the merits of conducting a review. In most cases, it is the expectation that a review **should** be performed unless the authority is reasonably satisfied that the plan remains sufficient, or the request is frivolous, inaccurate or is a complaint; for example this may be a where a person lodges multiple requests for a review in a short period of time. Local authorities **should** set out clearly the process that will be used to consider requests.

13.23. In considering whether to undertake a review the authority **must** involve the person, carer and anyone else the person requests to be involved where feasible. The local authority will need to identify those who may have significant difficulty in being fully involved in the decision to review and when there is no appropriate person who can represent or support their involvement and consider the duty to provide independent advocacy.[104]

Example 1

The local authority receives an email from a relative of an elderly person receiving care and support at home. The email provides details that the elderly person's condition is deteriorating and supplies evidence of recent visits to the GP. The local authority decides to work with the person to review their care and support plan to ensure that it continues to meet their needs.

Example 2

The local authority receives a phone call from Mr X who is angry as he feels that he has needs that have not been identified in his plan. The authority has on a separate recent occasion reviewed his plan, and came to the conclusion that no revision was necessary, and informed Mr X of the decision and reasons for taking this. Therefore, in this case the local authority declines the request and provides a written explanation to Mr X, with an anticipated date of when the authority will be formally reviewing the plan as well as information on the local authority's complaints procedure.

13.24. Where a decision is made not to conduct a review following a request, the local authority **should** set out the reasons for not accepting the request in a format accessible to the person, along with details of how to pursue the matter if the person remains unsatisfied. In most cases, it would be helpful for this to set out that the authority will continue to monitor the plan to ensure that it remains fit for purpose, and that the decision does not affect the right to make a future request for review. Although not mandatory, it **may** also be prudent for the local authority to set out when the person can expect a formal review of the plan.

[104] Link advocacy.

Revision of the care and support plan, support plan

13.25. Where a decision has been made following a review that a revision is necessary, the authority **should** inform the person, or a person acting on their behalf of the decision and what this will involve. Where the person has substantial difficulty in actively involved with the review, and where there are no family or friends to help them being engaged, an independent advocate **must** be involved.

13.26. When revising the plan the local authority **must** involve the person, their care and any other person, their advocate if they qualify for one, and to take all reasonable steps to agree the revision. In this way, the revision **should** wherever possible follow the process used in the assessment and care planning stages. Indeed, the local authority **must** if appropriate carry out an assessment and financial assessment, and then revise the plan and personal budget accordingly. The assessment process following a review should not start from the beginning of the process but pick up from what is already known about the person and should be proportionate.[105]

13.27. Therefore, when revising the plan the authority should follow the stages of the care and support planning process (see chapter 10). In some cases a complete change of the plan may be required, whereas in others minor adjustments may be needed.

[105] This process may be referred to as a 're-assessment'. As noted above, this **should not** be a new assessment from the beginning of the care and support process, but **should** be a proportionate assessment that takes into consideration what is already known of the person and incorporates revised elements as appropriate. A 're-assessment' cannot occur without the local authority first conducting a review and then deciding that a revision of a plan is necessary.

In either case, the following aspects of care planning **should** be followed:

- the person's wishes and feelings **should** be identified as far as possible and they should be supported to be involved;
- the revision **should** be proportionate to the needs to be met;
- where the plan was produced in combination with other plans, this **should** be considered at the revision stage;
- the person, carer or person acting on their behalf **should** be allowed to self-plan where appropriate;
- the development of the revised plan **must** be made with the involvement of the adult/carer, their representative or independent advocate;
- any additional elements that were incorporated into the original plan **should** be replicated in the revised plan where appropriate and agreed by all parties; and
- there needs to be clarity on the sign-off process, especially where the revised plan is developed by the person.

13.28. Particular attention should be taken if the revisions to the plan proposes increased restraints or restrictions on a person who has not got the capacity to agree them. This may become a deprivation of liberty, which requires appropriate safeguards to be in place. The local authority should have policies to address how these are recognised and responded to, and the social worker, occupational therapist or other relevant social care qualified professional or Mental Capacity lead should be involved, as well as an advocate.

13.29. The local authority **must** consider in all cases whether an independent advocate may be required to support the person through the revision of the plan. Where the

plan was produced with the assistance of an independent advocate, then consideration should be given to whether an independent advocate is also required for the revision of the plan. In these scenarios, the advocate would ideally be the same person to ensure consistency and continuity with the case details. Likewise, where a specialist assessor has been used previously in the care and support journey, the local authority should have regard whether they need to employ the expertise of the assessor in the review.

Timeliness and regularity of reviews

13.30. In the absence of any request of a review, or any indication that circumstances may have changed, the local authority should conduct a periodic review of plan. As stated earlier, this could be indicated at the planning stage by including an anticipated review date to allow for future planning. In addition, local authorities **may** wish to align the periodic review of the plan, with the compulsory review of the direct payment arrangements, where this is appropriate.

13.31. It is the expectation that authorities **should** conduct a review of the plan no later than every 12 months, although a light-touch review **should** be considered 6-8 weeks after agreement and sign-off of the plan and personal budget, to ensure that the arrangements are accurate and there are no initial issues to be aware of. This light-touch review **should** also be considered after revision of an existing plan to ensure that the new plan is working as intended, and in cases where a person chooses a direct payment, should be aligned with the review of the making of the direct payment (see chapter 12 on direct payments).

13.32. The periodic review **should** be proportionate to the needs to be met, and the process should not contain any surprises for the person concerned. Periodic reviews and reviews in general **must** not be used to arbitrarily reduce a care and support package. Such behaviour would be unlawful under the Act as the personal budget **must** always be an amount appropriate to meet the person's needs. Any reduction to a personal budget should be the result of a change in need or circumstance.

13.33. The **review should** be performed as quickly as is reasonably practicable. As with care and support planning, it is expected that in most cases the revision of the plan should be completed in a timely manner proportionate to the needs to be met. Where there is an urgent need to intervene, local authorities should consider implementing interim packages to urgently meet needs while the plan is revised. However, local authorities should work with the person to avoid such circumstances wherever possible by ensuring that any potential emergency needs are identified as part of the care and support planning stage and planned for accordingly.

Links to external resources

Outcome focused reviews – a practical guide, PPF, 2009: http://bit.ly/1gP91Hr

Guidance notes for outcomes focused reviews, PPF, 2009: http://bit.ly/1fyJs8h

The headings used in a person-centred review, HSA, 2009: http://bit.ly/1fLbWxS

From a person-centred review to a person-centred plan, HSA, 2009: http://bit.ly/1nX5XtE

Adult safeguarding

14. Safeguarding

This chapter provides guidance on sections 42-47 and 68 of the Care Act 2014.

This chapter covers:

- What is adult safeguarding and why it matters;
- What are abuse and neglect?
  - recognising the different types and patterns of and the circumstances in which they may take place;
  - criminal offences and adult safeguarding;
- What is the local authority's safeguarding role?
- Adult safeguarding procedures including multi-agency working;
- Carrying out safeguarding enquiries;
- Safeguarding and advocacy;
- The role of Safeguarding Adults Boards;
- Safeguarding Adults Reviews;
- Sharing information;
- Roles responsibilities and training of local authorities, NHS and the police;
- Protecting property for adults being cared for away from home.

What is adult safeguarding and why it matters

14.1. Adult safeguarding means protecting a person's right to live in safety, free from abuse and neglect. The Care Act requires that each local authority **must**:

- **make enquiries**, or ensure others do so, if it believes an adult is, or is at risk of, abuse or neglect (see paragraphs 14.36 to 14.75). An enquiry should establish whether any action needs to be taken to stop prevent abuse or neglect, and if so, by whom;
- **set up a Safeguarding Adults Board** (SAB) (see paragraphs 14.100 to 14.121);
- **arrange, where appropriate, for an independent advocate** to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in the process and where there is no

other appropriate adult to help them (see paragraphs 14.76 to 14.99);

- **cooperate with each of its relevant partners** (as set out in section 6 of the Care Act) in order to protect adults experiencing or at risk of abuse or neglect.

14.2. These duties apply in relation to any person who is aged 18 or over and at risk of abuse or neglect because of their needs for care and support. Where someone is over 18 but still receiving children's services and a safeguarding issue is raised, the matter should be dealt with as a matter of course by the adult safeguarding team. Where appropriate, they should involve the local authority's' children's safeguarding colleagues as well as any relevant partners (e.g. police or NHS) or other persons relevant to the case. The level of needs is not relevant, and the adult does not need to have eligible needs for care and support, or be receiving any particular service from the local authority, in order for the safeguarding duties to apply.

14.3. The aims of adult safeguarding are:

- To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives.
- To promote an outcomes approach in safeguarding that works for people resulting in the best experience possible.
- To raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.

14.4. In order to achieve these aims, it is necessary:

- To ensure that the roles and responsibilities of individuals and organisations are clearly laid out.
- To create a strong multi-agency framework for safeguarding.
- To enable access to mainstream community safety measures.
- To clarify the interface between safeguarding and quality of service provision.

Six key principles underpin all adult safeguarding work

- **Empowerment** – Personalisation and the presumption of person-led decisions **and** informed consent.

  "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

- **Prevention** – It is better to take action before harm occurs.

  "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.

  "I am sure that the professionals will work for my best interests, as I see them and they will only get involved as much as needed."

- **Protection** – Support and representation for those in greatest need.

  "I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able."

- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

  "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me."

- **Accountability** – Accountability and transparency in delivering safeguarding.

  "I understand the role of everyone involved in my life."

What are abuse and neglect?

14.5. This section considers the different types and patterns of abuse and neglect and the different circumstances in which abuse or neglect may take place. This chapter also contains a number of case studies demonstrating different types of abuse and neglect, and the action taken to help the adult stay or become safe.

The importance of responding quickly and appropriately to hate crime:

Andrew has a learning disability and goes to college, accompanied by a support worker.

Travelling home on the bus one afternoon, a teenager started swearing at Andrew, saying he shouldn't be allowed out in the community. Humiliated in front of the other passengers, he felt upset and angry about the incident.

Following a call from his support worker, the council investigated the situation starting by meeting with Andrew, who agreed to it contacting the police. The police watched CCTV footage and confirmed that, while Andrew wasn't physically assaulted, he did suffer verbal abuse and intimidation which amounted to hate crime.

Although they couldn't identify the teenager, the police recorded the event as a disability crime for future reference, and they meet with Andrew to report their findings. Andrew has also had some counselling to help him regain confidence using public transport.

14.6. Abuse and neglect can take many forms. Local authorities should not be constrained in their view of what constitutes abuse or neglect, and should always consider the circumstances of the individual case. Abuse includes:

- **Physical abuse –** including hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions;
- **Sexual abuse –** including rape and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting;

- **Psychological abuse –** including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or unreasonable and unjustified withdrawal of services or supportive networks;
- **Exploitation –** either opportunistically or premeditated, unfairly manipulating someone for profit or personal gain;
- **Financial or material abuse –** including theft, fraud, exploitation, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property , inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- **Neglect and acts of omission –** including ignoring medical or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating;
- **Discriminatory abuse –** including discrimination on grounds of race, gender and gender identity , disability, sexual orientation, religion, and other forms of harassment, slurs or similar treatment; and
- **Institutional abuse –** including neglect and poor care practice within an institution or specific care setting like a hospital or care home, for example. This may range from isolated incidents to continuing ill-treatment.

14.7. Abuse or neglect may be deliberate, or the result of negligence or ignorance. **Unintentional abuse or neglect** arises, for example, because pressures have built up and/or because of difficult or challenging behaviour which is not being properly addressed.

14.8. The intent of the abuse or neglect is likely to inform the type of response. For example, it is important to recognise unintentional abuse or neglect and this may include considering the impact of stress on a carer's ability to care for another person. Depending on the circumstances the appropriate response where unintentional abuse takes place could be a support package for a carer, but in another circumstance in which safeguarding concerns arise from harm suffered as a result of abuse which was intended to cause harm then it would be necessary to consider whether to refer the matter to the police to consider whether a criminal investigation would be required or appropriate.

A family mediation approach:

A young woman with a learning disability was living with her father. He had physically assaulted her in fits of anger several times.

Her social worker and psychologist worked together and with her and her father, separately and together. They developed a plan for her to live independently. The father attended anger management sessions. They both did some relationship/ family therapy.

This was not formally recorded as safeguarding by the council as it didn't involve a chaired and recorded strategy meeting, "investigation" and case conference. However, it can legitimately be described as safeguarding; the work with the woman achieved good outcomes and she was effectively safeguarded.

14.9. Anyone can carry out abuse or neglect, including, for example, partners, other family members, neighbours, friends, acquaintances, and local residents, organised gangs, paid staff or professionals, volunteers and strangers. For example a stranger may carry out targeted fraud or an internet scam but more often, the person responsible for the abuse is in a position of trust and power.[106]

14.10. Incidents of abuse may be one-off or multiple, and affect one person or more. Professionals and others should look beyond single incidents to identify patterns of harm, just as regulators do in understanding quality of care at home, in hospitals and care homes. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as institutional abuse. In order to see these patterns it is important that information is recorded and appropriately shared.

14.11. Patterns of abuse vary and include:

- **serial abusing** in which the perpetrator seeks out and 'grooms' individuals. Sexual abuse sometimes falls into this pattern as do some forms of financial abuse;
- **long-term abuse** in the context of an ongoing family relationship such as domestic violence between spouses or generations or persistent psychological abuse;
- **opportunistic abuse** such as theft occurring because money or jewelry has been left lying around.

14.12. Abuse can happen anywhere: for example, in someone's own home, in a public place, in hospital, in a care home or in college. It can happen when someone lives alone or with others. It is important to understand the circumstances of abuse, including the wider context such as whether others may be at risk of abuse, whether others have witnessed abuse and the role of family members and paid staff or professionals.

14.13. The nature of the intervention and who is best placed to lead will be, in part, determined by the circumstances. For example, where there is poor, abusive, neglectful care or practice then a clinical response may be more appropriate.

14.14. Early sharing of information is the key to providing effective help where there are emerging concerns. Fears of sharing information must not stand in the way of promoting and protecting the well-being of adults at risk of abuse and neglect. To ensure effective safeguarding arrangements:

- all organisations should have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and the SAB;
- and no professional should assume that someone else will pass on information which they think may be critical to the safety and well-being of an adult at risk of abuse or neglect. If a professional has concerns about an adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority.

14.15. Anyone can witness or become aware of abuse and neglect, from a worried neighbour, a concerned bank cashier, a benefits officer or a nurse on a ward. They must all understand what to do, and where to go locally to get help and advice about what to do if they suspect someone is

[106] http://www.hscic.gov.uk/catalogue/PUB13499/abus-vuln-adul-eng-12-13-fin-rep.pdf

being abused or neglected. It is vital that professionals, other staff and members of the public are vigilant on behalf of those unable to protect themselves. This will include:

- knowing about different types of abuse and neglect;
- supporting people to keep safe;
- knowing who to tell about suspected abuse or neglect; and,
- supporting people to think about risk when exercising choice and control.

Managing financial risk:

An acquaintance of a young man with learning disabilities was fraudulently using his bank card. The young man attended a safeguarding meeting with an advocate so that decisions could be made alongside him about how the risks might be reduced. The person already had the support of an appointee at the council in managing his finances. However he retained his own bank account. He wanted to maintain some degree of financial autonomy.

The advocate supported the young man in working out and then sharing with the meeting the steps he would take if he became aware again of fraudulent use of the card (calling the bank, cancelling the card, calling the police) and steps he was taking to monitor his account. It would have been easy for professionals to take a restrictive view point about his vulnerability and arrange for all his money to be deposited with the appointee so that he would have to come into the office to collect his money. With appropriate support and advice he is empowered to protect himself and to retain some autonomy.

14.16. Local authorities should not underestimate the potential impact of financial abuse. Much financial abuse is theft and fraud and therefore for the police to investigate. It may also be a significant threat to people's health and well-being and may require more attention and collaboration from a wider group of stakeholders, including financial institutions such as banks.

14.17. Organisations must avoid safeguarding arrangements that do not put people in control of their own lives, or that revert to a paternalistic and interventionist way of working. People have complex lives and being safe is only one of the things they want for themselves. Professionals and other staff should not be advocating "safety" measures that do not take account of individual well-being, as set out in section one of the Act.

Listening to the adults views:

An older man was living with his son and family. Concerns were raised by the District Nurse as he spent all his time alone in his room and the family were very boisterous and had sometimes been threatening to both the man and the nurse.

Professionals met several times over a six week period to plan what would be best for him, concluding that residential care should be offered. The gentleman was told of the plan but flatly refused to consider accepting it. He was clear, whatever the professionals' views, that he was happier remaining with his family.

The Mental Capacity Act (2005)

14.18. Professionals and other staff need to understand and always work in line with the Mental Capacity Act. They should use their professional judgment and balance many

competing views. They will need considerable guidance and support from their employers if they are to help individuals manage risk in ways that put them in control of decision-making.

14.19. Regular face-to-face supervision from skilled managers is essential to enable staff to work confidently and competently with difficult and sensitive situations.

14.20. Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the MCA in adult safeguarding enquiries challenges many professionals, particularly where it appears someone has capacity for making decisions that nevertheless results in them being abused or neglected.[107]

14.21. The Mental Capacity Act 2005 created the criminal offences of ill-treatment and wilful neglect in respect of people who lack the ability to make decisions. The offences can be committed by anyone responsible for that adult's care and support.

14.22. These offences are punishable by fines or imprisonment. Ill-treatment covers both deliberate acts of ill-treatment and also those acts which are reckless which results in ill-treatment. Wilful neglect requires a serious departure from the required standards of treatment and usually means that a person has deliberately failed to carry out an act that they knew they were under a duty to perform.

Criminal offences and adult safeguarding

14.23. Adults at risk of abuse and neglect are entitled to the protection of the law in the same way as all. Behaviour which amounts to abuse and neglect, for example assault and physical, sexual or psychological abuse, theft and fraud and certain forms of discrimination may also constitute specific criminal offences. If a local authority, other agency or individual believes that a criminal offence may have been committed then it must refer it to the police urgently.

14.24. Adults with care and support needs are potentially less likely to be able to protect themselves from the risk of abuse or neglect. This can include such adults who have capacity to make their own decision. Statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting.

Causing enquiries to be made

David has a learning disability and lives in a care home, where they advise him on managing his weekly personal allowance.

When at the bank, a carer noticed that David's balance was less than it should be and the statement included unusual transactions.

The staff member contacted the local authority, and it immediately began an enquiry. The local authority met with David and asked for his permission to contact the police. By looking at CCTV footage of the cash machine, the police identified a staff member from the care home taking money from David's account. The support worker was prosecuted, dismissed from his post and barred from working in regulated services.

[107] http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_186484.pdf

14.25. Whether or not a criminal act is committed does not depend on the consent of the victim. Criminal investigation by the police takes priority over all other enquiries but not over the adult's well-being. Close cooperation and coordination among the relevant agencies is critical to ensure safety and well-being is promoted during any criminal investigation process.

The local authority's safeguarding role

Multi-agency working and cooperation

14.26. Local authorities **must** cooperate with each of their relevant partners, and those partners must cooperate with the local authority, in order to protect adults with care and support needs experiencing or at risk of abuse or neglect.

14.27. Relevant partners of a local authority include any other local authority with which they agree it would be appropriate to co-operate (e.g. neighbouring councils with who they provide joint shared services) and the following agencies or bodies who operate within the local authority's area including:

- NHS England;
- Clinical Commissioning Groups;
- NHS trusts and NHS Foundation Trusts;
- job centres;
- the Police;
- prisons;
- probation services.

14.28. The six principles that underpin adult safeguarding (see above) apply to all sectors and settings including care and support services, social work, healthcare, welfare, housing providers and the police. The principles should inform the ways in which professionals and other staff work with people at risk of abuse or neglect. The principles can also help Safeguarding Adults Boards (SABs), and organisations more widely, by using them to examine and improve their local arrangements.

14.29. Agencies should stress the need for preventing abuse and neglect wherever possible. Observant professionals and other staff making early, positive interventions with individuals and families can make a huge difference to their lives, preventing the deterioration of a situation or breakdown of a support network. It is often when people become increasingly isolated and cut off from families and friends that they become extremely vulnerable to abuse and neglect. Agencies should implement robust risk management processes in order to prevent concerns escalating to a crisis point and requiring intervention under safeguarding adult procedures. Multi-agency safeguarding hubs can have a valuable role to play in early identification and de-escalation of risk. Policies and strategies for safeguarding adults at risk of abuse and neglect should include measures to minimise the circumstances, including isolation, which make people vulnerable to abuse.

14.30. Workers need to be vigilant to adult safeguarding concerns in all walks of life: in health and social care, welfare, policing, banking, and trading standards, leisure services, faith groups, and housing. Findings from Serious Case Reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, death or serious harm might have been prevented. The following examples illustrates that someone who you may not think of has a role to play in identifying adults at risk.

Safeguarding is everyone's business:[111]

A Serious Case Review in Bury found that a housing caseworker played a central role, in working with all parties in a housing dispute over noise, in seeking advice from colleagues in other statutory and independent sector agencies and in co-ordinating important meetings with colleagues. The caseworker had an anti-social behaviour brief and her interaction with all the tenants was focused but flexible. She showed good awareness of individual differences. There were several people whom she correctly identified as adults at risk of abuse and she actively sought advice from colleagues in partner agencies who knew them better than her. She worked persistently over a long period of time as the Individual Management Review (IMR) writer put it "in an efficient and professional manner to resolve problems", and she succeeded.

Potential abuse might initially be identified by a number of agencies including regulators or local authority housing authorities who have a duty of care to respond and report to the local authority, where appropriate. All those in contact with those vulnerable to abuse or neglect need to be vigilant.

14.31. It is important that all partners are clear where responsibility lies where abuse or neglect is carried out by employees or in a regulated setting, such as a care home, hospital, or college. The first responsibility to act must be with the employing organisation as provider of the service.

14.32. The employer should investigate any concern unless there is compelling reason why it is inappropriate or unsafe to do this (for example, serious conflict of interest on the part of the employer), or unless it considers a criminal offence may have occurred in which case it must urgently report it to the police.

14.33. An example of a conflict of interest where it is better for an external person to be appointed to investigate may be the case of a family-run business where institutional abuse is alleged, or where the manager or owner of the service is implicated. The circumstances where an external person would be required should be set out in the local multi-agency procedures. All those carrying out such enquiries should have received appropriate training.

14.34. There should be a clear understanding between partners at a local level when other agencies such as the local authority, Care Quality Commission or NHS Clinical Commissioning Group (CCG) need to be notified or involved and what role they have. The focus should be on promoting the well-being of those who are at risk of being abused or neglected. It may be that additional training or supervision will be the appropriate response, but this needs to be monitored. It is not useful for commissioners of care or other professionals to attempt to improve services by using safeguarding procedures as a threat to intimidate providers. CQC and commissioners have alternative means of raising standards of service, including support for staff training, contract compliance and, in the case of CQC, enforcement powers.

14.35. Commissioners should encourage an open culture around safeguarding, working in partnership with providers to ensure the best outcome for the adult at risk. A disciplinary investigation, and potentially a hearing, may result in the employer taking informal or formal measures which may include dismissal. If someone is dismissed or leaves

[108] http://www.bury.gov.uk/index.aspx?articleid=6554

employment because they have abused an adult, they **must** be referred to the Disclosure and Barring Service.[109]

Carrying out enquiries

14.36. Local authorities **must** make enquiries, or ensure others do so, if it reasonably suspects an adult who has care and support needs and is, or is at risk of, being abused or neglected and unable to protect themself against the abuse or neglect or risk of it because of those needs. An enquiry is the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place.

Mr. X had a family friend and his girlfriend living with him in his one bedroom flat, they had originally moved in temporarily. They were behaving in a threatening and aggressive manner, borrowing money and not paying it back, not contributing to the running of the house and taking advantage of Mr. X. They were alleged to have tormented him for example sleeping in his room, painting his toe nails when asleep, and putting underpants on his head.

This had been happening over a period of time and Mr. X had not wanted to do anything about it as part of previous safeguarding enquiries. Over time the social worker built up a rapport with Mr. X to gain his trust and confidence. Mr. X wanted to have the family friend and his girlfriend removed. Housing services were not able to support with eviction as they were not tenants of the property; it is for Mr X to agree to remove unwanted guests he has invited into his home. Mr. X did not want police involvement.

The social worker worked with Mr. X to offer alternatives, for example a place of safety, and gained information from the police as to how they might be able to help. Mr. X and the social worker agreed a plan to remove the family friend and his girlfriend's belongings during a period that they had planned to go away. The social worker worked with the police to assure that this was within the law, worked with the Council to store the belongings in Council storage, worked with housing services to change the locks, and made arrangements for the family friend and his girlfriend to contact the social worker to pick up their belongings.

The social worker offered options of a place of safety when Mr. X became anxious and although he refused that option it remained available throughout. It can be very difficult to remove people from a property when they have settled there and where there are family connections which mean that an adult at risk is unwilling to go to the police or take enforcement action themselves. In this case Mr. X was being financially and emotionally abused by a family friend, and the social worker used an innovative approach to support Mr. X to achieve the outcomes he wanted.

14.37. An enquiry could range from a conversation with the individual who is the subject of the concern to a much more formal multi-agency arrangement.

14.38. The purpose of the enquiry is to decide whether or not the local authority or another organisation, or person, should do something to protect them from any actual or risk of abuse or neglect. If the local authority decides that another organisation should take

[109] https://www.gov.uk/disclosure-and-barring-service-criminal-record-checks-referrals-and-complaints

action, for example a provider, then the local authority should be clear about timescales and the need to know the outcomes of the enquiry.

14.39. What happens as a result of an enquiry should reflect the individual's wishes wherever possible, and be in their best interests if they are not able to make the decision, and be proportionate to the level of concern.

14.40. If a crime is suspected then police should be informed and the police will then be under a duty to investigate. This may be in circumstances when the individual does not want this.

14.41. As far as possible, the adult about whom there is a concern should always be involved from the beginning of the enquiry. If the individual needs an independent advocate then the local authority must arrange for one where appropriate.

Adult safeguarding procedures

14.42. Professionals and other staff need to handle enquiries in a sensitive and skilled way to ensure distress to the individual is minimised. It is likely that many enquiries will require the input and supervision of a social worker, particularly the more complex situations. For example, where abuse or neglect is suspected within a family or informal relationship it is likely that a social worker will be the most appropriate lead. Personal and family relationships within community settings can prove to be both difficult and complex to assess and intervene in. The dynamics of personal relationships can be extremely difficult to judge and rebalance. For example, an adult may make a choice to be in a relationship that causes them emotional distress which outweighs, for them, the unhappiness of not maintaining the relationship.

Working with families:

Mrs. A had repeatedly refused support, stating that she was happy for her family to help her 'until she got back on her feet.' One of her daughters had stated that she was exhausted with the care and demands of her mother and she also claimed to the social worker that she was not supported by her two sisters.

The social worker had spent a significant number of hours on the phone over a long period of time to all members of the family, fielding their various concerns, and at differing points where it appeared the home situation was breaking down.

During the most recent contact the social worker was becoming so concerned at the level of the daughter's anxiety that she felt the situation may erupt.

A network meeting was held at short notice, the meeting took almost two hours and the agreement was for a staggered package of care with the daughters to ensure that Mrs. A's needs were met and that all of her daughters had free time. All parties agreed to trial period to be reviewed.

Shortly after one of the daughters contacted the social worker to say that the family continued to discuss the meeting and that they felt it had been a positive experience. Mrs. A was in agreement, and during this conversation she took herself to the shower, attended to her personal care, dressed herself and returned to the lounge. The daughter reported extreme surprise because she had been dealing with this element of her mother's 'care needs' for nearly two years. It appeared that the process had empowered Mrs. A to undertake these activities herself.

14.43. In order to respond appropriately where abuse or neglect may be taking place, anyone in contact with the adult, whether in a volunteer or paid role, must understand their own role and responsibility and have access to practical and legal guidance, advice and support. This will include understanding local inter-agency policies and procedures.

14.44. In any organisation that comes into contact with adults at risk, there should be adult safeguarding policies and procedures. These should reflect this statutory guidance and are for use locally to support the reduction or removal of risk, and securing any support to help the individual recover. Procedures may include:

- a statement of roles and responsibility, authority and accountability sufficiently specific to ensure that all staff and volunteers understand their role and limitations;
- a statement of the procedures for dealing with allegations of abuse, including those for dealing with emergencies by ensuring immediate safety, the processes for initially assessing abuse and deciding when intervention is appropriate, and the arrangements for reporting to the police, urgently when necessary;
- a full list of points of referral indicating how to access support and advice at all times, whether in normal working hours or outside them, with a comprehensive list of contact addresses and telephone numbers, including relevant national and local voluntary bodies;
- how to record allegations of abuse, any enquiry and all subsequent action;
- a list of sources of expert advice;
- a full description of channels of inter-agency communication and procedures for decision making;
- a list of all services which might offer access to support or redress; and,
- how professional disagreements are resolved especially with regard to whether decisions should be made, enquiries undertaken etc.

14.45. Procedures should be reviewed annually and routinely updated to incorporate lessons from recent cases. The procedures should also include the provisions of the law – criminal, civil and statutory – relevant to adult safeguarding. This should include local or agency specific information about obtaining legal advice and access to appropriate remedies.

Record-keeping

14.46. Whenever a complaint or allegation of abuse is made, all agencies should keep clear and accurate records and each agency should identify procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action taken. In the case of providers registered with CQC, these should be available to service commissioners and the CQC so they can take the necessary action.

14.47. Staff should be given clear direction as to what information should be recorded and in what format. The following questions are a guide:

- what information do staff need to know in order to provide a high quality response to the adult concerned?
- what information do staff need to know in order to keep people safe under the service's duty to protect people from harm?
- what information is not necessary?
- what may be a breach of an adult's legal rights?

14.48. Records should be kept in such a way that they have the potential to create statistical information both for local use and national data collections.

14.49. All agencies should identify arrangements, consistent with principles and rules of fairness, confidentiality and data protection for making records available to those affected by, and subject to, an enquiry. If the alleged abuser is using care and support themselves then information about their involvement in an adult safeguarding enquiry, including the outcome, should be included in their case record. If it is assessed that the individual continues to pose a threat to other people then this should be included in any information that is passed on to service providers or other people who need to know. Although the local authority has the lead role in making enquiries, the early involvement of the police is likely to have benefits in some cases.

14.50. In particular:

- early referral or consultation with the police will enable them to establish whether a criminal act has been committed and this will give them the opportunity of determining if, and at what stage, they need to become involved;
- a higher standard of proof is required in criminal proceedings ("beyond reasonable doubt") than in disciplinary or regulatory proceedings (where the test is the balance of probabilities) and so early contact with police may assist in obtaining and securing evidence and witness statements;
- early involvement of the police will help ensure that forensic evidence is not lost or contaminated;
- police officers need to have considerable skill in investigating and interviewing people with a range of disabilities and communication issues if early involvement is to prevent the adult being interviewed unnecessarily on subsequent occasions;
- police investigations should proceed alongside those considering possible health and social care issues but they may take priority;
- guidance should include reference to support relating to criminal justice issues which is available locally from such organisations as Victim Support and court preparation schemes; and,
- some witnesses will need protection.

Making safeguarding personal

14.51. It is important that local authorities take a broad community approach to establishing safeguarding arrangements. This includes the establishment of a Safeguarding Adult Board, agreeing inter-agency procedures, publishing a strategic plan, and increasing public awareness and vigilance.

14.52. However, it is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We are all individuals with different preferences, histories, circumstances and life-styles. It is therefore unhelpful to attempt a prescriptive process that can be followed in every case for concern. Nevertheless there are key steps and considerations that local authorities and their partners should include in local policies and procedures to ensure that everyone knows what to do and where to go to if they suspect or are made aware of abuse or neglect. Paragraphs 14.168 goes into more detail about what such guidelines should cover.

Procedures for responding in individual cases

When should an enquiry take place?

14.53. Local authorities **must** make enquiries, or require another agency to do so, whenever abuse or neglect are suspected in relation to an adult with care and support needs. The scope of that enquiry, who leads it and its nature, will be dependent on the particular circumstances. It will usually start with the individual who is the subject of the concern, and next steps will to some extent depend on their wishes.Everyone involved in an enquiry must focus on improving the individual's well-being and work together to that shared aim.

Objectives of an enquiry

14.54. The objectives of an enquiry into abuse or neglect are to:

- establish facts;
- ascertain the individual's views and wishes and seek consent;
- assess the needs of the adult for protection, support and redress; and,
- make decisions as to what follow-up action should be taken with regard to the person responsible, or the organisation, for the abuse or neglect.

14.55. The first priority should always be to ensure the safety and well-being of the adult at risk and, when the adult has capacity to make their own decisions, to aim for any action to be in line with their wishes as far as appropriate. The safeguarding process should be experienced as empowering and supportive – not as controlling and disempowering. Practitioners must always seek the consent of the individual before taking action or sharing personal information. However, there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it, but the best interests of the individual or others at risk demand action. It is the responsibility of all staff and members of the public to act on any suspicion or evidence of abuse or neglect and to pass on their concerns to a responsible person/agency.

What should an enquiry take into account?

14.56. Where an adult has capacity to make decisions about their safeguarding plans, and where no one else is at risk, then their wishes are very important. They may seek highly interventionist help, such as the barring of a person from their home, or they may wish to be helped in less interventionist ways, through the identification of options with time to choose between them.

14.57. Where an adult lacks capacity to make decisions about their safeguarding plans, then a range of options should be identified, which help the adult stay as much in control of their life as possible. Wherever possible, the adult should be supported to recognise risks and to manage them. Safeguarding plans should empower the adult as far as possible to make choices and to develop their own capability to respond to risks.

Taking the time to maximise the involvement of the individual:

Mrs. T has been suffering with extreme depression and is an inpatient within a local mental health unit. Extended family members have heard that she has made a will and the main beneficiary is a "lodger" who pays Mrs. T a nominal, small rent. The family members are also concerned about the "state of the house". They raised a safeguarding alert citing financial/material abuse and neglect at the hands of the "lodger".

There was some discussion of these concerns with Mrs. T on the ward. However there was concern about her capacity to consider the issues fully in her present condition. She was not able to discuss her Will or talk about the relationship between her and the lodger. Mrs. T was not well enough to participate in assessing the concerns raised or in making any decisions. She did not however indicate any negative feelings towards the lodger. She agreed for social services to visit the house to consider if there would be any need for assistance once she was discharged home. It was decided to go back to Mrs. T when her condition had improved to revisit the concerns rather than initiating a full safeguarding response immediately.

A visit to the house by the care coordinator took place, and no concerns regarding the neglect outlined by extended family were noted.

After two to three weeks Mrs. T was able to discuss in detail the arrangements she had with the "lodger" and her views about recent contact with extended family members. She talked fondly of the lodger. She felt the contribution he made to the household budget was adequate, that he was good company and that he provided day to day practical support.

The safeguarding adult's process was explained to Mrs. T and she did not want any further action taken in this regard. She was supported to speak with her family who were informed of the outcome. The family accepted this and the case was closed.

14.58. Any intervention in family or personal relationships needs to be carefully considered. While abusive relationships are never in the best interests of an adult, interventions which remove all contact with family members may also be experienced as abusive interventions and risk breaching the adult's right to family life if not justified or appropriate. Safeguarding needs to recognise that the right to safety needs to be balanced with other rights, such as rights to liberty and autonomy, and rights to family life. Action might be primarily supportive or therapeutic, or it might involve the application of sanctions, suspension, regulatory activity or criminal prosecution, disciplinary action or de-registration from a professional body.

14.59. It is important, when considering the management of any intervention, to approach reports of incidents or allegations with an open mind. In considering how to respond the following factors need to be considered:

- the individual's needs for care and support;
- the individual's risk of abuse or neglect;

- the individual's ability to protect themselves;
- the impact on the individual, their wishes;
- the possible impact on important relationships;
- potential of action increasing risk to individual; and,
- the risk of repeated or increasingly serious acts involving children, or another adult at risk of abuse or neglect.

Who can carry out an enquiry?

14.60. Although the local authority is the lead agency for making enquiries, it may ask others to undertake them. The specific circumstances will often determine the right person to begin an enquiry. In many cases a professional who already knows the individual will be the best person. They may be a social worker, a housing support worker, or health worker such as a community nurse. Where a crime is suspected, and referred to the police then the police must lead the criminal investigations, with the local authority's support where appropriate, for example by providing information and assistance.

14.61. Staff must be trained in recognising the symptoms of abuse or neglect, how to respond and where to go for advice and assistance. These are best written down in shared policy documents that can be easily understood and are used by all the key organisations.

14.62. All staff must keep accurate records, clearly stating what the facts are and what are the known opinions of professionals and others. It is vital that the views of the adult who is the subject of the concerns are sought and recorded.

Safeguarding plans

14.63. Once the facts have been established, a further discussion of the needs and wishes of the adult who has been abused or is at risk may need to take place. This could be a focused safeguarding assessment relating to safety and protection needs, or may require fuller assessments by health and social care agencies (e.g. a needs assessment under the Care Act).This will entail joint discussion, decision and planning with the adult at risk for their future safety and well-being. This applies if it is concluded that the allegation is true or otherwise, as many enquiries may be inconclusive.

14.64. In deciding what action to take, there should be the presumption that the majority of people can make choices which involve taking risks. Of course their capacity to make decisions about arrangements for enquiries or managing the abusive situation should be taken into account.

> Mrs. B gave control of her finances and bank cards to her milkman. She was isolated and had no family. Social services involved police and bank statements were obtained that did not show any unaccounted monies etc. However, the milkman relinquished this control which was then taken over by social services. This reduced the risk to Mrs. B without damaging her friendship with the milkman.

14.65. In order to make sound decisions, the adult's emotional, physical, intellectual and mental capacity in relation to self-determination and consent and any intimidation, misuse of authority or undue influence will have to be assessed.[110]

[110] http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf

14.66. The adult's capacity or ability to make decisions is the key to what happens next, since if someone has the capacity to make decisions in this area of their life and declines assistance this can limit the intervention that organisations can make. The focus should therefore be, on harm reduction. It should not however limit the action that may be required to protect others who are at risk of harm. The potential for 'undue influence' will need to be considered if relevant. If the adult suspected of being abused or neglected is thought to be refusing intervention on the grounds of duress then action must be taken.

Decision-making

14.67. Once enquiries are completed, the outcome should be notified to the local authority which should then determine with the adult who has been the subject of concern what, if any, further action is necessary and acceptable. One outcome of the enquiry may be the formulation of agreed action for the adult at risk to be recorded on their care plan. This will be the responsibility of the relevant agencies to implement.

14.68. In relation to the adult who has suffered abuse this should set out:

- what steps are to be taken to assure their safety in future;
- the provision of any support, treatment or therapy including advocacy;
- any modifications needed in the way services are provided (e.g. same gender care or placement);
- how best to support the individual through any action they take to seek justice or redress; and,
- any on-going risk management strategy as appropriate.

Person alleged to be responsible for abuse or neglect

14.69. When a complaint or allegation has been made against a member of staff, including people employed by the adult at risk, they should be made aware of their rights under employment legislation and any internal disciplinary procedures.

14.70. Where the person who is alleged to have carried out the abuse themselves has care and support needs and are unable to understand the significance of questions put to them or their replies, they should be assured of their right to the support of an 'appropriate' adult if they are questioned by the police under the Police and Criminal Evidence Act 1984 (PACE). Victims of crime and witnesses may also require the support of an 'appropriate' adult.

Safeguarding requires skilled working with sensitive and complex situations:

Susan is suffering from a mental illness and lives at home with her mother, the main carer. Last year, police were called to a domestic dispute in which Susan attacked her mother, who decided not to press charges. At this time, Susan was in denial about her illness and refused to ask for outside support. Other family members, concerned that both Susan and her mother were at risk, contacted the police.

They referred the family to the council and it began its enquiries. Susan and her mother were supported throughout this process including meetings at home, where they could both be safely involved.

Following the enquiry, a protection plan was agreed including respite care and an additional support worker for Susan. Over time, she built a relationship with the support worker, who continues to give support on a regular basis.

14.71. Under the Mental Capacity Act, people who lack capacity and are alleged to be responsible for abuse, should be entitled to the help of an Independent Mental Capacity Advocate, to support and represent them in the enquiries that are taking place. This safeguard was introduced to ensure that people in this situation have support and help. This is separate from the decision whether or not to provide the victim of abuse with an independent advocate under section 68 of the Care Act.

14.72. Allegations of criminal behaviour should always be reported to the police. Agencies such as care providers, housing providers, and the NHS should agree procedures to cover the following situations:

- action pending the outcome of the police and the employer's investigations;
- action following a decision to prosecute an individual;
- action following a decision not to prosecute;
- action pending trial; and,
- responses to both acquittal and conviction.

14.73. Employers who are also providers or commissioners of care and support have, not only a duty to the adult who has been abused, but also a responsibility to take action in relation to the employee when allegations of abuse are made against them. Employers should ensure that their disciplinary procedures are compatible with the responsibility to protect adults at risk of abuse or neglect.

14.74. With regard to abuse, neglect and misconduct within a professional relationship, some are governed by codes of professional conduct and/or employment contracts which will determine the action that can be taken. Where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation such as the General Medical Council and the Nursing and Midwifery Council and/or the Disclosure and Barring Service.

14.75. The standard of proof for prosecution is 'beyond reasonable doubt'. The standard of proof for internal discipline is usually the civil standard of 'on the balance of probabilities'. This means that when criminal procedures are concluded without action being taken this does not automatically mean that regulatory or disciplinary procedures should cease or not be considered.

Safeguarding and advocacy

14.76. The local authority must arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in contributing to the process and where there is no other appropriate adult to assist. A person who is engaged professionally to provide care or treatment for the adult in question cannot be an advocate.

14.77. The adult must also consent to being represented and supported by the advocate (or where the adult lacks capacity, the local authority must consider it in that adult's best interests to be represented and supported by the advocate).

14.78. This duty to provide an independent advocate is separate from the power of the local authority to provide an Independent Mental Capacity Advocate in safeguarding enquiries where someone lacks capacity to fully participate. Both these provisions are in recognition of the importance of providing support and representation for people who have experienced abuse and neglect. The IMCA can support and represent an adult at

risk of abuse and neglect, where necessary and appropriate. The local authority is not required to provide two different advocates. It is not likely to be in the adult's interest to do this.

14.79. Advocates have two roles. They need to provide support to the adult to assist them in understanding the safeguarding process. The second role is representation, particularly in ensuring that the individual's voice is heard and the safeguarding process takes account of their views wherever appropriate.

14.80. Effective safeguarding is about seeking to promote an adult's rights, rather than merely their physical safety[111] and taking action to prevent similar situations occurring again. There is increasing case law on safeguarding from the Court of Protection of which advocates and safeguarding leads should be aware.[112]

14.81. However, if an enquiry needs to start urgently, then it can begin before an advocate is appointed but one must be appointed as soon as possible. In such cases, all agencies should set out how the services of advocates can be accessed, and the role they should take.

14.82. The Care Act sets out four areas where a substantial difficulty might be found such that an independent advocate should be made available.

14.83. The first area to consider is whether or not the individual understands relevant information. Many people can be supported to understand information, if it is presented appropriately and if time is taken to explain it. Some people however may not be able to understand it, for example if they have advanced dementia, or substantial learning difficulties but nevertheless should be involved in all decisions that they do have capacity to make.

14.84. The second area to consider whether or not the individual can retain information. If the adult is unable to retain information long enough to be able to weigh up options within the decision making, then they are likely to have substantial difficulty in understanding the options open to them.

14.85. The third area is if the adult has substantial difficulty using or weighing information. An adult must be able to weigh up information, in order to participate fully and choose between options. For example they need to be able to weigh up the advantages and disadvantages of changing where they live or who they live with. If they are unable to do this, they will have substantial difficulty in coming to a decision.

14.86. And the fourth area involves communicating their views, wishes and feelings whether by talking, writing, signing or any other means. It is critical in this particularly sensitive area that people are supported in what may feel a daunting process which may lead to some very hard and difficult decisions.

111 http://www.bury.gov.uk/index.aspx?articleid=6554

112 http://www.bury.gov.uk/index.aspx?articleid=6554

A personalised approach to safeguarding through use of an advocate:

Mr. W experienced physical and financial abuse by his son who has alcohol issues.

An advocate was involved throughout the safeguarding process, mainly to talk through his concerns. This intervention resulted in this man receiving the support he required, resulting in some positive outcomes.

Mr. W's experience of the safeguarding adult's process was overall positive. He said he was kept informed of what was going on throughout the process, was listened to and was offered a lot of support.

Mr. W said a positive outcome from the process was the renewed contact he now has with his daughter that had ceased because of his son's behaviour.

He concluded by stating he felt much safer following the process and now has a good rapport with local neighbourhood police, an identified housing liaison officer, some telecare equipment, and he had received support to take out an injunction to stop his son visiting.

14.87. An adult with dementia, significant learning disabilities, a brain injury or mental ill health may need an advocate to participate in a safeguarding enquiry. That is usually likely to be an IMCA.

14.88. It is also possible that the person or people that would normally be considered as appropriate to support or represent the views of the individual, such as family or friends, do not themselves have the capacity to support the individual. This is one of the circumstances where an Independent Mental Capacity Advocate should be instructed by the local authority if the individual lacks capacity that would result in them having substantial difficulty in participating.

14.89. But equally an individual who is thought to have been abused or neglected may be so demoralised, frightened, embarrassed or upset that independent support provided under section 68 of the Care Act to help them to be involved will be crucial.

An appropriate person to facilitate the adult's involvement

14.90. The Care Act requires local authorities to consider whether there is an appropriate person who can facilitate an adult's involvement in the safeguarding process. The legislation contains three requirements.

14.91. First, it cannot be someone who is already providing care and treatment in a professional capacity or on a paid basis (regardless of who employs or pays them). That means it cannot be, for example, a GP, or a nurse, a key worker or a care and support worker involved in the adult's care or support.

14.92. Second, the adult who is the subject of the safeguarding enquiry or Safeguarding Adults Review (SAR) has to agree to the person supporting them, if the adult has the capacity to make this decision. Where an adult with capacity does not wish to be supported by a relative, for example, perhaps because they do not wish to discuss the nature of the abuse with them, then the local authority cannot consider the relative to be an appropriate person to act as the adult's advocate. The adult who is the subject of the enquiry or of the SAR has to agree to the appropriateness of the supporter. If the adult

in question does not have the capacity to consent to being represented or supported by a particular person, then the local authority has to be satisfied that it is in the adult's best interests to be supported and represented by the proposed person.

14.93. Third, the person is expected to support and represent the adult and to help their involvement in the processes. In some circumstances it is unlikely that they will be able to fulfil this role easily; for example, a family member who lives at a distance and who only has occasional contact with the adult; a spouse who also finds it difficult to understand the local authority processes, or a friend who expresses strong opinions of their own, prior to finding out those of the individual concerned. It is not sufficient to know the adult well; the role is to actively support the adult's participation in the process.

14.94. Sometimes the local authority will not know at the point of first contact or at an early stage of the enquiry or SAR whether there is someone appropriate to assist the adult in being involved. They may need to arrange initially for an advocate, and find later that there is a more appropriate person in the adult's own network to act. The advocate can at that stage 'hand over' to the appropriate person. Alternatively the local authority may agree with the adult, the appropriate person and the advocate that it would be beneficial and in the adult's best interest for the advocate to continue their role.

14.95. Equally it is possible that the local authority will consider someone appropriate who may then turn out to have difficulties in supporting the adult's involvement. The local authority must at that point arrange for another independent advocate.

14.96. There is nothing to prevent an appropriate family member or friend also offering support to an adult subject of an enquiry or SAR even where a safeguarding advocate has been appointed. There may also be some cases where the local authority considers that an adult needs the support of both a family member and an advocate; perhaps because the family member can provide a lot of information but not enough support, or because while there is a close relationship, there may be a conflict of interest with the relative, for example in relation to differences in what each want as the final outcome.

14.97. The local authority may be carrying out two enquiries or a SAR focusing on more than one individual, in the same household or setting. If both people agree, and it is in both their best interests where they lack capacity, to have the same advocate, and if the advocate and the local authority both consider there is no conflict of interest, then the same advocate may support and represent both of them.

14.98. For example if the adults who are subjects of the enquiries have had similar experiences and want similar outcomes then it may make sense for one advocate to support both. But where for example one wishes for quite a different outcome or resolution, there may be a conflict of interest and two advocates will be needed. If any of the people – the people who are the subjects of the concern, the local authority or the independent advocate – consider that it would be better to have different advocates, then separate advocates should be provided.

14.99. Some enquiries will be very short. This may be because there is actually no abuse or neglect, or because there is no ongoing risk of harm through abuse or neglect (e.g. one-off incidents), or because the adult has the capacity to make the decision not to take the matter further. In some cases where a crime is identified it is not always for the adult to decide whether or

not an investigation proceeds. It is a factor but the police are under wider duties to investigate crime and to protect the public at large.

Safeguarding Adults Boards

14.100. Each local authority must set up a Safeguarding Adults Board (SAB). A Safeguarding Adults Board has three functions:

- It must publish a strategic plan for each financial year that sets how it will met its main objective and what the members will do to achieve these objectives. The plan must be developed with local community involvement, and the SAB must consult the Local Healthwatch organisation.
- It must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews or any on-going reviews.
- It must conduct any Safeguarding Adults Review.

14.101. Adult safeguarding requires collaboration between partners in order to create a framework of inter-agency arrangements. Local authorities must collaborate and work together with its relevant partners as set out in the co-operation duties in the Care Act and, in doing so, must also always consider the wishes and feelings of the adult on whose behalf they are working.

14.102. Local authorities may co-operate with anyone else they consider appropriate where it is relevant to their care and support functions. The lead agency with responsibility for coordinating adult safe guarding arrangements is the local authority, but all the statutory members of the SAB should designate a lead officer. Other agencies for adult safeguarding should also consider the benefits of having a lead for adult safeguarding.

14.103. The objective of a SAB is to help and protect adults who have needs for care and support, who are experiencing or are at risk of abuse or neglect, and as a result of their needs are unable to protect themselves from abuse or neglect. This is whether or not the adult is having their needs met or they meet the local authority's eligibility criteria for care and support services.

14.104. Each Safeguarding Adults Board should:

- identify the role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of adults at risk of abuse or neglect;
- establish how it will hold partners to account and gain assurance of the effectiveness of its arrangements;
- determine its arrangements for peer review and self-audit;
- establish mechanisms for developing policies and strategies for protecting adults at risk of abuse and neglect which should be formulated, not only in collaboration and consultation with all relevant agencies but also take account of the views of people who use care and support, families and carer representatives;
- develop procedures for identifying circumstances giving grounds for concern and directing referrals to a central point;
- formulate guidance about the arrangements for managing adult

safeguarding, and dealing with complaints, grievances and professional and administrative malpractice;

- develop strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect;
- balance the requirements of confidentiality with the consideration that, to protect adults at risk of abuse or neglect, it may be necessary to share information on a 'need-to-know basis';
- identify mechanisms for monitoring and reviewing the implementation and impact of policy;
- carry out safeguarding adult reviews;
- produce an Annual Report and an Annual Business Plan; and,
- promote multi-agency training.

14.105. Members of a SAB should consider what assistance they can provide in supporting the SAB in its work. This might be through payment to the local authority or to a joint fund established by the local authority. Members might also support the work of the SAB by providing administrative help, premises to meet or hold training sessions.

14.106. A SAB can cover more than one geographical area. It may also be set up as a joint Board that covers children's safeguarding. Local SABs decide how they operate but they must ensure that their arrangements will be able to deliver the duties and functions under Schedule 2 of the Care Act.

14.107. The arrangements that the SAB needs to create include for example, how often it meets, the appointment of the Chair and other practical arrangements. It also needs to be clear about how it will seek feedback from the local community, particularly those people who have been involved in a safeguarding enquiry.

Camden effectively includes people who use care and support and carers in the work of the Safeguarding Adults Partnership Board (SAPB). One of the SAPB's sub-groups is the Safeguarding Engagement Group (SEG) which is chaired by a person who uses care and support (supported by one of the LA's engagement officers), and draws membership from different service user groups, carers, and voluntary/ community associations.

The sub-group also runs large and small public meetings and events to raise awareness in the community and hear from residents what concerns them.

14.108. The information about how the SAB works should be easily accessible to partner organisations and to the general public. The following organisations **must** be represented on the Board:

- the local authority which set it up;
- the NHS Clinical Commissioning Group(s) in the local authority's area; and
- the chief officer of police in the local authority's area.

14.109. As is common current practice, SABs are expected to involve a much wider range of organisations and individuals. Examples of other members that SABs may wish to include are:

- ambulance and fire services;
- representatives of providers of health and social care services;
- representatives of housing providers, housing support providers, probation and prison services;

- members of user, advocacy and carer groups;
- Local Healthwatch;
- Care Quality Commission;
- Representatives of children's safeguarding;
- Pension Service and Job Centre Plus;
- Community safety partnerships; and
- Public health.

14.110. This is not a definitive list, but SABs need to assure themselves that the Board has the involvement of all partners necessary to effectively carryout its duties.

Membership of Safeguarding Adults Boards

14.111. As with the Chair of the SAB and its core statutory members, all members of the SAB must have the necessary skills and experience to ensure that the SAB is an effective way of improving adult safeguarding arrangements in its area. Social workers' ability to understand the individual within complex social networks and other systems makes social work input a vital component in SAB arrangements. Members who attend in a professional and managerial capacity should be:

- able to present issues clearly in writing and in person;
- experienced in the work of their organisation;
- knowledgeable about the local area and population;
- able to explain their organisation's priorities;
- have a thorough understanding of abuse and neglect and its impact; and,
- understand the pressures facing front line practitioners.

14.112. Although it is not a requirement, the local authority should consider appointing a chair to the Safeguarding Adult Board who is not an employee or a member of an agency that is a member of the SAB. The chair should be in a position to constructively challenge and hold to account the main partner agencies of the SAB whilst also acting as a spokesperson for the SAB. It provides reassurance that the Board has some independence from the local authority and other partners.

14.113. The SAB must develop clear policies and processes that have been agreed with other interested parties, and that reflect the local service arrangements, roles and responsibilities. It will promote multi-agency training that ensures a common understanding of abuse and neglect and agree how to work together. Policies will state what organisations and individuals are expected to do where they suspect abuse or neglect. The SAB should also consider any specialist training that is required. A key part of the SAB's role will be to develop preventative strategies and aiming to reduce instances of abuse and neglect in its area.

SAB strategic plans and annual reporting

14.114. The SAB **must** publish a strategic plan every year. This plan **must** set out how it will protect and help adults in its area and what actions each member of the SAB will take to deliver the plan better.

14.115. When it is preparing the plan, the SAB **must** consult the Local Healthwatch and involve the local community. The local community has a role to play in the recognition and prevention of abuse and

neglect but active and on-going work with the community is needed to tap into this source of support.

14.116. SABs must understand the many and potentially different concerns of the various groups that make up its local community. These might include such things as scams targeted at older householders, bullying and harassment of disabled people, hate crime directed at those with mental health problems, cyber bullying and the sexual exploitation or forced marriage of people who may lack the capacity to understand that they have the right to say no.

14.117. The SAB **must** produce an annual report. This annual report **must** clearly state what both the SAB and its members have done to carry out and deliver the objectives and other content of its strategic plan.

14.118. Specifically, the annual report must provide information about any Safeguarding Adults Reviews (SARS) that the SAB has arranged which are ongoing or have reported in the year. The report must state what the SAB has done to act on the findings of the SARs or, where it has decided not to act on a finding, why not.

14.119. The annual report on the plan should set out how the SAB is monitoring progress against its policies and intentions to deliver. The SAB should consider the following in coming to its conclusions:

- community awareness of adult abuse and neglect and how to respond;
- what individuals who have experienced the process say;
- what front line practitioners say about implementing policies and procedures;
- feedback from Local Healthwatch, people who use care and support and carers, community groups, advocates, service providers and other partners;
- how successful adult safeguarding is at linking with other parts of the system, for example children's safeguarding, domestic violence, community safety;
- the effectiveness of training carried out in this area and analysis of future need; and,
- how well agencies are co-operating and collaborating.

14.120. The report is meant to be a document that can be read and understood by anyone. It is therefore critical that the report is in plain English and free from jargon and acronyms as far as possible. Most SABs are likely to publish reports on their websites. SABs should consider making the report available in a variety of formats including easy read. SABs will need to establish ways of publicising the report.

14.121. Every SAB must send a copy of its report to:

- the Chief Executive and leader of the local authority;
- the local policing body;
- the Local Healthwatch;
- the Chair of the Health and Wellbeing Board.

Safeguarding Adults Reviews (SARs)

14.122. SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

14.123. SABs must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. SABs are free to arrange

for a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice.

14.124. The adult who is the subject of the SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them.

14.125. SARs should reflect the six safeguarding principles. SABs should agree Terms of Reference for any SAR they arrange and these should be published and openly available. In addition, the SAB and the Chair of the SAR should always come to a decision as to whether the information should be anonymised or not.

14.126. SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learnt from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including . criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

14.127. It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty and sharing to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

14.128. The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. We do not believe a one-size-fits-all approach is an appropriate response. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of people who have died or been seriously abused or neglected. The recommendations and action plans from a SAR need to be followed through by the SAB.

14.129. When the SAB has decided to arrange a SAR it should appoint one or more suitable individuals to lead the SAR. The SAB should have evidence that those who are appointed are sufficiently skilled and experienced in adult safeguarding matters. The lead reviewer(s) will chair the SAR. The lead reviewer(s) should be independent of the SAB and the organisations involved in the case.

14.130. The SAB should ensure that there is appropriate involvement in the review process of professionals and organisations who were Involved with the adult.

14.131. The SAB should aim for completion of a SAR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings) every effort should be made while the SAR is in progress to (i) capture points from the case about improvements needed; and (ii) take corrective action.

Findings from SARs

14.132. The SAB should include the findings from any SAR in its Annual Report and what actions it has taken / intends to take in relation to those findings. Where the SAB decides not to implement an action from the findings it must state the reason for that decision in the Annual Report.

14.133. SAR reports should:

- provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence;
- be written in plain English;
- contain findings of practical value to organisations and professionals.

One approach to Safeguarding Adults Reviews:

SCIE's Learning Together model is a method for conducting case reviews and serious case reviews of multi-agency safeguarding practice. The model adapts thinking from accident investigation in the aviation, engineering and health settings to help us understand multi-agency work with children, vulnerable adults and families.

One of the principles behind a Learning Together review is to use scrutiny of one case to provide a better understanding of multi-agency practice more widely. This is sometimes referred to using a case as a 'window on the system' (Vincent, 2004). This means that we take one case as a starting point for exploring the strengths and weaknesses in the system as a whole.

Learning Together takes a collaborative approach to case reviews, involving professionals and managers throughout the process. This is important in order to get a rich understanding of the working context of different professionals, and what helps and hinders their practice. Learning Together as a mindset is helpful to Boards and individual organisations when it comes to thinking about how to most effectively take forward the learning generated by a case review process.

Information

14.134. In order to carry out its functions SABs will need access to information that a wide number of partners may hold. Some of these partners will be statutory, such as the NHS and the police. Others will not be, such as private health and care providers.

14.135. SABs are responsible for commissioning SARs. The purpose of SARs is to identify and apply lessons learnt from cases where there is reasonable cause for concern about how the SAB, its members or other relevant organisations worked together in any particular case, so as to prevent risks of abuse or neglect arising in the future.

14.136. In the past, there have been instances where the withholding of information has prevented organisations being fully able to understand what "went wrong" and so has hindered them identifying, to the best of their ability, the lessons to be applied to prevent or reduce the risks of such cases reoccurring.

14.137. An SAB may request a person to supply information to it or to another person. The person who receives the request **must** provide the information provided if:

- the request is made in order to enable or assist the SAB to do its job;
- the request is made of a person who is likely to have relevant information and then either–
  - the information requested relates to the person to whom the request is made and their functions or activities or
  - the information requested has already been passed on to-another person subject to this requirement.

Information for staff, people who use care and support, carers and the general public

14.138. All commissioners or providers of services in the public, voluntary or private sectors should disseminate information about the multi-agency policy and procedures. Staff should be made aware through internal guidelines of what to do when they suspect or encounter abuse of adults in vulnerable situations. This should be incorporated in staff manuals or handbooks detailing terms and conditions of appointment and other employment procedures so that individual staff members will be aware of their responsibilities in relation to safeguarding adults.

14.139. This information should emphasise that all those who express concern will be treated seriously and will receive a positive response from managers.

14.140. Information in a range of media should be produced in different, user friendly formats for people with care and support needs and their carers. These should explain clearly what abuse is and also how to express concern and make a complaint. People with care and support needs and carers should be informed that their concern or complaint will be taken seriously, be dealt with independently and that they will be kept involved in the process to the degree that they wish to be. They should be reassured that they will receive help and support in taking action on their own behalf. They should also be advised that they can nominate an advocate or representative to speak and act on their behalf if they wish. They should be advised of rights to legal aid in certain circumstances and to victim support and compensation. The involvement of adults at risk in developing such communication is sensible.

Camden has developed a leaflet for carers about the harm they can experience when caring for a loved one and the harm they may inadvertently perpetrate. This was developed in partnership with carers' organisations and carers themselves, and remains a partnership owned publication.

Confidentiality

14.141. Agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information based on the best interests of the adult at risk of abuse or neglect.

14.142. The most recent discussion of all aspects of an individual's identifiable information and how this is to be protected is to be found in the report of the Caldicott Committee *Report on the review of patient-identifiable information.* That report recognises that confidential information may need to be disclosed in the best interests of the individual and discusses in what circumstances this may be appropriate and what safeguards need to be observed. The principles can be summarised as:

- information will only be shared on a 'need to know' basis when it is in the best interests of the adult;
- confidentiality must not be confused with secrecy;
- informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement; and,
- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other vulnerable people may be at risk.

14.143. Decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework.

14.144. Principles of confidentiality designed to safeguard and promote the interests of an adult should not be confused with those designed to protect the management interests of an organisation. These have a legitimate role but must never be allowed to conflict with the interests of an adult. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of adults at risk of abuse or neglect then a duty arises to make full disclosure in the public interest.

14.145. In certain circumstances it will be necessary to exchange or disclose personal information which will need to be in accordance with the Data Protection Act 1998 where this applies.

14.146. The Home Office and the Office of the Data Protection Commissioner (formerly Registrar) have issued general guidance on the preparation and use of information sharing protocols.

The Caldicott principles

14.147. The Information Governance Review – To Share or Not to Share?

- **Justify the purpose(s).** Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.
- **Don't use personal confidential data unless it is absolutely necessary.** Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for adults to be identified should be considered at each stage of satisfying the purpose(s).
- **Use the minimum necessary personal confidential data.** Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.
- **Access to personal confidential data should be on a strict need-to-know basis.** Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.
- **Everyone with access to personal confidential data should be aware of their responsibilities.** Action should be taken to ensure that all those handling personal confidential data are made fully aware of their responsibilities and obligations to respect individuals' confidentiality.
- **Comply with the law.** Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.
- **The duty to share information can be as important as the duty to protect confidentiality.** Health and social care professionals and other staff should have the confidence to share information in

the best interests of adults within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

Local roles and responsibilities

14.148. Roles and responsibilities[113] should be clear and collaboration should take place at all the following levels:

- Operational;
- Supervisory line management;
- Senior management staff;
- Corporate / cross authority;
- Chief officers / chief executives; and,
- Local authority members.

Front line

14.149. Operational front line staff are responsible for identifying and responding to allegations of abuse. Staff at operational level need to share a common view of what types of behaviour may be abuse or neglect and what should be an initial response to suspicion or allegation of abuse or neglect.

14.150. There should be clear arrangements in place about what each agency should contribute at this level. These will cover approaches to enquiries and subsequent courses of action. The local authority is responsible for ensuring effective co-ordination at this level.

Line managers' supervision

14.151. Skilled and knowledgeable supervision focused on outcomes for individuals is critical in safeguarding work. Managers have a central role in enduring high standards of practice and that practitioners are properly equipped and supported. It is important to recognise that dealing with situations involving abuse and neglect can be stressful and distressing for staff.

14.152. Managers need to develop good working relationships with their counterparts in other agencies to improve cooperation locally and swiftly address any differences or difficulties that arise between front line staff.

Senior managers

14.153. Each agency should identify a senior manager to take a lead role in the organisation and in inter-agency arrangements, including the Safeguarding Adults Board. In order for the Board to be an effective decision-making body providing leadership and accountability, members need to be sufficiently senior and have the authority to commit resources and make strategic decisions. To achieve effective working relationships, based on trust and transparency, the members will need to understand the contexts and restraints within which their counterparts work.

Corporate/cross authority roles

14.154. To ensure effective partnership working, each organisation must recognise and accept its role and functions in relation to adult safeguarding. These should be set out in the SAB's strategic plan as well as its own communication channels.

[113] http://www.tcsw.org.uk/uploadedFiles/TheCollege/_CollegeLibrary/Policy/RolesFunctionsAdviceNote.pdf

Chief Officers and Chief Executives

14.155. As chief officer for the leading agency, the Director of Adult Social Services has a particularly important role to play in adult safeguarding.

14.156. However, all officers, including the Chief Executive of the local authority, should support and promote the development of initiatives to improve the prevention, identification and response to abuse and neglect. They need to be aware of and respond to national developments.

14.157. Chief Officers should receive regular briefings of case law from the Court of Protection and the High Court. They should have access to legal advice on when proposed interventions – such as a removal of a person against their or the family's wishes from the home, or the proposed stopping of contact between family members – require applications to the Court of Protection. They should have protocols for mediation and family group conferences and for various forms of dispute resolution.

Local authority member level

14.158. Local authority members need to have a good understanding of the range of abuse and neglect issues that can affect adults in vulnerable situations and of the importance of balancing safeguarding with empowerment. Local authority members need to understand proportionate interventions, the dangers of risk adverse practice and the importance of upholding human rights. Some Safeguarding Adults Boards include elected members and this is one way of increasing awareness of members and ownership at a political level. Managers must ensure that members are aware of any critical local issues, whether of an individual nature, matters affecting a service or a particular part of the community.

14.159. In addition, Local Authority Health Scrutiny Functions (for example the Council's Health Overview and Scrutiny Committee) can play a valuable role in assuring local safeguarding measures, and ensuring that SABs are accountable to local communities. Similarly, Local Health and Wellbeing Boards provide leadership to the local health and wellbeing system; ensure strong partnership working between local government and the local NHS; and ensure that the needs and views of local communities are represented. HWBs can therefore play a key role in assurance and accountability of SABs and local safeguarding measures.

Providers of services

14.160. All service providers, including housing and housing support providers, should have clear operational policies and procedures that reflect the framework set by the SABs in consultation with them. This should include what circumstances would lead to the need to report outside their own chain of line management, including outside their organisation to the local authority.

Voluntary organisations

14.161. Voluntary organisations need to work with the SAB to agree how their role fits alongside the statutory agencies and how they should work together. This will be of particular importance where they are offering independent advocacy, advice, and support or counseling services in safeguarding situations. This will include telephone or on-line services. Additionally, many voluntary organisations also provide care and support services, including personal acre. All voluntary organisations that work with adults at risk of

abuse or neglect need to have safeguarding procedures and lead officers.

Regulated professionals

14.162. Staff governed by professional regulation (for example, social workers, doctors, allied health professionals and nurses) should understand how their professional standards and requirements underpin their organisational roles to prevent, recognise and respond to abuse and neglect.[114]

Recruitment and training for staff and volunteers

14.163. The SAB should ensure that relevant partners should provide training for staff and volunteers on the policy, procedures and professional practices that are in place locally, which reflects their roles and responsibilities in safeguarding adult arrangements. This should include:

- basic mandatory induction training with respect to awareness that abuse can take place and duty to report;
- more detailed awareness training, including training on recognition of abuse and responsibilities with respect to the procedures in their particular agency;
- specialist training for investigators, and managers; and,
- training for elected members and others e.g. Healthwatch members.

14.164. Training should take place at all levels in an organisation and within specified time scales. To ensure that procedures are carried out consistently no staff group should be excluded. Training should include issues relating to staff safety within a Health and Safety framework and also include volunteers. In a context of personalisation, Boards should seek assurances that directly employed staff (e.g. Personal Assistants) have access to training and advice on safeguarding.

14.165. Training is a continuing responsibility and should be provided as a rolling programme.[115]

Rigorous recruitment practices relevant to safeguarding

14.166. There are three levels of a Disclosure and Barring Service (DBS) check. Each contains different information and the eligibility for each check is set out in law. They are:

- **Standard check:** This allows employers to access the criminal record history of people working, or seeking to work, in certain positions, especially those that involve working with children or adults in specific situations. A standard check discloses details of an individual's convictions, cautions, reprimands and warnings recorded on police systems and includes both 'spent' and 'unspent' convictions.
- **Enhanced checks:** This discloses the same information provided on a Standard certificate, together with any local police information that the police believe is relevant and ought to be disclosed.
- **Enhanced with barred list checks:** This check includes the same level of disclosure as the enhanced check, plus a check of the appropriate barred lists. An individual may only be checked against the children's and adults' barred lists if their job falls within the definition of

[114] http://www.tcsw.org.uk/professional-capabilities-framework/

[115] https://safe.bournemouth.ac.uk/

'regulated activity' with children and/or adults under the Safeguarding Vulnerable Groups Act 2006, as amended by the Protection of Freedoms Act 2012.

14.167. Skills for Care has produced a recruitment and retention toolkit for the adult care and support sector. 'Finders Keepers'[116] is designed to help care providers, particularly smaller organisations, to improve the way they recruit staff and keep them on board.

Internal guidelines for all staff

14.168. Provider agencies should produce for their staff a set of *internal guidelines* which relate clearly to the multiagency policy and which set out the responsibilities of all staff to operate within it. These should include guidance on:

- identifying adults who are particularly at risk;
- recognising risk from different sources and in different situations and recognising abusive behaviour from other service users, colleagues, and family members;
- routes for making a referral and channels of communication within and beyond the agency;
- assurances of protection for whistle blowers;
- working within best practice as specified in contracts;
- working within and co-operating with regulatory mechanisms; and,
- working within agreed operational guidelines to maintain best practice in relation to:
    - challenging behaviour;
    - personal and intimate care;
    - control and restraint;
    - gender identity and sexual orientation;
    - medication;
    - handling of people's money; and,
    - risk assessment and management.

14.169. Internal guidelines should also explain the rights of staff and how employers will respond where abuse is alleged against them within either a criminal or disciplinary context.

Protecting property of adults being cared for away from home

14.170. Local authorities must take all reasonable steps to protect the moveable property of a person adult with care and support needs who is being cared for away from home in a hospital or in accommodation such as a care home, and who cannot arrange to protect their property themselves. Local authorities must act where it believes that if it does not take action there is a risk of moveable property being lost or damaged.

14.171. For example, protecting property may include arranging for pets to be looked after when securing premises for someone who is having their care and support needs provided away from home in a care home or hospital, and who has not been able to make other arrangements for the care of their home or pets.

14.172. In order to protect property in these circumstances the local authority may enter the property with the adult's consent. They may also deal with the adult's movable property in order to protect it from damage. If the adult lacks the capacity to consent to the local authority entering the property, consent should be sought from a person authorised

[116] http://www.skillsforcare.org.uk/Document-library/Finding-and-keeping-workers/Practical-toolkits/FindersKeepers.pdf

under the Mental Capacity Act 2005 to give consent on the adult's behalf.

14.173. If a third party tries to stop an authorised entry into the home then they will be committing an offence, unless they can give a good reason. Committing such an offence could lead to the person being fined. If, by carrying out its duties, the local authority incurs expenses it can recover the money back from the adult. If a local authority intends to enter an empty home then it must give written authorisation to an officer of the council and that person must be able to produce it if asked for.

14.174. Local authorities can recover any reasonable expenses they incur in protecting property under this duty from the adult whose property they are protecting.

Integration and partnership working

15. Integration, cooperation and partnerships

This chapter provides guidance on:

- *Sections 3, 6, 7, 22, 23, 74 and Schedule 3 of the Care Act 2014;*
- *The Care and Support (Provision of Health Services) Regulations 2014;*
- *The Care and Support (Discharge of Hospital Patients) Regulations 2014.*

This chapter covers:

- integrating care and support with other local services;
  - Strategic planning;
  - Integrating service provision and combining and aligning processes;
- cooperation of partner organisations;
  - General duty to cooperate;
  - Who must cooperate;
  - Cooperation within local authorities;
  - Cooperating in specific cases;
- working with the NHS;
  - The boundary between the NHS and care and support;
  - Delayed transfers of care from hospitals;
- working with housing authorities and providers;
- working with welfare and employment support.

15.1. For people to receive high quality health and care and support, local organisations need to work in a more joined-up way, to eliminate the disjointed care that is a source of frustration to people and staff, and which often results in poor care, with a negative impact on health and wellbeing. The vision is for integrated care and support that is person-centred, tailored to the needs and preferences of those needing care and support, carers and families.

15.2. Sections 3, 6 and 7 of the Act require that:

- local authorities **must** carry out their care and support responsibilities with the aim of promoting greater **integration** with NHS and other health-related services;

- local authorities and their relevant partners **must cooperate generally** in performing their functions related to care and support; and, supplementary to this,
- local authorities and their partners **must cooperate** where this is needed in the case of **specific individuals** who have care and support needs.

Integrating care and support with other local services

15.3. Local authorities **must** carry out their care and support responsibilities with the aim of joining-up the services provided or other actions taken with those provided by the NHS and other health-related services (for example, housing or leisure services). This general requirement applies to all the local authority's care and support functions for adults with needs for care and support and carers, including in relation to preventing needs (see chapter 2), providing information and advice (see chapter 3) and shaping and facilitating the market of service providers (see chapter 4).

15.4. This duty applies where the local authority considers that the integration of services will:

- promote the wellbeing of adults with care and support needs or of carers in its area;
- contribute to the prevention or delay of the development of needs of people;
- improve the quality of care and support in the local authority's area, including the outcomes that are achieved for local people.

15.5. The local authority is not solely responsible for promoting integration with the NHS, and this responsibility reflects similar duties placed on NHS England and clinical commissioning groups (CCGs) to promote integration with care and support.[117] Under this provision, NHS England must encourage partnership arrangements between CCGs and local authorities where it considers this would ensure the integrated provision of health services and that this would improve the quality of services or reduce inequalities. Similarly, every CCG has a duty to exercise its functions with a view to securing that health services are provided in an integrated way, where this would improve the quality of health and/or reduce inequalities in access or outcomes. The Care Act adds further coherence by placing an equivalent duty on local authorities to integrate care and support provision with health services and health related services, for example housing (see paragraphs 15.7-15.8 below about the integration of health and health related services).

15.6. There are a number of ways in which local authorities can fulfil this duty, where they think this will integrate services: at the strategic level; at the level of individual service; and in combining and aligning processes. Some examples are discussed below.

Strategic planning

Integration with health and health-related services

15.7. A local authority **must** promote integration between care and support provision, health and health related services, with the aim of joining up services.

15.8. To ensure greater integration of services, a local authority should consider the different mechanisms through which it can promote integration, for example;

[117] See sections 13N and 14Z1 of the National Health Service Act 2006

(a) Planning – using adult care and support and public health data to understand the profile of the population and the needs of that population. For example, using information from the local Joint Strategic Needs Assessments to consider the wider need of that population in relation to housing. The needs of older and vulnerable residents should be reflected within local authorities' development plans with reference to local requirements for inclusive mainstream housing and specialist accommodation and/or housing services.

Case study: Promoting the integration of housing, health and social care across Leicestershire

District Councils in Leicestershire have taken a strategic approach to working with county wide providers on priority issues, including housing, health and wellbeing. A District Chief Executive leads across the 7 District Councils working with a network of senior managers in each individual council.

This has built the influence and credibility of District Councils with health and social care leaders who now have an increasing understanding of the vital role housing and housing based services play in the delivery of better outcomes for vulnerable people.

The Housing Offer to Health in Leicestershire is built into the County`s Better Care Fund priorities and work is underway across health, social care and housing in the following key areas:

- Housing's Hospital to Home discharge pathway – looking to place housing options expertise within the day-day discharge assessment and planning work of both acute and mental health providers so that the planning and decisions around an individual's hospital discharge includes early consideration, and actioning of appropriate and supportive housing options.
- Establishing an integrated service to provide practical support to people in their own homes across all tenures so that aids, equipment, adaptations, handy person services and energy efficiency interventions are available and delivered quickly. Through this we hope to reduce the time taken to provide practical help to individual people with care and support needs, reduce process costs for services paid for through the public purse and support vulnerable people to access the low level practical support that helps them remain independently at home.
- Establishing a locality based approach to prevention and housing based support which includes Local Area Co-ordination, Timebanking and delivery of low level support services to vulnerable older people through a mixture of community volunteers and multi-skilled workers.

(b) Commissioning – a local authority may wish to have housing represented at the Health and Wellbeing Board/Clinical Commissioning Groups (CCGs) making a visible and effective link between preventative spend (including housing related) and preventing acute/crisis interventions. Joint commissioning of an integrated information and advice service covering health, care and housing would be one way to achieve this.

(c) Assessment and information and advice – this may include integrating an assessment with information and advice about housing, care and related finance to help develop a care plan (if

necessary), and understand housing choices reflecting the person's strengths and capabilities to help achieve their desired outcomes. There may be occasions where a housing staff member knows the person best, and with their agreement may be able to contribute to the assessment process or provide information.

(d) Delivery or provision of care and support – that is integrated with an assessment of the home, including general upkeep or scope for aids and adaptations, community equipment or other modifications could reduce the risk to health, help maintain independence or support reablement or recovery. For example, some specialist housing associations and home improvement agencies may offer a support service which could form part of a jointly agreed support plan. A housing assessment should form part of any assessment process, in terms of suitability, access, safety, repair, heating and lighting (e.g. efficiency).

Joint Strategic Needs Assessments

15.9. Local authorities and clinical commissioning groups already have an equal and joint duty to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) through health and wellbeing boards. JSNAs are local assessments of current and future health and care needs that could be met by the local authority, CCGs or the NHS Commissioning Board, or other partners. JHWSs are shared strategies for meeting those needs, which set out the actions that each partner will take individually and collectively.

15.10. Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies are therefore key means by which local authorities work with CCGs to identify and plan to meet the care and support needs of the local population. JHWSs can help health and care and support services to be joined up with each other and with health-related services.

15.11. Under the Act, local authorities, when contributing to JHWSs, must consider greater integration of services if doing so would achieve any or all of the objectives set in paragraph 15.4 above (promoting wellbeing; preventing or delaying needs; improving the quality of care). The JHWSs should set the local context and frame the discussion with partners on how different organisations can work together to align and integrate services. However, local authorities should bear in mind that carrying out the JSNA and JWHS on their own is unlikely to be sufficient to fulfil the requirement to promote integration; it will be the agreed actions which follow the strategies and plans that will have the greatest impact on integration and on the experience and outcomes of people.

Integrating service provision and combining and aligning processes

15.12. There are many ways in which local authorities can integrate care and support provision with that of health and related provision locally. Different areas are likely to find success in different models. Whilst some areas may pursue for integrated organisational structures, or shared funding arrangements, others may join up teams of frontline professionals to promote multi-disciplinary working. There is no required format or mechanism for integrating provision, and local authorities should consider and develop their strategy jointly with partners.

15.13. At the strategic level, there are many examples of how local authorities can integrate services including:

- the use of "pooled budgets", which bring together funding from different organisations to invest jointly in delivering agreed, shared outcomes.[118] For example, the Better Care Fund, which provides local authorities and CCGs with a shared fund to invest in agreed local priorities which support health and care and support, will be a key opportunity to promote integration in provision.[119]
- the development of joint commissioning arrangements.

15.14. In terms of working practices to encourage greater integration at an individual level, this could include recruiting and training individual care coordinators who are responsible for planning how to meet an adult's needs through a number of service providers. Another example could be in relation to working with people who are being discharged from hospital, where staff from more than one body may be involved with providing or arranging care and support to allow the person to return home and live independently.[120] As with other examples of integration, this would not necessarily require structural integration – i.e. organisations merging – but a seamless service, from the point of view of the person, could be delivered by staff working together more effectively, for example, integrating an assessment with information and advice about housing options see paragraphs 15.54-15.75 on housing and integration.

15.15. Local authorities, together with their partners, **should consider** combining or aligning key processes in the care and support journey, where there may be benefit to the individual concerned from linking more effectively. For example, combining assessments may allow for a clearer picture of the person's needs holistically, and for a single point of contact with the person to promote consistency of experience, so that provision of different types of support can be aligned. A number of assessments could be carried out on the same person, for example a care and support needs assessment, health needs assessment and continuing health care assessments. Where it is not practicable for assessments to be conducted by the same professional, it may nonetheless be possible to align processes to support a better experience, for example , the 2nd or 3rd assessor could be obliged to read the 1st assessment (provided there is a lawful basis for sharing the information) and not ask any information that has already been collected, or the different bodies could work together to develop a single, compatible assessment tool. Local authorities have powers to carry out assessments jointly with other parties, or to delegate the function in its entirety.

Co-operation of partner organisations

15.16. All public organisations **should** work together and co-operate where needed, in order to ensure a focus on the needs of their local population. Whilst there are some local services where the local authority must actively promote integration, in other cases it must nonetheless co-operate with relevant local and national partners.

15.17. Co-operation between partners **should** be a general principle for all those concerned, and all should understand the

118 http://www.england.nhs.uk/wp-content/uploads/2012/10/lga-nhscb-concordat.pdf

119 Link to BCF guidance: http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

120 Hospital 2 Home guide http://www.housinglin.org.uk/hospital2home_pack/

reasons why co-operation is important for those people involved. The Act sets out five aims of co-operation between partners which are relevant to care and support, although it should be noted that the purposes of co-operation are not limited to these matters:

- promoting the wellbeing of adults needing care and support and of carers;
- improving the quality of care and support for adults and support for carers (including the outcomes from such provision);
- smoothing the transition from children's to adults' services;
- protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect;
- identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect.

15.18. The processes and systems behind the areas noted above, as well as how working with partners is integral to achieving the best outcomes, are set out in more detail in other chapters of this guidance.

15.19. Local Authorities and relevant partners **must** co-operate when exercising any respective functions which are relevant to care and support. This requirement relates to organisations existing functions only, and the Act does not confer new functions.

15.20. "Co-operation", like integration, can be achieved through a number of means, and is intended to require the adoption of a common principle, rather than to prescribe any specific tasks. There are a number of powers which local authorities may use to promote joint working. For example, local authorities may share information with other partners, or provide staff, services or other resources to partners to improve co-operation. Some of the actions may be the same as those undertaken to promote integration, for example under section 75 of the NHS Act 2006, a local authority may contribute to a "pooled budget" with an NHS body – a shared fund out of which payments can be made to meet agreed priorities. Other actions may be specific to particular circumstances or the needs of a specific group, for example the local authority co-operating with prisons in its area to develop a joint strategy for meeting the care and support needs of prisoners.

Who must co-operate?

15.21. The local authority **must** co-operate with each of its relevant partners, and the partners **must** also co-operate with the local authority, in relation to relevant functions. The Act specifies the "relevant partners" who have a reciprocal responsibility to co-operate. These are:

- other local authorities within the area (i.e. in multi-tier authority areas, this will be a district council);
- any other local authority which would be appropriate to co-operate with in a particular set of circumstances (for example, another authority which is arranging care for a person in the home area);
- NHS bodies in the authority's area (including the CCG, any hospital trusts and NHS England, where it commissions health care locally) [see paragraphs 15.29-15.53 about care and support and the NHS];
- local offices of the Department for Work and Pensions (such as Job Centre Plus) [see paragraphs 14.75-14.81 about care and support, welfare and employment];
- police services in the local authority area;

- prisons and probation services in the local area [see chapter 17 on care and support in Prisons].

15.22. In addition, there may be other persons or bodies with whom a local authority **should** co-operate if it considers this appropriate when exercising care and support functions, in particular independent or private sector organisations. Examples include, but are not limited to, care and support providers, NHS primary health providers, independent hospitals and private registered providers of social housing. In these cases, the local authority should consider what degree of co-operation is required, and what mechanisms it may have in place to ensure mutual co-operation (for example, via contractual means).

Ensuring co-operation within local authorities

15.23. Local authorities fulfil a range of different functions that have an impact on the health and wellbeing of individuals, in addition to their care and support responsibilities (e.g. children's services, housing, public health). It is therefore important that, in additional ensuring co-operation between the local authority and its external partners, there is internal co-operation between the different local authority officers and professionals who provide these services. Local authorities **must** make arrangements to ensure co-operation between its officers responsible for adult care and support, housing, public health and children's services, and should also consider how such arrangements may also be applied to other relevant local authority responsibilities, such as education, planning and transport.

15.24. For example, it is important that local authority officers responsible for housing work in co-operation with adult care and support, given that housing and suitability of living accommodation play a significant role in supporting a person to meet their needs and can help to delay deterioration. Similarly, the transition from children's social care to adult care and support will require local authority officers in the respective departments to co-operate to share information, prepare for transition, and ensure the young person's needs are met.

Co-operating with partners in specific cases

15.25. Co-operation should be a general principle for partners, which should inform how they undertake their day-to-day activities. However, there will be circumstances where a more specific approach will be required, and a local authority or partner will need to explicitly ask for co-operation which goes beyond the general approach, where this is needed in the case of an individual. The Care Act provides a new mechanism for the local authority, or partner, to use in such cases.

15.26. Where the local authority requires the co-operation of a partner in relation to a particular individual case, the Act allows for the local authority to request co-operation from that partner. The relevant partner **must** co-operate as requested, unless doing so would be incompatible with the partner's own functions or duties. The converse also applies: where a relevant partner asks for co-operation from a local authority in the case of an individual, then the local authority **must** co-operate, again providing this is compatible with its functions and duties.

15.27. This mechanism is intended to support partners with a means of identifying specific cases in which more targeted co-operation is required. In practice, it may be the case that general working protocols and

relationships between organisations mean that this further process is not required. However, there will be situations that arise which that necessitate a more tailored response to fit around the person concerned. This might include, for example:

- when a person is planning to move from one area to another, and the authorities involved require co-operation to support that move;
- when an assessment of care and support needs identified other needs that should be assessed (for instance, health needs that may indicate eligibility for NHS Continuing Healthcare);
- when a local authority is carrying out a safeguarding enquiry or review, and requires the support of another organisation.

15.28. Where the local authority or relevant partner decide to use this mechanism, they should notify the other in writing, making clear the relevant Care Act provisions. If the local authority or the relevant partner decide not to co-operate with a request, then they **must** write to the other, setting out reasons for not doing so. Local authorities and their relevant partners **must** respond to requests to cooperate under their general public law duties to act reasonably, and failure to respond within a reasonable time frame could be subject to judicial review.

Working with the NHS

The boundary between care and support and the NHS

15.29. Local authorities **must** carry out an assessment where someone appears to have needs for care and support. It has a duty to meet those needs for care and support that meet the eligibility criteria. Similarly, in the case of carers, the local authority must carry out an assessment if a carer appears to have, or is likely to have, needs for support and it has a duty to meet those needs for support that meet the eligibility criteria. However, local authorities cannot lawfully meet needs in either case by providing or arranging services that are clearly the responsibility of the NHS.

15.30. In order to support joint working, it is important that all partners involved are clear about their own responsibilities, and how they fit together. Section 22 of the Care Act sets out the limits on what a local authority may provide by way of healthcare and so, in effect, sets the boundary between the responsibilities of local authorities for the provision of care and support, and those of the NHS for the provision of health care.

15.31. Where the NHS has a clear legal responsibility to provide a particular service, then the local authority may not do so. This general rule is intended to provide clarity and avoid overlaps, and to maintain the existing legal boundary. However, there is an exception to this general rule, in that the local authority may provide some limited healthcare services as part of a package of care and support, but only where the services provided are "incidental or ancillary" (that is, relatively minor, and part of a broader package), and where the services are the type of support that an authority could be expected to provide.

15.32. The two most obvious relevant examples of healthcare that are clearly the responsibility of the NHS (and thus not something a local authority may provide) are nursing care provided by registered nurses, and services that the NHS has to provide because the individual is eligible for NHS Continuing Healthcare.

15.33. NHS Continuing Healthcare is a package of ongoing care that is arranged

and funded solely by the health service for individuals outside a hospital setting who have complex ongoing healthcare needs, and who have been found to have a 'primary health need'. Such care is provided to people aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. NHS Continuing Healthcare is not dependent on a person's condition or diagnosis, but is based on their specific care needs.

15.34. Where the person has a 'primary health need' as set out in regulations[121] and as determined following an assessment of need under national guidance (the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*[122] ('the National Framework'), it is the responsibility of the health service to meet all assessed health and associated care and support needs, including suitable accommodation, if that is part of the overall need.

15.35. The National Framework sets out a process for the NHS, working together with its local authority partners wherever practicable, to assess health needs, decide on eligibility for NHS Continuing Healthcare, and provide that assessed care. 'NHS-funded Nursing Care', is the funding provided by the NHS to care homes providing nursing, to support the provision of nursing care by a registered nurse. If an individual does not qualify for NHS Continuing Healthcare, the need for care from a registered nurse must be determined. If the person has such a need and it is determined that their overall needs would be most appropriately met in a care home providing nursing care, then this would lead to eligibility for NHS-funded Nursing Care. Once the need for such care is agreed, a CCGs (or in some case NHS England) must pay a flat-rate contribution to the care home towards registered nursing care costs.

15.36. The regulations and guidance referred to above, set out how the 'primary health need' test takes account of the limits of local authority responsibility. Although the regulations and guidance pre-date the coming into force of the Care Act 2014, the limits of local authority responsibility have not been changed by the Care Act 2014.

Supporting discharge of hospital patients with care and support needs

15.37. The provisions on the discharge of hospital patients with care and support needs are contained in Schedule 3 to the Care Act 2014 and the Care and Support (Discharge of Hospital Patients) Regulations 2014 ("the Regulations"). These provisions aim to ensure that the NHS and local authorities work together effectively and efficiently to plan the safe and timely discharge of NHS hospital patients from NHS acute medical care facilities to local authority care and support. The purpose of these provisions is to update existing provisions to reflect the current NHS and care and support landscape; in particular, the drive to improve integration between health and social care provision for those people whose needs span both areas.

---

121 See regulations under the National Health Service Act 2006 and the Health and Social Care Act 2012 (see Part 6 of *The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012,* as amended by *The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013)* ('the Standing Rules'),

122 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

15.38. Schedule 3 to the Care Act covers:

- the scope of the hospital discharge regime and the definition of the patients to whom it applies;
- the notifications which an NHS body must give a local authority where the NHS considers that it is not likely to be safe to discharge the patient unless arrangements for meeting the patient's needs for care and support are in place;
- the period for which an NHS body can consider seeking reimbursement from a local authority, where that local authority has not fulfilled its requirements to assess or put in place care and support to meet needs, or (where applicable) to meet carer's needs for support, within the time periods set such that the patient's discharge from hospital is delayed.

15.39. The Regulations and guidance both set out further details of the form and content of what the various types of NHS notification notices must and should contain to ensure the local authority has relevant information to comply with its requirements to undertake assessments, and to put in place any arrangements necessary for meeting any of the patient's care and support needs, or where applicable, carer's needs for support. They set out the circumstances when assessment notices and discharge notices must be withdrawn, and determine the period and amount of any reimbursement liability which a local authority may be required to pay the NHS for any delay in the transfer of care.

Definitions of delayed transfers of care

15.40. Delayed Transfers of Care (DTOC) mean that individuals are in a setting that is recognised as not being appropriate for the care they need. This potentially contributes to worse outcomes for the individual, particularly in the context of their quality of life, as well as placing additional and sometimes costly burdens on the NHS and local government.

15.41. The definition of a DTOC is when a patient is ready for transfer after being in receipt of acute care, when:

- A clinical decision has been made that a patient is ready for transfer; **AND**
- A multi-disciplinary team decision (involving the NHS body and the local authority) has been made that a patient is ready for transfer; **AND**
- The patient is safe to discharge/transfer; **YET**
- The patient is still occupying a bed.

15.42. NHS and local authorities **should** work together in order to reduce the number of delayed days where a patient is ready to be transferred from NHS acute medical care to other settings but where arrangements for care and support needs are not in place in order to ensure a safe discharge from hospital. The NHS **may** seek reimbursement from local authorities for a delayed transfer of care in certain circumstances. The potential for reimbursement liability is intended to act as an incentive to improve joint working between the NHS and local government. However, the use of these reimbursements is discretionary.

15.43. The potential for NHS seeking reimbursement from local authorities is not to be seen to operate in isolation, but to be considered as part of the bigger picture in terms of promoting joint working between the NHS and local government. For example, the Better Care Fund, which aims through the establishment of £3.8 billion of joint funding between the NHS and local authorities to

promote joint working, includes performance on delayed discharge as one of the national indicators against which progress will be assessed and resources released. This, with the significant resources available will therefore be a powerful driver to improving performance on delayed discharge.

15.44. Also, even if a particular case falls outside the scope of the provisions so that no reimbursement could be sought, this **should not** prevent the NHS and local authority still working together to plan the safe and timely discharge of all its patients. Both the NHS and local authorities are under a common law duty of care to people with care and support needs, and the good practice guidance on safe discharge planning and duties to co-operate and promote integration will apply.

15.45. As around 70% of delayed discharge days are attributable to the NHS and because the issues behind them are within their gift to address, it is important that NHS organisations in particular review this guidance alongside other guidance such as the updated April 2013 SitRep Guidance,[123] which provides clear advice on the steps the NHS needs to take in relation to undertaking NHS Continuing Health Care and the way that data should be collected and reported, irrespective of whether delays are reimbursable days or not.

To whom do the delayed transfers of care provisions apply

15.46. The delayed transfers of care regime only applies to NHS hospital patients in England who are receiving acute care, and who the NHS considers are likely to have care and support needs after discharge from hospital.

15.47. No notification notices can be issued, and accordingly no reimbursement liability could arise, in respect of any patient who falls outside scope of the regime. However, notwithstanding that a patient's case falls outside the reimbursement regime, this does not mean that the NHS and local authorities should not be working together to deliver the safe and timely discharges of all hospital patients with care and support needs for the reasons set out at paragraph 15.42 above.

15.48. NHS Hospital Patient in England: A hospital patient is a person who is ordinarily resident in England who is accommodated in an NHS hospital in England, or in an independent hospital in the United Kingdom under arrangements made by an English NHS body.

15.49. Adult Care and Support Needs: In terms of age, the discharge of hospital patient provisions do not apply in respect of patients who will be under the age of 18 at the proposed date of discharge, as they will have their relevant care and support needs met by children's social services provided under other provisions (e.g. the Children's Act 1989).

15.50. Acute Care: The provisions only apply to patients who are receiving, have received or can reasonably be expected to receive, acute care. Acute care means intensive medical treatment provided by or under the supervision of a consultant that lasts for a limited period after which the person receiving the treatment no longer benefits from it.

[123] *Monthly Delayed Transfers of Care Sitreps Definitions and Guidance Version 1.07,* www.england.nhs.uk/.../Monthly-**Sitreps**-Definitions-DTOC-**v1.07**.doc,

NHS hospital patients to whom the provisions do not apply

15.51. The following cases are excluded from the discharge provisions in the Care Act:

(a) **Mental health care –** Mental health care means psychiatric services, or other services provided for the purpose of preventing, diagnosing or treating illness, the arrangements for which are the primary responsibility of a consultant psychiatrist. However, if the patient is receiving treatment in an acute setting for a physical condition and is under the care of an acute medical consultant but has post-care needs that relate, for example, to their dementia, the case could fall within the scope of the discharge of hospital patient provisions. If a person is admitted with a physical condition but during their stay is subsequently transferred to the care of a consultant psychiatrist, then delays to that person's discharge would not count towards any potential reimbursement. However delayed discharges for patients under the care of a consultant psychiatrist should be recorded as is expected under the DTOC Sitrep reporting requirements and the duties to co-operate in improving discharge arrangements clearly apply.

(b) **Palliative care –** Patients with palliative care needs are excluded.

(c) **Private patients –** As the regime only applies to NHS patients, the Discharge of Hospital provisions do not apply to patients who have given an undertaking to pay for their care in an NHS hospital or who are accommodated at an independent hospital under private arrangements. However, patients who are admitted to NHS hospitals as private patients but who subsequently elect to change their status and become NHS patients while still receiving acute medical treatment fall within the scope of the Act from the point at which they start to be treated as NHS patients.

(d) **Other –** In addition, maternity care, intermediate care (this is where patients, their families and carers are provided with support to help them manage illness and avoid becoming dependent on long-term care), and care provided for recuperation or rehabilitation are excluded from the definition of acute care.

Patients in independent hospitals receiving NHS-commissioned acute care

15.52. NHS patients can receive acute treatment which is arranged and funded by an NHS body, but which takes place in an independent sector hospital. As they are NHS patients, they are covered by the Discharge of Hospital Patient provisions and as such the requirements to plan and provide services in order to facilitate a safe discharge **must** be implemented.

15.53. As such, the duty to issue notices will apply in respect of these cases, as may the potential for the NHS to seek reimbursement from the local authority for any delayed transfers of care. The Act allows an NHS body which has commissioned acute treatment at an independent hospital within the UK to make arrangements for the independent provider to issue assessment or discharge notifications on its behalf. This means that independent providers can take decisions such as whether the patient is likely to need care and support services, when the patient is to be discharged, what follow-up health needs they may have, etc. However, the NHS body will retain ultimate responsibility for the functions, including

any claim for reimbursement that might be appropriate.

Working with housing authorities and providers

15.54. Housing or suitable living accommodation is a place which is safe, healthy and suitable for the needs of a person, so as to contribute to promoting physical and emotional health and wellbeing and social connections. For example, a healthy home would be dry, warm and insulated and a safe home would meet particular needs, e.g. of an older person. Housing refers to the home and the neighbourhood where people live, and to the wider housing sector including staff and services around these homes.

15.55. Suitable living accommodation includes all places where people live; for example a house, flat, other general dwelling or an adult placement or other specialist housing.

15.56. Housing and the provision of suitable accommodation is an integral element of care and support. The setting in which a person lives, and its suitability to their specific needs, has a major impact on the extent to which their needs can be met, or prevented, over time. Housing is therefore a crucial component of care and support, as well as a key health-related service.

15.57. Local authorities have broad powers to provide different types of accommodation in order to meet people's needs for care and support. The Care Act is clear that suitable accommodation can be one way of meeting needs. However, the Act is also clear on the limits of responsibilities and relationship between care and support and housing legislation, to ensure that there is no overlap or confusion. Section 23 of the Care Act clarifies the existing boundary in law between care and support and general housing. Where housing legislation requires housing services to be provided, then a local authority must provide those services under that housing legislation. Where housing forms part of a person's need for care and support and is not required to be provided under housing legislation, then a local authority may provide those types of support as part of the care and support package under this Act.

15.58. This provision is to clarify the boundary in law between a local authority's care and support function and its housing function. It does not prevent joint working, and it does not prevent local authorities in the care and support role from providing more specific services such as housing adaptations, or from working jointly with housing authorities.

15.59. Housing plays a critical role in enabling people to live independently and in helping carers to support others more effectively. Poor or inappropriate housing can put the health and wellbeing of people at risk, where as a suitable home can reduce the needs for care and support and contribute to preventing or delaying the development of such needs. Housing services should be used to help promote an individual's wellbeing, by providing a safe and secure place in which people in need of care and support and carers can build a full and active life. That is why suitability of living accommodation is one of the matters local authorities must take into account as part of their duty to promote an individual's wellbeing.

15.60. Housing is an integral part of the health and care system and a local authority's responsibility for care and support. This could be in relation to a local authority's duty on prevention (see chapter 2) or through the duty to assess an adult or carer's needs for care

and support (see chapter 6), or in providing advice and information (see chapter 3).

15.61. Enabling individuals to recognise their own skills, ambitions and priorities and developing personal and community connections in relation to housing needs can help promote an individual's wellbeing. By way of example, providing good quality information and advice can help people make early choices about housing options and avoid leaving these until they are in crisis or decisions have to be taken by relatives or carers. Adaptations, modifications or extra support can help people stay independent for longer.

15.62. Health, care and support and housing services **should** centre on the individual and where appropriate their family and should support them in meeting the outcomes they want to achieve. By putting individuals and families at the centre and helping them to articulate the outcomes they want to achieve a local authority may be able to provide some support in or through the home.

Considering accommodation within the wellbeing principle

15.63. Local authorities have a general duty to promote an individual's wellbeing when carrying out their care and support functions. The Act is clear that one specific component of wellbeing is the suitability of living accommodation. Wherever relevant, a local authority **should** consider suitable living accommodation in looking at a person's needs and desired outcomes.

15.64. Housing has a vital role to play in other areas relating to a person's wellbeing. For example access to a safe settled home underpins personal dignity. A safe suitable home can contribute to physical and mental wellbeing and can provide protection. A home or suitable living accommodation can enable participation in work or education, social interactions and family relationships.

15.65. In relation to housing, a local authority can make an important contribution to an individual's wellbeing, for example by providing and signposting information that allows people to address care and support needs through specific housing related support services, or through joint planning and commissioning that enables local authorities to provide (or arrange for the provision of) housing and care services or housing adaptations to meet the needs of the local population.

Housing to support prevention of needs

15.66. In many cases, the best way to promote someone's wellbeing will be through preventative measures that allow people to live as independently as possible for as long as possible.

15.67. A local authority **must** provide or arrange for the provision of services that contribute towards preventing, reducing or delaying the needs for care and support (see chapter 2). The provision of suitable living accommodation can be a way to prevent needs for care and support, or to delay deterioration over time. Getting housing right and helping people to choose the right housing options for them can help to prevent falls, prevent hospital admissions and readmissions, reduce the need for care and support, improve wellbeing, and help maintain independence at home.

15.68. Housing and housing services can play a significant part in prevention, for example, from a design/physical perspective, accessibility, having adequate heating and

lighting, identifying and removing hazards or by identifying a person who needs to be on the housing register. In addition, community equipment, along with telecare, aids and adaptations can support reablement, promote independence contributing to preventing the needs for care and support.

15.69. A local authority may wish to draw on the assistance of the housing authority and local housing services. Housing-related support staff and scheme managers can contribute to prevention, for example by being alert to early signs of ill health, e.g. dementia, and signposting or supporting individuals to access community resources which may prevent, reduce or delay the need for care and support or a move into residential care.

15.70. The links between living in cold and damp homes and poor health and wellbeing are well-evidenced.[124] Local authorities may wish to consider the opportunities to prevent the escalation of health and care and support needs through the delivery or facilitation of affordable warmth measures to help achieve health and wellbeing outcomes.[125,126]

Integrating information and advice on housing

15.71. A local authority **must** establish and maintain a service for providing information and advice relating to care and support, and this **must** include advice on relevant housing and housing services which meet care and support needs. The authority is not required to provide all elements of this service, rather, they are expected under this duty to understand, co-ordinate and make effective use of other statutory, voluntary and or private sector information and advice resources within their area in order to deliver more integrated information and advice.

15.72. A person-centred approach to information and advice will consider the person's strengths and capabilities and the information or advice that will help them to achieve their ambitions. Information and advice **should** include services in the home that bring health, care and housing services together. This means that information and advice on housing, on adaptations to the current home, or alternative housing options services should be included. This will enable a person to choose how best they can meet or prevent their needs for care and support. (See chapter 3 on information and advice).

15.73. A person using care and support or carer **should** be supported to make fully informed decisions about how to prevent or meet their needs for care and support. A local authority **should** make use of information and advice that is already available at local and national levels. Examples of some national resources are;

www.firststopcareadvice.org.uk

www.moneyadviceservice.org.uk

www.nhs.uk/CarersDirect/Pages/CarersDirectHome.aspx

www.foundations.uk.com

15.74. People's care and support needs, their housing circumstances and financial resources are closely interconnected. It is only with full knowledge of the care and

124 (http://www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty, www.gov.uk/government/collections/housing-health-and-safety-rating-system-hhsrs-guidance).

125 The Energy Companies Obligation: https://www.gov.uk/government/policies/helping-households-to-cut-their-energy-bills/supporting-pages/energy-companies-obligation-eco

126 Energy Saving Advice Service: http://www.energysavingtrust.org.uk/Organisations/Government-and-local-programmes/Programmes-we-deliver/Energy-Saving-Advice-Service

Case Study: Putting health back into housing

The Gloucestershire Affordable Housing Landlords' Forum (GAHLF), comprising of the seven leading local housing providers in the county, have set out an 'offer' to the Health and Wellbeing Board that demonstrates how each is working to improve the quality of life of their residents, the neighbourhoods and wider communities, by investing in new homes, supporting independent living, developing the community and supporting older and vulnerable people.

£12 million is being invested, by Stroud District Council, over five years, to improve the quality of housing stock and reduce fuel poverty for tenants. Stroud has been upgrading the heating supply in properties not currently served by mains gas. Many properties have electric storage heating which does not give the same level of control and is more expensive than gas or renewable energy. Dryleaze Court is a Supported Housing unit where 53 properties have had mains gas installed this year. At the same time, the team has also installed uPVC privacy panels, replaced porches with insulated cavity brick walls and fitted new double-glazed windows. The works have improved tenants' quality of life, helping them to live more comfortably and reduce their fuel bills.

All in all, over the three years ending March 2013, GAHLF has improved over 14,900 homes, with an estimated savings to the NHS of around £1.4 million per annum.

http://www.housinglin.org.uk/_library/Resources/Housing/Regions/South_West/GAHLF_Health_and_Wellbeing_V.II1.pdf

support options open to them, including possible housing options and the related financial implications that people will be able to exercise informed choice. For example, some people with their families have made early decisions about moving into residential care possibly sooner than is necessary. Information and advice about the full range of accommodation/housing options and how these might be funded can contribute to more informed decision making for individuals and can extend independent living.

Link to further Case Study - Commissioning Advice Services in Portsmouth

http://www.adviceuk.org.uk/wp-content/uploads/2013/06/Breaking-the-Mould-Portsmouth.pdf

Working with employment and welfare services

15.75. Local authorities and local offices of the Department for Work and Pensions (i.e. the JobCentre Plus) **must** co-operate when exercising functions which are relevant to care and support. "Co-operation" and integration can be achieved in a number of ways and will depend on local circumstances as outlined above. When considering opportunities for fuller integration of commissioning, planning and delivery of local services local authorities **should** consider the links between care and support, employment and welfare (see chapter 4 on market shaping and commissioning).

15.76. In particular, when working to promote a diverse market under section 5, local authorities **must** consider the importance of enabling people to undertake work, education and training. Local authorities **should** also recognise the importance of identifying the needs of those

carers in their local population when drawing up Joint Strategic Needs Assessments, including their need to participate in paid employment alongside caring responsibilities.

15.77. The Disability and Health Employment Strategy[127] identified that many disabled people and people with health conditions, particularly those with more **complex needs**, receive a range of different services at local level, for example, care and support, primary and secondary health services, as well as support offered by Jobcentre Plus and contracted providers. It highlighted feedback from stakeholders that the support on offer at a local level to disabled people and people with health conditions can be confusing and inconsistent and often results in them having to give the same information to different services.

15.78. Local authorities **must** establish and maintain an information and advice service, but they are not required to provide all elements of this service. Rather, local authorities are expected to understand, co-ordinate and make effective use of other statutory, voluntary and/or private sector information and advice resources available to people within their areas. The information and advice available to the local population should include information and advice on eligibility and applying for disability benefits and other types of benefits and, on the availability of employment support for disabled adults.

15.79. Different people will need different levels of support from the local authority and other providers of financial information and advice depending on their capability, their care needs and their financial circumstances. People may just need some basic information and support to help them rebalance their finances in light of their changing circumstances. Topics may include welfare benefits, advice on good money management, help with basic budgeting and possibly on debt management. The local authority may be able to provide some of this information itself, for example of welfare benefits, but where it cannot, it should work with partner organisations to help people access it.

15.80. Local authorities, working with their partners, **must** also use the wider opportunities to provide targeted information and advice at key points in people's contact with the care and support, health and other local services. This **should** include application for disability benefits such as Attendance Allowance and Personal Independence Payments, and for Carers Allowance and access to work interviews.

Considering individual employment, training and education needs

15.81. In addition to considering how to join up care and support at a local level local authorities **must** consider education, training and employment when working with individuals. In particular:

- local authorities **must** promote wellbeing when carrying out care and support functions, or making a decision in relation to a person. This applies equally to people with care and support needs and their carers. In some specific circumstances, it also applies to children, their carers and to young carers (when they are subject to the transition assessments discussed in chapter 16). The definition of wellbeing includes participation in work education and training. As such local authorities **must** consider whether participation in work, education or training is a relevant

[127] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266373/disability-and-health-employment-strategy.pdf

consideration when they are promoting wellbeing.

- local authorities, when carrying out a needs assessment, carer's assessment or child's carer's assessment **must** have regard to whether the carer works or wishes to do so, and whether the carer is participating in or wishes to participate in education, training or recreation and this should be reflected, as appropriate in the way their needs are met. Local authorities and the Department for Work and Pensions should cooperate to ensure people are given appropriate employment support and opportunities – in particular where this is a person's preferred outcome. This should include consideration of how direct payments may be used for employment support.[128]
- sections 37 and 38 of the Act support people to move, including to pursue employment opportunities or move closer to family members. Local authorities **must** ensure continuity of care and support when people move between areas so that they can move without the fear that they will be left without the care and support they need (see chapter 20).

Sources of information

15.82. The integration clauses mirrors similar duties placed on Clinical Commissioning Groups and NHS England. There are a number of relevant documents that local authorities may find of interest:

- The Functions of Clinical Commissioning Groups, NHS England March 2013 http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf
- Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, Department of Health, April 2012. See part 4: Promoting integration between services. http://www.wakefield.gov.uk/NR/rdonlyres/37D0E9D1-C438-4388-B270-A527139D9F37/0/StatutoryGuidanceonJSNAsandJHWSs_DH2013.pdf
- National Voices, a national coalition of health and social care charities, have produced a narrative for person-centred co-ordinated care and support, showing what this would look like from the perspective of people with care and support needs: http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf

The following links provide further sources of information in relation to housing service and practical examples which support integration with care and support on a local level:

- http://www.housinglin.org.uk/Topics/browse/Housing/hwb/?parent=3691&child=8169
- http://www.cih.org/publication-free/display/vpathDCR/templatedata/cih/publication-free/data/Developing_your_local_housing_offer_for_health_and_care
- https://www.gov.uk/government/collections/housing-health-and-safety-rating-system-hhsrs-guidance
- http://www.housinglin.org.uk/hospital2home_pack/

[128] An example of personal budgets being used as a way to support and enterprise and employment can be found at: http://www.serendipity-chic.co.uk/

16. Transition to adult care and support

This chapter provides guidance on:

- *Sections 58 to 66 of the Care Act;*
- *The Care and Support (Children's Carers) Regulations 2014.*

This chapter covers:

- When a transition assessment must be carried out;
- Identifying young people who are not already receiving children's services;
- Child's carers and young carers;
- Features of a transition assessment;
- Cooperation between professionals and organisation;
- Providing information and advice once a transition assessment is completed;
- Provision of age appropriate local services and resources;
- After the young person in question turns 18;
- Combining EHC plans with care and support plans after the age of 18;
- Continuity of care after the age of 18;
- Safeguarding after the age of 18;
- Ordinary residence and transition to higher education;
- Transition from children's to adult NHS Continuing Health Care.

16.1. Effective person-centred transition planning is essential to help young people and their families prepare for adulthood. Transition to adult care and support comes at a time when a lot of change can take place in a young person's life. It can also mean changes to the care and support they receive from education, health and care services, or involvement with new agencies such as those who provide support for housing, employment or further education and training.

16.2. The years in which a young person is approaching adulthood should be full of opportunity. Some of the life outcomes that matter for young people approaching adulthood and their families, may include (but are not limited to):

- Paid employment;
- Good health;
- Completing exams or moving to further education;

- Independent living (choice and control over one's life and good housing options);
- Social inclusion (friends, relationships and community).

16.3. The wellbeing of each young person or carer **must** be taken into account so that assessment and planning is based around the individual needs, wishes, and outcomes which matter to that person (see chapter 1 on the wellbeing principle). Historically, there has sometimes been a lack of effective planning for people using children's services who are approaching adulthood. Looked-after children, young people with disabilities, and carers are often among the groups of people with the lowest life chances. Early conversations provide an opportunity for young people and their families to reflect on their strengths, needs and desired outcomes, and to plan ahead for how they will achieve their goals.

16.4. Professionals from different agencies, families, friends and the wider community **should** work together in a coordinated manner around each young person or carer to help raise their aspirations and achieve the outcomes that matter to them. The purpose of carrying out transition assessments is to provide young people and their families with information so that they know what to expect in the future and can prepare for adulthood.

16.5. Transition assessments can in themselves be of benefit in providing solutions that do not necessarily involve the provision of services, and which may aid planning that helps to prevent, reduce or delay the development of needs for care or support. Transition assessments will also allow local authorities to better understand the needs of people in their population, and to plan resources and commission services for young people and carers accordingly.

Definitions

16.6. The Care Act contains provisions to help preparation for adulthood for three particular groups of people – children, young carers and child's carers. In the context of this chapter, a 'child' is most probably a young person in their teenage years preparing for their adult life, although it can refer to anyone under the age of 18 years. This chapter therefore uses the term 'young person'. The term 'carer' can be taken to mean either a carer of a young person, or a young carer preparing for adulthood. Each group has their own specific transition assessment respectively; a child's needs assessment, a young carer's assessment, and a child's carer's assessment. The term used in this chapter for all three is 'transition assessment'.

16.7. The provisions in the Care Act relating to transition to adult care and support are not only for those who are already receiving children's services, but for anyone who is likely to have needs for adult care and support after turning 18.

When a transition assessment must be carried out

16.8. Transition assessments **should** take place at the right time for the young person and at a point when the local authority can be reasonably confident about what the young person's or carer's needs for care or support will look like after the young person in question turns 18. There is no set age when young people reach this point; every young person and their family are different, and as such, transition assessments **should** take place when it is most appropriate for them.

16.9. Local authorities must carry out a transition assessment of anyone in the three groups when there is *significant benefit to the*

young person or carer in doing so, and if they are *likely to have needs* for care or support after turning 18.

16.10. When considering whether the young person or carer is 'likely to have needs' this is intended to reflect any likely appearance of any need for care and support as an adult – not just those needs that will be deemed eligible under the adult statute. It is highly likely that young people and carers who are in receipt of children's services would be 'likely to have needs' in this context, and local authorities **should** therefore carry out a transition assessment for those who are receiving children's services as they approach adulthood, so that they have information about what to expect when they become an adult.

16.11. When considering if it is of 'significant benefit' to assess, the local authority **should** consider the circumstances of the young person or carer, and whether it is an appropriate time for the young person or carer to undertake an assessment which helps them to prepare for adulthood. The consideration of 'significant benefit' is not related to the level of a young person or carer's needs, but rather to the *timing* of the transition assessment. When considering whether it is of significant benefit to assess, a local authority **should** consider factors which may contribute to establishing the right time to assess (including but not limited to the following):

- The stage they have reached at school and any upcoming exams;
- Whether the young person or carer wishes to enter further/higher education or training;
- Whether the young person or carer wishes to get a job when they become a young adult;
- Whether the young person is planning to move out of their parental home into their own accommodation;
- Whether the young person will have care leaver status when they become 18;
- Whether the carer of a young person wishes to remain in employment when the young person leaves full time education;
- The time it may take to carry out an assessment;
- The time it may take to plan and put in place the adult care and support;
- Any relevant family circumstances;
- Any planned medical treatment.

16.12. For young people with special educational needs (SEN) who have an Education, Health and Care (EHC) plan under the Children and Families Act, preparation for adulthood **must** begin from year 9.[129] The transition assessment **should** be undertaken as part of one of the annual statutory reviews of the EHC plan, and **should** inform a plan for the transition from children's to adult care and support.

16.13. Equally for those without EHC plans, early conversations with local authorities about preparation for adulthood are beneficial – when these conversations begin to take place will depend on individual circumstances. For care leavers, local authorities **should** consider using the statutory Pathway Planning process as the opportunity to carry out a transition assessment where appropriate.

16.14. It is important that the assessment **must** be of *significant benefit to the young person or carer.* For example, local authorities **should not** carry out the

[129] See SEN Code of Practice "Preparing for Adulthood" Chapter when published

transition assessment at inappropriate times in a young person's life, such as when they are sitting their exams and it would cause disruption. The Special Educational Needs (SEN) Code of Practice similarly states that local authorities **must** minimise disruption to the child and their family – for example by combining multiple appointments where possible. Local authorities **should** seek to agree the best time for assessments and planning with the young person or carer, and where appropriate, their family and any other relevant partners.

16.15. A young person or carer, or someone acting on their behalf, has the right to request a transition assessment. The local authority **must** consider such requests and whether the likely need and significant benefit conditions apply – and if so it **must** undertake a transition assessment. If the local authority thinks these conditions do not apply and refuses an assessment on that basis, it **must** provide its reasons for this in writing in a timely manner, and it **must** provide information and advice on what can be done to prevent or delay the development of needs for support.

16.16. Where it is judged by the local authority that the young person or carer is likely to have needs for care and support after turning 18, but that it is not yet of significant benefit to carry out a transition assessment, the local authority **should consider** indicating (when providing its written reasons for refusing the assessment) when it believes the assessment will be of significant benefit. In these circumstances, the onus is on the local authority to contact the young person or carer to agree the timing of the transition assessment, rather than leaving the young person or carer in uncertainty or having to make repeated requests for an assessment.

Case study – when a transition assessment is of "significant benefit" – Isabelle's story

Isabelle is 15 years old with complex needs. She attends a residential school on a 38-week basis funded by education and social services. Care and support is currently required on the weekends and in holidays.

Isabelle's parents have approached the local authority requesting a transition assessment around the time of her 16th birthday. Initially the local authority's reaction is that this is too soon to be of significant benefit. Since the support from school can continue until she is 19, they feel transition will be straightforward as adult services simply need to begin funding the package which is already in place.

However, when they talk in more detail to the school and the parents they realise that when Isabelle leaves school at 19 it will not be appropriate for her to live with her parents and she will require substantial supported living support and a college placement. Due to the nature of Isabelle's needs, she will need a lengthy transition in order to get used to new carers, a new environment and a new educational setting. The college has also indicated that that they will need up to a year to plan for her start.

It is therefore of significant benefit for the transition assessment to take place around the age of 16, looking at both the funding for support from age 18 – 19 and the longer-term options. Once the assessment has identified the support Isabelle will be entitled to on leaving school, the planning process can begin and suitable support can be put in place by the time she leaves school.

16.17. Where someone is refused (or they themselves refuse) a transition assessment, but at a later time makes a request for an assessment, the local authority **must** again consider whether the likely need and significant benefit conditions apply, and carry out an assessment if so. In more complex cases, it can take some time not only to carry out the assessment itself but to plan and put in place care and support. Social workers will often be the most appropriate lead professionals for complex cases. Transition assessments **should** be carried out early enough to ensure that the right care and support is in place when the young person moves to adult care and support.

16.18. When transition assessments take place too late and care and support is arranged in a hurry, it can result in care and support which does not best meet the young person or carer's needs - and sometimes at greater financial cost to the local authority than if it had been planned properly in advance.

Identifying young people who are not already receiving children's services

16.19. Most young people who receive transition assessments will be children in need under the Children Act 1989 and will already be known to local authorities. However, local authorities **should consider** how they can identify young people who are not receiving children's services who are likely to have care and support needs as an adult. For example, this might include young people with degenerative conditions or with mental health problems who have not required children's services but whose needs increase as they approach adulthood. Another example is when a child's needs have been largely met by their educational institution, but who once they leave, will require their needs to be met in some other way.

16.20. Often when young people who have not been in contact with children's services present to the local authority as a young adult, they do so with a high level of need for care and support. Local authorities **should** consider how to establish mechanisms in partnership local educational institutions, health services and other agencies to identify these groups as early as possible in order to plan and prevent the development of care and support needs. (see chapter 15 on cooperation and integration and SEN Code Of Practice chapter 4 on joint commissioning, making effective relationships.[130]

Child's carers and young carers

16.21. Preparation for adulthood will involve not only assessing how the needs of young people change as they approach adulthood but also how carers', young carers' and other family members' needs might change. Local authorities **must** assess the needs of a child's carer where there is a likely need for support after the child turns 18 and it is of significant benefit to the carer to do so. For instance, some carers of disabled children are able to remain in employment with minimal support while the child has been in school. However, once the young person leaves education, it may be the case that the carer's needs for support increase, and additional support and planning is required from the local authority to allow the carer to stay in employment.

16.22. The SEN code of practice sets out the importance of full-time programmes for young people aged 16 and over. For instance, some sixth forms or colleges offer five-day placements which allow parents to remain in employment full time. However, for young

[130] Link when SEN code of practice is published and check chapter reference

people who do not have this opportunity, for example if their college offers only three-day placements, transition assessments **should** consider if there is other provision and support for the young person such as volunteering, community participation or training which not only allows the carer to remain in full time employment, but also fulfils the young person's wishes or equips them to live more independently as an adult. (see SEN Code of Practice chapter 8[131] on preparation for adulthood, and chapter 4 of this guidance on market shaping).

16.23. Local authorities **must** also assess the needs of young carers as they approach adulthood. For instance, many young carers feel that they cannot go to university or enter employment because of their caring responsibilities. Transition assessments and planning **must** consider how to support young carers to prepare for adulthood and how to raise and fulfil their aspirations.

16.24. Local authorities **must** consider the impact on other members of the family (or other people the authority may feel appropriate) of the person receiving care and support. This will require the authority to identify anyone who may be part of the person's wider network of care and support. For example, caring responsibilities could have an impact on siblings' school work, or their aspirations to go to university. Young carers' assessments **should** include an indication of how any care and support plan for the person(s) they care for would change as a result of the young carer's change in circumstances. For example, if a young carer has an opportunity to go to University away from home, the local authority should indicate how it would meet the eligible needs of any family members that were previously being met by the young carer.

Features of a transition assessment

16.25. The transition assessment **should** support the young person and their family to plan for the future, by providing them with information about what they can expect. All transition assessments **must** include an assessment of:

- current needs for care and support and how these impact on wellbeing;
- whether the child or carer is likely to have needs for care and support after the child in question becomes 18;
- if so, what those needs are likely to be, and which are likely to be eligible needs
- the outcomes the young person or carer wishes to achieve in day-to-day life and how care and support (and other matters) can contribute to achieving them.

16.26. Transition assessments for young carers or child's carers **must** also specifically consider whether the carer:

- is able to care now and after the child in question turns 18;
- is willing to care now and will continue to after 18;
- works or wishes to do so;
- is or wishes to participate in education, training or recreation.

16.27. The same requirements and principles apply for carrying out transition assessments as for other needs assessments under the adult statute (chapter 6 sets out the requirements and principles for carrying out needs assessments under the adult statute).

16.28. For example, assessments **must** include an assessment of the outcomes, views and wishes that matter to the child or

[131] Insert chapter number when COP published

carer in question, and an assessment of their strengths and capabilities.

16.29. The young person or carer in question **must** be involved in the assessment for it to be person centred and reflect their views and wishes. The assessment **must** also involve anyone else who the young person or carer wants to involve in the assessment. For example, many young people will want their parents involved in their process.

16.30. Transition assessments **should** be carried out in a reasonable timescale. Local authorities **should** inform the young person or carer of an indicative timescale over which the assessment will be conducted and keep them informed.

16.31. Transition assessments **should** be proportionate to a person's needs. For someone with a low level of need, this might be light-touch but it many cases it will also mean a more thorough examination of needs.

16.32. Transition assessments **should** consider the immediate short-term outcomes that a child or carer wants to achieve as well as the medium and longer-term aspirations for their life. Progress towards achieving outcomes **should** be monitored.

16.33. EHC plans must be person-centred, and must focus on preparation for adulthood from year 9. Therefore, for young people with EHC plans, transition assessments **should** build on the plans which will already contain information about the person, their aspirations and progress towards achieving their desired outcomes.

16.34. Similarly, for young people and carers who do not have an EHC plan, but who already have other plans under children's legislation, the transition assessment **should** build on existing information.

16.35. In all cases, the young person or carer in question **must** agree to the assessment where they have mental capacity and are competent to agree. Where a young person or carer lacks mental capacity or is not competent to agree, the local authority **must** be satisfied that an assessment is in their best interests. Everyone has the right to refuse a transition assessment, however the local authority **must** undertake an assessment regardless if it suspects that a child is experiencing or at risk of abuse or neglect.

16.36. The right of young people to make decisions is subject to their capacity to do so as set out in the Mental Capacity Act 2005. The underlying principle of the Act is to ensure that those who lack capacity are supported to make as many decisions for themselves as possible, and that any decision made or action taken on their behalf, is done so in their best interests. This is a necessity if the transition assessment is to be person-centred.

16.37. Even for young people or carers who don't necessarily lack mental capacity as defined under the Mental Capacity Act, the Care Act places a duty on local authorities to provide an independent advocate to facilitate the involvement in the transition assessment where the person in question would experience substantial difficulty in understanding the necessary information or in communicating their views, wishes and feelings – and if there is nobody else appropriate to act on their behalf (see chapter 7 for more detail on the provision independent advocacy).

Co-operation between professionals and organisations

16.38. People with complex needs for care and support may have several professionals involved in their lives, and numerous assessments from multiple organisations. For

children with special educational needs, the Children and Families Act 2014 brings these assessments together into a coordinated Education, Health and Care (EHC) Plan (see SEN Code of Practice Chapter 9).[132]

16.39. Local authorities **must** cooperate with relevant partners, and this duty is reciprocal (see chapter 15 on cooperation). This includes an explicit requirement which states that children and adult services **must** cooperate for the purposes of transition to adult care and support. Often, staff working in children's services will have built relationships and knowledge about the young person or carer in question over a number of years. As young people and carers prepare for adulthood, children's services and adults' services **should** work together to pass on this knowledge and build new relationships in advance of transition.

16.40. Local authorities **should** have a clear understanding of their responsibilities, including funding arrangements, for young people who are moving from children's to adult services. Disputes between different departments within a local authority about who is responsible can be time consuming and can sometimes result in disruption to the young person or carer.

16.41. Local authorities **must** also cooperate with relevant external agencies including local GP practices, housing providers and educational institutions. Again, this duty is reciprocal. This cooperation is crucial to help ensure that assessments and planning are person-centred. Furthermore, local health services or schools are vital to identifying young people and carers who may not already be in contact with local authorities.

16.42. It can be frustrating for children and families who have to attend multiple appointments for assessments, and who have to give out the same information repeatedly. The SEN Code of Practice highlights the importance of the 'tell us once' approach to gathering information for assessments and this will be important in other contexts as well. Local authorities **should** consult with the young person and their family to discuss what arrangements they would prefer for assessments and reviews.

16.43. The local authority **should** ensure that all relevant partners are involved in transition planning where they are involved in the person's care and support. Equally, the local authority **should** be involved in transition planning led by another organisation, for example a child and adolescent mental health service, where there are also likely to be needs for adult care and support.

16.44. Agencies **should** agree how to organise processes so that all the relevant professionals are able to contribute. For example, this might involve arranging a multi-disciplinary team meeting with the young person or carer. However, it may not always be possible for all the professionals from different agencies to be present at appointments, but where this is the case, they should still be able to contribute. Transition assessments **must** be person-centred, which means that contributions by different agencies should reflect the views of the person to whom the assessment relates.

16.45. The local authority **may** also combine a transition assessment with any other assessment it is carrying out, or it **may** carry out assessments jointly with, or on behalf of, another body. All such cases **must** meet the consent condition around mental capacity set out above (paragraph 16.37) to be carried out jointly. For example, transition assessments **should** be combined with

[132] Link to SEN code of practice when published

existing EHC assessments unless there are specific circumstances to prevent it.

16.46. Many people value having one designated person who coordinates assessments and transition planning across different agencies, and helps them to navigate through numerous systems and processes that can sometimes be complicated. Often there is a natural lead professional involved in a young person's care who fulfils this role and local authorities should consider formalising this by designating a named person to coordinate transition assessment and planning across different agencies. Local authorities may also wish to consider specialist posts in their workforce to carry out this coordination function for people who are preparing for adulthood and interacting with multiple agencies.

16.47. This coordinating role – sometimes referred to as a 'key working' or 'care coordination' can not only help to deliver person-centred, integrated care, but can also help to reduce bureaucracy and duplication for local authorities, the NHS and other agencies. Care coordinators are also often able to build close relationships with young people and families and can act as a valuable provider of information and advice both to the families and to local authorities. Care leavers will have Personal Advisers to provide support, for example by providing advice or signposting the young person to services. The Personal Adviser will be a natural lead in many cases to coordinate a transition from children's to adult care and support where relevant.

Case study: Matthew's story: person-centred transition planning, involving multiple agencies

To ensure that Matthew was fully involved in the transition process, four planning sessions were held with his Transition Officer and facilitated by an outside agency that had expertise in person-centred planning. Matthew's aspirations were to live independently in his own home and to have paid employment in an office.

It was vital to Matthew's preparation for adulthood that he was given information about what support he would be eligible for after 18 in order to plan for sustainable employment and to ensure the appropriate support would be available to enable Matthew to live independently. This involved considering:

- whether he would still have a Personal Budget;
- support with travel training;
- job coaching; and
- support to live independently, developing appropriate housing options locally.

Matthew and his family worked with the local authority and the housing association to identify a suitable home for him. The housing association then bought the house for Matthew and another young man to live in, with a carer. This whole process took over three years. Early, person-centred planning has been crucial to Matthew achieving his goals.

Here is a link to an update video on what Matthew is doing today: http://www.media19.co.uk/production/matthews-story/

On completion of the transition assessment – providing information and advice

16.48. Having carried out a transition assessment, the local authority **must** give an indication of which needs are likely to be eligible needs (and which are not likely to be eligible) once the young person in question turns 18, to ensure that the child or carer understands the care and support they are likely to receive and can plan accordingly.

16.49. There is a particularly important role for local authorities in ensuring that young people and carers understand their likely situation when they reach adulthood. The different systems for children's and adult care and support mean that there will be circumstances in which needs that were being met by children's services may not be eligible needs under the adult system. Adult care and support is also subject to means-testing and charging. However, from April 2016, people who turn 18 with eligible care and support needs, will have those needs met for free by their local authority for the rest of their lifetime.

16.50. It is critical that families are able to understand what support they are likely to receive when the young person or carer is in the adult system, and that the transition period is planned and managed as far in advance as is practical and useful to the individual to ensure that there is not a sudden gap in meeting the young person's or carer's needs. Where the transition assessment identifies needs that are likely to be eligible, local authorities **should consider** providing an indicative personal budget, so that young people and their families are able to plan their care and support before entering the adult system (see SEN code of practice for further information about right to a personal budget for people with EHC plans, and chapter 11 for personal budgets under the Care Act).

16.51. For any needs that are not eligible under the adult statute, local authorities **must** provide information and advice on how those needs can be met, and how they can be prevented from getting worse. Information and advice must be accessible and proportionate to whoever needs it and must consider individual circumstances. For example when providing information and advice to young people, it is often more effective if information is given face-to-face from a trusted source, such as the young person's care coordinator.

16.52. The Children and Families Act 2014 requires local authorities to publish a local offer, which includes provision of information and advice for children's social care in their local area, including specific requirements for young people who are preparing for adulthood (see chapter 4 SEN Code of Practice).[133] The Care Act places a similar duty on local authorities to provide information and advice about adult care and support (see chapter 3 for guidance on the provision of information and advice).

16.53. Given the similar requirements on both children and adult services to provide information and advice that is easily accessible, local authorities **should consider** jointly commissioning and delivering their information and advice services for both children's and adult care and support as part of their requirement to work together to smooth the transition between children and adult services.

16.54. The local authority and relevant partners **should** consider building on a transition assessment to create a person-centred transition plan that sets out the information in the assessment, along

[133] Link to SEN code of practice chapter on local offer when published

with a plan for the transition to adult care and support, including key milestones for achieving the young person or carer's desired outcomes. An advantage of a transition plan is that it is easier to update and refine without undertaking a new assessment – transition assessments and plans should be reviewed regularly to take account of changes both in circumstances and desired outcomes. The priorities of young people will often change a lot during their adolescent years, and plans should be updated frequently enough to reflect this. Local authorities **should** also accept reasonable requests from young people and their families to review transition plans (see chapter 13 for further on reviews of care plans).

Links to example templates of transition plans:

http://www.preparingforadulthood.org.uk/media/208807/william_s_draft_transition_plan.pdf

http://www.hertsdirect.org/docs/pdf/p/PfAtransplan

16.55. In the case of a child's carer, if the local authority has identified needs through a transition assessment which could be met by adult services, it **may** meet these needs under the Care Act in advance of the child being cared for turning 18. In deciding whether to do this the local authority must have regard to what support the child's carer is receiving under children's legislation.[134] If the local authority decides to meet the child's carer's needs through adult services, as for anyone else under the adult legislation, the child's carer must receive a support plan and a personal budget – as well as a financial assessment if they are subject to charges for the support they will receive.

[134] Specifically, to section 17 of the Children Act 1989

Provision of age-appropriate local services and resources

16.56. The Care Act requires local authorities to arrange preventative services, and to ensure a diverse range of quality providers of care and support in their local area. There are similar requirements in relation to the Local Offer in the Children and Families Act (see chapter 4 on market shaping).

16.57. Promoting a local market that offers a choice of high quality services will include having regard to the needs of young people transferring from children's services after turning 18. In order to prepare to live independently as adults, many young people leaving full-time education will require different types of care and support to that which is typically provided to children or older people. For young adults, this might include things such as advice on housing options, support to help them live in their own home or job training.

16.58. Given the clear similarities in the statutory requirements under both Acts, local authorities **should consider** jointly planning and commissioning these services where there is potential to make better use of resources. It can cause significant disruption to young people and their families if they would prefer to stay local but are forced to travel out of area due to lack of adequate local provision. This will also often result in high transport costs and high costs of out-of-area placements.

After the young person or carer turns 18

16.59. There is no obligation on local authorities to implement the move from children's social care to adult care and

support as soon as someone turns 18. Very few moves will take place on the day of someone's 18th birthday. For the most part, the move to adult services begins at the end of a school term or another similar milestone, and in many cases should be a staged process over several months or years.

16.60. In advance of the move taking place, the local authority must decide whether to treat the transition assessment as a needs or carers assessment under the Care Act (i.e. an assessment for the adult care and support system as set out in chapter 6). In making this decision the local authority **must** have regard to when the transition assessment was carried out and whether the person's circumstances have changed.

16.61. If the local authority will meet the young person's or carer's needs under the Care Act after they have turned 18 (based either on the existing transition assessment or a new needs assessment if necessary), the local authority **must** undertake the care planning process as for other adults – including creating a care and support plan and producing a personal budget as set out in chapters 10 and 11. Local authorities should ensure that this happens early enough that a package of care and support is in place at the time of transition.

Combining EHC plans and care and support plans after the age of 18

16.62. Where young people aged 18 or over continue to have EHC plans under the Children and Families Act 2014, and they make the move to adult care and support, the care and support aspects of the EHC plan will be provided under the Care Act. The statutory care and support plan must form the basis of the 'care' element of the EHC plan (chapter 10 sets out the requirements and guidance for care and support plans).

16.63. Under the Children and Families Act, EHC plans must clearly set out the care and support which is reasonably required by the learning difficulties and disabilities that result in the young person having SEN. For people over 18 with a care and support plan, this will be those elements of their care and support which are directly related to their SEN. EHC plans may also include other care and support that is in the care and support plan, but the elements that are directly related to SEN should always be clearly marked out separately as they will be of particular relevance to the rest of the EHC plan.

Continuity of care after the age of 18

16.64. Young people and their carers have sometimes faced a gap in provision of care and support when they turn 18, and this can be distressing and disruptive to their lives. Local authorities **must not** allow a gap in care and support when young people and carers move from children's to adult services.

16.65. If transition assessment and planning is carried out as it should be, there **should not** be any gap in provision of care and support. However, if adult care and support is not in place on a young person's 18th birthday, and they or their carer have been receiving services under children's legislation,[135] the local authority **must** continue providing services until the relevant steps have been taken, so that there is no gap in provision. The 'relevant steps' are if the local authority:

[135] Specifically, under section 17 of the Children Act 1989 or section 2 of the Sick and Disabled Persons Act 1970 or section 2 of the Carers and Disabled Children Act 2000

- concludes that the person does not have needs for adult care and support; or
- concludes that the person does have such needs and begins to meet some or all of them (the local authority will not always meet all of a person's needs – certain needs are sometimes met by carers or other organisations); or
- concludes that the person does have such needs but decides they are not going to meet any of those needs (for instance, because their needs do not meet the eligibility criteria under the Care Act 2014)

16.66. In order to reach such a conclusion, the local authority **must** have conducted a transition assessment (that they will use as a needs or carers assessment under the adult statute). Where a transition assessment was not conducted and should have been (or where the young person's circumstances have changed), the local authority **must** carry out an adult needs or carer's assessment as described in chapter 6.

16.67. In the case of care leavers, the *Staying Put* Guidance[136] states that local authorities **may** choose to extend foster placements beyond the age of 18. All local authorities **must** have a Staying Put policy to ensure transition from care to independence and adulthood that is similar for care leavers to that which most young people experience, and is based on need and not on age alone.

16.68. For some people with complex SEN and care needs, local authorities and their partners **may** decide that children's services are the best way to meet a person's needs – even after they have turned 18. Both the Care Act 2014 and the Children and Families Act 2014 allow for this.[137]

16.69. The Children and Families Act enables local authorities to continue children's services beyond age 18 and up to 25 for young people with EHC plans if they need longer to complete or consolidate their education and training and achieve the outcomes set out in their plan. Under the Care Act 2014, if, having carried out a transition assessment, it is agreed that the best decision for the young person is to continue to receive children's services, the local authority **may** choose to do so. Children and adults' services **must** work together, and any decision to continue children's services after the child turns 18 will require agreement between children and adult services.

16.70. Where a person over 18 is still receiving services under children's legislation through their EHC plan and the EHC plan ceases, the transition assessment and planning process **must** be undertaken as set out elsewhere in this chapter. Where this has not happened at the point of transition, the requirement under the Care Act to continue children's services (as set out above) applies.

16.71. Both the Children and Families Act 2014 and the Care Act 2014 also require young people and their parents to be fully involved making decisions about their care and support. This includes decisions about the most appropriate time to make the transition to adult services. The EHC plan or any transition plan **should** set out how this will happen, who is involved and what support will be provided to make sure the transition is as seamless as possible.

136 https://www.gov.uk/government/publications/staying-put-arrangements-for-care-leavers-aged-18-years-and-above

137 Both Acts make insertions to the Children Act 1989 and "children's services" in the rest of this section means services provided under section 17 of that Act.

Safeguarding after the age 18

16.72. Where someone is over 18 but still receiving children's services and a safeguarding issue is raised, the matter should be dealt with as a matter of course by the adult safeguarding team. Where appropriate, they **should** involve the local authority's children's safeguarding colleagues as well as any relevant partners (e.g. police or NHS) or other persons relevant to the case. The same approach should apply for complaints or appeals, as well as where someone is moving to a different local authority area after receiving a transition assessment but before moving to adult care and support.

Ordinary residence and transition to Higher Education

16.73. Where a young person is intending to move to a higher or further education institution which is out of the area where they were receiving children's services, they will usually remain ordinarily resident in the area where their parents live (or the local authority area which had responsibility for them as a child). However, this is not always the case and Chapter 20 and Annex J contain more detailed guidance about ordinary residence principles when young people move from children's to adult services, and when they move away to university. This includes example case studies to help local authorities in making decisions about which area is responsible – it will be an important aspect of transition planning to confirm as early as possible where someone will be ordinarily resident as an adult.

16.74. Where a young person or carer wishes to attend a higher or further education institution, local authorities should help them identify a suitable institution as part of transition planning (if they have not done so already). Once an offer has been accepted, local authorities **should** ensure the relevant institution is made aware as soon as possible of the young person's or carer's needs and desired outcomes and discuss a plan for meeting them.

16.75. Wherever possible, this should be a conversation involving the young person or carer, anyone else they wish to involve, the local authority, and the institution – as well as the local authority where the institution is located where appropriate. All higher and further education institutions have clear duties and responsibilities under the Equality Act 2010 with regard to ensuring that disabled students do not face discrimination or less favourable treatment whilst applying to, and studying in these institutions. They are likely to have a learning support team or similar that can lead transition discussions on their behalf. These conversations should also ensure young people and carers are aware of their rights to the Disabled Students Allowance[138] and student loans.

16.76. The objective **should** be to ensure that there will be an appropriate package of care and support in place from the day the young person or carer starts at the institution. In many cases a young person or carer studying at university will have a dual location, for example coming home to stay with the parents during weekends or holidays. Where this is the case, local authorities must ensure their needs are met all year round.

Transition from children's to adult NHS Continuing Health Care

16.77. Clinical Commissioning Groups (CCGs) should use the National Framework

[138] https://www.gov.uk/disabled-students-allowances-dsas/overview

for NHS Continuing Healthcare[139] and supporting guidance and tools (especially the Decision Support Tool) to determine what on-going care services people aged 18 years or over should receive. The framework sets out that CCGs should ensure that adult NHS continuing healthcare is appropriately represented at all transition planning meetings to do with individual young people whose needs suggest that there may be potential eligibility. CCGs and LAs should have systems in place to ensure that appropriate referrals are made whenever either organisation is supporting a young person who, on reaching adulthood, may have a need for services from the other agency.

16.78. The framework sets out best practice for the timing of transition steps as follows:

- Children's services **should** identify young people with likely needs for NHS CHC and notify the relevant CCGs when such a young person turns 14;
- There **should** be a formal referral for adult NHS CHC screening at 16;
- There **should** be a decision in principle at 17 so that a package of care can be in place once the person turns 18 (or later if agreed more appropriate)

16.79. If a young person who receives children's continuing health care has been determined by the relevant CCG not to be eligible for a package of adult NHS CHC when they reach the age of 18, they should be advised of their non-eligibility and of their right to request an independent review. The CCG should continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care.

[139] https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Links to external resources

Code of Practice for Children with Special Educations Needs
https://www.gov.uk/government/consultations/special-educational-needs-sen-code-of-practice-and-regulations

Preparing for Adulthood website
http://www.preparingforadulthood.org.uk/

Together for Short Lives website
http://www.togetherforshortlives.org.uk/

Transition Information Network website
http://www.transitioninfonetwork.org.uk/

17. Prisons, approved premises and bail accommodation

This chapter provides guidance on section 76 of the Care Act 2014. It also provides guidance on other sections of the Act where they relate to care and support for adults in prison, approved premises and bail accommodation and those released from custody.

This chapter covers:

- Information sharing;
- Assessments of need;
- Assessments of a carer's needs;
- Charging and assessing financial resources;
- Next steps after assessments;
- Direct payments and deferred payment agreements;
- Continuity of care and support when an adult moves or is released;
- Partnerships and interdependencies;
- End of life care;
- Safeguarding adults at risk of abuse or neglect;
- Transition from children's to adult care and support;
- Independent advocacy support;
- Complaints;
- Standards and assessments.

17.1. People in custody or custodial settings who have needs for care and support should be able to access the care they need, just like anyone else. In the past, the responsibilities for meeting the needs of prisoners have been unclear, and this has led to confusion between local authorities, prisons and other organisations. On occasion, this has meant that people's eligible needs have gone unmet, with an impact on their health and wellbeing, as well as on their longer-term rehabilitation. Section 76 of the Care Act sets out to clarify local responsibilities, and to describe how the partners involved should work together.

17.2. Throughout this chapter, references to *custody* or *custodial settings* only relate to prisons, approved premises and other bail accommodation. It can also apply to people aged over 18 years in young offender institutions, secure children's homes and secure training centres. Please see the

Definitions section below. People bailed to a particular address in criminal proceedings are, like those in prison or approved premises, treated for the purposes of the Care Act as ordinarily resident in the local authority where they are required to reside and the provisions in the Care Act apply accordingly.

17.3. The guidance in this chapter relates only to custodial settings in England.

17.4. The Act and this chapter applies to anyone residing in a custodial setting. Where they have previously been detained under sections 47 and 48 of the Mental Health Act 1983 and transferred back to prison their entitlement to Section 117 aftercare should be dealt with in the same way as it would be in the community[140] apart from any provisions which are disapplied in custodial setting, such as direct payments and choice of accommodation, which are set out in more detail below.

17.5. This chapter of the guidance does not apply to individuals aged under 18 years. Details of where to find information on provision for children can be found at the end of this chapter. Please refer to paragraphs 17.62-17.63 of this chapter for information about transition from children's to adult care and support in custodial settings. For more detail please see chapter 16 in this guidance on transition from children's to adult care and support .

17.6. 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 principle of equivalence of care forms the basis of the policy intent for the Act and this guidance. This is crucial in ensuring that those in need of care and support achieve the outcomes that matter to them, and that will support them to live as independently as possible when leaving prison. In addition to ensuring that individual needs are met, this will contribute to the effectiveness of rehabilitation and improve community safety.

17.7. Local authorities are responsible for the assessment of all adults who are in custody in their area and who appear to be in need of care and support, regardless of which area the individual came from or where they will be released to. If an individual is transferred to another custodial establishment in a different local authority area this responsibility will transfer to the new area. The prison or approved premises to which an individual is allocated is a matter for the Ministry of Justice.

17.8. Local authorities **should** also be aware that prisoners, especially those serving long sentences, may develop eligible needs over time whilst in prison. Local authorities **should consider** how best to provide information and advice to both individuals and establishments on what can be done to prevent or delay the development of care and support needs.

17.9. Not all local authority areas contain prisons or approved premises. Those that do will assume responsibility for the eligible needs of the people residing in these sites. However, all local authorities will be responsible for continuity of care for offenders with a package of care coming into their area on release from prison. Provision of care and support, where an adult has eligible needs, should be provided in line with chapter 6 of this guidance once these individuals move into the community. Similarly local authorities **must** support continuity of care for any of their residents moving into custody.

17.10. Local authorities, provider organisations and their staff working in

[140] Mental Health Act 1983, section 117 http://www.legislation.gov.uk/ukpga/1983/20/section/117

custodial settings **should** abide by all rules and practices for that establishment, including (but not restricted to) security policies such as restricted items and searches on entry, equality and safeguarding procedures.

Definitions

17.11. **Prison:** This has the same meaning as the Prison Act 1952, section 53(1). A reference to a prison includes a reference to a young offender institution, secure training centre or secure children's home (see Care Act section 76(11)(a)). A reference to a governor, director or controller of a prison includes a reference to the governor, director or controller of a young offender institution, to the governor, director or monitor of a secure training centre and to the manager of a secure children's home (see Care Act section 76(11)(b)). A reference to a prison officer or prisoner custody officer includes a reference to a prison officer or prisoner custody officer as a young offender institution, to an officer or custody officer at a secure training centre and to a member of staff at a secure children's home (see Care Act section 76(11)(c)).

17.12. **Approved premises:** Premises approved as accommodation under section 13 of the Offender Management Act 2007 for the supervision and rehabilitation of offenders, and for people on bail. They are usually supervised hostel-type accommodation.

17.13. **National Offender Management Service (NOMS):** An executive agency of the Ministry of Justice, its role is to commission and provide offender services in the community and in custody in England and Wales, ensuring best value for money from public resources. NOMS works to protect the public and reduce reoffending by delivering the punishment and orders of the courts and supporting rehabilitation by helping offenders to change their lives.

17.14. **Her Majesty's Inspectorate of Prisons/Probation:** Her Majesty's Inspectorate of Prisons for England and Wales (HMI Prisons) is an independent inspectorate which reports on conditions for and treatment of those in prison, young offender institutions and immigration detention facilities.

17.15. Her Majesty's Inspectorate of Probation for England and Wales is an independent inspectorate on the effectiveness of work with adults, children and young people who have offended aimed at reducing reoffending and protecting the public.

17.16. **Prisons and Probation Ombudsman (PPO):** The Prisons and Probation Ombudsman investigates complaints from prisoners, those on probation and those held in immigration removal centres. The Ombudsman also investigates all deaths that occur among prisoners, immigration detainees and the residents of approved premises.

Information sharing

17.17. Local Authorities **should** ensure the security of information held on people who are in custodial settings, and **should** develop agreements consistent with policies and procedures of Ministry of Justice and the National Offender Management Service and with relevant legislation which enable appropriate information sharing on individuals, including the sharing of information about risk to the prisoner and others where this is relevant.

17.18. If a local authority is providing care and support for a person in the community and that person is subsequently remanded or sentenced to custody, or bailed to an approved premises, or required to live in

approved premises as part of a community sentence, the local authority **should** share details of the most recent assessment and care and support plan to the relevant custodial setting and the local authority in which it is based so that care and support may continue.

17.19. It is unlikely that local authorities will know when an individual is remanded or sentenced to custody, or when a prisoner is moved to another prison in a new local authority area. Prisons and/or prison health services **should** inform local authorities when someone they believe has care and support needs arrives at their establishment. Either party may use the mechanism to require co-operation to support working in an individual case, set out in chapter 15. Local authorities may also receive requests for information from managers of custodial settings when an individual who has already received care and support in the community is remanded or sentenced to custody. Local authorities **should** take all reasonable steps to provide the information requested as soon as practicable after receiving the request.

Assessments of need

17.20. Where a local authority is made aware that an adult in a custodial setting may have care and support needs, they **must** carry out an assessment as they would for someone in the community. It is likely that there will be complexities for carrying out assessments in custodial settings and consideration should be given to how such assessments will be carried out (for example making appointments and consideration of the number and type of staff required to be involved).

17.21. The local authority **may** also combine a needs assessment with any other assessment it is carrying out, or it **may** carry out assessments jointly with, or on behalf of another body, for example prisoners' health assessments.

17.22. Local authorities **should** consider processes for identifying people in custodial settings who are likely to have or to develop care and support needs. Further guidance will be issued to prison and approved premises managers regarding sharing this information with local authorities and partnership working.

17.23. Local authorities **should** aim to conduct assessments of those who appear to have care and support needs promptly following receipt of the referral from managers of custodial settings or the prison's health providers. People in a custodial setting have a right to self-refer for an assessment and the managers of the custodial setting, together with the local authority, should consider how to handle self-referrals. The local authority **should** provide appropriate types of care of and support prior to completion of the assessment where it is clear the person has urgent needs (as per section 19 (3) of the Care Act).

17.24. If someone in a custodial setting refuses a needs assessment the local authority is not required to carry out the assessment, subject to the same conditions as in the community. That is, this does not apply if:

- the person lacks the capacity to refuse and the local authority believes that the assessment will be in their best interests; or
- the person is experiencing, or is at risk of, abuse or neglect (see chapter 6 on assessment).

17.25. Once a local authority has assessed an individual in custody as needing care and support they **must** then determine if some or

all of these needs meet the eligibility criteria. Where an individual does not meet the eligibility criteria, the local authority **must** then give him or her written information about:

- what can be done to meet or reduce needs and what services are available; and
- what can be done to prevent or delay the development of needs for care and support in the future.

17.26. The threshold for the provision of care and support does not change in custodial settings and will be the same as described in chapter 6. However, the setting in which the care and support will be provided is likely to be different from community or other settings, and this **should** be taken into account when considering how to meet the need for care and support as part of the care planning process.

17.27. For any needs that are not eligible under the Act, local authorities **must** provide information and advice to the individual on how those needs can be met, and how they can be prevented from getting worse (as per Section 13 (5) of the Care Act). It is good practice to copy this information to managers of custodial settings, with the person's consent. Prisoners, especially those serving long sentences, may develop eligible needs over time. Local authorities **should** consider how best to provide information and advice to both individuals and establishments on what can be done to prevent or delay the development of care and support needs.

17.28. The right to a choice of accommodation does not apply to those in a custodial setting except when an individual is preparing for release or resettlement. Release into an approved premises amounts to moving from one custodial setting to another, unless specified otherwise in this guidance.

Assessments of a carer's needs

17.29. It is not the intention of the Care Act that any prisoner, resident of approved premises or staff in prisons or approved premises should take on the role of carer as defined by the Act and should therefore not in general be entitled to a carer's assessment. Separate guidance will be issued to prison and approved premises staff on the role of prisoners and residents of approved premises in providing assistance to others.

Charging and assessing financial resources

17.30. Those in custodial settings will be subject to a financial assessment to determine how much they may pay towards the cost of their care and support, as they would be in the community (see chapter 8). Consideration **should** be given to the best way of handling financial assessments, taking into account the resources required. In particular local authorities should consider how "light touch" assessments could be carried out where a person is unlikely to be required to contribute towards the cost of their care and support.

Next steps after assessment

17.31. The local authority **should** ensure that all relevant partners are involved in care and support planning and take part in joint planning with health partners.

17.32. Where a local authority is required to meet needs it **must** prepare a care and support plan for the person concerned and involve the individual to decide how to have their needs met. The local authority **should** also speak to others concerned with the person's health and wellbeing, including

prison staff, staff of approved premises and health care staff, to ensure integration of care, and fit with the custodial regime as appropriate, including enabling access to regime services such as libraries and education.

17.33. Whilst every effort should be made to put people in control of their care and for them to be actively involved and influential throughout the planning process (see chapter 10 on care and support planning) local authorities **should** make it clear to individuals that the custodial regime may limit the range of care options available, and some, such as direct payments do not apply in a custodial setting. However, the plan **must** contain the elements defined in the Act, including the personal budget. This will ensure that the person is clear of the needs to be met, and the cost attributed to meeting those needs.

17.34. Local authorities **should** aim to ensure that consent is given so that individual care plans are shared with other providers of custodial and resettlement services including custodial services, probation service providers including Community Rehabilitation Companies, prison healthcare providers and managers of approved premises. For residents of approved premises, the local authority should always liaise with the responsible Offender Manager in probation services.

17.35. For those assessed as being in need of equipment or adaptations to their living accommodation to meet their needs, local authorities **should** discuss with their partners in prisons, approved premises and health care services where responsibility lies. Where this relates to fixtures and fittings (for instance a grab rail or a ramp), it will usually be for the prison to deliver this. But for specialised and moveable items such as beds and hoists, then it **may** be the local authority who is responsible.

17.36. Local authorities **may** commission or arrange for others to provide care and support services, or delegate the function to another party (see chapter 18 on delegation). Local authorities should consider how this fits alongside the commissioning of health and substance misuse services in prison directly commissioned by NHS England and the commissioning of education services by the Skills Funding Agency. If such an arrangement is implemented, local authorities **should** consider retaining the functions relating to requirements for continuity of care between settings and must retain the functions in relation to charging and safeguarding.

17.37. Care and support plans for those in custodial settings will be subject to the same review processes as all other plans (see chapter 13). Local authorities **should** also review an individual's care and support plan each time they enter custody from the community, or are released from custody.

17.38. People in custody may experience episodes of hospital care, for example following an incident such as a stroke. Local authorities **should** co-operate with hospital staff and prison health service providers and commissioners to prevent delays in discharge from hospital and support a timely return to custody.

Direct payments

17.39. Any references to direct payments in the Act or this guidance **will not apply in prisons and approved premises**. Direct payments may not be made to people in custodial settings.

17.40. Individuals in **bail accommodation and approved premises** who have not yet been convicted **are entitled** to direct payments, as they would have been whilst in their own homes. For more information see the main guidance at chapter 12.

Continuity of care and support when an adult moves

17.41. Individuals in custody with care and support needs **must** have continuity of care where they are moved to another custodial setting or where they are being released from prison and are moving back in to the community. To ensure that the individual continues to receive care during the move local authorities should follow a similar process to that set out in chapter 20 on continuity of care.

17.42. The individual in custody will be ordinarily resident in the local authority where the custodial setting is located. Where the adult is being released from prison, their ordinary residence will generally be in the authority where they intend to live on a permanent basis, but see paragraphs 17.47-17.50 below.

17.43. There will be circumstances where the process to ensure continuity of care will need to differ. The prison or approved premises to which an individual is allocated is a matter for the Ministry of Justice, and individuals may be moved between different custodial settings. The Governor of the prison or a representative, **should** inform the local authority in which the prison is located (the first authority) that the adult is to be moved or is being released as soon as practicable. If this is a move to a custodial setting or release into the community in the same authority, then the first authority will remain responsible for meeting the individual's care and support needs. Where the new custodial setting or the community, if being released, is in a different local authority area (second authority), the first authority **must** inform the second authority of the move once it has been told by the prison.

17.44. The prison, both local authorities and where practicable, the individual, **should** work together to ensure that the adult's care is continued during the move, bearing in mind this may be a long distance at short notice. Both local authorities **must** share the relevant information as set out in chapter 20 on continuity of care, including their care and support plan.

17.45. The second authority **should** assess the individual before they are moved, but this may not always be possible as the authority could be informed of the transfer at short notice. In such circumstances the second authority **must** continue to meet the care and support needs that the first authority was meeting. It **must** continue to meet these needs until it has carried out its own assessment.

17.46. The requirements outlined in this guidance only apply to custodial settings in England. (Guidance to cover prisoners who are moved to Scotland, Wales or Northern Ireland is still to be developed)

People leaving prison – ordinary residence

17.47. The deeming provisions in section 39 of the Care Act, which provide that in most circumstances a person's ordinary residence is retained where they have their needs met in certain types of accommodation in another local authority area, do not apply to people who are leaving prison. However, local authorities can reasonably follow the approach set out in section 39 for people who are due for release from

prison. Therefore, where a person requires a specified type of accommodation (see chapter 19 on ordinary residence) to be arranged to meet their eligible needs on release from prison, local authorities should start from a presumption that they remain ordinarily resident in the area in which they were ordinarily resident before the start of their sentence.

17.48. However, determining an offender's ordinary residence on release from prison will not always be straightforward and each case must be considered on an individual basis. For example, it may not be possible for an offender to return to their prior local authority area due to the history of their case and any risks associated with a return to that area. Therefore, any presumption of ordinary residence may be rebutted by a number of factors, including the offender's wishes and intentions about where to live, the length of their sentence and remaining ties with their previous area.

17.49. In situations where an offender is likely to have needs for care and support services on release from prison and their place of ordinary residence is unclear and/or they express an intention to settle in a new local authority area, the local authority to which they plan to move should take responsibility for carrying out the needs assessment.

17.50. Given the difficulties associated with determining some offenders' ordinary residence on release, prisons and the local authority providing care and support in the prison should initiate joint planning for release in advance. Prisons **should** support assessment and care and support planning for those offenders who will require care and support services on their release from prison.

Partnerships and interdependencies

17.51. It is essential that local arrangements for the delivery of care and support are made in partnership with health and education commissioners and providers within a custodial environment so that those with eligible needs experience integrated services. This **should** take account of the need for close working with prison staff and regime service (see chapter 15 on integration and cooperation).

17.52. Consideration should be given to the duty to promote integration contained in section 3 of the Act. This includes health and health related services provided by prisons and providers of probation services. In support of this local authorities **should** consider the value of regular inter-agency meetings with all those involved in the person's care and support.

17.53. Local authorities **should** ensure that contracts with providers of care and support cover staff supervision and that staff are supported to deliver high quality services in custodial settings. As part of their responsibilities for shaping and facilitating the market in care and support services, local authorities should work with prisons and approved premises to develop and test contingency plans to cover the event of provider failure. These plans should be aligned with wider prison and local authority business continuity and contingency planning (see chapter 4 on market shaping and commissioning and chapter 5 provider failure).

End of life care

17.54. The provision of care and support for those in custodial settings extends to those who reach the end of life whilst in prison. For this provision of palliative care, some will transfer to a local hospital, hospice or care home or move to an alternative prison where a more suitable environment is available. In these cases, responsibility for care and support will pass to the NHS or new local authority, once the individual arrives at the new location. Approved Premises are not in general a suitable location for the provision of end of life care.

17.55. Prison managers and health care providers **should** consider informing local authorities when a prisoner receives a terminal diagnosis or when the condition of such a patient deteriorates significantly. Information could be shared with local authorities for the purpose of offender management under s.14 of the Offender Management Act 2007. The individual's consent should be obtained where possible.

17.56. Where it is not possible to obtain consent to share the information, managers of custodial settings and health care providers should make an individual assessment of the nature of the information and the requirements of the Data Protection Act 1998.

17.57. Local authorities **should** work with the prison healthcare provider to ensure that the care and support needs of the prisoner are met throughout the provision of end of life care.

NHS Continuing Health Care

17.58. NHS Continuing Healthcare is a package of ongoing care that is arranged and funded solely by the health service for individuals outside a hospital setting who have complex ongoing healthcare needs, and who have been found to have a 'primary health need'. Such care is provided to people aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. NHS Continuing Healthcare is not dependent on a person's condition or diagnosis, but is based on their specific care needs.

17.59. Section 22 of the Care Act sets out the limits on what a local authority may provide by way of healthcare and so, in effect, sets the boundary between the responsibilities of local authorities for the provision of care and support, and those of the NHS for the provision of health care. In order to support joint working, it is important that all partners involved are clear about their own responsibilities, and how this sits together (see chapter 15 for more detail). NHS England is responsible for commissioning healthcare for prisoners, where necessary this includes NHS continuing healthcare.

Safeguarding adults at risk of abuse or neglect

17.60. Local authorities **should** follow the safeguarding policies and procedures of custodial settings in their area and work with prison and approved premises staff to ensure that all people in custodial settings are safeguarded.

17.61. Local authorities **should consider** inviting prison and probation staff to be members of Safeguarding Adult Boards. Separate guidance for prisons and probation will be developed by the National Offender Management Service on safeguarding adults. The inclusion of prison and probation staff on safeguarding adult boards should be agreed with all statutory board members.

Transition from children's to adult care and support

17.62. Local authorities **should** be aware of children and young people in Young Offender Institutions, Secure Children's Homes, Secure Training Centres or other places of detention as well as children and young people in the youth justice system, who are likely to have eligible needs for care and support as adults, and are approaching their eighteenth birthday. Local authorities **should** ensure that appropriate arrangements are in place to identify these young people and ensure they receive a transition assessment when appropriate.

17.63. This also applies where an offender moves from the youth custodial estate to the adult custodial estate, which may include a change in the responsible local authority. A request for an assessment can be made on the young person's behalf by the professional responsible for their care in the Young Offenders' Institution, Secure Children's Home or Secure Training Centre. Good communication between professionals, institutions and local authorities is essential to prepare for transfer and ensure a smooth transition.

Care leavers

17.64. If a young person is entitled to support and services as a care leaver, this status remains unchanged while in custody and the local authority that looked after the young person retains responsibility for providing leaving care services during his/her time in custody and on release.

17.65. Responsibilities for planning continuing support applies to all care leavers until they reach the age of 21 or, if they are being helped with education or training, to the end of the agreed programme of education or training (which can take them beyond their 25th birthday).

17.66. Good communication is essential between the local authority responsible for leaving care services and the local authority responsible for providing care and support in custody.

Independent advocacy support

17.67. Adults in custody are entitled to the support of an independent advocate during needs assessments and care and support planning and reviews of plans if they would have significant difficulty in being involved in the process, as in the community, see chapter 7 of this guidance for further details.

17.68. Local authorities **should** agree with leaders of custodial services how the advocacy scheme will work in their establishments, including the possibility of training some prison staff to act as advocates. Local authorities **should** notify managers of custodial settings if they identify a need for advocacy where that need is not already being met.

Complaints and appeals

17.69. Local authorities **should** provide information to those in custodial settings on how to make complaints, and seek redress about provision of care and support services.

17.70. Managers of custodial settings **should** inform local authorities where an offender wishes to make a complaint as soon as they are made aware. A prisoner may choose to complain or appeal by alternative methods, such as by letter or telephone to the care and support provider. This correspondence **should** be processed

in the same way as all other appeals and complaints once received by local authorities.

17.71. Current complaints provision for care and support is set out in regulations.[141] The provisions of the regulations mean that anyone who is dissatisfied with a decision made by the local authority would be able to make a complaint about that decision and have that complaint handled by the local authority. The local authority must make its own arrangements for dealing with complaints in accordance with the 2009 regulations.

17.72. The Department of Health intends to develop detailed proposals for a system of reviewing local authority decisions which will be set out in regulations. The detail will specify the scope of decisions which will be covered by the new proposals, including whether decisions made by local authorities on care planning and personal budgets will be eligible for appeal. It is envisaged that the Department will consult on more detailed proposals late in 2014 and that the appeals system would come into force in April 2016, in line with funding reform.

Standards and assessments

17.73. The Prisons and Probation Ombudsman (PPO) conducts investigations in prisons following complaints about prison services, as well as deaths in custody or other significant events. The PPO will commission a relevant body to assist their investigations where it is felt that an aspect of care and support provision has contributed to the event. Local authorities **should** co-operate with any investigations as required.

17.74. The party commissioned by the PPO will investigate any relevant aspect of care and support provision and report back to the PPO for inclusion in the final report.

17.75. Both prisons and probation services are inspected by Her Majesty's Inspectorate of Prisons and Her Majesty's Inspectorate of Probation. Local authorities **should** make any relevant assessments and other documents available to inspecting bodies as part of the investigation.

17.76. Local authorities will receive copies of all investigation reports that are relevant to them. It is good practice for local authorities to contribute to the responses and action plans in conjunction with NOMS managers, prison managers and health care providers and commissioners. This could include work to prevent and reduce reoffending, and to prevent harm to others or to the offender.

17.77. Local authorities **should** co-operate with and attend any inquests that are held following a death in custody, where they are requested to do so or they have relevant information.

Links to other sources of information/products which support implementation

For information on the provision of social care for children visit https://www.gov.uk/childrens-services/childrens-social-care

For more information on the National Offender Management Service and contact details, visit https://www.justice.gov.uk/about/noms

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

For information on the forthcoming changes to the prison estate and to offender supervision on release under Transforming Rehabilitation, visit: http://www.justice.gov.uk/downloads/rehab-prog/competition/target-operating-model-2.pdf

To contact the National Offender Management Service about social care, please e-mail health.co-comissioning@noms.gsi.gov.uk

For information on care leavers in the youth justice system: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300342/Guidance_revised_following_consultation.pdf)

18. Delegation of local authority functions

This chapter provides guidance on section 79 of the Care Act 2014.

This chapter covers:

- Overview of the policy;
- Local authorities retain ultimate responsibility for how its functions are carried out;
- Importance of contracts;
- Which functions may not be delegated;
- The difference between outsourcing a legal function and activities relating to the function;
- Conflicts of interest.

18.1. Part 1 of the Care Act sets out local authorities' functions and responsibilities for care and support. Sometimes external organisations might be better placed than the local authority itself to carry out some of its care and support functions. For instance, an outside organisation might specialise in carrying out assessments or care and support planning for certain disability groups, where the local authority does not have the in-house expertise. External organisations might also be able to provide additional capacity to carry out care and support functions.

18.2. The Care Act allows local authorities to delegate some, but not all, of their care and support functions to other parties. This power to delegate is intended to allow flexibility for local approaches to be developed in delivering care and support, and to allow local authorities to work more efficiently and innovatively, and provide better quality care and support to local populations.

18.3. As with all care and support, individual wellbeing **should** be central to any decision to delegate a function. Local authorities **should not** delegate its functions simply to gain efficiency where this is to the detriment of the wellbeing of people using care and support.

18.4. Local Authorities retain ultimate responsibility for how its functions are carried out Delegation **does not** absolve the local authority of its legal responsibilities. When a local authority delegates any of its functions, it retains ultimate responsibility for how the function is carried out. The Care Act is clear that anything done (or not done) by the third party in carrying out the function, is to be treated as if it has been done (or not done) by the local authority itself. This is a core principle of allowing delegation of care and support functions.

18.5. People using care and support will always have a means of redress against the local authority for how any of its functions under Part 1 of the Act are carried out. For example, a local authority might delegate needs assessments to another organisation, which has its own procedures for handling complaints. If the adult to whom the assessment relates has a complaint about the way in which it was carried out, the adult might choose to take it up with the organisation in question. However, if this does not satisfy the adult, or if the adult simply chooses to complain directly to the local authority, the local authority will remain responsible for addressing the complaint.

Importance of contracts

18.6. The success of a policy by a local authority to delegate its functions to a third party will be determined to a large extent, by the strength and quality of the contracts that the local authorities make with the delegated third party. Local authorities **should** therefore ensure that contracts are drafted by staff with the necessary skills and competencies to do so. Local authorities should consider the findings of the Social Work Practice pilot scheme,[142] which tested approaches to delegation, when considering how to construct contracts.

18.7. Through the terms of their contracts with authorised third parties, local authorities have the power to impose conditions on how the function is carried out. For example, when delegating assessments the local authority could choose to require that assessments **must** be carried out by people with a particular training or expertise, and that the training **must** be kept up to date.

18.8. The delegated organisation will be liable to the local authority for any breach of the contract, and as such this is the mechanism through which local authorities are able to ensure that its functions are carried out properly, and through which they may hold the contractor to account.

18.9. Where a local authority uses its power under the Act to authorise another party to carry out its care and support functions, it **should** specify how long the authorisation lasts, and it **should** make clear that it may revoke the authorisation at any time during that period.

18.10. Local authorities **should** put in place monitoring arrangements so that they can assure themselves that functions that have been delegated, are being carried out in an appropriate manner. This **should** involve building good working relationships which allow local authorities to guide third parties about how they are exercising the functions, but equally for the local authority to learn about innovations and knowledge that third parties may be able to provide.

18.11. Since care and support functions are public functions, they **must** be carried out in a way that is compatible with all of the local authority's legal obligations. For example, the local authority would be liable for any breach by the delegated party, of its legal obligations under the Human Rights Act or the Data Protection Act. Local authorities **should** therefore draw up its contracts so as to ensure that third parties carry out functions in a way that is compatible with all of their legal obligations.

18.12. Although local authorities retain overall responsibility for how its functions are carried out, delegated organisations will be responsible for any criminal proceedings brought against them.

[142] Insert link to final King's College evaluation when published

18.13. Local authorities are able to choose the extent to which they delegate their functions. For example, they could authorise an external party to carry out all the elements of the function, including for example taking final decisions, or it can limit the steps the authorised organisation may take, leaving any final decisions to the local authority. Local authorities **should** make clear in its contracts with authorised parties, the extent to which the function is being delegated.

18.14. The fact that a local authority delegates its functions does not mean that it cannot also continue to exercise that function itself. So, for instance the local authority could ask a specialist mental health organisation to carry out care and support planning for people with specific mental health conditions, but it may choose to do care and support planning for people with other mental health conditions itself. Or it may choose to offer people a choice between itself and the external organisation.

Which care and support functions may not be delegated?

18.15. The Care Act does not allow certain functions to be delegated. These are:

- **Integration and cooperation** – local authorities **must** cooperate and integrate with local partners. Delegating these functions would not be compatible with meeting their duties to work together with other agencies. However, local authorities **should** take steps to ensure that authorised parties co-operate with other partners, work in a way which supports integration, and is consistent with their own responsibilities.
- **Adult Safeguarding** – the Care Act puts in place a legal framework for adult safeguarding, including the establishment of Safeguarding Adults Boards (SABs), carrying out safeguarding adult reviews and making safeguarding enquiries. Since the local authority **must** be one of the members of SABs, and it **must** take the lead role in adult safeguarding, it may not delegate these statutory functions to another party. However, it may commission or arrange for other parties to carry out certain related activities (see paragraph 22.18 below).
- **Power to charge** – the Care Act gives local authorities the power to charge people for care and support in certain circumstances. Local policies relating to what can and cannot be charged for **must** rightly remain a decision of the local authority, and therefore the Act does not permit local authorities to delegate this decision to outside parties. However, it may commission or arrange for other parties to carry out related activities (see paragraph 22.19 below).

What is the difference between delegating a statutory care and support function and commissioning other related activities?

18.16. For those functions which may not be delegated (outlined in paragraph 22.15 above), as well as other functions which may be delegated, local authorities may wish to use outside expertise to assist in carrying out practical activities to support it in discharging those functions, rather than fully or formally delegating the function itself to be carried out by another party.

18.17. There can be some uncertainty about the difference between delegation of a statutory care and support function and

commissioning, arranging or outsourcing other procedural activities relating to a function. Local authorities **should** seek legal advice about whether the activity it is seeking to commission another party to undertake is a legal function under Part 1 of the Act or not.

18.18. For example, as set out above local authorities may not delegate its functions relating to establishing Safeguarding Adult Boards, making safeguarding enquiries or arranging safeguarding reviews. However, it may decide to authorise an external agency to run a contact centre for people to report safeguarding incidents, and manage referrals to the local authority. It may be that the contact centre is not carrying out the local authority's statutory functions (although its activities are related to the functions), and as such the local authority would not require any legal authority to outsource these activities, so may choose to do so.

18.19. Another example is the local authorities' function which allows them discretion over charging people for care and support. The Act does not allow delegation of this decision to other organisations. As such the local authority itself must decide its charging policies. However, local authorities may commission an external agency to carry out the administration, billing and collection of fees for care and support on its behalf. These activities may not be classed as care and support functions under the Care Act, even though they are related to the charging function. It should be noted that the care and support function relating to financial assessments (section 17 of the Act) may be delegated.

Conflicts of interest

18.20. There might be instances where there is the potential for a conflict of interest when delegating functions. For example, when the same external organisation carries out care and support planning, but also provides the resulting care and support that is set out in the plan. Local authorities **should** consider whether the delegation of its functions could give rise to any potential conflict and **should** avoid delegating their functions where they deem that there would be an inappropriate conflict.

18.21. Local authorities **should** consider imposing conditions in their contracts with delegated parties to mitigate against the risk of any potential conflicts. For example, the local authority may choose to delegate care and support planning, but retain the final decision-making, including signing off the amount of the personal budget (see chapter 10 on care and support planning and chapter 11 on personal budgets). Local authorities **should** also consider including conditions that allow the contract to be revoked at any time, if having authorised an external party to exercise its functions, a conflict becomes apparent.

Conflict of interest relating to making direct payments

18.22. The Act places various functions on local authorities relating to the provision of direct payments. These functions include determining whether someone is capable of managing a direct payment, being satisfied that the direct payment is being used in a way that is meeting the person's needs, and monitoring this periodically. Local authorities may choose to delegate these functions. For example, where an authorised external party is carrying out care and support planning, the local authority may decide that the direct payment functions could also usefully be delegated to that party (see chapter 12) for more detail on direct payments.

18.23. The Act also gives local authority the function of making direct payments to people, that is, paying them money to meet their care and support needs. This function may also be delegated to an external party. However, where local authorities delegate their functions relating to assessment of needs or calculation of personal budgets to an external party, they **should not** allow that same party to make direct payments. In these cases, the actual payment of money **should** be made directly from the local authority to the adult or carer. This is because it is not appropriate for an external party to determine both how public funds are to be spent, as well as handling and those funds. This is in line with standard anti-fraud practice.[143]

Case study: delegation of local authority care and support functions

A local Authority has agreed a contract with a local user-led organisation (ULO), to carry out specialist needs assessments and care and support planning for people with learning disabilities. The expertise provided by the ULO allows for better interaction with the people undergoing assessments and a better understanding of their needs, resulting in more accurate and person-centred needs assessments.

The ULO's specialist knowledge of local facilities, befriending groups and employment schemes allows them to broker more personalised care and support planning which allows the person's needs to be met in a number of imaginative ways which support local people with learning disabilities to live independently, improves their wellbeing – and often with less costly care packages.

As part of the delegation, the local authority builds a good working relationship with the ULO, as it needs to monitor how the needs of the adults to whom they have a responsibility are being met. The local authority realises that the ULO has had some difficulty in advising its clients on employment laws for people who are employing personal assistants with their direct payments. The local authority has much experience of providing this type of advice to people with disabilities, and provides support to the ULO to help with this aspect of function.

Through the delegation, the local authority has been able to build its knowledge of specialist resources in its area that it did not previously know about, and has been able to learn about new practices in carrying out assessments and planning care and support packages more imaginatively and efficiently – learning which it is able to apply to other groups of people with care and support needs. The more personalised assessment and care planning has resulted in fewer reviews of care plans. More people with learning disabilities in the area are supported to live independently for longer which results in better outcomes for them while simultaneously reducing costs to the local authority.

143 http://webarchive.nationalarchives.gov.uk/20130129110402/http://www.hm-treasury.gov.uk/psr_managing_risk_of_fraud.htm.

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

19. Ordinary residence

This chapter provides guidance on:

- *Sections 39-41 of the Care Act 2014;*
- *The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014;*
- *The Care and Support (Ordinary Residence Disputes etc.) Regulations 2014.*

This chapter covers:

- How ordinary residence affects the legal framework in the Care Act;
- How to determine ordinary residence;
- Determining ordinary residence when a person moves into certain types of accommodation out of area;
- Disputes between authorities, and the process for seeking a determination by the Secretary of State for Health or appointed person;
- Further information around ordinary residence and relevant scenarios (see annexes J1-J8).

19.1. It is critical to the effective operation of the care and support system that local authorities understand for which people they are responsible; and that people themselves know who to contact when they need care and support. Many of the local authority's care and support responsibilities relate to the entire local population (for instance, in relation to information and advice or preventive services). However, when it comes to determining which individuals have needs which a local authority is required to meet, the local authority is only required to provide needs in respect of an adult who is ordinarily resident in their area.

19.2. "Ordinary residence" is crucial in deciding which local authority is required to meet the needs in respect of adults with care and support needs and carers. Whether the person is "ordinarily resident" in the area of the local authority is a key test in determining where responsibilities lie between local authorities for the funding and provision of care and support.

19.3. Ordinary residence is not a new concept – it has been used in care and support for many years. However, there have been in the past, and will continue to be cases in which it is difficult to establish precisely where a person is ordinarily resident, and this guidance is intended to

help resolve such situations. The Care Act also extends the principle of "deeming" certain people to be ordinarily resident in a particular local authority when some types of accommodation are arranged for them in another area, and the guidance also describes how these provisions should be put into practice.

19.4. This chapter of the guidance should also be read with Annexes J1-J8, which provides further detailed guidance on specific situations and circumstances which may arise, and where the question of ordinary residence may be unclear.

How does ordinary residence affect the provision of care and support?

19.5. Ordinary residence is one of the key tests which must be met to establish whether a local authority is required to meet a person's eligible needs. It is therefore crucial that local authorities establish at the appropriate time whether a person is ordinarily resident in their area, and whether such duties arise.

19.6. The test for ordinary residence, which determines which local authority would be responsible for meeting needs, applies differently in relation to adults with needs for care and support and carers. For adults with care and support needs, the local authority in which the adult is ordinarily resident will be responsible for meeting their eligible needs. For carers, however, the responsible local authority will be the one where the adult for whom they care is ordinarily resident. Establishing responsibility for the provision of care and support for carers, therefore, requires the local authority to consider the ordinary residence of the adult needing care.

19.7. Local authorities **must** determine whether an individual is ordinarily resident in their area following the needs or carer's assessment, and after determining whether the person has eligible needs (see chapter 6). Determining ordinary residence is a key additional requirement in establishing whether the duty to meet needs under section 18 or 20 of the Act is triggered, so this must be taken into consideration when deciding if the local authority is to meet the person's needs.

19.8. Local authorities **should not** use a decision on ordinary residence to exclude people from the assessment process inappropriately.

19.9. The determination of ordinary residence **should not** delay the process of assessment or determination of eligible needs, nor should it stop the local authority from meeting the person's needs. In cases where ordinary residence is not certain, the local authority **should** meet the individual's needs first, and then resolve the question of residence subsequently. This is particularly the case where there may be a dispute between two or more local authorities.

How to determine ordinary residence

19.10. The local authority's responsibility for meeting a person's eligible needs under the Care Act is based on the concept of "ordinary residence". However, there is no definition of "ordinary residence" in the Act. Therefore, the term should be given its ordinary and natural meaning.

19.11. In most cases, establishing the person's ordinary residence is a straightforward matter. However, this is not always the case. There will be circumstances in which ordinary residence is not as clear-cut, for example when people spend their

time in more than one area, or move between areas. Where uncertainties arise, local authorities **should** always consider each case on its own merits.

19.12. The concept of ordinary residence involves questions of both fact and degree. Factors such as time, intention and continuity (each of which may be given different weight according to the context) have to be taken into account. The courts have considered the meaning of "ordinary residence" and the leading case is that of Shah v London Borough of Barnet (1983). In this case, Lord Scarman stated that:

> *'unless … it can be shown that the statutory framework or the legal context in which the words are used requires a different meaning I unhesitatingly subscribe to the view that "ordinarily resident" refers to a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration.'*

19.13. Local authorities **should** always have regard to this case when determining the ordinary residence of people who have capacity to make their own decisions about where they wish to live. For people who lack capacity to make decisions about their accommodation, an alternative approach is appropriate because a person's lack of mental capacity may mean that they are not able to voluntarily adopt a particular place.[144]

19.14. Local authorities **should** in particular apply the principle that ordinary residence is the place the person has voluntarily adopted for a settled purpose, whether for a short or long duration. Ordinary residence can be acquired as soon as the person moves to an area, if their move is voluntary and for settled purposes, irrespective of whether they own, or have an interest in, a property in another local authority area. There is no minimum period in which a person has to be living in a particular place for them to be considered ordinarily resident there, because it depends on the nature and quality of the connection with the new place.

Cases where a person lacks capacity

19.15. All issues relating to mental capacity should be decided with reference to the Mental Capacity Act 2005 ("the 2005 Act").[145] Under this Act, it **should** always be assumed that adults have capacity to make their own decisions, including decisions relating to their accommodation and care, unless it is established to the contrary.

19.16. The test for capacity is specific to each decision at the time it needs to be made, and a person may be capable of making some decisions but not others. It is not necessary for a person to understand local authority funding arrangements to be able to decide where they want to live.

19.17. If it can be shown that a person lacks capacity to make a particular decision, the 2005 Act makes clear who can take decisions on behalf of others, in which situations and how they should go about doing this. For example, if a person lacks capacity to decide where to live, a best interests decision about their accommodation should be made under the 2005 Act. Under section 1(5) of the 2005 Act, any act done, or decision made (which would include a decision relating to where a person without capacity should live), must be done in the

[144] The use of this approach – known as Vale 1, is currently the subject of litigation and the guidance will be amended in due course

[145] The Mental Capacity Act 2005 Code of Practice is available at the following address: http://www.dca.gov.uk/menincap/legis.htm#codeofpractice

best interests of the person who lacks capacity. Section 4 of the 2005 Act sets out how to work out the best interests of a person who lacks capacity and provides a checklist of factors for this purpose.

19.18. If a person has been placed in accommodation following a best interests decision under the 2005 Act and uncertainties arise about their place of ordinary residence, an alternative test should be used to establish ordinary residence. However, a person's mental capacity **should** always be taken into account when making any decision about their ordinary residence and different tests should only be used where it can be shown that a person is not capable of forming their own decision as to where to live. This is because the use of a different test is based on the assumption that the person lacking capacity cannot have adopted their place of residence voluntarily, as would usually be the case.

19.19. In the case of a person whose parents are deceased, people who have become ordinarily resident in an area and then lost capacity or have limited contact with their parents, the approach known as Vale 2 is appropriate. This involves considering a person's ordinary residence as if they had capacity. All the facts of the person's case should be considered, including physical presence in a particular place and the nature and purpose of that presence but without requiring the person have voluntarily adopted the place of residence.

People with no settled residence

19.20. Where doubts arise in respect of a person's ordinary residence, it is usually possible for local authorities to decide that the person has resided in one place long enough, or has sufficiently firm intentions in relation to that place, to have acquired an ordinary residence there. Therefore, it should only be in rare circumstances that local authorities conclude that someone is of no settled residence. For example, if a person has clearly and intentionally left their previous residence and moved to stay elsewhere on a temporary basis during which time their circumstances change, a local authority may conclude the person to be of no settled residence.

19.21. Sections 18 and 20 of the Care Act make clear that local authorities have a duty to meet the eligible needs of people if they are present in its area but of no settled residence. In this regard, people who have no settled residence, but are physically present in the local authority's area, **should** be treated the same as those who are ordinarily resident.

19.22. A local authority may conclude that a person arriving from abroad is of no settled residence, including those people who are returning to England after a period of residing abroad and who have given up their previous home in this country. For more details on people returning to England after a period of living abroad, see Annex J6 (British citizens resuming permanent residence in England after a period abroad).

Scenario: persons of no settled residence

David is 20 years old and has a physical disability together with mild learning disabilities. Until four months ago, he lived with his family in local authority A. However, his family relationship broke down and his parents asked him to leave their home for good. They have since changed the locks on their house.

He sought help from local authority A and was placed in a care home for young people with disabilities located in local authority A. This placement was made on a short-term basis until a more permanent solution for David could be found. However, David chose to leave the care home after a few weeks and stayed with friends in local authority B for a short period. However, he has recently presented at local authority B seeking accommodation on the basis that he is a destitute adult who is in need of care and attention. Local authority B provides David with residential accommodation but falls into dispute with local authority A over his place of ordinary residence.

Local authority B contends that David remains ordinarily resident in local authority A given his previous residence there and his recent discharge from their care. Local authority A argues that David has acquired a new ordinary residence in local authority B.

As David is being provided with a type of accommodation by local authority B, as specified by the regulations, S39(1)(a) applies. Therefore, he is deemed to continue to be ordinarily resident in the area in which he was ordinarily resident immediately before the residential accommodation was provided for him. The day before David presented at local authority B he was staying with friends in that local authority area. His friends made it clear that this was a short-term temporary arrangement, to prevent him becoming homeless upon leaving the care home in local authority A. He had not built up any community ties within the area of local authority B; nor had he chosen to reside in local authority B voluntarily and for settled purposes. Therefore, under the [Shah] test, David has not acquired an ordinary residence in local authority B.

However, nor does it appear that David has retained his ordinary residence in local authority A where he lived with his parents. He left the care home in local authority A intentionally and has no settled residence to which he can return. As David appears not to have been ordinarily resident in either local authority A or local authority B immediately before he presented at local authority B and was provided with accommodation, it is decided that he is a person of no settled residence. Section 18 of the Care Act 2014 makes clear that local authorities have a duty to meet the needs of someone, if they are present in its area but of no settled residence. Local authority B is therefore the authority responsible for David's eligible care and support needs and can therefore treat David as if he were ordinarily resident in their area and provide him with accommodation. If he is in urgent need, they will be under a duty to do so.

Ordinary residence when arranging accommodation in another area

19.23. There may be some cases where the local authority considers it appropriate for the person's care and support needs to be met by the provision of accommodation in the area of another authority. If the person has needs which can only be met through certain types of accommodation, then in addition to their involvement in the planning process, the person will also have a right to make a choice about their preferred accommodation (see chapter 8 and Annex A about choice of accommodation). This right allows the person to make a choice about a particular individual provider, including where that provider is located. Provided that certain conditions are met, the local authority **must** arrange for the preferred accommodation.

19.24. This will mean that local authorities will in some circumstances be required to arrange accommodation that is located in a different area. Moreover, there will also be other situations in which a local authority chooses to arrange accommodation for a person in another area, because that has been agreed with the person concerned. In any such case, it should be clear which local authority is responsible for meeting the person's needs in the future.

19.25. Section 39 of the Care Act, and the regulations made under it[146] set out what should happen in these cases, and specify which local authority is responsible for the person's care and support when the person is placed in another authority's area. Together, these create the principle that the person placed 'out of area' is deemed to continue to be ordinarily resident in the area of the first or 'placing' authority, and does not acquire an ordinary residence in the 'host' or second authority. The local authority which arranges the accommodation, therefore, retains responsibility for meeting the person's needs.

19.26. The regulations specify the types of accommodation to which this provision applies. The regulations explicitly set out three types of accommodation:

- nursing homes/care homes – residential accommodation which includes either nursing care or personal care;
- supported living/extra care housing – specialist or adapted accommodation, in which personal care is also available, usually from a different provider. It should be noted that there are two types of supported accommodation defined in the regulations, and the availability of personal care is not a requirement of the first type, which can be accommodation alone; and,
- shared lives schemes – accommodation in which the person lives with a host family.

19.27. Where an adult has needs which can only be met through the provision of one of these types of accommodation, and the accommodation arranged is in another area, then the principle of "deeming" ordinary residence applies. This means that the adult is treated as remaining ordinarily resident in the area where they were resident before the placement began. The consequence of this is that the local authority which arranges the accommodation will remain responsible for meeting the person's eligible needs, and responsibility does not transfer to the authority in whose area the accommodation is physically located.

[146] The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014

19.28. The first, or placing, local authority's responsibility will continue in this way for as long as the person's eligible needs are met by a specified type of accommodation. This will include situations where the person moves between different specified types of accommodation in another (or more than one other) area.

19.29. As an example, if the first authority places someone in one type of accommodation in the area of the second authority (for example a care home) and the person's needs change, leading to them moving into another type of accommodation still in the second authority (for example a supported living scheme), the person would continue to be ordinarily resident in the first authority, and that authority would remain responsible for the care and support. However, should the person's needs no longer require a specified type of accommodation, and should the person choose to settle in their own accommodation in the second authority (or another area), then it is likely that their ordinary residence will change, and the first local authority will no longer retain responsibility.

19.30. The ordinary residence "deeming" principle applies most commonly where the local authority provides or arranges the accommodation directly. However, the principle also applies where a person takes a direct payment and arranges their own care. In such cases, the individual has the choice over how their needs are met, and arranges their own care and support. If the care plan stipulates that person's needs can be met only if the adult is living in one of the specified types of accommodation and the person chooses to arrange that accommodation[147] in the area of a local authority which is not the one making the direct payments then the same principle would apply; the local authority which is meeting the person's care and support needs by making direct payments would retain responsibility. However, if the person chose accommodation that is outside what was specified in the care plan or of a type of accommodation not specified in the regulations, then the 'deeming' principle would not apply.

19.31. At present, direct payments may not be made to meet needs by the provision of long term care and support in a care home. However, the individual may request a direct payment to meet needs for other types of accommodation specified in the regulations. Where someone chooses a type of supported living accommodation, the direct payment would be for the care but usually not the accommodation. Local authorities **should** therefore ensure that they have in place effective, proportionate processes for recording how the individual chooses to meet their needs. More information on direct payments can be found in chapter 12.

19.32. If a local authority arranges a type of accommodation as specified in the regulations in another area, or becomes aware that an individual with a direct payment has done so themselves, the authority **should** inform the host authority, to ensure the host authority is aware of the person in their area. The first authority **should** ensure that satisfactory arrangements are made before the accommodation begins for any necessary support services which are provided locally, such as day care, and that clear agreements are in place for funding all aspects of the person's care and support.

19.33. In practice, the first local authority **may** enter into agreements to allow the authority where the accommodation is located to carry out functions on its behalf. This may particularly be the case where the

147 Care and Support (Ordinary Residence) (Specified Accommodation)) Regulations 2014

accommodation is located some distance away, and some functions can be performed more effectively locally. Local authorities **may** make arrangements to reimburse to each other, any costs occurred through such agreements. However, local authorities **should** take account of their on-going obligations towards the individual when arranging for such types of accommodation.

19.34. There may be occasions where a provider chooses to change the type of care which it provides, for instance to de-register a property as a care home and to redesign the service as a supported living scheme. Where the person remains living at the same property, and their needs continue to be met by the new service, then ordinary residence **should not** be affected, and the duty to meet needs will remain with the first authority. This will occur even if the person temporarily moves to another address whilst any changes to the property occur.

NHS accommodation

19.35. Where a person goes into hospital, or other NHS accommodation, there may be questions over where they are ordinarily resident, especially if they are subsequently discharged into a different local authority area. For this reason, the Care Act makes clear what should happen in these circumstances.

19.36. A person for whom NHS accommodation is provided is to be treated as being ordinarily resident in the local authority where they were ordinarily resident before the NHS accommodation was provided. This means that where a person, for example, goes into hospital, they are treated as ordinarily resident in the area where they were living before they went into hospital. This applies regardless of the length of stay in the hospital, and means that responsibility for the person's care and support does not transfer to the area of the hospital, if this is different from the area in which the person lived previously.

19.37. This requirement also applies to NHS accommodation in the devolved administrations. If a person who is ordinarily resident in England goes into hospital in Scotland, Wales or Northern Ireland, their ordinary residence will remain in England (in the local authority in which they resided before going into hospital) for the purposes of responsibility for the adult's care and support.

Mental health aftercare

19.38. Under section 117 of the Mental Health Act 1983, local authorities together with Clinical Commissioning Groups (CCGs)[148] have a duty to provide mental health aftercare services for people who have been detained in hospital for treatment under certain sections of the 1983 Act who are in need of such services.[149] These services must have the purposes of "meeting a need arising from or related to the person's mental disorder" and "reducing the risk of a deterioration of the person's mental condition and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder." The range of services which can be provided is broad.[150]

19.39. The duty on local authorities to commission or provide mental health aftercare rests with the local authority for the

[148] Regulations made under section 117 may impose the duty of the CCG on NHS England instead

[149] These are patients who leave hospital after being detained under section 3, admitted to a hospital under section 37, or transferred to a hospital under section 45A, 47 or 48

[150] For detailed information mental health after-care see the "Code of Practice Mental Health Act 1983 (updated version to be published for consultation shortly)"

area in which the person concerned was ordinarily resident immediately before they were detained under the 1983 Act, even if the person becomes resident in another area where they are detained, or on leaving hospital. The responsible local authority may change, if the person is ordinarily resident in another area immediately before a subsequent period of detention.

Other common situations

Temporary absences

19.40. Having established ordinary residence in a particular place, this **should not** be affected by the individual taking a temporary absence from the area.[151] The courts have held that temporary or accidental absences, including for example holidays or hospital visits in another area,[152] should not break the continuity of ordinary residence, and local authorities should take this into account.

19.41. The fact that the person may be temporarily away from the local authority in which they are ordinarily resident, does not preclude them from receiving any type of care and support from another local authority if they become in urgent need (see Annex J1 for further guidance regarding persons in "urgent need"). Local authorities have powers in the Care Act to meet the needs of people who are known to be ordinarily resident in another area, at their discretion and subject to their informing the authority where the person is ordinarily resident.

People with more than one home

19.42. Although in general terms it may be possible for a person to have more than one ordinary residence (for example, a person who divides their time equally between two homes), this is not possible for the purposes of the Care Act 2014. The purpose of the ordinary residence test in the Act is to determine which single local authority has responsibility for meeting a person's eligible needs, and this purpose would be defeated if a person could have more than one ordinary residence.

19.43. If a person appears genuinely to divide their time equally between two homes, it would be necessary to establish (from all of the circumstances) to which of the two homes the person has the stronger link. Where this is the case, it would be the responsibility of the local authority in which the person is ordinarily resident, to provide or arrange care and support to meet the needs during the time the person is temporarily away at their second home.

19.44. Further scenarios which may occur are set out in Annex J, and may be used by local authorities to support cases where there may be uncertainty as to an individual's ordinary residence.

Resolving ordinary residence and continuity of care disputes

19.45. In the majority of cases, determining ordinary residence should be straightforward. However, there will be occasions where a person's residency status is more complicated to define, and in such cases, disputes may arise between two or more local authorities as to which should be responsible for meeting that person's needs.

[151] Levene v Inland Revenue Commissioners (1928) AC 217

[152] Fox v Stirk 1970 2 QB 463

19.46. As required in the regulations, where disputes occur, local authorities **must** take all reasonable steps to resolve the dispute between the various parties. This may include one local authority agreeing responsibility, or bespoke agreements to share any costs involved in meeting the person's needs. Where disputes cannot be resolved through discussion, the Secretary of State or an appointed person may be required to determine disputes.

19.47. Disputes **should not** run on indefinitely. Local authorities **must** take all steps necessary to resolve the dispute themselves before making a referral for a determination. If having taken appropriate legal advice and considered the position they are still unable to resolve a particular dispute, they must apply for a determination. A determination by the Secretary of State or appointed person **should only** be considered as a last resort.

19.48. It is critical that the person does not go without the care they need, should local authorities be in dispute. One of the local authorities involved in the dispute **must** provisionally accept responsibility for the person at the centre of the dispute and be providing services. Where local authorities cannot agree which authority should accept provisional responsibility for the provision of services, *the Care and Support (Ordinary Residence Disputes) Regulations 2014*[153] provide that the local authority in which the person is living or is physically present **must** accept responsibility until the dispute is resolved. If the person is homeless, the authority in whose area that person is physically present must do so. The local authority which has accepted provisional responsibility is referred as the "the lead local authority".

19.49. The Secretary of State or appointed person will not make a determination unless there is evidence that one local authority has provisionally accepted responsibility for the provision of services. The provisional acceptance of responsibility by one local authority does not influence any determination made by the Secretary of State.

19.50. If a determination by the Secretary of State or an appointed person subsequently finds another local authority to be the authority of ordinary residence, the lead local authority can recover costs from the authority which should have been providing the relevant care and support.

19.51. The Secretary of State or appointed person cannot make determinations in relation to services that may be provided in the future. Local authorities should note that where disputes arise as set out in the regulations, the assessed needs of the person **should** be met during the period of dispute. Local authorities **should not** provide reduced packages of care while the dispute is being determined.

19.52. A question as to a person's ordinary residence can only arise where two or more local authorities are in dispute about the place of ordinary residence of a person. In such a case, the authorities may apply for a determination. Where the local authorities concerned are in agreement about a person's ordinary residence, but the person is unhappy with the decision, the person would have to pursue this with the authorities concerned, and could not apply to the Secretary of State or an appointed person for a determination.

[153] The Care and Support (Ordinary Residence Disputes) Regulations 2014. These regulations also apply to disputes in relation to continuity of care and provider failure (see chapters X and Y)

Process for seeking a determination

19.53. A local authority seeking a determination **should** make a request in writing to the Secretary of State or appointed person. The *Care and Support (Ordinary Residence Disputes etc.) Regulations 2014* set out the documents that must be submitted to the Secretary of State for this purpose. Applications for determinations must be submitted before or by the end of the period of four months during which local authorities have attempted to resolve the dispute themselves.

19.54. Where two or more local authorities fall into dispute of a person's ordinary residence, they should take all steps necessary to resolve the dispute locally. If, having taken appropriate legal advice, engaged in discussion and considered the position in the light of this guidance and regulations, as a last resort, the lead local authority **should** submit to the Secretary of State or appointed person, a statement of facts and the other documentation mentioned in the regulations. It should also provide evidence of the attempts it has made to engage with the other authority which is party to the dispute. If the Secretary of State or appointed person is satisfied that the lead local authority has done all it can to engage with the other authority, the Secretary of State or appointed person will, after warning the other local authority of his intention to do so, proceed to make a determination on the basis of the information provided by the lead local authority.

19.55. Where a lead local authority approaches another authority about a person's ordinary residence, but then does not continue engaging in a constructive dialogue to resolve the dispute with the other local authority, the other local authority can apply to the Secretary of State or appointed person for a determination. The other local authority **should** follow the steps set out in the regulations, including providing evidence of the attempts it has made to engage with the other authority as set out in the preceding paragraph.

19.56. The Secretary of State or appointed person will not allow ordinary residence disputes to run on indefinitely once they have been referred for a determination. The Secretary of State – or appointed person – once satisfied that the parties have had adequate opportunities to make representations, will proceed to make a determination. Any local authority failing to have due regard to a determination by the Secretary of State or appointed person, would put itself at risk of a legal challenge by the resident or their representative or the other local authorities to the dispute.

19.57. Local authorities may wish to seek legal advice before making an application for a determination, although they are not required to do so. If legal advice is sought, local authorities may, in addition to the required documentation, provide a separate legal submission. Where legal submissions are included, there should be evidence that the submissions have been exchanged between the local authorities in dispute.

19.58. All applications for Secretary of State determinations should be sent to the Department of Health at the address below:

Department of Health
Quality and Safety Team
Social Care Policy Division
Area 313B, Richmond House
79 Whitehall
London
SW1A 2NS

19.59. If during a determination of the ordinary residence dispute by the Secretary of State or appointed person, a local authority in dispute is asked to provide further information to the Secretary of State or appointed person, that local authority **must** provide that information without delay.

19.60. If the local authorities involved in the dispute reach an agreement whilst the Secretary of State is considering the determination, they **should** notify the Department of Health at the above address. Both parties must confirm that the dispute has been resolved after which the determination will be closed down.

19.61. The Department of Health makes available anonymised copies of determinations it has made.[154] Although these do not set a precedent, as each case must be considered in the light of its own particular facts, they may provide local authorities with useful guidance when faced with similar circumstances.

19.62. Disputes about a person's ordinary residence in connection with section 117 arising between a local authority in England and a local authority in Wales, can be referred to the Secretary of State or appointed person, or Welsh Minister for determination.

Reconsidering disputes

19.63. If further facts come to light after a determination has been made, if may be appropriate for the Secretary of State or appointed person to reconsider the original determination. As a consequence of this, a different determination may be substituted. For example, because of the first determination, local authority A has paid and amount to local authority B but because of the effect of the second determination, some or all of the amount paid by local authority A to local authority B was not required to be paid. In this situation local authority B must repay that sum to local authority A.

19.64. Any review of the determination must begin within three months of the date of the original determination. This is needed to ensure clarity and fairness in the process and minimise the amount of time taken for determinations to be made.

Financial adjustments between local authorities

19.65. Sometimes a local authority has been paying for a person's care and support, but it becomes apparent that the person is in fact ordinarily resident elsewhere. In these circumstances the local authority which has been paying for that person's care can reclaim the costs from the local authority where the person was ordinarily resident.

19.66. This can occur in cases where it is not clear initially where the person is ordinarily resident. In order to ensure that the individual does not experience any delay to their care due to uncertainty over their ordinary residence, local authorities **should** be able to recover any losses due to initial errors in deciding where a person is ordinarily resident. This also extends to costs spent supporting the carer of the person whose ordinary residence was in dispute.

19.67. However it does not apply where the local authority has chosen to meet the person's needs in the knowledge they were ordinarily resident elsewhere. If a determination has been revised as referred to in the paragraphs above that covers reconsideration of dispute, and because of the first determination, local authority A has paid an amount to local authority B, but because of the effect of the second

[154] https://www.gov.uk/government/collections/ordinary-residence-pages

determination, some or all of the amount paid by local authority A to local authority B was not required to be paid, local authority B must repay that sum to local authority A.

The types of settings and scenarios where these issues arise

19.68. The following annexes signposts other areas of legislation and guidance which are of relevance to ordinary residence. It provides information and scenarios in which a person's ordinary residence may be an issue. It also provides information regarding other legislation under which an ordinary residence determination can be sought.

Annex J1 – Persons in urgent need.

Annex J2 – People who are party to deferred payment agreements.

Annex J3 – People who are accommodated under the 12 week property disregard.

Annex J4 – People who are arranging and paying for their own care.

Annex J5 – NHS Continuing Health Care.

Annex J6 – British citizens resuming permanent residence in England after period abroad.

Annex J7 – Armed forces veterans and the families of armed forces personnel.

Annex J8 – Young people in transition from children's services to adult care and support.

Annex J9 – Other provisions under which an ordinary residence determination can be sought.

20. Continuity of care

This section provides guidance on:

- *Sections 37-38 of the Care Act 2014;*
- *The Care and Support (Continuity of Care) Regulations 2014.*

This chapter covers:

- Making an informed decision to move to a different local authority; confirming intention to move; supporting people to be fully involved in the process;
- What local authorities take into account when they are planning the move with people;
- How to ensure continuity of the person's care if the second local authority has not carried out an assessment ahead of the day of the move;
- What happens if a person does not move.

20.1. People with care and support needs may decide to move home just like anyone else, such as to be closer to family or to pursue education or employment opportunities, or because they want to live in another area. Where they do decide to move to a new area, it is important that the person's well-being is maintained, and ensuring that their care and support is in place during the move will be key to doing this.

20.2. In circumstances where a person is receiving local authority support and moves within their current local authority (for example, moving between homes in the same area), they would remain ordinary resident within that authority and it **must** continue to meet their needs. Where the person chooses to live in a different local authority area, the local authority that is currently arranging care and support and the authority to which they are moving **must** work together to ensure that there is no interruption to their care and support.

20.3. The "continuity of care" procedures set out the processes local authorities **must** follow to ensure that the person's care and support continue, without disruption, during the move. These procedures also apply where the person's carer is receiving support and is moving with the individual. In addition to meeting their responsibilities in these sections, authorities are reminded that the other requirements of Part 1 of the Act apply during this process, and authorities **should** refer to the guidance on wellbeing, prevention, information and advice, integration, assessment and eligibility, and care and support planning.

20.4. The aim of this process is to ensure that the person with care and support needs, and any carer moving with them, will be able to move with the confidence that

arrangements will be in place on the day of the move. To achieve this local authorities have to place the adult and their carer, if he or she is also moving, at the centre of the process. Local authorities should work together and maintain contact with the adult and carer throughout the process.

Definitions

20.5. For the purpose of this chapter the following meaning applies:

- 'Adult' means the person who needs care and support, and is or is intending to move to another authority.
- 'Carer(s)' refers to any carer(s) that the person may have who has decided to move with the adult.
- 'New carer' refers to any new person who will take over the caring role when the adult moves to the new area.
- 'Person' or 'individual' refer to both the adult needing care and support and the carer.
- 'First authority' means the local authority where the person lives and is ordinarily resident prior to moving.
- 'Second authority' means the local authority the person is wishing to move to.
- 'Assessment' refers to both a needs assessment and a carer's assessment.

Making an informed decision to move to a different local authority

20.6. When an adult with care and support needs and any carer, if moving with the adult, are contemplating the possibility of moving, they **must** be provided with information and advice about the care and support available in the authority they are thinking of moving to. A person may want to find out information about the care and support available in two or more local authorities. In any case where a local authority is approached by an individual considering moving to that area, the local authority **should** provide relevant information and advice, in accordance with its general duties under the Care Act (see also Chapter 3).

20.7. Local authorities may find out about the person's intention to move from the individual directly or through someone acting on their behalf, who may contact either the first authority or the second authority to tell them of their intentions. If the person has approached the first authority and informed them of their intention to move, the first authority **should** make contact with the second authority to tell them that the person is planning on moving to their area.

20.8. When the second authority has been informed of the person's intentions, it **must** provide the adult and the carer if also intending to move, with information about the care and support available in its area. This **should** include but is not limited to, details about:

- the types of care and support available to people with similar needs;
- support for carers;
- the local care market and organisations that could meet their needs;
- the local authority's charging policy, including any charges which the person may be expected to meet for particular services in that area.

20.9. Where the person moving currently receives a direct payment to meet some or all of their needs, the first authority **should** advise the person that they will need to consider how to meet any contractual

arrangements put in place for the provision of their care and support. For instance, any contracts a person may have with personal assistants who may not be moving with them.

20.10. Both authorities can provide the adult and their carer with relevant information or advice to help inform their decision. When providing relevant information and advice, local authorities **should** guard against influence over the final decision. The authorities can, for example, provide advice on the implications for the individual's care and support (and their carer's support), but the final decision on whether or not to move is for the adult and, if relevant, the carer to make.

Confirming the intention to move

20.11. When the person has confirmed their intention to move with the second authority, the authority **must** assure itself that the person's intention is genuine. This is because the duties in the Act flow from this point.

20.12. To assure itself that the intention is genuine, the second authority **should**:

- establish and maintain contact with the person and their carer to keep abreast of their intentions to move;
- continue to speak with the original authority to get their view on the person's intentions;
- ask if the person has any information or contacts that can verify their intention.

Supporting people to be fully involved

20.13. The person may request assistance from either the first or second authority in helping them understand the implications of their move on their care and support, and the authority **should** ensure that they have access to all relevant information and advice. This **should** include consideration of the need for an independent advocate in helping the person to weigh up their options (see chapter 7 on advocacy).

20.14. There will be situations where the adult lacks capacity to make a decision about a move, but the family wish to move the adult closer to where they live.

20.15. The local authority **must** in these situations carry out supported decision making, supporting the adult to be as involved as possible and **must** carry out a capacity assessment and take "best interests" decisions. The requirements of the Mental Capacity Act 2005 apply to all those who may lack capacity.[155]

People receiving services under children's legislation

20.16. The continuity of care provisions will not apply for people receiving services under children's legislation. Where such a person has had a transition assessment (see chapter 16) but is moving area before the actual transition to adult care and support takes place, the first local authority **should** ensure that the second is provided with a copy of the assessment and any resulting transition plan. Similarly, where a child's carer is having needs met by adult care and support in advance of the child turning 18 (following a transition assessment), the first local authority **should** ensure that the second is provided with a copy of the assessment and the carer's support plan.

[155] https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice http://www.legislation.gov.uk/ukpga/2005/9/contents

Preparing for the move

20.17. Once the second authority has assured itself that the adult's and where relevant the carer's intentions to move are genuine, it **must** inform the first authority. At this stage, both authorities **should** identify a named staff member to lead on the case and be the ongoing contact during the move. These contacts **should** lead on the sharing of information and maintaining contact on progress towards arranging the care and support arrangements for the adult and support for the carer.

20.18. The second authority **should** provide the adult and carer with any relevant information that it did not supply when the person was considering whether to move.

20.19. When the first authority has been notified by the second authority that it is satisfied that the person's intention to move is genuine, the first authority **must** provide it with:

- a copy of the person's most recent care and support plan;
- a copy of the most recent support plan where the person's carer is moving with them; and
- any other information relating to the person or the carer (whether or not the carer has needs for support), that the second authority may request. The information requested should be reasonable and should include information about the person's financial assessment.

Assessment and care and support planning

20.20. If the person has substantial difficulty and requires help to be fully involved in the assessment or care planning process and there is no other suitable person who can support them, the Act requires that they **must** be provided with an independent advocate. In this case the advocate **should** be provided by the second authority because it takes over the responsibility for carrying out the assessment and care planning with the individual. As an understanding of the new area and its community may be important, the advocacy or advocate **should** wherever possible, and subject to the person's preference and advocate's view, be from the area where the person is moving to.

20.21. The second authority **must** contact the adult and the carer to carry out an assessment and to discuss how arrangements might be made. The second authority **should** also consider whether the person might be moving to be closer to a new carer and whether that new carer would benefit from an assessment.

20.22. Throughout the assessment process, the first authority **must** keep in contact with the second authority about progress being made towards arranging necessary care and support for the day of the move. The first authority **must** also keep the adult and the carer informed and involved of progress so that they have confidence in the process. This **should** include involving them in any relevant meetings about the move. Meetings **may** not always be face-to-face where there are long distances between the local authorities involved. Having this three-way contact will keep the individuals at the centre of the process, and help ensure that arrangements are in place on the day of the move.

20.23. All assessments, for adults with care and support needs and carers, **must** be carried out in line with the processes described in chapter 6 of this guidance. The adult and the carer, and anyone else requested, **must** be involved in the respective assessments. The assessments **must** identify the person's needs and the outcomes they want to achieve. These could be the same as the outcomes the first authority was meeting or they could have changed with the person's circumstances.

20.24. The assessment **must** consider whether any preventative services or advice and information would help either person meet those outcomes. The assessments **should** also consider the individuals' own strengths and capabilities and whether support might be available from family, friends or within the new community to achieve their outcomes. In carrying out the assessments, the second authority **must** take into account the previous care and support plan (or support plan) which has been provided by the first authority.

20.25. Following the assessment and after determining whether the adult or carer has eligible needs, the second authority **must** involve the adult, the carer and any other individual the person requests, in the development of their care and support plan, or the carer's support plan as relevant, and take all reasonable steps to agree the plan. The development of the care and support plan or carer's support plan **should** include consideration of whether the person would like to receive a direct payment. Further guidance on care and support planning is provided in chapter 10.

20.26. The second authority **should** agree the adult's care and support plan and carer's support plan, including any personal budget, in advance of the move to ensure that arrangements are in place when the person moves into the new area. This **should** be shared with the individuals before the move so that they are clear how their needs will be met, and this **must** also set out any differences between the person's original plan and their new care and support or support plan.

20.27. The care and support plan **should** include arrangements for the entire day of the move. This **should** be agreed by the adult, the carers (existing and new as relevant) and both authorities. The first authority **should** remain responsible for meeting the care and support needs the person has in their original home and when moving. The second authority is responsible for providing care and support when the person and their carer move in to the new area. The person moving is responsible for organising and paying for moving their belongings and furniture to their new home.

20.28. In considering the person's personal budget, the second authority **should** take into consideration any differences between the costs of making arrangements in the second authority compared with the first authority and provide explanation for such a difference where relevant. Where there is a difference in the amount of the personal budget, this should be explained to the person. It **should** also look to ensure that the person's direct payment is in place in a timely manner, for example, the person moving may have a personal assistant that is also moving and will requiring paying.

Integration

20.29. The adult and their carer may have health needs as well as care and support needs. Both local authorities **should** work with their local Clinical Commissioning Groups (CCGs) to ensure that all of the adult's and carer's health and care needs are being

dealt with in a joined up way. Guidance to CCGs is set out in *Who Pays.*[156]

20.30. If the person also has health needs, the second authority **should** carry out the assessment jointly with their local CCG. Alternatively, if the CCG agrees, the second authority can carry out the assessment on its behalf. Having a joint assessment ensures that all of the person's needs are being assessed and the second authority can work together with the CCG to prepare a joint plan to meet the adult's care and support and health needs. Where relevant, the local authority may use the cooperation procedures set out in the Care Act to require cooperation from the CCG, or other relevant partner, in supporting with the move. More detail on these procedures is set out in chapter 15.

20.31. Providing joint care and support and health plans will avoid duplication of processes and the need for multiple monitoring regimes. Information **should** be shared as quickly as possible with the minimum of bureaucracy. Local authorities **should** work alongside health and other professionals where plans are developed jointly to establish a 'lead' organisation which undertakes monitoring and assurance of the combined plan. Consideration **should** be given to whether a person should receive a personal budget and a personal health budget to support integration of services. More information about personal health budgets can be found in chapter 11.

Equipment and adaptations

20.32. Many people with care and support needs will also have equipment installed and adaptations made to their home. Where the first authority has provided equipment, it **should** move with the person to the second authority where this is the person's preference and it is still required. This **should** apply whatever the original cost of the item.

20.33. As adaptations are fitted based on the person's accommodation, it may be more practicable for the second authority to organise the installation of any adaptations. For example, walls need to be checked for the correct fixing of rails. The second authority **should** discuss this with the individual and the first authority. Further information and examples are provided in the annex.

20.34. Where the person has a piece of equipment on long-term loan from the NHS, the second local authority **should** discuss with the relevant NHS body. The parties are jointly responsible for ensuring that the person has adequate equipment with them when they move (see chapter 15 on cooperation and integration).

Copy of documentation

20.35. The second authority **must** provide the adult and the carer and anyone else requested with a copy of their assessments. This **must** include a written explanation where it has assessed the needs as being different to those in the care and support plan or the carer's support plan provided by the first authority. The second authority **must** also provide a written explanation if the adult's or carer's personal budget is different to that provided by the first authority.

[156] More detail can be found in NHS (August 2013) *Who Pays?*

Disputes about ordinary residence

20.36. Where local authorities are in dispute over the person's ordinary residence status, the authorities who are parties to the dispute **must not** allow their dispute to prevent, delay or adversely affect the meeting of the person's needs. Where the authorities cannot resolve their differences, the steps described in chapter 20 on ordinary residence disputes **must** be taken to ensure that the person is unaffected by the dispute and will continue to receive care for the needs that were identified by the first local authority.

Appealing decisions

20.37. It is important that individuals have confidence in the assessment process and the wider care and support system. Therefore any individual **should** be able to make a complaint and challenge decisions where they believe a wrong decision has been made in their case. Current complaints provision for care and support is set out in regulations Local Authority Social Services and NHS Complaints Regulations 2009, made under powers in Sections 113 to 115 of the Health and Social Care (Community Health and Standards Act) 2003. The provisions of the regulations mean that anyone who is dissatisfied with a decision made by the local authority would be able to make a complaint about that decision and have that complaint handled by the local authority. The local authority **must** make its own arrangements for dealing with complaints in accordance with the Local Authority Social Services and National Health Service (England) Complaints Regulations 2009 No. 309.

What happens where the second authority has not carried out an assessment?

Interim arrangements

20.38. The second authority **must** have made contact with the adult and their carer in advance of the move. However, there may be occasions where the authority has not carried out the assessments or has completed the assessments but has not made arrangements to have support in place. This might happen where the second authority wants to assess the person in their new home and consider if their needs have changed, for example because they have started a new job or are now in education, or they have moved to be closer to family.

20.39. Where the full assessment has not taken place prior to the move, the second authority **must** put in place interim arrangements that meet the adult's or carer's needs for care and support which were being met by the first authority. These interim arrangements **must** be in place on the day of the move and continue until the second authority has carried out its own assessment and put in place a care and support plan which has been developed with the person.

20.40. The second authority **must** involve the adult and carer, and any relevant independent advocate, as well as any other individual that either person may request, when deciding how to meet the care and support needs in the interim period. The authority **must** take all reasonable steps to agree these interim plans with the relevant person.

Matters local authorities must have regard to when planning interim arrangement

20.41. In developing the interim care and support plan, the second authority must have regard to the following matters:

- **Care and support plan**: The adult's care and support plan, and the carer's support plan if the carer is also moving, which were provided by the first authority. The second authority **should** discuss with the adult and the carer how to meet their eligible needs and any other needs that the first authority was meeting that are not deemed as eligible but were included in either plan.
- **Outcomes**: Whether the outcomes that the adult and the carer were achieving in day-to-day life in their first authority are the outcomes they want to achieve in the new authority, or whether their aims have changed because of the move.
- **Preferences and views**: The preferences and views of the adult and the carer on how their needs are met during the interim period.

20.42. The second authority **must** also consider any significant difference to the person's circumstances arising from a change in any of the following matters, where that change may impact on the individual's wellbeing:

- **Support from a carer**: Whether the adult is currently receiving support from a carer and whether that carer is also moving with them. Where the carer is not moving the second authority **must** consider how to meet any needs previously met by the carer, even if the first authority was not providing any service in relation to those needs.
- **Suitability of accommodation**: Where the new accommodation is significantly different from the original accommodation and this changes the response needed to meet the needs. For example, the adult may move from a ground floor flat to a first floor flat and now need assistance to manage stairs.
- Where the person has received **equipment or had adaptations** installed in their original home by the first authority, the procedures as set out in paragraphs 20.32 to 20.34 and Annex H **should** be followed.
- **Access to services and facilities**: Where the services and facilities in the new area are different, and in particular fewer than those in the originating area; for example access to food deliveries or other food outlets, access to public transport, or access to leisure or recreational facilities. A move from an urban to a rural environment could bring this about.
- **Access to other types of support**: Where the person was receiving support from friends, neighbours or the wider community and this may not readily be available in their new area.
- Where the person makes **use of universal services** such as council day services, drop in support, or befriending schemes, and these are not available in the new area.

20.43. If the person has substantial difficulty in being fully involved in the assessment, care planning or review process the second authority **should** consider whether the person needs an independent advocate or whether their original advocate is moving with them (see chapter 7 on advocacy).

20.44. The second authority **should** ascertain this information from relevant documentation sent to them or by talking to the individuals involved, and the first authority.

20.45. The adult or carer **should** not be on an interim care and support (or support) package for a prolonged period of time as a tailored care and support (or support) plan **must** be put in place. The second authority **should** carry out the assessment in a timely manner.

When the adult does not move or the move is delayed

20.46. There are a range of reasons why a person might not move on the designated day. This may be, for example, because they have become unwell, there has been a delay in exchanging contracts. Where there has been a delay because of unforeseen circumstances, both authorities **should** maintain contact with the person to ensure that arrangements are in place for the new date of the move.

20.47. Where the person has changed their mind about moving and decides to remain resident in the area of the first authority, they will normally continue to be ordinarily resident in that area and so the first authority will remain responsible for meeting the person's and the carer's needs. The second authority may already have put arrangements in place before the person changed their mind. Where the second authority is putting in place interim arrangements and the person decides not to move, the second authority can claim the cost of putting in place these arrangements from the first authority.

21. Cross-border placements

This chapter provides guidance on:

- *Section 39 and Schedule 1 of the Care Act 2014;*
- *The Care and Support (Cross-border Placements and Business Failure: Temporary Duty) (Dispute Resolution) Regulations 2014.*

This chapter covers

- Local authorities' (in Northern Ireland, Health and Social Care (HSC) Trusts) responsibilities with respect to placing individuals into residential care accommodation in different territories of the UK;
- Those matters local authorities (or HSC Trusts) should have regard to when considering, planning and carrying out a cross border placement;
- Process for resolving disputes that may arise following a cross border placement.

Definitions

21.1. **First authority** – the local authority (or Health and Social Care (HSC) Trust in Northern Ireland) in which the individual is ordinarily resident/that local authority (or HSC Trust) the individual is residing in prior to the cross-border placement occurring.

21.2. **Second authority** – that local authority (or HSC Trust) into whose area the individual is placed/the local authority (or HSC Trust) in which the individual is physically present following the cross-border placement.

Principles and purpose of cross border placements

Purpose

21.3. People's health and wellbeing are likely to be improved if they are close to a support network of friends and family. In a small number of cases an individual's friends and family may be located in a different country of the UK from that in which they reside.

21.4. In the production of a care and support plan,[157] the authority[158] and the individual concerned may reach the conclusion that the individual's wellbeing is best achieved by a placement into residential care in a different country of the UK. Schedule 1 of the Care Act sets out certain principles governing cross border residential care placements.

21.5. As a general rule, responsibility for individuals who are placed in cross-border residential care remains with the first authority. This guidance sets out how the first and second authorities should work together in the interests of individuals receiving care and support through a cross-border residential placement.

Principles

21.6. The four administrations of the UK (England, Scotland, Wales and Northern Ireland) have worked together to agree Schedule 1 and this accompanying guidance. Underpinning this close co-operation have been two guiding principles that those involved in making cross-border residential care placements should abide by.

A person-centred process

21.7. The underlying rationale behind Schedule 1 is to improve the wellbeing of individuals who may benefit from a cross-border residential care placement. If a local authority, in creating an individual's tailored care and support plan, believes a cross-border placement could be appropriate they **should** discuss this with the individual and/or their representative. In making the resulting arrangements, authorities **should** and in certain cases, **must** have regard to views, wishes, feelings and beliefs of the individual (see chapter 1 on wellbeing).

Reciprocity and cooperation

21.8. The smooth functioning of cross-border arrangements is in the interests of all parties – and most importantly the interests of those in need of residential care – in all authorities and territories of the UK. It is not envisaged that authorities will suffer added financial disadvantage by making cross-border placements. All authorities are expected to co-operate fully and communicate properly. In the circumstances where individuals may need care and support from the second authority (e.g. in the event of unforeseen and urgent circumstances such as provider failure) such care **must** be provided without delay (arrangements to recoup costs can always be made subsequently).

Cross-border residential care placements

21.9. Authorities **should** follow the following broad process for making cross-border residential care placements. Authorities may wish to adapt this process to fit their needs; but in general, authorities should aim to follow, as far as possible, the processes set out below.

21.10. These steps **should** be followed whenever a cross-border residential placement is arranged by an authority, regardless of whether it is paid for by that authority or by the individual.

[157] In Wales, the requirement to prepare a care and support plan will be commenced under the Social Services and Well-being (Wales) Act in April 2016. Until then, references in this document to "care and support plans" should be understood to refer to existing care management arrangements

[158] Authority = Local Authority in England, Wales and Scotland. HSC Trust in Northern Ireland

Step One: Care and support planning

21.11. A need for a cross-border residential care placement will be determined as part of the overall care and support plan prepared by the local authority, in partnership with the individual concerned.

21.12. Authorities **should**, in assessing care and support needs, establish what support networks (e.g. friends and family) the individual concerned has in their current place of residence.[159] In discussions with the individual and other relevant parties, enquiries **should** be made as to whether a support network exists elsewhere. Alternatively, the individual (or their family or friends) may proactively raise a desire to move to an area with a greater support network[160] or to move to another area for other reasons.

21.13. Authorities **should** give due consideration as to how to reflect cross-border discussions with the individual in the care and support planning process (see chapter 10 on care and support planning for further information).

21.14. Where it emerges that residential care in a different territory of the UK may be appropriate for meeting the person's needs, the authority **should** inform the individual concerned (and their representative) of the potential availability of a cross-border placement if the individual (or their representative) has not already raised this themselves.

21.15. Should the individual wish to pursue the potential for a cross-border placement, the authority will need to consider carefully the pros and cons. Questions the authority may wish to address could include:

- Would the support network in the area of the proposed new placement improve (or at least maintain) the individual's wellbeing?
- What effect might the change of location and/or environment have on the individual's wellbeing? How well are they likely to adapt to their new surroundings? For example, are there relevant cultural issues? Might the physical environment be significantly different?
- Is the individual in receipt of any specialist health care? Will the locality of the proposed new placement allow for the satisfactory continuation of this treatment?
- Where the individual lacks the mental capacity to decide where to live, who is the individual's representative? The representative should be consulted and in certain cases there will be a duty to involve such persons in carrying out a needs assessment.[161]

21.16. With the permission of the individual concerned (or their representative), the authority **should** approach the friends and/or family of the individual concerned who are resident in the area of the proposed new

159 Cross border placements could occur where a person is living at home or where they are already living in residential care accommodation

160 See section 9(5) of the Care Act as to the duties on English local authorities in relation to the assessment of adults' needs for care and support. This includes a duty to involve the adult, any person whom the adult asks the authority to involve, or where the adult lacks capacity to ask the authority to involve any person who appears to the authority to be interested in the adult's welfare. English authorities **must** also consider whether and, if so, to what extent, matters other than the provision of care and support could contribute to the achievement of the outcomes the adult wishes to achieve

161 See clause 9(5) of the Act as to the duties on English local authorities to involve persons in carrying out needs assessments.

placement (and, any friends and/ or family in the area of their current residence) to seek their views of the perceived benefits of the placement and any concerns they may have.

21.17. Should a cross-border placement still appear to be in the interests of the individual's wellbeing (including wellbeing relating to health), the authority **should** take steps to investigate which providers in the proposed new placement area exist and which are likely to be able to meet the needs of the individual. The authority **should** conduct all necessary checks and exercise due diligence as it would with any other residential care placement.

21.18. In preparing a care and support plan, local authorities should (and in England **must**) involve the individual, any carer of the individual, and any person whom the individual asks the authority to involve or, where the person lacks capacity to ask the authority to involve others, any person who appears to the authority to be interested in the individual's welfare. In involving the individual, the authority **must** take all reasonable steps to reach agreement with the individual about how the authority should meet the needs in question.

21.19. The individual **should** be kept informed and involved throughout the process. Their views on suitable providers **should** be sought and their agreement achieved before a final decision is made.

21.20. The individual **should** also be informed of the likelihood of the first authority giving notification of the placement to the second authority, seeking that authority's assistance with management of the placement or with discharge of other functions, for example reviews, and of what this would involve. Where, for example, this would involve the sharing of information or the gathering of information by the second authority on behalf of the first, (see next section) the individual **should** be informed of this at the outset and their consent sought.

21.21. Authorities **should** strive to offer people a choice of placements.[162]

Step Two: Initial liaison between "first" and "second" authority

21.22. Once the placement has been agreed in principle (with the individual concerned and/or their representative) and the authority has identified a potential provider they **should** immediately contact the authority in whose area the placement will be made (the "second authority").

21.23. The first authority **should**:

- notify the second authority of their intention to make a cross border residential care placement;
- provide a provisional date on which they intend for the individual concerned to commence their placement;
- provide the second authority with details of the proposed residential care provider;
- seek that authority's views on the suitability of the residential accommodation.

21.24. The initial contact can be made by telephone, but **should** be confirmed in writing.

21.25. The second authority has no power to "block" a residential care placement into its area as the first authority contracts

[162] In Wales, local authorities should refer to the Guidance Circular NAFWC 46/2004 and Welsh Health Circular 2004(066): Updated Guidance on National Assistance Act 1948 (Choice of Accommodation) Directions 1993. From April 2016 this will be superseded by arrangements under the Social Services and Well-being (Wales) Act

directly with the provider. In the event of the second authority objecting to the proposed placement, all reasonable steps **should** be taken by the first authority to resolve the issues concerned before making the placement.

21.26. Following the initial contact and any subsequent discussions (and provided no obstacles to the placement taking place have been identified) the first authority **should** write to the second authority confirming the conclusions of the discussions and setting out a timetable of key milestones up to the placement commencing.

21.27. The first authority **should** inform the provider that the placement is proposed – in the same way as with any residential care placement. The first authority should ensure that the provider is aware that this will be a cross-border placement.

21.28. The first authority **should** contact the individual concerned and/or their representative to confirm that the placement can go ahead and to seek their final agreement. The first authority **should** also notify any family/friends that the individual has given permission and/ or requested be kept informed.

21.29. The first authority **should** make all those arrangements that it would normally make in organising a residential care placement in its own area.

21.30. A key necessity is for the first authority to consider with the second authority, arrangements for the on-going management of the placement and assistance with the performance of relevant care and support functions.

21.31. The first authority will retain responsibility for the individual and the management and review of their placement. As such, the authority's responsibilities to the individual are no different than they would be if the individual was placed with a provider in the authority's own area.

21.32. However, it is recognised that the practicalities of day-to-day management of a placement potentially hundreds of miles distant from the authority may prove difficult.

21.33. As such, the first authority may wish to make arrangements for the second authority to assist with the day-to-day placement management functions for example where urgent in-person liaison is required with the provider and/or individual concerned, or with regular care reviews which are for the first authority to perform (in accordance with its statutory obligations)[163] and may not be delegated, but with which the second authority may be able to assist (e.g. by gathering information necessary for the review and passing this to the first authority to make a decision).

21.34. It **should** be made clear that responsibility for exercising the functions remains with the first authority (they are obtaining assistance with the performance of these functions).

21.35. Any such arrangement **should** be detailed in writing – being clear as to what role the second authority is to play and for how long. Clarity should also be provided on the regularity of any reporting to the first authority.

Step Four: Confirmation of placement

21.36. When the placement has been confirmed, the first authority **should** notify the second authority and summarise in writing all the arrangements made with the second authority for assistance with on-going placement management and other matters.

[163] See clause 27 of the Act as to the review of care and support plans by English local authorities

The first authority **should** also confirm the date at which the placement will begin. The second authority **should** acknowledge receipt of these documents/information and its agreement to the arrangements in writing.

21.37. The first authority **should** provide the individual concerned and/or their representative with contact details (including whom to contact during an emergency) for both the first and second authority.

21.38. If required, it is expected that the first authority will be responsible for organising and the costs of suitable transport to take the individual and their belongings to their new placement.

21.39. As would be the case normally, the first authority will normally be responsible for closing off previous placements or making other necessary arrangements regarding the individual's prior residence.

Other issues to be considered during the organisation of a placement

Timeliness of organising and making a placement

21.40. Steps one to four **should** be conducted in a timely manner; the time taken **should** be proportionate to the circumstances.

Self-arranged placements

21.41. This guidance does not apply to individuals who arrange their own care. Individuals who arrange and pay for their own care will normally become ordinarily resident in and/or the responsibility of the area to which they move.

21.42. This guidance does apply to individuals who pay for their own care where that care is arranged by the local authority. The principles described in the Care Act for how local authorities assist people who pay for their care apply equally to cross-border arrangements.

Issues that may arise once a placement has commenced

Where the individual requires a stay in NHS accommodation

21.43. Should the individual placed cross-border need to go into hospital for any period of time then this stay will not interrupt the position regarding ordinary residence or responsibility deemed under Schedule 1.

21.44. If, while the individual is in hospital, a "retention" fee is payable to the care provider to ensure the individual's place is secured, this will be the responsibility of the first authority.

Where the individual requires NHS funded nursing care

21.45. Should the individual being placed require NHS-funded nursing care, the arrangements for delivering this **should** be discussed between the first authority, the NHS body delivering the care, the NHS body funding the care (if required) and the residential care provider prior to the placement commencing.

21.46. Where the need for nursing care becomes evident after the placement has commenced, the relevant authorities **should** work together to ensure this is provided without delay.

21.47. The four administrations of the UK have reached separate bilateral agreements as to which administration shall bear the cost of NHS funded nursing care required for individuals placed cross-border into residential care.

21.48. In the event of cross-border placements between England and Scotland or between England and Northern Ireland (in either direction) the health service of the country of the first authority will be responsible for nursing costs. (In England therefore, the individual's responsible Clinical Commissioning Group will pay the costs. The NHS standing rules have been amended to make this responsibility clear therefore individual CCG consent is not required but the CCG **should** be informed of the arrangements being made and of the expected costs they are now likely to incur).

21.49. In the event of a cross-border placement between England and Wales (in either direction), the second authority's health service will be responsible for the costs of NHS nursing care. However, in the event of a cross-border placement between Wales and Scotland, Wales and Northern Ireland, or between Scotland and Northern Ireland, the first authority's health service will retain responsibility for the costs of NHS nursing care.

Where the individual's care needs change during the placement

21.50. In the event that an individual's care and support needs change during the course of the placement, these **should** be picked up in the course of a review and the care and support plan amended as needed.

21.51. The first authority retains responsibility for review and amendment of the individual's care and support plan, although it may have agreed with the second authority that the latter will assist it in certain ways. In this case, clarity and communication will be important as to each authority's roles. (see chapter 13 for more information on reviews of care and support plans).

Handling complaints

21.52. If the complaint relates to the care provider, it should normally be made to the provider in the first instance and dealt with according to the complaints process of the provider as governed by the applicable legislation, which will normally be the legislation of the administration into which the individual has been placed.

21.53. If the complaint relates to NHS-provided care, it should be dealt with by either the service provider or service commissioner. The service provider and service commissioner should discuss and agree which of them should lead on the complaint.

21.54. Complaints regarding the first authority should be dealt with by the first authority. As should complaints regarding the care and support plan.

21.55. Complaints regarding the second authority should be dealt with by the second authority.

21.56. If referral to the health ombudsmen is necessary this should be made to the ombudsmen with responsibility for the provider or authority that is the subject of the complaint.

21.57. See subsequent section for how to deal with a dispute that might arise between two or more local authorities.

Reporting arrangements

21.58. There is no legal requirement for local authorities to notify national authorities that a cross-border placement has taken place.

21.59. However, as UK-wide cross-border placements will generally be a new occurrence, it will be sensible to record the number of placements occurring to best inform future application of the policy.

21.60. Therefore, authorities **should** record the number of placements made into their area from other territories of the UK and vice versa.

Disputes between authorities

21.61. If authorities have regard to and apply the suggested process and procedures outlined above and, more importantly, if first and second authority work together in a spirit of reciprocity and cooperation and promptly communicate in order to ensure matters go smoothly, then there should be no need for dispute resolution.

21.62. A dispute is most likely to occur because of lack of communication or following a communication breakdown/ misunderstanding between first and second authority during the process of arranging the placement.

21.63. The four administrations of the UK have worked together on the contents of specific regulations governing the process of resolving a dispute.

21.64. These regulations include provision to state:

- A dispute **must not** be allowed to prevent, interrupt, delay or otherwise adversely affect the meeting of an individual's care and support needs.
- The authority in whose area the individual is residing at the time the dispute arises is the lead authority for the purposes of duties relating to coordination and management of the dispute.

21.65. In the event of a dispute between two authorities where the individual is living in the area of one of those authorities when the dispute is referred, the Minister/Northern Ireland Department (NID) in whose jurisdiction that authority sits would determine the dispute.

21.66. In the event of other disputes between authorities, the Ministers/NID in whose jurisdictions those authorities sit would decide between themselves as to who would determine the dispute.

21.67. Before a dispute is referred to the relevant individual, the local authorities concerned must take a number of steps.

21.68. The lead authority **must**:

- Co-ordinate the discharge of duties by the authorities in dispute.
- Take steps to obtain relevant information from those authorities.
- Disclose relevant information to those authorities.

21.69. Authorities in dispute **must**:

- Take all reasonable steps to resolve the dispute between themselves.
- Co-operate with each other in the discharge of their duties.

21.70. Each authority in dispute must:

- Engage in constructive dialogue with other authorities to bring about a speedy resolution.

- Comply with any reasonable request made by the lead authority to supply information.

21.71. The regulations specify the contents of a dispute referral as follows. When a dispute is referred, the following **must** be provided:

- A letter signed by the lead authority stating that the dispute is being referred.
- A statement of the facts.
- Copies of related correspondence.

21.72. The statement of facts **must** include:

- Details of the needs for care and support of the individual to whom the dispute relates.
- Which authority, if any, has met those needs, how they have been met and the relevant statutory provision.
- An explanation of the nature of the dispute.
- Any other relevant steps taken in relation to the individual.
- Details of the individual's place of residence and any former relevant residence.
- Chronology of events leading up to the dispute.
- Details of steps authorities have taken to resolve dispute.
- Where the individual's mental capacity is relevant, relevant supporting information.

21.73. The authorities in dispute may make legal submissions and if they do, they must send a copy to the other authorities in dispute, and provide evidence that they have done so.

21.74. The Responsible Person (i.e. Minister or Northern Ireland Department) to whom the dispute has been referred **must**:

- Consult other responsible persons (i.e. Ministers or NI Department) in determining the dispute
- Notify those responsible persons of their determination.

Provider failure

21.75. In the event that a provider with which cross-border arrangements for an individual have been made or funded fails and is unable to carry on the care activity as a result, the authority in whose area that individual's care and support needs were being met has duties to ensure those needs continue to be met for so long as that authority considers it necessary. In the case of residential placements, as the first authority will normally continue to be responsible for the individual, it **should** resume responsibility as soon as possible. The temporary duty to meet needs in the event of provider failure will apply to authorities in England and Northern Ireland but is not expected to apply to local authorities in Wales until April 2016.

21.76. In the event of provider failure in Scotland, local authorities are required to perform duties provided for under Part 2 of the Social Work (Scotland) Act 1968 as specified in regulations made by the Secretary of State under paragraphs 1(7), 2(10) and 4(6) of Schedule 1 of the Care Act 2014.

21.77. The Act enables the second authority (where this is an authority in England, Wales or Northern Ireland) to recover costs from the authority which made or funded the arrangements. This power will be commenced in relation to local authorities

in Wales at the same time as the temporary duty is commenced.

21.78. If a dispute later emerges, for example regarding costs incurred as a result of the provider failure situation, then the Schedule One dispute regulations described above will apply (where this concerns duties on authorities in England, Wales or Northern Ireland).

Potential future cross-border arrangements

21.79. Schedule One makes provision for regulation-making powers with respect to applying cross-border principles to direct payments and/ or other types of accommodation which are not care homes (for example, supported living arrangements).

21.80. The UK Government and the Devolved Administrations will be keeping under review the possibility of exercising these regulation-making powers, in light of the implementation of residential cross-border placements and policy developments across all UK administrations.

Frances is a 78 year old lady with severe arthritis who lives alone in south London. Frances slips whilst walking down her stairs and breaks a wrist and leg. Frances is admitted to a local general hospital. At the hospital, Francis is visited by a local authority social services member, Ray who conducts a needs assessment. During the assessment, Ray asks Frances about her support network – does she have any friends and/or family nearby? Frances says her best friend passed away last year. She has one son but he lives outside Edinburgh with his young family.

When Ray re-visits Frances, he informs her that she is eligible for care and support. He also says, that whilst a number of options exist, it is Ray's opinion, that Frances's severe arthritis now means she is unable to live independently and that residential care may be the best way forward. Frances agrees. She expresses relief that she will not have to return home alone but is anxious at moving to an unfamiliar setting.

Ray asks Frances whether she has considered moving to be nearer her son. Frances says yes, but has previously dismissed the idea because she didn't want to get in the way. Ray asks whether a move to a care home near her son might be attractive. The local authority would take care of the arrangements and her son and his family could visit more easily. Frances is keen to take this further. Ray asks Frances's permission to contact her son. Frances agrees.

Ray contacts Frances's son, Ian. Ian says he wishes he could visit Frances more often but with two young children and a busy job it is hard to do so. Ian phones every few days and says he knows Frances has been feeling down since her friend passed away. Ian's house is too small to accommodate Frances and is empty all day so no-one would be available to support Frances. Ray explains the possibility of a cross-border placement for Frances into a residential home close to Ian. Ian says he would find this very attractive. Frances has always enjoyed her visits to Scotland before, especially seeing her grandchildren. Ian agrees to talk to Frances about the possibility.

Ray hears from Frances the next day – she and her son would like to go forward with a cross-border placement. Ray researches possible residential homes close to Ian, taking Frances's preferences into account and select three possibilities which Frances, in conference with Ian, pick from. The preferred home is in a suburban area similar to that in which Frances currently lives and close to a church – Frances is a regular church-goer. Ray contacts the care home provider and confirms availability and fees and informs the provider that this would be a cross-border placement.

Ray phones his opposite number, Rhian, in the Edinburgh local authority where the care home is based. Ray informs Rhian that it appears likely a cross-border placement will take place. Rhian says she knows the care home in question and the standard of care is good based on inspectorate findings. Ray thanks her and follows up in writing with the provisional date when the placement will occur and details of the care provider identified.

Over the next week, arrangements for the placement are firmed up. Ray draws up an agreement as to how Frances's care will be managed on a day-to-day basis with assistance from Rhian's authority. Rhian has agreed that her local authority will take on several roles: assistance for Ray's local authority to carry on regular care reviews will be given by Rhian's team and they will provide all assistance necessary in an emergency. Should care needs arise, Ray will be able to pick this up via care reviews as assisted by Rhian. Rhian will notify Ray, and Frances and Ian (at Frances's request) of any other developments. Rhian agrees that no costs shall be charged to Ray's local authority – it is likely that placements from Rhian's local authority to Ray's may occur in the future.

Rhian also agrees to liaise with the local NHS to ensure that Frances is registered with a GP prior to her arrival and that this GP is aware of the health care Frances requires.

When all details have been confirmed, Ray and Rhian exchange written correspondence that details the date at which Frances will move into her new home and the arrangements for on-going management of the placement. Ray arranges transport for Frances to her new care home. Rhian and Ian both arrange to be there to greet her.

Other provisions

22. Sight registers

This chapter provides guidance on:

- *Section 77 of the Care Act 2014;*
- *The Care and Support (Registers) Regulations 2014.*

This chapter covers:

- Registration;
- Certification;
- Transferring and retaining the Certificate of Vision Impairment (CVI);
- Making contact;
- Continuity of care;
- Care planning;
- Rehabilitation;
- Care and support for deafblind children and adults;
- Other registers.

22.1. Local authorities **must** keep a register of people who are severely sight impaired and sight impaired.

22.2. Registration is voluntary, however individuals **should** be encouraged to consent to inclusion on the register as it may assist them in accessing other concessions and benefits. The data which are provided on registration are also of benefit in service planning for health and care and support. However, individuals' access to care and support is not dependent upon registration, and those with eligible needs for care and support **should** continue to receive it regardless of whether they consent to inclusion on the register.

22.3. Local authorities **should** help health and social care organisations to work together to meet the needs of people who are sight impaired, for example, ensuring that care and support services know what help somebody needs in their home when they leave hospital. Timely assessment and care and support that is integrated with health care and person-centred offer the potential to make improvements in experience and outcomes of people who are sight impaired, as well as improving system efficiency. Effective collection of data on registered sight impaired people will also aid the planning and delivery of effective services.

Registration

22.4. Local authorities **must** keep a register of people who are severely sight impaired and sight impaired. Local authorities may wish to use this opportunity to bring forward information from existing registers and update details, for example, to check if the information on the register is still current, for example a person may have moved out of the area.

22.5. The Certificate of Vision Impairment (CVI) formally certifies someone as being sight impaired or as severely sight impaired. A copy of the CVI should be sent to the relevant local authority by the hospital staff. However, people in receipt of a CVI should not be added to the local register until they have given their specific consent to the local authority for registration. If the person has given consent he or she may then be registered. Local authorities may take the date of certification given on the CVI as the effective date of registration. However, if consent has not been given, the person **should** still be offered a needs assessment.

22.6. The CVI is an important source of information for local authorities in relation to their registration duties. Local authorities should satisfy themselves that the CVI is completed correctly and contains signatures of both the ophthalmologist and patient when receiving a hard copy of the form. Electronic versions and copies of CVIs should be accepted for registration.

22.7. People who agree to be registered may be entitled to some benefits, for example, an increase in personal tax allowance, a reduction in the cost of a TV license, a free bus pass and parking concessions under the Blue Badge Scheme.

22.8. It is important that strong links exist between local authorities, health services and voluntary organisations to identify those who may benefit from registration. Appendix C of the UK Vision Strategy 2013 contains a tool that offers a pathway, approved by the Strategic Advisory Group of the UK Vision Strategy.

22.9. Schedule 2 of the 1989 Children Act requires local authorities to keep registers of disabled children, which must include children with sight impairments.

Certification

22.10. The CVI is issued by a Consultant Ophthalmologist to the patient certifying as sight impaired or severely sight impaired. The DH guidelines in the "Certificate of Vision Impairment: Explanatory Notes for Consultant Ophthalmologists and Hospital Eye Clinic Staff" states who should be certified as severely sight impaired and sight impaired.

22.11. Certification is not the final stage, but often it is the point when people begin to accept the severity of their sight loss and get access to practical and emotional support.

22.12. It is expected that NHS services will keep the completed certificate, signed by the consultant and the patient, for their records. A copy of the certificate should be sent to the relevant local authority and the patient's GP within five working days of its completion. The "Certificate of Vision Impairment *Explanatory Notes for Consultant Ophthalmologists and Hospital Eye Clinic Staff*" provides information on this.

22.13. The Public Health Outcomes Framework (Domain 4: Healthcare public health and preventing premature mortality) has the overarching objective to reduce numbers of people living with preventable ill health and people dying prematurely and has the "preventable sight loss" indicator. The CVI is the key data source for the preventable sight loss indicator and a copy of the form

is also sent to Moorfields Eye Hospital for epidemiological analysis of cases where sight loss is due to age-related macular degeneration, glaucoma, diabetic retinopathy and any other cause.

22.14. The Certifications Office at Moorfield's Eye Hospital receives the CVIs from hospitals across England and Wales for anonymised analysis by age, sex, visual status, location and ethnicity. These figures are reported to Public Health England, diabetic screening programmes so that they can monitor the numbers of newly certified people in their areas with potentially avoidable eye disease and to the CVI Committee. The CVI figures are benchmarked against the Health and Social Care Information Centre's (HSCIC) data on numbers of people newly registered so mapping health and social care data. The HSCIC's publication in September 2013 "Registers of people who are blind or partially sighted: SSDA902 return Information and guidance for the collection period 1 April 2013 – 31 March 2014" provides latest data information.

22.15. Local authorities should note that there will also be people who have a reduced/low vision but do not meet the criteria for certification who may need to be considered in service planning.

Transferring and retaining the CVI

22.16. The CVIs should be kept until the person moves to another area or has passed away.

22.17. In the event of a person's death, the local authority should keep the CVI for least three years after the person's death as it may be necessary for tax purposes to establish if a deceased person was registered with a local authority.

Making contact

22.18. Upon receipt of the CVI, the local authority **should** make contact with the person issued with the CVI (regardless of whether the person has decided to register or not) within two weeks to arrange their inclusion on the local authority's register (with the person's informed consent) and offer individuals a registration card as identified on the CVI registration form. Where there is an appearance of need for care and support, local authorities **must** arrange an assessment of their needs in a timely manner.

22.19. To minimise unnecessary costs and maximise the ability of people who have sight impairment, they **should** have early access to information and advice in an accessible format so that they can adapt to their situation as quickly as possible and obtain any aids and support that will help them to manage their lives better.

Continuity of care

22.20. A person may decide to move home and live in another local authority area. In such circumstances local authorities **must** follow the process which is set out in chapter 18. This is aimed at ensuring that the person's care and support needs will continue to be met during their move. The process requires the original authority to provide the authority the person is moving to with relevant information to support the move such as a copy of the person's care and support plan, their latest assessment, and any other documentation the second authority requests. This **should** include a copy of their CVI. The second authority **should** register the person with the person's consent on their register, and the former authority should remove that person's name to avoid duplication.

Care planning

22.21. *Providing excellent services for blind and partially sighted people – A guide for local authorities,* published by Royal National Institute for Blind People (RNIB) and Action for Blind People, is a good practice guide that helps inform local authorities' understanding of the extent and impact of sight impairment, the main causes and risk factors and the effects on people's lives.

22.22. A vital part of modern care and support is the care and support plan. Having carried out a needs assessment, local authorities must prepare a care and support plan for everyone with eligible needs or other needs which the local authority is going to meet. Where someone has a sight impairment, this should be recorded in the care and support plan. Further details are set out in chapter 10 of this guidance.

Rehabilitation

22.23. Local authorities **should** consider securing specialist qualified rehabilitation and assessment provision (whether in-house, or contracted through a third party), to ensure that the needs of people with sight impairment are correctly identified and their independence maximised. Certain aspects of independence training with severely sight impaired and sight impaired people require careful risk management and should only be undertaken by professionals with relevant experience and training. This type of rehabilitation **should** be provided to the person for a period appropriate to meet their needs. This will help the person to gain new skills, for example, when training to use a white cane. As aspects of rehabilitation for people with sight-impairment are distinct from other forms of reablement, it **should not** be time prescribed. Local authorities should also refer to the Association of Directors of Adults Social Services' (ADASS) position statement of December 2013.[164]

22.24. This makes it clear that rehabilitation for sight impaired people is a specific form of reablement. However, there are some intrinsic characteristics which define rehabilitation as being distinct from other forms of reablement. It is therefore not appropriate to take a one-size-fits-all approach, and local authorities need to ensure that individual needs are met appropriately.

Care and support for deafblind children and adults

22.25. This guidance relates to adults with sight impairment only. Guidance in relation to care and support for deaf-blind children and adults is issued separately under different legal powers, and should be considered in parallel.

Other registers

22.26. Local authorities **may** also establish and maintain a register of people living in their area that have a disability (a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities) or who need care and support or are likely to do so in the future.

22.27. Inclusion on registers is voluntary and with the individual's informed consent. However local authorities **should** encourage individual's consent to inclusion on the register as such registers may support the establishment of an accurate and useful local record of people whose needs may change over time, for example:

[164] http://www.vision2020uk.org.uk/library.asp?libraryID=4329&section=000100050005

- someone with a progressive long-term condition whose needs may increase over time; or
- when the person on whom they are mainly dependent for their care has stopped providing care; or
- those who are ordinarily resident but may be receiving temporary care and support out of area, or in-patient treatment in health services, but who are likely to require care and support on their discharge or return.

22.28. For information on ordinary residence and out of area placements see chapter 17 of this guidance. This information can help local authorities to plan and commission services appropriately for those who need or are anticipated in the future to need care and support. This information could be useful, for example, in helping the local authority to meet its obligation to take steps to prevent reduce or delay needs, which requires local authorities to consider the importance of identifying adults whose needs are not being met and to arrange the provision of local preventative services, facilities and resources for its population. It may also support the local authority to undertake its "market shaping" function, which requires the local authority to consider identifying current and future needs and how providers might meet that demand. For further detail see chapter 4 of this guidance.

22.29. Local authorities may wish to link the information collected to the Joint Strategic Needs Assessments as well as the Joint Health and Wellbeing Strategies. They may also, as part of local JSNA and Health and Wellbeing Strategy development, want to look at this information alongside complementary information from other partners, for example, information drawn appropriately from registers of people with learning disabilities or particular health conditions which are held by GPs, in order to produce a comprehensive and accurate shared local picture.

Links to other relevant guidance and documentation

The benefits of registering as blind or partially sighted

http://www.nhs.uk/ipgmedia/national/royal%20national%20institute%20of%20blind%20people%20(rnib)/assets/standardsizedversionofthebenefitsofregisteringasblindorpartiallysighted.pdf

The Adult UK sight loss pathway is a process map for the Seeing it my way outcomes framework.

http://www.vision2020uk.org.uk/ukvisionstrategy/page.asp?section=299&sectionTitle=Adult+UK+sight+loss+pathway

ADASS's position statement of December 2013

http://www.vision2020uk.org.uk/library.asp?libraryID=4329&section=000100050005

The DH guidelines in *Certificate of Vision Impairment: Explanatory Notes for Consultant Ophthalmologists and Hospital Eye Clinic Staff:*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127399/CVI-Explanatory-notes-in-DH-template.pdf.

The Health and Social Care Information Centre (HSCIC) publishes the number of people registered with councils with Adult Social Services Responsibilities in England.

http://www.hscic.gov.uk/media/12854/SSDA902InformationGuidanceProForma2013-14pdf/pdf/SSDA902_InformationGuidanceProForma_2013-14.pdf

Making local councils more transparent and accountable to local people

https://www.gov.uk/government/policies/making-local-councils-more-transparent-and-accountable-to-local-people/supporting-pages/single-data-list

Care and support for Deafblind adults and children

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101113.pdf

Providing excellent services for blind and partially sighted people – A guide for local authorities

http://www.actionforblindpeople.org.uk/assets/Uploads/downloads/Excellentservicesguide.pdf

Progress in Sight, the ADSS National Standards

http://www.adss.org.uk/eyes.shtml)

23. Transition to the new legal framework

This chapter provides guidance on transition to the provisions in Part 1 of the Care Act 2014:

This chapter covers:

- Transition to the new legal framework in 2015/16 for people receiving care and support;
  - Status of previous assessments and eligibility determinations under the Care Act;
  - The role of care planning and review in implementation;
- Preparing for funding reforms in 2016/17;
  - Understanding the likely demand;
  - Awareness raising;
  - Carrying out early assessments and managing capacity;
  - Other systems implications.

23.1. The Care Act provides an updated legal framework for care and support, and introduces a number of new rights, responsibilities and processes. It will be crucial to the experience of people who use care and support, carers and their families, as well as those who provide and work in the system, that the transition to the new legal framework from April 2015 onwards is smooth and effectively-managed by local authorities. How people currently in contact with the care and support system move into the new system will affect their ability to achieve their outcomes, and it will also impact on local authorities' ability to deliver their obligations.

23.2. The additional reforms to the way that care and support is funded, which are to be implemented from 2016/17, will both pose further challenges to local authorities, and provide new opportunities for contact with new groups of people. The steps that local authorities take over 2015/16 to prepare for the reforms in the following year are likely to have a significant impact on their capacity and readiness.

23.3. This chapter of the guidance consider how local authorities should bring people into the new system in the first year, and also how authorities should prepare for the funding reforms of 2016/17. Necessary secondary legislation will be put in place to give effect to the arrangements described in this chapter.

Transition to the new legal framework in 2015/16

Assessment

23.4. Where a person has received an assessment under the previous legislation, local authorities will not be required to re-assess their needs purely because of the new duties around assessment coming into force. However where local authorities identify (whether through a review or otherwise) that a person's needs or circumstances have changed, a needs assessment must be carried out in line with the responsibilities set out in the Care Act.

23.5. Similarly, a carer who has been previously assessed will not automatically require a separate carer's assessment under the Care Act. However, local authorities should consider the fact that the new duty for assessment of carers under the Care Act means that a significant number of carers are likely to have a right to assessment under the Act that have not been assessed previously. Local authorities should consider whether and how they need to increase their expertise and capacity to fulfil this duty.

23.6. Where a local authority has begun or recently completed an assessment under previous legislation, whether for an adult with care and support needs or a carer, it may take this to be the assessment which it is required to carry out under the Care Act, provided that the needs or other circumstances have not changed, and the person concerned agrees.

Eligibility determinations

23.7. The new national minimum eligibility threshold replaces the current guidance on levels of access set out in *Prioritising need in the context of Putting People First.* The minimum threshold, set out in regulations, describes a level of need that has a significant impact on the person's wellbeing. This is intended to allow for the same level of access to care and support to be maintained in the vast majority of circumstances and local areas.

23.8. Local authorities should review their previous local approach to eligibility, and consider how this relates to the minimum threshold. Local authorities must meet needs at least at this threshold, though they will remain able to meet needs locally at more generous levels. Where this review indicates that local authorities have not previously met needs which are described in the minimum threshold, they will need to take steps to identify and review the needs of any individuals who may be affected.

23.9. Local authorities should adopt a targeted approach to reviewing the needs of any individuals who may be affected by the implementation of the minimum eligibility threshold. Where the local authority considers that a person whose needs have been met by the local authority in the past will continue to have eligible needs under the Care Act, it need not take any specific steps in relation to that person, if there has been no change. However, where a local authority identifies an individual or a specific cohort who may become eligible, it should target an assessment of needs at those individuals in order to determine whether they now have eligible needs which must be met.

23.10. Local authorities should determine whether and how to use their powers to meet needs beyond the level of the minimum threshold. Where local authorities have previously provided care and support to people with lower level needs, they should consider carefully any proposal to restrict local eligibility to only those needs described

within the minimum threshold, and should consult with their local population before making such a change.

23.11. In relation to support for carers, local authorities should review existing local policies in light of the new national minimum eligibility threshold for carers. Where this indicates individuals or groups who may have become eligible as a result, then a carer's assessment should be offered.

Financial assessment

23.12. Local authorities should review the operation of their local charging framework, to ensure that this is consistent with the obligations set out by the Care Act and associated regulations, and the provisions set out in chapter 8. Where local authorities are satisfied that their approach to charging follows the detail required by the Act and regulations, they do not need to take further steps to review funding arrangements for individuals or to carry out new financial assessments, unless other circumstances have changed.

23.13. Where local authorities consider that there will be a change in practice which affects the amount of charges people will pay, for example as a result of changes to the upper capital limits, they must take steps to ensure that individuals concerned are subject to the correct charges. This may include carrying out new financial assessments where circumstances have changed and a new assessment is required.

Meeting needs

23.14. The Care Act's approach to "meeting needs", as opposed to duties to provide specific services, is not intended to place additional requirements on local authorities, and should not give rise to any particular transitional issues to the new system. Where a local authority is providing a service under previous legislation, it should ensure that the person's needs continue to be met through these new arrangements, as part of the usual process of review. "Passporting" people into the new legislation should normally take place at the point of that review, when the authority satisfies itself that the needs are being met.

23.15. From April 2015, local authorities will have a duty to meet the eligible care and support needs of people ordinarily resident in their area, (which may include those needs identified via previous assessments). The general rules on determining ordinary residence have not changed, and previous ordinary residence determinations will continue to apply. The extension of ordinary residence to other types of accommodation provided in another authority's area (including shared lives and extra care housing) will be introduced from April 2015 and will not be retrospective.

23.16. From April 2015 any adult in prison, a young offender institution, bail accommodation or an approved premise will be considered to be resident in the area in which that prison, young offender institution, bail accommodation or approved premises is situated, making that local authority area responsible for meeting their care and support needs.

Care planning and review

23.17. Where someone is already receiving care and support under existing legislation, their first review after April 2015 **must** consider whether their existing plan fulfils the requirements set out in Chapter 10 of this guidance and take any steps necessary to bring it into line. For most people, this review will be the point at which their care and support transfers into the new legislation,

but in practice, this should not require any change beyond what might be expected as part of a usual review, where needs or circumstances have changed in some way.

23.18. In particular, the plan will need to include a personal budget for all people whose needs the local authority is meeting, including carers (the only exception to this is set out in chapter 10). Where the person has not previously received a personal budget, this should be provided and explained during the review, to align the plan with the Act's requirements. All existing personal budgets will also need to be reviewed to ensure that they reflect the requirements of the Act, in particular that they are based on meeting needs (delineating eligible needs where appropriate) rather than directly on the costs of particular services.

23.19. At the same point, people should be made aware if they have a right to a direct payment under the Care Act if this has not been discussed before. Where someone is currently receiving a direct payment, the direct payment should continue, but local authorities must use the first review after April 2015 to establish a personal budget and thereafter use this as the basis for the direct payment.

Deferred payment agreements

23.20. Where a local authority has entered into a deferred payment agreement (DPA) with a person prior to April 2015, that DPA must remain in place until such a time as it would expire under the existing agreement. The DPA must continue subject to the same terms and conditions as have been agreed between the local authority and the person concerned. Local authorities must not remake an old DPA into a new one via the new regulations, but should use the provisions in the Care Act to make all future agreements after April 2015.

Debt recovery

23.21. From April 2015, local authorities must only use the debt recovery powers under Section 70 of the Care Act in order to recover any debts from the date the Act comes into force, including for debts that were incurred before that date. Any arrangements that are already in place, or proceedings that are already underway, prior to that may continue to their conclusion, but no new arrangements can be made under those routes. The above includes debts being recovered under Section 22 of HASSASSA (1983).

Preparing for funding reform

Summary of 2016/17 reforms

23.22. April 2016 will see the introduction of the biggest funding reforms to care and support in over 65 years with more people than ever before contacting their local authority. It is vital that every local authority starts to plan and prepare for these changes now to ensure that people are able to benefit immediately.

23.23. The statutory guidance will be updated and re-published in advance of April 2016, to set out how the capped cost system will impact practically on the processes and requirements of the Act, and how the obligations of local authorities will change. In summary, the key reforms will be:

- A cap on the care costs which a person pays over their lifetime. This will be set at £72,000 for those over retirement age. How a person progresses towards the cap will be based on what the cost of meeting their eligible needs would be to

the local authority. Where a local authority is arranging a person's care, this will be provided through the personal budget. Where they are not, this will be provided through an "independent personal budget".

- Keeping track of how people progress towards the cap and providing a record of progress to the person. Every person with assessed eligible needs will need to have a "care account". This will keep track of what they are paying, what the local authority is paying and what their progress is towards the cap. Local authorities will need to provide regular statements.
- Extending the financial support provided by the local authority, by raising the upper capital limit to £118,000 where someone's property is taken into account. This will mean that more people with modest assets are able to receive financial support to meet their eligible needs.

Understanding the likely demand

23.24. Local authorities should take steps now to understand the additional likely demand for support as a result of the funding reforms. It is anticipated that a significant number of people who would previously have arranged and paid for their own care may approach the local authority for support in accessing care, or for an assessment of their needs. This is needed so that the local authority can record the cost of meeting their eligible needs for the purposes of establishing their care account, and counting costs towards their cap.[165]

23.25. In order to prepare for the implementation of the capped costs system, local authorities should take steps to identify the number of "self-funders" (i.e. people who arrange and pay for their own care and support) in their local area. This group are unlikely to currently be in contact with the local authority, and local authorities should work with other partners who may be better placed to scope the local population, including for example the local NHS, provider organisations and the voluntary sector.

23.26. In identifying people who currently arrange their own care, local authorities should consider specific groups who would benefit most from the introduction of the cap on care costs, and may be most likely to approach the authority – for example:

- People who currently arrange their own care and support, and would be likely to have eligible needs if assessed by the local authority. People already living in care homes who are not funded by the local authority may be most likely to fall into such a category, and may be reasonably estimated using CQC registration data or information available from providers themselves.
- People with modest assets, who would benefit from the rise in the upper capital limit, and may become eligible for financial support from the local authority.
- Working-age adults whose needs for care and support are likely to meet the eligibility criteria.

23.27. In estimating the impact of additional demand, local authorities should take into account other factors in their local population which may influence the likelihood of individuals seeking care and support. For example, information on existing access to universal services by self-funders (e.g. any universal reablement service) may provide a useful indication of the willingness of such groups to contact the local authority. Similarly, information derived from contact centres or

165 Link to impact assessment

existing information and advice services may also indicate the preferences of such groups. Other local services (e.g. local GPs) may also have information and experience with the same groups.

Awareness-raising

23.28. Local authorities should take steps to raise awareness of the reforms, in keeping with their obligations for providing information and advice on the care and support system (see chapter 3). In order to predict and manage additional demand, local authorities should seek out groups, for example those identified above, for targeted communications and the local approach to implementation. Local authorities should consider how to contact any specific groups who may benefit from earlier information, for example individuals who may be at risk of losing mental capacity in the near future. In targeting information and communications, local authorities should follow the same factors of proportionality and appropriateness as in providing any other information and advice.

23.29. Communications which raise awareness of the capped costs system should in particular reflect the aims of the reforms to support people to plan for future care costs and make more informed decisions which reduce needs over time. Earlier contact with professionals who may support financial planning, for example, could support local authorities in managing demand over the longer-term. Information should include helping those targeted to access different types of support, including those options available in the local community, to prevent needs, delay deterioration or prepare for the future wherever possible.

Carrying out early assessments

23.30. Where local authorities have identified groups who would be likely to approach them for support under the capped costs system, they **should** consider carrying out the relevant processes early in order to manage capacity and workload over a longer period. For example, early needs assessments should be carried out in order to pre-determine eligible needs and record the cost of meeting those needs for people who would benefit.

23.31. Local authorities **should** consider which groups of individuals may benefit most from such an approach. One such example may be those self-funding people with eligible needs who are in the most settled populations, where needs are least likely to change before April 2016, such as care home residents. However, groups that are difficult to reach or particularly vulnerable may also benefit from early assessment given the potential challenges thereafter; and it may be helpful for local authorities to understand the practicalities of these assessments well in advance of April 2016 to ensure that they have robust processes in place.

23.32. If needs change, the local authority will be required to carry out a further assessment, and authorities should consider how to mitigate such risks in the approach adopted. It is therefore suggested that local authorities do not carry out any assessments solely for the purpose of preparing for the capped costs system before October 2015. However, local authorities should bear in mind their duty to carry out an assessment if any person has the appearance of needs, subject to the usual provisions in the Care Act.

23.33. The assessment carried out **must** meet the same legal obligations as for any other needs assessment (see chapter 6). However, where a local authority carries out

such an assessment, this should be assumed to be on the basis that the person does not wish for the authority to meet the person's needs at that time (because the purpose of the assessment is to pre-determine eligible needs and care costs, in advance of April 2016, and not to seek local authority support) and this should be made clear to the person. However, if the person subsequently asks the local authority to meet their eligible needs, then the usual obligations under the Care Act would apply and the local authority would be required to do so. The local authority should make this clear to the individual at the outset.

23.34. Having carried out an assessment, the local authority **must** determine whether the individual has eligible needs for care and support (see chapter 6.81 onwards). If the person does not have eligible needs, then the authority must provide information and advice as set out in chapter 6. If the person does have eligible needs, then provided the person concerned does not wish for the local authority to meet their needs, the authority will not be required to do so. The local authority should provide the individual with a written record, which includes:

- a record of the assessment and eligibility determination setting out the needs assessed, and of those which needs are eligible;
- the cost to the local authority of meeting the eligible needs. This should use the processes which the local authority will already have in place for calculating indicative personal budgets, in order to provide an interim cost of meeting the needs; and,
- information and advice on how to prevent or delay needs, how to access financial advice, and the anticipated process for confirming their care account from April 2016.

23.35. The cost of meeting the person's eligible needs which is calculated at this point may form their independent personal budget from April 2016, provided that their needs do not change. The costs will not start counting towards the cap and their care account will not begin before this date, and there is no retrospective element. This **should** be made clear to the person, and if appropriate their family, in the manner in which the information above is provided.

23.36. Where the local authority has carried out an assessment and pre-determined eligible needs, it **should** contact the person concerned around April 2016 to satisfy itself that the needs or other circumstances (e.g. the person's financial resources) have not changed. The person may ask the local authority to review their needs, and the local authority should respond to such a request. If the needs or circumstances have not changed, or if no request for a review is made, then the authority may take the record of the needs and costs as accurate, and provide an independent personal budget and start the care account on that basis. This **must** be communicated to the individual in writing.

Managing capacity

23.37. Local authorities **should** consider the steps that could be taken to manage capacity issues associated with early assessments as described above, as well as additional assessments after April 2016. This could include, for instance, the role of self-assessment in supporting individuals to identify their own needs and make a judgement on eligibility. It may also include adopting a more proportionate approach to the financial assessment for those individuals with assets substantially above the financial limits, or using powers to delegate some or all such assessments to other organisations.

Practical guidance has been developed to support local authorities to consider their own capacity and workforce requirements.[166]

23.38. Local authorities should develop a clear understanding of their current workforce and future needs in determining their approach to delivering additional assessments. They may consider a role for strategic partners in the voluntary sector or others who are already in touch with some of the people concerned and who would be open to being trained to carry out assessments on the authority's behalf. Where authorities pursue such an approach, they should consider the effect on other elements of the care and support process and how to manage interactions between the organisations (for example, the audit process put in place by the local authority to assure the assessments carried out on their behalf).

23.39. Where a person carries out a self-assessment, the local authority should consider how the self-assessment is verified and how this links with subsequent steps, such as calculating the cost of meeting eligible needs. Where this is delegated to an external organisation there should be clear protocols in place for quality assurance and ongoing monitoring.

Systems and training requirements

23.40. All these changes will place new requirements on local information systems and processes. Local authorities should review the impact on their information systems in conjunction with their suppliers and consider whether new systems and technology is required. Local authorities should start early conversations with suppliers to identify the changes required and carefully consider their procurement approach. In particular, local authorities should take into account the wider health and care technology strategy, including use of open APIs, when making decisions in this area.[167] Local authorities should also consider whether business processes also need to be reviewed and changed in parallel to changes in systems.

23.41. In particular, informatics systems for ongoing case management will need to be revised to incorporate the additional requirements for independent personal budgets, care accounts, deferred payment agreements and changes to charging and assessments (for both people with care and support needs and carers). In addition, authorities should consider how digital approaches can put citizens in control by making systems open and accessible, including online assessment, care planning, access to records and care accounts. Authorities will also need to consider how systems can be made open and accessible to people where digital internet systems are not accessible, or even not permitted, such as in prison.

23.42. Local authorities should consider the training needs of staff, and in particular the needs of those who carry out the relevant assessments to ensure that there is sufficient understanding of the new system. Where local authorities propose to commission or delegate some activities to other organisations, they should ensure that staff are trained to the same standard. Practical learning and development modules to support the training of staff to implement the

166 Link to Skills for Care.

167 See: http://www.local.gov.uk/documents/10180/11411/Social+care+information+and+technology_care+and+support+reform+discussion+paper.pdf/f4dbc387-2106-45f1-8402-56492bdd4cf1

Care Act are under development to support this process.[168]

23.43. Local authorities should also review their provision of financial advice and relationships with existing local independent providers. Local authorities should take steps to identify sources of independent advice which are accessible to local people, and make arrangements for future signposting.

[168] Link to Skills for Care L&D plan.

Annexes

Annex A: Choice of accommodation and additional payments

Annex B: Treatment of capital

Annex C: Treatment of income

Annex D: Recovery of debts

Annex E: Deprivation of assets

Annex F: Temporary residents in care homes

Annex G: The process for managing transfers of care from hospital

Annex H: Continuity of care: equipment and adaptations

Annex J: Ordinary residence

Annex K: Repeals and revocations

Annex A: Choice of accommodation and additional payments

This annex covers:

- Choice of accommodation when arranging care and support in a residential setting;
- Making additional payments for preferred accommodation.

1. A person's ability to make an informed choice is a key element of the care and support system. This **must** extend to where the care and support planning process has determined that a person needs to live in a specific type of accommodation to meet their care and support needs.

2. The care and support planning process will have determined what type of accommodation will best suit the person's needs. This could be, for example, a care home, shared lives or extra care housing. Where the type of accommodation is one of those specified in regulations, the person will have a right to choose the particular provider or location, subject to certain conditions. Where this is the case, the following guidance should be applied and in doing so, local authorities should have regard to the following principles:

- Good communication of clear information and advice to ensure well informed decisions;
- A consistent approach to ensure genuine choice;
- Clear and transparent arrangements for choice and any 'top-up' arrangements;
- Clear understanding of potential consequences should 'top-up' arrangements fail with clear exit strategies; and
- The choice is suitable to the person's needs.

3. Local authorities should also be mindful of their duties under Section 1 of the Care Act 2014 to promote individual wellbeing. Further detail is available in Chapter 1.

Choice of accommodation

4. Where a local authority is responsible for meeting a person's care and support needs and their needs have been assessed as requiring a particular type of accommodation in order to ensure that they are met, the person **must** have the right to choose between different providers of that type of accommodation provided that:

- The accommodation is suitable in relation to the person's assessed needs;
- To do so would not cost the local authority more than the amount specified in the adults personal budget for accommodation of that type;
- The accommodation is available; and

- The provider of the accommodation is willing to enter into a contract with the local authority to provide the care at the rate identified in the person's personal budget on local authority's terms and conditions.

5. This choice **must not** be limited to those settings or individual providers with which the local authority already contracts with or operates or those that are within that local authority geographical boundary. It **must** be a genuine choice across the appropriate provision.

6. If a person chooses to be placed in a setting that is outside the local authority's area, the local authority **must** still arrange for their preferred care. In doing so, the local authority should have regard to the cost of care in that area when setting a person's personal budget. Local authorities should also read the guidance on ordinary residence in Chapter 20.

Suitability of accommodation

7. In exercising a choice, a local authority **must** ensure that the accommodation is suitable to meet a person's assessed needs and identified outcomes established as part of the care and support planning process.

8. People are able to express a preference about the setting in which their needs are met through the care and support planning process. This process considers both the person's needs and preferences and detailed guidance is set out in Chapter 10. Once this is agreed, the choice is between different settings, not different types. For example, a person cannot choose a shared lives scheme when the care and support planning process, which involves the person, has assessed their needs as needing to be met in a care home.

Cost

9. The care and support planning process will identify how best to meet a person's needs. As part of that, the local authority **must** provide the person with a personal budget, except in cases or circumstances set out in the Care Act (Personal Budget) Regulations. The Personal Budget is an important tool that provides clear information on the cost of meeting the person's needs. Further guidance on how to undertake care and support planning and calculate a personal budget is set out in Chapters 10 and 11.

10. The personal budget is defined as the cost to the local authority of meeting the person's needs which the local authority chooses or is required to meet. However, the local authority **should** take into consideration cases or circumstances where this 'cost to the local authority' may need to be adjusted to ensure that needs are met. For example, a person may have specific dietary requirements that can only be met in specific settings. In all cases the local authority **must** have regard to the actual cost of good quality care in deciding the personal budget to ensure that the amount is one that reflects local market conditions. This should also reflect other factors such as the person's circumstances and the availability of provision. In addition, the local authority should not set arbitrary amounts or ceilings for particular types of accommodation that do not reflect a fair cost of care. Guidance on market shaping and commissioning is set out in Chapter 4.

11. A person must not be asked to pay a 'top-up' towards the cost of their accommodation because of market inadequacies or commissioning failures. Therefore at least one setting **should** be offered that could meet the person's needs

within the amount in their person budget. If no preference has been expressed and no suitable accommodation is available at the amount identified in a personal budget, the local authority **must** arrange care in a more expensive setting and adjust the budget accordingly to ensure that needs are met. In such circumstances, the local authority **must not** ask for the payment of a 'top-up' fee. Only when a person has chosen a more expensive accommodation can a 'top-up' payment be sought. Paragraphs 19 and 20 set out guidance on Additional Costs.

Availability

12. Local authorities have specific duties to shape and facilitate the market of care and support services locally, including ensuring sufficient supply. As a result, a person should not have to wait for their assessed needs to be met. However, in some cases, a short wait may be unavoidable, particularly when a person has chosen a particular setting that is not immediately available. This **may** include putting in place temporary arrangements – taking in to account the person's preferences and securing their agreement – and placing the person on the waiting list of their preferred choice of provider for example.

13. In such cases, the local authority **must** ensure that in the interim adequate alternative services are provided and set out how long the interim arrangement may last for. In establishing any temporary arrangements, the local authority **must** provide the person with clear information in writing on the detail of the arrangements as part of their care and support plan. As a minimum this should include the likely duration of the arrangement, information on the operation of the waiting list for their preferred setting alongside any other information that may be relevant. If any interim arrangements exceed 12 weeks, the person **may** be reassessed to ensure that both the interim and the preferred option are still able to meet the person's needs and that remains their choice.

14. Where a person contributes to the cost of their care following a financial assessment they **must** not be asked to pay more than their assessment shows they can afford.

15. In some cases a person may decide that they wish to remain in the interim setting, even if their preferred setting subsequently becomes available. If the setting where they are temporarily resident is able to accommodate the arrangement on a permanent basis this **should** be arranged and they **should** be removed from the waiting list of their original preferred setting. Before doing so, the local authority **must** make clear any consequences of that choice, including any financial implications.

Choice that cannot be met and refusal of arrangements

16. Whilst a local authority **should** do everything it can to meet a person's choice, inevitably there will be some instances where a choice cannot be met for example if the provider does not have capacity to accommodate the person. In such cases, a local authority **should** set out in writing why it has not been able to meet that choice and offer suitable alternatives. It **should** also set out the detail of the local authority's complaints procedure and if and when the decision may be reviewed.

17. A local authority **must** do everything it can to take in to account a person's circumstances and preferences when arranging care. However, in all but a very small number of cases, such as where a person is being placed under guardianship under Section 7 of the Mental Health Act 1983, a person has a right to refuse to

enter a setting whether that is on an interim or permanent basis. Where a person unreasonably refuses the arrangements, a local authority is entitled to consider that is has fulfilled its statutory duty to meet needs and may then inform the person in writing that as a result they need to make their own arrangements. This **should** be a step of last resort and local authorities **should** consider the risks posed by such an approach, for both the authority itself and the person concerned. Should the person contact the local authority again at a later date, the local authority **should** reassess the needs as necessary and re-open the care and support planning process.

Contractual terms and conditions

18. In supporting a person's choice of setting, the local authority **may** need to enter into a contract with a provider that they do not currently have an arrangement with. In doing so, they **should** ensure that the contractual conditions are broadly the same as those they would negotiate with any other provider whilst taking account of the individual circumstances. Strict or unreasonable conditions should not be used as a means to avoid or deter the arrangement.

Additional costs or 'top ups' payments

19. In some cases, a person may proactively choose a setting that is more expensive than the amount identified in the personal budget. Where they have chosen a setting that costs more than this, an arrangement will need to be made as to how the difference will be met. This is known as an additional cost or 'top-up' payment and is the difference between the amount specified in the personal budget and the actual cost. In such cases, the local authority **must** arrange for them to be placed there, provided a third party or in certain circumstances the person in need of care and support, is willing and able to meet the additional cost.

20. The following sections of guidance only apply where the person has chosen a more expensive setting. Where someone is placed in a more expensive setting solely because the local authority has been unable to make arrangements the personal budget **must** reflect this amount. The person would then contribute towards this personal budget according to the financial assessment. The additional cost provisions must not apply in such circumstances.

Agreeing a 'top-up' fee

21. Having chosen a setting that is more expensive, the local authority **should** ensure that the person understands the full implications of this choice. This should include for example that a third party or in certain circumstances the person needing care and support, will need to meet the additional cost of that setting for the full duration of their stay and that should the additional cost not be met they may be moved to an alternative setting.

22. The local authority **must** ensure that the person paying the 'top-up' is willing and able to meet the additional cost for the likely duration of the arrangement, recognising that this may be for some time into the future. Therefore it **must** ensure that the person paying the 'top-up' enters into a written agreement with the local authority, agreeing to meet that cost. The agreement **must**, as a minimum, include the following:

- The additional amount to be paid;

- The amount specified in the person's personal budget;
- The frequency of the payments;
- To whom the payments are to be made;
- Provisions for reviewing the agreement;
- A statement on the consequences of ceasing to make payments;
- A statement on the effect of any increases in charges that a provider may make;
- A statement on the effect of any changes in the financial circumstances of the person paying the 'top-up'.

23. Before entering into the agreement, the local authority must provide the person paying the 'top-up' with sufficient information and advice to ensure that they understand the terms and conditions. Further detail on each of these points is set out below.

24. Ultimately, if the arrangements for a 'top-up' were to fail for any reason, the local authority would need to meet the cost or make alternative arrangements, subject to a needs assessment. Further details are set out below in the consequences of ceasing to make payments. Local authorities **should** therefore maintain an overview of all 'top-up' agreements and **should** discourage arrangements for 'top-up' payments to be paid directly to a provider.

The amount to be paid

25. The amount of the 'top-up' should be the difference between the actual costs of the preferred provider and the amount that the local authority would have set in a personal budget to meet the person's eligible needs by arranging or providing accommodation of the same type.

26. When conducting its cost of care exercise, the local authority is likely to identify a range of costs which apply to different circumstances and settings. For the purposes of agreeing a 'top-up' fee the local authority **must** consider what personal budget it would have set at the time care and support is needed. It should not automatically default to the cheapest rate or to any other arbitrary figure.

Frequency of payments

27. In agreeing any 'top-up' arrangement, the local authority must clearly set out how often such payments need to be made, e.g. on a weekly or monthly basis.

Responsibility for costs and to whom the payments are made

28. When entering into a contract to provide care in a setting that is more expensive than the amount identified in the personal budget, the local authority is responsible for the total cost of that placement. This means that if there is a break down in the arrangement of a 'top-up', for instance if the person making the 'top-up' ceases to make the agreed payments, then the local authority would be liable for the fees and must either recover the additional costs it incurs or make alternative arrangements to meet the cared for person's needs.

29. In terms of securing the funds needed to meet the total cost of the care (including the 'top-up' element) a local authority has three options, except where it is being funded by a Deferred Payment Agreement in which case it is added to the amount owed. In choosing which option to take it will need to consider the individual circumstances of the case, should be able to assure itself of the security of the arrangements and that there

is no undue pressure on the person making the 'top-up' payment to increase the level of payment. Whichever option it chooses, it remains responsible for the total amount. The options are:

- Treat the 'top-up' payment as part of the person's income and therefore recover the costs from the person concerned through the financial assessment (where the 'top-up' payments are being made by a third party rather than the cared for person, this is on the assumption that the third party makes the payment to the person with care needs); or
- Agree with the person, the third party paying the 'top-up' (if this is not the cared for person) and the provider that payment for the 'top-up' element can be made directly to the provider with the local authority paying the remainder; or
- The person making the 'top-up' payments pays the 'top-up' amount to the local authority. The local authority then pays the full amount to the provider.

30. In the case of people with eligible needs who pay in full for their own care and support who ask the local authority to arrange their care, refer to paragraph 39.

Provisions for reviewing the agreement

31. As with any financial arrangement, an agreement to make a 'top-up' payment **must** be reviewed from time to time. A local authority **must** set out in writing details of how the arrangements will be reviewed, what may trigger a review and circumstances when any party can request a review.

32. Local authorities **should** also consider how often it may be appropriate to review the arrangements. In doing so it **should** bear in mind how often it reviews other financial arrangements, such as deferred payment agreements.

Consequences of ceasing to make payments

33. The local authority must make clear in writing the consequences should there be a break down in the arrangement to meet the cost of the 'top-up'. This **should** include that the person may be moved to an alternative accommodation where this would be suitable to meet their needs and affordable within the personal budget. As with any change of circumstance, a local authority **must** undertake a new assessment before considering this course of action, including any assessment of health needs and have regard to the person's wellbeing.

Price increases

34. Arrangements will need to be reviewed from time to time for example in response to any changes in circumstances of the cared for person, the person making the 'top-up' payments (if this is different from the cared for person), local authority commissioning arrangements or a change in provider costs. However, these changes may not occur together and a local authority **must** set out in writing how these changes will be dealt with.

35. The local authority **must** clearly set out in writing to the person or persons concerned its approach to how any increased costs may be shared. This **should** also include details of how agreement will be reached on the sharing of any price increases. This **should** also state that there is no guarantee that these increased costs will automatically be shared evenly should the provider's costs rise more quickly than the amount the local authority would have increased the personal

budget and there is an alternative option that would be affordable within that budget.

36. A local authority **may** wish to negotiate any future prices rises with the provider at the time of entering into a contract. This can help provide clarity for adults and providers and help ensure that the top up remains affordable.

37. The local authority **should** also make clear that where the person has a change in circumstances that requires a new financial assessment and this results in a change in the level of contribution the person themself makes, this may not reduce the need for a 'top-up' payment.

Consequences of changes in circumstances of the person making the 'top-up' payment

38. The person making the 'top-up' payment could see an unexpected change in their financial circumstances that will impact their ability to continue to pay the 'top-up' fee. Where a person is unable to continue making 'top-up' payments the local authority **may** seek to recover any outstanding debt and have power to make alternative arrangements to meet a cared for person's needs, subject to a needs assessment. The local authority **must** set out in writing how it will respond to such a change and what the responsibilities of the person making the 'top-up' payment are in terms of informing the local authority of the change in circumstances.

Self 'top ups'

39. The person whose needs are to be met by the accommodation may themself choose to make a 'top-up' payment only in the following circumstances:

- where they are subject to a 12-week property disregard; or
- they have a deferred payment agreement in place with the local authority. Where this is the case, the terms of the agreement should reflect this arrangement. For further guidance on deferred payment agreements see Chapter 9.

People who are unable to make their own choice

40. There will be cases where a person lacks capacity to express a choice for themself. Local authorities **should** therefore act on the choices expressed by the person's advocate, carer or legal guardian in the same way they would on the person's own wishes unless in the local authority's opinion it would be against the best interests of the person.

Self-funders who ask the local authority to arrange their care

41. The Care Act 2014 enables a person who can afford to pay for their own care and support in full to ask the local authority to arrange their care on their behalf. In such circumstances, the same rules on choice must apply. However, where a person then chooses a setting that is more expensive than the amount identified in the personal budget, the local authority is not liable for the total cost.

42. In supporting such people to arrange care, the local authority **may** choose to enter into a contract with the preferred provider, or may broker the contract on behalf of the person. Where the local authority is

arranging and managing the contract with the provider, it **should** ensure that there are clear arrangements in place as to how the costs will be met, including any 'top-up' element.

43. Ultimately, the local authority **should** assure itself that robust contractual arrangements are in place in such circumstances that clearly set out where responsibilities for costs lie and ensure that the person understands those arrangements.

Choice of accommodation and mental health after-care

44. Regulations made under section 117A of the Mental Health Act 1983 enable persons who qualify for mental health after-care under section 117 to express a preference for particular accommodation if accommodation of the types specified in the regulations is provided as part of that after-care. Local authorities are required to provide or arrange the provision of the preferred accommodation if the conditions in the regulations are met.

45. The regulations give people who receive mental health after-care broadly the same rights to choice of accommodation as someone who receives care and support under the Care Act 2014. But some differences arise because after-care is provided free of charge and, as the legislative requirement for a care and support plan under the Care Act 2014 does not apply to section 117 after-care, the care plan should instead be drawn up under guidance on the Care Programme Approach (CPA). Care planning under the CPA should, if accommodation is an issue, include identifying the type of accommodation which is suitable for the person's needs and affording them the right to choice of accommodation set out in the regulations made under section 117A. The person should be fully involved in the care planning process.

46. An adult has the right to choose accommodation provided that:

- the preferred accommodation is of the same type that the local authority has decided to provide or arrange;
- it is suitable for the person's needs;
- it is available (see guidance in paragraphs 12, 13 and 15; for mental health after-care purposes, "assessed needs" means needs identified in the CPA care plan); and
- where the accommodation is not provided by the local authority, the provider of the accommodation agrees to provide the accommodation to the person on the local authority's terms (see guidance in paragraph **18**).

47. The principles in paragraphs 4(i) to (v), 5, 6 and 40 apply equally where a local authority is providing, or arranging the provision of, accommodation in discharge of its after-care duty. The guidance in paragraphs 16 and 17 applies when the preferred choice cannot be met.

48. Where the cost of the person's preferred accommodation is more than the local authority would provide in a personal budget to meet the person's needs, then the local authority must arrange for them to be placed there, provided that either the person or a third party is willing and able to meet the additional cost.

49. The guidance in paragraphs 21 to 23, 25 to 27 and 31 to 38 applies where the adult has chosen more expensive accommodation. For the purposes of section 117 after-care, however, references to a third party should be read as including the adult receiving the after-care (because an adult can also meet the additional cost when a local authority is providing, or arranging for the provision of

accommodation in discharge of the after-care duty).

50. In securing the funds needed to meet the additional cost, a local authority may:

- Agree with the person and the provider, and in cases where a third party is paying the 'top-up', agree with that third party, that payment for the additional cost can be made directly to the provider with the local authority paying the remainder; or
- The person or the third party pays the 'top-up' amount to the local authority. The local authority then pays the full amount to the provider.

Information and advice

51. Under Section 4 of the Care Act 2014 a local authority **must** establish and maintain a service for providing people in its area with information and advice in relation to care and support needs. This **must** include information and advice to enable choice and to help people understand care charges, ways to pay and how to access advice on money management as well as facilitating access to independent financial information and advice to support people in making informed financial decisions. Local authorities **should** also consider whether it is in a person's best interested that they be signposted, directed or referred to sources of financial information and advice independent of the local authority. In particular this may be appropriate when a person is entering into a legal agreement with a local authority or other party.

52. Where a 'top-up' arrangement is being entered in to, all parties should fully understand their responsibilities, liabilities and the consequences of the arrangements. A local authority **must** provide the third party with sufficient information and advice to support them to understand the terms of the proposed written agreement before entering in to it. Local authorities **must** also have regard to the general guidance on Information and Advice set out in Chapter 3.

Complaints

53. Complaints about how choice or any 'top-up' arrangement is exercise by the local authority fall within the scope of the local authority's statutory complaints procedure.

Annex B: Treatment of capital

This annex covers:

- The treatment of capital when conducting a financial assessment in all circumstances.

1. This section of the guidance applies where a local authority has chosen to charge a person for the services it is arranging and therefore **must** undertake a financial assessment. When doing so, it **must** assess the income and capital of the person. This Annex covers the treatment of capital and should be read in conjunction with Annex C on the treatment of income. The details of the sources capital which local authorities **must** disregard are set out the regulations.

2. The financial assessment will need to look across all of a person's assets – both capital and income – decide which is capital and which is income, and assess those assets according to the regulations and guidance. A local authority therefore **must** also refer to Annex C on the treatment of income and Annex E on deliberate deprivation of assets before conducting a financial assessment. The treatment of income will vary depending on the type of setting a person is receiving care in. The treatment of capital, as set out in this chapter, is the same for all settings.

3. In assessing what a person can afford to contribute a local authority **must** apply the upper and lower capital limits. The upper capital limit is currently set at £23,250 and the lower capital limit at £14,250.

4. A person with assets above the upper capital limit – subject to local authority discretion – will be deemed to be able to afford the full cost of their care. Those with capital between the lower and upper capital limit will be deemed as able to make a contribution, known as "tariff income", from their capital. Any capital below the lower capital limit should be disregarded. Further details are set out in paragraphs 24 to 28.

Defining capital

What is capital?

5. Capital can mean many different things and the intention is not to give a definitive definition here as a local authority will need to consult the regulations and consider the individual asset on its merits. In general it refers to financial resources available for use and tends to be from sources that are considered more durable than money in the sense that they can generate a return.

6. The following list gives examples of capital. This list is intended as a guide and is not exhaustive.

(a) Buildings

(b) Land

(c) National Savings Certificates and Ulster Savings Certificates

(d) Premium Bonds

(e) Stocks and shares

(f) Capital held by the Court of Protection or a Deputy appointed by that Court

(g) Any savings held in:

  (i) Building society accounts.

  (ii) Bank current accounts, deposit accounts or special investment accounts. This includes savings held in the National Savings Bank, Girobank and Trustee Savings Bank

  (iii) SAYE schemes

  (iv) Unit Trusts

  (v) Co-operatives share accounts

  (vi) Cash

(h) Trust funds

7. It is important that people are not charged twice on the same resouces. Therefore, resources should only be treated as income or capital but not both. If a person has saved money from their income then those savings should normally be treated as capital. However they should not be assessed as both income and capital in the same period. Therefore in the period when they are received as income the resource should be disregarded as capital.

Cases where it is not clear whether a payment is capital or income

8. In assessing a person's assets it may not be immediately clear where a resource is capital or income, particularly where a person is due to receive planned payments. In order to guide a local authority's decision, in general, a planned payment of capital is one which is:

(a) Not in respect of a specified period; and

(b) Not intended to form part of a series of payments.

9. Local authorities should also have regard to the guidance on capital treated as income at paragraph 56.

Who owns the capital?

10. A capital asset is normally defined as belonging to the person in whose name it is held. The legal owner. However in some cases this may be disputed and/or beneficial ownership argued. Beneficial ownership is where someone enjoys the benefits of ownership, even though the title of the asset is held by someone else or where they directly or indirectly have the power to vote or influence a transaction regarding a particular asset. In most cases the person will be both the legal and beneficial owner.

11. Where ownership is disputed, a local authority **should** seek written evidence to prove where the ownership lies. If a person states they are holding capital for someone else, the local authority **should** obtain evidence of the arrangement, the origin of the capital and intentions for its future use and return to its rightful owner.

Example of capital dispute:

Arlene has £14,000 in a building society account in her own name. She says that £3000 is set aside for her granddaughter's education. Unfortunately there is no deed of trust or other legal arrangement which would prevent Arlene using the whole amount herself. She is therefore treated as the beneficial owner of the whole amount.

Example of capital dispute:

Lisa has £10,000 in a bank account in her own name and shares valued at £6,500. She provides evidence to show that the shares were purchased on behalf of her son who is abroad and that they will be transferred to her son when he returns to the UK. Although Lisa is the legal owner, she is holding the shares in trust for her son who is the beneficial owner. Only the £10,000 is therefore treated as Lisa's capital.

12. Where a person has joint beneficial ownership of capital the total value **should** be divided equally between the joint owners and the person **should** be treated as owning an equal share. Once the person is in sole possession of their actual share, they can be treated as owning that actual amount.

Example of joint ownership:

Claire is resident in a care home. She and her son Leon have £21,000 in a joint building society account. Claire has contributed £8,500 and Leon, £12,500. Each is treated as owning £10,500.

The joint account is then closed and Claire and Leon open separate accounts. Claire now has £8,500 in her account and so is assessed as owning £8,500.

13. In some cases a person may be the legal owner of a property but not the beneficial owner of a property. In other words, they have no rights to the proceeds of any sale. In such circumstances the property **must** not be taken into account.

Calculating the value of capital

14. A local authority will need to work out what value a capital asset has in order to take account of it in the financial assessment. Other than National Savings Certificates, valuation **must** be the current market or surrender value of the capital asset, e.g. property, whichever is higher, *minus*:

(a) 10% of the value if there will be any actual expenses involved in selling the asset. This **must** be expenses connected with the actual sale and not simply the realisation of the asset. For example the costs to withdraw funds from a bank account are not expenses of sale, but legal fees to sell a property would be; and

(b) Any outstanding debts secured on the asset, for example a mortgage.

15. A capital asset may have a current market value, for example stocks or shares, or a surrender value, for example premium bonds. The current market value will be the price a willing buyer would pay to a willing seller. The way the market value is obtained will depend on the type of asset held.

16. If the person and the assessing officer both agree that after deducting any relevant amounts set out in paragraph 14 that the total value of the person's capital is more than the upper capital limit of £23,250 or less then the lower capital limit of £14,250 that it is not necessary to obtain a precise valuation. If there are any disputes, a precise valuation should be obtained. However, the local authority **should** bear in mind how close someone is to the upper capital limit when deciding whether or not to obtain a precise valuation.

17. Where a precise valuation is required, a professional valuer should be asked to provide a current market valuation. Once the asset is sold, the capital value to be taken into account is the actual amount realised from the sale, minus any actual expenses of the sale.

18. Where the value of a property is disputed, the aim should be to resolve this as quickly as possible. Local authorities should try to obtain an independent valuation of the person's beneficial share of the property within the 12-week disregard period. This will enable local authorities to work out what charges a person should pay and enable the person, or their representative, to consider whether to seek a deferred payment agreement.

19. The value of National Savings Certificates (and Ulster Savings Certificates) is assessed in the same way as other capital assets. A valuation for savings certificates can be obtained by contacting the NS&I helpline on 0845 964 5000. An alternative method to get the value of National Savings Certificates is to use the NS&I online calculator.[169] To enable an accurate value for the savings certificates the person must provide details of the:

- certificate issue number(s);
- purchase price;
- date of purchase.

Assets held abroad

20. Where capital is held abroad and all of it can be transferred to the UK, its value in the other country should be obtained and taken into account *less* any appropriate deductions under paragraph 14. Where capital is held jointly, it should be treated the same as if it were held jointly within the UK. The detail will depend on the conditions for transfer to the UK.

21. Where the capital cannot be wholly transferred to the UK due to the rules of that country, for example currency restrictions, the local authority **should** require evidence confirming this fact. Examples of acceptable evidence could include documentation from a bank, Government official or solicitor in either this country or the country where it is held.

22. Where some restriction is in place, a local authority **should** seek evidence showing what the asset is, what its value is and to understand the nature and terms of the restriction so that should this change, the amount can be taken into account. It **should** also take into account the value that a willing buyer would pay in the UK for those assets, but be aware that it may be less than the market or surrender value in the foreign country.

Capital not immediately realisable

23. Capital which is not immediately realisable due to notice periods, for example National Savings Bank investment accounts or Premium Bonds, **should** be taken into account in the normal way at its face value. This will be the value at the time of the financial assessment. It may need to be confirmed and adjusted when the capital is realised. If the person chooses not to release the capital, the value at the time of assessment should be used and it should be reassessed at intervals in the normal way.

Capital limits

Upper and lower capital limits

24. The capital limits set out at what point a person is able to access local authority support and how much support they receive. The local authority **must** apply the capital limits. The capital limits for 2015/16 are:

(a) Upper capital limit: £23,250;

(b) Lower capital limit: £14,250.

[169] See http://www.nsandi.com/savings-index-linked-savings-certificates#interest-calculator

25. If a person clearly has capital in excess of the upper capital limit, there is no need to make a wider assessment. If a person is near the upper capital limit, the local authority **should** be mindful of the need to plan ahead for when assets have been spent down and a person may therefore fall below the upper capital limit. This will help reduce burdens on both the local authority and the person from needing to repeat the financial assessment within a short timeframe.

26. The capital which a person has below the lower capital limit **must** be disregarded in the calculation of tariff income (see below).

Tariff income

27. Where a person has assets between the lower and upper capital limits the local authority **must** apply tariff income. This assumes that for every £250 of capital, or part thereof, a person is able to afford to contribute £1 per week towards the cost of their eligible care needs.

Example of tariff income:

Nora has capital of £18,100. This is £3,850 above the lower capital limit of £14,250. Dividing the £3,850 by £250 produces a figure of £15.40. When calculating tariff income, the amount is always rounded up. This therefore gives a tariff income of £16 per week.

28. Where a person is benefiting from the 12 week property disregard and has chosen to pay a "top-up" fee from their capital resources between the upper and lower capital limits, the level of tariff income that applies during those 12 weeks is the same as it would be if the person were not using the capital to "top-up".

Notional capital

29. In some circumstances a person may be treated as possessing a capital asset even where they do not actually possess it. This is called notional capital.

30. Notional capital may be capital which:

(a) Would be available to the person if they applied for it;

(b) Is paid to a third party in respect of the person;

(c) The person has deprived themselves of in order to reduce the amount of charge they have to pay for their care.

31. A person's capital **should** therefore be the total of both actual and notional capital. However, if a person has actual capital above the upper capital limit, it **may** not be necessary to consider notional capital.

32. Where a person has been assessed as having notional capital, the value of this **must** be reduced over time. The rule is that the value of notional capital **must** be reduced weekly by the difference between the weekly rate the person is paying for their care and the weekly rate they would have paid if notional capital did not apply.

Example of diminishing notional capital:

Hayley is receiving care and support in a care home. She is assessed as having notional capital of £20,000 plus actual capital of £6,000. This means her assets are above the upper capital limit and she needs to pay the full cost of her care and support at £400 per week.

If she did not have the notional capital it would not affect her ability to pay. This is as she has an income of £120.40 and a personal allowance of £24.40 per week

and would therefore be assessed as being able to pay £100.

The notional capital should therefore be reduced by £300 per week – the difference between the sum Hayley is paying (£400) and would have paid without the notional capital (£100).

Capital disregarded indefinitely

33. The following capital assets **must** be disregarded indefinitely:

(a) Property in specified circumstances (see paragraph 34);

(b) The surrender value of any:

  (i) Life insurance policy;

  (ii) Annuity.

(c) Payments of training bonuses of up to £200;

(d) Payments in kind from a charity;

(e) Any personal possessions such as paintings or antiques, unless they were purchased with the intention of reducing capital in order to avoid care and support charges;

(f) Any capital which is to be treated as income or student loans;

(g) Any payment that may be derived from:

  (i) The Macfarlane Trust;

  (ii) The Macfarlane (Special Payments) Trust;

  (iii) The Macfarlane (Special Payment) (No 2) Trust;

  (iv) The Caxton Foundation;

  (v) The Fund (payments to non-haemophiliacs infected with HIV);

  (vi) The Eileen Trust;

  (vii) The MFET Trust;

  (viii) The Independent living Fund (2006);

  (ix) The Skipton Fund;

  (x) The London Bombings Relief Charitable Fund.

(h) The value of funds held in trust or administered by a court which derive from a payment for personal injury to the person. For example, the vaccine damage and criminal injuries compensation funds;

(i) The value of a right to receive:

  (i) Income under an annuity;

  (ii) Outstanding instalments under an agreement to repay a capital sum;

  (iii) Payment under a trust where the funds derive from a personal injury;

  (iv) Income under a life interest or a life-rent;

  (v) Income (including earnings) payable in a country outside the UK which cannot be transferred to the UK;

  (vi) An occupational pension;

  (vii) Any rent. Please note however that this does not necessarily mean the income is disregarded. Please see Annex C for guidance on the treatment of income.

(j) Capital derived from an award of damages for personal injury which is administered by a court or which can only be disposed of by a court order or direction;

(k) The value of the right to receive any income under an annuity purchased pursuant to any agreement or court order to make payments in consequence of personal injury or from funds derived from a payment in consequence of a personal injury and any surrender value of such an annuity;

(l) Periodic payments in consequence of personal injury pursuant to a court order or agreement to the extent that they are not a payment of income and area treated as income (and disregarded in the calculation of income);

(m) Any Social Fund payment;

(n) Refund of tax on interest on a loan which was obtained to acquire an interest in a home or for repairs or improvements to the home;

(o) Any capital resources which the person has no rights to as yet, but which will come into his possession at a later date, for example on reaching a certain age;

(p) Payments from the Department of Work and Pensions to compensate for the loss of entitlement to Housing Benefit or Housing Benefit Supplement;

(q) The amount of any bank charges or commission paid to convert capital from foreign currency to sterling;

(r) Payments to jurors or witnesses for court attendance (but not compensation for loss of earnings or benefit);

(s) Community charge rebate/council tax rebate;

(t) Money deposited with a Housing Association as a condition of occupying a dwelling;

(u) Any Child Support Maintenance Payment.

(v) The value of any ex-gratia payments made on or after 1st February 2001 by the Secretary of State in consequence of a person's, or person's spouse or civil partner's imprisonment or internment by the Japanese during the Second World War;

(w) Any payment made by a local authority under the Adoption and Children Act 2002 (under section 2(b)(b) or 3 of this act);

(x) The value of any ex-gratia payments from the Skipton Fund made by the Secretary of State for Health to people infected with Hepatitis C as a result of NHS treatment with blood or blood products;

(y) Payments made under a trust established out of funds provided by the Secretary of State for Health in respect of persons suffering from variant Creutzfeldt-Jakob disease to the victim or their partner (at the time of death of the victim);

(z) Any payments under Section 2, 3 or 7 of the Age-Related Payments Act 2004 or Age Related Payments Regulations 2005 (SI No 1983);

(aa) Any payments made under section 63(6)(b) of the Health Services and Public Health Act 1968 to a person to meet childcare costs where he or she is undertaking instruction connected with the health service by virtue of arrangements made under that section;

(ab) Any payment made in accordance with regulations under Section 14F of the Children Act 1989 to a resident who is a prospective special guardian or special guardian, whether income or capital.

Example of indefinitely disregarded capital:

Mr T is a former Far East prisoner of war and receives a £10,000 ex-gratia payment as a result of his imprisonment. He now requires care and support and has a total of £25,000 in capital. When calculating how much capital should be taken into account, the local authority **must** disregard the first £10,000 – the value of the ex-gratia payment. The normal capital rules are then applied to the remaining £15,000.

In this case, the first £14,250 would be completely disregarded in addition to the £10,000. Tariff income would therefore only be applied to the remaining £750 giving a charge of £3.

Property disregards

34. In the following circumstances the value of the person's *main or only* home **must** be disregarded:

(a) If the person's stay in residential or nursing care is temporary and they:

  (i) Intend to return to that property and that property is still available to them; **or**

  (ii) Are taking reasonable steps to dispose of the property in order to acquire another more suitable property to return to.

(b) Where the person no longer occupies the property but it is occupied in part or whole as their main or only home by any of the people listed below, the mandatory disregard only applies where the property has been continuously occupied since before the person went into a care home (for discretionary disregards see below):

  (i) The persons partner, former partner or civil partner, except where they are estranged;

  (ii) A lone parent who is the person's estranged or divorced partner;

  (iii) A relative as defined in paragraph 33 of the person or member of the person's family who is:

    (1) Aged 60 or over, or

    (2) Is a child of the resident aged under 18, or

    (3) Is incapacitated.

35. For the purposes of the disregard a relative is defined as including any of the following:

(a) Parent (including an adoptive parent)

(b) Parent-in-law

(c) Son (including an adoptive son)

(d) Son-in-law

(e) Daughter (including an adoptive daughter)

(f) Daughter-in-law

(g) Step-parent

(h) Step-son

(i) Step-daughter

(j) Brother

(k) Sister

(l) Grandparent

(m) Grandchild

(n) Uncle

(o) Aunt

(p) Nephew

(q) Niece

(r) The spouse, civil partner or unmarried partner of a to k inclusive.

36. A member of the person's family is defined as someone who is living with the qualifying relative as part of an unmarried couple, married to or in a civil partnership.

37. For the purposes of the disregard the meaning of "incapacitated" is not closely defined. However, it will be reasonable to conclude that a relative is incapacitated if either of the following conditions apply:

(a) The relative is receiving one (or more) of the following benefits: incapacity benefit, severe disablement allowance, disability living allowance, personal independence payments, armed forces independence payments, attendance allowance,

constant attendance allowance, or a similar benefit; or

(b) The relative does not receive any disability related benefit but their degree of incapacity is equivalent to that required to qualify for such a benefit. Medical or other evidence may be needed before a decision is reached.

38. For the purpose of the property disregard, the meaning of "occupy" is not closely defined. In most cases it will be obvious whether or not the property is occupied by a qualifying relative as their main or only home. However, there will be some cases where this may not be clear and the local authority **should** undertake a factual inquiry weighing up all relevant factors in order to reach a decision. An emotional attachment to the property is not sufficient for the disregard to apply.

39. Circumstances where it may be unclear might include where a qualifying relative has to live elsewhere for the purposes of their employment, for example a member of the armed services or the diplomatic service. Whilst they live elsewhere in order to undertake their employment, the property remains their main or only home. Another example may be someone serving a prison sentence. It would not be reasonable to regard the prison as the person's main or only home and they may well intend to return to the property in question at the end of their sentence. In such circumstances the local authority may wish to consider the qualifying relative's length of sentence and the likelihood of them returning to the property. Essentially the qualifying relative is occupying the property but is not physically present.

Example of emotional attachment to a property:

Bea is 62 years' old and lives with her family in Kent. Her father Patrick is a widower who has been living in the family home in Teddington that she and her sister grew up in and where she occasionally stays to help her father. Patrick has been assessed as having eligible care and support needs that are best met by moving into a care home.

Although Bea is over the age of 60, the family home is not her main or only home and the property is therefore not disregarded.

Example of occupying a property when not physically present:

Matt is 60 years old and has been living overseas for the past 10 years due to his job in the diplomatic service. When he is in England, he lives at the family home he grew up. His father Ken has been assessed as having eligible care and support needs that are best met by moving into a care home.

In Ken's financial assessment, the value of his property is disregarded as his son Matt is a qualifying relative that occupies the property as his main or only home. Although Matt is not physically present at the property at the point Ken moves into the care home, his alternative accommodation is only as a result of his employment and the family home is his main home.

40. The local authority will need to take account of the individual circumstances of each case; however, it may be helpful to

consider the following factors in making a decision:

- Does the relative currently occupy another property?
- If the relative has somewhere else to live do they own or rent the property (i.e. how secure/permanent is it?)
- If the relative is not physically present is there evidence of a firm intention to return to or live in the property
- Where does the relative pay council tax?
- Where is the relative registered to vote?
- Where is the relative registered with a doctor?
- Are the relatives belongings located in the property?
- Is there evidence that the relative has a physical connection with the property?

41. A property **must** be disregarded where the relative meets the qualifying conditions (i.e. is aged 60 or over or is incapacitated) and has occupied the property as their main or only home since before the resident entered the care home.

Discretionary disregard

42. A local authority **may** also use its discretion to apply the disregard in other circumstances. However, the local authority will need to balance this discretion with ensuring a person's assets are not maintained at public expense. An example where it may be appropriate to apply the disregard is where it is the sole residence of someone who has given up their own home in order to care for the person who is now in a care home or is perhaps the elderly companion of the person.

Example of local authority discretion to apply a property disregard:

Jayne has the early signs of dementia but wishes to continue living in her own home. She is not assessed as having eligible needs, but would benefit from some occasional support. Her best friend Penny gives up her own home to move in with Jayne. At this point, there is no suggestion that Jayne may need residential care.

After 5 years Jayne's dementia has reached the point where she needs a far greater level of care and support and following an assessment it is agreed her needs would best be met in a care home. On moving into the care home, the local authority uses its discretion to apply the property disregard as this has now become Penny's main or only home.

43. A property **may** be disregard when a qualifying relative moves into the property after the resident enters the care home. Where this happens the local authority will need to consider all the relevant factors in deciding whether the property must be disregarded. Factors such as the timing and purpose of the move may be relevant to establishing if the property is the relative's main or only home. The purpose of the disregard in these circumstances is to safeguard certain categories of people from the risk of homelessness.

44. The local authority **should** consider if the principle reason for the move is that it is necessary to ensure the relative has somewhere to live as their main or only home. A disregard would not be appropriate, for example where a person moves into a property solely to protect the family inheritance. Local authorities need to ensure that people are not needlessly maintained at public expense. A local authority will need to take account of the individual circumstances

of each case; however, it may be helpful to consider the factors listed above for the mandatory disregard plus the following additional factors in making a decision:

- Was the relative occupying another property as their main or only home at the time of the previous financial assessment?
- Could the relative have reasonably expected to have the property taken into account at the time they moved into the property?
- Would failure to disregard the property result in the eligible relative becoming homeless?
- Would failure to disregard the property negatively impact on the eligible relatives own health and wellbeing?

Example of local authority discretion to apply a property disregard where the qualifying person moves into the property after the resident entered the care home:

Fred's family home is unoccupied because his father has died and his mother is in a care home and Fred and his siblings have their own homes. The property is subject to a deferred payments agreement. Fred has a serious accident and becomes incapacitated. As a result he unable to work or pay for his existing home. He has nowhere else to live so he moves into the family home which becomes his only home.

In the circumstances, the local authority exercises its discretion to disregard the property.

Hilda is over 60. Her brother, Stephen, has died and his wife, Charlotte, is in a care home. The property is subject to a deferred payment agreement. Hilda loses her job and is unable to afford to live in her rented flat. Hilda moves into Stephen and Charlotte's house and this becomes her only home.

In the circumstances, the local authority exercises its discretion to disregard the property.

12-week property disregard

45. A key aim of the charging framework is to prevent people being forced to sell their home at a time of crisis. The regulations under the Care Act 2014 therefore create space for people to make decisions as to how to meet their contribution to the cost of their eligible care needs. A local authority **must** therefore disregard the value of a person's *main or only* home when the value of their non-housing assets is below the upper capital limit for 12 weeks in the following circumstances:

(a) When they first enter residential care as a permanent resident; or

(b) When a property disregard other than the 12-week property disregard unexpectedly end.

46. In addition, a local authority has discretion to choose to apply the disregard when there is a sudden and unexpected change in the person's financial circumstances. In deciding whether to do so, the local authority will want to consider the individual circumstances of the case. Such circumstances might include a fall in share prices or an unanticipated debt. An example is given below.

Example of the end of a property disregard:

Win and Ern have been married for 60 years and brought a home together. 18 months ago, Win moved into residential care as a result of dementia. During her financial assessment, the value of the home she shared with Ern was disregarded as Ern was over 60 years old and still lived in the property.

Ern has been in good health and there is no reason to anticipate a sudden change in circumstance. Unfortunately Ern suffers a heart attack and passes away, leaving the property to Win. There is no longer an eligible person living in the property, meaning its value can now be taken into account in what Win can afford to contribute to the cost of her care.

Given this was unplanned for, Win and her family need time to consider what the best option might be. The 12 week disregard would therefore be applied.

Example of an unexpected change in financial circumstances:

Harry is a widower who owns his own home. 10 months ago he moved into residential care as a self-funder. He has been meeting the bulk of his costs from shares he received as part of his redundancy package. Due to an unexpected events, the value of his shared is suddenly reduced by half, meaning he is unable to meet the cost of his care.

Although already in residential care and likely to remain responsible for paying for this care, Harry approaches the local authority for assistance and to seek a Deferred Payment Agreement. During the financial assessment the local authority agrees that the circumstances could not have been foreseen and uses its discretion to disregard the value of his property for the first 12 weeks. This provides Harry with the space he needs to make arrangements for the Deferred Payment Agreement to be put in place and enable him to continue to meet the cost of his care.

26-week disregard

47. The following capital assets **must** be disregarded for at least 26 weeks in a financial assessment. However, a local authority **may** choose to apply the disregard for longer where it considers this appropriate. For example where a person is taking legal steps to occupy premises as their home, but the legal processes take more than 26 weeks to complete.

(a) Assets of any business owned or part-owned by the person in which they were a self-employed worker and has stopped work due to some disease or disablement but intends to take up work again when they are fit to do so. Where the person is in residential care, this should apply from the date they first took up residence. **[Schedule 2 Paragraph 8]**

(b) Money acquired specifically for repairs to or replacement of the person's home or personal possessions provided it is used for that purpose. This should apply from the date the funds were received. **[Schedule 2 Paragraph 11]**

(c) Premises which the person intends to occupy as their home where they have started legal proceedings to obtain possession. This should be from the date legal advice was first sought or proceedings first commenced. **[Schedule 2 Paragraph 21]**

(d) Premises which the person intends to occupy as their home where essential repairs or alterations are required. This should apply from the date the person takes action to effect the repairs. **[Schedule 2 Paragraph 21]**

(e) Capital received from the sale of a former home where the capital is to be used by the person to buy another home. This should apply from the date of completion of the sale. **[Schedule 2 Paragraph 6]**

(f) Money deposited with a Housing Association which is to be used by the person to purchase another home. This should apply from the date on which the money was deposited. **[Schedule 2 Paragraph 11]**

(g) Grant made under a Housing Act which is to be used by the person to purchase a home or pay for repairs to make the home habitable. This should apply from the date the grant is received. **[Schedule 4 Paragraph 22]**

52-week disregard

48. The following payments of capital **must** be disregarded for a maximum of 52 weeks from the date they are received.

(a) The balance of any arrears of or any compensation due to non-payment of:

(i) Mobility supplement

(ii) Attendance Allowance

(iii) Constant Attendance Allowance

(iv) Exceptionally Severe Disablement Allowance

(v) Severe Disablement Occupational Allowance

(vi) Armed forces service pension based on need for attendance

(vii) Pension under the Personal Injuries (Civilians) Scheme 1983, based on the need for attendance

(viii) Income Support/Pension Credit

(ix) Minimum Income Guarantee

(x) Working Tax Credit

(xi) Child Tax Credit

(xii) Housing Benefit

(xiii) Special payments to pre-1973 war widows.

As the above payments will be paid for specific periods, they should be treated as income over the period for which they are payable. Any money left over after the period for which they are treated as income has elapsed should be treated as capital. **[Schedule 4 Paragraph 8]**

(b) Payments or refunds for:

(i) NHS glasses, dental treatment or patient's travelling expenses;

(ii) Cash equivalent of free milk and vitamins;

(iii) Expenses in connection with prison visits. **[Schedule 4 Paragraph 22]**

Example of a disregard for 52 weeks:

During his financial assessment it is identified that Colin is eligible for Pension Credit but is not currently claiming the support. He is therefore assessed as being able to pay £75 per week towards the cost of his care.

Colin tells the local authority that he will apply for Pension Credit. It is explained to him that the level of what he can afford to contribute will be reassessed once he started receiving the additional support. If the payments are backdated, his contributions to the cost of his care will

also be backdated and he may therefore need to make an additional payment to meet any arrears. Colin therefore chooses to pay £90 per week.

After six weeks, arrears of Pension Credit at £35 per week (£210) are received. What Colin can afford to contribute is reassessed and he is now asked to pay £110 per week. As Colin has been paying £15 a week more than required, he only owes £120 rather than the full £210 of Pension Credit arrears. The remaining £90 of arrears payments should therefore be treated as capital and disregarded.

2-year disregard

49. Local authorities **must** disregard payments made under a trust established out of funds by the Secretary of State for Health in respect of vCJD to:

(a) The victim's parent (or guardian) for 2 years from the date of death of the victim (or from the date of payment from the trust if later); or

(b) A dependent child or young person until they turn 18. **[Schedule 2 Paragraph 27]**

Other disregards

50. In some cases a person's assets may be tied up in a business that they own or part-own. Where a person is taking steps to realise their share of the assets, these should be disregarded during the process. However, the person **should** be required to show that it is their clear intention to realise the asset as soon as practicable.

51. In order to show their intent, the local authority **should** request the following information:

(a) A description of the nature of the business asset;

(b) The person's estimate of the length of time necessary to realise the asset or their share of it;

(c) A statement of what, if any, steps have been taken to realise the asset, what these were and what is intended in the near future; and

(d) Any other relevant evidence, for example the person's health, receivership, liquidation, estate agent's confirmation of placing any property on the market.

52. Where the person has provided this information to show that steps are being taken to realise the value of the asset, the local authority **must** disregard the value for a period that it considers to be reasonable. In deciding what is reasonable it **should** take into account the length of time of any legal processes that may be needed.

53. Where the person has no immediate intention of attempting to realise the business asset, its capital value should be taken into account in the financial assessment. Where a business is jointly owned, this should apply only to the person's share.

Treatment of investment bonds

54. The treatment of investment bonds is currently complex. This is in part because of the differing products that are on offer. As such, local authorities may wish to seek advice from their legal departments.

55. Where an investment bond includes one or more element of life insurance policies that contain cashing-in rights by way of options for total or partial surrender, then the value of

those rights **must** be disregarded as a capital asset in the financial assessment.

Capital treated as income

56. The following capital payments should be treated as income. Local authorities therefore **must** have regard to Annex C before conducting their assessments.

(a) Any payment under an annuity.

(b) Capital paid by instalment where the total of:

  (i) The instalments outstanding at the time the person first becomes liable to pay for their care, or in the case of as person in temporary care whom the local authority had previously decided not to charge, the first day on which the local authority decided to charge; and

  (ii) The amount of other capital held by the resident is over £16,000. If it is £16,000 or less, each instalment should be treated as capital. **[Regulation 15]**

Earnings

57. Any income of the person derived from employment **must** be treated as earnings and not taken into account in the financial assessment.

Income treated as capital

58. The following types of income **should** be treated as capital:

(a) Any refund of income tax charged on profits of a business or earnings of an employed earner;

(b) Any holiday pay payable by an employer more than 4 weeks after the termination or interruption of employment;

(c) Income derived from a capital asset, for example, building society interest or dividends from shares. This should be treated as capital from the date it is normally due to be paid to the person. This does not apply to income from certain disregarded capital;

(d) Any bounty payment paid at intervals of at least one year from employment as:

  (i) A part time fireman

  (ii) An auxiliary coastguard

  (iii) A part time lifeboat man

  (iv) A member of the territorial or reserve forces.

(e) Any advance of earnings or loan made to an employed earner by the employer if the person is still in work. This is as the payment does not form part of the employee's regular income and would have to be repaid;

(f) Charitable and voluntary payments which are neither made regularly nor due to be made regularly, apart from certain exemptions such as payments from AIDS trusts. Payments will include those made by a third party to the person to support the clearing of charges for residential accommodation;

(g) Any payments of arrears of contributions by a local authority to a custodian towards the cost of accommodation and maintenance of a child. **[Regulation 18]**

Capital available on application

59. In some instances a person may need to apply for access to capital assets but has not yet done so. In such circumstances

this capital should be treated as already belonging to the person except in the following instances:

(a) Capital held in a discretionary trust;

(b) Capital held in a trust derived from a payment in consequence of a personal injury;

(c) Capital derived from an award of damages for personal injury which is administered by a court;

(d) Any loan which could be raised against a capital asset with is disregarded, for example the home. **[Regulation 21(2)]**

60. A local authority **should** distinguish between:

(a) Capital already owned by the person but which in order to access they must make an application for. For example:

  (i) Money held by the person's solicitor;

  (ii) Premium Bonds;

  (iii) National Savings Certificates;

  (iv) Money held by the Registrar of a County Court which will be released on application; and

(b) Capital not owned by the person that will become theirs on application, for example an unclaimed Premium Bond win. This should be treated as notional capital. **[Regulation 21(2)]**

61. Where a local authority treats capital available on application as notional capital they should do so only from the date at which it could be acquired by the person. **[Regulation 21(2)]**

Annex C: Treatment of income

This annex covers:

- The treatment of income when conducting a financial assessment in all circumstances. This is divided into:
  - Care homes
  - All other settings

The purpose of this annex is to provide local authorities with detailed guidance on how to apply to the Care and Support (Assessment of Resources) Regulations 2014, in terms of how to treat different types of income when calculating what a person can afford to contribute to the cost of their eligible care needs.

1. This section of the guidance only applies where a local authority has chosen to charge a person for the services it is arranging and therefore **must** undertake a financial assessment. When doing so, it **must** assess the income and capital of the person.

2. There are differences in how income is treated in a care home and in all other settings. Charging a person in a care home is provided for in a consistent national framework, set out in this guidance. When charging a person in all other settings, a local authority has more discretion to enable it to take account of local practices and innovations. However, it **must** read this guidance in all circumstances.

3. This annex covers the treatment of income and should be read in conjunction with Annex B on the treatment of capital. The detail of the sources of income which local authorities **must** disregard are set out in the regulations which accompany this guidance.

Overview

4. Only the income of the cared-for person can be taken into account in the financial assessment of what they can afford to pay for their care and support. Where a cared-for person receives income as one of a couple the starting presumption is that the cared-for person has an equal share of the income.

5. Income is net of any tax or National Insurance contributions.

6. Income will always be taken into account unless it is disregarded under the regulations. Income that is disregarded will either be:

(a) Partially disregarded: or

(b) Fully disregarded.

7. In all cases, irrespective of setting, employed and self-employed earnings are disregarded. **[Regulation 7]**

8. Earnings in relation to an employed earner are any remuneration or profit from employment. This will include:

(a) any bonus or commission;

(b) any payment in lieu of remuneration except any periodic sum paid to the person on account of the termination of their employment by reason of redundancy;

(c) any payments in lieu of notice or any lump sum payment intended as compensation for the loss of employment but only in so far as it represents loss of income;

(d) any holiday pay except any payable more than four weeks after the termination or interruption of employment;

(e) any payment by way of a retainer;

(f) any payment made by the person's employer in respect of any expenses **not** wholly, exclusively and necessarily incurred in the performance of the duties of employment, including any payment made by the person's employer in respect of travelling expenses incurred by the person between their home and the place of employment and expenses incurred by the person under arrangements made for the care of a member of the person's family owing to the person's absence from home;

(g) any award of compensation made under section 112(4) or 117(3)(a) of the Employment Rights Act 1996 (remedies and compensation for unfair dismissal);

(h) any such sum as is referred to in section 112 of the Social Security Contributions and Benefits Act 1992 (certain sums to be earnings for social security purposes);

(i) any statutory sick pay, statutory maternity pay, statutory paternity pay or statutory adoption pay, or a corresponding payment under any enactment having effect in Northern Ireland;

(j) any remuneration paid by or on behalf of an employer to the person who for the time being is on maternity leave, paternity leave or adoption leave or is absent from work because of illness;

(k) the amount of any payment by way of a non-cash voucher which has been taken into account in the computation of a person's earnings in accordance with Part 5 of Schedule 3 to the Social Security (Contributions) Regulations 2001.

9. Earnings in relation to an employed earner do not include:

(a) any payment in kind, with the exception of any non-cash voucher which has been taken into account in the computation of the person's earnings – as referred to above;

(b) any payment made by an employer for expenses wholly, exclusively and necessarily incurred in the performance of the duties of the employment;

(c) any occupational/personal pension.

10. Earnings in the case of employment as a self-employed earner mean the gross receipts of the employment. This includes any allowance paid under section 2 of the Employment and Training Act 1973 or section 2 of the Enterprise and New Towns (Scotland) Act 1990 to the person for the purpose of assisting the person in carrying on his business.

11. Earnings in the case of employment as a self-employed earner do not include:

(a) any payment to the person by way of a charge for board and lodging accommodation provided by the person;

(b) any sports award.

12. Earnings also include any payment provided to prisoners to encourage and reward their constructive participation in the regime of the establishment, this may include payment for working, education or participation in other related activities.

Care homes

13. As all earnings **must be** disregarded, this leaves other sources of income such as benefits, pensions and payments from other products that can be taken into account.

Personal expenses allowance

14. The local authority **must** leave the person with a minimum amount of income. This is known as the Personal Expenses Allowance (PEA) and the amount is set out in regulations each year and updates sent via a local authority circular. Anything above this may be taken into account in determining charges.

15. The PEA is not a benefit but the amount of a person's own income that they should be left with after charges have been deducted. However, where a person has no income, the local authority is not responsible for providing one. However, the local authority **should** support the person to access any relevant state benefits or independent advocacy service.

16. The purpose of the PEA is to ensure that a person has money to spend as they wish. It **must not** be used to cover any aspect of their care and support that have been contracted for by the local authority and/or assessed as necessary to meet the person's eligible needs. This money is for the person to spend as they wish and any pressure from a local authority or provider to do otherwise is not permitted.

17. There may be some circumstances where it would not be appropriate for the local authority to leave a person only with the personal expenses allowance after charges. For example:

(a) Where a person has a dependent child the local authority **should** consider the needs of the child in determining how much income a person should be left with after charges. This applies whether the child is living with the person or not.

(b) Where a person is paying half their occupational or personal pension or retirement annuity to a spouse or civil partner who is not living in the same care home, the local authority must disregard this money. This does not automatically apply to unmarried couples although the local authority may wish to exercise its discretion in individual cases.

(c) Where a person is temporarily in a care home and is a member of a couple – whether married or unmarried – the local authority **should** disregard any Income Support or Pension Credit awarded to pay for home commitments. It should also consider disregarding other costs related to maintain the couple's home (see below).

(d) Where a person's property has been disregarded the local authority **should** consider whether the PEA is sufficient to enable the person to meet any resultant costs. For example, allowances should be made for fixed payments (like mortgages, rent and Council Tax), building insurance, utility costs (gas, electricity and water, including basic heating during the winter) and reasonable property maintenance costs.

Benefits

18. The following types of benefits **must** be taken fully into account when considering what a person can afford to pay towards their care from their income:

(a) Attendance Allowance, including Constant Attendance Allowance and Exceptionally Severe Disablement Allowance

(b) Bereavement Allowance

(c) Carer's Allowance

(d) Disability Living Allowance

(e) Employment and Support Allowance or the benefits this replaces such as Severe Disablement Allowance and Incapacity Benefit

(f) Income Support

(g) Industrial Injuries Disablement Benefit or equivalent benefits

(h) Jobseeker's Allowance

(i) Maternity Allowance

(j) Pension Credit

(k) Personal Independence Payments

(l) State Pension

(m) Universal Credit

(n) Working Tax Credit.

19. Where any Social Security benefit payment has been reduced (other than a reduction because of voluntary unemployment), for example because of an earlier overpayment, the amount taken into account should be the gross amount of the benefit before reduction.

Annuity income

20. An annuity is a product that provides a regular income for a predetermined number of years in return for an investment. This can be made as a single lump sum or in instalments. Such products are usually purchased at retirement in order to provide a regular income. While the capital is disregarded, any income from an annuity **must** be taken fully into account except where it is:

(a) Purchased with a loan secured on the person's main or only home; or

(b) A gallantry award such as the Victoria Cross Annuity or George Cross Annuity.

21. For those who have purchased an annuity with a loan secured on their main or only home, this is known as a 'home income plan'. Under these schemes, a person has purchased the annuity against the value of their home – similarly to a Deferred Payment Agreement.

22. In order to qualify for the disregard, one of the annuitants **must** still be occupying the property as their main or only home. This may happen where a couple have jointly purchased an annuity and only one of them has moved into a care home. If this is not the case, the disregard **must** not be applied.

23. Where the disregard is applied, only the following aspects may be disregarded:

(a) The net weekly interest on the loan where income tax is deductible from the interest; or

(b) The gross weekly interest on the loan in any other case.

24. Before applying the disregard, the following conditions must be met:

(a) The loan must have been made as part of a scheme that required that at least 90% of that loan be used to purchase the annuity;

(b) The annuity ends with the life of the person who obtained the loan, or

where there are two or more annuitants (including the person who obtained the loan), with the life of the last surviving annuitant;

(c) The person who obtained the loan or one of the other annuitants is liable to pay the interest on the loan;

(d) The person who obtained the loan (or each of the annuitant where there are more than one) must have reached the age of 65 at the time the loan was made;

(e) The loan was secured on a property in Great Britain and the person who obtained the loan (or one of the other annuitants) owns an estate or interest in that property; and

(f) The person who obtained the loan or one of the other annuitant occupies the property as their main or only home at the time the interest is paid.

25. Where the person is using part of the income to repay the loan, the amount paid as interest **must** be disregarded. If the payments the person makes on the loan are interest only and the person qualifies for tax relief on the interest they pay, disregard the net interest. Otherwise, disregard the gross interest.

Mortgage protection insurance policies

26. Any income from an insurance policy is usually taken into account. In the case of mortgage protection policies where the income is specifically intended to support the person to acquire or retain an interest in their main or only home or to support them to make repairs or improvements to their main or only home it **must** be disregarded. However, the income **must** be being used to meet the repayments on the loan.

27. The amount of income from a mortgage protection insurance policy that should be disregarded is the weekly sum of:

(a) The amount which covers the interest on the loan; plus

(b) The amount of the repayment which reduced the capital outstanding; plus

(c) The amount of the premium due on the policy.

28. It should be remembered that Income Support and Pension Credit may be adjusted to take account of the income from the policy.

Other income that must be fully disregarded

29. Any income from the following sources **must** be fully disregarded:

(a) Armed Forces Independence Payments and Mobility Supplement

(b) Child Support Maintenance Payments and Child Benefit

(c) Child Tax Credit

(d) Disability Living Allowance (Mobility Component) and Mobility Supplement

(e) Christmas bonus

(f) Dependency increases paid with certain benefits

(g) Gallantry Awards

(h) Guardian's Allowance

(i) Guaranteed Income Payments made to Veterans under the Armed Forces Compensation Scheme

(j) Personal Independence Payment (Mobility Component) and Mobility Supplement

(k) Social Fund payments (including winter fuel payments)

(l) Any payment from the:

(i) Macfarlane Trust

(ii) Macfarlane (Special Payments) Trust

(iii) Macfarlane (Special Payment) (No 2) Trust

(iv) Caxton Foundation

(v) Fund (payments to non-haemophiliacs infected with HIV)

(vi) Eileen Trust

(vii) MFET Limited

(viii) Independent Living Fund (2006)

(ix) Skipton Fund

(x) London Bombings Relief Charitable Fund.

Charitable and voluntary payments

30. Charitable payments are not necessarily made by recognised charity, but could come from charitable motives. The individual circumstances of the payment will need to be taken into account before making a decision. In general a charitable or voluntary payment which is not made regularly is treated as capital.

31. Charitable and voluntary payments that are made regularly are fully disregarded.

Partially disregarded income

32. The following income is partially disregarded:

(a) The first £10 per week of War Widows and War Widowers pension, survivors Guaranteed Income Payments from the Armed Forces Compensation Scheme, Civilian War Injury pension, War Disablement pension and payments to victims of National Socialist persecution (paid under German or Austrian law).

(b) A savings disregard based on qualifying is made to people as follows:

For individuals

- Where a person is in receipt of qualifying income of less than £120.35 per week there will be no Savings Disregard made.
- Where a person is in receipt of qualifying income between £120.35 and £148.35 per week the savings disregard is made, which will equal the actual amount of the savings credit received or a sum of £5.75 whichever is less.
- Where a person is in receipt of qualifying income in excess of £148.35 per week, and a savings credit reward is in payment, a flat rate savings disregard of £5.75 per week is made irrespective of how much the savings credit payment is.
- Where a person has qualifying income above the limit for receiving a savings credit reward (around £190.35 but could be higher if the person is severely disabled, has caring responsibilities or certain housing costs) a flat rate savings disregard of £5.75 is made.

For couples

- Where a person is part of a couple (including a civil partnership) and is in receipt of qualifying income of less than £192.00 per week there will be no savings disregard made.
- Where a person who is part of a couple (including a civil partnership) and is in receipt of qualifying income between £192.00 and £226.50 per week the savings disregard is made,

which will equal the actual amount of the savings credit received or a sum of £8.60 whichever is less.

- Where a person who is part of a couple (including a civil partnership) and is in receipt of qualifying income in excess of £226.50 per week, and a savings credit reward is in payment, a flat rate savings disregard of £8.60 per week is made irrespective of how much the savings credit payment is.
- Where a person who is part of a couple (including a civil partnership) and has qualifying income above the limit for receiving savings credit (around £278.25 but could be higher if the person is severely disabled, has caring responsibilities or certain housing costs) a flat rate savings disregard of £8.60 is made.

The values of £148.35 and £226.50 above represent the standard minimum guarantee for an individual and couple respectively. These amounts are increased to an appropriate minimum guarantee where individuals and couples qualify as severely disabled or as carers because of receipt of qualifying benefits. Details of Pension Credit are given in Annex I. Examples of how the savings reward is calculated, plus a list of qualifying income, are given in the document *Pension Credit and the Savings Disregard*.[170]

Notional income

33. In some circumstances a person may be treated as having income that they do not actually have. This is known as notional income. This might include for example income that would be available on application but has not been applied for, income that is due but has not been received or income that the person has deliberately deprived themselves of for the purpose of reducing the amount they are liable to pay for their care. For guidance on deprivation of assets, see Annex E. In all cases the local authority **must** satisfy itself that the income would or should have been available to the person.

34. Notional income should also be applied where a person who has reached retirement age and has a personal pension plan but has not purchased an annuity or arranged to draw down the maximum income available from the plan. Estimates of the notional income can be received from the pensions provider.

35. Where notional income is included in a financial assessment, it **should** be treated the same way as actual income. Therefore any income that would usually be disregarded should continue to be so.

36. Notional income should be calculated from the date it could be expected to be acquired if an application had been made. In doing so, a local authority **should** assume the application was made when it first became aware of the possibility and take account of any time limits which may limit the period of arrears.

Example of notional income:

Darren is 69 and has moved into a care home. He has not been receiving his state pension to which he is entitled, had he applied. The local authority became aware of this on the 30th September 2013. State pension can only be back dated a year from the date of claim. The local authority can therefore only apply notional income from 1 October 2012.

[170] www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/ResidentialCare/fs/en

Example of notional income:

Andrew is 70 and is living in a care home. He has not been receiving his occupational pension to which he would have been entitled to from age 65. After contacting his former employer, they state Andrew will be paid the entire pension due from age 65. The local authority can therefore apply notional income from age 65.

37. However, there are some exemptions and the following sources of income **must not** be treated as notional income:

(a) Income payable under a discretionary trust;

(b) Income payable under a trust derived from a payment made as a result of a personal injury where the income would be available but has not yet been applied for;

(c) Income from capital resulting from an award of damages for personal injury that is administered by a court;

(d) Occupational pension which is not being paid because:

  (i) The trustees or managers of the scheme have suspended or ceased payments due to an insufficiency of resources; or

  (ii) The trustees or managers of the scheme have insufficient resources available to them to meet the scheme's liabilities in full.

(e) Working Tax Credit.

All other settings

38. As all earnings **must** be disregarded, this leaves other sources of income such as benefits, pensions and payments from other products.

Minimum income guarantee

39. Local authorities **must** ensure that a person is left with a minimum level of income. This **must** be the value of Income Support or the Guaranteed Credit element of Pension Credit plus a minimum buffer of 25%. This approach will maintain consistency between the charging framework and established income protections under the income support rules. We will keep this under review and seek to update the charging framework in line with the roll-out of Personal Independent Payments and updating/repeal of the income support rules.

40. The purpose of the minimum income guarantee is to promote independence and social inclusion and ensure that they have sufficient funds to meet basic needs such as purchasing food. This **must** be after any housing costs such as rent, utilities, insurance – and any benefits to support meeting these costs – and any disability related expenditure.

41. Separate guidance applies when determining an appropriate contribution from income under a deferred payment agreement.

Benefits

42. Local authorities may take most of the benefits cared-for people receive into account. Those they must disregard are listed below. However, they need to ensure that in addition to the minimum guaranteed income people retain enough of their benefits to pay for things to meet those needs not being met by the local authority.

Income other than earning that must be fully disregarded

43. Any income from the following sources **must** be fully disregarded:

(a) Guaranteed Income Payments made to Veterans under the Armed Forces Compensation Scheme;

(b) The mobility component of Disability Living Allowance;

(c) The mobility component of Personal Independence Payments.

Disability-related expenditure

44. Where disability-related benefits are taken into account, the local authority **should** make an assessment and allow the person to keep enough benefit to pay for necessary disability-related expenditure to meet any needs which are not being met by the local authority.

45. In assessing disability-related expenditure, local authorities should include the following:

(a) Payment for any community alarm system.

(b) Costs of any privately arranged care services required, including respite care.

(c) Costs of any specialist items needed to meet the person's disability needs, for example:

(i) Day or night care which is not being arranged by the local authority;

(ii) specialist washing powders or laundry;

(iii) additional costs of additional costs of special dietary needs due to illness or disability (the person may be asked for permission to approach their GP in cases of doubt);

(iv) special clothing or footwear, for example, where this needs to be specially made; or additional wear and tear to clothing and footwear caused by disability;

(v) additional costs of bedding, for example, because of incontinence;

(vi) any heating costs, or metered costs of water, above the average levels for the area and housing type, occasioned by age, medical condition or disability;

(vii) reasonable costs of basic garden maintenance, cleaning, or domestic help, if necessitated by the individual's disability and not met by social services;

(viii) purchase, maintenance, and repair of disability-related equipment, including equipment or transport needed to enter or remain in work; this may include IT costs, where necessitated by the disability; reasonable hire costs of equipment may be included, if due to waiting for supply of equipment from the local council;

(ix) personal assistance costs, including any household or other necessary costs arising for the person;

(x) other transport costs necessitated by illness or disability, including costs of transport to day centres, over and above the mobility component of DLA or PIP, if in payment and available for these costs. In some cases, it may be reasonable for a council not to take account of claimed transport costs – if, for example, a suitable, cheaper form of transport, e.g. council-provided transport to day centres is available, but has not been used;

(xi) in other cases, it may be reasonable for a council not to allow for items where a reasonable alternative is available at lesser cost. For example, a council might adopt a policy not to allow for the private purchase cost of continence pads, where these are available from the NHS.

46. The care plan may be a good starting point for considering what is necessary disability-related expenditure. However, flexibility is needed. What is disability-related expenditure should not be limited to what is necessary for care and support. For example, above average heating costs should be considered.

Annex D: Recovery of debts

This annex covers:

- This section of the guidance is designed to provide an overview of what a local authority must take into account when deciding what steps to take in recovering debts, in particular:
  - Steps to take when considering debts
  - Debts and deferred payments agreements
  - Timing of debt recovery
  - Court action
  - Complaints

1. The Care Act 2014 consolidates local authorities' powers to recover money they are owed for arranging care and support for a person. Ultimately the local authority **may** take the person or other party to the County Court to recover the debt.

2. These powers can be exercised where a person refuses to pay the amount they have been assessed as being able to pay. They can also be exercised where the person, or their representative, misrepresents or fails to disclose (whether fraudulently or otherwise) information relevant to the financial assessment of what they can afford to pay.

3. The principles of the approach to debt recovery should be:

- Taking Court action to recover a debt should be the last resort,
- The local authority should act reasonably,
- Possible debts should be discussed with the person receiving care,
- Arrangements for debt repayments should be agreed, if possible, with the person receiving care or their representative,
- Repayments should be affordable for the person receiving care.

Steps to take when considering debt recovery

4. Local authorities are bound by the public law principle of acting reasonably at all times and must act in accordance with human rights legislation, as well as the well-being principle.

5. A local authority **should not**, as a matter of course, use these powers to recover debts without first having discussed other options with the person concerned. In most cases, especially those where the failure to pay the correct charges was inadvertent,

there will be other simpler routes to follow, such as agreeing a repayment plan which allows for recovery over time in a way that is affordable and manageable for the person and their family.

6. The local authority should discuss the situation with the person receiving care and support and their family when appropriate to establish what, if anything, is owed to the local authority. The local authority can recover the money it over-spent on the person's care (i.e. the difference between the amount it would have spent on arranging care and support if the person had declared all their assets so that they were not under-charged and the amount it actually spent). In addition, the local authority can recover the costs it incurred in recovering the debt.

7. Even if there is a debt, the local authority will need to consider whether it is appropriate to recover it. The local authority does not have to recover the debt – it can choose not to do so. The local authority should consider not recovering a debt where:

(a) The amount of the debt is small and the costs of recovery would be disproportionate.

(b) The impact of recovering the debt would adversely affect the well-being of the person receiving care and support.

(c) The person or their representative could not reasonably have been aware that the asset in question needed to be included in the financial assessment.

Debts and deferred payment agreements

8. Where a person is eligible for a deferred payments agreement (DPA) the local authority **must** offer the person the option of repaying the debt through a DPA. Where a person is eligible for a DPA the local authority can only use its debt recovery powers if the person has been offered a DPA and refused it. However where offering a DPA for the purposes of debt recovery a local authority may offer to defer only the amount of existing debts and will not be obliged to offer to defer the costs of further care and support.

Timing of debt recovery

9. A debt which arises after the Care Act 2014 comes into force **must** be recovered within six years of the date when the sum became due to the local authority. This is an extension to the previous limits for a debt that arose before the Care Act 2014 came into force which had to be recovered within three years of the date when it became due.

Court action

10. Where, after all the other options have been exhausted, the person receiving care refuses to repay the debt the local authority **may** seek to recover the money through the County Court. More information about how to go about this can be found on the GOV.UK website.[171]

Complaints

11. A person may wish to make a complaint about any aspect of the way a local authority uses its powers under the Care Act. A local authority **must** make clear what its complaints procedure is and provide information and advice on how to lodge a complaint.

[171] https://www.gov.uk/make-court-claim-for-money/overview

Annex E: Deprivation of assets

This annex covers:

- The deprivation of capital in order to avoid or reduce care and support charges.
- The deprivation of income in order to avoid or reduce care and support charges.

The purpose of this annex is to provide local authorities with detailed guidance on how to respond when they suspect that a person has deliberately deprived themselves of assets in order to avoid or decrease the amount they are asked to pay towards any care and support charges. For the purposes of this section, "assets" means capital and/or income.

Setting the context

1. Where an adult has been assessed as having an eligible care and support need and the local authority has a duty or power to meet their needs, the local authority **must** make a decision as to whether or not to charge a person for meeting their care needs. In doing so, it **may** choose to undertake a financial assessment.

2. The financial assessment will need to look across all of our person's assets – both capital and income – decide which is which and assess those assets according to the regulations and guidance. A local authority therefore **must** also refer to Annex C on the treatment of income and Annex B on the treatment of capital before conducting a financial assessment.

3. When undertaking a financial assessment a local authority may identify circumstances that suggest that a person may have deliberately deprived themselves of assets in order to reduce the level of the contribution towards the cost of their care. In such circumstances, the local authority should have regard to this guidance.

4. It is important that people pay the contribution to their care costs that they are responsible for. This is key to the overall affordability of the care and support system. A local authority **should** therefore ensure that people are not rewarded for trying to avoid paying their assessed contribution.

5. The overall principle **should** be that when a person has tried to deprive themselves of assets, this **should** not affect the amount of local authority support they receive.

What is meant by deprivation of assets?

6. Deprivation of assets means where a person has intentionally deprived or decreased their overall assets in order to reduce the amount they are charged towards their care.

7. Where this has been done to remove a debt that would otherwise remain, even if

that is not immediately due, this **must** not be considered as deprivation.

Has deprivation of capital occurred?

8. It is up to the person to prove to the local authority that they no longer have the asset. If they are not able to, the local authority **must** assess them as if they still had the asset. For capital assets, acceptable evidence of their disposal would be:

(a) A trust deed

(b) Deed of gift

(c) Receipts for expenditure

(d) Proof that debts have been repaid.

9. A person can deprive themselves of capital in many ways, but common approaches may be:

(a) A lump-sum payment to someone else, for example as a gift or to repay a debt;

(b) Substantial expenditure has been incurred;

(c) The title deeds of a property have been transferred to someone else;

(d) Assets have been put in to a trust that cannot be revoked;

(e) Assets have been converted into another form that would be subject to a disregard under the financial assessment for example personal possessions;

(f) Assets have been reduced by living extravagantly, for example gambling;

(g) Assets have been used to purchase an investment bond with life insurance.

10. However, this will not be deliberate in all cases. Questions of deprivation therefore **should** only be considered where the person ceases to possess assets that would have otherwise been taken into account for the purposes of the financial assessment or has turned the asset into one that is now disregarded.

Example of assets to be considered:

Emma gives her daughter Imogen a painting worth £2,000 the week before she enters residential care. The local authority should not consider this as deprivation as the item is a personal possession and would not have been taken into account in his financial assessment.

However, if Emma had purchased the painting immediately prior to entering residential care to give to her daughter with £2,000 previously in a savings account, deprivation should be considered.

11. There may be many reasons for a person depriving themselves of an asset. A local authority **should** therefore consider the following before deciding whether deprivation for the purpose of avoiding care and support charges has occurred:

(a) Whether avoiding the care and support charge was a significant motivation;

(b) The timing of the disposal of the asset. At the point the capital was disposed of could the person have a reasonable expectation of the need for care and support?; and

(c) Did the person have a reasonable expectation of needing to contribute to the cost of their eligible care needs?

12. For example, it would be unreasonable to decide that a person had disposed of an asset in order to reduce the level of charges for their care and support needs if at the time the disposal took place they were fit and healthy and could not have foreseen the need for care and support.

Example of assets to be considered:

Mrs Kapoor has £18,000 in a building society and uses £10,500 to purchase a car. Two weeks later she enters residential care and gives the car to her daughter Juhie.

If Mrs Kapoor knew when she purchased the car that she would be moving to residential care, then deprivation should be considered. However, all the circumstances must be taken into account so if Mrs Kapoor was admitted as an emergency and had no reason to think she may need care and support when she purchased the car, this should not be considered as deprivation.

Has deprivation of income occurred?

13. It is also possible for a person to deliberately deprive themselves of income. For example, they could give away or sell the right to an income from an occupational pension.

14. It is up to the person to prove to the local authority that they no longer have the income. Where a local authority considers that a person may have deprived themselves of income, they **may** treat them as possessing notional income.

15. The local authority will need to determine whether deliberate deprivation of income has occurred. In doing so it **should** consider:

(a) Was it the person's income?

(b) What was the purpose of the disposal of the income?

(c) The timing of the disposal of the income? At the point the income was disposed of could the person have a reasonable expectation of the need for care and support?

16. In some circumstances the income may have been converted into capital. The local authority **should** consider what tariff income may be applied to the capital and whether the subsequent charge is less or more than the person would have paid without the change.

Local authority investigations

17. In some cases a local authority **may** wish to conduct its own investigations into whether deprivation of assets has occurred rather than relying solely on the declaration of the person. There is separate guidance under the Regulation of Investigatory Powers Act 2000 that has recently been updated.[172] That sets out the limits to local authority powers to investigate and local authorities **should** have regard to it before considering any investigations.

What happens where deprivation of assets has occurred?

18. If a local authority decides that a person has deliberately deprived themselves of assets in order to avoid or reduce a charge for care and support, they will first need to decide whether to treat that person as still having the asset for the purposes of the financial assessment and charge them accordingly.

19. As a first step, a local authority **should** seek to charge the person as if the deprivation had not occurred. This means assuming they still own the asset and treating it as notional capital or notional income.

[172] https://www.gov.uk/government/publications/changes-to-local-authority-use-of-ripa

Recovering charges from a third party

20. Where the person has transferred the asset to a third party to avoid the charge, the third party is liable to pay the local authority the difference between what it would have charged and did charge the person receiving care. However, the third party is not liable to pay anything which exceeds the benefit they have received from the transfer.

21. If the person has transferred funds to more than one third party, each of those people is liable to pay the local authority the difference between what it would have charged or did charge the person receiving care in proportion to the amount they received.

22. As with any other debt, the local authority can use the County Court process to recover debts, but this should be as a last resort. When pursing the recovery of charges from a third party, a local authority **must** read Annex D on debt recovery.

Example of liability of a third party:

Mrs Tong has £23,250 in her savings account. This is the total of her assets. One week before entering care she gives her daughters Louisa and Jenny and her son Frank £7,750 each. This was with the sole intention of avoiding care and support charges.

Had Mrs Tong not given the money away, the first £14,250 would have been disregarded and she would have been charged a tariff income on her assets between £14,250 and £23,250. Assuming £1 for every £250 of assets, this means Mrs Tong should have paid £36 per week towards the cost of her care. After 10 weeks of care, Mrs Tong should have contributed £360. This means Louisa, Jenny and Frank are each liable for £120 towards the cost of their mother's care.

Annex F: Temporary residents in care homes

This annex covers:

- How to undertake a financial assessment of someone who is temporarily placed in a care home.

Setting the context

1. Following an assessment of a person's eligible care and support needs a decision may be taken that the person would benefit from a temporary stay in a care home. This could be for a number of reasons such as providing respite care to a carer or to provide a period of more intense support owing to an additional, but temporary, care need.

2. As the move is not permanent, the financial assessment of what they can afford to contribute to the cost of their care and support needs **must** be undertaken with regard to the following guidance.

3. The financial assessment must be based on the individual resources of the person. However a local authority should give regard to any partner or spouse remaining at home and ensure they are left with a basic level of income support or pension credit to which they may be entitled in their own right.

Who is a temporary resident?

4. A temporary resident is defined as a person whose need to stay in a care home is *intended* to last for a limited period of time and where there is a plan to return home. The person's stay should be unlikely to exceed 52 weeks, or in exceptional circumstances, unlikely to substantially exceed 52 weeks.

5. A decision to treat a person as a temporary resident **must** be agreed with the person and/or their representative and written into their care plan.

6. In some cases a person may enter a care home with the intention of a permanent stay but a change in circumstances could result in it being temporary. In such cases the local authority should **treat** the person as temporary from the date of admission for the purposes of charging.

7. Similarly a stay which was initially intended to be temporary could become permanent. In such cases, the financial assessment of the person as a permanent resident **should** only be from the date that the care plan is amended and agreed with the person and/or their representative.

Charging for the first 8 weeks

8. Whether a person is a temporary or permanent resident, a financial assessment of a person's ability to pay is not required for the first 8 weeks of a stay in a care home and a local authority **may** choose not to charge and therefore not to undertake an assessment. After 8 weeks, the local authority must

decide whether it intends to charge and if so, undertake a financial assessment.

Assessing ability to pay

9. Once a local authority has decided to charge a person and it has been agreed that they are a temporary resident, the local authority **must** undertake the financial assessment in accordance with the following guidance.

Capital

10. The person's *main or only* home **must** be disregarded where the person:

(a) Intends to return to that property as their main or only home and it remains available to them; or

(b) Has taken steps to dispose of the home in order to acquire one that is more suitable and intends to return to that property.

11. Any other capital assets should be treated in the same way as for permanent residents. Guidance is set out in Annex B.

Income and earnings

12. Both income and earnings should be treated in the same way as for permanent residents, as set out in Annex C on income. However, any additional amounts the person may need so they can maintain their home during their temporary stay so that it is in a fit condition for them to return to **must** be disregarded. Such expenses may include, but are not limited to, ground rent, service charges, water rates or insurance premiums.

13. However, the local authority **should** also take into account the following additional points.

14. Where Attendance Allowance or Disability Living Allowance is being received, these **should** be completely disregarded. However, a local authority **should** note that eligibility for both these benefits ceases after 4 weeks of local authority support and they **should** make sure they consider the impact on the person's ability to maintain their home.

15. Where a stay in a care home is temporary, the amount of an Income Support or Pension Credit a person receives will usually remain the same as they will be treated as normally residing in their own home. However, any severe disability premium or enhanced disability premium that may have been included will no longer be paid if the Disability Living Allowance or Attendance Allowance has ceased. There are special rules for Income Support and income related Employment Support Allowance where one member of a couple enters a care home for a temporary period. This should be taken into account in considering what a person can afford to pay.

16. If Housing Benefit is paid to the person, this **should** be disregarded as they will still be responsible for meeting any costs associate with their main or only home. Housing Benefit can also be paid as part of Income Support or Pension Credit. Local authorities **should** check if this is the case, and if so, disregard the Housing Benefit element.

17. The local authority **should** also disregard any other payment the person receives in order to meet the cost of their housing and/or to support independent living. For example this may include payments to provide warden support, emergency alarms or the meeting of cleaning costs where the person or someone in the household is unable to do this themselves.

18. The local authority **should** also consider whether any payments to support the cost of housing and/or independent living are

sufficient to cover the person's commitments during their temporary stay. This might be as these costs were met from earnings, which are disregarded, that are not being accrued during the temporary stay. In such cases, the local authority **should** calculate the additional cost and disregard this amount.

19. Where a person is sub-letting their property, this **should** be disregarded where the person occupies the property as their main or only home as they intend to return to the property.

20. Alternatively a person may have a boarder living in their property. A boarder is someone for whom at least one cooked meal is provided. Where a person has income from a boarder, the first £20 of the income should be ignored **plus** half of any balance over £20.

Annex G: The process for managing transfers of care from hospital

This annex covers:

- Overview of the requirements of the regulations;
- Legibility of notices;
- Assessment notices (including content, withdrawal and time to carry out assessment);
- Discharge notices (including content, withdrawal and timing of discharge notice);
- Delayed discharge reimbursement;
- Days exempt from payment liability;
- Ordinary residence;
- Dispute resolution;
- Sign-off of data between the NHS and local authority;
- Reporting of all delayed transfers of care days;
- Data and information;
- Patient and carer consultation; and
- Patient choice.

1. The Care and Support (Discharge of Hospital Patients) Regulations 2014 set out:

- the details of what the NHS body responsible for a relevant patient must include in the assessment notice that it issues, so that the local authority can then comply with its requirements to undertake assessments and put in place any arrangements necessary for meeting any of the patient's care and support needs or where applicable the carer's needs;
- the minimum period that the local authority has to undertake the assessment;
- the details of what must be included in the discharge notice;
- the minimum period of notice that the NHS must give the local authority in terms of discharge;
- the circumstances when an assessment notice and a discharge notice must be withdrawn;
- the period and amount of any reimbursement liability which a local authority may be required to pay the NHS for any delayed discharge.

2. The regulations also set out what is to happen when a local authority disputes that the patient is ordinarily resident in its area and to recover expenditure incurred as a result.

Legibility of notices

3. All notices issued by the relevant NHS body must be provided in writing to Local Authorities. This means that each notice (whether an assessment notice, discharge notice or withdrawal notice) must be in a legible form capable of being reproduced (e.g. capable of being photocopied, emailed or faxed). Any notice which is not reasonably legible would therefore not be valid. In order to ensure the legibility of all notification notices, the NHS body who issues the notice should type or print the notices and use a digital format wherever possible. This ensures that the receiving local authority can read the information it requires to comply with its duties and helps to prove that a notice has been issued if ever this was disputed.

4. However, while it is important to establish an audit trail, the system which NHS bodies and local authorities set up around issuing notices should not impede good working practice. Where hospitals and local authorities are already operating joint discharge teams, which are often co-located in the same office with access to a shared database, an update to the database may be all that is required. It should also be clear as to the date and time when a notice is issued, since this determines the period for which the NHS may seek reimbursement liability from a local authority.

Assessment notices

5. The NHS is required to issue a notice to the local authority where they consider that an NHS hospital patient in receipt of acute care may need care and support as part of supporting a transfer from an acute setting. The relevant local authority who the NHS must notify is the one in which the patient is ordinarily resident or, if it is not possible to determine ordinary residence, the local authority area in which the hospital is situated.

6. Not everyone who is admitted to hospital will need care and support after discharge. Indeed, in the majority of hospital discharges, the NHS will not consider that there is likely to be any care and support needs after discharge, so no duty to issue an assessment notice will arise.

7. However, the relevant NHS body **must** issue an assessment notice where it considers that a patient may require care and support on discharge and the local authority must or may be required to meet such needs. Before issuing any assessment notice, the NHS must consult with the patient and, where applicable, the carer. This is to avoid unnecessary assessments where, for example, the patient wishes to make private arrangements for care and support without the involvement of the local authority.

8. A locally agreed protocol between the NHS and local authorities which allows NHS staff to identify those likely to need care and support on discharge will provide help and advice as to when a patient should be considered to have possible care and support needs, in order to ensure the NHS issue assessment notices appropriately.

Timescales for NHS to issue an assessment notice

9. In general, the NHS should seek to give the local authority as much notice as possible of an impending discharge. This is so the local authority has as much notice as

possible of its duty to undertake a needs and (where applicable) carer's assessment.

10. However, an assessment notice must not be issued more than 7 days before the patient is expected to be admitted into hospital. This is so the notice is not provided too far in advance of admission to avoid the risk of wasting preliminary planning in the event that the patient's condition changes. A balance should be struck between giving the local authority early notice of the need to undertake an assessment of the patient and the risk that the patient's condition may change significantly such that any early planning needs to be reviewed.

11. Accordingly, if the NHS is able either to issue an assessment notice up to seven days before the date of the patient's admission into hospital and/or have a good indication of the likely proposed discharge date which is unlikely to change, then the NHS should issue the assessment notice as soon as possible.

Content of assessment notice

12. The information contained in an assessment notification is intended to be minimal, both to reflect patient confidentiality requirements and to minimise bureaucracy – it is only the trigger for assessment and care planning.

13. The assessment notice must state that it is an assessment notice given under paragraph 1(1) of Schedule 3 to the Care Act. This is so the local authority is aware of the consequences that could flow from the receipt of the assessment notice (i.e. that it has to take steps to assess the patient and (where applicable) the patient's carer and put in place any arrangements to meet those needs it proposes to meet. Ultimately if the local authority fails to carry out such steps then the local authority may, in certain circumstances, be liable to pay the NHS for any delayed discharge period.

14. The assessment notice must include the following:

- the name of the patient;
- the patient's NHS number;
- if given before the patient's admission, the expected date of admission and the name of the hospital in which the patient is being accommodated;
- an indication of the patient's discharge date, if known
- a statement:
  - (i) that the NHS body by whom the assessment notice has been given ("the NHS body") has complied with the requirement to consult the patient and, where feasible, any carer the patient has;
  - (ii) that the NHS body has considered whether or not to provide the patient with NHS continuing health care and the result of that consideration;
  - (iii) as to whether the patient or carer has objected to the giving of the notice;
  - (iv) the name and contact details of the person at the hospital who will be responsible for liaising with the local authority in relation to the patient's discharge from that hospital. This must be one or a combination of the person's telephone number and/or their work based E-mail address.

15. Further to (ii) above, where the NHS considers that the patient may have needs for continuing health care to be met by the NHS after discharge, then it must have carried out a continuing health care assessment and made a decision as to what (if any) services the NHS is to provide to the patient after

discharge and inform the local authority of these details.

16. The requirements above are intended to make the assessment notice process work more effectively, including the requirements to include the patient's NHS number and also the contact details of the person at the hospital who will be responsible for liaising with the local authority in relation to the patient's discharge from that hospital.

17. These requirements may be built on at a local level to produce a form that meets the agreed needs of the NHS and local authority. Although not exhaustive, local systems might also want to include on the assessment notice the patient's address and the lead clinician's details. The following template provides a model that the NHS might want to use:

NOTICE OF REQUEST FOR Assessment under The *Care and Support (Discharge of Hospital Patients) Regulations 2014*	
Name	
Date of Birth	
Address*	
NHS Number	
Expected Date Of Admission (where known)	
Name and contact details of the person at the hospital liaising with the local authority	
Patient's Lead clinician at hospital*	
Please confirm the following	
The patient has been consulted with regarding the assessment	
An assessment of their continuing health care needs has been completed and a decision made	
The patient has not objected to having an assessment of their care and support needs	

*Those marked with an * are not legal requirements but should be included where known as a matter of good practice.*

Timescales for local authorities' responsibilities to carry out assessments

18. On receiving an assessment notice, the local authority must carry out a needs assessment of the patient and (where applicable) a carer's assessment so as to determine, in the first place, whether it considers that the patient and where applicable, carer has needs. If so, the local authority must then determine whether any of these identified needs meet the eligibility criteria and if so, then how it proposes to meet any (if at all) of those needs which meet the eligibility criteria. The local authority must inform the NHS of the outcome of its assessment and decisions.

19. The local authority must carry out a needs assessment and put in place any arrangements for meeting such needs that it proposes to meet in relation to a patient and, where applicable, carer, before "the relevant day". The relevant day is either the date upon which the NHS proposes to discharge the patient (as contained in the discharge notice – see below) or the minimum period, whichever is the later.

20. The minimum period by which the local authority must carry out its assessments and put in place any arrangements to meet care and support and carer's needs is 2 days after it has received an assessment notice.

21. However, any assessment notice which is given after 2pm on any day is treated as being given on the following day.

22. Examples of these timescales are set out below:

- The NHS issue an assessment notice to the local authority at 1pm on Monday. The assessment notice must specify the date of the proposed discharge date. The earliest date which would be permitted is 2 days after the date the assessment notice is given (although a later proposed discharge date could be set out in the discharge notice.) This means that Wednesday would be the earliest day by which the local authority would need to have carried out the assessment and put in place any care and support services and, where applicable, carer's services that it proposes to meet.
- The NHS issue an assessment notice to the local authority at 3pm on Monday. The assessment notice is treated as having been given on the following day, Tuesday. This would mean that Thursday would be the earliest day by which the local authority would need to have carried out the assessment and put in place any care and support services and, where applicable, carer's services that it proposes to meet. Again, the assessment notice and later the discharge notice (see below) could set out a proposed discharge date after Thursday, in which case this would be the actual deadline by which the local authority would be required to have carried out the assessment and put in place any care and support and carer's service that is proposes to meet.

Assessment notice withdrawal

23. The NHS body which issued the assessment notice may withdraw that assessment notice at any time. Once an assessment notice has been withdrawn by the NHS, this means that the local authority that has been given the assessment notice is no longer required to comply with the requirements to assess or, where an assessment has been carried out, to put in place arrangements to meet some or all

of the patient's care and support needs. This is even if a discharge notice has been subsequently issued.

24. Once an assessment notice is withdrawn no liability to the local authority can accrue after that date. But any liability which may have accrued before the withdrawal of the assessment notice is unaffected.

25. There are a number of circumstances when the NHS **must** withdraw an assessment notice. These are where:

- The NHS body considers that it is likely to be safe to discharge the patient without arrangements being put in place for the meeting of the patient's needs for care and support or (where applicable) the carer's needs for support;
- The NHS body considers that the patient's on-going need is for NHS Continuing Health Care;
- Following the decision as to which (if any) services the relevant local authority will make available to the patient or (where applicable) carer, the NHS body still considers that it is unlikely to be safe to discharge the patient from hospital unless further arrangements are put in place for the meeting of the patient's care and support needs or (where applicable) the carer's needs for support;
- The patient's proposed treatment is cancelled or postponed;
- The NHS body has become aware that the relevant authority is not required to carry out any assessment because the patient has refused a needs assessment or (where applicable) the carer has refused a carer's assessment;
- The NHS body becomes aware that either:
  - the patient's ordinary residence has changed since the assessment notice was given; or
  - the notice was given to a local authority other than the one in whose area the patient is ordinarily resident.

26. The regulations do not prescribe what a withdrawal notice must contain. However, it must be in writing, and local systems should be established to ensure that the withdrawal notice provides sufficient information for both the NHS and local authority to be clear as to which patient and assessment notice the withdrawal notice refers to, and the reason(s) as to why the assessment notice is being withdrawn. In the context of identifying the person, mirroring either in full or part what is required for the assessment notice itself should be considered.

Discharge notices

27. Where the NHS has issued an assessment notice to a local authority (so as to require the local authority to asses a patient's care and support needs to facilitate a transfer of care), it must also give written notice to the local authority of the proposed date of the patient's discharge.

28. Patients and carers should be informed of the discharge date at the same time as, or before the local authority. In addition, hospital staff may give the local authority an early indication of when discharge is likely to be to help with planning. (The assessment notice may include the proposed discharge notice, if this is known). However, the NHS must also still issue a formal discharge notice, containing the required details set out below to give confirmation of the intended date in the event this was not previously given

or has changed from that included in the assessment notice.

29. The NHS could not seek to recover any reimbursement from the local authority in respect of a patient's delayed transfer of care unless it has first issued both an assessment notice and a discharge notice.

Content of a discharge notice

30. A discharge notice must contain:

- The name of the patient;
- The patient's NHS number;
- The name of the hospital in which the patient is being accommodated;
- The name and contact details (telephone and/or email) of the person at the hospital who is responsible for liaising with the relevant authority in relation to the patient's discharge from hospital;
- The date on which it is proposed that the patient be discharged;
- A statement confirming that the patient and, where appropriate, the carer has been informed of the date on which it is proposed that the patient be discharged;
- A statement that the discharge notice is given under paragraph 2(1)(b) of Schedule 3 to the Act. This is to make it clear that the notice is a formal "discharge notice" for the purposes of the Discharge of Hospital Patient provisions.

Timing of discharge notice

31. To ensure that a local authority receives fair advance warning of the discharge, the NHS body must issue a discharge notice indicating the date of the patient's proposed discharge. The minimum discharge notification allowed is at least one day before the proposed discharge date. Again, where the discharge notice is issued after 2pm, it will not be treated as having been served until the next day.

32. Taking the examples above:

- The NHS issue an assessment notice to the local authority at 1pm on Monday. The assessment notice must specify the date of the proposed discharge date. The earliest date which would be permitted is 2 days after the date the assessment notice is given (although the proposed discharge date can be later than this) i.e. Wednesday. This means the discharge notice must be issued no later than Tuesday.
- The NHS issue an assessment notice to the local authority at 3pm on Monday. The assessment notice is treated as having been given on the following day, Tuesday. This would mean that Thursday would be the **earliest** date by which the local authority would need to have carried out the assessment and put in place any care and support services and, where applicable, carer's services that it proposes to meet. So, this means the discharge notice must be issued no later than Wednesday.

33. The NHS body can issue the discharge notification with a much longer period of advance warning if appropriate and it should continue to seek to provide the local authority with as much notice of the proposed discharge date as possible. However, it will need to consider the likelihood of such a date being inaccurate and then the potential need to withdraw and reissue the discharge notification in the event the patient's condition changes in the meantime.

34. The NHS body is required to inform the local authority, by way of a withdrawal notice withdrawing the discharge notice, when it

considers that it is no longer likely to be safe to discharge the patient on the proposed discharge date for any reason other than the fact that it would be likely to be unsafe to discharge the patient because the local authority has not taken the require steps. So, for example, the NHS must inform the local authority of changes in circumstances affecting the discharge date, for instance if the patient's medical condition changes or the patient dies.

35. The NHS should also take into account the appropriateness of issuing the assessment and discharge notices too closely together, as this may result in extremely short time frames for local authorities to put in place what may be complex and comprehensive packages of care, which will also need to be subject to discussion with the patient and/or their carer.

Withdrawal of discharge notice

36. The NHS body which issued the discharge notice to a local authority may withdraw that discharge notice at any time. Such a withdrawal must also be in writing. It is important that the NHS body informs the local authority as soon as possible of a withdrawal of a discharge notice so that the local authority is not unnecessarily expending resources arranging a discharge on a date, which is no longer correct.

37. A discharge notice must be withdrawn where the NHS body considers that it is no longer likely to be safe to discharge the patient from hospital on the proposed discharge date.

38. However, this does not apply where the reasons for withdrawal are that the local authority has not taken the steps required to inform the NHS body of the outcome of the assessment the needs of the patient (and the carer, where applicable), and whether it intends to put in place care and support to meet any eligible needs.

39. Local systems should be established to ensure that the withdrawal notice provides sufficient information for both the NHS and local authority to be clear who the person is that the notice refers to, and the reason(s) as to why it is being withdrawn. In the context of identifying the patient, mirroring either in full or part what is required for the discharge notice itself should be considered.

40. Once a discharge notice is withdrawn, no further liability for the local authority to pay the NHS for any delayed transfer of care arises.

Delayed discharge reimbursement

41. While reimbursement remains available for use by the NHS body, they and local authorities are encouraged to use the provisions on the discharge of hospital patients (such as the issue of assessment and discharge notices) to seek to focus on effective joint working so as to improve the care of those people whose needs span both NHS and local authority care settings. While reimbursement is a potential way of exposing local difficulties in the relationship between the NHS body and the local authority, NHS bodies should not use reimbursement as the first approach to address any local difficulties around delayed transfers of care.

42. The NHS will only be able to seek any reimbursement from the local authority arising from a delayed transfer of care, if the NHS has first sent both an assessment notice and a discharge notice to the local authority, but the local authority has then either not carried out an assessment or put arrangements in place for the meeting of care and support and, where applicable, carer's needs which it proposes to meet by the end of the delayed discharge date or minimum period and it is

for this reason alone that there has been a delay in the patient's delayed transfer of care.

43. In these circumstances, it is then in the NHS's discretion whether to recover payments for reimbursable delayed discharge days. Having these payments available will remain useful not from the context of moving money around the system (local authority to health), but where the local authority on a routine basis does not engage with the relevant NHS body in line with the requirements. Their use can be a useful signal locally and beyond that specific actions and interventions may be needed in a locality to address gaps in joint working.

44. In terms of the level of reimbursement, the regulations provide that:

- for local authorities outside London, the penalty amount per day will be £130 and;
- for London authorities, the penalty amount per day will be £155.

45. The amounts above have risen in line with the CPI measure of inflation since 2003, and the higher rate only applies to local authorities in London.

46. The period for which liability can be sought, if the NHS so chooses, starts on the day after the relevant day i.e. after the date of the proposed discharge date contained in the discharge notice or the minimum period which is at the earliest 2 days after the assessment notice is given (see example at paragraph 21 above).

47. It then ends when any of the following occurs:

- the NHS withdraws either the assessment notice or the discharge notice;
- the local authority notifies the NHS that it has now carried out the assessment and put in place arrangements for meeting any of the needs it proposes to meet in respect of that patient or where applicable carer;
- the local authority is informed that it is no longer required to put arrangements in place either because the patient or someone else is to arrange care for the patient and ,where applicable, the carer or someone else is to arrange support for the carer;
- the patient discharges themselves;
- the NHS decided that the patient now needs to remain in hospital for a further course of treatment;
- the patient dies.

Days exempt from payment liability

48. Both the NHS and local authorities should have established systems in place by April 2015 that provide for seven-day coverage. This means that the exemptions that previously existed for weekends and Bank Holidays no longer apply and as such all days become potentially reimbursable. However, a day is not to be treated as a day for which a local authority could be liable for reimbursement when the local authority has by 11am that day put in place arrangements for meeting some or all of the needs that it proposes to meet in relation to the patient and, where applicable, carer.

49. Also, no liability will arise for any day where the NHS considers that the patient is not able to be discharged because they have suffered a deterioration in their condition on that date so that it would not be safe to discharge them even if the local authority had put in place arrangements for meeting the patient's care and support and, where applicable, carers' needs.

50. If the patient's deterioration becomes more established such that the patient requires a further course of treatment in hospital, and it would be unsafe to discharge the patient then the NHS body must withdraw the discharge notice and should consider withdrawing the assessment notice.

Ordinary residence

51. The NHS should serve the assessment notice on the local authority where the patient is ordinarily resident or where the patient has no settled address, the local authority in which the hospital is located.

52. Where a local authority disputes the assertion that they are responsible for that individual based on ordinary residence, they must in the period of dispute still comply with the requirements of the Regulations in terms of providing an assessment and any care and support provision which is identified as being needed to secure a safe transfer from one care setting to another. If subsequently it is shown that the wrong local authority has been asked to take responsibility they can reclaim any relevant costs from the NHS organisation or the correct local authority.

Dispute resolution

53. Where any dispute arises because a local authority disputes that the patient is ordinarily resident in its area (so that it should not be the local authority to whom an assessment notice is given), then that local authority must accept provisional responsibility and undertake the steps required under the discharge of hospital patient provisions. If no agreement can be reached on ordinary residence, it must then seek a determination as the patient's ordinary residence from the Secretary of State or an appointed representative. Further information on this process can be found in chapter X.

54. All other disputes in relation to delayed discharge payments (e.g. whether to seek reimbursement, whether the day should be counted as a day of delayed discharge period etc.) should be resolved between the NHS body and local authority. Where they cannot be resolved then resolution would have to be way of an application for judicial review to the High Court.

Sign-off of data between the NHS and local authority

55. As set out in existing guidance, the NHS organisation must ensure that before reporting days attributable to care and support that it has verified their accuracy with the local authority, irrespective of whether the NHS body is seeking reimbursement or not. This should happen in advance of them being reported into the formal system so that any errors can be identified and addressed. The system by which this happens is for local determination, although it is expected that it would be the relevant Director of Adult Social Services or their nominated representative who would be the local authority point of contact for this.

Reporting of all DTOC days

56. Irrespective of whether the delayed days fall into the reimbursement category or not, they must be reported by the relevant NHS body. These include any person with a delayed discharge at any point in the given month, as well as that those patients who meet the DTOC definition on the last Thursday of each month.

Data and information

57. The exchange of data needed for the purposes of NHS bodies and local authorities carrying out their respective functions is allowed under data protection legislation. It is the responsibility of the individual bodies to ensure they have robust data protection safeguards in place to ensure a patient's personal data is kept secure and only used for the purposes that it is required (i.e. seen by those it needs to be seen by on a needs to know basis).

Patient and carer involvement

58. It is important that both the NHS body and the local authority involve the patient and, if appropriate, their carer about their current and ongoing care and support needs. In doing this, it should have already undertaken an assessment of the patient's capacity to participate in an informed way in these discussions and, where they do not believe that the capacity exists, they should move forward by taking account of other existing regulation and guidance such as for example the Mental Capacity Act.

Patient choice

59. The patient's choice of care and support, whether that be type or location, should be at the heart of the assessment and decision making process when it comes to current and future care and support.

60. If the NHS agree that the local authority have offered a package of care that is suitable and has sought to reflect the patient's choice, if the patient continues to unreasonably refuse the care package offered by the local authority, they cannot stay in a hospital bed indefinitely and will need to make their own arrangements so that they can be discharged safely.

Annex H: Continuity of care: Equipment and adaptations

1. Many people with care and support needs will also have equipment and adaptations made to their home and these have been provided to:

- Aid independence;
- Assist carers to manage the individual safely and comfortably;
- Minimise a moving and handling issue under Health and Safety guidance.

2. Local authorities fund equipment that will include:

- Small cost items such as bathing equipment, sensory equipment, bed aids;
- Larger cost items (£1.000+) would include hoists, riser recliner chairs.

3. Where the first authority has provided equipment, these **should** move with the person to the second authority where this is the person's preference and they are still required. This **should** apply whatever the original cost of the item. For those items of equipment that were provided following a moving and handling assessment, both authorities **should** discuss with the adult, and carers if relevant, as to whether this equipment would be suitable in the property they are moving into. If this is agreed, the equipment **should** be transferred with the person and a follow up moving and handling assessment **should** be carried out quickly to check the moving and handling status in the new property. The second authority would also need to be aware if a hoist had been transferred as this would need to be recorded for Lifting Operations and Lifting Equipment Regulations 1998 No. 2307 (LOLER) checks.

4. In terms of adaptations, where rails are required it would be more practicable if the second authority organised installation so that walls are checked for correct fixings. Items such as level access showers will remain *in situ*. It may be possible in some situations for stair lifts to be re-installed into a new home. Where a stair lift is provided, then it **should** become property of the person unless there are alternative local arrangements such as leasing. Advice should be sought by the stair lift manufacturer.

Annex J: Ordinary residence

Annex J1 – People with "urgent needs"

1. A person who is ordinarily resident in one local authority area may become in **urgent need** of accommodation whilst they are in another local authority area. The Care Act provides local authorities with powers[173] to meet the person's needs in such urgent cases, if the adult (or in the case of a carer, the adult for whom they care) is known to be ordinary resident in the area of another local authority.

2. For example, an urgent need for accommodation may arise where a person with severe learning disabilities is on holiday or visiting someone with their carer in another area, and the carer unexpectedly has to be taken to hospital. In this case, the person with learning disabilities may be without assistance and/or unable to care for himself or herself, and may become in urgent need of accommodation, albeit on a short-term basis. Similarly, an urgent need may arise where an older person, who is ordinarily resident in one local authority area, stays with their family in another local authority area during a holiday period, but the caring responsibilities prove too much for the family and they seek assistance from their local authority on the basis that their relative is in urgent need.

3. In circumstances where a person who is ordinarily resident in one local authority area becomes in urgent need in another local authority area, the person's local authority of ordinary residence would have a duty to meet the person's eligible needs. However, since it is unlikely to be practicable for that authority to meet urgent needs, the local authority "of the moment" (i.e. where the person is physically present at the time) should exercise their power to meet the urgent needs and provide the necessary accommodation, even if only on a temporary basis. The local authority of the moment should, in carrying out any assessment of needs and providing any necessary accommodation, inform the local authority where the person is ordinarily resident that it is doing so.

4. The local authority of the moment is not required to seek the consent of the local authority where the person is ordinarily resident, in deciding whether and how to exercise the power to meet urgent needs. However, it should notify the other authority of its intention to do so, to ensure that information is shared on the individual case. The local authorities concerned may come to an agreement about sharing or transferring the costs involved in meeting urgent needs. For instance, the local authority of the moment, which is providing the accommodation, may recover some or all of the costs of the accommodation from the local authority where the person is ordinarily resident (and where the duty to meet needs would otherwise fall).

173 Sections 19(3) and 20(6) provide powers which can be used for meeting urgent needs for adults with care and support needs and carers respectively

5. On rare occasions, a person with urgent needs who has been provided with accommodation by the local authority of the moment may be unable to return to their own local authority because of a change in circumstances. In this situation, decisions relating to ordinary residence must be made on an individual basis: the local authority of the moment and the person's local authority of ordinary residence would need to consider all the facts of the case to determine whether the person's ordinary residence had changed.

6. A local authority may also meet a person's needs through the provision of accommodation, where the person is not ordinarily resident in that area, even if the needs themselves are not considered to be urgent.

7. For example, a local authority may need to provide accommodation on behalf of another in a situation where a person has been discharged from hospital and needs accommodation but wishes to remain living in the local authority in which he or she received hospital treatment, perhaps to be near family members. In these circumstances, the local authority where the person was living on discharge from hospital could provide the accommodation, with the notification of his or her local authority of ordinary residence.

Annex J2 – People who are party to deferred payment agreements

8. Deferred payment agreements are designed to prevent people from being forced to sell their home in their lifetime to pay for the costs of their care. They also extend choice, providing people with additional flexibility over how they meet the cost of their care.

9. An individual enters into an agreement with their local authority by which payment for their care and support is 'deferred', being paid in the interim period by the local authority. The money owed to the local authority is subsequently repaid either when the home is sold, from the person's estate, or when the amount due to the local authority is repaid. The local authority could be repaid by either the person with the deferred payment agreement or by a third party. The individual grants the local authority a charge over their property for the purposes of security and to facilitate reclamation of the amount due to the local authority.

10. The regulations and guidance require local authorities to offer deferred payments in certain circumstances, and give local authorities discretion to offer deferred payments in other situations**.** For further information on deferred payments please see chapter 9 of the guidance.

11. It is the local authority in which the person is ordinarily resident that has responsibility for offering and making arrangements for a deferred payment agreement. That local authority then remains responsible for the deferred payment agreement until the agreement is concluded.

12. Information about deferred payment agreements should be offered when a person approaches a local authority, or at the time the person decides to enter residential accommodation. Where a person is initially accommodated under the 12-week property disregard, the information should be given and arrangements made during this 12-week period.

13. For example, where a person who is ordinarily resident in the area of local authority A chooses to meet their care and support needs in residential accommodation in the area of local authority B, and the value of that person's home is being disregarded for 12 weeks, (see Annex J3 – People who are accommodated under the 12 week property disregard), local authority A should offer the person the option of having a deferred payment during the 12-week period. If the person accepts the offer and enters into a deferred payment agreement, local authority A remains responsible for funding their care (minus any contributions from means-tested income and assets).

Annex J3 – People who are accommodated under the 12 week property disregard

14. A key aim of the charging framework is to prevent people being forced to sell their home at a time of crisis. The framework therefore creates the space for people who are at risk of needing to sell their home to meet the cost of their care to make informed decisions on how best to do that. This means that a local authority must disregard the value of a person's main or only home when the value of their non-housing assets are below the upper capital limit of £23,250 for a period of 12 weeks from when a person:

- First enters residential care; or
- Where an alternative property disregard is lost.

15. A local authority also has discretion to choose to apply the disregard where a person has a sudden and unexpected change in their financial circumstances. In doing so, it must consider the individual circumstances of the case.

16. This is known as the "12 week property disregard" and full details are set out in chapter 8, annex A.

17. During the 12 week disregard period, the person's accommodation is provided and funded by the local authority in which they are ordinarily resident. The local authority may place the person in residential care in the area of another local authority, for example because they have expressed a desire to be near family members. However, the placing authority remains the responsible authority during this period.

18. At the end of 12 weeks, the value of the person's home is taken into account (unless it is subject of an alternative disregard. See chapter 8). This may result in the person becoming liable to pay for all of the costs of their care and choosing to enter into a private contract with the care home for the provision of their care on a permanent basis, rather than continuing to be provided with accommodation by their placing authority. In such a case the person would be likely to acquire an ordinary residence in the new area, in line with the settled purpose test in Shah.

19. If the person's needs or circumstances change and they subsequently require additional or different care and support, including residential care, they should approach the local authority where their care home is situated. However, if they enter into a deferred payment agreement with the original authority or there is another reason such as lack of mental capacity as to why they were unable to enter into a private contract with the care home, they will remain the responsibility of the original authority.

20. If a person arranges for their care and support needs to be met in a care home without regard to the local authority but subsequently contact the local authority in order to receive support, it is likely that they would have acquired ordinary residence in the area in which their care home is situated. If this is the case, it would be the local authority in whose area the care home is situated which would be responsible for funding the person's accommodation.

Annex J4 – People who are arranging and paying for their own care

21. When a person moves into permanent accommodation in a new area under private arrangements, and is paying for their own care, they usually acquire an ordinary residence in this new area. If so, and if their needs subsequently change meaning that they require other types of care and support, they should approach the local authority in which their accommodation is situated.

22. A person who has sufficient financial means to pay for their own care, but who has eligible needs, may ask the local authority to meet their needs. This may be, for instance, where a person has capacity, but lacks the skills or confidence to arrange their own care, and would benefit from the local authority's support in managing a contract with a provider. If such a person asks the local authority to do so, then the authority must meet their needs.[174] Where an adult with enough means to pay for their own care and support makes such a request, the adult would still pay for the care and support in full, and the local authority will have a power to charge a fee to cover the additional costs of arranging or brokering that care and support. In such circumstances, the local authority should treat the person in the same manner as it would anyone else whose needs it is meeting – including the agreement of a care and support plan, and the right to a choice of accommodation.

23. Sometimes, a person with sufficient means to pay for their care, who was intending to arrange their own care, may not be able to enter into a private agreement with their care home. This may be because they do not have the mental capacity to do so and have no attorney or deputy to act on their behalf, or it may be that, even though they have the capacity to decide where to live, they are not able to manage the making of the arrangements and have no friends or relatives to assist them. In such cases, the local authority is responsible for making arrangements for the provision of their accommodation, with reimbursement from the person as necessary.[175] The person would remain ordinarily resident in their placing local authority, even where they enter the accommodation in another local authority area.

174 See Section 18(3) of the Care Act

175 See Section 18(4) of the Care Act

Scenario: people who are arranging and paying for their residential care

Wendy is 82 years old and very frail. Following a fall and a stay in hospital, she is assessed as having eligible needs for care and support under the Care Act. A financial assessment undertaken by her local authority, local authority A, concludes that she does not qualify for local authority financial assistance.

Wendy wants to arrange her own care and support, but does want some help in choosing the right care home. Local authority A provides advice to Wendy and her family on care homes in Local authority A and surrounding areas and help her to select a home that best meets her requirements. The care home is located in local authority B, as Wendy has expressed a desire to move closer to her family. Wendy moves into the care home as a self-funder and signs a contract with the care home for the provision of her care.

A few months after Wendy moves into the care home, her savings fall below the capital limit and she approaches local authority A for support. She is advised by local authority A that she is no longer ordinarily resident in their local authority and that she should seek financial assistance from local authority B. Local authority B agrees to fund Wendy's accommodation costs, but immediately falls into dispute with local authority A over her place of ordinary residence. Local authority B disagrees with A's argument that Wendy has acquired an ordinary residence in their area and contends that she remains the responsibility of local authority A as that is where she has lived for most of her life.

As Wendy is being provided with accommodation, under the Care Act she is deemed to continue to be ordinarily resident in the area in which she was ordinarily resident immediately before her accommodation was provided by a local authority. Immediately before Wendy was provided accommodation, she was living in the same care home, but was responsible for paying for her own care. She had voluntarily left local authority A and moved to the care home in local authority B, which she had adopted voluntarily and for settled purposes. Therefore, Wendy is found to be ordinarily resident in local authority B.

Annex J5 – NHS Continuing Health Care

24. NHS Continuing Health Care (NHS CHC) is a package of ongoing health and care and support that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need', as set out in The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.[176] Such care is provided to people aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. Eligibility for NHS CHC places no limits on the settings in which the package of support can be offered or on the type of services provided.

25. Where an individual is eligible for NHS CHC, the relevant Clinical Commissioning Group (CCG) is responsible for care planning, commissioning health and care and support services, and for case management. Local authorities will continue to have a wider role, for example in relation to safeguarding responsibilities. However, if a review of a person's care and support needs subsequently determines that the individual is no longer eligible for NHS CHC – perhaps because they needed intensive health and care following an operation and they have now recovered – the NHS ceases to be responsible for the provision of the person's care and support. Instead, the responsibility for the provision of care and support to meet eligible needs falls to the local authority in which the person is ordinarily resident.

26. Where a person has been provided with NHS accommodation as part of a package of NHS CHC, then prior ordinary residence is retained, based on the local authority in which the person had been previously ordinarily resident. Therefore, where a person is placed in a care home (or other accommodation funded by the NHS) in another local authority area for the purpose of receiving NHS CHC, they continue to be ordinarily resident in the local authority area in which they were ordinarily resident before entering the NHS accommodation. Where a CCG places a person in such accommodation, it should inform the person's local authority of ordinary residence and, if the person is placed "out of area", it is also good practice for the CCG to inform the local authority in which the care home is located.

27. Where a person is accommodated in a care home as part of their package of NHS CHC, it is possible that they may cease to be eligible for NHS CHC, but still need to remain in their care home, or to be provided with accommodation elsewhere. In such a case, the local authority in whose area the person was ordinarily resident immediately before being provided with NHS accommodation would be the authority responsible for arranging care and support to meet the person's eligible needs, and for funding the person's accommodation, subject to any financial assessment.

28. When a person has health needs as well as care and support needs but does not qualify for NHS Continuing Healthcare, they may be eligible for a joint package of care that contains both health and care and support services.

176 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

Scenario: a person is discharged from NHS Continuing Healthcare

Maureen is 72 years old. Three years ago, she suffered a stroke which left her severely disabled with complex care needs. She was assessed as needing NHS CHC and was moved from hospital to a rehabilitation unit within an independent sector care home in local authority B. This placement was fully funded by Maureen's CCG. Before her stroke, Maureen had lived with her husband in local authority A.

A recent reassessment of Maureen's needs concludes that she is no longer eligible for NHS CHC, but has eligible needs for care and support and requires accommodation under the Care Act 2014 instead. The care home in which Maureen has been living offers her a place on a long-term basis and all those involved in her care agree that this arrangement best meets Maureen's needs.

Local authority B agrees to fund the placement on a 'without prejudice' basis but immediately falls into dispute with local authority A over Maureen's place of ordinary residence. Local authority B contends that Maureen remains ordinarily resident in local authority A, where she had been living with her husband before her placement at the care home began. Local authority A argues that Maureen has acquired an ordinary residence in local authority B due to the length of time she has spent at the care home.

In this situation, when Maureen first enters the care home she is receiving NHS CHC. Therefore, whilst Maureen is receiving NHS CHC at the care home she remains ordinarily resident in local authority A, where she was living before her stroke.

Once Maureen's NHS CHC ceases and she is instead provided with accommodation under the Care Act, she is deemed to be ordinarily resident in the area in which she was ordinarily resident immediately before the accommodation was provided. Immediately before Maureen was provided with accommodation she was living in the care home but was still ordinarily resident in local authority A. Therefore, Maureen remains ordinarily resident in local authority A.

29. Under section 9 of the Care Act, local authorities have a duty to assess the needs of any person who appears to have needs for care and support. If it becomes apparent during the course of the assessment that the person has health needs, the local authority should notify the person's CCG and invite them to assist in the assessment.

30. It is the responsibility of the local authority in which the person is ordinarily resident to provide any care and support identified as necessary to meet eligible needs, in the light of the assessment. Any health services identified by the assessment should be met by the person's CCG. CCGs and local authorities should work in partnership to agree their respective responsibilities in relation to the provision of the joint package of care.

31. Where a person is placed in accommodation out of area, they remain ordinarily resident in the area of the placing local authority and the placing authority remains responsible for the provision of any other care and support services required. However, the person's GP may be based in the area in which they are living, and it is this CCG that is responsible for the provision of

any health services. This may mean that a local authority and a CCG located several miles apart, need to work together to provide a joint package of health and care and support. In the case of a person in receipt of NHS Continuing Healthcare, the placing CCG remains responsible for the provision of care, even where the person changes their GP practice.

Annex J6 – British citizens resuming permanent residence in England after period abroad

32. British citizens returning to England after a period of residing abroad (who had given up their previous home in this country) are entitled to an assessment as soon as they return if they appear to have needs for care and support.

33. Accordingly, a returning British citizen would usually acquire an ordinary residence in the area in which they chose to locate, if their intention was to stay living there for settled purposes. For example, they may have family in a particular area and choose to settle there for that reason or they may have no particular reason to locate in a given area. As long as they can demonstrate an intention to remain in the place they are living for settled purposes, they are able to acquire an ordinary residence there.

34. However, if a returning citizen presents to a local authority on their return to England but has no particular intention to settle in that area, the local authority may decide they may be found to be of "no settled residence" and/or in "urgent need" (see Annex J1). Each case should be decided on an individual basis.

35. It should be noted that ordinary residence can be acquired as soon as a person moves to an area, if their move is voluntary and for settled purposes. There is no minimum period in which a person has to be living in a particular place for them to be considered ordinarily resident there, because it depends on the nature and quality of the connection with the new place.

Annex J7 – Armed forces veterans and the families of armed forces personnel

36. The ordinary residence provisions apply to armed forces veterans and the families of armed forces personnel in active service in the same way as they apply to other people. If veterans have needs for care and support upon leaving the forces, they would usually acquire an ordinary residence in the area to which they chose to locate. If a veteran does not have a permanent place to live on leaving the forces or does not have a settled purpose in relation to where they are living, they may be found to be of "no settled residence" and/or in "urgent need". If the person is found to be of no settled residence, then the local authority in which they are physically present will be responsible for meeting their eligible needs for care and support. If the person is determined to have urgent needs, then the same local authority should consider using its powers to meet those needs, in advance of establishing where the person's ordinary residence lies.

37. Where family members (who are 18 or over) of armed forces personnel in active service need care and support, their ordinary residence would fall to be assessed and they would generally be ordinarily resident in the area in which they were living. If the member of the armed forces was subsequently posted to another area of the country, the Shah test would again apply and the family member in need of services would usually acquire an ordinary residence in the area to which they were posted. However, if the family member was in receipt of accommodation, prior to the posting and was placed in accommodation in the new area by their original authority in order to be near their family, they would remain ordinarily resident in the area of the placing authority.

38. In the event of a service family returning from overseas, the ordinary residence of any family members (aged 18 or over) requiring care and support would be assessed and they would usually acquire an ordinary residence in the area in which they chose to reside for settled purposes. If the family had no settled purpose in relation to where they were living, the family member in need of services may be found to be of "no settled residence" and/or in "urgent need".

Annex J8 – Young people in transition from children's services to adult care and support

39. Children who are in need of care and support, including children who are 'looked after',[177] are provided with accommodation and/or services under the Children Act 1989 (the "1989 Act"). They may also be provided with care and support under the Chronically Sick and Disabled Persons Act 1970 (the "1970 Act"), though they receive universal services such as access to schools and primary health care in the same way as all other children. When a young person with care and support needs reaches the age of 18, the duty on local authorities to provide accommodation under the 1989 Act ceases and duties to provide other services usually cease. From their 18th birthday, care and support is generally under the Care Act 2014. This is provided by the local authority in which the young person is ordinarily resident as an adult, which may or may not be the same local authority where they were ordinarily resident under the 1989 Act.

Determining ordinary residence

40. When a young person reaches 18 and has eligible needs for care and support under the Care Act 2014, their ordinary residence should be assessed to determine which local authority is responsible for ensuring these needs are met.

41. Neither the 1989 Act nor the 2014 Act makes provision for how to determine ordinary residence when a young person moves from being eligible under the 1989 Act to being eligible under the 2014 Act. Therefore, when making decisions about the ordinary residence of young people in transition to adult care and support, local authorities should have regard to both Acts. It is important to note that there is no set procedure for determining ordinary residence in this situation: every case must be decided on an individual basis, taking into account the circumstances of the young person and all the facts of their case.

42. Although the provisions of the 1989 Act do not usually apply once a young person reaches 18 (other than the leaving care provisions where relevant), local authorities could reasonably have regard to the 1989 Act and start from a presumption that the young person remains ordinarily resident in the local authority in which the child was ordinarily resident when they turned 18. Section 105(6) of the 1989 Act provides that, in determining the ordinary residence of a child for any purposes of that Act, any period in which a child lives in the following places should be disregarded in determining the child's ordinary residence for certain purposes under the 1989 Act:

- a school or other institution;
- in accordance with the requirements of a supervision order under the 1989 Act;
- in accordance with the requirements of a youth rehabilitation order under Part 1 of the Criminal Justice and Immigration Act 2008; or
- while he or she is being provided with accommodation by or on behalf of a local authority.

43. Therefore, where a local authority in which the child is ordinarily resident has placed a child in accommodation out of

[177] A child who is 'looked after' is defined in section 22(1) of the Children Act 1989 and this term means, broadly, that a child is in a local authority's care by virtue of a care order or is provided with accommodation by a local authority in the exercise of their social services functions

area under the 1989 Act, that local authority remains the child's place of ordinary residence for the purposes of the 1989 Act unless the child subsequently acquires a new place of ordinary residence. In such a case, there would be a starting presumption that the young person's place of ordinary residence remains the same for the purposes of the 2014 Act when they turn 18.

44. However, this starting presumption may be rebutted by the circumstances of the individual's case and the application of the [Shah or Vale] tests. Under these tests, a number of factors should be taken into account when considering a person's ordinary residence for the purposes of the 2014 Act. These include: the remaining ties the young person has with the authority where they were ordinarily resident as a child, ties with the authority in which they are currently living, the length and nature of residence in this area and the young person's views in respect of where he or she wants to live (if he or she has the mental capacity to make this decision). If the young person is being provided with residential accommodation under the of 2014 Act at the time ordinary residence is assessed, it would be necessary to assess their place of ordinary residence immediately before such accommodation was provided.

45. In many cases, establishing a young person's local authority of ordinary residence will be a straightforward matter. However, difficulties may arise where a young person has been placed in residential accommodation out of area as a child under the 1989 Act. In this situation, the young person may be found to be ordinarily resident in the local authority where they were ordinarily resident under the 1989 Act, or they may be found to have acquired a new ordinary residence in the area in which they are living or in the area in which their parents are living,[178] depending on the facts of their case.

46. For example, where a young person (who has been placed out of area) moves out of their residential accommodation under the 1989 Act and into independent living arrangements in their 'host area' on or around their 18th birthday, the starting presumption would be that they are ordinarily resident in the area where they were ordinarily resident under the 1989 Act. However, in this situation, the starting presumption is more likely to be rebutted than in other situations. By the time the young person reaches the age of 18, they may have been living in another local authority area for several years under the 1989 Act. Shortly before their 18th birthday, they may have a well-established support network outside of their authority of ordinary residence under the 1989 Act which they wish to continue into adulthood. More importantly, they may have made a decision to stay in their host area for settled purposes. In such a case, a consideration of all the facts may lead to the conclusion that, for the purposes of the 2014 Act, the young person is ordinarily resident in the area in which they are living at the time of their 18th birthday. Scenarios 1, 2 and 3 below provide some examples of how ordinary residence is determined when a young person moves from accommodation provided under the 1989 to accommodation or other care and support provided under the 2014 Act.

47. Similarly, where a young person is intending to move areas to go to university, the starting presumption would be that they are ordinarily resident in the same place as they were ordinarily resident under the 1989 Act. Again, this presumption may be rebutted. If the young person moves to the area in

[178] Under the 1989 Act, a child's ordinary residence is by default that of their parents. However, they may acquire an ordinary residence of their own if, for example, they are placed into care

which the university is located for settled purposes and has no intention to return to his authority of ordinary residence under the 1989 Act, then the facts of his case may lead to the conclusion that he or she has acquired an ordinary residence in the area of the University.

48. Alternatively, if the young person has a base with his or her parents (or those with parental responsibility for him or her) in the local authority where he or she was ordinarily resident under the 1989 Act, and he or she intends to return to this base during the university holidays (including the long summer holiday) then the facts of his case may lead to the conclusion that he or she remains ordinarily resident in the "base" local authority.

49. It is not possible for a person to be ordinarily resident in two different local authorities under the 2014 Act. Therefore, where a young person goes away to university or college, it is necessary to establish, from all the facts of their case, to which local authority they have the stronger link. If it is the local authority where they were ordinarily resident under the 1989 Act, this local authority would be responsible for meeting eligible needs under the 2014 Act, both during term time at university and during holidays when the young person is staying elsewhere (for example with the parents in the local authority where they are ordinarily resident). The young person's absence from their local authority of ordinary residence during term time would not result in their ordinary residence being lost: it would be considered a temporary absence. Scenarios 4 and 5 below provide further guidance on how ordinary residence is determined when a young person attends university in a different local authority area.

Care leavers

50. Where a child's "looked after status" under the 1989 Act ends, the local authority which was formerly responsible for them might retain some duties after they reach the age of 18. These young people are referred to as "young people eligible for care leaving services" or "care leavers".

51. In order to provide care leavers with the assistance they need to achieve their aspirations, local authorities must allocate a personal adviser and work with a care leaver to maintain a pathway plan that sets out the support and services available (which may include assistance with education or training). This support may continue until the young person reaches the age of 21 or for longer if they remain in an approved programme of education or training.[179] Where a young person qualifies for advice and assistance under section 24 of the 1989 Act, the local authority may be required to advise and befriend him or her. They may also be required to give him or her assistance in kind and, exceptionally, by providing accommodation or cash.

52. A local authority which is responsible for providing support to a care leaver is not under a general duty to provide accommodation. Therefore, when a care leaver with assessed care and support needs reaches the age of 18 and requires residential accommodation, their accommodation is usually provided under the 2014 Act, by their local authority of ordinary residence. However, in 2014, the government introduced a duty on local authorities to support those

[179] See section 23CA of the 1989 Act which was inserted by the Children and Young Persons Act 2008. Where a former relevant child resumes a programme of training up to age 25, they are entitled to continuing support from a leaving care personal adviser allocated by their authority of ordinary residence under the 1989 Act

care leavers aged 18 and eligible for care leaving services, who want to stay with their former foster parents until their 21st birthday, known as "Staying Put".

53. There are, however, certain powers and duties to provide accommodation to care leavers in particular cases. Under section 24B(5) of the 1989 Act, local authorities have a duty to provide certain young people who qualify for advice and assistance under section 24 of the 1989 Act[180] with vacation accommodation if they are in full-time further or higher education and their term-time accommodation is not available. They also have a power to provide assistance during term-time, such as expenses to cover travel or equipment costs and expenses incurred by the young person in living near the place where he or she is studying.

54. Local authorities do not have a duty to provide accommodation to care leavers during term time. Such accommodation is funded by whatever mainstream funding sources are available to support higher education students. Nor is there a duty under the 1989 Act to provide care and support in the home to care leavers who are in higher education – such services would be provided under the 2014 Act by the local authority of ordinary residence.

55. Local authorities also have a power to provide accommodation under section 24A(5) of the 1989 Act to a young person whom they are advising and befriending under section 24A. Such accommodation may only be provided in exceptional circumstances and if, in the circumstances, assistance may not be given under section 24B (vacation accommodation). A young person who is eligible for residential accommodation under the 2014 Act would be unlikely to be regarded as being in "exceptional circumstances".

56. If a care leaver had been placed out of area as a looked after child, and wishes to remain in this area on reaching the age of 18, they may be found to be ordinarily resident there for the purposes of the 2014 Act. In this situation, their accommodation would be provided by the local authority in which they are living but the provision of any leaving care services under the 1989 Act would remain the responsibility of the responsible local authority under the 1989 Act.

57. Where this is the case, the 1989 Act and the 2014 Act would operate in parallel. This means the responsible authority under the 1989 Act and the authority of ordinary residence under the 2014 Act would need to work together to ensure the young person eligible for leaving care services was provided with joined up care and support.

58. It should be noted that where a child has been placed out of area under the 1989 Act and becomes eligible for leaving care services upon reaching the age of 18, this does not automatically mean they are ordinarily resident in the area where they were ordinarily resident under the 1989 Act or in the authority responsible for providing them with the leaving care services under the 1989 Act. Whilst the young person remains entitled to leaving care support from their responsible authority under the 1989 Act, all the circumstances of their case must be considered. Scenarios 3 and 5 below provide examples of how the 1989 Act and the 2014 Act operate in parallel when a young person is eligible to leaving care services under the 1989 Act and accommodation or other care and support under the 2014 Act.

[180] That is, a young person who is under the age of 25 and who either (a) had a special guardianship order in force in relation to them when they reached the age of 18, and immediately before the making of that order was a looked after child, or (b) was a looked after child before they were 18

Scenario 1: transition from accommodation under the 1989 Act to accommodation under the 2014 Act

Sunil is 18 years old and has physical and learning disabilities. Since the age of 10 he has been accommodated in a specialist residential school under section 20 of the 1989 Act. The primary purpose of Sunil's placement is to meet his health and education needs. The school is located in local authority B but paid for by local authority A, the local authority where his family live. For the purposes of the 1989 Act, Sunil is the responsibility of local authority A.

Now that Sunil is 18, he is ready to leave school. His needs are assessed and it is decided that he should remain living in residential accommodation. As Sunil has capacity to make some decisions for himself, he is able to express a desire to remain living in local authority B, near his friends from school and within the local community to which he feels he now belongs. Therefore, at the end of the school year he moves into residential care in local authority B and his accommodation changes from being provided under the 1989 Act to being provided under the 2014 Act.

At this point, local authority B falls into dispute with local authority A over Sunil's ordinary residence. Local authority B's view is that Sunil should remain the responsibility of local authority A. However, local authority A argues that their duty to Sunil ended when he left school and that he has become ordinarily resident in local authority B.

In these circumstances, the starting presumption is that Sunil is ordinarily resident in local authority A as this is the local authority in which he was ordinarily resident when he turned 18. However, this is only a starting presumption and it may be rebutted by considering all the facts of Sunil's case under the 2014 Act.

Sunil has been living in local authority B for 8 years and he has expressed a wish to remain there as he feels part of the local community. Although his family still live in local authority A, their home is not a base to which he returns often, other than for short spells over Christmas and other occasional events. Therefore, in line with the settled purpose test in the [Shah] case, it seems that Sunil has adopted local authority B voluntarily and for settled purposes. As such, the presumption that he remains ordinarily resident in local authority A can be rebutted: for the purposes of the 2014 Act, he is ordinarily resident in local authority B.

As Sunil is being provided with residential accommodation, section 39(1)(a) of the 2014 Act applies and he is deemed to continue to be ordinarily resident in the area in which he was ordinarily resident immediately before residential accommodation was provided for him. Immediately before Sunil entered residential accommodation under section 39 of the 2014 Act, he was living in local authority B where he was ordinarily resident for the purposes of that Act. Therefore, in Sunil's case, the deeming provision does not change his ordinary residence.

Scenario 2: transition from accommodation under the 1989 Act to independent living accommodation with care and support provided under the 2014 Act

Rosie is 18 years old and has Down's Syndrome. She has been 'looked after' by local authority E from a young age and has spent the last 5 years living with foster carers "out of area" in local authority F. Although she is living in local authority F, she remains the responsibility of local authority E under the provisions in the 1989 Act.

When Rosie turns 18, she will be ready to leave care and a transition assessment is carried out to determine her future care needs. A move to independent living is agreed in line with Rosie's own wishes. Rosie's support workers in local authority E, together with her foster carers, help her to find a flat share with friends in local authority F. Rosie signs her own tenancy agreement and the move takes place. She receives housing benefit to pay her rent and Supporting People money to fund housing related support. She also receives care and support under the 2014 Act.

Local authority E provides Rosie with care and support but immediately falls into dispute with local authority F. In their view, Rosie has acquired a new ordinary residence in local authority F and any care and support should be its responsibility. However, local authority F argues that local authority E's responsibility towards Rosie has not ended simply because her accommodation status has changed.

As Rosie is in transition from being provided with care and support under the 1989 Act to being provided with care and support under the 2014 Act, the starting presumption is that her place of ordinary residence is local authority E, the authority where she was ordinarily resident in when she turned 18. However, this presumption may be rebutted by looking at all the facts of Rosie's case.

Rosie has been 'looked after' from a young age and has lived in local authority F for 5 years by the time she turns 18. She has no contact with her birth parents and no links with anyone in local authority E other than her social workers. She has a well-established support network in local authority F, including her foster parents who she intends to maintain a relationship with. Rosie has chosen to live in local authority F and has a flat share there which indicates that she has a settled purpose to remain there. Therefore, in line with the [Shah] test, Rosie has acquired an ordinary residence in local authority F: the starting presumption that she is ordinarily resident in local authority E can be rebutted.

As Rosie has been 'looked after' by local authority E for the requisite period of time, she is eligible for after-care services under the leaving care provisions in the 1989 Act. Local authority E, the authority that last looked after Rosie, is responsible for the provision of these services, despite the fact that Rosie is now ordinarily resident in local authority F and receiving care and support under the 2014 Act from that authority. Therefore, local authority E and local authority F must work together to ensure that Rosie gets a holistic support package that meets all her eligible needs.

Scenario 3: transition from care and support under the 1989 Act to care and support under the 2014 Act where a young person goes to university

Olu is 18 years old and has a physical disability which requires the use of a wheelchair. He currently lives at home with his parents in local authority G but has a place to study at university in local authority H, which is several miles away from his home town. Olu's disability means that he requires help with his personal care needs and this is currently provided by carers in his parents' home under section 17 of the 1989 Act, in conjunction with section 2 of the Chronically Sick and Disabled Persons Act 1970.

Olu starts his university course at the beginning of term. He lives in university accommodation which has been specially adapted for him by the university in line with their duties under the Equalities Act 2010. His accommodation is funded through mainstream education sources and his personal care is provided by a local domiciliary care agency, arranged by local authority G under the 2014 Act.

However, local authority G immediately falls into dispute with local authority H. It argues that Olu has moved to local authority H for settled purposes and has acquired an ordinary residence there. In the authority's view, local authority H should be providing Olu's care and support under the 2014 Act. By contrast, local authority H argues that Olu is in its local authority on a temporary basis only and has not acquired an ordinary residence there. It believes local authority G remains responsible for the provision of Olu's care and support under the 2014 Act.

As Olu is in transition from receiving care and support under the 1989 Act to receiving them under the 2014 Act, the starting presumption is that he remains ordinarily resident in local authority G, the local authority where he was ordinarily resident under the 1989 Act. However, this presumption may be rebutted by considering all the facts of his case.

Olu has lived in local authority G all his life. He has a close relationship with his parents who provide him with emotional, and some financial, support. He regards their home as his home and plans to return there during his university holidays, and once his course is over. As such, his parents' home can be said to be his "base". Therefore, it does not appear that Olu satisfies the [Shah] settled purpose test as his move to local authority H is not for settled purposes: his home remains with his parents and his absence from their house can said to be temporary. The presumption that Olu is ordinarily resident in local authority G has not been rebutted.

As Olu spends a significant amount of time in local authority H, several miles away from his local authority of ordinary residence, local authority G believes it would be more practical for Olu's care and support to be provided and overseen locally. Therefore, it makes arrangements for local authority H to provide care and support to Olu under the 2014 Act on their behalf. Local authority H is able to recover the cost of Olu's care from local authority G.

Scenario 4: transition from care and support under the 1989 Act to care and support under the 2014 Act where a young person goes to university

Marcus is almost 18 years old and has a physical disability which requires the use of a wheelchair. He has been a 'looked after' child since the age of 5 and has been accommodated in several different local authority areas, although his responsible authority is local authority J. For the past two years he has lived in a residential school in local authority K where he has made good progress. He has been offered a university place that he wishes to take up. The university is located in local authority L.

When Marcus turns 18 an assessment is carried out with a view to putting a package of care in place that will support him at university. He is assessed as requiring assistance with personal care tasks such as washing and dressing as his disability means he has difficulty doing these tasks unaided. He plans to live in university accommodation which has been adapted for his use in line with the university's duties under the Equalities Act 2010. This is funded through mainstream education sources.

Local authority J agrees to meet Marcus's personal care needs through care and support provided under the 2014 Act and Marcus's move to university takes place. As Marcus has been a looked after child for the requisite period, he also qualifies for leaving care services under the 1989 Act. Local authority J also arranges these services.

However, local authority J immediately falls into dispute with local authority L over Marcus's place of ordinary residence. In its view, Marcus has moved to local authority L for settled purposes and has acquired an ordinary residence there. As such, Local authority J argues that local authority L should be providing Marcus's care and support under the 2014 Act. However, in local authority L's view, Marcus remains the responsibility of local authority J, where he was ordinarily resident under the 1989 Act. Local authority L also argues that he may have an ordinary residence in local authority K, the local authority where he last lived. In its view, Marcus's presence in local authority L is temporary in nature and does not amount to a "settled purpose" under the Shah test.

To establish Marcus's ordinary residence, all the facts of his case must be considered. As Marcus is in transition from receiving care and support under the 1989 Act to receiving care and support under the 2014 Act, the starting presumption is that he is ordinarily resident in local authority J, the local authority where he was ordinarily resident under the 1989 Act. However, this presumption may be rebutted.

Marcus has been looked after by local authority J for most of his life. However, he has only lived within local authority J's boundary for brief periods – most of his care placements have been out of area in neighbouring local authorities. Marcus has no contact with his birth parents, who were originally from local authority J, and no intention to return to the area for settled purposes.

Marcus's only real link to local authority J is the fact that it remains responsible for the provision of his leaving care services. However, this in itself is not enough to affirm the presumption that he is ordinarily resident there. In other respects, Marcus has no connection with the local authority area and has no "base" there. Therefore, the presumption that he remains ordinarily resident in local authority J can be rebutted.

Most recently, Marcus has lived in a residential school in local authority K. However, he only lived there for only 2 years, during which time he remained the responsibility of local authority J. He did not build up any relationships outside his school nor did he establish links within the local community. He has no intention to return there. Therefore, Marcus has not established an ordinary residence in local authority K.

Marcus is, however, in local authority L for a settled purpose. He intends to live there for the duration of his university course and has no other place which can be considered his base. His life is now based in local authority L and he has started to build friendships there and establish links with the local community. Therefore, Marcus acquires an ordinary residence in local authority L. As such, it is local authority L who is responsible for the provision of Marcus's care and support under of the 2014 Act.

As Marcus is eligible for leaving care services under the 1989 Act, local authority J, the local authority that last looked after him, is responsible for the provision of his vacation accommodation. Local authority J is also responsible for providing him with expenses during term time to cover things such as travel and equipment costs, as well as offering him general advice and support. Therefore, local authority J and local authority L need to work together to ensure that Marcus is fully supported during his time at university.

Marcus's situation can be contrasted with that of Olu (above, scenario 4). Olu did not acquire a new ordinary residence in his university town because he had a base to which he was intending to return regularly and at the end of his course, and, as such, his presence in his university town was on a temporary basis only. By contrast, Marcus had been a looked after child and had no base in any local authority. Therefore, when he moved to his university town he intended to live there for settled purposes for the duration of his university course.

Annex J9 – Other provisions under which an ordinary residence determination can be sought

Schedule 3 to the Care Act 2014

59. Schedule 3 to the Care Act places a duty on local authorities and the NHS to work together to ensure the safe hospital discharge of people with care and support needs. Where a person remains in hospital because a local authority has not carried out an assessment or put in place arrangements to meet the care and support that it proposes to meet in order to ensure that the person can be safely discharged from hospital, the local authority may be liable to pay the relevant NHS body a charge per day of delay.

60. Schedule 3 to the Care Act requires NHS bodies to take reasonable steps to ensure that eligibility for NHS Continuing Healthcare is assessed in all cases where it appears to the NHS body that the person may have a need for such care, in consultation, where it considers it appropriate, with the local authority appearing to the NHS body to be the authority in whose area the patient is ordinarily resident.

61. Where it is not likely to be safe to discharge a hospital patient unless arrangements for meeting their care and support are put in place, the NHS body must notify the patient's local authority of this. Under the Act, it is the local authority in which the patient appears to the NHS body to be ordinarily resident. Or where a person is not ordinarily resident in any local authority, i.e. a person of "no settled residence", the Care Act provides that it is the local authority in which the hospital is situated that the NHS body must notify. Once notification has been received, the local authority must arrange for an assessment of the person's need for care and support to be carried out and for the provision of any services.

62. If a local authority receives notification from the NHS body of a person who it believes is ordinarily resident in another local authority area, it should inform the NHS body that has issued the notification immediately. If the NHS body agrees that the person is ordinarily resident elsewhere, it should withdraw the notification and re-issue it to the correct local authority. If the NHS body does not agree that the person is ordinarily resident elsewhere, the local authority in receipt of the notification must proceed with carrying out the assessment and arranging for the provision of any necessary care and support. A person ready for discharge from hospital should not remain in hospital for longer than necessary because two or more local authorities have fallen into dispute about the person's place of ordinary residence.

63. Where a local authority has provisionally accepted responsibility for a person discharged from hospital but remains in dispute with one or more local authorities over the person's ordinary residence in relation to which authority should reimburse the NHS body for the person's delayed discharge, a determination from the Secretary of State can be sought. Determinations should only be sought as a last resort: local authorities should take all steps necessary to resolve the disputes themselves first.

64. It should be noted that a determination can only be sought in relation to ordinary residence questions that arise in connection with delayed hospital discharges. Where ordinary residence disputes arise in relation to the provision of care and support to a person upon their discharge from hospital, determinations should be sought under section 40 of the 2014 Act.

The Mental Capacity Act 2005 Deprivation of Liberty Safeguards

65. The Deprivation of Liberty Safeguards ("MCA DOLS")[181] in the Mental Capacity Act 2005 ("the 2005 Act") provide a framework for authorising the deprivation of liberty of people who lack the capacity to consent to arrangements made for their care or treatment (in either a hospital or care home)[182] and who meet the qualifying requirements in Schedule A1, including that they need to be deprived of liberty in their own best interests, to protect them from harm.

66. Under the MCA DOLS, the "managing authorities" of hospitals and care homes must request a standard authorisation from a local authority (a "supervisory body") if they believe a person will, or will be likely to be, deprived of their liberty in hospital or care home setting within the next 28 days.

67. In most cases, it should be possible to obtain an authorisation in advance of deprivation of liberty occurring. Where this is not possible and a person needs to be deprived of their liberty in their own best interests before the standard authorisation process can be completed, the managing authority must give itself an urgent authorisation and apply to the supervisory body for a standard authorisation to be issued within 7 calendar days.

68. Where a person needs to be deprived of liberty in a care home in England or Wales, the 2005 Act provides that the supervisory body is always the local authority in which the person is ordinarily resident.[183] This remains the case regardless of whether the person has been placed in the care home in another authority's area by the local authority or a CCG.

69. If a person is arranging and paying for their care under private arrangements, they usually acquire an ordinary residence in the area in which their care home is located. Therefore, the local authority in which the care home is located will be the supervisory body.

70. Where a person is not ordinarily resident in any local authority (for example a person of "no settled residence"), the 2005 Act provides that it is the local authority in which the care home is situated that becomes the supervisory body.[184]

71. Under paragraph 183 of Schedule A1 to the 2005 Act, the "deeming" provisions in section 39(1) of the Care Act apply for the purposes of determining where a person is ordinarily resident so that the local authority that is the supervisory body can be identified. A person remains ordinarily resident in the area of the local authority in which the person is ordinarily resident before the local authority places the person in another local authority area under a deprivation of livery authorisation. Therefore the placing local authority remains the supervisory body.

72. If a person needs to be deprived of liberty in a care home upon their discharge from hospital, and the care home applies for the MCA DOLS authorisation in advance,[185] whilst the person is still in hospital (as would be good practice in this situation), it is the local authority in which the person was ordinarily resident before their admission to

181 The Mental Capacity Act Deprivation of Liberty Safeguards were inserted into the Mental Capacity Act 2005 by section 50 and Schedules 7,8 and 9 to the Mental Health Act 2007 which inserted Schedules A1 and 1A into the 2005 Act

182 Applications may be made to the Court of Protection under the 2005 Act to authorise deprivation of liberty in settings other than hospital or care homes

183 Paragraph 18(2(1) of Schedule A1 to the 2005 Act

184 Paragraph 18(2) of Schedule A1 to the 2005 Act

185 A standard authorisation comes into force when it is given, or at any later time specified in the authorisation: paragraph 52 of Schedule A1 to the 2005 Act

hospital which is responsible for exercising the MCA DOLS functions and acting as the supervisory body. This remains the case even where it is planned that the person will be discharged from hospital to a care home located in another local authority area.

73. If the person arranges and pays for their own care in that care home (usually a deputy appointed by the Court of Protection under the 2005 Act would enter into a contract with the care home on their behalf), they would generally acquire an ordinary residence in the area in which their care home is located. However, if the person does not reside in the care home at the point when the care home applies for the deprivation of liberty authorisation, they cannot be ordinarily resident in that local authority, despite any imminent plans to move there. Whilst the person remains in hospital, they are ordinarily resident in their previous local authority until they are discharged from hospital. It is likely that the person would become ordinarily resident in the local authority in which their care home is located as soon as their move takes place but their supervisory body under the MCA DOLS would be their previous local authority.

74. Section 39(5) of the Care Act applies to all NHS accommodation and not just hospitals. This means that where a person is placed in a care home "out of area" by a CCG under NHS CHC arrangements, they remain ordinarily resident in the area in which they were ordinarily resident before being provided with NHS CHC. Therefore, if the person in receipt of NHS CHC subsequently needs to be deprived of their liberty, it is the local authority in which they were ordinarily resident immediately before being provided with NHS CHC that is responsible for performing the supervisory body role.

75. Where two or more local authorities dispute the person's ordinary residence for the purpose of identifying which authority is the supervisory body, the 2005 Act provides that disputes may be determined by the Secretary of State or appointed person, or by the Welsh Ministers[186] where they cannot be resolved locally. Disputes between a local authority in England and a local authority in Wales, are determined by the Secretary of State or Welsh Minister under cross-border arrangements made under paragraph 183(4) of Schedule A1 to the 2005 Act.

76. It should be noted that a determination under the 2005 Act can only be sought in relation to ordinary residence disputes that arise in connection with which local authority should take on the role of supervisory body for the purpose of granting (and reviewing) a deprivation of liberty authorisation. Where ordinary residence disputes occur in relation to the general provision of care accommodation or services, determinations should be sought under section 40 of the Care Act.

77. Regulations made under the 2005 Act[187] put in place arrangements for when disputes occur between local authorities over the ordinary residence of a person who needs a standard authorisation to be deprived of liberty. They set out that, in the event of a dispute occurring, the local authority which receives the request for a deprivation of liberty authorisation must act as the supervisory body until the dispute is resolved, unless another local authority agrees to perform this role.

---

186 A standard authorisation comes into force when it is given, or at any later time specified in the authorisation: paragraph 52 of Schedule A1 of the 2005 Act

187 The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 (S.I. 2008/1858) as amended by article 118 of the National Treatment Agency (Abolition) and the Health and Social Care Act 2012 (Consequential, Transitional and Saving Provisions) Order 2013 (S.I. 2013/235). These Regulations apply only to England

Scenario: moving from hospital to a care home under a MCA DOLS authorisation

Geeta is 86 years old and has dementia. She lives on her own in local authority A but receives some care and support at home. She requires a routine operation to remove gallstones and is admitted to hospital in local authority B.

During Geeta's stay in hospital she becomes increasingly confused and starts to wander, making various attempts to leave the ward. She also starts to shout and is sometimes aggressive to other patients. To protect Geeta and other patients, her doctors and nursing staff feel it would be in her best interests to place her in a side room and to lock her in. As Geeta is having her movements so restricted as to amount to a deprivation of liberty, hospital staff place Geeta under an urgent deprivation of liberty authorisation and apply to local authority A, the local authority for the area in which the hospital is located, for a standard deprivation of liberty authorisation to last for the remainder of her hospital stay. The authorisation is granted.

Geeta recovers well from her operation but remains very confused. She continues to shout and wander, and becomes increasingly aggressive. In preparation for her hospital discharge, she is assessed by a multi-disciplinary team who conclude that she is no longer able to live independently in the community and recommends that she enters a care home. A place in a care home specialising in dementia care is found for Geeta in neighbouring local authority C. Due to Geeta's worsening dementia and the fact that she is unable to consent to the arrangements being made for her at the care home, the care home manager feels she will need to be deprived of her liberty as soon as she enters the care home, at least for the short-term until she settles in.

The care home manager requests a MCA DOLS authorisation from local authority B, the area in which the hospital is located, mistakenly believing that local authority B is Geeta's local authority of ordinary residence. Local authority B immediately falls into dispute with local authority A over which authority should act as the supervisory body. Local authority C also becomes involved in the dispute.

Local authority A argues that local authority C should be the supervisory body. Its argument is based on the fact that the MCA DOLS application is to begin as soon as Geeta moves into the care home in local authority C, at which point she will become ordinarily resident there. Local authority B argues that Geeta has not acquired an ordinary residence in their local authority during her hospital stay and, as such, local authority A or C should be the supervisory body. Finally, local authority C argues that, as Geeta is still in hospital and has not yet moved to their local authority area, she cannot be ordinarily resident in local authority C, despite her impending move.

As local authority B has received the request for the DOLS authorisation, it is obliged to act as the supervisory body until the dispute is resolved, as set out in the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008. However, local authority C feels strongly that local authority B is not the correct authority to make the MCA DOLS authorisation and agrees to take on the supervisory body role until the question of Geeta's ordinary residence is decided.

To determine Geeta's ordinary residence for purpose of granting and overseeing a DOLS authorisation, Schedule A1 to the Mental Capacity Act 2005 sets out that the supervisory body is the local authority in which the person is ordinarily resident. Therefore, Geeta's ordinary residence must be established at the point in time when the request for a MCA DOLS authorisation is made.

When the care home requests the MCA DOLS authorisation, Geeta is in hospital in local authority B. Therefore, whilst Geeta is in hospital in local authority B, she remains ordinarily resident in local authority A. When Geeta moves to the care home in local authority C her ordinary residence will not change because local authority A was the area she was living in for settled purposes before she went to the care home. Local authority A is also the supervisory body responsible for considering the request for the MCA DOLS authorisation.

MCA DOLS authorisations should be granted for as short a time as possible within the period of authorisation being set by the supervisory body. It would be sensible for local authority A to grant a short MCA DOLS authorisation so her situation can be reviewed once she moves to the care home. If the review concludes that a further MCA DOLS authorisation is in Geeta's best interests, the care home should request a fresh authorisation from the supervisory body, Geeta's local authority of ordinary residence, local authority A. This is because while Geeta remains in receipt of services her ordinary residence does not change and remains with local authority A where she was living immediately before she was admitted to hospital.

Annex K: Repeals and revocations

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

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

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

Primary legislation to be repealed or disapplied

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

Secondary legislation to be revoked

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

Statutory guidance to be cancelled

Title of guidance to be cancelled
Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care (2010)
Fairer Charging Policies for Home Care and other non-residential Social Services (2013) and LAC (2001)32
Charging for residential accommodation guidance (CRAG) (2014)
Guidance on direct payments for community care, services for carers and children's services (2009)
The Personal Care at Home Act 2010 and Charging for Reablement (LAC (2010)6)
Charging for residential accommodation guidance (CRAG) (2014)
Identifying the ordinary residence of people in need of community care services (2013)
Transforming Adult Social Care (LAC (2009)1)
Guidance on National Assistance Act 1948 (Choice of Accommodation) Directions 1992 and National Assistance (Residential Accommodation) (Additional Payments) Regulations 2001 (LAC (2004)20)
The Community Care (Delayed Discharges etc.) Act 2003 guidance for implementation (LAC (2003)21)
Fair Access to Care Services (FACS): Guidance on eligibility criteria for adult social care (2002)
Carers and people with parental responsibility for disabled children (2001)
No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (2000)
Caring for people: community care in the next decade and beyond (1990)

Glossary

This glossary refers to key terms used throughout the guidance. More specific terms that are relevant to individual chapters are defined in the section to which they relate.

Definitions of more common terms can be found on Think Local Act Personal's care and support "jargon buster": http://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster

Act of Parliament

If the House of Commons and the House of Lords agree proposals for a new law (called a Bill), and it then receives Royal Assent from the monarch, it becomes an Act of Parliament.

Adult

Any person over the age of 18 years.

Adult with care and support needs

A person over the age of 18 years who has a need for care and support (see below). Depending on the context, this could be an adult receiving a particular care and support service, or an adult who has such needs but are not receiving a service (for example, someone coming forward for an assessment).

Assessment

This is what a local authority does to find out the information so that it can decide whether a person needs care and support to help them live their day-to-day lives. A carer can also have an assessment.

Care and support

The mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent – including older people, people with a disability or long-term illness, people with mental health problems, and carers. Care and support includes assessment of people's needs, provision of services and the allocation of funds to enable a person to purchase their own care and support. It could include residential care, home care, personal assistants, day services, or the provision of aids and adaptations.

Carer

Somebody who provides support or who looks after a family member, partner or friend who needs help because of their age, physical or mental illness, or disability. This would not usually include someone paid or employed to carry out that role, or someone who is a volunteer.

Commissioners

The people or organisations that arrange the care and support that is available in an area to meet the needs of the population.

Direct payment

Payments made directly to someone in need of care and support by their local authority to allow the person greater choice and flexibility about how their care is delivered.

Domiciliary care

Also known as home care or non-residential care, it enables people to remain independent and living in their own homes.

Duty

This is something that the law says that someone (in this case, usually a local authority) must do, and that if they do not follow may result in legal challenge.

Local authority

An administrative unit of local government.

Person/people

This is used to refer to an individual or individuals. It may include carers as well as adults with care and support needs.

Personal budget

This is a statement that sets out the cost to the local authority of meeting an adult's care needs. It includes the amount that the adult must pay towards that cost themselves (on the basis of their financial assessment), as well as any amount that the local authority must pay.

Primary legislation

This a general term used to describe the main laws passed by Parliament, usually called Acts of Parliament.

Provider

An individual, institution, or agency that provides health, care and/or support services to people.

Provisions

The contents of a legal instrument, like an Act or regulations.

Regulations (see also secondary legislation)

A type of secondary legislation made under an Act of Parliament, setting out extra details that help the Act to be implemented.

Residential care

Residential care often refers to nursing homes and care homes that provide around-the-clock care for vulnerable adults who can longer be supported in their own homes. Homes may be run by local councils or independent providers. Admissions to residential care can be made on a temporary or permanent basis.

Secondary legislation (see also regulations)

This is additional law that is made by Ministers under powers that are given to them in Acts of Parliament.

Department
of Health

© Crown copyright 2014
2902364 Produced by Williams Lea for the Department of Health