Briefing 1: Promoting Wellbeing

Local authorities **must**:

- Promote wellbeing when carrying out **any** of their care and support functions in respect of a person
- Consider how to meet each person's specific needs rather than simply considering what service they will fit into
- Include a focus on wellbeing by delaying and preventing care and support needs, and supporting people to live as independently as possible for as long as possible

The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. Underpinning all of these individual "care and support functions" is to ensure this focuses on the needs and goals of the person concerned.

"Wellbeing" **should** be seen as the common theme around which care and support is built at local and national level.

When does it apply?

The wellbeing principle applies in all cases where a local authority is carrying out a care and support function, or is making a decision in relation to a person; it applies **equally** to:

- Adults with care and support needs;
- Carers;
- Children, their carers and young carers when they are subject to transition assessments; and
- Those who do not have eligible needs but come into contact with the system in some other way

The individual aspects of wellbeing, as set out in the Act, are of **equal** importance when considering a person's individual wellbeing:

- 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.

Promoting wellbeing

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 provision of information to reviewing care & support plan.

How wellbeing is promoted will depend on the individual circumstances, need, goals and wishes of the person and how they impact on wellbeing.

The Act **signifies a shift** from existing duties on local authorities to provide particular services, to the concept of 'meeting needs'. 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.

The concept of 'meeting needs' recognises that everyone's needs are different and personal to them and 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. Local authorities **must** consider how to meet each person's specific needs rather than simply considering what service they will fit into.

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 achieve their desired outcomes.

A flexible approach **should** be adopted to allow a focus on which aspects of wellbeing matter most to the individual concerned.

The principle of promoting wellbeing **should** be embedded through the local authority care and support system.

Local authorities **must** consider the following key principles and standards in relation to every individual:

a) The importance of beginning with the assumption that the individual is best-placed to judge the individual's wellbeing
b) The individual's views, wishes, feelings and beliefs.
c) The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist.
d) 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)
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
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
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
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

The purpose of these principles is to set common expectations for how local authorities **should** approach and engage with people.

Independent living

Supporting people to live as independently as possible, for as long as possible, is a guiding principle of the Care Act and the concept of "independent living" is a **core part** of the wellbeing principle. 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.

Wellbeing throughout the Act

Wellbeing **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.

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.

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.

Briefing 2: Preventing, reducing or delaying needs

Local authorities **must**:

- Provide or arrange for services, resources or facilities that maximise independence for those already with such needs
- Identify and understand both the current and future demand for preventative support, and the supply in terms of services, facilities and other resources available.
- Consider the importance of identifying the services, facilities and resources that are already available in their area
- Consider how to identify "unmet need"
- Provide intermediate care or reablement free of charge for a period of up to six weeks, irrespective of whether people have eligible needs for ongoing care and support.

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.

The LA'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 LA or not; and
- 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 LA or other organisation.

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. There are three general approaches:

1. Prevent: primary prevention/ promoting wellbeing

Aimed at individuals who have no current particular health or care and support needs, these are services, facilities or resources 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** services, which may include, but not limited to interventions and advice that:

- Provide universal access to good quality information;
- Support safer neighbourhoods;
- Promote healthy and active lifestyles
- Reduce isolation or,
- Encourage early discussions in families or groups about potential changes in the future, e.g. conversations about care arrangements/suitable accommodation should a family member become ill.

2. Reduce: secondary prevention/ early intervention

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, LAs **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 local government.

- Targeted interventions should also include approaches to identifying carers, including those who are taking on new caring responsibilities.
- Early intervention could include a falls 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.

3. Delay: tertiary prevention

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.

LAs **must** provide or arrange services that maximise independence for those already with such needs, for example, rehabilitation/ reablement, joint case-management of people with complex needs, community equipment etc.

The focus of prevention

Regard **must** be given to promoting wellbeing and the principles set out in chapter 1. LAs **should** look at an individual's life holistically and consider care and support needs in context of person's skills, ambitions, and priorities.

Developing resilience and promoting individual strength

LAs **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.

Participation **should** be actively promoted in providing interventions that are co-produced with individuals, families, carers & the community. Such interventions can contribute to developing individual resilience and help promote self-reliance and independence, as well as ensuring that services reflect what is wanted by the people who use them want.

Developing a local approach to preventative support

A LA **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. A clear, local approach to prevention **should** be developed, which sets out how they plan to fulfil this responsibility, taking into account the different types and focus of preventative support as described above.

Whilst LAs **may** choose to provide some preventative support themselves, others may be more effectively provided in partnership with other local partners (e.g.

rehabilitation provided with local NHS) and other organisations e.g. specialist housing providers. The commissioning strategy for prevention **should** consider different routes available, and benefits presented by each.

Local Authorities **must** identify and understand both the current and future demand for preventative support, and the supply in terms of services, facilities and other resources available.

Additionally, they **must** identify the services, facilities and resources 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 LA to consider what gaps may remain, and what further steps it should take to promote the market or to put in place its own services.

LAs must **promote** diversity and quality in provision of 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.

There **should** be engagement with 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.

Consideration **should** be given to 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 particular, LAs **must** consider how to identify "unmet need"; this is crucial to developing a longer-term approach to prevention that reflects the true needs of the local population. They **should** consider how they can work with different partners to identify unmet needs for different groups.

Working with other partners to focus on prevention

LAs should consider how to align or integrate its approach with that of other local partners and **must** ensure the integration of care and support provision, including prevention with health and health-related services, which includes housing. It **must** cooperate with each of its relevant partners and the partners must cooperate with the LA

Identifying those who may benefit from preventative support

Arrangements **should** be in place to identify and target individuals who may benefit from particular types of preventative support. They **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 LA e.g:

- 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 LA;
- An assessment of needs or a carer's assessment, which identifies that the person would benefit from a preventative service.

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;
- Contact with/use of local support groups;
- Contact with/use of private care;
- Changes in housing.

Helping people access preventative support

LAs **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. Where a LA 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.

Where a person is provided with any type of service, or supported to access any facility or resource as a preventative measure, the LA **should** also provide the person with information in relation to the measure undertaken. They are 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

The person concerned **must** agree to the provision of any service or other step proposed by the LA. 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 LA **must** proceed to offer the individual an assessment.

Charging for preventative support

Preventative services, like other forms of care and support, **are not always provided free**, and charging for some services is vital to ensure affordability. Where a LA 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. When charging for any type of preventative support, steps **should** always be taken to ensure that any charge is affordable to the person concerned.

LAs **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.

Local Authorities **must not charge** more than it costs to provide or arrange for the particular type of support.

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.

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 LA does have the power to charge for such types of support where it is provided beyond six weeks, they **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.

Briefing 3a: Information and Advice

Local Authorities must:

- Establish and maintain an accessible service for providing people in its area with information and advice relating to care
- Take an active role in the provision of information and advice
- Information and advice services **must** cover prevention of care and support needs, finances, health, housing, employment and what to do in cases of abuse or neglect
- Identify people who may benefit from financial information and advice
- LAs, working with its partners **must** use the wider opportunities to provide targeted information and advice at key points
- Provide information and advice via more than just leaflets and web-based materials
- Recognise and respond to carers' specific requirements

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.

Duty to establish & maintain a service

LAs **must** establish and maintain a service for providing people in its area with information and advice relating to care. They **should** engage widely with people with care and support needs, carers, wider public and local providers (of information and advice and other types of care), to identify what is available and what is **needed** locally, and how and where it **should** best be provided.

An active role must be taken in the provision of information and advice and they 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** include provision of a service or parts of a service with one or more LAs, health services, children's services. Careful consideration **should** be given about whether a particular information and advice service **should** be provided by the LA or by another agency

The Council **must** ensure that information and advice services cover 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.

Local government **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.

LAs **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.

The audiences for the information and advice service

LAs **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. 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, LAs are expected to take action to prevent, delay and/ or reduce the care and support needs for these people
- People who have not presented to LAs for assessment but are likely to be in need of care and support. LAs are expected to take steps to identify such people and encourage them to come forward for an assessment of their needs
- People who become known to the LA at first contact where an assessment of needs is being considered
- People who are assessed by LAs 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
- People whose eligible needs for care and support the LA is currently meeting (whether this is paying for some, all or none of the costs of meeting those needs)
- People whose care and support or support plans are being reviewed
- 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, LAs are expected to identify carers and take action to reduce their needs for support
- Adults who are subject to adult safeguarding concerns
- People who may benefit from financial information and advice on matters concerning care and support. Regard must be given 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

LAs **must** recognise and respond to the specific requirements that carers have for both general and personal information and advice. 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

The local authority **must** ensure that there is an accessible information and advice service including making reasonable adjustments under the Equality Act 2010. 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. Information and advice channels are likely to include:

- Face-to-face contact;

- Use of peer-to-peer contacts;
- Telephone;
- Mass communications, and targeted use of leaflets, posters etc;
- Use of 'free' media such as newspaper, local radio stations, social media;
- LAs own/other appropriate websites, including support for the self-assessment of needs;
- Third party internet content and applications;
- Email

LAs **must** ensure that their information and advice service has due regard to the needs of some particular groups, including but 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.

What should be provided – information and advice content

Information and advice must be provided on:

- **The care and support system locally** – how the system works, including:
  - What the 'process' may entail;
  - judgements that may need to be made;
  - Specific information on the assessment process, eligibility, and review stage and what they involve
  - When independent advocacy should be provided
  - Wider information and advice to support individual wellbeing
  - The charging arrangements for care and support costs
  - How a person might plan for their future care and support needs and how to pay for them
- **How to access the care and support available locally –** where/ who and how to make contact. This includes:
  - Information on how and where to request an assessment of needs, a review or to complain or appeal against a decision;
- **The choice of types of care and support,** and the choice of care providers available in the local authority's area. This includes:
  - Prevention and reablement services and wider services that support wellbeing;
  - The likely costs to the person of the care and support services available to them;
  - Information on different types of service or support that allow people personal control over their care and support such as Independent Service Funds and direct payments
- **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. This includes:
  - What information and advice people may wish to consider when making financial decisions about care
- **How to raise concerns about the safety or wellbeing of an adult with care and support needs**

LAs **must** ensure that the areas covered by their information and advice service go much further than a narrow definition of care and support, including but not limited to:

- Housing and housing-related support
- Effective treatment and support for health conditions
- Health services
- Services that may help people remain independent for longer such as handyman or maintenance services
- Befriending services and other services to prevent social isolation
- Intermediate care entitlements such as aids and adaptations
- Eligibility and applying for disability benefits and other types of benefits
- Employment support for disabled adults, children's social care services and transition
- Careers' 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

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, including:

- 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.

LAs, working with its partners, **must** use the wider opportunities to provide targeted information and advice at key points. 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

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;
- Printed products **should** be produced to appropriate guidelines with important materials available in easy read;
- Telephone services **should** also be available to those with hearing impairments;
- LAs **should** particularly be aware of the needs of individuals with complex but relatively rare conditions, such as deaf-blindness.

It **should** be ensured that the information supplied is clear, 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**.

Proportionality of information and advice

The type, extent and timing of information and advice provided **should** be appropriate to the needs of the person.

LAs **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.

There **should** be consideration of when information and advice might be most effectively be provided by an independent source rather than by the local authority itself; and how joining up with other providers of information and advice could be beneficial.

Reviewing and developing a plan or strategy

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 plan **should** build on local and national best practice and make best use of national resources.

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.

The plan and the resulting service **should** adapt to changing needs and as a result of feedback and learning on what works best. As a minimum, the process **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, 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 LAs; and
- Building into the plan opportunities to record, measure and assess the impact of information and advice services rather than simply service outputs.

Each local authority will need to analyse and understand the specific needs of its population. Some of the factors and circumstances that **should** be considered 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).

LAs **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.

The local authority's plan **should** allow for the urgent provision of information and advice when necessary. All information and advice provided **should** be of a good standard and, where appropriate, delivered by trained or suitably qualified individuals.

Briefing 3b: Financial Information & Advice

Local authorities **must**:

- Establish services that **must** include financial information and advice on matters relevant to care.
- Provide information to help people understand what they may have to pay, when and why and how it relates to people's individual circumstances.
- Support people to make informed, affordable and sustainable financial decisions about their care throughout all stages of their life.
- Provide people with information on the availability of different ways to pay for care.

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.

"Independent financial information and advice" 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.

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 LA **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.

Local authorities **must** have regard to the importance of identifying those who may benefit from independent financial advice or information as early as possible. They **may** also include how care and support costs interact with retirement decisions.

This **should** include:

- Working with partners to get the right message to people in the authority's area; 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.

The 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

People **must** be provided with the information to help them understand what they may have to pay, when and why and how it relates to their individual circumstances. This **must** include the charging framework for care and support, how contributions are calculated; and how care and support choices may affect costs. 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

The local authority **must** provide people with information on the availability of different ways to pay for care including through income and assets, a deferred payment agreement, a financial product or a combination of these things. An authority **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

Some 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 LA **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

The local authority **must** support people to make informed, affordable and sustainable financial decisions about their care throughout all stages of their life. LAs **must** consider a person's specific circumstances and discuss with them which methods of paying for their care may be available to them.

They **should** have a clear view of the information and advice services available locally and what they provide and have a role in joining up information and advice organisations locally so they can work collaboratively; including helping providers and people to understand the role of each information and advice provider. They **should** provide and publicise links and information on access to wider sources of information and advice, including those available nationally.

Facilitating access to independent financial information and advice

Financial information and advice, which is independent of a local authority, **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. They **should** actively describe the general benefits of independent information and advice and be able to explain the benefits to an individual.

LAs **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.

Briefing 4: Market shaping and commissioning of adult care and support

Local authorities **must:**

- Facilitate markets to offer continuously improving, high-quality, appropriate and innovative services
- Ensure their commissioning practices and the services delivered on their behalf comply with the requirements of the Equality Act 2010
- Consider how to help foster and enhance the care sector's workforce to underpin effective, high quality services.
- Work to develop markets for care and support that ensure the overall provision of services remains healthy
- Encourage a range of different types of service provider organisations to ensure people have a genuine choice of different types of service
- Have regard to ensuring a sufficiency of provision
- Understand local markets and develop knowledge of current and future needs for care and support services, and understand providers' businesses.

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, regardless of the way it is funded.

Local authorities **should** review the way they commission services, as this is a prime way to achieve effective market shaping.

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.

Market shaping activity **should** stimulate a diverse range of appropriate high quality, and ensure the market as a whole remains vibrant and sustainable.

The **core activities** of market shaping are:

- People wanting to plan for their future care and support needs;
- To engage with stakeholders to develop an understanding of supply and demand and articulate likely trends that reflect people's evolving needs and aspirations;
- 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;
- Ensuring that those who purchase their own services are empowered to be effective consumers, for example by providing information and advice; and
- Working to the local authority's own commissioning practices are likely to have a significant influence on the market to achieve the desired outcomes

Principles of market-shaping and commissioning

Focusing on outcomes

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, emphasizing the importance of enabling people to stay independent for as long as possible.

An authority **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.

They **should** consider the Adult Social Care Outcomes Framework (ASCOF) in addition to any locally-collected information on outcomes and experiences 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. Outcomes **should** be considered both in terms of outcomes for individuals and outcomes for groups of people and populations.

Consideration should be given to 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. They **should** consider emerging best practice on outcomes-based commissioning.

Moving more to an outcomes-based approach therefore **means** changing the way services are bought: from units of provision to meet a specified need 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.

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 approach. 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.

Promoting quality

Local authorities **must** facilitate markets to offer continuously improving, high-quality, appropriate and innovative services, including fostering a workforce which underpins the market.

When considering the quality of services, LAs **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.

A wide range of service provision **should** be encouraged to ensure that people have a choice of appropriate services.

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.

They **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.

Consideration **should** be given to the cost-effectiveness and value for money that services offer for public funds.

Local authorities **must** consider how to help foster and enhance the care sector's workforce to underpin effective, high quality services. They **should** consider how to encourage training and development for this workforce.

Remuneration of care and support staff **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.

Local authorities **should** assure themselves and have evidence that contract terms, conditions and fee levels are appropriate to provide the delivery of the agreed care packages with agreed quality of care.

They **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.

Supporting sustainability

There **must** be work to develop markets for care and support that ensure the overall provision of services remains healthy in terms of the adequate provision of high quality care and support needed to meet expected needs.

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, LAs **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.

The process of developing and articulating a Market Position Statement or equivalent **should** be central to this process.

Local authorities **should** consider the impact of their own activities on the market as a whole. They **should not** undertake any actions which may threaten the sustainability of the market as a whole.

LAs **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.

Ensuring choice

A range of different types of service provider organisations **must** be encouraged 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; and
- 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.

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.

Genuine choice of service type **should** be encouraged, **not only** a selection of providers offering similar services, encouraging 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.

Choice over the way services are delivered **should** also be encouraged, 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; and
- 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.

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. LAs **should** consider **all types** of service that are required to provide care and support for their population.

They **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.

Individual Service Funds **can** help to secure these kinds of flexibilities for people and providers.

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. Web-based systems such as e-Marketplaces **should** support people to become more effective consumers, helping to match people's wider needs with services.

Co-production with stakeholders

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 should be pursued.

Developing local strategies

Published strategies **should** be in place 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.

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.

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. Plans **should** be developed in **partnership** and collaboration with stakeholders, in particular:

- Provider organisations;
- People needing care and support themselves;
- Carers;
- Health professionals;
- Care and support managers and social workers;
- Independent advocates; and
- Wider citizens to reflect the range and diversity of communities and people with specific needs.

Engagement **should** be arranged to include hard-to-reach individuals and groups, including those who have communication issues and involving representatives of those who lack mental capacity.

A fully co-produced approach will stress the value of meaningful engagement with people at all stages.

Local strategies for market shaping and commissioning should be published, to support local accountability and engagement with the provider market and the public.

Engaging with providers and local communities

Engagement with people needing care and support **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.

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.

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.

Understanding the market

Local authorities **must** understand local markets and develop knowledge of current and future needs for care and support services, and understand providers' businesses.

They **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.

Robust methods should be in place 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.

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.

They **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.

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.

There **should** be consideration of the extent to which people receiving services 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.

Facilitating the development of the market

Collaboration **should** take place 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.

There **should** be consideration of 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.

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.

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.

Developing and then making publicly available a Market Position Statement 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.

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.

Market interventions **could** 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.
- Promoting integration with local partners

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

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

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

LAs **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.

Where they arrange services, the LA **should** ensure the assessed needs of a person with eligible care and support needs are translated into effective, appropriate commissioned services that are adequately resourced.

Due diligence about the effectiveness of potential providers to deliver services to agreed criteria for quality **should** be undertaken, 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.

Contracts **should** incentivize 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.

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.

Their 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.

Briefing 5: Managing Provider Failure

Local Authorities **must:**

- Meet people's needs when a provider is unable to continue to carry on because of business failure
- Involve the person concerned, any carer that the person has, or anyone whom the person asks the authority to involve.
- Not charge for the provision of information and advice to the person.
- Ensure continuity of care in respect of business failure of all providers

Definitions

"Business failure"; defined by a list of different events such as the appointment of an administrator, receiver, administrative receiver or liquidator.

Service interruption because of business failure relates to the whole of the regulated activity and not to parts of it.

"Temporary duty" or "duty" means the duty on LAs to meet needs in the case of business failure. "Temporary" means the duty continues for as long as the LA considers it necessary. This duty applies regardless of whether a person is ordinarily resident in the authority's area.

Service interruptions because of business failure

LAs 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.

The needs that **must** be met are those being met by the provider immediately before the provider became unable to carry on the activity. LAs **must** ensure the needs are met but how that is done is for the LA to decide, and there is significant flexibility in determining how to do so. It is not necessary to meet those needs through exactly the same combination of services that were previously supplied. LAs **must** involve the person concerned, any carer that the person has, or anyone whom the person asks the authority to involve.

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.

The LA **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. LAs **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, regardless of how they pay for their services. However, LAs **may** charge the person for the costs of meeting their needs, and it **may also** charge another LA 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 f**or the provision of information and advice to the person.

Business failure involving a provider in the CQC oversight regime

From April 2015, the financial "health" of certain care and support providers will become subject to monitoring by CQC. These are intended to be providers, which because of their size, geographic concentration or other factors, would be difficult for one or more LAs to replace. CQC **will** determine which providers satisfy the criteria.

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 LAs**, so that they can prepare for the local consequences of the business failure.

In these circumstances the CQC **may** work closely with the affected LAs to help them fulfil their temporary duty. LAs **should** consider CQC guidance on market oversight, which will be published in autumn 2014.

Business failure involving a provider not in the CQC oversight regime

There are many thousands of providers in England and only a relatively small number of providers will fall under the CQC regime. The temporary duty on LAs applies regardless of whether the provider is in the market oversight regime. LAs **must** ensure continuity of care in respect of business failure of all providers.

Service interruptions other than business failure

The power (stated above) can be exercised in order to meet urgent needs without having first conducted a needs assessment, financial assessment or eligibility criteria determination. The LA **may** meet urgent needs regardless of whether the adult is ordinary resident in its area. This means the LA can act quickly if circumstances warrant. This section gives LAs a power to act to meet needs, **but it does not require that authorities must act.**

Not all situations where a service has been interrupted or closed will merit LA involvement because not all cases will result in adults having urgent needs.

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 LA **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 LA judges that the needs of individuals are urgent.

Where the LA does get involved, that involvement might be short-lived (e.g. the giving of advice) or enduring over some months. Acts of God (e.g. flooding) or complications with suppliers **should not** in themselves automatically be considered to trigger the use of the power. **In all cases, the test is whether the LA considers there is an urgent need to be met**.

When considering action in relation to service interruption or closure, there is a balance to be struck. On the one hand, if LAs 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. It may be possible and justifiable for the LA to act in a way that maximises the provider's chances of continuing to provide the service and avoiding a business failure. LAs **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.

The need for contingency planning

Most service interruptions are on a small scale and are easily managed. But service interruptions on a large scale pose far greater problems. LAs **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.

LAs **should** have the capacity to react quickly to the media consequences of service interruption and **should** consider how to undertake contingency planning most effectively at a local level, to ensure preparedness for possible business failures in the future.

Briefing 6a: Assessment

Local authorities **must:**

- Undertake an assessment for any adult who appears to have care and support needs regardless of whether they think the person is eligible
- Consider the impact of a person's needs on other members of their family or network
- Consider a carer's assessment where an individual provides or intends to provider care
- Consider a carer's potential future care and support needs in their own right
- Determine whether the person is able to engage in the assessment process and consider the need for independent advocacy where appropriate
- Involve a carer and **any** other person requested
- Offer a supported self-assessment
- Ensure that an expert is involved in the assessment of adults who are deaf-blind

The assessment **must:**

- Seek to establish the impact on their individual wellbeing
- Be person-centred and proportionate

When people approach a local authority for an assessment, or are referred by a third party, 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.

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.

The purpose of a needs assessment

Local authorities **must** undertake a person-centred assessment for any adult who appears to have any level of needs for care and support, regardless of **whether or not** the LA thinks the individual has eligible needs.

The aim of the assessment is to identify what needs the adult 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.

The assessment **must** seek to establish the total extent of needs and impact on their individual wellbeing 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.

The purpose of a carer's assessment

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.

Carers' assessments **must** seek to establish not only the carer's needs for support, but also the sustainability of the caring role itself. The local authority **must** consider the carer's potential future care and support needs in their own right and the sustainability of their caring role. They **must** also consider whether the carer is currently able and will continue to be able; and willing, and likely to continue to be willing to care for the adult needing care.

The carer's assessment **must** also consider the carer's activities beyond their caring responsibilities, and the impact of caring upon those activities, including a carer's desire and ability to work, to partake in education, training or recreational activities, such as having time to themselves.

Refusal of assessment

An adult with possible care and support needs or a carer **may** choose to refuse to have an assessment because they do not feel that they need care or they **may not** want local authority support. The person or carer **may** request an assessment at a later date.

In such circumstances local authorities are **not required** to carry out an assessment, unless they identify that an adult lacks capacity or is subject to abuse or neglect **and** that an assessment would be in the person's best interests.

First contact with the authority

From the very first contact, local authorities **should** provide as much information as possible about the assessment process, including what can be expected during the assessment process and allow them to be as involved in the process as possible.

It **must be** ensured 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.

Staff **must** also be able to identify a person who may lack mental capacity and to act accordingly.

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

Assessments **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 and individuals **should** be informed of an indicative timescale for assessment.

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.

In these cases, the local authority has the **power** to meet these urgent needs without having carried out an assessment first.

LAs **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.

Local authorities also **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; for example where a person lacks

mental capacity a face-to-face assessment **must** be arranged.

Supporting the person's involvement in the assessment

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 **and** any other person requested. There should be 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.

Local authorities **should** consider at first point of contact whether the individual would have substantial difficulty in being involved 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 will need assistance and the local authority **must** consider the need for independent advocacy. This **should** be done as early as possible in the assessment process so that the individual can be supported throughout the process.

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.

Some people **may** require an assessment, tailored to their circumstances, their needs and their ability to engage.

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.

The more serious a person's needs, the more support they **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.

Considering the person's strengths and abilities

At the same time as carrying out the assessment, the local authority **must** consider other services that might assist the person in meeting the outcomes they want to achieve. There **should** be consideration of 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

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).

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.

The local authority **should** establish the individual's communication needs and seek to adapt the assessment process accordingly; this will include providing information in an accessible format and considering the need for a specialist assessor or interpreter.

An authority **should** also consider the impact of the assessment process itself on the individual's condition(s) and consider the preferences of the individual with regards to the timing, location and medium of the assessment.

The assessment **should** be flexible in each case and **must** have regard to:

- The person's wishes and preferences and desired outcomes
- The severity and overall extent of the person's needs
- The potential fluctuation of a person's needs.

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 feelings 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.

Whole family approach

Local authorities **should take a holistic view** of the person's needs and consider both how the adult or their support network or the wider community **can** contribute towards meeting the outcomes they want to achieve.

There **must** also be consideration of the impact of the person's needs for care and support on family members or other people the authority may feel appropriate. This will include considering whether or not the provision of any information and advice would be beneficial to those people.

The LA **must** also identify any children who are involved in providing care and consider:

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

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 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, including:

- 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.

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.

Local authorities **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 or a young carer's assessment under section 63 of the Care Act.

Supported self-assessment

A person **must** be offered the choice of a supported self-assessment if the adult or carer is able and willing to undertake it. The person should be asked to complete the same assessment questionnaire that the authority uses in their needs or carers assessments.

Before offering a supported self-assessment local authorities must ensure that the individual has capacity to fully assess and reflect their own needs. Where a person has capacity but significant 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 family member or an independent advocate as appropriate.

The local authority **must** assure itself that the person's self-assessment is an accurate and complete reflection of their needs. This process **should not** be a repeat of the full assessment, but **may** involve seeking seek the views of those who are in regular contact with the person.

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.**

Fluctuating needs

An authority **should** consider whether a person's current level of need 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 LAs **must** consider the person's care and support history over a suitable period of time, both the frequency and degree of fluctuation. This **should** include considering the person's wider care and health needs and the medical history.

Integrated assessments

Close work **should** be carried out with any other agencies to prevent a person having to undergo a number of assessments at different times, which can be distressing and confusing.

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. 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**

When working with other organisations in this way, local authorities **should** share resources and facilities as appropriate and the local authority **can** also undertake the other assessment on behalf of the other body, where this is agreed.

Combining assessments

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.

NHS Continuing Healthcare

Where it appears that a person may be eligible for NHS Continuing Healthcare (NHS CHC), local authorities **must** notify the relevant body. Local authorities **cannot** arrange services that are the responsibility of the other. 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.

Local authorities and CCGs **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 where appropriate.

A person could have a joint package of care **could** of NHS-funded nursing care and other NHS services that are beyond the powers of a local authority to meet and **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.

Assessment for people who are deafblind

Local authorities **must** ensure that an expert is involved in the assessment of adults who are deafblind, including where both sensory impairments appear relatively mild. Specialist assessors **should** have specific training and expertise, including communication, one-to-one human contact, social interaction and emotional wellbeing, support with mobility, assistive technology and rehabilitation. In addition, LAs should use an appropriately trained interpreter where required.

It **should** also be recognised 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.

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.

Briefing 6b: Eligibility

Local authorities **must:**

- Comply with the national eligibility threshold.
- Meet the needs of someone they have determined as eligible.
- Provide a written record of their determination about a person's eligibility and the reasons for coming to their decision.
- Look at the adult's needs over a sufficient period of time where they have fluctuating needs
- Consider carers' legibility in their own right

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.

The eligibility threshold for adults with care and support needs and carers is based on identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing.

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

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 basic care activities, which are activities that the person carries out as part of normal daily life, including:
  - Eating and drinking;
  - Maintaining personal hygiene;
  - Getting up and dressed;
  - Getting around one's home;
  - Preparing meals; and
  - The cleaning and maintenance of one's home
- To maintain their family or other significant personal relationships;
- 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;
- Is able to achieve the outcome without assistance but doing so causes the adult significant pain, distress or anxiety;
- 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; or
- Is able to achieve the outcome without

assistance but takes significantly longer than would normally be expected

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. LAs 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.

An adult's needs are only eligible where they meet all three of these conditions.

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.

Where a person has fluctuating needs, an authority **must** look at the adult's needs over a sufficient period of time to get a complete picture of those needs.

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.

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.

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.

In considering whether a carer is unable to carry out their caring role, local authorities **must** consider if a carer i**s unable or requires support** to provide some of the necessary care to the adult needing care. They **must** 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.

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 that:

- 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:
  - Carrying out some or all basic household activities in the carer's home
  - Carrying out any caring responsibilities the carer has for a child;

- Providing care to other persons for whom the carer provides care;
- Maintaining family or other significant personal relationships;
- Engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community;
- Engaging in recreational activities.

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.

Meeting needs that are not eligible

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.

Where the power choose to meet other needs is exercised, the LA **must** inform the person that they are doing so.

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

Local authorities **must** provide a written record of their determination about a person's eligibility and the reasons for coming to their decision.

Where the LA has determined that the person has needs 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.

Where they have determined that a person has any eligible needs, they **must** meet these needs, subject to meeting the financial criteria and provided that the person meets the ordinary residence requirement and the person agrees to the authority meeting their needs.

Consideration **should** also be given to whether needs which are not eligible can be met by any services in the community or through information and advice.

The local authority **must** also establish whether the individual wants to have their eligible needs met by the local authority.

Briefing 7: Independent Advocacy

Local authorities **must:**

- Judge whether a person has substantial difficulty in being involved;
- Consider whether there is an appropriate individual who can facilitate a person's involvement in the first place;
- Ensure that there is sufficient provision of independent advocacy;
- Take into account any representations made by an advocate;
- Provide someone who qualifies with an advocate - it will be **unlawful** not to do so.

Local authorities have a **duty** to provide independent advocacy to all adults and carers as part of the assessment, care and support planning and review process in **all** settings. This **duty** 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.

Advocacy and the duty to involve

Local authorities **must** involve people in decisions made about them and their care and support. This **will** involve considering the best way of involving them from the point of first contact and helping people understand how they can be involved, how they can contribute and take part and sometimes lead or direct the process.

LAs **must** arrange an independent advocate to facilitate the involvement of a person, where the following two conditions are met:

- A person has substantial difficulty in being fully involved in these processes; and
- 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, including access to information and advice.

Where a person qualifies for advocacy under the Care Act as well as the Mental Capacity Act 2005, the **same advocate can** provide support 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

Local authorities **must** consider for each person, whether they would have substantial difficulty in engaging with the care and support processes. The four areas to consider are:

- Understanding relevant information
- Retaining information
- Using or weighing the information as part of engaging
- Using or weighing the information as part of engaging

Any person with these difficulties is **required** under the Care Act and the Mental Capacity Act to be supported and represented, either by family or friends, or by an advocate in order to communicate their views, wishes and feelings.

When the duty to provide independent advocacy applies

From the start of the assessment and throughout, local authorities **must** judge whether a person has substantial difficulty in involvement with the assessment, the care and support planning or review processes.

Where the local authority considers that a person has substantial difficulty in engaging with the assessment process, they **must** consider whether there is anyone appropriate who can help the person get fully involved. Where there is **no one appropriate** in the person's existing network, the local authority **must** arrange for an independent advocate. Advocacy support applies to the following:

- Needs assessment under section 9 of the Care Act;
- Carer's assessment under section 10;
- The preparation of a care and support plan or support plan under section 25;
- Review of care and support plan or support plan under section 27;
- Child's needs assessment under section 60;
- Child's carer's assessment under section 62;
- Young carer's assessment under section 65.

Continuity of care and ordinary residence

The local authority carrying out the assessment or review is responsible for considering whether an advocate is required.

Where a person is moving from one local authority area to another authority, the **responsibility** will be with the authority the person is moving to as their ordinary residence will be in the new authority. For a person whose care and support is being provided out of area it will be the authority in which the person is ordinarily resident.

Reviews

Local authorities **must** consider whether an advocate is required to facilitate the person's involvement in a review, 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;
- 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.

An appropriate individual to facilitate the person's involvement

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 the following three considerations:

- Cannot be someone who is already providing care or treatment in a professional capacity or on a paid basis to the person;
- The person who is to be supported must agree to the particular individual supporting them, or in case of no capacity the local authority **must** be satisfied that it is in the person's best interests to be supported and represented by this individual;
- Some people might be unlikely to fulfill

the role of actively involving the person in the process easily, for example someone who lives far away or a friend who expresses strong opinions of their own.

Where it later emerges that there is an appropriate person in the person's own network, the advocate **may** at that stage 'hand over' to the appropriate person. The LA **may** also consider that a person needs the support of both a family member and an advocate.

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 same advocate **may** support and represent **two people in the same household**, where both people agree to have the same advocate, and the advocate and the local authority both consider there is no conflict of interest.

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

A person who has substantial difficulty in being involved will **only become eligible** for an advocate where there is no one appropriate to support the 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, and the local authority and the appropriate person agree that the involvement of an independent advocate would be beneficial;
- Where a deprivation of liberty may be the result of the proposed care and support plan.

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.

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;
- Be alert to and identify any restrictions and restraint which may be of a degree or intensity that mean an individual is being, or is likely to be, deprived of their liberty;
- 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?

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 treatment to the individual in a professional or a paid capacity. Advocates **must** have:

- A suitable level of experience
- Appropriate training
- National Qualification in Independent Advocacy (level 3); or work towards this qualification within 1 year
- Integrity and good character
- The ability to work independently of the local authority
- Arrangements for regular supervision

The role of the independent advocate

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. 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, the Care Act **requires** the advocate to consult both the records and the family and others, where this is in the best interest of the person.

Acting as an advocate includes:

- Assisting a person to understand the assessment, care and support planning and review processes;
- 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;
- Assisting the person to make decisions about their care and support arrangements including weighing up various options;
- Assisting the person to understand their rights under the Care Act;
- 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.

Representations

The local authority **must** take into account any representations made by an advocate, including where an advocate has concerns about how the local authority has acted or what decision has been made or what outcome is proposed and written a report outlining their concerns for the local authority. The LA **should** convene a meeting with the advocate to consider the concerns and to provide a written response to the advocate following the meeting.

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 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, facilitate access to the person and to the records; and keep the advocate informed of any developments.

Availability of advocacy services to people in the area

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.

Independent advocacy under the duty flowing from the Care Act is similar in many ways to the Mental Capacity Act (MCA) and enables advocates to **carry out both roles**. However, the duty 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 (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 appropriate to consult for the purpose of best interest decisions under the Mental Capacity Act, but who is not able and/or willing to facilitate the person's involvement in this process.

The expectation is that people will frequently be requiring advocates under **both** Acts. In these cases, local authorities **do not have to** commission one organisation to provide both types of advocacy, but there may be advantages of doing this, where:

- 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.

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 process - 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 – this group are already entitled to advocacy under the Mental Capacity Act, including for care planning when this involves a change in accommodation decision.

Briefing 8: Charging and Financial Assessment

Local Authorities **must:**

- Develop and maintain a charging policy for settings outside care homes.
- Carry out a financial assessment, where it has decided to charge.
- Regularly reassess the person's ability to meet the cost of any charges.
- Take steps to make people aware that they have the right to ask the local authority to arrange their care and support, even if they are above the financial limit.

Where a local authority arranges care and support to meet a person's needs, it **may** charge the person, except where the LA is required to arrange free care. Where it decides to charge, an LA must follow the regulations and have regard to the guidance.

A single model is provided for charging in care homes. The Local Authority **should** develop and maintain a charging policy for settings other than care homes.

Principals of charging

When charging, the following principals **should** be considered when making decisions on charging:

- People are not charged more than it is reasonably practicable for them to pay;
- Be comprehensive and 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

The Local Authority **must not** charge for:

- Immediate care/ enablement (up to 6 weeks)
- Community equipment such as a minor adaptation costing £1,000 or less
- Care for people with Creutzfeldt-Jacob Disease (CJD)
- Aftercare/ support under section 117 or Mental Health Act 1983

- Any service which the NHS is under duty to provide
- Any service the Local Authority is under duty to provide through other legislation.
- Arrangement of administration fees **except** where a person has assets above the upper-capital limit

Capital limit

The upper-capital limit set at £23,250, below this a person can seek means-tested support. The lower capital limit is £14,250; below this a person will not contribute towards the cost of their care. A person above the upper capital limit can ask still the Local Authority to arrange their care and support for them (subject to charging and administration costs)**.**

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.

Carrying out a financial assessment

Where an authority has decided to charge, it **must** carry out a financial assessment of what a person can afford to pay. They **must** regularly reassess the person's ability to meet the cost of any charges. The LA has no power to assess couples or civil partners for joint resources. Each person must be treated individually.

Where a person lacks capacity the local authority **must** find out if the person has any of the following that must be consulted:

- Enduring power of attorney
- Lasting power of attorney for property and affairs
- Lasting power of attorney for health and welfare
- Property and affairs deputyship under the court of protection
- Any other person dealing with that person's affairs.

Tariff income

For those who have capital between the upper and lower capital limit they may be charged £1 per week for every £250 in capital between the two amounts. The local authority **must** take into account a person's income, but earnings from current employment **must** be disregarded.

There are different approaches to how income is treated depending on whether a person is in residential care or receiving care in their own home (Annex C).

"Light tough" financial assessment

A local authority **may** consider carrying out a light touch financial assessment if:

- A person has significant financial resources and does not wish to undergo a full financial assessment.
- Where an local authority charges a small or nominal fee
- Where the person is in receipt of benefits that demonstrate they would not be able to contribute towards their care and support.

Deprivation and debts

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. Where a local authority believes a person to be deliberately avoiding care costs by depriving themselves of assets (Annex E), such as capital or property, the local authority **may** either charge the person

as if they still had the asset or seek to recover the cost from the person to whom they transferred the asset.

The local authority may institute County Court proceedings to recover debt under the Care Act, but should consider the circumstances of the case. (note: this replaces a local authorities right to place a charge on the person's property)

Requesting local authority support

A person above the financial limit can still ask the local authority to arrange their care and support. The local authority **must** take steps to make people aware that they have this right. Where a person's resources are above the financial limit the local authority **should** make clear that a person may be liable to pay an arrangement fee in addition to the costs.

The arrangement fee must not be higher than the cost the local authority has incurred in arranging that care and support.

The information on this right and how they would be charged should be included in the information provided after a financial assessment. 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.

Charging for care and support in a care home

(See Annexe B & C)

Where a local authority has decided to charge and undertaken a financial assessment, it **should** support a person in identifying options of how best to pay the charge- this **may** include offering a deferred payment.

People in a care home will contribute most of their income, excluding their earnings, to care and support, but the local authority **must** leave the person with a specified amount of their own income to spend on personal items.

The local authority **should** normally hold responsibility for contracting with the care provider (except where a local authority is arranging care for someone with resources above the financial limit) unless all parties agree to a different approach.

Care home top ups

(Annex A) A person can choose to be placed in a setting more expensive than identified in their personal budget. The local authority must arrange this. The authority must ensure the person paying the top-up is willing and able to meet the costs and they must enter into a written agreement with the local authority.

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

This includes: a person's own home, extra care housing, supported living accommodation or shared lives.

Local charging policy

Local authorities **should** consider how to use their discretion around charging to support the objectives of charging. They should consult people when deciding how to exercise this discretion and develop and maintain a local charging policy.

- A person must be left with at least the basic level of Income Support plus a buffer of 25%

- Where a person receives benefits to meet their disability needs that do not meet the eligibility criteria the local authority should ensure they keep enough money to cover the cost of meeting these disability-related costs.
- Additionally the financial assessment of their capital **must** exclude the value of the property which they occupy as their main or only home
- Local authority **may** choose to disregard additional sources of income, set maximum charges or charge a person a percentage of their disposable income

Charging for support to carers

A local authority **must** not charge a carer for care and support provided directly to the person they care for under any circumstances (e.g. for respite care).

When deciding whether to charge an LA **should** consider:

- The way it values carers as partners in care and recognise the contribution they make;
- The likely impact on charges on their willingness and ability to continue caring;
- Ensure that charges do not negatively impact on their ability to look after their own health and wellbeing.

If a local authority takes a decision to charge a carer, it **must** charge in accordance with non-residential charging rules and **should** usually carry out a financial assessment (consider light-touch assessment).

Briefing 9: Deferred Payment Agreements

Local authorities **must:**

- Offer a Deferred Payment Agreement (DPA) to anyone who meets the three criteria
- Provide information about a DPA, if it identifies some may benefit from or be eligible for one
- Set an upper limit on how much can be deferred
- Secure a valuation, if the DPA is being taken out against a property
- Clearly set out any interest or administrative charges of a DPA

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 and support. The scheme will be universally available throughout England and local authorities will be required to offer it to those who meet the criteria and local authorities are encouraged to offer the scheme more widely to anyone they feel would benefit who does not fully meet the criteria.

Deferral can last until death, but people may choose to use a deferred payment as a 'bridging loan'.

Criteria

The local authority **must** offer a Deferred Payment Agreement (DPA) to people who meet all the criteria below and who are able to provide adequate security. This includes people with local authority arranged care and people who arrange and pay for their own care.

- Anyone assessed as having eligible needs that are being met through residential care, and
- Who have less than £23,250 in assets excluding the value of their home, and
- Whose home is not occupied by a spouse or dependent relative

Authorities are **permitted** to be more generous and offer a DPA to people in residential care who do not meet the other criteria, for example:

- If someone would like to use wealth tied up in their homes to fund reasonable top-ups
- If a person is likely to meet the financial criteria in the near future.

Permission to refuse a DPA

Circumstances where a LA **may** refuse a request for a DPA include:

- where a local authority is unable to secure a charge on the property
- where someone wishes to defer a larger amount than they can provide security for (the local authority **must** still offer a deferral but use the guidance to set a maximum amount and agree a weekly deferral)
- where a person's property is uninsurable

Permission to refuse further payment deferrals

The local authority **may** refuse to defer any more charges (but **cannot** demand

repayment and **should** provide 30 days advance notice) if:

- the person has reached the 'upper limit' or the value has dropped so the 'upper limit' has been reached earlier than expected
- where a spouse or dependent relative has moved into the property *after* the agreement has been made, thus meaning the person is eligible for local authority support
- where a relative who was living in the property at the time of the agreement subsequently becomes a dependent relative.

Information and advice

People should access appropriate information and advice before taking out a DPA and kept informed throughout the agreement. LAs **should** invite carers and/or families to participate in discussions and provide them with all the information that would otherwise be given to the person they care for.

Information **should** be provided on DPAs during the period of 12-week disregard and aim to ensure a smooth transition from the period of disregard to the DPA.

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. As a minimum this **should**:

- 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
- Explain the types of security that a local authority is prepared to accept
- 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 DPA;
- Explain the implications that a deferred payment agreement may have on their income, their benefit entitlements, and charging
- 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

People **should** be advised that they will need to consider how they plan, use, maintain, and insure their property and they **must** advise if they intend to place conditions on how the property is maintained.

Information throughout the DPA

LAs **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.

Authorities **may** offer people a way to check their statement at any point in the year via an online facility. They **may** choose to develop advice and guidance around maintaining a home, renting, and income; and they **may** also offer services/ products to help the person meet the requirements for maintenance and insurance.

How much can be deferred?

The upper limit

When considering the equity available in a person's asset, LAs **must** set an 'upper limit' leaving some equity remaining to act as a buffer to cover subsequent interest payments. When calculating progress towards the upper limit they **must** also include any interest fees to be deferred.
If a person intends to secure a DPA with a property**:** the LA **must** secure a valuation. In addition people **may** request an independent valuation. The upper limit **must** be set at a maximum loan-to-value ratio of 70-80% to provide security against house price fluctuations.

The LA **should**, when someone is approaching or hits the maximum loan-to-value ratio, use this as a point at which they and the person review the cost of care, any means tested support they are now receiving and whether a DPA continues to be the best way for someone to meet these costs.

The LA has discretion to allow someone to defer more than the stated maximum loan-to-value. This discretion should be exercised if someone does not have sufficient income or assets to meet their care costs or if the deferral is likely to continue for a short period of time. They can allow up to the full sale value of the home minus the lower capital limit used in the charging framework (£14,250).

Making it sustainable

LAs **may** require a contribution towards fees from a person's income but **must not** leave a DPA holder with a disposable income allowance of less than £144 pw.

A DPA should be approached with an approximate idea of what the person's care home charges are likely to be. When deciding on the amount to be deferred, both parties should consider if the arrangement is sustainable:

- Likely period the person would want a DPA if known
- Equity available;
- Sustainability of a person's contributions from their savings
- Flexibility to meet future care needs;
- Period of time a person would be able to defer their weekly care costs for

The Department of Health will develop a tool to aid LAs in assessing sustainability.
People should be able to defer their full care home costs including any top-ups. At a minimum, when the LA is required to offer a DPA they **must** allow someone to defer the care costs. To ensure sustainability of the deferral, they will have discretion over the amount people are permitted to top-up. They **should** accept any top-up deemed to be affordability, sustainability and available equity. The amount being deferred **should** be reviewed on an annual basis

Obtaining security

LAs **must** accept a legal mortgage charge as adequate security. In cases where an agreement is to be secured with a jointly-owned property, LAs **must**

seek both owners' consent to a charge being placed on the property.

Other forms of security an authority **may** choose to consider include:

- a third-party guarantor – subject to the guarantor having/offering appropriate form of security
- a solicitor's undertaking letter;
- a valuable object such as a painting or other piece of art
- an agreement to repay the amount deferred from the proceeds of a life insurance policy.

The security **should** be revalued periodically, if there is any substantial change the LA **should** review the amount being deferred.

Interest rate and administration charge

The DPA scheme is intended to be run on a cost-neutral basis. LAs are able to recoup the costs through interest rates and administrative charges. These will usually be added on to the total amount deferred as they are accrued although a person may request to pay these separately. The DPA **must** clearly set out that all fees deferred, alongside any interest and administrative charges incurred.

Interest rates

LAs will have the ability to charge interest on any amount deferred, including any administration charge deferred. Where interest is charged this **must not** exceed the maximum amount specified in regulations. This will be an amount between 3.5% and 5%.

Administration fees

LAs **must** set their administration charge at a reasonable level, and this **must** reflect actual costs incurred by the local authority. Relevant costs may include (but are not limited to):

- 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.

LAs **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.

Making the agreement

LAs **should** aim to have the agreement finalised and in place by the end of the 12-week disregard period. They **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, (page 130 lists what is to go in the agreement) The LA **should** have regards to the requirements on lenders of the Consumer Credit Act 1974.

Contractual responsibilities on the individual

The deferred payment agreement sets out various contractual requirements on

the individual as well as on the local authority. The LA **should** include contract provisions that the home is maintained adequately with adequate insurance. They **may** also require a person to nominate a third party who is aware of their deferred payment agreement. This may be the nominated executor.

Termination of the agreement

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); or

(c) Automatic termination when the person dies.

Briefing 10: Care and Support Planning

Local authorities **must**:

- Provide a plan for the needs to be met
- Inform the person which, if any, of their needs **may** be met by a direct payment
- Consider any needs that are being met by a carer
- Take **all reasonable steps** to agree with the person, how the plan details the way in which needs will be met
    - The final plan **must** incorporate a core set of elements, including the personal budget and information and advice
    - Any additional content to the plan **must** be agreed with the adult and any other person that the adult requests

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.

When to undertake care and support planning, and support planning

Following the needs and carer's assessment and determination of eligibility, a plan **must** be provided where a local authority is required to or decides to meet the person's needs.

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 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 LA is not meeting.

How to undertake care and support planning, and support planning

The guiding principle 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.

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.

Production of the plan

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, 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.

When developing the plan, the following elements **must** always be incorporated in the final plan:

- 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;
- 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, the needs to be met via the direct payment and the amount and frequency of the payments.

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.

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.

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.

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. There **should** 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

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.

The local authority **must** take into consideration any needs that are being met by a carer, for example where the person 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 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.

LAs **must** inform the person which, if any, of their needs **may** be met by a direct payment. In addition to this, the local authority **should** provide the person (and/or their advocate) 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
- 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
- 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.

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.

The LA **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. The local authority **should** refrain from any action that could be seen to restrict choice and impede flexibility.

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, 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' **must** be avoided.

Involving the person

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.

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. 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. The person **should** be supported to understand what is being discussed and what options are available for them.

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; and people **should** be allowed to gain support from individuals who they choose to assist their involvement in the planning process. (See criteria for independent advocacy in chapter 7)

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.

Authorising others (including the person) to prepare the plan

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.

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. 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.

Planning for people who lack capacity

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.

The local authority **must** support the person to understand and weigh up information, to offer choices and help people to exercise informed choice; and **must** be given all practicable help to make the specific decision before being assessed as lacking capacity to make their own decisions.

Authorities **must** understand that people **have the right** to make what others might

regard as an unwise or eccentric decision. 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.

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.

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.

Combining plans

Local authorities **should** not develop plans in isolation from other plans and **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 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. The plan **should only** be combined if all parties to whom it is relevant agree and it is the responsibility of the local authority to obtain consent from all parties involved.

In cases 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.

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. In these cases, it is important that the individual aspects of each person's plan and their needs and circumstance are not lost in the process of combining plans.

Where a person is receiving both local authority care and support and NHS health care, local authorities **should** 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.

In all of these cases, 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.

Sign-off and assurance

The local authority **must take all reasonable steps** to agree with the person, how the plan details the way in which needs will be met.

The local authority **should not** introduce measures that place any undue burden on the person and avoid developing processes that undermine the self-development of plans, such as excessive quality control.

Where the person or third-party are undertaking the development of the plan, the LA's role **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.

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.

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. They **should** consider how to delegate responsibility to their staff to ensure sign-off takes place at the **most appropriate level**.

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.

A copy of the final plan **must** be given 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.

Briefing 11a: Personal Budgets

Local authorities **must:**

- Provide a personal budget which **must** be a sufficient amount to meet the assessed needs **and** reflect the costs of the local authority of meeting the needs
- Break down the amount into the amounts the person and the local authority will pay
- Exclude intermediate care and reablement services from the personal budget

The Act places personal budgets into **law** for the first time. The personal budget, together with the 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;
- 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 or a combination of the above;
- 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.

Elements of the personal budget

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.

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.

Integration of other aspects of public support 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.

Local authorities **should** take a lead in driving the integration of support services for their population.

Where a LA 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). 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.

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, 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.

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

The regulations set out that the provision of intermediate care and reablement to meet eligible needs **must** be excluded from the personal budget. Intermediate care (including reablement support) services are defined as:

- Consisting of a programme of care and support
- For a specified period of time
- With the purpose of the provision of assistance to an adult to enable them to maintain or regain the skills needed to live independently in their own home

Calculating the personal budget

Local authorities **should** ensure that the method used for calculating the personal budget produces equitable outcomes to ensure fairness in care and support packages.

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.

Regardless of the process used, the most important principles in setting the personal budget are transparency, timeliness and sufficiency:

- **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.
- **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.
- **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 and must also take into account the reasonable preferences to meet needs as detailed in the care and support plan, or support plan.

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, including any 'on-costs', and whether 'cost to the local authority' is less due to the local authority's bulk purchasing and block contract arrangements.

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. This may be the case where the costs of an alternate provider arranged via a direct payment **would** be substantially more than the local authority would pay.

In all circumstances, consideration **should** be given to the expected outcomes of each potential route and any decision **should** be based on outcomes and value for money, rather than purely financially motivated.

Agreeing the final budget

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 or decrease.

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.

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.

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

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 as for direct payments. There are three main ways in which a personal budget can be deployed:

- 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.
- 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.

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.

Where there are no ISF arrangements available locally, the local authority **should** consider establishing this as an offer for people.

Local authorities **should** also consider how choice could be increased by pooling

budgets together. 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.

Briefing 11b: Carers' Personal Budgets

Local authorities **must:**

- Consider how to align personal budgets where they are meeting the needs of both the carer and the adult needing care concurrently
- Provide a budget that enables the carer to meet their needs to continue to fulfil their caring role
- Provide a support plan, specifying how the carer's needs are going to be met and the personal budget for the costs of meeting the carer's needs

The Act specifies that a carer's need for support **can** be met by providing care to the person they care for.

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.

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, and consider whether joint plans (and therefore joint personal budgets) for the two individuals where this may be of benefit.

There **should** be consideration of how to align personal budgets where they are meeting the needs of both the carer and the adult needing care concurrently.

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.

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 maintain personal relationships.

Carers' personal budgets where the adult being cared for is not a personal budget holder

The carer **must** 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 and the personal budget for the costs of meeting the carer's needs.

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.

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 and that they are involved in the decision-making process and agrees with the intended course of action, especially where there is a charge for the service.

Briefing 12: Direct Payments

Local authorities **must:**

- Inform the person which, if any, of their needs may be met by a direct payment
- **Not** force people to take a direct payment against their will
- Explain to people what needs could be met by direct payments during the care and support planning process
- Consider requests for direct payments made at any time
- Review the making of the direct payment within the first six months of making the first payment

A Direct Payment is a cash payment given to a person to meet their eligible social care needs to live independently in the community. Direct payments, along with personal budgets and personalised care planning are **mandated** for the first time in the Care Act. 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.

Direct payments are designed to be used flexibly and innovatively and there **should be no unreasonable restriction** placed on the use of the payments, as long as it is being used to meet eligible care and support needs.

Direct payments **can be made** to the person in need of care and support, or a nominated person on acting on their behalf (if agreed by the person with care needs).

Making direct payments available

Local authorities **must** explain to people what needs could be met by direct payments during the care and support planning process. 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 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.

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. Instead local authorities are **encouraged to prompt** people to consider direct payments and how they could be used to meet needs.

LAs **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.

When considering a request for a direct payment, an authority will have to consider whether the person has been assessed as **having capacity** to make a decision about having a direct payment or not.

Considering a request for a direct payment

After considering the suitability of the person requesting the direct payment against the appropriate conditions in the Care Act in a timely fashion, 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.

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. However, local authorities **must not** use this condition to arbitrarily decline a request for a direct payment.

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. All reasonable steps should therefore be taken to provide this support to people who may require it. This condition **should not** be used to deny a person from receiving a direct payment without consideration of support needs.

Where the decision has been declined, the person in need of care and support, and any other person involved in the request **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.

Administering direct payments

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. 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.

These processes **must not** restrict choice or stifle innovation, and **must not** place undue burdens on people to provide information.

Monitoring **should** also be proportionate to the needs to be met and the care package. Authorities **should** also consider lowering monitoring requirements for people that have been managing direct payments without issues for a long period.

The amount of the direct payment **must** be sufficient to meet the needs the local authority has a duty or power to meet. The 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.

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.

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.

The local authority **must** ensure that the direct payment is sufficient to meet all costs associated with employment.

There **should** also be consideration of how to recover unspent direct payments if the recipient dies. 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.

Local authorities **should** ensure all direct payment recipients are supported and given information in regards to having the correct insurance cover in place.

Paying family members

Direct payments **must not** be used to pay a close family member living in the same household to meet the care and support needs of the person receiving a direct payment, except in exceptional circumstances.

However, the Act gives local authorities a new **discretion** to allow a person to pay a close family member for **administrative and/or management support.** This discretion is in recognition of the fact that in some cases the amount of direct payment may be substantial making the management and administration along with organising care and support a complex and time consuming task.

This administrative and management support should enable the person to:

- Meet with their legal obligations arising from the direct payment
- Monitor the receipt and expenditure of the direct 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.

All 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.

Direct payments in residential care

Direct payments **cannot** currently be used to pay for people to live in long-term residential care. People who are living in care homes long-term **may** receive direct payments in relation to non-residential care services

Direct payments **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.

Becoming an employer

Local authorities **should** give people clear

advice as to their responsibilities when managing direct payments, and whether they need to register with HM Revenue & Customs (HMRC) as an employer. The LA **should** also have regard to the guidance published by Skills for Care detailing minimum levels of support for individual employers and PAs.

As part of the monitoring of the direct payment arrangement, the local authority **should** check to make sure any employee deductions are in turn paid to HMRC and that employment payments conform to the national minimum wage. Where it is clear that payments or returns have not been made, the direct payment arrangement **should** be reviewed.

Direct payments and hospital stays

Where a direct payment recipient requires a stay in hospital, 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. 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.

Where the nominated or authorised person managing the direct payment requires a hospital stay, the authority **must** conduct an urgent review to ensure that the person continues to receive care and support to meet their needs.

Direct payments in the form of pre-paid or pre-payment cards

Pre-paid cards **should not** be provided as the only option to take a direct payment; the offer of a cash payment **should** always be available if requested by the person.

Local authorities **should** give consideration to how they develop card systems that encourage flexibility and innovation to ensure the person is free to exercise 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.

Integrating direct payments

Local authorities **should** consider integrating a person's plan and budget, such as personal health budgets, where this is in the person's interest.

Attempts **should** be made to harmonise the different payments so that the person does not have multiple payments each with their own monitoring regime.

Reviewing direct payments

There **must** be a review of the making of the direct payment within the first six months of making the first payment and no later than 12 months thereafter. When doing so, local authorities **must not** place a disproportionate reporting burden upon the person. 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.

The outcome of the review **should** be written down, and a copy given to all parties.

Briefing 13: Review of care and support plans

Local authorities **must:**

- Conduct a review if the person or someone acting on their behalf requests one
- Involve the person needing care and the carer in the review
- **Not** use the review to arbitrarily reduce a care and support package

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.

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 where required.

Local authorities have a **duty** to ensure that a review occurs, and if needed, a revision follows this. The review will help to identify if the person's needs have changed and can in such circumstances lead to a reassessment. 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.

Keeping plans under review generally

The Act specifies that plans must be kept under review generally. 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.

The review **should** be a positive opportunity to take stock, but **should not** be overly complex or bureaucratic. It **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?
- 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?

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

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.

Where there is an anticipated review date, 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, the local authority **should** be aware of the review arrangements with these other plans and seek to align reviews together.

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. 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, and the method should be agreed with the person wherever reasonably possible.

Where a person has a mental impairment and lacking capacity to make some decisions, the local authority **should** consider the appropriate date for review carefully.

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 review or monitoring **may** need to be more frequent.

Unplanned reviews

If there is any information or evidence to suggest that circumstances have changed in a way that **may** affect the efficacy, appropriateness or content of the plan, the local authority **should** immediately conduct a review.

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.

Considering a request for a review of a plan

Local authorities also have a **duty** to conduct a review if the person or someone acting on their behalf requests one (right to request a review). Information and advice **should** be provided 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. The information given to people **should** also set out what happens after a request is made, and the timescales involved in the process.

Considering a review

Upon receipt of a request to conduct a review, the local authority **must** consider this and judge the merits of conducting a review. 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.

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. The local authority might also want to set out when the person can expect a formal review of the plan.

Revision of the care and support plan, support plan

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.

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. 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.

Therefore, when revising the plan the authority **should** follow the stages of the care and support planning process. In some cases a complete change of the plan may be required, whereas in others minor adjustments may be needed.

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, career 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.

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.

In all cases the local authority **must** consider whether an independent advocate may be required to support the person through the revision of the plan, in the same way as during the assessment and planning process.

Timeliness and regularity of reviews

A review of the plan **should** be conducted 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.

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.

The review **should** be performed as quickly as is reasonably practicable. Where there is an urgent need to intervene, local authorities **should** consider implementing interim packages to urgently meet needs while the plan is revised.

Briefing 15: Integration, cooperation and partnerships

Local authorities **must**:

- Promote integration between care and support provision, health and health related services.
- Carry out all care and support responsibilities with the aim of joining-up the services provided or by the NHS and other health-related services
- Co-operate with each of its relevant partners, and the partners **must** also co-operate with the local authority
- Make arrangements to ensure co-operation between its officers responsible for adult care and support, housing, public health and children's services
- Include advice on relevant housing and housing services. Information and advice should include services in the home that bring health, care and housing services together.

The Act requires 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;
- **Cooperate generally** with their partners in performing their functions related to care and support;
- **Cooperate** with their partners where this is needed in the case of **specific individuals** who have care and support needs.

Integrating care and support with other local services

All care and support responsibilities **must** be carried out with the aim of joining-up the services provided or by the NHS and other health-related services (for example, housing or leisure services).This includes providing information and advice and, shaping the market of service providers.

This duty applies when the local authority considers that integration will:

- Promote wellbeing of adults with needs and carers;
- Contribute to the prevention or delay of needs;
- Improve the quality of care and support in the area.

The local authority is not solely responsible for promoting integration with NHS. Similar duties are placed on NHS England and CCGs.

There are a number of ways in which authorities can fulfill this duty that includes; at a strategic level, at a level of individual service and in combining and aligning processes.

Strategic planning

Integration with health and health-related services

A local authority **must** promote integration between care and support provision, health and health related services. There should be consideration of the different mechanisms through which it can promote integration. For example;

a) Planning- using data to understand the profile of the population. For example, using a joint strategic needs assessment in relation to housing.
b) Commissioning- for example, joint commissioning of an integrated information and advice service covering health, care and housing.

Joint Strategic Needs Assessments

Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) are key means by which local authorities work with CCGs. 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 out above. LAs should bear in mind that carrying out a JSNA and JWHS is unlikely to be sufficient to fulfil the requirement to promote integration; it will be the agreed actions which follow the strategies that will have the greatest impact on integration and on the experience and outcomes of people.

Integrating service provision and combining and aligning processes

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. Local authorities should consider and develop their local strategy jointly with partners.

At a strategic level examples include:

- The use of 'pooled budgets'. The Better Care Fund is a key opportunity to promote integration.
- The development of joint commissioning arrangements.

Local authorities, together with their partners, **should** consider combining or aligning key processes in the care and support journey. 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. 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.

Co-operation of partner organisations

All public organisations **should** work together and co-operate where needed, in order to ensure a focus on the needs of their local population. Co-operation between partners **should** be a general principle for all those concerned.

The Act sets out five aims of co-operation between partners which are relevant to care and support (co-operation is 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;
- 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.

Who must co-operate?

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.

These are:

- other local authorities within the area (i.e. in multi-tier authority areas);
- any other local authority which would be appropriate to co-operate with a particular set of circumstances (e.g. a local authority arranging care in another area);
- NHS bodies in the authority's area;
- Local offices of the Department for Work and Pensions (such as Job Centre Plus);
- Police services in the authority area;
- Prisons and probation services in the area.

There may be other persons or bodies with whom an authority **should** co-operate if it considers this appropriate.

Ensuring co-operation within local authorities

Arrangements must be made 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.

Co-operation with partners in specific cases

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 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.

Examples include

- when a person is planning to move from one area to another;
- when an assessment of care and support needs identified other needs that should be assessed;
- when a local authority is carrying out a safeguarding enquiry or review.

Where the local authority or partner decides to use this mechanism they should notify the other in writing. If the local authority or partner decides not to co-operate they **must** write to the other, setting out the reasons. Failure to respond within a reasonable time frame could be subject to a judicial review.

Working with the NHS

The boundary between care and support and the NHS

Local authorities cannot legally meet needs by providing or arranging services that are clearly the responsibility of the NHS. However, there is an exception to this general rule, in that the local authority may provide some limited healthcare services where they are part of a package of care and support and considered "incidental or ancillary".

Two relevant examples of health care that are clearly the responsibility of the NHS are nursing care provided by a registered nurse, and services provided as part of NHS continuing healthcare.

Supporting Discharge of hospital patients with care and support needs.

The provisions on the discharge from hospital of patients with care and support needs are contained the Schedule 3 to the Care Act 2014 and the Care and Support Regulations 2014.

Schedule 3 covers:

- the scope of the hospital discharge regime and the definition of the patients and 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 care and support arrangements are in place;
- the period for which an NHS body can consider seeking reimbursement from the local authority where they have not fulfilled its requirements to put in place care and support to meet needs.

Delayed transfers of care

NHS and local authorities **should** work together to reduce the number of delayed days where a patient is ready to be transferred from NHS acute medical care to other care and support settings but where arrangements are not in place. The NHS **may** seek reimbursement from local authorities for a delayed transfer of care in certain circumstances. This is intended to act as an incentive to improve joint working and is discretionary.

Working with housing authorities and providers

The boundary between care and support and housing

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.

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.

This provision is to clarify the boundary in law between local authority's care and support function and housing function. It does not prevent joint working.

Working with housing

Considering accommodation within the wellbeing principal

Local authorities have a general duty to promote the individual's wellbeing. 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.

Integrating information and advice on housing

A service **must** be maintained for providing information and advice relating to care and support, and **must** include advice on relevant housing and housing services.

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 and services should be included.

Working with employment and welfare services

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. 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.

In particular, when working promote a diverse care and support market, local authorities **must** consider the importance of enabling people to undertake work, education and training.

The importance of identifying the needs of carers in their local population should also be recognised when drawing up Joint Strategic Needs Assessments, including their need to participate in paid employment alongside caring responsibilities.

Considering individual employment, training and education needs

Local authorities **must** consider education, training and employment when working with individuals.

Information and advice when working with welfare and employment services

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.

People may 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.

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. This **should** include application for disability benefits such as Attendance Allowance and Personal Independence Payments, and for Carers Allowance and access to work interviews.

Briefing 16: Transition to adult care and support

Local authorities **must:**

- Carry out transition assessments at the right time for the child, young carer or child's carer
- Carry out a transition assessment for those receiving children's service as they approach 18.
- Begin preparations from year 9 for young people with special educational needs or an ECH plan.
- Cooperate with the relevant partners; services **should** work together to pass on knowledge
- **Not** allow a gap in care and support when young people and carers move into adult services

Effective person-centred transition planning is essential to help young people and their families prepare for adulthood. 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

Transition assessments can in themselves be of benefit as they may aid planning that helps to prevent, reduce or delay the development of needs for care or support.

Definitions

The Care Act contains provision to help preparation for adulthood for three groups: children, young carers and child's carers. Each group has their own specific transition Assessment.

The provision relating to transition is not just 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

Transition assessments **should** take place at the right time for a young person and when the local authority can be reasonably confident about what the child's or carer's needs will look like after they turn 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.

Local authorities **must** carry out a transition assessment to anyone in the three groups when there is *significant benefit to the young person or carer* and they are likely to have needs after turning 18. This refers to any need for care and support as an adult- not just those needs that will be deemed eligible. Local authorities **should** therefore carry out a transition assessment for those who are receiving children's services as they approach 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. In establishing the right time, factors the local authority **should** consider include:

- The stage they have reached at school and upcoming exams;
- Whether the young person/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

Young people with special educational needs

For a young person with special education needs (SEN) or an education health and care (ECH) plan, preparation **must** begin from year 9. The transition assessment **should** be undertaken as part of one of the annual statutory reviews and **should** inform a plan for transition. The assessment **must** be of *significant benefit* and local authorities **must** minimise disruption to the child and their families. The local authority **should** seek to agree the best time with the child or child's carer and, where appropriate, their family and any other relevant partners.

The LA **must** consider requests for a transition assessment and whether the likely need and significant benefit conditions apply. If these conditions do not apply, it **must** provide information and advice on what can be done to prevent or delay development of needs.

Transition assessments **should** be carried out early enough to ensure the right care and support is in place when the young person moves to adult services. 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.

Child's carers and young carers

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.

LAs **must** also assess the needs of young carers as they approach adulthood. Transition assessments and planning **must** consider how to support young carers to prepare for adulthood and how to raise and fulfill their aspirations.

The impact on other members of the family **must** also be considered.

Features of a transition assessment

All transition assessment **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

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.

The same requirements and principles apply for carrying out transition assessments as for other needs assessments.

For young people with EHC plans or who have other plans under children's legislation, the transition assessment **should** build on existing information.

Co-operation between professionals and organisations

Under the Children and Families Act 2014, for children with SEN assessments are brought together into a coordinated education, health and care (EHC) plan.

Local authorities **must** cooperate with relevant partners- for the purpose of transition children and adult services **must** cooperate. Services **should** work together to pass on knowledge and build new relationships ahead of the transition. They **must** also cooperate with relevant external agencies including local GP practices, housing providers and educational institutions.

Cooperation in EHC plans

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

The authority **should** ensure that all relevant partners are involved in transition planning. Equally, the LA **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.

Agencies **should** agree how to organise processes so that all the relevant professionals are able to contribute.

Assessments should be combined with existing EHC assessment unless there are specific circumstances to stop it.

Specialist post

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.

On completion of the transition assessment - providing information and advice.

An indication of which needs are likely to be eligible needs **must** be given on the completion of the transition assessment.

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.

For any needs that are not eligible under the adult statute, information and advice on how those needs can be met, and how they can be prevented from getting worse **must** be provided.

Joining information and advice

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.

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 this case 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.

Provision of age-appropriate local services and resources

Given the clear similarities in the requirements of both Acts, LAs **should consider** jointly planning and commissioning age-appropriate services to make better use of resources.

After the young person or carer turns 18: Combining EHC plans and care and support plans after the age of 18

Where a young person is aged 18 or over and continue to have EHC plans, care and support aspects of the EHC will be provided under the Care Act

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.

EHC plans and continuing children's services after the age of 18

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 education. If it is agreed that the best decision for the young person is to continue 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.

Continuity of care after the age of 18

Local authorities **must not** allow a gap in care and support when young people and carers move into adult services. If adult support is not in place on the 18th birthday, and they or their carer have been receiving services under the children's Act the LA

must continue providing services until the relevant steps have been taken. These are if the local authority:

- 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
- 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)

In order to reach such a conclusion, a transition assessment **must** have been conducted. Where a transition assessment should have been conducted but was not, an adult's needs or carer's assessment **must** be carried out.

Ordinary residence and transition to Higher Education

Where a young person is intending to move to a higher or further education institution they will usually remain ordinary resident in the area where their parents live. (More information chapter 20 and annexe J)

Transition from children's to adult NHS Continuing Health Care

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)

Briefing 18: Delegation of local authority functions

Local authorities**:**

- **Can** delegate some of their care and support functions. Wellbeing **should** be central to the decision to do this
    - Delegation **does not** absolve the local authority of its legal responsibilities or accountability
- **Should** put in place monitoring arrangements
- **Should** consider and avoid any potential conflict of interest when delegating functions
- **Should not** allow the same outside organisation to both calculate direct payments and make the payments

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.

The Care Act allows LAs to delegate some, but not all, of their care and support functions to other parties. 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.

LAs retain ultimate responsibility for how its functions are carried out. Delegation **does not** absolve the local authority of its legal responsibilities. 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.

Importance of contracts

The success of delegating functions to a third party will be determined to a large extend by the quality of its contracts. . Local authorities **should** therefore ensure that contracts are drafted by staff with the necessary skills and competencies to do so.

Monitoring arrangements **should** be put in place so that they can assure themselves that functions that have been delegated, are being carried out in an appropriate manner.

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.

Which care and support functions may not be delegated?

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. However, steps **should** be taken to ensure that authorised parties co-operate and work in a way which supports integration.
- **Adult Safeguarding**: a local authority **must** be one of the members of

safeguarding adult boards, and it **must** take the lead role in adult safeguarding.

- **Power to charge**: Policies relating to what can and cannot be charged for must remain a decision of the local authority.

What is the difference between delegating a statutory care and support function and commissioning other related activities?

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.

For example, a local authority may not delegate the decision over charging to other organisations. However, it may commission an external agency to carry out the administration, billing and collection of fees.

Conflicts of interest

There might be instances where there is the potential for a conflict of interest when delegating functions. For example, when the same external organization carries out care and support planning and also provides the supporting care. 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.

Conflict of interest relating to making direct payments

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.

Briefing 19: Ordinary Residence

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
- Meet the eligible needs of people if they are present in the area but of no settled residence.
- Take all reasonable steps to resolve the dispute between the various parties before referring for determination
    - One of the local authorities involved in a dispute **must** provisionally accept responsibility for the person at the centre of the dispute and be providing services

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 LAs establish at the appropriate time whether a person is ordinarily resident in their area, and whether such duties arise.

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 authority to **consider the ordinary residence of the adult needing care**.

It **must** be determined 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. 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.

Local authorities **should not** use a decision on ordinary residence to exclude people from the assessment process inappropriately. 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 individual's needs **must** be met first, and then the question of residence resolved subsequently.

How to determine ordinary residence

There is no definition of "ordinary residence" in the Act and the term should be given its ordinary and natural meaning.

There will be circumstances in which ordinary residence is not 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.

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.'

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.

An authority **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 any 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.

People with no settled residence

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.

Local authorities **have a duty** to meet the eligible needs of people if they are present in its area but of no settled residence. 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.

Ordinary residence when arranging accommodation in another area

If the person has needs, which can only be met through certain types of accommodation, the person will have a **right** to make a choice about their preferred 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. This might include arranging accommodation in another local authority area.

The regulations specify 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 regulations specify the types of accommodation to which this provision applies:

- **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.

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.

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.

NHS accommodation

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.

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 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.

This requirement also applies to NHS accommodation in the devolved administrations.

Mental health aftercare

The duty on local authorities to commission or provide mental health aftercare **rests** with the authority for the 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 authority **may** change, if the person is ordinarily resident in another area immediately before a subsequent period of detention.

Temporary absences

Having established ordinary residence in a particular place, this **should not** be affected by the individual taking a temporary absence from the area. The courts have held that temporary or accidental absences, including for example holidays or hospital visits in another area, **should not** break the continuity of ordinary residence, and local authorities **should** take this into account.

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.

LAs 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

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.

If a person appears genuinely to divide their time equally between two homes, it **would be necessary** to establish 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.

Resolving ordinary residence and continuity of care disputes

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.

All reasonable steps **must** be taken 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.

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.

A determination by the Secretary of State or appointed person should only be considered as a last resort.

It is critical that the person does not go without the care they need where local authorities are in dispute. One of the authorities involved in the dispute **must provisionally accept responsibility** for the person at the centre of the dispute and be providing services.

Where authorities cannot agree which **should** accept provisional responsibility for the provision of services, the 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".

Process for seeking a determination

A local authority seeking a determination **should** make a request in writing to the Secretary of State or appointed person.

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. 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.

Evidence **should** be provided 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.

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 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.

LAs **may** wish to seek legal advice before making an application for a determination.

Financial adjustments between local authorities

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. The local authority, which has been paying for that person's care **can** then reclaim the costs from the local authority.

This **does not** apply where the local authority has chosen to meet the person's needs in the knowledge they were ordinarily resident elsewhere.

Briefing 20: Continuity of Care

Local authorities **must**:

- Work together to ensure that there is no interruption to a person's care and support
    - The second authority **must** provide the adult and the carer with information about the care and support available in its area
    - The second authority **must** contact the adult and the carer to carry out an assessment and to discuss how arrangements might be made
    - 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 second authority **must** also set out any differences between the person's original plan and their new care and support or support plan.

Where people with care and support needs do decide to move to a new area, it is important that the person's wellbeing is maintained, and ensuring that their care and support is in place during the move will be key to doing this.

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.

Making an informed decision to move to a different local authority

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.

Where a LA is approached by an individual who is considering moving to that area, it should provide relevant information and advice, in accordance with its general duties under the Care Act.

Local authorities may find out about the person's intention to move from the individual directly or through someone acting on their behalf.

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.

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, including:

- 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.

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.

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.

Confirming the intention to move

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. 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

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 option.

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.

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.

People receiving services under children's legislation

The continuity of care provisions will not apply for people receiving services under children's legislation. Where such a young person has had a transition assessment 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.

Preparing for the move

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.

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.

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

Where independent advocacy is required, this should be provided by the second authority because it takes over the responsibility for carrying out the assessment and care planning with the individual.

The second authority must contact the adult and the carer to carry out an assessment and to discuss how arrangements might be made. It 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.

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, including involving them in any relevant meetings about the move.

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.

The care and support plan should include arrangements for the entire day of the move.

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.

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.

Equipment and adaptations

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.

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.

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.

Copy of documentation

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.

Disputes about ordinary residence

Where local authorities are in dispute over the person's ordinary residence status, the relevant authorities must not allow their dispute to prevent, delay or adversely affect the meeting of the person's needs.

What happens where the second authority has not carried out an assessment?

Interim arrangements

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.

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.

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

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.

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.
- 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.

The adult or carer should not be on an interim care and support (or support) package for a prolonged period of time.

When the adult does not move or the move is delayed

Where there has been a delay to a move 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.

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.

Briefing 21: Cross-border Placements

Local authorities **must:**

- Co-operate fully and communicate properly in cross-border placements
    - The second authority has **no power to "block"** a residential care placement into its area as the first authority contracts directly with the provider.
- Not allow disputes to prevent, interrupt, delay or otherwise adversely affect the meeting of an individual's care and support needs
- Follow the steps outlined in the guidance when dealing with a dispute

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.

Reciprocity and cooperation

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

Step One: Care and support planning

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.

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. 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 or to move to another area for other reasons.

Authorities **should** give due consideration as to how to reflect cross-border discussions with the individual in the care and support planning process.

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.

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.

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 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.

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.

The individual **should** 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.

Authorities **should** strive to offer people a choice of placements.

Step Two: Initial liaison between "first" and "second" authority

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").

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.

The initial contact **can** be made by telephone, but **should** be confirmed in writing.

The second authority **has no power to "block"** a residential care placement into its area as the first authority contracts 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.

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.

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.

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.

The first authority **should** make all those arrangements that it would normally make in organising a residential care placement in its own area.

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.

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.

Step Four: Confirmation of placement

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. 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.

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.

Where the individual requires a stay in NHS accommodation

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.

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

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.

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.

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 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.

Where the individual's care needs change during the placement

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.

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.

Reporting arrangements

There is **no legal requirement** for local authorities to notify national authorities that a cross-border placement has taken place.

However, as UK-wide cross-border placements will generally be a new occurrence, authorities **should** record the number of placements made into their area from other territories of the UK and vice versa.

Disputes between authorities

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.

The four administrations of the UK have worked together on the contents of specific regulations governing the process of resolving a dispute. 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.

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.

Before a dispute is referred to the relevant the Minister/ Northern Ireland Department (NID) in whose jurisdiction that authority sits, the local authorities concerned **must** take a number of steps. 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.

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.

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.

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.

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.

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.

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.

Briefing 22: Sight Registers

- Local authorities **must** keep a register of people who are severely sight impaired and sign impaired
- Registration is voluntary and those with eligible needs should continue to receive it regardless of inclusion on the register

Local authorities **must** keep a register of people who are severely sight impaired and sight impaired. 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.

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.

Registration

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.

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.

Transferring and retaining the CVI

The CVIs should be kept until the person moves to another area or has passed away. 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

Upon receipt of the CVI, the LA **should** make contact with the person issued with the within two weeks to, with their consent, arrange their inclusion on the register 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.

The individual **should** have early access to information and advice in an accessible format so that they can adapt to their situation as quickly as possible.

Continuity of care

If a person decides to move home and live in another local area, LAs **must** provide the local authority to which they are moving with relevant information to support the move. 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.

Rehabilitation

There **should be** consideration towards securing specialist qualified rehabilitation and assessment provision, to ensure that the needs of people with sight impairment is correctly identified and their independence maximised.

This type of rehabilitation **should** be provided to the person for a period appropriate to meet their needs.

Other registers

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.

Briefing 23: Transition to the new legal framework

Local authorities **must**:

- Carry out new needs assessments in line with the responsibilities set out in the Care Act.
- Meet people`s needs at least at the minimum threshold, though they may meet local needs at more generous levels.
- Use a person`s first review after April 2015 to establish a personal budget and use this as basis for the direct payment (where someone is currently receiving a direct payment).
- Only use, from April 2015, the debt recovery powers under Section 70 of the Care Act in order to recover any debts including those that were incurred before this date.
- Meet the same legal obligations for the new assessments carried out as for any other assessment.
- Determine whether the individual has eligible needs for care and support. If the person does not have eligible needs, the authority **must** provide information and advice. This **must** be communicated to the individual in writing.

This briefing provides guidance on how local authorities should bring people into the new system within the first year and how to prepare for the funding reforms of 2016/17.

Person/ Carer Assessment

Where a person/carer has received an assessment under the previous legislation, local authorities will not be required to reassess their needs unless the person/carer`s circumstances have changed. The new needs assessment **must** be carried out in line with the responsibilities set out in the Care Act.

Carer Assessment

LAs **should** consider that the duty for assessment of carers means that a significant numbers of carers are likely to have a right to an assessment that have not been assessed previously.

Eligibility determinations

The minimum threshold describes a level of need that has a significant impact on the person`s wellbeing. Local governments **should** review their previous local approach to eligibility and consider how this relates to the minimum threshold.

Local authorities **must** meet the needs at least at the minimum threshold, though they may meet local needs at more generous levels. An authority **should**:

- Determine whether and how to use powers to meet needs beyond the level of the minimum threshold
- Consider carefully any proposal to restrict local eligibility to only those needs described within the minimum threshold
- Review existing local policies in light of the new national minimum eligibility threshold for carers

Financial assessment

Each LA **should** review their local charging framework to ensure consistency with the Care Act. Where the approach is aligned there is no requirement to take steps to review funding arrangements or carry out new financial assessments. If there is a change in practice which affects the amount of charges people will pay then the Council **must** ensure individuals concerned are subject to the correct charges.

Meeting needs

The Care Act does not intend to place additional requirements on local authorities and **should not** give rise to any particular transitional issues to the new system. "Passporting" people into the new legislation **should** normally take place at the review when LAs can satisfy themselves that the needs are met.

Care planning and review

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 the guidance. This will include a personal budget for all people whose needs are met by the local authority; including carers (see exception in chapter 10). All existing personal budgets need to be reviewed to ensure they reflect the requirements of the Act, in particular that they are based on meeting needs.

People **should** be made aware if they have a right to a direct payment under the Care Act. Where someone is currently receiving a direct payment, this should continue, but local authorities **must** use the first review after April 2015 to establish a personal budget and use this as basis for the direct payment.

Deferred payment agreements

Where an authority has entered into a Deferred Payment Agreement with a person prior to April 2015 the existing terms and conditions remain in place until its expiry. Future agreements will be made after April 2015.

Debt recovery

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 including those that were incurred before this date. Any arrangements that are already in place or proceedings already underway prior to this date **may** continue to their conclusion but no new arrangements can be made under these routes.

Preparing for funding reform

Summary of 2016/17 reforms

- A cap on the care costs which a person pays over their lifetime (£72,000 for those over retirement age). 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"
- Every person with assessed eligible needs will have a "care account". The LA will keep track of how people progress towards the cap and will provide a record of progress to the person (regular statements).

- Raising the financial support provided to £118,000 where someone`s property is taken into account.

Understanding the likely demand

Local authorities **should** take steps to understand the additional likely demand for support as a result of the funding reforms. This is needed to scope the costs of meeting eligible needs for the purposes of establishing people`s care account and counting costs towards their cap.

To prepare for the implementation of the capped costs system, councils **should** identify the number of "self-funders" in their local areas (with help from local NHS, provider organisation and voluntary sector).

There **should** be consideration of specific groups who would benefit more from the introduction of the cap on care costs, for example:

- People who currently arrange their own care and support and would be likely to have eligible needs (e.g. people already living in care homes)
- People with modest assets
- Working – age adults whose needs for care and support are likely to meet the eligibility criteria

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. (E.g. info on reablement service may provide a useful indication of the willingness of self-funders to contact the local authority).

Raising Awareness

Steps **should** be taken to raise awareness of the reforms. In order to predict and manage additional demand local authorities **should** seek out groups for targeted communications and the local approach to implementation. In targeting information and communications LAs **should** follow the same factors of proportionality and appropriateness as in providing other information and advice.

Communications which raise awareness of the capped costs system **should** reflect the aims of the reforms to support people to plan for the future care costs and make more informed decisions which reduce needs over time.

Carrying out early assessments

Where local groups have been identified, the Council **should** consider carrying out the relevant processes early in order to manage capacity and workload over a longer period. Early needs assessment **should** be carried out in order to pre determine eligible needs and record the costs of meeting those needs for people who would benefit.

LAs **should** consider which groups of individuals may benefit most from an early assessment. If needs change, the authority will be required to carry out a further assessment and mitigate possible risks. It is suggested that local government do not carry out any assessments solely for the purpose of preparing for the capped costs system before October 2015.

The assessment carried out **must** meet the same legal obligations as for any other assessment; however, the assessment **should** be done on the basis

that the person does not wish for the local authority to meet his/her needs at that time (the purpose is to pre determine eligible needs and care costs).

Having carried out the assessment, the local authority **must** determine whether the local authority has eligible needs for care and support. If the person does not have eligible needs, the authority **must** provide information and advice. If the person has eligible needs, provided the person 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 of the local authority of meeting the eligible needs
- Information and advice on how to prevent or delay needs, how to access financial advice and anticipated process for confirming their care account from April 2016

The cost of meeting the person`s eligible needs **may** form their independent personal budget from April 2016 provided that their needs to not change. The costs will not start counting towards the cap and their care account will not begin before this date. This **should** be made clear to the person and/or their family.

Where the local authority has carried out an assessment and pre-determined eligible needs, it **should** contact the person concerned around April 2016 to clarify if the needs or other circumstances have changed. The person **may** ask the local authority to review their needs, and the local authority **should** respond to such 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 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

Local authority **should** consider the steps that could be taken to manage capacity issues associated with early assessments as well as additional assessment after April 2016. This **could** include:

- The role of self-assessment in supporting individuals to identify their own needs and make a judgement on eligibility
- Adopting a more proportionate approach to the financial assessment for those individuals with assets substantially above the financial limits
- Using powers to delegate some or all such assessments to other organisations

A clear understanding **should** be developed of their current workforce and future needs in determining their approach to delivering additional assessments. Strategic partners as the voluntary sector or others who are already in touch with people **should** be sought.

There **should** be consideration of how to verify the self-assessments linking with subsequent steps such as calculating the cost of meeting eligible needs. Clear protocols **should** be in place for quality

assurance and ongoing monitoring when this function is delegated to an external organisation.

Systems and training requirements

Local authorities **should** review the impact on their information systems in conjunction with their suppliers and consider whether new systems and technology is required.

LAs **should** take into account the wider health and care technology strategy, including use of open APIs. Focus on whether business processes need to be changed in parallel to changes in systems.

Informatics systems for ongoing case management will need to be revised to incorporate the following:

- Independent personal budgets
- Care accounts
- Deferred payment agreements
- Changes to charging and assessments (for both people with care and support needs and their carers)

Authorities **should** consider the training needs for staff and in particular the needs of those who carry out the relevant assessments to ensure there is sufficient understanding of the new system.

LAs **should** also review the provision of financial advice and should take steps to identify sources of independent advice which are accessible to local people.