

The Care Act 2014 overview

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This briefing builds on earlier notes reviewing the provisions in the [Care Act 2014](#).

The final pages of this briefing consider the measures in the [Care Act 2014](#) and the [Children and Families Act 2014](#) which impact on young carers, disabled children and their carers.

This briefing is concerned with the impact of the legislation on disabled, elderly and ill people and their carers. It considers only briefly the purely macro / strategic challenges that local authorities will face in relation to such new obligations as 'integration' (with the NHS where possible) and 'managing market failure' (ie when one of its major providers goes out of business).

Since the last briefing a number of developments have occurred – to which makes reference, including:

1. Bearing the logos of the Department of Health, the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) a series of training materials have been published on various aspects of the Act – prepared by a barristers Chambers and in this briefing referred to as the '[legal literacy](#)'² presentations. Despite the logos, the materials ([Baldrick like](#)) 'deny all' in terms of what they represent.³
2. Bearing the same logos (but without the disclaimers) the Social Care Institute of Excellence (SCIE) has issued a web-based guide entitled 'Care Act 2014: Beyond compliance – towards excellence'. This contains useful information on all aspects of the Act and is referred to in this briefing as the '[SCIE Guide](#)'.⁴ In a number of respects it can be construed as practice guidance – ie guidance to which the local authority should have regard and for which cogent reasons would be expected if the authority decided to make material departures from it.
3. A draft Order has been published setting out the proposed repeals – [The Care Act 2014 and Children and Families Act 2014 \(Consequential Amendments\) Order 2015](#)⁵ from which it can be gleaned that neither the Carers (Recognition & Services) Act 1995 nor the NHS Community Care Act 1990 are now going to be repealed in England.
4. The Government has launched its promotional '[The Care and Support & you](#)' campaign to inform the public of their new rights including large numbers of radio adverts and around 2.5 million leaflets.⁶
5. Last minute amendments have been made to various regulations to correct drafting defects – eg the ordinary residence provisions (see below).⁷

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² Accessible at www.local.gov.uk/care-support-reform/-/journal_content/56/10180/7003936/ARTICLE

³ The disclaimer includes 'They do not represent the official view of the Department of Health, the Local Government Association or any other body involved in their production. Nor are they to be treated as containing legal advice provided by Cornerstone Barristers.'

⁴ Accessible at www.scie.org.uk/care-act-2014/assessment-and-eligibility/process-map/

⁵ Accessible at www.legislation.gov.uk/ukdsi/2015/978011128626/article/3.

⁶ See www.gov.uk/careandsupport

⁷ [The Care and Support \(Miscellaneous Amendments\) Regulations 2015 SI 644 reg 4](#)).

Overview

The Care Act 2014 repeals most of the principal adult social care statutes⁸ (as they apply in England⁹) – the laws that oblige social services departments to assess and to provide services for disabled, elderly and ill adults as well as their carers. The list of ‘repeals’ is extensive including the National Assistance Act 1948, as well as the Acts and regulations that govern such things as direct payments, charging for social care and so on. The intention was that the reform would create a single Act that regulated all adult social care law – but due to the rushed implementation this is no longer the case – so (as noted in this briefing) some of the Act will remain in force in England – for example, the NHS & Community Care Act 1990, section 467 and the Carers (Recognition & Services) Act 1995, section 1.

A major problem with the Act is revealed in its long title – namely that it is an ‘Act to make provision to reform the law relating to care and support for adults and the law relating to support for carers’ The problem being in the word ‘adults’: many of the ‘community care’ and ‘carers’ statutes also have provisions relating to children (ie young carers; disabled children and parent carers). This has the result that an Act such as the Chronically Sick and Disabled Persons Act 1970 will be repealed in so far as it applies to people over 18 but not for those under that age. As a result of a vigorous campaign by a number of disabled children’s and carers’ activists / organisations many of the problems concerning the rights of young carers, disabled children and parent carers have been addressed – but in large measure via the [Children and Families Act 2014](#). These changes are considered at the end of these notes under the heading ‘Provisions relating to disabled children, young carers and parent carers’ (and it will be noted that not all of these problems have been resolved – particularly those relating to ‘grandparent’ carers). The first part of the briefing considers the changes that will be made by the Care Act 2014.

Implementation timetable

The implementation timetable for the Care Act 2014 has been the subject of significant criticism. The [Statutory Guidance](#) that accompanies it extends to almost 500 pages and there are in addition 17 sets of regulations. The final guidance and regulations were approved in mid-October – leaving local authorities less than 5 months to make the necessary (and major) reconfigurations (including training their workforce) before the Act comes into force: an Act described by the Government as ‘the most significant reform of care and support in more than 60 years’.¹⁰

The equivalent Welsh legislation ([Social Services & Well-being \(Wales\) Act 2014](#)¹¹) is, in contrast, not coming into force until 2016.¹² In July 2014 the [Public Accounts Committee](#) noted the concern of the Association of Directors of Adult Social Services (ADASS), about the timescales and expressed the view that ‘it may not be feasible for local authorities to

⁸ A list of the legislation to be repealed, in whole or in part was provided as Annex E of Department of Health *The Care Act 2014 Consultation on draft regulations and guidance for implementation of Part 1 of the Act in 2015/16* June 2014 at

www.gov.uk/government/uploads/system/uploads/attachment_data/file/317820/CareAct_cons_040614.pdf

⁹ Most of these Statutes will remain in force in Wales – until the [Social Services & Well-being \(Wales\) Act 2014](#) comes into force (expected to be in April 2016). The Act is accessible at

www.legislation.gov.uk/anaw/2014/4/contents/enacted - and for a detailed briefing on this Act - see

www.lukeclements.co.uk/whats-new/.

¹⁰ Care & Support Minister Norman Lamb 15 May 2014 at www.gov.uk/government/speeches/care-bill-becomes-care-act-2014

¹¹ Accessible at www.legislation.gov.uk/anaw/2014/4/contents/enacted - and for a detailed briefing on this Act - see www.lukeclements.co.uk/whats-new/.

¹² There was a three year implementation period for the last major change to English adult social services law (NHS & Community Care Act 1990).

implement all the proposed changes to the intended timetable.¹³ In August 2014 a LGA survey revealed that 90% of authorities considered that the Care Act reforms were being put in jeopardy by the lack of adequate government funding.¹⁴

While it is certain that the bulk of the Act will come into force in April 2015, it is open to question whether the 'cap on costs' provisions will come into force in April 2016 – as currently stated. The potential impact of these provisions could be massive (as detailed below); there will be a general election before this date; and we have already seen one associated aspect of the reforms delayed. In October the Government announced that the right of self funders to ask councils to arrange their care in care homes will be delayed for a year (ie until 2016) – stating:

Given the nature of the concerns arising in the consultation, and recognising the need for further evidence, we have decided to delay the implementation of this provision for one year, until April 2016, insofar as it relates to people whose needs are to be met in care homes. This additional time will allow for further analysis and a better common understanding of the issues, to identify risks to the care and support system and to individuals, and to develop strategies for implementing this most effectively.¹⁵

In December 2014 the Government confirmed the (2015 - 16) funding it is to provide for implementation of the new legislation. Having postponed for a year the right of self funders to opt for the local authority arranging their care home accommodation, and having revised down the likely cost impact of the revised deferred payments scheme – a sum of £55.5m was 'released' which becomes as 'Carers and Care Act Implementation Grant,' primarily aimed at meeting the expected increased the potential demand from carers to access their 'new rights'.¹⁶

Final guidance and regulations

While the 'indecent haste' with which the legislation is being implemented is of serious concern, it is necessary to note that there is much in the [Statutory Guidance](#) and the regulations to be welcomed – as this note explains. The guidance has the potential to metamorphose into the Code of Practice that the Law Commission and the Select Committee recommended and the English government rejected. The guidance is likely to be of considerable importance – in much the same way that the policy guidance accompanying the Community Care reforms in 1993¹⁷ proved to be highly influential in shaping that system.

The speed with which the [Statutory Guidance](#) has been produced has resulted in it having a number of material errors and omissions (including some which must embarrass the government¹⁸) and some of these are referred to in this overview. One omission is a section explaining the guidance's status at law. The draft guidance contained a statement (page 3) that 'local authorities are required to act under the guidance, which means that they must

¹³ House of Commons Committee of Public Accounts Adult social care in England HC 518 (Stationery Office 2014) p.7 at www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/518/518.pdf accessed 13 July 2014

¹⁴ See Andy McNicoll *Lack of funding could threaten Care Act reforms, councils warn* in Community Care 7 August 2014 at www.communitycare.co.uk/2014/08/07/lack-adequate-funding-threaten-care-act-reforms-councils-warn/ accessed 11th August 2014.

¹⁵ Response to the consultation on draft regulations and guidance for implementation of Part 1 of the Care Act 2014 Cm 8955 HMSO October 2014 page 8 accessible at www.gov.uk/government/uploads/system/uploads/attachment_data/file/366047/43374_2902887_Cm_8955_Web_Accessible.pdf

¹⁶ Department of Health *Response to the consultation on funding formulae for implementation of the Care Act in 2015/16* (2014).

¹⁷ Department of Health (1990) *Community Care in the Next Decade and Beyond: policy guidance*.

¹⁸ My colleague [Dr Lucy Series](#) (author of 'Small Places') has highlighted a number including – para 14.4; para 14.22 (first sentence); the footnote to para 7.26; the reliance on hyperlinks (which will inevitably change) without providing in addition, basic information about the cited document – see for example the footnote to para 14.1.

follow it, unless they can demonstrate sound legal reasons for not doing so'. This obligation stems from section 78 of the 2014 Act – which replicates the current duty (in section 7(1) Local Authority Social Services Act 1970) and means that if the [Statutory Guidance](#) is section 78 guidance, then existing case law concerning Department of Health 'policy guidance' will remain relevant under the new legal regime.¹⁹ The main evidence that the guidance is issued under section 78 is in its name 'Statutory': whereas the removal of the reference to section 78 in the final guidance, and the many references in to its status as requiring local authorities to 'have regard' to it (rather than 'act under') suggests otherwise. The probability is that it is guidance intended to be issued under section 78 – and so 'binding' on local authorities – but this is clearly a point that will be litigated as was the status of the guidance accompanying the 1993 reforms.²⁰

The [Draft Regulations](#)²¹ detail specific obligations relating to market oversight / business failure (3 sets of regulations); the assessment of need; eligibility criteria; advocacy; charging; choice of accommodation; deferred payments; personal budgets; direct payments; the NHS interface; delayed hospital discharge; ordinary residence (2 sets of regulations); portability of care packages and cross-border placements; and registers for people with visual impairments. The longest set of regulations concern charging and there are none on some key questions – notably adult safeguarding.

The guidance contains a number of 'examples'. While these had the potential to be of considerable value, they are disappointing: generally limp and have the predominant outcome that once the person had been pointed in the right direction, there was no need to provide them with any local authority support.

Terminology

Adult needing care

The Act does not talk of disabled, elderly or of ill people: instead it uses the word 'adult' – but this is generally qualified as being an adult 'needing care'. The [Eligibility Regulations](#) however stipulate that this is an adult who has 'a physical or mental impairment or illness'.²² These terms are not defined, although the [Statutory Guidance](#) advises (para 6.105) that they include 'physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury'. It is therefore almost certain that 'adults needing care' will be given a very wide interpretation (as with the equivalent terms under the previous legislation²³). Accordingly it will cover not only those whose illness is caused by the misuse of drugs or alcohol²⁴ but also those with 'any disorder or disability of the mind'.²⁵ This latter category would comprise such conditions as depression, dementia, learning disability, personality disorder as well as hyperactive / attention deficit disorders, 'high functioning' autism and Asperger's syndrome. In this context the [Statutory Guidance](#) advises (para 6.105) that authorities 'should base their judgment on the assessment of the adult and a formal diagnosis of the condition should not be required'.

¹⁹ See in particular *R v Islington LBC ex p Rixon* (1997–98) 1 CCLR 119 at 123.

²⁰ The status of the 1990 guidance *Community Care in the Next Decade and Beyond: policy guidance* was contested in the Gloucestershire proceedings – only being agreed in the Court of Appeal – see *R v Gloucestershire County Council ex p Barry* (CA) 1 CCLR (1997) p24 B.

²¹ These can be accessed at www.gov.uk/government/consultations/updating-our-care-and-support-system-draft-regulations-and-guidance

²² The Care and Support (Eligibility Criteria) Regulations reg 2, (Department of Health 2014).

²³ Section 29 National Assistance Act 1948 defined disabled people as people who were 'blind, deaf or dumb or who suffer from mental disorder of any description, and ... who are substantially and permanently handicapped by illness, injury, or congenital deformity' and section 17(11) Children Act 1989 contains a similar definition.

²⁴ See Schedule 20 NHS Act 2006 and the relevant Directions specific to drug and alcohol misusers, continued in Department of Health Circular LAC (93) 10 para 3(3)(g).

²⁵ ie, within the ambit of section 1 Mental Health Act 1983.

Carer

A carer is someone 18 or over²⁶ who provides or intends to provide care for someone but is not contracted to provide the care or providing the care as formal 'voluntary work'.

Individual

When the Act uses the term 'individual' it means either an adult 'in need' or a carer.

Underpinning 'principles' (section 1)

The consultation process leading to the drafting of the legislation resulted in demands that the Act be underpinned by a coherent set of guiding principles (rather like those that apply in relation to the Mental Capacity Act (MCA) 2005, s1). The Act does not admit to being governed by any 'principles' although the [Statutory Guidance](#) (para1.2) when referring to the obligation in section 1 to promote 'individual well-being' states that this 'may sometimes be referred to as "the wellbeing principle" because it is a guiding principle that puts well-being at the heart of care and support.

The well-being obligation applies to every act of a local authority that relates to an adult in need or carer (when exercising 'any function' under Part 1 of the Act ie sections 1-80) – from a telephone conversation to the setting by the authority of its social care budget.

The Act does not define 'well-being' merely stating in section 1(2) that it relates to a list of nine factors, that can be summarised in the following list:

- (a) personal dignity; (b) physical / mental health / emotional well-being; (c) protection from abuse and neglect; (d) control over day-to-day life inc nature of care provided; (e) participation in work, education, training or recreation; (f) social and economic well-being; (g) domestic, family and personal relationships; (h) suitability of living accommodation; (i) the adult's contribution to society.

The emphasis on the importance of 'control' has been seen as a cause for concern by some commentators: Lydia Hayes for example, while noting that the Law Commission expressly declined to include it as a 'well-being principle' on the grounds that 'it is choice rather than control that is the key principle',²⁷ considers that it has the potential to be used as 'tool of regressive employment reform':²⁸ in many respects the inclusion of 'control' can be seen as a further manifestation of the 'responsibilization' agenda.²⁹ Despite the Law Commission's comments, 'choice' does not appear as a well-being principle.

When discharging any obligation under the Act, the local authority must 'have regard to' eight further questions (which in many respects echo the principles in the MCA 2005 section 1 on which they have undoubtedly been based). These are summarised below—

- (a) the assumption that the 'individual' is best placed to judge well-being;
- (b) individual's views, wishes and feelings;
- (c) take into account all the individual's circumstances (and non-discriminatory in terms of stereotyping etc);
- (d) individual participating (with support if needs be) as fully as possible in decisions about them;
- (e) a balance between the individual's well-being and that of any friends or relatives involved in their care;
- (f) the need to protect people from abuse and neglect;
- (g) any restrictions kept to the minimum necessary.

²⁶ The Act has provisions for 'young carers' (ss63-64) – ie people who are under 18 – but these provisions use the term "young carers".

²⁷ Law Commission Adult Social Care Law Com No 326, Stationery Office HC 941 para 4.25

²⁸ Lydia Hayes –publication pending.

²⁹ Ferguson I (2007) *Increasing User Choice or Privatizing Risk? The Antinomies of Personalization*, British Journal of Social Work; vol 37: 387 – 403.

Although well-being is expressed as relating to such a widely range of considerations that there is a risk that it will prove to be of little practical application – there are two particular ‘principles’ that are likely to be much asserted. The first is ‘(a) assumption that the ‘individual’ is best placed to judge well-being’. This creates a default position (rather like the presumption of capacity in the MCA 2005) which a local authority will have to produce evidence if it wishes to rebut. The second concerns the right to ‘independent living’ (which although absent from the Act³⁰) is expressed with force in the [Statutory Guidance](#), stating at para 1.19:

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 (in particular, Article 19 of the Convention). Supporting people to live as independently as possible, for as long as possible, is a guiding principle of the Care Act

Such an express statement is of considerable value – not least because the courts and Ombudsmen have shown a surprising willingness to have regard to the Convention in recent judgments / reports.³¹

Well-being is defined as including being protected from ‘abuse and neglect’ (s1(2)(c)) and the guidance gives emphasis to this stating that ‘it is not possible to promote wellbeing without establishing a basic foundation where people are safe and their care and support is on a secure footing’ (para 1.26).

The problem, as is noted below, is that the eligibility criteria do not list ‘keeping safe’ as an outcome and so on one interpretation it could be argued that being protected from ‘abuse and neglect’ will not in itself be an eligible need.

Prevention (section 2)

Local authorities will be under a general duty to provide a range of preventative services that they ‘consider’ will:

- (a) contribute towards preventing or delaying the development by adults in its area of needs for care and support;
- (b) contribute towards preventing or delaying the development by carers in its area of needs for support;
- (c) reduce the needs for care and support of adults in its area;
- (d) reduce the needs for support of carers in its area.

In July 2014 the Public Accounts Committee referred to the severe problems local authorities faced in relation to adult social care funding and noted that the Department of Health accepted that it did ‘not know whether some preventative services and lower level interventions are making a difference’.³² An [ADASS & LGA Joint Response to the Care Act Regulations and Guidance Consultation](#) (August 2014) expressed scepticism about investing in preventative services given the scale of the budget reduction their members were experiencing (para 21). A separate LGA report [Under Pressure](#) noted that ‘2015/16 is the year in which 60% of councils anticipate some degree of service reduction to help meet the budget gap’ and that there was a ‘significant lack of confidence’ in the Government’s funding projections particularly the in the assumption that legal reform will lead to saving. These

³⁰ See T Collingbourne ‘The Care Act 2014: a missed opportunity?’ in Web JCLI (2014) 20(3) at <http://webjcli.org/article/view/365/464>

³¹ See for example *Burnip v. Birmingham City Council* [2012] EWCA Civ 629 and *R (Bracking and others) v. Secretary of State for Work and Pensions* [2013] EWCA Civ 1345.

³² House of Commons Committee of Public Accounts Adult social care in England HC 518 (Stationery Office 2014) p.7 at www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/518/518.pdf.

reductions (on average of 12%) will impact on 'funding levels that have already been reduced by a third in the four years to 2014/15'.

Given the very serious financial problems of most local authorities and the lack of any significant 'new' money to accompany this legislation – it is difficult to see how (in the short term) this duty can be made to be more than cosmetic. To invest in preventative services, without new money would require a local authority to disinvest in an existing area. In many local authorities this would require (in essence) disinvestment in crisis services and this is unrealistic.³³ The problem is much the same with the NHS. In 2015 the Public Accounts Committee identified a need for radical change that involved the better use of community and primary care services – but noted that this reconfiguration would require significant upfront investment – which was available.³⁴,

There is however a longer term value to such a provision – in that it creates an expectation that such preventative support arrangements will be developed. Accordingly, when increased funding flows to social services (as it inevitably must) aspirational provisions of this kind may gain traction and prove to be significant.

The existing duties in relation to the provision of intermediate care and reablement are rolled over into the new regime: the guidance (paras 2.12 – 2.14) endeavours to distinguish between different types of intermediate care and reablement – broadly suggesting that 'intermediate care' is a time limited structured programme of care to assist a person to maintain / regain the ability to live independently at home whereas 'reablement' is a species of intermediate care that helps the person regain capabilities and to live independently in their own home.

Local authorities must develop a 'clear, local approach to prevention' (para 2.22); must identify 'unmet need' in order to identify strategies to improve the provision of such services; and must share this information with local partners (para 2.30).

A potential problem with the promotion of preventative services is that they can be used to restrict access to personalised support programmes. This appears to be a danger into which the Welsh reform programme is slipping – suggesting that individuals will have to establish that preventative services had been tried (and have failed) before formal support is available.³⁵ The English scheme does not fall into this trap, with the guidance advising that even if a person's needs are not to be met by the local authority, it must 'in any case provide information and advice in an accessible form, about what can be done to prevent, delay, or reduce development' of these needs 'to ensure that all people are provided with targeted, personalised information' (para 2.52).

The guidance (para 2.49) gives young carers as an example of where specific preventative services are required – that where a local authority becomes aware that a child is carrying out a caring role 'it should consider how supporting the adult with needs for care and support can prevent the young carer from under taking excessive or inappropriate care and support responsibilities'

³³ SCIE has a [Prevention Library](#) resource that 'aims to help inform commissioners and service providers to find information and examples of emerging research and practice in the provision of prevention services across England'.

³⁴ House of Commons Committee of Public Accounts [Financial sustainability of NHS bodies](#) Thirty-fifth Report of Session 2014–15 HC 736 The Stationery Office 2015.

³⁵ For a discussion of this danger – see Luke Clements [The Social Services & Well-being \(Wales\) Act 2014: an overview at \[www.lukeclements.co.uk/whats-new/\]\(http://www.lukeclements.co.uk/whats-new/\)](#)

Charging and preventative services

The current requirement that intermediate care and reablement must be provided without charge is carried into the new regime.³⁶ While it will continue to be a time-limited service, the guidance advises that ‘where it is provided beyond six weeks, local authorities should consider continuing to provide it free of charge beyond six weeks in such circumstances’ (para 2.61).

Where a local authority decides to charge for preventative services the guidance advises that it is ‘vital to ensure affordability’ and that it balances the ‘affordability and viability ... with the likely impact of charging on the uptake’ – and that this be considered individually as well as at a general policy level (paras 2.54 – 2.56).

Integration with the NHS (section 3)

Section 3 places a duty on local authorities to promote integration with health provision where it would—

- (a) promote the well-being of adults with needs & carers in its area; or
- (b) contribute to the prevention of the development of needs in adults / carers; or
- (c) improve the quality of care for adults / carers, provided

As noted above, this briefing is not directly concerned with Act’s macro / strategic challenges to local authorities (and the NHS) of this kind – and so this major requirement is considered only briefly here.

A component of this new duty includes the establishment of what has come to be called the ‘Better Care Fund’.³⁷ The legal mechanism for this fund is slightly complex - essentially s121 Care Act 2014 amends s223B NHS Act 2006 to enable the Secretary of State to attach strings to payments he makes to the NHS Commissioning Board – including that the relevant NHS body have a pooled fund with its local authority(ies) aimed primarily at easing pressure on NHS acute beds – eg to facilitate hospital discharges / prevent unnecessary admissions; promote integrated packages of care etc. The current proposals envisages the NHS transferring to the fund for 2015 £3.8 billion – although this is not all ‘new’ money.³⁸

In July 2014 the Public Accounts Committee expressed concern about Government departments’ understanding of the pressures on the adult social care system and that ‘its policies to drive change (the Care Act and the Better Care Fund) are risky, are not supported with new money, and do not acknowledge the scale of the problem’.³⁹ This report confirms doubts as to whether the NHS will be able to make these ‘transfers’ and there is substantial research evidence to suggest that such ‘integrations’ are unlikely to be successful. Nevertheless there is a degree of ‘integration frenzy’ in political policies at the moment (much the same as the ‘personalisation frenzy’ that has ruled for the last 5 years) and so local authorities will have little or no choice but to be seen to be taking steps to create pooled budgets / integrated funding arrangements. Further criticism concerning the quality planning

³⁶ Support provided up to six weeks, and minor aids and adaptations provided up to the value of £1,000: The Care and Support (Charging and Assessment of Resources) Regulations 2014 reg 3(3) and see para 2.59 of the guidance.

³⁷ For technical detail about the fund see NHS England ‘Better Care Fund Planning’ at www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/ and Department of Health ‘Better Care fund’ guidance (2013) at www.gov.uk/government/publications/better-care-fund; and for general requirements for NHS / social services transfers see ss76 and 256/257 NHS Act 2006, the NHS (Conditions Relating to Payments by Local Authorities to NHS Bodies) Directions 2013 and the NHS (Conditions Relating to Payments by NHS Bodies to Local Authorities) Directions 2013.

³⁸ The fund will, for example, include £130m CCG Carers’ Breaks funding; £300m CCG reablement funding; £350m capital grant (inc £220m DFGs monies); and it appears, some of the Care Act 2014 implementation monies – eg for training.

³⁹ House of Commons Committee of Public Accounts Adult social care in England HC 518 (The Stationery Office 2014) p.6 at www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/518/518.pdf.

for the Better Care Fund followed in November 2014 from the National Audit Office report⁴⁰ and in February 2015 the [Public Accounts Committee](#) noted that the Government was only confident that proposed savings it would produce would be £55 million rather than the £1 billion assumed and that 'planning for the Fund was deeply flawed'.⁴¹

In August 2014 NHS England issued further Guidance on the Better Care Fund - including revised 'Better Care Fund planning templates' which local authorities and CCGs can use to document their agreements⁴² and in December 2014 the policy framework for the implementation of the fund, was summarised / restated in a Department of Health publication [Better Care Fund Policy Framework](#).⁴³

There are a number of legal mechanisms by which that the integration process can be advanced – including through the development of agreements under the NHS Act 2006, section 75.⁴⁴ 'Section 75 agreements' are relatively common in relation to mental health services and to a lesser degree in relation to other health and social care functions. Authorities will need to check existing agreements – to update and specific references to pre-Care Act provisions in the delegation sections.

Information (section 4)

Local authorities will have an enhanced duty to provide adults in need / carers with information about care and support arrangements, including:- how the care system operates; the care and support choices they have (including the choice of providers); how to access this support and how to raise safeguarding concerns. The information duty will also include how to access independent financial advice – which will be of considerable relevance given the choices 'self-funders' will have to make under the new regime – particularly with regard to the 'cap on care cost' reforms (see below).⁴⁵

ADASS has expressed concern that the increased emphasis on the provision of independent financial advice may result in more people getting advice how to avoid making contributions to care fees. It is also concerned that these reforms will be taking place at a time when major changes are being implemented to pensions (specifically the end of the requirement to purchase an annuity) and the choices that people make may also be directed at reducing their contributions to their care fees.⁴⁶

The guidance explains that authorities 'must establish and maintain a service for providing people with information and advice relating to care and support' (para 3.11); that this must be provided for a variety of different formats; that the 'duty in the Care Act will not be met through the use of digital channels alone' and that the mix of provision will be expected to include 'face-to-face contact' (para 3.29). Increasingly information is only available on the internet and the effect of the so-called 'digital divide' is that significant sections of the population are thereby excluded – many of whom are disproportionately in need of care and support (eg older people, poor people, people with significant intellectual impairments).

⁴⁰ See at www.nao.org.uk/wp-content/uploads/2014/11/Planning-for-the-better-care-fund.pdf

⁴¹ Public Accounts Committee Chair's comments: *Planning for the Better Care Fund report* 26 February 2015 at www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/report-planning-for-the-better-care-fund/

⁴² See www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/.

⁴³ Accessible at www.gov.uk/government/uploads/system/uploads/attachment_data/file/381848/BCF.pdf

⁴⁴ See generally chapter 15 of the [Statutory Guidance](#).

⁴⁵ Department of Health Care and Support Legal Reform (Part 1 of the Care Act) Impact Assessment 61067 October 2013 para 1.25.

⁴⁶ LGA and ADASS [Joint consultation response Care Act: regulations and guidance](#) (August 2014) at para 31.

Duty to promote effective high quality providers (section 5)

The Act (fleshed out by three sets of regulations⁴⁷) contains a range of provisions designed to address the ‘supply side’ problems of the social care market – ie (a) the problem of large providers collapsing (such as Southern Cross failure in 2011); and (b) the increasing belief that the quality of services is generally poor and deteriorating. These provisions include ‘market oversight’ arrangements involving the Care Quality Commission (CQC) – amongst others (ss 53 – 57 Care Act 2014) and a temporary duty on social services to intervene if a particular provider ‘fails’ (ss 48-52). In July 2014 the Public Accounts Committee was of the view that the CQC (which will monitor the top 40 - 50 providers) lacked ‘the skills to undertake this expanded level of monitoring’.⁴⁸

[Regulations](#)⁴⁹ have now been issued to provide for eleven fundamental standards⁵⁰ of safety and quality that should always be met by providers of health and social care and draft [CQC guidance](#)⁵¹ on how this is to be achieved (and policed) in practice.

Section 5 places a duty on local authorities to promote an efficient / effective local market ‘with a view to ensuring’ that there is a variety of providers and high quality services to choose from. A key problem concerning diversity / quality is that councils hold a dominant position in this market and have (due to their chronic underfunding) been requiring providers to deliver the same quantity of services each year whilst concurrently imposing cuts to the amount paid. The National Audit Office consider that this relentless pressure by local authorities on fee rates is jeopardizing financial sustainability of some providers⁵² and the ADASS accept that local authorities do not always consider the profit margins of their suppliers, or the impact that reducing fees will have on their viability.⁵³ The Select Committee⁵⁴ considered that there had to be a mechanism that required local authorities to ‘properly take into account the actual cost of care when setting the rates they are prepared to pay providers’. Such a mechanism is not to be found in the Act – but the guidance is surprisingly direct and likely to be cited frequently in cases challenging arbitrary local authority rates. It reminds local authorities that the way they commission services is ‘a prime way to achieve effective market shaping’ (para 4.4) as these have a ‘significant influence on the market’ (para 4.7). The effect of the guidance will, inevitable, make the provider market fee levels ‘more transparent’ and this, together with the obligation to mitigate provider failure and have an overview of the market will – in the opinion of ADASS - ‘exacerbate providers’ concerns about the fee levels local authorities are willing’⁵⁵ and may in consequence lead to further litigation in this field.⁵⁶

The problem of course is not merely that of driving down standards as cost reductions are required, but of driving out smaller providers as only the larger corporations are able to

⁴⁷ The Care and Support (Market Oversight Information) Regulations 2014; The Care and Support (Cross-border Placements) (Business Failure Duties) (Scotland) Regulations 2014; and The Care and Support (Market Oversight Criteria) Regulations 2014.

⁴⁸ House of Commons Committee of Public Accounts Adult social care in England HC 518 (Stationery Office 2014) p.8 at www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/518/518.pdf.

⁴⁹ The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

⁵⁰ these being: Person-centred care; Dignity and respect; Need for consent; Safe care and treatment; Safeguarding service users from abuse; Meeting nutritional needs; Cleanliness, safety and suitability of premises and equipment; Receiving and acting on complaints; Good governance; Staffing; and Fit and proper persons employed.

⁵¹ CQC *Guidance for providers on meeting the fundamental standards and on CQC’s enforcement powers* Consultation July 2014

⁵² Report by the Comptroller and Auditor General Adult social care in England: overview HC 1102 Session 2013-14 (National Audit Office 2014) para 2.11-13.

⁵³ House of Commons Committee of Public Accounts Adult social care in England HC 518 (Stationery Office 2014) p.13 at www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/518/518.pdf.

⁵⁴ Joint Committee on the Draft Care and Support Bill, ‘Draft Care and Support Bill’ Stationery Office (2013) HL Paper 143 HC 822 para 113.

⁵⁵ LGA and ADASS *Joint consultation response Care Act: regulations and guidance* (August 2014) at para 31.

⁵⁶ For example, *R (Sefton Care Association) v Sefton Council* [2011] EWHC 2676 (Admin).

compete on cost. The guidance addresses this concern requiring that local authority commissioning procedures ‘must encourage a variety of different providers and different types of services’ (para 4.37), including ‘voluntary and community based organisations, including user-led organisations, mutual and small businesses’ (para 4.38) and should support people who ‘micro-commission’ their own care (para 4.46). While the guidance envisages that local authorities may have ‘approved lists and frameworks that are used to limit the number of providers they work with’ it requires that they ‘must have regard to ensuring that there is still a reasonable choice for people who need care and support’ (para 4.39).

The guidance encourages ‘outcomes based’ commissioning – ie that instead of a local authority simply commissioning ‘units of provision to meet a specified need (eg hours of care provided)’ it moves towards specified outcomes for the individual which ‘emphasise prevention, enablement, ways of reducing loneliness and 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’ (para 4.16). The guidance cautions however that this move should not, have the result of disadvantaging or excluding ‘smaller, specialist, voluntary sector and community-based providers’ (para 4.18).

The guidance also contains a timely reminder to local authorities that they ‘understand relevant procurement legislation’ and in particular make themselves aware of the fact that ‘there is significant flexibility in procurement practices’ which can ‘support effective engagement with provider organisations and support innovation in service delivery, potentially reducing risks and leading to cost-savings’ (para 4.98) and that this includes an obligation ‘to consider added social value when letting contracts’ under the Public Services (Social Value) Act 2012⁵⁷ (para 4.104).

Workforce issues

The social care workforce has been a direct victim of local authority pressure on providers to reduce their fees. The guidance stresses the importance of authorities ‘fostering a workforce which underpins the market’ (para 4.21) and encouraging (by for example providing funding – para 4.29) ‘training and development’. Local authorities when commissioning services must assure themselves that their fee levels do not (among other things) compromise the service provider’s ability to: (1) ‘meet the statutory obligations to pay at least minimum wages; (2) ‘provide effective training and development of staff’ (para 4.31); and (3) pay remuneration that is:

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 (para 4.30).

The guidance advises that where a provider has previously been in breach of national minimum wage legislation it should in general be excluded from the tendering process (para 4.102).

Cooperation

As part of the current ‘integration frenzy’ at the macro policy framing, we see in the Act further obligations on public bodies to cooperate. ‘Exhortations to organisations, professionals and other service providers to work together more closely and effectively, litter the policy landscape’⁵⁸ and sections 6 & 7 of the Care Act are now added to this list. Section 6 creates a general duty to cooperate and s7 a specific duty when requested by a local

⁵⁷ For guidance on the application of the Act see guidance at www.gov.uk/government/news/government-reviews-ground-breaking-social-value-act

⁵⁸ Clements L and Thompson, P. *Community Care & the Law* Legal Action 2011 para 13.33.

authority. Section 7 is new to adult social care. It is based on an existing provision in the Children Act 1989 (s27) and fills a gap. The problem under the present law is that there is a duty on social services to notify housing / health bodies if a health / housing need is identified in a community care assessment – but no obligation on the notified bodies to do anything. Section 7 enables social services to request assistance and this must be provided – unless it would be ‘incompatible with its duties, or have an adverse effect on the exercise of its functions’ (and in such a case the body must provide ‘reasons’). This constitutes a substantial new power for local authorities: for example to require a CCG to take positive action for a carer / group of carers – or in relation to a delayed assessment – for example for community equipment or an NHS Continuing Care decision. Although the corresponding provision in the Children Act 1989 has been little used⁵⁹ adult social services should be prepared to make such requests and to develop a protocol with NHS partners to ensure they are dealt with promptly.

Services / care and support responses (section 8)

Under the current legal regime the object of a community care / carers assessment is to determine (among other things) whether there is a need for ‘services’. The community care statutes⁶⁰ provide exhaustive lists of services that can be provided and the Carers and Disabled Children Act 2000 provides a generalised statement as to what a carer’s ‘service’ might be. The Care Act repeals these statutes and (in keeping with its ‘outcomes’ rhetoric) avoids referring to the word ‘service’ when describing what may be provided to meet a person’s needs. Instead, section 8(1) contains an illustrative list of what may be ‘provided’ to an adult in need or carer – namely:

- a) accommodation in a care home or in premises of some other type;
- b) care and support at home or in the community;
- c) counselling, advocacy and other types of social work;
- d) goods and facilities;
- e) information and advice.

The absence of such things as ‘adaptations’ ‘travel’; and ‘holidays’ (which are specifically cited in the current law) was considered problematical by the Select Committee and in response to a question it asked the Department of Health, received confirmation that the Department considered that these services did fall within the ambit of the list.⁶¹ The Committee expressed the hope that the subsequent guidance would ‘make clear that the list is not intended to limit the ways in which a local authority might meet any eligible needs or agreed outcomes, removing any possible ambiguity on that point’ (para 170). Unfortunately the guidance does not make this sufficiently clear.

Support such as home adaptations, equipment and transport is often vital to enable ‘adults in need’ to live independently in the community. The facilitation / provision of suitable adaptations / equipment requires explicit guidance, given that the overlap of responsibilities between housing and social services authorities will remain (with such support being capable of being delivered under both the Housing Grants, Construction and Regeneration Act 1996 and the Care Act 2014). This subject has attracted a disproportionately high number of complaints to the Local Government Ombudsman – particularly the failure of social services authorities to be aware of their responsibilities (which will now rest in section 8). The guidance fails to reiterate and build on the current guidance on this question.⁶²

⁵⁹ See for example, *R Northavon DC ex p. Smith* 1994 3WLR 403 HL.

⁶⁰ Primarily s2 Chronically Sick and Disabled Persons Act 1970 and ss 21 & 29 National Assistance Act 1948.

⁶¹ Joint Committee on the Draft Care and Support Bill, ‘Draft Care and Support Bill’ Stationery Office (2013) HL Paper 143 HC 822 para 168 - 170.

⁶² Guidance that will of course cease to apply when the Care Act 2014 comes into force.

The importance of adaptations are however central to eligibility determinations. Regulation 2(2) of [Eligibility Regulations](#) however list as key outcomes (among others) '(e) being able to make use of the adult's home safely'; and '(f) maintaining a habitable home environment'. The [Statutory Guidance](#) at para 6.107 gives examples of what these might mean – including consideration (in relation to (e)) of:

the adult's ability to move around the home safely, which could for example include getting up steps, using kitchen facilities or accessing the bathroom. This should also include the immediate environment around the home such as access to the property, for example steps leading up to the home

The [Statutory Guidance](#) is also disappointing in relation to the responsibility to ensure: (1) adequate transport for individuals in need; and (2) the responsibilities of local authorities for the social care support needs of disabled people in education (currently the subject of specific duties under Chronically Sick and Disabled Persons Act 1970, s2). Many such 'adults in need' will not be eligible for a Plan under the Children and Families Act 2014 and it is troubling that the guidance fails to make it clear that these responsibilities remain and are implicit within list in the Care Act 2014, section 8.

Section 8(2) slips out of the 'outcomes' mode and gives examples of the ways need may be met which include the 'service' word – namely:

- (a) by arranging for a person other than it to provide a service;
- (b) by itself providing a service;
- (c) by making direct payments.

Local authorities will be able to charge (under section 14) for the costs that they incur in providing care and support (under section 8) to meet the 'needs' of individuals – ie carers as well as elderly ill and disabled people. The question arises therefore as to whether local authorities will start charging for support such as advocacy, social work and information (and indeed how 'social work' is to be defined). The question is all the more pressing since local authorities will be able to delegate assessments (and most of their other functions) to independent sector organisations (section 79 – see below). In answer to a specific question on this point, the Minister (Norman Lamb) stated that these provisions do 'not give a power to local authorities to charge for carrying out a needs or carer's assessment in any circumstances'.⁶³

Delegation (section 79)

Local authorities will be able to delegate all of their functions under the Act – with few exceptions (eg safeguarding⁶⁴ (sections 42 – 47) and charging (section 14)). Section 79(6) makes it clear that ultimate responsibility in such cases will still rest with the local authority (any acts /omissions by the delegated body will be treated as done / omitted to be done by the local authority). A series of pilots have run since 2011 to explore the potential for delegation: these have been small scale and almost all have been third sector not for profit organisations.⁶⁵ Section 79 opens up the possibility of full scale delegation of quite a different order and might be contemplated by local authorities facing a steep rise in their assessment / care planning obligations resulting from their new duties to carers and to self

⁶³ 14 January 2014 column 154 Public Bill Committee.

⁶⁴ The extent to which a local authority can continue to delegate its safeguarding functions under a section 75 NHS Act 2006 is unclear at present and will depend upon the amendments made to the [NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000](#) SI 617.

⁶⁵ www.scie.org.uk/workforce/socialworkpractice/pilots.asp

funders (see below). In anticipation of these reforms all English local authorities have been given power to delegate virtually all of their adult social services powers.⁶⁶

Many local authorities have already delegated aspects of carers' assessments to local independent carer support groups. This was possible under the pre-Care Act legislation so long as the actual decision on the carer's eligibility for support was made / approved by the local authority: the theory being that the carers' group did the data gathering / discussions with the carer and the local authority then signed off their recommendations. This arrangement can of course continue, but the local authority is now able to delegate the 'sign-off' in addition.

Prior to the implementation of the Care Act the main way by which authorities were enabled to delegate their assessment functions was via agreements under the NHS Act 2006, section 75. As noted above, where such agreements already exist, authorities may need to check update these to ensure they make (where necessary) specific references to the 2014 Act.

Assessment of adults in need⁶⁷ (section 9)

The Act, the regulations and the guidance create important and welcome obligations on local authorities in relation to the advocacy and safeguarding needs of individuals that are identified during the assessment and care planning processes: these are addressed under the Advocacy' and the 'Safeguarding' headings below.

The duty in the Care Act to assess adults in need is closely aligned to the existing duty (under s47 NHS and Community Care Act 1990). As with the current law, the duty is triggered by the appearance of need and arises regardless of the 'level' of those needs or the person's financial resources (it applies, as now, to self-funders). The assessment must have specific regard to the well-being criteria (ie section 1(2) above) and must involve the adult and any carer. It is difficult to see how this can be achieved without a face-to-face assessment (unless the adult agrees this is not necessary) however para 6.28 of the guidance states that:

Where appropriate, an assessment may be carried out over the phone or online. In adopting such approaches, local authorities should consider whether the proposed means of carrying out the assessment poses any challenges or risks for certain groups, particularly when assuring itself that it has fulfilled its duties around safeguarding, independent advocacy, and assessing mental capacity.

The section 9(5) duty to 'involve' 'any carer that the adult has' may create problems where there are a large number of problem providing care for the adult (ie many family carers). The only leeway, at law, concerns the meaning of 'involves' and in cases of multiple low level carers, the courts would probably accept a pragmatic approach by a local authority on this question.

There appears to be a downgrading (or at least a welcome acceptance of reality) of the value of 'supported self-assessments'. Rhetorically they have promoted the unrealistic notion of disabled people identifying their own needs and mapping out their support – with a social worker giving gentle guidance and the benefit of her or his wisdom. In reality they have too often been the posting of a Self Assessment Questionnaire (SAQ) to the person in need and then running the ticked boxes through a Resource Allocation System (RAS): highly impersonalised and designed to reduce care costs: to 'lower expectations'. The guidance

⁶⁶ The Contracting Out (Local Authorities Social Services Functions) (England) Order 2014 SI No. 829 made pursuant to the Deregulation and Contracting Out Act 1994 s70(2) and (4) and s77(1).

⁶⁷ A number of guides have been published concerning the practicalities of assessing under the new legal regime – see for example, Think Local Act Personal [Delivering Care & Support Planning - supporting implementation of the Care Act 2014](#).

requires individuals who are able and willing to undertake a supported self-assessment be offered one (para 6.44) but that: (a) the local authority must assure itself that it 'is an accurate reflection of the person's needs' (para 6.3); and (b) that regardless of what the individual may think 'the final decision regarding eligibility will rest with the local authority' (para 6.53).

The guidance gives useful emphasis to the need for assessors to be 'appropriately trained', but also states that registered 'social workers and occupational therapists can provide important support and may be involved in complex assessments which indicate a wide range of needs, risks and strengths that may require a coordinated response from a variety of statutory and community services' (para 6.7). In so doing the implication is that for non-complex cases social workers may not be necessary. The general (and welcome) tenor of the guidance is, however, that assessors must be 'appropriately trained'. Para 6.88, for example states that if an 'assessor does not have the knowledge of a particular condition or circumstance, they must consult someone who has relevant expertise' and at para 6.86 it requires that:

assessors undergo regular, up-to-date training on an ongoing basis. The training must be appropriate to the assessment, both the format of assessment and the condition(s) and circumstances of the person being assessed. They must also have the skills and knowledge to carry out an assessment of needs that relate to a specific condition or circumstances requiring expert insight, for example when assessing an individual who has autism, learning disabilities, mental health needs or dementia.

The guidance requires that assessments be 'person-centred, involving the individual and any carer that the adult has, or any other person they might want involved' (para 6.9) and that they must 'establish the total extent of needs' (para 6.10). Local authorities are also required to 'provide in advance, and in accessible format, the list of questions to be covered in the assessment' (para 6.38).

Carer support ignored

The 'eligibility criteria' regulations⁶⁸ make explicit that the decision about whether an adult has eligible needs, is made on the basis that it does not take into account any support that is being provided by third parties (ie carers): 'instead, where a person receives support from a carer, this will be taken into account during the development of the care and support plan.'⁶⁹ This important point is addressed in the guidance, which at chapter 6 (Assessment and eligibility) states:

6.15 During the assessment, local authorities must consider all of the adult's care and support needs, regardless of any support being provided by a carer. Where the adult has a carer, information on the care that they are providing can be captured during assessment, but it must not influence the eligibility determination.

This approach is restated in the care and support planning section of the guidance (para 10.26) which requires that authorities 'must identify, during the assessment process, those needs which are being met by a carer at that time, and determine whether those needs would be eligible'.

Carers Assessments (section 10)

⁶⁸ The Care and Support (Eligibility Criteria) Regulations 2014, reg 2(3) which provides that 'an adult is to be regarded as being unable to achieve an outcome if the adult ... is unable to achieve it without assistance'.

⁶⁹ Department of Health *Draft national minimum eligibility threshold for adult care and support A discussion document* June 2013 para 1.23.

The Act makes material changes to the current duty to assess carers' needs. The new duty is triggered by the appearance of need and is no longer dependent upon the carer providing (or intending to provide) regular / substantial care or on the carer making a request. There is a 'clear consensus' among local authorities that the 'costs related to carers – in terms of both assessments and associated services pose one of the greatest financial risks to the reforms going live in 2015/16'.⁷⁰ While the Act may not lead to many more carers requesting an assessment any significant increase in cost may be attributable to carers having to be assessed 'on the appearance of need'.

Although the principal carer assessment duty is only owed to adult carers caring for other adults – the Act contains specific provisions covering carers of disabled children and young carers who are in transition into adulthood (considered below – sections 58 – 66). These are complemented by measures in the Children and Families Act 2014 which provide for significant new duties in relation to parent carers and young carers as well as enhanced obligations on local authorities to 'identify any children who are involved in providing care' (para 6.68 of the guidance) – and these are considered separately below.

What is 'care'

Pre-Care Act guidance has recognised that at law 'caring' is a much wider concept than simply providing physical or practical care – stating, for example, that care may relate to being 'anxious and stressed waiting for, or actively seeking to prevent, the next crisis'.⁷¹ It has also suggested that it encompasses both the notion of 'caring about someone' as well as 'caring for them'.⁷²

The 2014 Act does not seek to define 'care', although the guidance states that it 'includes both the practical and emotional support' (para 61.8). Since care is directed towards enhancing individual well-being, this brings with it a requirement to consider the section 1 checklist – including the 'physical and mental health and emotional well-being'.

Carers assessments – basic principles

Section 10 of the Act requires that carers' assessments must ascertain:

- whether the carer able / willing to provide and continue to provide the care;
- the impact on the carers 'well-being';
- the outcomes the carer wishes in day-to-day life;
- whether the carer works or wishes to (and / or) to participate in education, training or recreation.

Willing and able

The 'carer blind' element to the new regime (see note above 'Carer support ignored') is perhaps the most important new 'explicit' dimension to the guidance and one that is mentioned repeatedly.

At law it is arguable that assessments have always had to take this approach, since there is no requirement at law that adults provide care for other adults (this aspect of the liable family

⁷⁰ [ADASS & LGA Joint Response to the Care Act Regulations and Guidance Consultation](#) (August 2014) para 51.

⁷¹ See for example, Department of Health *Carers and Disabled Children Act 2000: Carers and people with parental responsibility for disabled children: Practice Guidance* (2000) para 67-8; Welsh Assembly Government *Guidance 2000 Act* (2001) para 4.11 and Welsh Government (2012) *Carers Strategies (Wales) Measure 2010* Guidance issued to Local Health Boards and Local Authorities, Annex 2.

⁷² Department of Health *Carers (Recognition & Services) Act 1995 Practice Guidance* LAC (96)7 at para 9.8; WOC 16/96 and WHC (96)21 in Wales (also at para 9.8).

rule was repealed in 1948⁷³). Section 10(5) requires that assessments must take into account the extent to which the carer is 'willing, and is likely to continue to be willing' to provide care. The guidance at para 2.48 that 'authorities 'should not assume that others are willing or able to take up caring roles' echoes earlier guidance – for example the original 1990 policy guidance to the Community Care reforms⁷⁴ and guidance to the Carers (Recognition & Services) Act 1995.⁷⁵

ADASS has expressed its concern that one effect of this new transparency over the right of carers to decline to provide care, may be that they will withdraw their care in order to accelerate the point at which the cared for person reaches the cap on care costs.⁷⁶

Private versus combined assessments

As with the pre-Care Act guidance, emphasis is given to the importance of carers having the opportunity to have their assessments in private – ie away from the 'adult in need', where the carer so chooses.⁷⁷ At para 6.40 authorities are required to consider the 'preferences of the individual with regards to the timing, location and medium of the assessment' and at para 6.18 'where appropriate' carers 'views should be sought in a separate conversation independent from the adult's needs assessment'. The Act, and guidance, provides for assessments to be 'combined' but this can only be with consent: section 12(5) stating 'only if the adult to whom the needs or carer's assessment relates agrees' – a point emphasised at para 6.74 of the guidance – namely that if 'either of the individuals concerned does not agree to a combined assessment, then the assessments must be carried out separately'.

In relation to young carers there is a move (considered below) to use 'whole family' assessments. While this may work for some young carers – this will not always be the case and it is clear from the legislation, that combined assessments are an option that cannot be imposed by the authorities. The danger, of course, is that such an approach can result in a 'rounding down': compromising personal ambitions in the stir of family complexities. Carers' difficulties in accessing their right to a separate assessment are well documented – parent carers and young carers particularly⁷⁸ – and the explicit statutory recognition of their right to a separate assessment is of importance.⁷⁹

The nature and setting of the assessment

The guidance advises that to enable individuals to prepare for their assessment, they should be provided in advance (in an accessible format) with the list of questions to be covered in the assessment (para 6.38). At the same time the authority must consider if the individual may have 'substantial difficulty' in being involved in the assessment process and if so consider the need for independent advocacy (para 6.23: the advocacy requirements are considered below). At the conclusion of the assessment the local authority must 'ensure that

⁷³ National Assistance Act 1948, section 1: see generally Luke Clements '[Does your carer take sugar?](#)' Washington and Lee Journal of Civil Rights and Social Justice: (2013) pp397 – 434.

⁷⁴ *Community Care in the Next Decade and Beyond* (HMSO 1990) para 3.28.

⁷⁵ Department of Health *Carers (Recognition & Services) Act 1995 Practice Guidance* LAC (96)7 at para 9.8; WOC 16/96 and WHC (96)21 in Wales (also at para 9.8).

⁷⁶ LGA and ADASS *Joint consultation response Care Act: regulations and guidance* (August 2014) at para 31.

⁷⁷ See for example, Practice Guidance LAC (96)7 and WOC 16/96 and WHC (96)21 in Wales – para 9.1 and Carers and Disabled Children Act 2000: Carers and people with parental responsibility for disabled children: Practice Guidance para 59 and the Welsh Assembly publication 'Guidance 2000 Act' 3.11.

⁷⁸ See for example, Luke Clements *Carers and their Rights* 5th ed (Carers UK 2012) paras 10.4 – 10.6 and 11.3 – 11.4.

⁷⁹ The practice guidance to the Carers & Disabled Children Act 2000 advised that in order that the carer have an opportunity to opt for a confidential meeting, the assessor should endeavour to make arrangements for the assessment 'over the phone, and away from the home or while the cared for person is out' – see Department of Health *Carers and Disabled Children Act 2000: Carers and people with parental responsibility for disabled children* Practice Guidance para 59 and the Welsh Assembly publication 'Guidance 2000 Act' para 3.11.1.

it is an accurate and complete reflection of the person's needs' (para 6.46) – which must presumably mean sharing a draft and getting it agreed (or details of what is not agreed) – since a copy of the assessment must then be given to the carer / adult in need (para 6.98).⁸⁰ The duty to endeavour to reach agreement at this stage is not however explicit – unlike the requirement in para 10.83, that authorities 'must take all reasonable steps to reach agreement with the person for whom the plan is being prepared'.⁸¹

Individuals must be 'at the heart' of their assessments and in the case of an adult 'in need' the authority 'must also involve any carer the person has (which may be more than one carer)'.⁸²

Carers' assessments must seek to establish not only the carer's needs for support, but also the sustainability of the caring role ... [ie] ... the carer's potential future needs for support (6.18). They must specifically consider the carer's 'desire and ability to work and to partake in education, training or recreational activities, such as having time to themselves' and the carers wishes in this respect should be considered over the short and longer term (section 10(6) and para 6.19 of the guidance).

Assessments should be 'proportionate'⁸³ ('light touch' or detailed depending on the extent of need) – but the guidance advises that even if done quickly, people should not be 'removed' from the 'process too early' (para 6.25). However, as noted above, the guidance recognise that assessments may 'where appropriate' be carried out over the phone or online although requiring that authorities consider whether in doing so this 'poses any challenges or risks for certain groups, particularly when assuring itself that it has fulfilled its duties around safeguarding, independent advocacy, and assessing mental capacity' (para 6.28) – and presumably satisfying its duty to ascertain if there are carers involved – so they can be contacted and offered an assessment. Every assessment must also 'identify any children who are involved in providing care' so that 'where appropriate ... the child or young carer' is referred for an assessment (para 6.68 – see young carers discussion below).

Advocacy support

The Act, regulations and guidance make specific provision for advocates to be provided where a person has 'substantial difficulty' in being actively involved with the planning process (see below). Less is said concerning the needs of those who don't have such a difficulty – but nevertheless feel the need for support from friends or advocates. The pre-Care Act guidance addressed this need directly – requiring authorities to make carers aware that they could have a friend or advocate present at their assessment.⁸⁴

The duty must, nevertheless remain under the 2014 Act. Section 10(7) obliges local authorities, when carrying out a carer's assessment, to 'involve' (among others) 'any person whom the carer asks the authority to involve'. Para 6.31 of the Act guidance requires that authorities identify adults who are unable to 'effectively engage in the assessment process independently' and to seek to 'involve somebody who can assist' – and the well-being duty (section 1(3)(e)) highlights the importance of individuals 'participating as fully as possible' in these processes and of the need to be provided with the 'support necessary' to enable them to participate.

⁸⁰ The Care and Support (Assessment) Regulations 2014 reg 3(1)

⁸¹ An almost identical to obligation to that in the Community Care Assessment Directions 2004 (Direction 2).

⁸² Section 9(5) and para 6.30 of the guidance.

⁸³ The Care and Support (Assessment) Regulations 2014 reg 3(1)

⁸⁴ Department of Health *Carers and Disabled Children Act 2000: Practice Guidance* (DH 2000) para 60 and Welsh Assembly Government *Guidance 2000 Act* (WAG 2001) para 3.11.

Carers' assessments - timescale

The Care Act (as with the previous legislation) does not stipulate a period within which a carer's assessment must be commenced or indeed completed. Para 6.29 of the guidance states that 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. Local authorities should inform the individual of an indicative timescale over which their assessment will be conducted and keep the person informed throughout the assessment process.

Where a statute does not prescribe a time for the discharge of one of its requirements, the courts require that it be done 'within reasonable period' and of course what this is, will depend upon the facts of any particular case. However, in relation to community care assessment the Local Government Ombudsman has stated that s/he 'normally considers that it is reasonable for this to take between four and six weeks from the date of the initial request'.⁸⁵ Given that a carers assessment is almost invariably undertaken as part of this process (and that the outcome of this assessment is to be taken into account when deciding what community care services are provided) it must follow that as a general rule a carers assessment must also be undertaken well within the four and six weeks period.

Carers and mental health law

The guidance is brief in relation to the 2014 Act's relevance for carers of people detained under the Mental Health Act 1983. At para 6.76 (in the context of 'Integrated assessments' – ie assessments for people who 'have needs that are met by various bodies') it is stated:

A local authority may carry out a needs or carer's assessment jointly with another body carrying out any other assessment ... provided that person agrees. An integrated approach may ... include putting processes in place to ensure that the person is referred for other assessments such as an assessment for after-care needs under the Mental Health Act 1983.

In the care planning section of the guidance reference is made (at para 10.9) to care plans meeting the needs identified under sections 18 – 20 of the Care Act 2014, adding:

Where a local authority is required to meet needs under section 117 of the Mental Health Act 1983 this chapter should be read in conjunction with chapter 34 of the "Mental Health Act 1983 Code of Practice" [2014] (on the Care Programme Approach) and "Refocusing the Care Programme Approach" [2008].

The lack of a clear 'read across' between the Acts is also evident in the (2014) Code of Practice for the 1983 Act, which fails to make it clear that the Care Act applies to carers of people who have been detained. This must however be the case, given how much more widely 'carer' has been defined.⁸⁶

⁸⁵ Local Government Ombudsman (2011) Fact Sheet S4 'Complaints about councils that conduct community care assessments' at <http://www.lgo.org.uk/publications/fact-sheets/complaints-about-community-care-assessments/>

⁸⁶ See above: ie that carers no longer need to be providing (or intending to provide) substantial amounts of care on a regular basis (section 10(3)).

Eligibility criteria (section 13)

Where an assessment identifies that an individual has needs for care / support then the authority must decide if these needs are sufficient to meet the eligibility criteria. The pre-Care Act legislation contains no reference to 'eligibility criteria': locating them instead in guidance (commonly referred to as FACS⁸⁷). The Care Act places eligibility criteria in a statutory footing (section 13) with the detail being spelled out in the regulations⁸⁸ – which contain separate criteria for adults in need and for carers. Whether this change of status – or indeed the significant changes to the criteria themselves – will result in material change in practice is difficult to predict. Research suggests that for both carers⁸⁹ and disabled / older people,⁹⁰ the content of national criteria is less influential than 'social work attitudes' and local interpretations of the national criteria.

A key concept to be grasped with the new eligibility process concerns the interlocking nature of the various criteria. Even if it is determined that the adult does not satisfy the adult criteria, she or he may still be entitled to support because their carer is deemed eligible – and even if this does not trigger a duty to provide support – the 'safeguarding obligations' may require that support is provided. The following sections consider the eligibility criteria as they apply to 'adults in need' and to 'carers'. The overarching safeguarding obligations (and the duty to provide care and support that may arise in consequence) are considered in the later 'safeguarding' section.

Adults in need eligibility criteria

For adults in need, although the Care Act criteria have some similarities to the FACS guidance: the most obvious change is the absence of 'bands' (the 'critical', 'substantial', 'moderate' and 'low' bands in FACS). Under the new eligibility scheme, adults in need are either eligible or they are not – and to be eligible three requirements must be satisfied:

- (1) their needs must be the result of a physical or mental impairment or illness;
- (2) as a result they must be unable to achieve **two or more** specified outcomes; and
- (3) as a consequence, there is (or there is likely to be) a **significant** impact on their well-being.

In this process – a key word is 'significant' and it is one that also appears in the carers eligibility criteria (see below). The guidance avoids a precise definition of what 'significant' means – para 6.110 stating that it is to have its 'everyday meaning – but then adding that authorities must consider:

whether the adult's needs and their consequent inability to achieve the relevant outcomes will have an important, consequential effect on their daily lives, their independence and their wellbeing' (para 6.110) – and that:

'Needs may affect different people differently, because what is important to the individual's wellbeing may not be the same in all cases. Circumstances which create a significant impact on the wellbeing of one individual may not have the same effect on another' (para 6.111);

⁸⁷ 'Fair Access to Care Services' although the 2002 Department of Health guidance that bore this name was replaced in 2010 by *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care. Guidance on Eligibility Criteria for Adult Social Care, England 2010*.

⁸⁸ The Care and Support (Eligibility Criteria) Regulations 2014.

⁸⁹ Wendy Mitchell *How local authorities allocate resources to carers through carer personal budgets* (National Institute for Health Research 2014).

⁹⁰ See for example Jose-Luis Fernandez and Tom Snell *Survey of Fair Access to Care Services (FACS) Assessment Criteria among Local Authorities in England* PSSRU Discussion Paper 2825 (2012) and Jose-Luis Fernandez, Tom Snell and Gerald Wistow *Changes in the patterns of social care provision in England: 2005/6 to 2012/13* PSSRU Discussion Paper 2867 (2013).

Inevitably it would appear to follow that, as with the FACS criteria, the eligibility determination will continue to be subjective and made on the basis of the assessor's professional opinion. The 'inherently subjective'⁹¹ nature of this process led a number of commentators, including the LGA and ADASS, to suggest that the draft eligibility criteria (published in June 2014) placed the threshold of entitlement closer to the 'moderate' band in FACS than the 'substantial' band.⁹² The final (ie revised) criteria appear to be 'tighter' – most noticeably requiring that the person is 'unable to achieve two or more specified outcomes'. However, in this context, regulation 3 defines 'unable' in expansive terms: a person is to be deemed 'unable' if he or she:

- (a) is unable to achieve it without assistance;
- (b) is able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety;
- (c) is able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or
- (d) is able to achieve it without assistance but takes significantly longer than would normally be expected.

The broad definition of inability to achieve – has also led commentators to suggest that even in this final formulation, the eligibility remain more generous than under the FACS guidance.⁹³

Regulation 2 details 'outcomes' as being:

- (a) managing and maintaining nutrition;
- (b) maintaining personal hygiene;
- (c) managing toilet needs;
- (d) being appropriately clothed;
- (e) being able to make use of the adult's home safely;
- (f) maintaining a habitable home environment;
- (g) developing and maintaining family or other personal relationships;
- (h) accessing and engaging in work, training, education or volunteering;
- (i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services;⁹⁴ and
- (j) carrying out any caring responsibilities the adult has for a child.

Para 6.107 of the guidance provides examples of how local authorities should consider each of the above outcomes – while emphasising that the guidance does not constitute an exhaustive list of examples.

The 'two or more' requirement means that the adult will be eligible if unable to achieve two outcome areas overall. Some needs will be so substantial that they will result in the adult being unable to achieve several of the specified outcomes whereas some will only have this impact on a single outcome. All that is required is that the individual is – as a result of their various 'needs' – unable to achieve two or more outcomes and that as a consequence there is a significant impact on their well-being. In such cases (subject to the other qualifying requirements in section 18 being satisfied) the authority is under a duty to produce a Care

⁹¹ LGA and ADASS *Joint consultation response Care Act: regulations and guidance* (August 2014) at para 45.

⁹² Ibid.

⁹³ See for example, Steve Broach Care Act 2014 – first thoughts on eligibility – a 'moderate' success? at <http://rightsinreality.wordpress.com/2014/10/27/care-act-2014-first-thoughts-on-eligibility-a-moderate-success/>

⁹⁴ SCIE has produced a *Strengths-based approaches* resource (accessible at www.scie.org.uk/care-act-2014/assessment-and-eligibility/strengths-based-approach/) which is designed to find ways of meeting a person's needs through the use of informal community / social networks and it considers particularly relevant to 'needs related to connecting with people, staying (physically) active, socialising, learning new skills and/or offering skills or knowledge to others in the community' (although the one practical example it gives is of a person who has care needs and female neighbour agrees to provide this for her without charge www.scie.org.uk/care-act-2014/assessment-and-eligibility/strengths-based-approach/what-do-practitioners-need-to-consider.asp)

and Support Plan. This must then be constructed (as a minimum) to ensure that the individual is enabled to achieve the two or more outcomes that resulted in their eligibility determination.

For those whose needs fluctuate, the [Statutory Guidance](#) advises on the importance of establishing their care and support history over a suitable period of time, both the frequency and degree of fluctuation (see para 6.58 – 6.59) and the [SCIE Guide](#)⁹⁵ provides further advice on this question.

Significant

The [SCIE Guide](#)⁹⁶ gives helpful insight into what is ‘significant’ including the suggestion that this could be a consequence of a cumulative effect eg ‘the individual may have needs across several of the eligibility outcomes, perhaps at a relatively low level, but as these needs affect the individual in various areas of their life, the overall impact on the individual is significant’. Various examples are given, including:

an adult is struggling to manage and maintain their nutrition, personal hygiene and toilet needs as their standards are reducing due to low social interaction and decreasing mobility around the home. The adult is consequently very close to becoming unable to meet most of the outcomes. It could be argued that the adult does not meet condition 3 of the eligibility criteria for adults with care and support needs due to the level of needs being relatively low. However, taking a holistic view of the level of impact of the individual’s mobility needs, and the accumulation of a number of the ‘low/medium’ levels of needs, this adds up to a ‘significant impact’ in the adult’s wellbeing.

Significant impact could be a consequence of a domino effect: this means that currently the individual may have needs in relation to few eligibility outcomes, but it can be anticipated that in the near future other outcomes will be affected, causing a significant impact on the individual’s wellbeing.

Keeping safe

One of the interesting observations concerning the outcomes, concerns what is not listed: for example ‘help with finances’ and ‘help with medication’ – but more particularly the absence of ‘keeping safe’. It is difficult to imagine a more important outcome for any individual: to feel safe in one’s own home or in one’s neighbourhood. As noted below (in the ‘safeguarding’ section) a duty exists on local authorities to provide support to protect people from harm. It follows that either the descriptions of the above ‘outcomes’ need to be expanded to encompass the concept of ‘keeping safe’ or a separate public law / human rights law ‘safeguarding eligibility criteria’ has to be developed to address this obligation.

Two of the criteria have the potential to be expanded to fill the gap – namely:

- (e) being able to make use of the home safely; and
- (i) making use of necessary facilities or services in the local community including public transport and recreational facilities or services

The [Statutory Guidance](#) at para 6.107 gives examples of what is envisaged by (e) stating:

Local authorities should consider the adult’s ability to move around the home safely, which could for example include getting up steps, using kitchen facilities or accessing the bathroom. This should also include the immediate environment around the home such as access to the property, for example steps leading up to the home

⁹⁵ Accessible at www.scie.org.uk/care-act-2014/assessment-and-eligibility/process-map/

⁹⁶ Accessible at www.scie.org.uk/care-act-2014/assessment-and-eligibility/process-map/

The examples in the [SCIE guide](#)⁹⁷ do not dramatically broaden the scope of this ‘outcome’ but it is clearly possible for a court or Ombudsman to read into ‘using the home safely’ the need for the provision of support measures to address significant risks (ie alarms; door entry controls; warden services of night sitting support etc).

In similar terms the [Statutory Guidance](#) at para 6.107 gives examples of what is envisaged by (i) stating:

Local authorities should consider the adult’s ability to get around in the community safely and consider their ability to use such facilities as public transport, shops or recreational facilities when considering the impact on their wellbeing. Local authorities do not have responsibility for the provision of NHS services such as patient transport, however they should consider needs for support when the adult is attending healthcare appointments

Once more, the examples in the [SCIE guide](#)⁹⁸ do not dramatically broaden the scope of this ‘outcome’ but again it is conceivable that the court or Ombudsman could interpret the ‘ability to get around in the community safely’ as requiring consideration as to the provision of support workers and other measures to address the harms the adult may encounter in the local environment.

If an adult in need is facing a significant risk to their safety and the authority deems them ineligible (either because it is not prepared to expand the definitions in outcomes (e) and (i) as suggested) or because there is only one outcome that cannot be achieved – then (if this cannot be remedied via a carers assessment) principles of public law and human rights law will have to be called in aid to address this shortfall (discussed in the safeguarding section below).

‘Carer blind’ eligibility determinations

As noted above, the regulations and guidance are unequivocal concerning the input of carers: this must be ignored during the assessment process of the adult and during the determination of eligibility. As the guidance states (para 6.119):

The eligibility determination must be made based on the adult’s needs and how these impact on their wellbeing. Authorities must only take consideration of whether the adult has a carer, or what needs may be met by a carer after the eligibility determination when a care and support plan is prepared. 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.

The pre-Care Act rule – that the eligibility criteria can be sidestepped for people whose needs are urgent⁹⁹ – is carried forward into the new regime (section 19(3)). The guidance advises that where ‘an individual with urgent needs approaches or is referred to the local authority [it] should provide an immediate response and meet the individuals care and support needs’ and it then provides as an example, ‘where an individual’s condition deteriorates rapidly or they have an accident, they will need a swift response to ensure their needs are met’ (para 6.26).

⁹⁷ SCIE *Outcomes for adults with care and support needs – Eligibility* accessible at www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/outcomes-care-support-needs.asp

⁹⁸ SCIE *Outcomes for adults with care and support needs – Eligibility* accessible at www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/outcomes-care-support-needs.asp

⁹⁹ NHS and Community Care Act 1990 section 47(5) and see for example *R (Alloway) v Bromley LBC* [2004] EWHC 2108 (Admin), (2005) 8 CCLR 61.

Carers eligibility criteria

The eligibility criteria for carers (put broadly) measure whether as a consequence of providing care, the carer is unable to undertake certain key roles / tasks (ie household activities / other caring responsibilities / employment / education / recreation) or that their health is at significant risk. These criteria are thought by many to be more generous than those currently in place.

Regulation 3 of the Care and Support (Eligibility Criteria) Regulations 2014 provides that:

A carer's needs meet the eligibility criteria if

- a) The needs arise as a consequence of providing **necessary** care for an adult
- b) The effect of the carer's needs is that any of the circumstances specified below apply to the carer
- c) As a consequence there is, or is likely to be, a **significant** impact on the carer's well-being.

As noted above, in this process – a key word is 'significant'. As with adults in need, no definition is provided for 'significant' in the regulations and the guidance states that it should be given its 'everyday' meaning (para 6.130) – and then adding that authorities must consider:

whether the carer's needs and their inability to achieve the outcomes will have an important, consequential effect on their daily lives, their independence and their own wellbeing (para 6.130) – and that:

the impact of needs may affect different carers differently, because what is important to the individual's wellbeing may not be the same in all cases. Circumstances which create a significant impact on the wellbeing of one individual may not have the same effect on another (para 6.131)

The circumstances specified in (b) above are as follows—

- (a) the carer's physical or mental health is, or is at risk of, deteriorating;
- (b) the carer is unable to achieve any of the following outcomes—
 - i. carrying out any caring responsibilities the carer has for a child;
 - ii. providing care to other persons for whom the carer provides care;
 - iii. maintaining a habitable home environment in the carers home (whether or not this is also the home of the adult needing care);
 - iv. managing and maintaining nutrition;
 - v. developing and maintaining family or other personal relationships;
 - vi. engaging in work, training, education or volunteering;
 - vii. making use of necessary facilities or services in the local community, including recreational facilities or services; and
 - viii. engaging in recreational activities.

As with the 'adults in need' criteria, the carers criteria ultimately leave considerable discretion to the assessor and their professional opinion.

Carer eligible vs 'adult in need' ineligible

The guidance makes clear that 'carers' eligibility does not depend on whether the 'adult for whom they care has eligible needs' (para 6.123). Accordingly the fact that an adult is not eligible for support is irrelevant in so far as the carers assessment is concerned. This obligation stems from section 20 of the Act, which states:

- (7) A local authority may meet some or all of a carer's needs for support in a way which involves the provision of care and support to the adult needing care, even if the authority would not be required to meet the adult's needs for care and support under section 18.
- (8) Where a local authority is required by this section to meet some or all of a carer's needs for support but it does not prove feasible for it to do so by providing care and support to the adult needing care, it must, so far as it is feasible to do so, identify some other way in which to do so.

A problem that could arise in cases such as this concerns a carers assessment that identifies a need for replacement care for the carer – but the person for whom she / he carers is a self-funder who refuses to pay for this? Since there is a duty to meet the eligible needs of the carer, and only a 'power' to charge – it would seem to follow that one option would be for the local authority to waive the charge. This outcome might also be required by section 20(8) (above) which requires the local authority to identify some way of meeting the need.

Funding panels

Many local authorities use 'panels' of various types (sometimes termed 'allocation panels', 'funding panels' or 'purchasing panels') as a means of rationing services. The legality of the way that some of these panels operate is open to question – creating as they do, an additional non-statutory hurdle for people in need and their carers.¹⁰⁰ The 2014 Act makes no change to this situation and so the concerns raised by the courts and the Joint Committee on Human Rights concerning the legality of such 'panels' overruling social work recommendations will remain relevant.¹⁰¹ The Local Government Ombudsman has also expressed similar misgivings. In a 2005 report, for example, he held that where an assessment has been carried out, a purchasing panel (and by implication a manager) cannot override the judgment of the assessor without providing clear reasons for doing so.¹⁰² In relation to the use of panels, the 2014 guidance comments (at para 10.85):

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. Where used, panels should be appropriately skilled and trained, and 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. ...

Duty /power to provide care & support for adults /carers (section 18 - 20)

The duty on local authorities to meet the eligible needs of disabled, elderly and ill people is retained and widened by the Care Act. The pre-2014 legislation contains no duty to meet

¹⁰⁰ For a general discussion on panels – see Luke Clements and Pauline Thompson *Community Care & the Law*, para 3.188 (5th edn, Legal Action Group 2011) the relevant extract 'Allocation and funding panels' being accessible at www.lukeclements.co.uk/resources-index/files/PDF%2008.pdf

¹⁰¹ For a detailed commentary on these decisions / reports see Luke Clements and Pauline Thompson *Community Care & the Law*, (5th edn, Legal Action Group 2011) para 3.188 – 3.191 which can be accessed at www.lukeclements.co.uk/resources-index/files/PDF%2008.pdf

¹⁰² LG Ombudsman Complaint no 04/A/10159 against Southend on Sea BC, 1 September 2005. The decision concerned a matter in which a plan drafted by a social worker following a detailed assessment was rejected by the local authority's care purchasing panel on the advice of the social worker's manager with limited knowledge of the service user. The Ombudsman stated: 'Having correctly prepared a detailed assessment in accordance with the statutory guidance, it was wrong for the council to dismiss all the information gathered in that process, and make a decision on the basis of [the acting manager]'s assurance. The decision flew in the face of the assessment'.

carers' eligible needs (just a power)¹⁰³ nor (in general) does the pre-2014 legislation create a duty to meet the needs of 'self-funders' (ie people whose savings are above the capital limit – currently £23,750). Both these limitations are removed by the 2014 Act. Where an individual's needs (ie a carer or an 'adult in need') meet the eligibility criteria then there will be a duty to ensure their care and support needs are addressed. The only stipulation being that they are ordinarily resident in the local authority's area (as at present) and that if their assets are above the financial limit, that they 'ask the authority' to meet their needs. Until April 2014 the right of self-funder's to require the local authority to meet their care needs will only extend to non-care home settings.¹⁰⁴

Even if a self funder with eligible needs does not ask the local authority to meet their needs – the local authority will (once the 'cap on care costs' comes into force in 2016) be under a duty to provide them with a statement (an 'independent personal budget' – see below) detailing what the cost would be to the local authority of meeting their needs – since this notional budget will count towards the 'cap'.

Section 20 creates a duty to meet the assessed needs of carers and is, the Government states, 'the first ever legal entitlement to public support, putting them on the same footing as the people for whom they care.'¹⁰⁵ The duty rests with the local authority responsible for the adult in need and extends to self-funders (ie carers with assets above the new maximum limits) who request help.

The Government's impact assessment considers that these new obligations will increase in the number of assessments (for new care users) by between 180,000 and 230,000 in 2016/17 and the number of reviews (for people already receiving care) by between 440,000 and 530,000 in 2016/17 – increasing local authority costs by over £2bn per annum.¹⁰⁶ The LGA has expressed 'major concern' as to the validity of these calculations.¹⁰⁷ The ADASS has also raised concerns about the preparedness of local authority for the influx of self-funders and whether the individual fee levels paid by councils are capable of withstanding challenge – ie of whether they reflect the actual costs of the service providers.¹⁰⁸

Self funders

The National Audit Office has confirmed the general perception that a 'cross-subsidy' exists by which self funded care costs proportionately more than local authority funded care. In doing so, it has warned of the risks that this is causing to the financial sustainability of some

¹⁰³ This change should not be over-stated since, as the Commission for Social Care Inspection (CSCI) observed in 2008 'there is a duty to address carers' eligible needs but discretion about whether to meet these through carers services or community care services – however, some practitioners appear to think [incorrectly] the discretion is about whether to help carers' - CSCI *Cutting the cake fairly: CSCI review of eligibility criteria for social care* (CSCI 2008) para 3.22.

¹⁰⁴ Response to the consultation on draft regulations and guidance for implementation of Part 1 of the Care Act 2014 Cm 8955 HMSO October 2014 page 8 accessible at www.gov.uk/government/uploads/system/uploads/attachment_data/file/366047/43374_2902887_Cm_8955_Web_Accessible.pdf

¹⁰⁵ Department of Health *The Care Bill explained: Including a response to consultation and pre-legislative scrutiny on the Draft Care and Support Bill* Cm 8627 (The Stationery Office 2013) para 73.

¹⁰⁶ Department of Health Social Care Funding Reform Impact Assessment IA No: 9531 8 April 2013 at www.gov.uk/government/uploads/system/uploads/attachment_data/file/197939/Social_Care_Funding_Reform_IA_FINAL_.pdf. All the Care Bill impact assessments can be accessed at <https://www.gov.uk/government/publications/the-government-published-a-series-of-impact-assessments-alongside-the-care-bill>

¹⁰⁷ See Andy McNicoll *Lack of funding could threaten Care Act reforms, councils warn* in *Community Care* 7 August 2014 at www.communitycare.co.uk/2014/08/07/lack-adequate-funding-threaten-care-act-reforms-councils-warn/ accessed 11th August 2014.

¹⁰⁸ ADASS *Procurement Survey Report 2014* July 2014 para 7.3 at www.adass.org.uk/adass-procurement-survey2014/ accessed 2nd July 2014.

providers.¹⁰⁹ In this context, the Public Accounts Committee concluded that the Government does 'not know the extent of cross-subsidisation between self-funders and local authority funded users'.¹¹⁰

Until the 'cap on care costs' comes into force in 2016, the incentive for self-funders to have their care and support needs assessed and / or arranged by a local authority will be limited. This will be particularly so, given that the potential benefits of care home residents in being able to get the price of their placement at the local authority rate (rather than the self funder rate) – has now been removed by this opportunity being delayed until 2016 (see above). This point is emphasised in the final guidance (para 8.55):

People with eligible needs and financial assets above the upper capital limit may ask the local authority to meet their needs. This could be for a variety of reasons such as the person finding the system too difficult to navigate, or wishing to take advantage of the local authority's knowledge of the local market of care and support services. Where the person asks the local authority to meet their eligible needs, and it is anticipated that their needs will be met by a care home placement, then the local authority may choose to meet their needs, but is not required to do so. In other cases, where the needs are to be met by care and support of some other type, the local authority must meet those eligible needs.

The main benefits for self-funders will flow once the 'cap on care costs' comes into effect in April 2016 together with the new capital rules (considered below). Many adults who may benefit from the cap will want to ensure that their care costs start to be recorded on the 'taxi meter' from the first day that these provisions take effect (ie 1st April 2016). There is likely therefore to be a surge of demand from self-funders in advance of this date. In consequence the Government believes that local authorities should 'consider beginning assessing people who arrange their own care and support from November 2015'.¹¹¹ In 2014 the Public Accounts Committee noted that neither the Government nor the ADASS understood fully the challenges that local authorities will face in commissioning and providing adult social care and supporting carers.¹¹²

The full financial impact of the cap on costs will only crystallise when people start hitting the 'cap' and this is not likely to arise for several years. However until that time the administrative cost of keeping track of all these accumulating 'independent personal budgets' will be very considerable and almost certainly significantly in excess of the £175m the Government as allocated for this in 2015-16.¹¹³

Care & support plans (section 25-26)

The assessment process involves identifying 'needs' and then determining which of these (if any) are 'eligible needs'. This stage is then followed by the development of a care and support plan that explains how the eligible needs will be met. These stages are two sides of

¹⁰⁹ Report by the Comptroller and Auditor General Adult social care in England: overview HC 1102 Session 2013-14 (National Audit Office 2014) para 2.11-13.

¹¹⁰ House of Commons Committee of Public Accounts Adult social care in England HC 518 (Stationery Office 2014) p.13 at www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/518/518.pdf accessed 13 July 2014

¹¹¹ Department of Health *Caring for our future Consultation on reforming what and how people pay for their care and support* July 2013 para 278 at www.gov.uk/government/uploads/system/uploads/attachment_data/file/239393/CONSULTATION_CaringForOurFuture_acc.pdf

¹¹² House of Commons Committee of Public Accounts Adult social care in England HC 518 (Stationery Office 2014) p.12-13 at www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/518/518.pdf accessed 13 July 2014

¹¹³ Department of Health *Consultation on funding formulae for implementation of the Care Act in 2015/16. Allocations for additional assessments for the cap, universal deferred payment agreements and social care in prisons* for the financial year ending April 2016 (the consultation closes on 9 October 2014) at www.careknowledge.com/uploadedFiles/Redbox/Pavilion_Content/Our_Content/Social_Care_and_Health/webw_atch_for_CK_only/2014/201407/Consultation_document.pdf accessed 11th August 2014

an equation: on one side there are the eligible needs that have to be met and on the other are the details of how this will be done. In order that the individual can determine whether their assessed needs are fully addressed in the care plan, the guidance requires that they 'must be given a record of their needs or carer's assessment' (para 6.98)¹¹⁴ and also their final care plan (para 10.87).

Needs versus 'outcomes'

The Act seeks to distinguish 'needs' from 'outcomes'. This chimes with the views of many commentators who consider that the 'social model' approach requires a 'focus on outcomes' rather than personal 'needs'.¹¹⁵ There is much to be said for this, but there are dangers too.

On the positive side outcomes aim to identify the person's 'aspirations, goals and priorities'.¹¹⁶ The theory is that if the assessment focuses on these issues it will break free from the shackles of thought processes tied to existing service models – thinking about 'what services are available'. Once the person 'in need' / carer have been helped to explain what they would like happen in their lives – then they (with the support of the authority) can seek to develop a care and support plan designed to enable these things to be achieved. The theory is that this process leads to better and sometimes more imaginative solutions.

On the negative side, however, there is evidence that the emphasis on outcomes is rhetorical rather than of substance (a criticism also made of many local authority 'personalisation' programmes). Much of the research concerning outcomes focused assessments identifies the importance of avoiding prescriptive 'tick box' questionnaires and of the need for a strong human relationships with assessors who have the skills and time to enable this approach to succeed. Local authorities are however moving to greater standardisation, more prescriptive assessment forms, less skilled / trained workforces with ever higher caseloads. The result has been described as an:

increasing disconnect between what service users (and often carers) say and related evidence, and the thinking of government and policy-makers and what they seem to be doing.¹¹⁷

A further reason for caution lies in the very ambiguity as to what constitutes an 'outcome'. Just as some disabled people have historically been told that their asserted 'need' is merely a 'want' – some are now being told that their 'need' is no longer relevant – it is the 'outcome' that counts (and the local authority then proceed to tell them what this is). Not infrequently there is a pedantic circularity to the distinction – and one that should be confronted. Outcomes arise out of needs, which stem from impairments – so, for example, the regulations (when dealing with the criteria for an adult in need') state that because of a person's needs, a statutory 'outcome' could be 'managing toilet needs'.¹¹⁸ The guidance (para 6.107) then explains how local authorities should consider each statutory 'outcome' for the purposes of determining eligibility – and in relation to 'managing toilet needs' it states that this requires a consideration of their 'ability to access and use a toilet and manage their

¹¹⁴ Even if it is decided that none of their needs are eligible needs, the authority must nevertheless provide them with 'information and advice in an accessible form, about what can be done to prevent, delay, or reduce development of their needs' (para 2.52).

¹¹⁵ For a succinct overview see Emma Miller, 'Can the shift from needs-led to outcomes-focused assessment in health and social care deliver on policy priorities?' (2010) *Research, Policy and Planning* 28(2), 115-127.

¹¹⁶ Caroline Glendinning et al *Outcomes-focused Services for Older People Social Care Institute for Excellence (SCIE) Knowledge Review* (SCIE 2006) p. 2

¹¹⁷ Peter Beresford and Eamon Andrews *Caring for our Future: What Service Users Say* Joseph Rowntree Foundation 2012.

¹¹⁸ The Care and Support (Eligibility Criteria) Regulations 2014, reg 2(2)(c)

toilet needs.¹¹⁹ It would appear to follow that a ‘need’ to get to the toilet is only a ‘need’ but a need to manage my toilet needs’ is an outcome.

It is at this stage one asks whether the well-being requirement – that the authority starts from the ‘assumption that the individual is best-placed to judge the individual’s well-being’ (section 1(3)) – extends to accepting that the individual is best placed to say what they want to be able to do (their outcome) and to do so in their own terms – including using the language of need? One would hope that the answer to this is a simple ‘yes’.

Provided the potential for casuistry in the ‘outcomes versus needs’ analysis is avoided, there is much to welcome in having a statutory list of ‘outcomes / needs’.¹²⁰

Care and support planning – principles

Section 25 details what must be in every care and support plan¹²¹ (ie for a carer or an adult ‘in need’) and this duty is analysed in the guidance (para 10.36). The requirements include:

- 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.

The effect of section 25 is that the current requirements for care and support plans will continue – but they now become statutory creatures rather than requirements of Department of Health guidance. Existing case law concerning care plans will remain relevant – particularly so, given that it places great emphasis on the importance of local authorities following guidance¹²² (which will now be the detail in the 2014 guidance). In *R v Islington LBC ex p Rixon* (1997)¹²³ it was held that central importance of a care plan was described as:

the means by which the local authority assembles the relevant information and applies it to the statutory ends, and hence affords good evidence to any inquirer of the due discharge of its statutory duties.

In *R (J) v Caerphilly CBC*¹²⁴ it was held that care plans must ‘set out the operational objectives with sufficient detail – including detail of the “how, who, what and when” – to enable the care plan itself to be used as a means of checking whether or not those objectives are being met’. A 2014 Ombudsman’s report held (in similar terms) that an

¹¹⁹ This is not of course to deny that having this explicitly stated in the regulations and statutory guidance will not prove to be of very substantial practical advance for disabled people such as Elaine McDonald and as a result most probably reverse the finding in *R (McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33 (see also *McDonald v UK* (2014) Applic No. 4241/12 20 May 2014).

¹²⁰ Notwithstanding that there are clear omissions from the list ie ‘help with finances’ and ‘keeping safe’.

¹²¹ Unless excluded by the Care and Support (Personal Budget Exclusion of Costs) Regulations 2014 – which concerns the exclusion of costs associated with the provision of intermediate care (including reablement support) services.

¹²² *R v Islington LBC ex p Rixon* (1997–98) 1 CCLR 119 at 128, QBD.

¹²³ (1997–98) 1 CCLR 119 at 128, QBD.

¹²⁴ [2005] EWHC 586 (Admin); (2005) 8 CCLR 255. This case is discussed in detail at para 10.73.

assessment must be more than merely a descriptive document: it must spell out with precision what the needs are, what the impact of the disability is on the carer(s) and whether the disabled person and the carers needs can be met and can continue to be met into the future. The assessment must result in a care plan that identifies the needs, what is to be done about these needs, by whom and when. If a direct payment is made, it must specify precisely what need these payments are intended to meet, why this level of payment is considered appropriate, or what outcome this will result in.¹²⁵

The most significant difference under the new regime is that every such plan for an 'adult' must have a 'personal budget' (s25(1)(e) – discussed below). Since most local authorities already do this – it will probably make little practical difference.

The 2014 guidance requires that the person being assessed must be 'genuinely involved and influential throughout the planning process and that: 'it should be made clear that the plan 'belongs' to the person it is intended for, with the local authority role to ensure the production and sign-off of the plan to ensure that it is appropriate to meet the identified needs (para 10.2). The care and support plan 'must take into consideration the individual's preferences' (para 10.21) may include helping the person to access some disability-related benefits and allowances (para 10.24).

Of considerable importance to people whose needs could be met by various bodies – ie young people for whom education have responsibilities or people who have chosen not to seek a particular social security benefit, the guidance states (para 10.25):

The duty to meet eligible needs is not discharged just because a person has another entitlement to a different service which could meet those needs, but which they are not availing themselves of. The needs remain 'unmet' (and so the local authority under a duty to meet them) until those needs are actually met by the relevant service bring provided or arranged.

Carer input into adults 'in need' care plan

In relation to support provided by a carer – the guidance repeats its reoccurring theme, that assessments are 'carer blind'. Para 10.26 stating:

LAs are not under a duty to meet any needs that are being met by a carer. any eligible needs met by a carer are not required to be met by the LA, for so long as the carer continues to do so. The LA should record in the care and support plan which needs are being met by a carer, and should consider putting in place plans to respond to any breakdown in the caring relationship.

In preparing a care / support plan section 25(3) requires that local authorities must involve (among others) the adult for whom it is being prepared; 'any carer that the adult has', and 'any person who appears to the authority to be interested in the adult's welfare'. In relation to carers, the requirement is to involve the carer for whom it is being prepared, 'the adult needing care, if the carer asks the authority to do so' and any other person whom the carer asks (section 25(4)).

In the same vein, para 10.40 states that where a person with eligible needs is having these met by a carer at the time the plan is developed, the 'carer must be involved in the planning process' and the authority 'should record the carer's willingness to provide care and the extent of this in the plan ... so that the authority is able to respond to any changes in circumstances ... more effectively. Para 10.40 also provides that:

¹²⁵ Local Government Ombudsman complaint number 13 002 982 against Birmingham City Council 12 March 2014.

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, and establish if the carer requires an independent advocate.

Carers services: 'replacement care' / respite / short breaks care

As noted above, the result of a carer's assessment will often be that the care and support plan for the adult 'in need' or a third party is adapted / changed to enable the carer to achieve the outcomes they consider to be of importance.

The Act and guidance re-emphasises the legal position – that 'respite / short break care' is (where it consists of a service delivered to the adult 'in need' - for example as a sitting service or placement in a residential setting etc) a care and support arrangement for the adult in need and not for the carer. A 2000 Department of Health note explained this well:¹²⁶

People who care may be assessed as needing a break from their caring role. This need will be clearly recorded on their own assessment documentation.

The person they care for will then be assessed for the additional support that they will need to allow their usual carer to take a break. This need will be recorded on their assessment documentation. The additional service remains a community care service delivered to the cared for person, not a carer service under this Act.

In some situations this process (addressing carer's eligible needs in the care and support plans of others) can raise issues that may be less common. One such example is given in the guidance (page 196) and it concerns Divya, who is caring for her dying father and for her young children. Her father has a care package in addition, but Divya's carer's assessment identifies her as eligible for support due to her additional child care responsibilities.¹²⁷ The support plan that is developed for her consists of a carers' direct payment 'which she uses for her children to attend summer play schemes so that she get some free time to meet with friends and socialise when the family member providers care to her father'.

The guidance refers to support that involves the local authorities meeting a carer's needs by providing a service directly to the adult needing care as 'replacement care which:

may be needed to enable a carer to look after their own health and wellbeing alongside caring responsibilities, and to take a break from caring it should be considered a service provided to the cared-for person, and thus must be charged to them, not the carer. (para 11.39)

Of importance is the statement (para 11.45) that if the local authority have a policy of charging for a particular type of replacement care 'then it would be the adult needing care that would pay, not the carer, because they are the direct recipient of the service'. This will also be the case where the a carer is assessed as eligible for support but the adult being cared for does not have eligible needs – and accordingly 'does not have their own personal budget or care plan' (para 11.42). In such cases the carer could (for example) request a direct payment, and use that to commission their own replacement care from an agency (para 11.44).

Replacement care and NHS Continuing Care

There will be situations where a need for replacement care is identified in carer's assessment, but the adult 'in need' is in receipt of NHS CC funding. In such cases, the replacement care would have to be provided / funded by the CCG. Presumably, if the CCG

¹²⁶ Department of Health *Questions and Answers* – a note that accompanied the enactment of the 2000 Act; (the Answer to Question 7 'Are short term breaks (respite care) a service for carers or cared for people?')

¹²⁷ By virtue of The Care and Support (Eligibility Criteria) Regulations 2014 Reg (3)(2)(b)(i)

failed or refused to provide this then the local authority could make a request under section 7 (see above) – namely requesting co-operation from a ‘relevant partner’ in relation to an ‘individual with needs’ or a carer, a carer of a child or a young carer. The CCG would have to comply with the request unless it would:

- (a) be incompatible with its duties, or
- (b) have an adverse effect on the exercise of its functions

It would appear that neither of these exceptions could apply in such a case – however if the CCG body chose to comply with the request it would have to provide ‘written reasons for the decision’ (section 7(3)). The guidance suggests that relevant partner bodies (eg a CCG) ‘must respond to requests to cooperate under their general public law duties to act reasonably, and failure to respond within a reasonable time frame could be subject to judicial review’ (para 15.28). Judicial review as a remedy is likely to be unrealistic / unavailable for most individuals and one many local authorities would hesitate to activate. For individuals a local complaint / followed by an Ombudsman referral (if needs be) would be the most accessible option.

Carers support services generally

The wide range of arrangements that local authorities are able to provide to support carers under the pre-Care Act will continue. As noted above the range of support under section 8 is wide. Para 11.41 of the guidance gives illustrative examples of the type of support that are envisaged for carers:

relaxation classes, training on stress management, gym or leisure centre membership, adult learning, development of new work skills or refreshing existing skills (so they might be able to stay in paid employment alongside caring or take up return to paid work), pursuit of hobbies such as the purchase of a garden shed, or purchase of laptop so they can stay in touch with family and friends.

Many of these support arrangements will be facilitated by a direct payment – and the Act (sections 31 – 33), regulations¹²⁸ and guidance in large measure replicate the legal position.¹²⁹ This means that pre-Care Act 2014 case law and Ombudsman decisions will be of continued relevance.

The relevance of local authority financial difficulties

Para 10.27 of the guidance makes clear that the current law concerning the relevance of a local authority’s financial position remains (as first detailed in the *Gloucestershire* judgment¹³⁰) namely that although authorities can ‘take into reasonable consideration’ of their finances, they ‘must comply’ with their legal obligations. A local authority’s finances are relevant when it decides *how* to meet the eligible needs of an individual ‘but not *whether* those needs are met’. The guidance goes on to stress that authorities ‘should not set arbitrary upper limits on the costs [they are] willing to pay to meet needs through certain routes’ – although they may:

take decisions on a case-by-case basis which weigh up the total costs of different potential options for meeting needs, and include the cost as a relevant factor in deciding between

¹²⁸ The Care and Support (Direct Payments) Regulations 2014.

¹²⁹ The only significant change is that direct payments are expected to be available for residential care placements – from April 2016: see Department of Health Policy Research Unit in Policy Innovation Research *Direct Payments in Residential Care Trailblazer Programme Evaluation Preliminary report* 2014 at www.piru.ac.uk/assets/files/DP%20Trailblazer%20Preliminary%20report.pdf.

¹³⁰ *R v Gloucestershire County Council ex p Barry* 1 CCLR 40; [1997] 2 All ER 1; and reiterated in *R (KM) v. Cambridgeshire County Council* (2012) [2012] UKSC 23.

suitable alternative options for meeting needs. This does not mean choosing the cheapest option; but the one which delivers the outcomes desired for the best value. (para 10.27)

Sign off and copies of care plans

The 'sign off of a plan should only occur once the authority has taken 'all reasonable steps to reach agreement with the person for whom the plan is being prepared' and 'any third party involved in the preparation of the plan' and this 'agreement should be recorded and a copy placed within the plan' (para 10.83). If the plan is not agreed then the authority should 'state the reasons for this and the steps which must be taken to ensure that the plan is signed-off' (para 10.86).

The Act also requires that a copy of the care and support plan be given to the adult in need / carer (and anyone else they request) (section 25(9) and (10)) and the guidance at para 10.87 makes clear that the copy must be 'in a format that is accessible to the person for whom the plan is intended' and copies should also be given to any independent advocate involved. Many care and support plans are computer generated and incomprehensible to all but the initiated. The requirement that the copies be 'in a format that is accessible' must require that this practice ends and plain English, jargon free plans are provided to those who require them.

Review of care & support plans

Section 27(1) of the 2014 Act places a general duty on local authorities to keep under review care and support plans (as well as when a reasonable request by the adult in need or a carer and section 27(4) requires that if they believe that that circumstances have changed materially, then they must undertake a further needs or carer's assessment and revise the plan accordingly. The guidance creates an expectation that the care and support plans will be reviewed 'no later than every 12 months, although a light-touch review should be considered 6-8 weeks after the plan and personal budget have been signed off' (para 10.42 – and see also para 13.32).

The guidance requires that reviews (like assessments) must be person-centred, accessible and proportionate: must involve the 'person needing care and also the carer where feasible' (para 13.2) and their purpose is 'identify if the person's needs (or any other circumstances) have changed' (para 13.4). Very welcome is the note in the guidance that the 'review must not be used as a mechanism to arbitrarily reduce the level of a person's personal budget' (para 13.4). Reviews should not be 'overly-complex or bureaucratic' and should cover the specified matters – which 'should be communicated to the person before the review process begins' para 13.12). These include: whether the person's needs / circumstances have changed; what parts of the plan are working / not working / need changing; have the outcomes identified in the plan been achieved and are there any new outcomes they want to meet; is the person's personal budget adequate and is there a need to change the way it is managed / paid; are there material changes in the person's support networks which might impact negatively or positively on the plan; have any changes occurred which could give rise to a risk of abuse or neglect; and is the person, carer, independent advocate satisfied with the plan?

The guidance goes into considerable detail about the different ways that a review may be triggered – ie as a result of a planned review (where the date is detailed in the care and support plan); an unplanned review (resulting from a change in needs / circumstances); and a requested review (ie by the person with the plan, or any interested party on their behalf) (para 13.13).

Charging (section 14)

As noted, local authorities will be able to charge for the cost they incur in providing social care support services. Under the pre-Care Act law, there was a duty to charge for residential care services¹³¹ and a power to charge for non-residential care¹³² (including carers' services¹³³). The 2014 Act repeals the previous law and section 14 gives authorities the power (but not a duty) to charge. In the short term it is unlikely that there will be material changes to local authority charging policies – although reference to the well-established Charging for Residential Accommodation Guidance (CRAG) will change as this is repealed – but it is replicated in large measure by the Care and Support (Charging and Assessment of Resources) Regulations and the guidance (including Annexes B, C, D and E).

Section 14(1) Act opens the way for the charging of self-funders for the cost a local authority incurs for 'for putting in place the arrangements for meeting' needs.¹³⁴ The guidance explains that local authorities can charge such people an 'arrangement fee' which takes into account 'the cost of negotiating and/or managing the contract with a provider and cover any administration costs incurred' (para 8.58) – but local authorities cannot 'charge people for a financial assessment, a needs assessment or the preparation of a care and support plan' (para 8.59).

Until the new 'cap on costs' provisions come into force (expected in April 2016) the regime will continue largely as at present. Although the guidance makes much of the fact that the charging regimes of residential and non-residential care will be governed by 'a single legal framework' (para 8.1) the reality is that they will be dealt with differently by the regulations and guidance. At law a significant difference with the new process is that for residential care accommodation local authorities will have discretion to charge – whereas it is currently a duty. Although the likelihood is that local authorities will continue to impose charges, as at present, they will have to develop a policy on this and consult on it – which will, in itself, be a not insignificant administrative obligation.¹³⁵

The power to register land charges

A further change is that the new legal regime fails to replicate the current powers of local authorities to place a charge on land where a person has failed to pay their care charges or transferred their property to a third party (using the Health and Social Services and Social Security Adjudications Act (HASSASSA) 1983, s21, s22 and s24). This has caused local authorities concern – (1) that they will be unable to recover outstanding fees when someone dies or sells their property; and (2) that this may result in 'more older people being involved in complicated and potentially distressing court cases'.¹³⁶

Charging 'principles'

The guidance states (para 8.2) that a single set of principles will condition local authority approaches to charging, namely:

- ensure that people are not charged more than it is reasonably practicable for them to pay;
- be comprehensive, to reduce variation in the way people are assessed and charged;
- be clear and transparent, so people know what they will be charged;
- promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control;
- support carers to look after their own health and wellbeing and to care effectively and

¹³¹ National Assistance Act 1948, section 22.

¹³² Health and Social Services and Social Security Adjudications Act 1983, section 17.

¹³³ Carers and Disabled Children Act 2000, section 8 (which amended the 1983 Act above, inserting s17(2)(f)).

¹³⁴ See also The Care & Support (Charging and Assessment of Resources) Regulations 2014 reg 5.

¹³⁵ LGA and ADASS *Joint consultation response Care Act: regulations and guidance* (August 2014) at para 31.

¹³⁶ LGA and ADASS *Joint consultation response Care Act: regulations and guidance* (August 2014) at para 30.

- 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; and
- be sustainable for local authorities in the long-term.

Welcome as is the requirement that 'people are not charged more than it is reasonably practicable for them to pay' this represents (for people receiving non-residential care support) a dilution of their legal rights. At present the prohibition is contained in the statute¹³⁷ and so is only capable of being removed by Parliament (whereas guidance can be re-written on Ministerial whim). The advice by the Select Committee that the prohibition be retained in statute (or at least in regulations) has therefore been rejected.¹³⁸

One problem with the approach of applying 'the charging rules equally so those with similar needs or services are treated the same' is that local authorities may start charging carers for services. The guidance anticipates this problem – but in a relatively 'limp' section seeks to argue that charging carers is not inevitable stating (para 8.50):

Local authorities are not required to charge a carer for support. a local authority should consider how it wishes to express the way it values carers within its local community as partners in care, and recognise the significant contribution carers make. ... Local authorities should consider carefully the likely impact of any charges on carers, particularly in terms of their willingness and ability to continue their caring responsibilities.

A novel introduction to the charging regime is the possibility of 'light touch' financial assessment for certain groups (paras 8.18 - 8.22). Most obviously this will apply to people who are wealthy and don't want to undergo the indignity of being assessed – but nevertheless do wish to have the local authority care manage their support plan (see below). The guidance suggests however that this may extend to other groups – for example where there is only a 'small or nominal amount' charged for a particular service and person is 'clearly able to meet' the cost – or where a person is 'in receipt of benefits which demonstrate that they would not be able to contribute towards their care and support costs' and the guidance then gives the example of 'jobseekers allowance'.

The upper capital limit is stated as being £23,250 (which would mean no increase for 2014-15) and lower limit at £14,250. There will be a notional interest charged on capital falling between these figures on the same basis as present. There will continue to be a personal expense allowance – and the same services must be provided without charge as at present – ie intermediate care / reablement; community equipment, and costing £1,000 or less; services under section 117 of the Mental Health Act 1983 and so on.

Major reforms to the charging regime – particularly the capital allowances – are expected when (and 'if') the 'cap on costs' reforms come in – and these are considered below.

¹³⁷ S17 Health and Social Services and Social Security Adjudications Act 1983.

¹³⁸ Joint Committee on the Draft Care and Support Bill, 'Draft Care and Support Bill' Stationery Office (2013) HL Paper 143 HC 822 para 196.

Cap on costs (sections 15 - 16)

The Act implements aspects of the Dilnot Commissions proposals.¹³⁹ The Commission recommended that the lifetime contribution an individual should make to their care costs should be capped at a maximum of £35,000. The Government has indicated however that when implemented in 2016, the maximum will be £72,000.¹⁴⁰ The figure will only apply to social care costs and will not apply to the costs incurred by self-funding carers. It is proposed that for residents in care homes, £12,000 pa of their care home fees will be deemed to be for 'daily living costs' (ie for the cost of their accommodation and their food etc). Ignoring the annual inflation up-rating, it would take 5½ years for a person paying £25,000 pa care home costs to reach the maximum figure. Only then would they feel any benefit from the proposals (and by then they would have paid over £135,000.00 in care costs). Even at this stage the full costs would not be met – as residents would still be liable for their daily living costs – ie a contribution of £12,000 pa (inflation updated).

In February the Department of Health issued a consultation on the details of the cap on costs proposals which included the suggestion (in line with the Dilnot recommendations) that for people who became eligible for social care services before the age of 25 the cap be set at zero.¹⁴¹

In 2016 it is also proposed that changes will be made to the capital limits - rising from the current £23,750 to £118,000 – if a home is included in the calculation – and £27,000 if not. The lower capital limit will rise to £17,000. The assumption will continue that every £250 above the lower limit will yield notional income of £1 per week. This means that for someone with savings of £117,000 who seeks local authority assistance, they will have a contribution of £20,000 pa. from the capital (ie over £400.00 per week) – and at the same time lose their DLA / Attendance Allowance care component (because they are local authority supported).

The proposals – in effect – offer self funders with significant capital a free insurance policy. Once assessed as having 'eligible needs' they will have an account opened by the local authority and (in the current jargon) the 'Dilnot taxi meter' will start ticking. The self funder can then purchase their care privately and the local authority will record this on their 'care account' (section 29) – having agreed their 'independent personal budget' (section 28 – see below), namely their social care expenditure (ie the amount attributable to 'daily living costs' having been deducted). This will of course give rise to disputes / complaints / ombudsman interventions concerning the amount to be recorded and result in many requests for reassessments when care needs increase. The Act provides for a new statutory appeals process to deal with (amongst other things) this expected increase (section 72). Care accounts will be up-rated for inflation each year, transferred when the person moves to a new local authority and retained for 99 years (section 29(2)).¹⁴²

Deferred payments (sections 34-36)

The right to have a deferred payment in relation one's main residence is retained and entrenched under the new regime. The Care and Support (Deferred Payment) Regulations 2014 enable local authorities to charge interest on the loan and interest on their expenses in creating the charge to secure the loan. The rate put simply can be no more than 1.5%

¹³⁹ Commission on Funding of Care and Support *Fairer Care Funding: The Report of the Commission on Funding of Care and Support* 2011

¹⁴⁰ It is likely that there will be a graduated maximum depending on the age that the person first becomes in need of care - and possibly nil if the need exists when the person is 18.

¹⁴¹ Department of Health [Care Act 2014: cap on care costs and appeals](#) 2015 accessible at www.gov.uk/government/consultations/care-act-2014-cap-on-care-costs-and-appeals

¹⁴² The Commission's report ignored almost entirely the bureaucracy that its scheme would generate – stating only that there 'will be some additional administration as a result' (p.64).

greater than the 'relevant rate' of interest for the period.¹⁴³ The right to a deferred payment will be subject to a number of conditions including a maximum capital allowance of £23,750 (reg 2(2)(c)).

The Government has proposed additional funding to cover the cost of new deferred payment agreements at £108.5m for 2015-16.¹⁴⁴

NHS Interface (section 22)

A number of amendments were made to the Bill to ensure that the current boundary between local authority responsibilities and the NHS (the so called 'NHS Continuing Care' boundary as defined in the *Coughlan* Court of Appeal judgment¹⁴⁵) remained unchanged. The phrasing of section 22 appears to achieve this aim, and the Minister has confirmed that:¹⁴⁶

The provisions in section 22 are not intended to change the current boundary—let me place that clearly on the record—and we do not believe that they will have that result. The limits on the responsibility by reference, as now, to what should be provided by the NHS remain the same'.

A number of provisions in the draft guidance and regulations appeared to undermine this helpful statement¹⁴⁷ but in large measure these have been removed from the final guidance – or remain in heavily qualified terms.

Regulation 7 of the [Assessment Regulations](#)¹⁴⁸ obliges local authorities, when assessing the needs of an individual (and a disabled child in transition – see below), who they believe to be eligible for NHS Continuing Healthcare funding to refer them to the relevant NHS body. Although the regulations create no concomitant obligations on the NHS to respond to such a referral – such a duty exists by virtue of separate NHS regulations¹⁴⁹ and if any specific problem occurred over such a referral the local authority would be able to use its powers under section 7 of the 2014 Act (see above).

Personal budgets

Section 26 states that the amount of an adult's personal budget is 'the cost to the local authority of meeting those of the adult's needs which it is required or decides to meet'. The Select Committee expressed concern that this phrasing was different to the current requirement (in relation to direct payments) – namely that the amount be that which the "the authority estimate to be equivalent to the reasonable cost of securing the provision of the service concerned': it considered that the word 'reasonable' was important and should be included in the Act. In response the Government stated that the wording meant that the amount had to be 'sufficient to meet' the adult's needs. The Select Committee was not

¹⁴³ A rate one assumes that will be published each year by the Government (currently the Office of Budget Responsibility) see reg 9(4).

¹⁴⁴ Department of Health *Consultation on funding formulae for implementation of the Care Act in 2015/16. Allocations for additional assessments for the cap, universal deferred payment agreements and social care in prisons* for the financial year ending April 2016 (the consultation closes on 9 October 2014) at www.careknowledge.com/uploadedFiles/Redbox/Pavilion_Content/Our_Content/Social_Care_and_Health/webw_attach_for_CK_only/2014/201407/Consultation_document.pdf accessed 11th August 2014

¹⁴⁵ *R v. North and East Devon health authority ex p Coughlan* [2000] 2 WLR 622; [2000] 3 All ER 850.

¹⁴⁶ Public Act Committee Report 16 January 2014 (page 205/208).

¹⁴⁷ See L. Clements [NHS Continuing Healthcare: the draft Care Act 2014 regulations and guidance](http://www.lukeclements.co.uk/nhs-continuing-healthcare-the-draft-care-act-2014-regulations-and-guidance/) at www.lukeclements.co.uk/nhs-continuing-healthcare-the-draft-care-act-2014-regulations-and-guidance/

¹⁴⁸ The Care and Support (Assessment) Regulations 2014 SI 2827 accessible at

www.legislation.gov.uk/uksi/2014/2827/pdfs/uksi_20142827_en.pdf

¹⁴⁹ See [The National Health Service Commissioning Board and Clinical Commissioning Groups \(Responsibilities and Standing Rules\) Regulations 2012 SI 2996 Part 6 \(regulations 21 - 22\)](#).

reassured by this response. The guidance goes some way to allay these concerns, stating at para 11.10 that:

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.

It follows from the above, that a personal budget may include an amount attributable to support that the local authority funds as a 'discretion' (ie support that it considers is needed – but which does not meet the eligibility criteria). Since the amount that an individual pays for their care will be added (from April 2016) to their 'Dilnot taxi meter' – towards their 'cap on costs' – the guidance needs to make clear whether the charges for discretionary services are included for 'cap on costs' purposes. If these charges do not count – then there is an obvious temptation for local authorities to include them in the plan as a discretionary support.

The expectation is that (for non-self funders) the personal budget will change as the care and support planning process progresses. At the start of the planning process it will be an 'indicative amount' shared with the person, and anybody else involved, with 'final amount of the personal budget confirmed through this process' (para 11.7). This means there is no need for an authority to use a Resource Allocation System (RAS) to generate a figure at the commencement of the process – an authority might have (for example) a simple set of 'bands'. Research suggests that most RAS generate incorrect figures which and have serious defects – not least their complexity and the rigidity with which some local authorities then apply them.¹⁵⁰ In support of this approach the guidance advises that 'complex RAS models of allocation may not work for all client groups' (para 11.23) and that 'regardless of the process used, the most important principles in setting the personal budget are transparency, timeliness and sufficiency' (para 11.24).

The Act does not (it appears¹⁵¹) impose a duty on local authorities to provide a personal budget for carers. The guidance ignores this point and (para 11.7) states that 'Everyone whose needs are met by the local authority ... must receive a personal budget as part of the care and support plan, or support plan' and at para 11.34 suggests the pooling of budgets, for example, where an adult and a carer are living in the same household. The guidance considers, however the possible complexities that may arise when it is unclear as to whether a particular service is for a carer or for the 'adult' – para 11.38 advising that local authorities:

should consider how to align personal budgets where they are meeting the needs of both the carer and the adult needing care concurrently. Where an adult has eligible needs for care and support, and has a personal budget and care and support plan in their own right, and the carer's needs can be met, in part or in full, by the provision of care and support to that person needing care, then this kind of provision should be incorporated into the plan and personal budget of the person with care needs, as well as being detailed in a care and support plan for the carer.

Independent personal budgets

Where a local authority arranges a person's care, this will be provided through the personal budget. Where the care is arranged independently of the authority (ie by a self-funder) this will be recorded as an 'independent personal budget' which will apply from April 2016. As discussed above, the Act (section 28) provides for such budgets solely to identify the sum that the authority is required to add to the 'Dilnot taxi meter' for 'cap on costs' purposes.

¹⁵⁰ See for example Lucy Series and Luke Clements, '[Putting the Cart before the Horse: Resource Allocation Systems and Community Care](#)' *The Journal of Social Welfare Law* [2013] (2) 207-226.

¹⁵¹ The s25(1)(e) duty requires PBs for 'adults' as does s26. As noted above, the general convention in the Act is that 'adults' are distinguished from 'carers'.

Direct Payments (sections 31-33)

The new legislation provides for an almost identical 'direct payments' regime as at present and the detail (as with the current system) is to be found in the regulations¹⁵² and the guidance. There are two material changes.

The first concerns a 'softening' of the presumption against making payments to spouses / partners / relatives living in the same house as the adult. Such payments will be able to be made 'if the local authority considers it is necessary to do so'¹⁵³ – and the payment will be able to cover not only the cost of meeting the adult's need – but also for the cost of providing 'administrative and management support or services for the purpose of enabling a person to whom the direct payments are made to—

- (i) comply with legal obligations arising from the making of and use of the direct payment, or
- (ii) monitor the receipt and expenditure of the direct payment.'

The second change (expected to come into force in April 2016) is that direct payments will be available for residential care placements. 18 local authority pilots areas assessing the potential for the change are currently underway.¹⁵⁴

Continuity of care (portability) (sections 37-38)

The Act prescribes the way local authorities transfer responsibility for the care and support of an adult – when she or he moves from one local authority area to another. It does this by attempting to embed 'good practice' (ie what should happen) into legislation. The problem is that there are no sanctions if either the first or second local authority fails to act properly – and so (as now) an individual would have to make a complaint/ go to the Ombudsman if a problem occurs.¹⁵⁵

Sections 37 – 38 are replete with detailed procedural obligations – but in essence they provide that where a local authority (the 1st local authority) is providing¹⁵⁶ care and support for an adult and another authority (the 2nd authority) is notified that the adult intends to move into their area (and it is satisfied that the intention is genuine) then it must (among other things) undertake an assessment of the adult's needs (and those of any carers he or she may have). If the assessment(s) have not been completed by the time the adult actually moves, then the second authority must meet the needs identified by the 1st authority (until its assessment is complete).

Chapter 20 of the guidance fleshes out how the process should operate – but signally fails to deal with what will happen when a person moves and the second local authority fails to act properly – for example by failing to fund the person's needs to the same level as the first authority until it has completed its assessment. The guidance should have cautioned against the first authority stopping the funding in such cases – but it does not.

A problem that has yet to be resolved, concerns individuals who move to live in Wales, Scotland and Northern Ireland. Attempts are being made by the four nations to agree a

¹⁵² The Care and Support (Direct Payments) Regulations 2014.

¹⁵³ The Care and Support (Direct Payments) Regulations 2014 reg 3(2).

¹⁵⁴ See Department of Health Policy Research Unit in Policy Innovation Research *Direct Payments in Residential Care Trailblazer Programme Evaluation Preliminary report* 2014 at www.piru.ac.uk/assets/files/DP%20Trailblazer%20Preliminary%20report.pdf. The pilot sites are Enfield LBC, Havering LBC, Redbridge LBC, Surrey, Hertfordshire, Norfolk, Bristol, Cornwall, Dorset, Lincolnshire, Milton Keynes, Nottinghamshire, Staffordshire, Hull, North Lincolnshire, Gateshead, Manchester and Stockport.

¹⁵⁵ The Act adopts many of the provisions in Baroness Jane Campbell's Social Care Portability Bill 2012 – but not those that required one local authority to reimburse the other if it had failed to comply with its responsibilities during such a transfer.

¹⁵⁶ Or if the adult is a self funder and the local authority is keeping a care account for that person for the purposes of the 'cap').

protocol setting out 'Principles of Cross-Border Continuity of Care within the United Kingdom' – but these (as at January 2015) have not been concluded). The 'ordinary residence' implications for people who move across national borders are considered in the next section.

Ordinary residence (section 39 – 41)

The existing law concerning the determination of a person's 'ordinary residence' continues under the new legislation – with one major change.

The case law concerning the notion of 'ordinary residence' will remain applicable – ie that it refers to a person's 'abode in a particular place ... adopted voluntarily and for settled purposes ... whether of short or long duration'.¹⁵⁷ As with the current law there are two significant 'deeming' rules – and it is in relation to the second of these that the material change is made.

The first deeming rule (now found in section 39(5)) concerns adults in NHS accommodation: such people are deemed to be ordinarily resident in the area in which they were immediately before they entered the NHS accommodation / ambulance.

The second deeming rule concerns adults whose accommodation is arranged by a local authority in the area of another local authority. At present this is restricted to cases where a local authority arranges accommodation in a registered care home. The legislation¹⁵⁸ extends this rule to include not only care home accommodation, but also shared lives scheme¹⁵⁹ accommodation and supported living accommodation.¹⁶⁰ Local authority responsibility only attaches if the care and support 'can be met only' in the specified accommodation and the accommodation is in England (section 39(1)).

Para 19.31 of the guidance explains that:

Need should be judged to "only be able to be met" through a specified type of accommodation where the local authority has made this decision following an assessment and a care and support planning process involving the person. Decisions on how needs are to be met, made in the latter process and recorded in the care and support plan, should evidence that needs can only be met in that manner. The local authority must have assessed those needs in order to make such a decision – the "deeming" principle therefore does not apply to cases where a person arranges their own accommodation and the local authority does not meet their needs.

Responsibility will however continue even if the person moves between different specified types of accommodation in another (or more than one other) area and it will also exist where the person takes a direct payment¹⁶¹ and arranges their own care (see paras 19.32 – 19.34).

It appears inevitable that the extension of the 'ordinary residence' rule to cover shared lives schemes and supported living accommodation will result in inter-authority disputes. The Act (s40) and the regulations¹⁶² provides for an updated dispute process – in which, as at present the Department of Health will make the final determination. The process will also cover disputed ordinary residence of the purposes of Mental Health Act 1983, s117 (see below).

¹⁵⁷ See para 19.14 guidance and *Shah v London Borough of Barnet* [1983] 1 All ER 226.

¹⁵⁸ Section 39(1)(a) and The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014, reg 2.

¹⁵⁹ Defined in The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014, reg 4.

¹⁶⁰ Defined in The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014, reg 5.

¹⁶¹ ie when entitlement to a direct payment of long term accommodation comes into effect – expected April 2016 – see the analysis above concerning Care Act 2014 sections 31- 33.

¹⁶² The Care and Support (Ordinary Residence Disputes, etc.) Regulations 2014.

Ordinary residence and individuals who move across-borders.

Schedule 1 of the 2014 Act and chapter 21 of the guidance outline (in gruesome detail / complexity) how it is to be determined where an individual's ordinary residence is – when they move from one of the UK's four nations to another.

The guidance stresses the importance of authorities being 'person centered' in the way they approach such moves (para 21.7) and suggests that there will, overall be little 'financial disadvantage by making cross-border placements' and that 'all authorities are expected to co-operate fully and communicate properly' (para 21.8). It sets out a four stage process, namely:— (1) care and support planning; (2) initial liaison between "first" and "second" authority; (3) arrangements for on-going management of placement; (4) confirmation of placement. At page 375 a 'case study' example is given of an elderly person moving from England to Scotland. Everything goes smoothly in the example which makes no reference to the financial implications of such a move.

Ordinary residence drafting problems

Problems have been identified in relation to the interpretation of section 39(1). As currently drafted, a literal interpretation could create result in a significant number of inter-authority disputes: these arise from the use of the present tense ('the adult is living'); and the stipulation that the deeming rule would only apply people whose needs 'can only be met' by living in accommodation of a specified type (the question being how 'can only' should be interpreted). The [legal literacy](#) briefing (see above) on '*Ordinary residence and The Care Act 2014 B*' at para 90 indicated that amending regulations were proposed to address one (hopefully both) of these significant problems. In March 2015 amending regulations were issued which may address the first difficulty but not the second.¹⁶³

Safeguarding (sections 42 – 47))

The Act places on a statutory footing some of the safeguarding obligations that are at present, only located in the guidance (principally the 'No Secrets' guidance¹⁶⁴) – for example the duty to make enquiries / decide what action should to be taken. The new Statutory Guidance (that replaces 'No Secrets') is to be found in chapter 14 of the [Statutory Guidance](#).

Section 42 contains the duty to make enquiries if:

- an adult with care & support needs;
- is experiencing, or is at risk of abuse of neglect; and
- is unable to protect him/herself against the abuse / neglect.

The Act does not explain what is meant by 'abuse' – save to specify that it includes financial abuse which is broadly defined – eg including putting the adult 'under pressure in relation to money or other property' and/or the adult 'having money or other property misused'.

The guidance (at para 14.17) provides a much more expansive explanation of what is considered to be 'abuse', cautioning authorities against limiting 'their view of what constitutes abuse or neglect'. The following extracts give an indication of the breadth of what local authorities are required to regard as abuse / neglect:

- **Physical abuse**;
- **Domestic violence**, including psychological and emotional abuse;
- **Sexual abuse** including 'inappropriate looking or touching';

¹⁶³ [The Care and Support \(Miscellaneous Amendments\) Regulations 2015 SI 644 reg 4](#).

¹⁶⁴ Department of Health and Home Office (2000) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*.

- **Psychological abuse** including 'deprivation of contact, blaming, controlling, cyber bullying, isolation';
- **Financial or material abuse** (as above);
- **Modern slavery**;
- **Discriminatory abuse** – including forms of 'harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion';
- **Organisational abuse** – including 'neglect and poor care practice within an institution or specific care setting such as a hospital or care home' ranging from 'one off incidents to on-going ill-treatment' and 'neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation'.
- **Neglect** and acts of omission – including 'ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating'
- **Self-neglect** including 'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.

The Act provides no new powers to protect adults from abuse – merely 'process' obligations (eg to have a Safeguarding Board; to undertake investigations and to require individuals to provide information etc). The Welsh Act¹⁶⁵ provides a power of entry – to enable social services to gain access and to speak with a person suspected of being abused – and the Scottish Act¹⁶⁶ contains (in addition) a power of removal. Not only are such powers absent from the English Act, the existing National Assistance Act 1948 section 47 power to remove, is repealed. The Care Act 2014 does however retain the obligation on local authorities to protect property (section 47).

There has been some discussion about whether safeguarding is or is not a statutory function¹⁶⁷ - but this is arguably academic: social services authorities are subject to an overarching range of public law obligations and positive duties under the Human Rights Act 1998 as noted below. The failure to provide for specific statutory powers to protect adults and to identify the obligation to support people to 'stay safe' (even if this is the only need – see above) is nevertheless problematic.

Safeguarding referrals recorded by local authorities' rose 13% between 2011 and 2013 (of which 43% were substantiated) and this is thought to be either an increased awareness of abuse 'or may reflect overstretched resources and pressure within the system'.¹⁶⁸

Safeguarding is of course a difficult subject for the guidance to address – since it is at present (and will remain) 'a complex mishmash of legislation, guidance and ad hoc court interventions'¹⁶⁹. a patchwork of differing / overlapping powers and duties arising out of: vetting and barring legislation; the MCA 2005; Guidance (ie 'No Secrets'); CQC and its inspections regime; local authority commissioning responsibilities and its duty of care; the human rights obligations of public bodies and their powers to seek declaratory relief. The Act, by failing to provide new powers, fails to clarify / simplify the system. This is however all the more reason why the guidance should be assured, authoritative and clear. It is none of these: it does not 'guide' and in a number of respects it is materially defective. A number of commentators have noted that the safeguarding section is the least satisfactory: Dr Lucy

¹⁶⁵ Social Services and Well-being (Wales) Act 2014 s127.

¹⁶⁶ Adult Support and Protection (Scotland) Act 2007, ss 7, 8, 11 & 14.

¹⁶⁷ See for example Belinda Schwehr 'Why the Care Act 2014 guidance on safeguarding short-changes social workers' Community Care 21 July 2014 at www.communitycare.co.uk/2014/07/21/care-act-2014-guidance-safeguarding-short-changes-social-workers/#.U84GckAvCpo.

¹⁶⁸ House of Commons Committee of Public Accounts Adult social care in England HC 518 (Stationery Office 2014) p.8 at www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/518/518.pdf.

¹⁶⁹ *The Mental Health Trust v DD* (2015) [2015] EWCOP 4 (Cobb J) para 23.

Series suggesting that it ‘lacks legal literacy’.¹⁷⁰ The inappropriate haste with which the guidance has been compiled is perhaps more evident in this section than elsewhere – ranging from the absurd - para 14.22 states simply ‘Financial abuse is the main form of abuse by the Office of the Public Guardian both amongst adults and children at risk’ – to the incomprehensible, para 14.4 states ‘The safeguarding duties have a legal effect in relation to organisations other than the local authority on for example the NHS and the Police’.

During the debate on the Care Bill the Minister¹⁷¹ argued that there was no need for additional powers (such as a power of entry) referring to the existing power to apply to the High Court to use its inherent jurisdiction (cross refer) and evidence from the Association of Chief Police Officers, that:

the police already have sufficient powers of entry to protect people from harm. Powers of entry are provided to us under both common law and PACE and I am satisfied that these would afford us access to premises where vulnerable individuals are considered to be at risk.

In this respect the Social Care Institute for Excellence (SCIE) has issued guidance ‘Gaining access to an adult suspected to be at risk of neglect or abuse: a guide for social workers and their managers in England’¹⁷² in which it provides an overview of the powers which may be relevant to adult safeguarding situations – including under the Mental Capacity Act 2005, the Mental Health Act 1983 and the Police and Criminal Evidence Act 1984 (together with the common law including the inherent jurisdiction of the High Court and common law powers of the police to prevent or deal with a breach of the peace).

On one level, it is perhaps not surprising that this chapter of the guidance is so disappointing. The political regime is most comfortable when discussing autonomy – and is particularly queasy when discussing paternalism: the state’s duty to protect people who are ‘vulnerable’ – even the word engenders fear in those charged with the writing of policy.

Safeguarding as a route to eligibility

As noted above, there is a significant problem with the way the [Eligibility Regulations](#) fail to identify an inability on the part of the person to ‘keep safe’ as an eligible need in itself (unlike the Welsh Act¹⁷³). The reason for this omission is unclear – but it is certainly not due to an oversight since forceful submissions on this point were made during the consultation process. What is almost as troubling is the failure of the [Statutory Guidance](#) to address this question. Various sections of the guidance skirt the question without stating (what must be the legal position) ‘that if a significant safeguarding issue can be resolved by the provision of care and support – then a duty exists to ensure that provision is made available’. By way of example, para 6.54 refers to the obligation on an authority (where a person is ‘experiencing, or at risk of, abuse or neglect’) ... to ‘decide ... what action, if any, is necessary and by whom’; at para 6.56 that where ‘the actions required to protect the adult can be met by LAs, they should take appropriate action’; at para 7.25 that ‘effective safeguarding is about seeking to promote an adult’s rights as well as about protecting their physical safety and taking action to prevent the occurrence or reoccurrence of abuse or neglect; and at para 10.39 that where an enquiry ‘leads to further specific interventions being put in place to address a safeguarding issue, this may be included in the care and support plan’.

¹⁷⁰ Lucy Series *Care Act 2014: Consultation on Draft Guidance & Regulations* (2014)

<http://thesmallplaces.wordpress.com>

¹⁷¹ The Minister of State, Department of Health (Norman Lamb) House of Commons Public Bill Committee 4th February 2014 Hansard 609 – 610.

¹⁷² SCIE October 2014 at <http://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-suspected-at-risk-of-neglect-abuse/files/adult-suspected-at-risk-of-neglect-abuse.pdf?res=true>

¹⁷³ The Social Services and Well-being (Wales) Act 2014 section 32(1)(b) addresses this issue directly.

The duty on local authorities to protect ‘vulnerable adults from harm stems from the Human Rights Act 1998 and not domestic tort ‘duty of care’ law. *X & Y v Hounslow LBC* (2009)¹⁷⁴ illustrates this point. The case concerned a married couple with learning disabilities who had two children. The family was well known to the authority, as was the fact that they were exploited by local youths. The family suffered serious injuries and as a result a claim was made for compensation against Hounslow on the basis that it owed a duty of care. The Court of Appeal held that there was – in tort – no duty of care. A subsequent complaint to the European Court of Human Rights (alleging a violation of Article 3 amongst others) was however settled by the Government on payment of €57,000.¹⁷⁵

Đorđević v. Croatia (2012)¹⁷⁶ concerned the harassment by school children of an adult with learning disabilities and his mother, with whom he lived. The police and authorities were aware of this harassment – but took no effective action. The court held that for a positive obligation to arise under article 3, it had to be established that: (1) the authorities knew or ought to have known at the time of the existence of a real and immediate risk of ill-treatment of an identified individual from the criminal acts of a third party and (2) that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. Given the facts and the finding by the court that ‘no serious attempt was made to assess the true nature of the situation complained of ... the lack of any true involvement of the social services ... no counselling has been provided to the [learning disabled] applicant’ it found a violation of Article 3. The Court also found a violation of Article 8 in relation to his mother – since this Article placed a ‘positive obligation ... upon States to ensure respect for human dignity and the quality of life in certain respects and that the harassment of her son also affected her.

For a recent review of the human rights obligations on states to protect vulnerable adults see [The Mental Health Trust v DD](#) (2015).¹⁷⁷

Human Rights Protection (section 73)

The Care Act extends the current Human Rights Act 1998 protection for care home residents funded by a local authority. Section 73 provides that where care or support is arranged by a local authority, or paid for (directly or indirectly, and in whole or in part) by the authority and that care is provided by a registered care provider to an adult or a carer either in their own home or in care home – then the provider is deemed to be a public authority for the purposes of the 1998 Act.

After April 2015, therefore, the human rights protection will include individuals (ie carers or adults in need) who receive care / support from a registered care provider in their own homes or the community and will also cover ‘self-funders’ who have asked the local authority to undertake their care and support arrangements individuals (ie under section 18 – see above).

Independent advocacy (section 67)

Section 67 of the Act and the regulations place a duty on local authorities to arrange independent advocacy if the authority considers that: (1) an individual would experience ‘substantial difficulty’ in participating in (amongst other things) their assessment and / or the preparation of their care and support plan; and (2) there is no one appropriate available to support and represent the person’s wishes. As the guidance states at para 7.4:

¹⁷⁴ [2009] EWCA Civ 286.

¹⁷⁵ *X, Y & Z v. UK* Application no. 32666/10 by 5 July 2012.

¹⁷⁶ Application no. 41526/10 24th July 2012.

¹⁷⁷ [2015] EWCOP 4 (Cobb J).

Local authorities must arrange an independent advocate to facilitate the involvement of a person in their assessment, in the preparation of their care and support plan and in the review of their care plan, as well as in safeguarding enquiries and SARs [Safeguarding Adults Reviews] if two conditions are met. That if an independent advocate were not provided then the person would have substantial difficulty in being fully involved in these processes and second, there is no appropriate individual available to support and represent the person's wishes who is not paid or professionally engaged in providing care or treatment to the person or their carer. 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 and other organisations as required for the safeguarding enquiry or SAR.

The guidance explains that a person experiences 'substantial difficulty' when this exists in relation to any one of four areas - namely (para by 6.33):

understanding the information provided; retaining the information; using or weighing up the information as part of the process of being involved; and communicating the person's views, wishes or feelings. Where a person has substantial difficulty in any of these four areas, then they need assistance.

If there is a significant difficulty in relation to any of these four areas, then the local authority 'must find someone appropriate and independent to support and represent the person, for the purpose of facilitating their involvement' (para 6.34). Not infrequently this role will be fulfilled by a family member or friend (para 7.18) but if there is no one appropriate, then the local authority must arrange for an independent advocate.

Section 67(3) specifies that the duty applies in relation to any of the following:

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

The Care and Support (Independent Advocacy Support) Regulations 2014 detail (among other things) the competency requirements for independent advocates – requiring (a) appropriate experience; (b) having undertaken appropriate training; (c) being competent to represent and support the individual; (d) integrity and good character; and (e) arrangements to be in place for appropriate supervision.

The Government has allocated £14.5m in 2014-15 for this service and is advising local authorities to 'map out which staff need to refer people to them and ensure they are trained to know who to refer and how to refer' and not to commission too small a service or 'one that is poor quality'.¹⁷⁸ The Social Care Institute for Excellence (SCIE) has issued a 'resource guide' to help commissioning officers in local authorities 'think through their new duties and understand what they are required to do to comply with the new requirements of the Act'.¹⁷⁹

Dr Lucy Series, in commenting favourably on the advocacy provisions and the draft guidance suggests that what is being required goes beyond advocacy and encompasses a duty of 'support and the duty to involve'.¹⁸⁰ Her paper also highlights the overlap between Care Act 2014 duty and the more limited obligation under the Mental Capacity Act 2005 to appoint an Independent Mental Capacity Advocate (IMCA). In her opinion there are at least 6 reasons why the Care Act advocate will be 'far superior' to the IMCA – one being that

¹⁷⁸ Lucy Bonnerjea *Advocacy and the Care Act* PowerPoint (Department of Health 2014).

¹⁷⁹ See SCIE Guidance on the Care Act 2014 (issued October 2014) Commissioning independent advocacy www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/.

¹⁸⁰ Lucy Series *Care Act 2014: Consultation on Draft Guidance & Regulations* (2014) <http://thesmallplaces.wordpress.com>.

advocates under the 2014 Act will be better paid – being allocated 17 hours per referral compared with the 8 hours allocated to IMCA's.

Prisoners (section 76)

Section 76 of the Act provides welcome clarification as to local responsibilities for prisoners who have care and support needs and provides that the responsible local authority for 'ordinary residence' purposes is the one in which the prison is located (section 76(1)). However on release the prisoner will be presumed to be ordinarily resident in the area that he or she was resident immediately before the start of their sentence (para 17.47).¹⁸¹ This is a presumption that appears to be easily rebutted, since para 17.49 suggests that on release a prisoner's 'ordinary residence will generally be in the authority where they intend to live on a permanent basis'.

The Act starts from the principle that all 'adults in custody, as well as offenders and defendants in the community, should expect the same level of care and support as the rest of the population' (para 17.9). It however provides a list of Care Act entitlements that will not be available to prisoners – for example the right to direct payments and to choice of accommodation. Provisions such as the right to continuity of care do however apply (see guidance para 17.48) as does the duty to 'involve' the person in need in all aspects of the assessment and care planning process (para 7.7). Where a local authority is made aware that an adult in a custodial setting may have care and support needs, then, as the guidance para 17.24 states 'they must carry out an assessment as they would for someone in the community'.

The Government have allocated £11.2m in 2014-15 for the additional costs associated with the clarification of the duty to prisoners.¹⁸²

New statutory appeals process (section 72)

At a fairly late stage in the Bill process the Government introduced an amendment to provide for a new social care appeals system. It is not entirely clear why this was done – but it may be to enable the Government to react to the expected increase in challenges, when significant numbers of self-funders are catered for in the system. The Act merely provides for regulatory powers to flesh out what this system might look like. The Government statement announcing the new process explained that it would be:¹⁸³

1. be a flexible, local, proportionate system avoiding unnecessary bureaucracy;
2. include an element of independence from the local authority;
3. seek to avoid duplication with existing arrangements for complaints and redress .

In February the Department of Health issued a consultation proposals for the new system¹⁸⁴ which it intends to implement in April 2016. The proposals seek to narrow considerably the issues on which complaints can be made; have as the 'independent element 'reviewers' (appointed by the local authority) who it appears will not routinely meet the complainant –

¹⁸¹ Para 17.47 also advises that the deeming provisions in section 39 of the Care Act 2014 do not apply to people who are leaving prison

¹⁸² Department of Health *Consultation on funding formulae for implementation of the Care Act in 2015/16. Allocations for additional assessments for the cap, universal deferred payment agreements and social care in prisons* for the financial year ending April 2016 (the consultation closes on 9 October 2014) at www.careknowledge.com/uploadedFiles/Redbox/Pavilion_Content/Our_Content/Social_Care_and_Health/webw_atch_for_CK_only/2014/201407/Consultation_document.pdf accessed 11th August 2014

¹⁸³ Minister of State (Norman Lamb) Public Bill Committee (Bill 123) 2013-2014 4th February 2014 p585 (The Stationery Office 2014)

¹⁸⁴ Department of Health *Care Act 2014: cap on care costs and appeals 2015* accessible at www.gov.uk/government/consultations/care-act-2014-cap-on-care-costs-and-appeals

and who can only make recommendations – with the final decision being made by the local authority (as at present) .

s117 Mental Health Act 1983 (section 75)

The duty on health and social care bodies to provide support services under s117 remain. This means that the assessment obligation lies outside the new care Act duty and so it has been determined that duty under section 47 NHS and Community Care Act 1990 will remain in relation to this provision.¹⁸⁵ This in turn means that the eligibility criteria (discussed above) will not apply to such assessments.

Currently ‘after-care services’ are not defined by the 1983 Act. The Care Act inserts a new subsection (5) into the 1983 Act to limit services to those:

- (a) ‘arising from or related to the mental disorder’ and
- (b) reducing the risk of a deterioration of the person’s mental condition (ie that may require re-admission).

The Act confirms that ordinary residence for the purposes of s117 is determined by where a person was based immediately before they were detained and gives the Secretary of State power to resolve ordinary residence disputes. It also inserts a new ‘s117A’ that provides for regulations¹⁸⁶ to introduce a limited ‘choice of accommodation’ for persons subject to s117¹⁸⁷ and also to confirm that people eligible for s117 support can ‘top-up’ their care and support packages.¹⁸⁸on

In relation to ordinary residence the guidance (para 19.43) confirms that the primary social care obligation rests with the authority for the area in which the person was ordinarily resident immediately before being detained. It then goes on to state:

Although any change in the patient’s ordinary residence after discharge will affect the local authority responsible for their social care services, it will not affect the local authority responsible for commissioning the patient’s section 117 after-care. ... section 117 [as amended] provides that, if a person is ordinarily resident in local authority area (A) immediately before detention under the 1983 Act, and moves on discharge to local authority area (B) and moves again to local authority area (C), local authority (A) will remain responsible for providing or commissioning their after-care. However, if the patient, having become ordinarily resident after discharge in local authority area (B) or (C), is subsequently detained in hospital for treatment again, the local authority in whose area the person was ordinarily resident immediately before their subsequent admission (local authority (B) or (C)) will be responsible for their after-care when they are discharged from hospital. (para 19.44)

¹⁸⁵ See [The Care Act 2014 and Children and Families Act 2014 \(Consequential Amendments\) Order 2015](#) accessible at www.legislation.gov.uk/ukdsi/2015/9780111128626/article/3.

¹⁸⁶ The Care and Support and After-care (Choice of Accommodation) Regulations 2014.

¹⁸⁷ See *R (Wiltshire) v Hertfordshire CC* [2014] EWCA Civ 712 19 para 20.

¹⁸⁸ See [Statutory Guidance](#) Annex A: Choice of accommodation and additional payments para 39.

Young Carers, Disabled Children, and Parent Carers

Although the primary purpose of Part 1 of the Care Act 2014 is to reform adult social care law, the Act also contains provisions relating to disabled children and carers 'in transition' into adulthood (ie young carers and the parents of disabled children who are in the transition process). These provisions are designed to mesh with reciprocal provisions in the [Children and Families Act 2014](#), and also come into force in April 2015.

The amendments to [Children and Families Act 2014](#) were made at a very late stage (and as a result of a vigorous campaign by a number of disabled children's and carers' activists / organisations). In early 2015 it emerged that the rights of one group were 'missed' and this is considered below (under the 'grandparent carers').

In March 2014 regulations were approved, concerning the assessment of young carers (see below).¹⁸⁹ However at the time of writing (12th March 2015) the Department has yet to publish its draft guidance to the carer related provisions in the [Children and Families Act 2014](#). The Department also proposes to provide advice concerning the obligations to disabled children and to young carers / parent carers in an updated version of [Working together to safeguard children](#) (2013).¹⁹⁰

Transition into adulthood responsibilities

The Care Act contains the detail of the legal obligations of authorities for supporting carers and disabled children whose care and support needs will transfer to the adult social services. The Act has a formulaic approach to the duty – essentially that if it appears to an authority that (1) it is 'likely' that [a disabled child and/or the child's carer / a young carer] will have care & support needs after transition; and (2) it will be of 'significant benefit' to be assessed – then the authority must assess or give reasons if it refuses to assess.

Chapter 16 of the [Statutory Guidance](#) to the Care Act provides considerable detail on the way authorities should approach their duties in relation to disabled children; the parents of disabled children and young carers.

Disabled children in transition (sections 58 – 59 Care Act 2014)

The Care Act 2014 provisions relating to disabled children (as well as those concerning carers 'in transition' to adulthood) are overly complicated – as the Act contains considerable detail on the issue of consent / capacity to consent and what must be included in the assessment.¹⁹¹ Put simply however the general formula (above) applies - namely: a local authority must undertake a needs assessment of a disabled child if it considers that the child is likely to have needs for care and support after becoming 18 and that the assessment would be of '*significant benefit*' to the child. Such an assessment is referred to as a 'child's needs assessment'. If a local authority decides not to undertake such an assessment it must give reasons for its refusal. Para 1.25 of the [Statutory Guidance](#) to the Care Act is however helpful in advising that 'control' not only encompasses the idea of moving from one area to another – but also 'from children's services to the adult system without fear of suddenly losing care and support'.

The right to a Care Act 2014 transition assessment is triggered when the local authority consider that it would be of significant benefit for the young carer / disabled child or the

¹⁸⁹ It is understood that the Department does not intend to use its regulatory powers (in s17ZE(4) & (5) Children Act 1989 concerning the rights of the parents of disabled children.

¹⁹⁰ See Department for Education *Revisions to Working Together to Safeguard Children* January 2015 Appendix A page 13 at www.gov.uk/government/consultations/working-together-to-safeguard-children-revisions

¹⁹¹ Important as these issues are – it is a level of detail one would have expected to find in the regulations rather than the primary statute.

parent carer of a disabled child and that the young person or carer is 'likely to have needs' – neither of which terms are defined in the legislation.

Likely need

Para 16.9 advises that a young person or carer is 'likely to have needs' if they have 'any likely appearance of any need for care and support as an adult':

not just those needs that will be deemed eligible under the adult statute. It is highly likely that young people and carers who are in receipt of children's services would be 'likely to have needs' in this context, and local authorities should therefore carry out a transition assessment for those who are receiving children's services as they approach adulthood, so that they have information about what to expect when they become an adult.

Significant benefit

The guidance (para 16.6) advises that it will generally be of 'significant benefit' to assess 'at the point when their needs for care and support as an adult can be predicted reasonably confidently, but will also depend on a range of other factors'. In relation to young people with special educational needs (SEN) who have an Education, Health and Care (EHC) plan the guidance is unequivocal in stating that the transition assessment process should begin from year 9¹⁹² (para 16.11), adding that even 'for those without EHC plans, early conversations with local authorities about preparation for adulthood are beneficial' (para 16.12).

Para 16.7 gives further guidance as to the point at which the young persons' needs for care and support (as an adult) can be predicted reasonably confidently, stating:

Transition assessments should take place at the right time for the young person or carer and at a point when the local authority can be reasonably confident about what the young person's or carer's needs for care or support will look like after the young person in question turns 18. There is no set age when young people reach this point; every young person and their family are different, and as such, transition assessments should take place when it is most appropriate for them.

Para 16.10 states that the considering 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'. It then provides an illustrative list of factors that should be considered when trying to establish the right time to assess - namely:

- The stage they have reached at school and any upcoming exams;
- Whether the young person or carer wishes to enter further/higher education or training;
- Whether the young person or carer wishes to get a job when they become a young adult;
- Whether the young person is planning to move out of their parental home into their own accommodation;
- Whether the young person will have care leaver status when they become 18;
- Whether the carer of a young person wishes to remain in or return to 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.

An informative case study is provided in the guidance (para 16.15) concerning the timing of a transition assessment. It concerns a 15 year old disabled child who attends an education

¹⁹² Department of Health *SEN Code of Practice Preparing for Adulthood* (2014) para 88.11.

funded residential school and who also receives a funding package from social services – both at the school and on the weekends / holidays with her parents. The parents request a transition assessment on her 16th birthday. After a discussion with the family the local authority realises that when the young person leaves school at 19 ‘it will not be appropriate for her to live with her parents and she will require substantial supported living support and a college placement’. The local authority then appreciates that this will necessitate ‘a lengthy transition in order to get used to new staff, a new environment and a new educational setting’ not least because the ‘college has also indicated that that they will need up to a year to plan for her start’. On this basis the local authority concludes that it would be of ‘significant benefit’ for the transition assessment to take place .

Parent carers in transition (sections 60 -62 Care Act 2014)

In very similar terms (to the rights of a disabled child to a transition assessment), sections 60 – 62 of the Act places obligations on local authorities to assess the disabled child’s adult carers (referred to as a ‘child’s carer’) during this transition process. In simple terms¹⁹³ the Act provides that a local authority must undertake a needs assessment of the carer of a disabled child if it considers that the carer is likely to have needs for support after the child becomes 18 and that the assessment would be of significant benefit to the carer. Such an assessment is referred to as a ‘child’s carer’s assessment’. If a local authority decides not to undertake such an assessment it must give reasons for its refusal. See discussion above as to how ‘significant benefit’ and ‘likely to have needs’ should be construed.

A child’s carer is defined as ‘an adult an adult (including one who is a parent of the child) who provides or intends to provide care for the child’ (section 61(7)) but is not paid to provide the care or a formal volunteer (section 61(8)).

Young carers in transition (sections 63 – 64 Care Act 2014)

Prior to the enactment of the Care Act 2014 and the Children and Families Act 2014, ‘young carer’ was not a term that appeared in any legislation. For a local authority to have an obligation to a young carer (ie someone aged under 18 who provided care on an unpaid basis for another person), she or he has to be labelled a ‘child in need’ – for the purposes of Children Act 1989, section 17. This has now changed, as both Acts address the needs of ‘young carers’ directly.

The Care Act 2014, sections 63 – 64 concern young carers ‘in transition’. The Act (in simple terms¹⁹⁴) requires a local authority to undertake a needs assessment of a young carer if it considers that she/ he is likely to have needs for support after becoming 18 and that the assessment would be of significant benefit to him / her. Such an assessment is referred to as a ‘young carer’s assessment’. If a local authority decides not to undertake such an assessment it must give reasons for its refusal. . See discussion above as to how ‘significant benefit’ and ‘likely to have needs’ should be construed.

A young carer is defined as ‘a person under 18 who provides or intends to provide care for an adult (section 63(6)) but is not paid to provide the care or a formal volunteer (section 63(7)).

¹⁹³ The Act, again, contains overly complicated provisions on the issue of consent / capacity to consent and what must be included in the assessment – see footnote above.

¹⁹⁴ The Act contains overly complicated provisions on the issue of consent / capacity to consent and what must be included in the assessment – see footnote above.

Disabled children; parent carers and young carers not in transition

Parent carers in general

The Children & Families Act 2014, section 97 amends the Children Act 1989¹⁹⁵ to oblige local authorities to assess parent carers (referred to in the Care Act 2014 as ‘child’s carers’ – sections 60 – 62 above) on the ‘appearance of need’ – ie if it appears to a local authority that a parent carer may have needs for support (or is requested by the parent) then it must assess whether that parent has needs for support and, if so, what those needs are. Such an assessment must include an assessment of whether it is appropriate for the parent to provide, or continue to provide, care for the disabled child, in the light of the parent’s needs for support, other needs and wishes.

A ‘parent carer is defined as an adult ‘who provides or intends to provide care for a disabled child for whom the person has parental responsibility’.¹⁹⁶ As will be seen below (the ‘grandparent problem’) this is a definition that is now seen to be too restrictive.

The assessment must include ‘an assessment of whether it is appropriate for the parent carer to provide, or continue to provide, care for the disabled child, in the light of the parent carer’s needs for support, other needs and wishes’¹⁹⁷ and must also have regard to:¹⁹⁸

- the well-being of the parent carer (‘well-being’ has the same meaning as the Care Act 2014 section 1¹⁹⁹), and
- the need to safeguard / promote the welfare of the disabled child and any other child for whom the parent carer has parental responsibility.

The requirement to consider ‘well-being’ brings with it the duty of the authority to consider (among other things) the parent carers’ (a) personal dignity; (b) physical and mental health and emotional well-being; (c) protection from abuse and neglect; (d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided); (e) participation in work, education, training or recreation; (f) social and economic well-being; (g) domestic, family and personal relationships; (h) suitability of living accommodation; (i) the individual’s contribution to society.

This obligation replicates but considerably broadens the pre-Care Act duty under the Carers (Equal Opportunities) Act 2004. The duty in the 2004 Act, section 2 was to consider whether the carer: (i) works or wishes to work; or (ii) is undertaking, or wishes to undertake, education, training or any leisure activity. This restatement of the pre-Care Act law means that previous case law and ombudsman’s reports will remain relevant. A key ombudsman’s report²⁰⁰ in this context concerned a parent who sought direct payments to enable him to purchase respite care so that he could pursue his University’s studies. In the Ombudsman’s opinion there was an obligation on the local authority to ensure that the parent was not ‘disadvantaged in pursuit of education/training any more than other parents’.

Carers’ employment rights also benefit from the protection provided by the Equality Act 2010.

Having undertaken such an assessment the local authority must then decide whether the parent has needs for support; whether the disabled child for has needs for support; and if so

¹⁹⁵ By adding s section 17ZD and section 17ZE.

¹⁹⁶ Children Act 1989, section 17ZD(2).

¹⁹⁷ Children Act 1989, section 17ZD(9).

¹⁹⁸ Children Act 1989, section 17ZD(10).

¹⁹⁹ Children Act 1989, section 17ZD(11).

²⁰⁰ Public Service Ombudsman (Wales) Complaint No. B2004/0707/S/370 against Swansea City Council 22 February 2007 see in particular paras 78, 133 &137.

whether those needs could be satisfied (wholly or partly) by services under Children Act 1989, section 17. The parent must be given a written copy of the assessment (s17ZD(13)).

There is in addition a strategic duty on the local authorities to take reasonable steps to identify the extent to which there are parent carers within their area who have needs for support.

The 'grandparent' problem

The Government's 11th hour amendments to the Children and Families Act 2014 appeared to have resolved the problems caused by the failure in the Care Act 2014 to address the needs those caring for disabled children. Unfortunately on analysis this has not been fully effective. The amendments secure the position of parent carers²⁰¹ - but adults who care for a disabled child – but who do not have parental responsibility²⁰² for that child have no rights to a carer's assessment or support under either of the 2014 Acts. A grandparent providing care for a disabled child would come into this category – but so too would some unmarried father's, some step parents, as well as all adult siblings, relatives, friends providing care.

The problem caused by the definition of a parent carer as one who has parental responsibility' for the child would appear to have been unforeseen, and one that requires urgent attention. The omission of other carers was clearly unintended – not least because the [Statutory Guidance](#) to the Care Act highlights the importance of support for people such as grandparents who are providing care²⁰³ - but of course this provision (in the Care Act) is predicated on them also caring for an adult.

The problem has been resolved in the short term by not repealing the relevant sections of the Carers (Recognition and Services) Act 1995 that provide for the assessment of (non-parental) carers of disabled children.²⁰⁴ This is however only a short-term 'patch'. The 1995 Act creates a higher assessment threshold for carers than does the Children & Families Act 2014, section 97 (ie the 'regular / substantial care' requirement and the obligation on the carer to request an assessment). In the medium term there appears no option other than that the definition of a 'parent carer' be amended, so that it is not an exclusive right of those with parental responsibility.

Young carers in general (section 96 Children & Families Act 2014)

The Children & Families Act 2014, section 96 amends the Children Act 1989²⁰⁵ to address the needs of young carers. This creates detailed obligations (fleshed out in regulations) including a duty to assess a 'on the appearance of need' (ie without a 'request' having to be made (section 17ZA (1)) and a strategic duty on the local authorities to take reasonable steps to identify the extent to which there are young carers within their area who have needs for support (section 17ZA (12)). The provisions will come into force in April 2015 to coincide with Care Act implementation. It is expected that where eligible needs are identified in relation to young carers, local authorities will have to either provide support under section 17

²⁰¹ Children & Families Act 2014, section 97 which amends the Children Act 1989, inserting section 17ZD – subsection (2) of which defines a parent carer as an 'adult who provides or intends to provide care for a disabled child for whom the person has parental responsibility' Children Act 1989, section 17ZD(2).

²⁰² Parental responsibility (PR) is a legal status governed by the Children Act 1989 section 3(1). All mothers and most fathers have legal PR. For an overview of the law concerning PR see Manjit Gheera *Parental responsibility* House of Commons Library Briefing Note 8 September 2014 at www.parliament.uk/briefing-papers/SN02827.pdf. *Some unmarried fathers of children lack parental responsibility – in the absence of an agreement or court order and this is also the case for some step parents.*

²⁰³ See for example, Department of Health [Care and Support Statutory Guidance](#) para 6.128 (DH 2014)

²⁰⁴ See [The Care Act 2014 and Children and Families Act 2014 \(Consequential Amendments\) Order 2015](#) accessible at www.legislation.gov.uk/ukdsi/2015/9780111128626/article/3.

²⁰⁵ By inserting a new section 17ZA.

CA 1989 to the young carer or demonstrate that the ‘cared for person’s’ assessment has provided adequate care and support to prevent inappropriate care being required from the young carer.

The [Young Carers’ \(Needs Assessments\) \(England\) Regulations 2015](#)²⁰⁶ SI 527 ‘enable a “whole family approach” to providing assessment and support.’ The Consultation document accompanying the draft Regulations stated that the Department of Health will ‘shortly’ be publishing best practice guidance on ‘Whole Family Approaches’ to assessment – and it explains that a “whole family approach” (defined in draft regulation 2) is:

an assessment that takes into account and evaluates how the needs of the person being cared for impact on the needs of the child who is identified as a possible young carer, or on any other child or on other members of the household. This approach also allows the local authority to combine a young carer’s needs assessment with any other assessment in relation to the young carer, the person cared for or another member of the young carer’s family.

Regulation 2 requires that local authorities undertake ‘young carer’s needs assessments’ in a manner ‘which is appropriate and proportionate to the needs and circumstances of the young carer’ and that in doing so they must have particular regard to—

- (a) the young carer’s age, understanding and family circumstances;
- (b) the wishes, feelings and preferences of the young carer;
- (c) any differences of opinion between the young carer, the young carer’s parents and the person cared for, with respect to the care which the young carer provides (or intends to provide); and
- (d) the outcomes the young carer seeks from the assessment.

As with assessments under the Care Act, authorities are required to provide relevant parties²⁰⁷ with information ‘about the manner and form of the assessment’ to enable their effective participation.

Regulation 3 requires that those undertaking the assessment must have sufficient knowledge and skill (having regard amongst other things to the young carer’s age, sex and understanding), and be appropriately trained. Where necessary the authority is required to consult third parties with ‘expertise and knowledge in relation to the young carer’ and consider any other relevant assessments that have been carried out.

Regulation 4 details what must be determined by the assessment – including

- (a) the amount, nature and type of care which the young carer provides / intends to provide;
- (b) the extent to which this care is (or will be) relied upon by the family, including the wider family, to maintain the well-being of the person cared for;
- (c) whether the care which the young carer provides (or intends to provide) impacts on the young carer’s well-being, education and development;
- (d) whether any of the tasks which the young carer is performing (or intends to perform) when providing care are excessive or inappropriate for the young carer to perform having regard to all the circumstances, and in particular the carer’s age, sex, wishes and feelings;
- (e) whether any of the young carer’s needs for support could be prevented by providing services to—
 - (i) the person cared for, or
 - (ii) another member of the young carer’s family;
- (f) what the young carer’s needs for support would be likely to be if the carer were relieved of part or all of the tasks the young carer performs (or intends to perform) when providing care;
- (g) whether any other assessment of the needs for support of the young carer or the person cared for has been carried out;
- (h) whether the young carer is a child in need;
- (i) any actions to be taken as a result of the assessment; and
- (j) the arrangements for a future review.

²⁰⁶ Accessible at www.legislation.gov.uk/uksi/2015/527/contents/made

²⁰⁷ Regulation 2(4) specifies that these are (a) the young carer; (b) the person cared for; (c) the young carer’s parents; and (d) any other person whom the young carer or a parent of the young carer requests should participate in the assessment.

Continuity of support for disabled children / young carers in transition (section 66)

The Care Act 2014, section 66 creates a complex set of provisions,²⁰⁸ the effect of which is (in essence) that the assessments of disabled children / young carers that take place before the young people become 18, will either continue to apply when they become 18 until reviewed²⁰⁹ or if the local authority do not treat the assessments as a continuing obligation – then they must reassess.

Disabled young people / young carers not receiving children's services

The guidance to the Care Act highlights the importance of local authorities being proactive in relation to transition assessments: particularly in relation to disabled young people and young carers who are not already receiving children's services. An approach suggested by the guidance is for authorities should consider how to 'establish mechanisms in partnership with local educational institutions, health services and other agencies' (para 16.19) and gives as examples of those who might be targeted, including (para 16.18):

- young people (for example with autism) whose needs have been largely met by their educational institution, but who once they leave, will require their needs to be met in some other way;
- young people and young carers receiving Children and Adolescent Mental Health Services (CAMHS) may also require care and support as adults even if they did not receive children's services from the local authority.

Transition planning should consider, not only the sustaining of the care and support needs of disabled young people and carers – but also 'how carers', young carers' and other family members' needs might change' – the example given being (para 16.20):

... some carers of disabled children are able to remain in employment with minimal support while the child has been in school. However, once the young person leaves education, it may be the case that the carer's needs for support increase, and additional support and planning is required from the local authority to allow the carer to stay in employment.

In this context, the guidance (para 16.21) requires social services to be aware of the SEN code of practice relating to the transition arrangements for disabled young people and the importance of them gaining access to full-time programmes. It notes however that such an option may not be suitable or available for all young people and advises that in addition the authority should consider 'other provision and support ... such as volunteering, community participation or training'.

²⁰⁸ These are delivered by inserting in the CA 1989 new sections (s17ZB and s17ZC) and also by amending the Chronically Sick and Disabled Persons Act 1970 by adding a new s2A.

²⁰⁹ ie be treated as a 'needs assessment under s60 Care Act 2014'.