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 macro/strategic challenges that authorities will face in relation to such obligations as 'integration' (with the NHS where possible) and 'managing market failure' (ie when one of its major providers goes out of business).

The revised Statutory Guidance[2] to the Care Act is available on-line and it has been revised on a number of occasions since the first issue in October 2014. The Department of Health, issuing the first revision (in March 2016) explained that the changes were designed to improve accuracy and/or clarity – although 'some are more substantial, such as those around safeguarding and the previously announced postponement to the funding reforms.'

Of significant concern, however, is the fact that the revised Statutory Guidance is not available as a hard copy or in PDF format. A LGA statement note states that the 'new format … is intended to be read online and has improved navigation and search functionality'. It adds that 'if a chapter is updated a note will appear under the chapter title indicating when it was last updated'. Given that the revised Statutory Guidance has something approaching the force of law – it is troubling that no official hard copy will exist and seriously troubling that the intention is that it will be subject to *ad hoc* changes. This casual approach to statutory formalities (not to say the 'Rule of Law') should be reconsidered. It certainly adds weight to the recommendations of the Law Commission and the Select Committee[3]' that the Act be the subject of a Parliamentary Code of Practice (rather than departmental guidance).

There have been a series of subsequent amendments to the guidance (most recently December 2016 amendments to the ordinary residence section). The Department of Health has provides an updated cumulative summary of the changes.[4]

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[2] The current version of the guidance can be accessed at www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance and this includes and *Update on final Orders under the Care Act 2014*

[3] Joint Committee on the Draft Care and Support Bill, 'Draft Care and Support Bill' Stationery Office (2013) HL Paper 143 HC 822 para 61 - 66.

[4] Department of Health *List of changes made to the Care At guidance*.

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Overview

The Care Act 2014 repeals most of the principal adult social care statutes[5] (as they apply in England[6]) – 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 47 and the Carers (Recognition & Services) Act 1995, section 1.

A key statute that has been amended but not repealed is the Local Authority Social Services Act 1970. Accordingly local authority social services functions continue to be defined by reference to the list of provisions in Schedule 1 (which now includes the Care Act 2014, Part 1[7]). Additionally the duty under section 6 on local authorities to appoint a director of adult social services is retained and equally importantly (under section 6(6)) the duty to 'secure the provision of adequate staff for assisting him in the exercise of his functions'.

A major problem with the 2014 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 had 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 has been 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 have been made by the Care Act 2014.

2016 guidance and regulations

There is much in the revised 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 1993[8] proved to be highly influential in shaping that system.

The Care and Support Regulations that accompany the Act detail specific obligations relating to market oversight / business failure (3 sets of regulations); the assessment of

[5] A list of the legislation it was proposed 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

[6] 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/.

[7] But excluding section 78 – see The Care Act 2014 and Children and Families Act 2014 (Consequential Amendments) Order 2015 SI 914 Schedule 1 para.18(8).

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

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.

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 2015 Eligibility Regulations however stipulate that this is an adult who has 'a physical or mental impairment or illness'.[9] These terms are not defined, although the revised Statutory Guidance advises (para 6.102) 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 legislation[10]). Accordingly it covers not only those whose illness is caused by the misuse of drugs or alcohol[11] but also those with 'any disorder or disability of the mind'.[12] 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 revised Statutory Guidance advises (para 6.102) that authorities 'should base their judgment on the assessment of the adult and a formal diagnosis of the condition should not be required'.

Carer

A carer is someone 18 or over[13] 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 – although – just to cause confusion – it is clear that on other occasions that the use of the word 'adult' also includes a carer (eg in relation to direct payments, s31 – see below).

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 revised Statutory Guidance (para 1.2) 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 wellbeing 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. It will be

[9] The Care and Support (Eligibility Criteria) Regulations 2015 SI 313 reg 2.
[10] 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.
[11] See Schedule 20 NHS Act 2006 and the relevant Directions specific to drug and alcohol misuers, continued in Department of Health Circular LAC (93) 10 para 3(3)(g).
[12] ie, within the ambit of section 1 Mental Health Act 1983.
[13] The Act has provisions for 'young carers' (ss63-64) – ie people who are under 18 – but these provisions use the term ''young carers''.

maladministration[14] for a local authority to impose 'restrictive interpretations of Care Act outcomes' that fail to take proper account of an adult's well-being.

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: Dr 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',[15] considers that is has the potential to be used as 'tool of regressive employment reform':[16] in many respects the inclusion of 'control' can be seen as a further manifestation of the 'responsibilization' agenda.[17] 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 (under section 1(3)) '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.

Although wellbeing is expressed as relating to such a widely range of considerations, there is a risk that it may prove to be of little practical application. There are however a few 'principles' that are likely to be much asserted.

1. The first is the section 1(3)(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 revised Statutory Guidance indicates that this 'principle' should be given an expansive interpretation – for example at para 6.35, that inherent with this principle is the wider assumption that individuals must also be 'best placed to understand the impact of their condition(s) on their outcomes and wellbeing'.
2. The second is the section 1(2)(e) identification of the importance of 'participation in work, education, training or recreation' which is of especial relevance for carers; and
3. The third concerns the right to 'independent living' (which although absent from the Act[18]) is expressed with force in the revised Statutory Guidance, stating at para 1.19:

[14] Complaint 15 011 661 against London Borough of Hammersmith & Fulham 21 July 2016 para 25.
[15] Law Commission Adult Social Care Law Com No 326, Stationery Office HC 941 para 4.25
[16] Lydia Hayes 'Care and control: are the National Minimum Wage entitlements of homecare workers at risk under the Care Act 2014?' in Industrial Law Journal (2015) 44 (4), pp. 492-521..
[17] Ferguson I (2007) *Increasing User Choice or Privatizing Risk? The Antinomies of Personalization,* British Journal of Social Work; vol 37: 387 – 403.
[18] See T Collingbourne 'The Care Act 2014: a missed opportunity?' in Web JCLI (2014) 20(3) at http://webjcli.org/article/view/365/464

> 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.

This affirmation is repeated at para 23.28 where it is asserted that:

> The concept of 'independent living' is a core part of the wellbeing principle, and is detailed in the requirement to consider the person's control over their day-to-day life, the suitability of their living accommodation and their contribution to society.

Such express statements are of considerable value – not least because the courts and Ombudsmen have shown a surprising willingness to have regard to the Convention[19] including the 2015 Supreme Court judgment in *Mathieson v Sec State Work & Pensions*.[20]

Well-being is defined as including being protected from 'abuse and neglect' (s1(2)(c)) and the revised Statutory 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 are 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'.[21] 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 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'. The ADASS Budget Survey 2015 noted that

[19] 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.
[20] *Mathieson v Sec State Work & Pensions* [2015] UKSC 47.
[21] 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.

spending on preventative services fell between 2014 and 2105 by 6% and its 2016 Survey found that spending on preventative services had fallen by a further 4%.

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.[22] 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.[23]

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 revised Statutory 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 2.23); 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 2.31).

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.[24] The English scheme does not appear to 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 2.53).

The revised Statutory Guidance (para 2.50) 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'. The research evidence suggests that funding carer support services is in general a highly cost effective preventative investment – that for every £1.00 invested in carers, there is a potential equivalent reduction in local authority cost of £5.90[25] and with significantly greater social returns (ie when a 'Social

[22] 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'.
[23] 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.
[24] For a discussion of this danger – see Luke Clements '*Welsh social care law risks taking us back 20 years by providing bare minimum*' Community Care 2014
[25] Department of Health (and others) Economic Case for Local Investment in Carer Support (2015) at http://www.local.gov.uk/documents/10180/5756320/The+Economic+Case+for+Investment+in+Carers/a39c3526-c8a4-4a18-9aa4-b5d8061df8a2

Return on Investment' methodology considers a range of associated factors such as future tax receipts from carers enabled to return to work).[26]

Charging and preventative services

The pre-Care Act requirement that intermediate care and reablement must be provided without charge is retained in the new regime.[27] While this continues to be a time-limited service, the revised Statutory 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 2.62).

Where a local authority decides to charge for preventative services the revised Statutory Guidance advices 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 2.55 – 2.57).

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 the 'Better Care Fund'.[28] The underpinning legal mechanisms for this fund are complex – essentially CA 2014 s121 amended the NHSA 2006 s223B to enable the Secretary of State to attach strings to payments made to the NHS England – 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.

Since its inception doubts have been expressed about the true level of 'new' resources that the Government has provided the fund and about its strategic viability. In 2014 the Public Accounts Committee expressed concern about Government departments' understanding of the pressures on the adult social care system and that the impact on this of the Better Care Fund.[29] The Committee's report confirmed doubts as to whether the NHS was able to make the anticipated transfers to social services and the general scepticism about the success of

[26] Baker Tilly (June 2011), Social Return on Investment in support for carers, The Princess Royal Trust for Carers (now The Carers Trust) - which found that a £5 million investment in carer support services produced approximately £73 million of value to society.
[27] 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 2.60 of the revised Statutory Guidance.
[28] For technical detail about the fund see NHS England 'Better Care Fund Planning' (2016) and Department of Health 'Better Care Fund: how it will work in 2016 to 2017' and for general requirements for NHS / social services transfers see The National Health Service (Conditions Relating to Payments in connection with property by NHS Bodies to Local Authorities and other bodies) Directions 2016.
[29] House of Commons Committee of Public Accounts Adult social care in England HC 518 (The Stationery Office 2014) p.6.

such 'integrations'.[30] Further criticism concerning the quality planning for the Better Care Fund followed in November 2014 from the National Audit Office[31] and in 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'.[32] Local authority perception of the fund appears to be 'predominantly negative': that at the local level plans were being 'dictated' by CCGs 'without much space for collaboration'[33] and generally it appears that the integration proposals have made 'little progress'.[34]

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.[35] '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.

In 2016 the Department of Health announced that for the financial year 2016-17,[36] the Better Care Fund will be a minimum of £3.9 billion. Locally agreed plans must be signed off by NHS England and must meet four key conditions:

- The project funding is made from pooled funds via a s75 NHS Act 2006 agreement;
- The agreement must be approved by the Health and Wellbeing Boards and signed-off by the relevant local authority and CCG(s);
- A proportion of the Better Care Fund allocation must be spent on NHS 'commissioned out of hospital services, which may include a wide range of services including social care'.
- There is a 'clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets'.[37]

Information (section 4)

Local authorities 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 was envisaged as containing a significant 'independent financial advice' component – which would have advised 'self-funders' on the (now delayed) choices they had under the 'cap on care cost' reforms.[38]

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 are taking place at a time when major changes are being implemented to pensions (specifically the end of the requirement to

[30] See for example, A Cameron, R Lart, L Bostock & C Coombe F*actors that promote and hinder joint and integrated working between health and social care services* Social Care Institute for Excellence Research Briefing 41 (2012) and B Hudson 'Joint commissioning: organisational revolution or misplaced enthusiasm?' (1995) 23 *Policy & Politics* p233.
[31] Department of Health, Department for Communities and Local Government and NHS England *Planning for the Better Care Fund* HC 781 Session 2014-15 11 (National Audit Office 2014).
[32] Public Accounts Committee Chair's comments: *Planning for the Better Care Fund report* 26 February 2015
[33] R Humphries et al *Social care for older people: Home truths* (Kings Fund 2016) p.69.
[34] David Williams *Little progress by 'integration pioneers'* Health Service Journal 6th May 2016
[35] See para <?> above and generally the Statutory Guidance chapter 15.
[36] Department of Health *2016/17 Better Care Fund Policy Framework* January 2016
[37] See also The Better Care Fund *Delayed Transfers of Care Signposting resource* March 2016
[38] Department of Health Care and Support Legal Reform (Part 1 of the Care Act) Impact Assessment 61067 October 2013 para 1.25.

purchase an annuity) and the choices that people make may also be directed at reducing their contributions to their care fees.[39]

The revised Statutory 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).

Duty to promote effective high quality providers (section 5)

The Act (fleshed out by regulations[40])) 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 2014 the Public Accounts Committee was of the view that the CQC (which monitors the top 40 - 50 providers) lacked 'the skills to undertake this expanded level of monitoring'.[41]

Regulations[42] provide for eleven fundamental standards[43] of safety and quality that should always be met by providers of health and social care and CQC guidance[44] 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 providers[45] 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.[46] The Select

[39] LGA and ADASS *Joint consultation response Care Act: regulations and guidance* (August 2014) at para 31.
[40] These include the Care and Support (Market Oversight Information) Regulations 2014 SI 2822; and The Care and Support (Market Oversight Criteria) Regulations 2015 SI 314 (as well as business failure regulations specific to cross-border placements).
[41] 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.
[42] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
[43] 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.
[44] CQC *Guidance for providers on meeting the regulations* 2015
[45] 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.
[46] 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.

Committee[47] 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 revised Statutory 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'[48] and may in consequence lead to further litigation in this field.[49]

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 compete on cost. The revised Statutory 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 4.47). 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 consider how to ensure that there is still a reasonable choice for people who need care and support' (para 4.39).

The revised Statutory 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 revised Statutory 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 revised Statutory 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 4.99) and that this includes an obligation 'to consider added social value when letting contracts' under the Public Services (Social Value) Act 2012[50] (para 4.105).

Workforce issues

The social care workforce has been a direct victim of local authority pressure on providers to reduce their fees. The revised Statutory Guidance stresses the importance of authorities 'encouraging a workforce which effectively 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

[47] Joint Committee on the Draft Care and Support Bill, 'Draft Care and Support Bill' Stationery Office (2013) HL Paper 143 HC 822 para 113.
[48] LGA and ADASS *Joint consultation response Care Act: regulations and guidance* (August 2014) at para 31.
[49] For example, *R (Sefton Care Association) v Sefton Council* [2011] EWHC 2676 (Admin).
[50] For guidance on the application of the Act see guidance at www.gov.uk/government/news/government-reviews-ground-breaking-social-value-act

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 Statutory 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 4.103).

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'[51] 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 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 with the pre-Care Act legislation was that there was a duty on social services to notify housing / health bodies if a health / housing need was 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'). Although the section 7 duty only applies between different authorities – it is almost certain that the courts will interpret as requiring the same degree of co-operation between departments in a unitary authority.[52] Section 7 provides 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 used[53] 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 pre-Care Act legal regime the object of a community care / carers assessment was to determine (among other things) whether there is a need for 'services'. The community care statutes[54] provided exhaustive lists of services that could be provided and the Carers and Disabled Children Act 2000 provided a generalised statement as to what a carer's 'service' might be. The Care Act repealed 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;

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[51] Clements L and Thompson, P. *Community Care & the Law* Legal Action 2011 para 13.33.
[52] See *M & A v Islington LBC* [2016] EWHC 332 (Admin) para 15 where this conclusion was reached in relation to the Children Act 1989 s.27, on which section – CA 2014 s7 is based.
[53] See for example, *R v. Northavon DC ex p. Smith* 1994 3WLR 403 HL.
[54] Primarily s2 Chronically Sick and Disabled Persons Act 1970 and ss 21 & 29 National Assistance Act 1948.

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.[55] 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 revised Statutory 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 remains (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 now rests in section 8). The guidance fails to reiterate and build on the current guidance on this question.[56]

The importance of adaptations are however central to eligibility determinations. Regulation 2(2) of the 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 revised 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 revised 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 (formerly (for adults) 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 are 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 are now able to delegate assessments (and most of their other functions) to

[55] 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.
[56] Guidance that will of course cease to apply when the Care Act 2014 comes into force.

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'.[57]

Delegation (section 79)

Local authorities are able to delegate all of their functions under the Act – with few exceptions (eg safeguarding[58] (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.[59] 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 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.[60]

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 update these to ensure they make (where necessary) specific references to the 2014 Act.

Assessment of adults in need[61] (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.

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[57] 14 January 2014 column 154 Public Bill Committee.

[58] 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.

[59] www.scie.org.uk/workforce/socialworkpractice/pilots.asp

[60] 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).

[61] 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*.

As with the previous duty (under s47 NHS and Community Care Act 1990) the Care Act duty to assess adults in need is triggered by the 'appearance of need' and arises regardless of the 'level' of those needs or the person's financial resources. The assessment must have specific regard to the well-being criteria (ie section 1(2) above) and must involve the adult and any carer. In this context 2015 'whole family' guidance[62] states that whatever assessment process is adopted:

> the question of whether there is a carer should always be asked, the assessment must include any carer, and there must be an assessment of their needs for support where it appears they have such needs. There also needs to be a check on whether there are any children in the household and if they are undertaking any caring role.

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 revised Statutory 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' requires some local authorities to rethink their approach – if based on the paradigm of there being 'primary carers'

There appears to be a welcome acceptance that the practical reality of 'supported self-assessments' does not always live up to their marketing fervour. Rhetorically they have promoted the 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 practice they have often been little more than Self Assessment Questionnaires (SAQ) being posted to individuals, which (once returned) have had their 'tick boxes' run through a Resource Allocation System (RAS): highly impersonalised and designed to reduce care costs: to 'lower expectations'. Although the revised Statutory Guidance requires individuals who are able and willing to undertake a supported self-assessment be offered one (para 6.44) it stresses that: (a) the local authority must assure itself that it 'is an accurate and complete reflection of the person's needs' (para 6.46); and (b) that regardless of what the individual may think 'the final decision regarding eligibility rests with the local authority' (para 6.53). SCIE Guidance concerning supported self assessments,[63] emphasises that they must include:

> appreciating the role of the practitioner in the supported self-assessment process: it is a supported process, based on joint working between the individual and the local authority, but ultimately it is the practitioner's responsibility to determine if the supported self-assessment is complete and accurate, drawing on their experience and knowledge of the individual.

The revised Statutory 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 always be necessary. The general (and welcome) tenor of the revised Statutory Guidance is, however, that assessors

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[62] Department of Health (and others) *The Care Act and Whole-Family Approaches* (2015) at www.local.gov.uk/documents/10180/5756320/The+Care+Act+and+whole+family+approaches/080c323f-e653-4cea-832a-90947c9dc00c page 15.

[63] Social Care Institute for Excellence (SCIE) on line guidance - The *Care Act 2014 Implications for practice - Supported self-assessment* at www.scie.org.uk/care-act-2014/assessment-and-eligibility/process-map/

must be 'appropriately trained'. Para 6.88, for example states that if an 'assessor does not have the necessary 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 revised Statutory 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 Regulations[64] 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.'[65] This important point is addressed in the revised Statutory 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)

The Act makes material changes to the pre-Care Act 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

[64] The Care and Support (Eligibility Criteria) Regulations 2015, 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'.
[65] Department of Health *Draft national minimum eligibility threshold for adult care and support A discussion document* June 2013 para 1.23.

financial risks to the reforms going live in 2015/16'.[66] 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 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'.[67] It has also suggested that it encompasses both the notion of 'caring about someone' as well as 'caring for them'.[68]

The 2014 Act does not seek to define 'care', although the revised Statutory Guidance states that it 'includes both the practical and emotional support' (para 6.18). 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 revised Statutory 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 rule was repealed in 1948[69]). 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 revised Statutory Guidance at para 2.49 that 'authorities 'should not

[66] ADASS & LGA Joint Response to the Care Act Regulations and Guidance Consultation (August 2014) para 51.
[67] 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.
[68] 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).
[69] 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.

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 reforms[70] and guidance to the Carers (Recognition & Services) Act 1995.[71]

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.[72]

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.[73] 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 6.72 of the revised Statutory 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 particularly[74] – and the explicit statutory recognition of their right to a separate assessment is of importance.[75]

The nature and setting of the assessment

The revised Statutory 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 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

[70] *Community Care in the Next Decade and Beyond* (HMSO 1990) para 3.28.
[71] 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).
[72] LGA and ADASS *Joint consultation response Care Act: regulations and guidance* (August 2014) at para 31.
[73] 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.
[74] See for example, Luke Clements *Carers and their* Rights 5th ed (Carers UK 2012) paras 10.4 – 10.6 and 11.3 – 11.4.
[75] 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.

(para 6.96).[76] 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'.[77] Section 12(3)/12(4) requires that a copy of the assessment must be given to the adult in need / carer.

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)'.[78]

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 revised Statutory Guidance).

Assessments should be 'proportionate'[79] ('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 the 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 revised Statutory 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.[80]

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 revised Statutory Guidance requires that authorities identify adults who are unable to 'engage effectively 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.

Carers' assessments - timescale

[76] The Care and Support (Assessment) Regulations 2014 reg 3(1)
[77] An almost identical to obligation to that in the Community Care Assessment Directions 2004 (Direction 2).
[78] Section 9(5) and para 6.30 of the revised Statutory Guidance.
[79] The Care and Support (Assessment) Regulations 2014 reg 3(1)
[80] 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.

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'.[81] 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 revised Statutory Guidance is brief in relation to the 2014 Act's relevance for carers of people detained under the Mental Health Act 1983. At para 6.74 (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 revised Statutory 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.[82]

Eligibility criteria (section 13)

[81] 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/ a view she reiterated in 2015 – see Report on Complaint against Cornwall Council (13 006 400) 26 February 2015 at para 7.

[82] 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)).

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 contained no reference to 'eligibility criteria': locating them instead in guidance (commonly referred to as FACS[83]). The Care Act places eligibility criteria in a statutory footing (section 13) with the detail being spelled out in the Eligibility Regulations[84] – 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 carers[85] and disabled / older people,[86] the content of national criteria is less influential than local managerial culture,[87] '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

Although the Care Act criteria have some similarities to the FACS guidance, an obvious difference is the absence of 'bands' (the 'critical', 'substantial', 'moderate' and 'low' bands in FACS). Under the Care Act 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.

Unable to achieve

Regulation 2(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.

Significant

[83] '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.*
[84] The Care and Support (Eligibility Criteria) Regulations 2015.
[85] Wendy Mitchell *How local authorities allocate resources to carers through carer personal budgets* (National Institute for Health Research 2014).
[86] 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).
[87] Colin Slasberg *Resource allocation: Leaders' Briefing* (Dartington 2015).

In this process – a key word is 'significant' and it is one that also appears in the carers eligibility criteria (see below). The revised Statutory Guidance avoids a precise definition of what 'significant' means – para 6.109 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 6.107) – 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 6.108);

SCIE Guidance suggests that in addition 'significant impact' could be a consequence of:[88]

- a single effect: this means that the inability to achieve two or more outcomes affects at least one of the areas of wellbeing in a significant way.
- a cumulative effect: this means that 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.
- 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.

A 2016 ombudsman complaint[89] concerned the reassessment of an adult with mental health difficulties who had been receiving a support package. The re-assessment found that it took her significantly longer than would generally be expected to achieve outcomes associated with work, accessing community services, maintaining hygiene, and maintaining a home environment due to her mental health conditions. Nevertheless (unlike the first assessment) it concluded that the difficulties did not significantly impact her wellbeing. In finding maladministration the ombudsman noted the absence of any explanation as to why her wellbeing was not significantly impacted by her difficulties in achieving the specified outcomes and this is maladministration. This omission was compounded by the failure to provide reasons as to why she was considered to be no longer eligible for support she had previously been assessed as needing.

Specific outcomes

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; and
(j) carrying out any caring responsibilities the adult has for a child.

[88] Social Care Institute for Excellence (SCIE) on line guidance - The *Care Act 2014: What does significant impact mean?* at www.scie.org.uk/care-act-2014/assessment-and-eligibility/process-map/
[89] Complaint no 15 001 422 against Milton Keynes Council dated 20th September 2016.

Para 6.106 of the revised Statutory 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. In the following section (analysing each of these 'outcomes') the text of the relevant outcome in the regulations is underlined and the text of the revised Statutory Guidance (para 6.106) is in italics.

managing and maintaining nutrition.

whether the adult has access to food and drink to maintain nutrition, and that the adult is able to prepare and consume the food and drink.

A 2016 ombudsman complaint[90] found it to be maladministration for a council to fail to recognise that 'fresh food is essential to meet nutritional needs' and that 'consumption of fresh food once it has started to perish carries a significant health risk' (a complaint concerning a visually impaired adult who needed help to check the contents of her fridge, read cooking instructions and on occasions to be escorted to a local shopping centre.

maintaining personal hygiene

LAs should, for example, consider the adult's ability to wash themselves and launder their clothes.

Two relevant 2016 ombudsman decisions include:

- A complaint[91] concerning an adult who was unable to manage getting in or out of her bath. The OT decided that there was no need for a level access shower as she is able to maintain her hygiene by strip washing at the sink. In finding maladministration the ombudsman referred to the DFG duty 'facilitating access by the disabled occupant to, or providing for the disabled occupant, a room in which there is a bath or shower (or both), or facilitating the use by the disabled occupant of such a facility'.
- A complaint [92] concerning an adult who had been assessed as having eligible needs for support with showering, washing her hair and dressing. The 'Funding Panel' (see below) however refused all support. The ombudsman held this to be maladministration. While it was possible that her needs could be met in other ways this could not be decided in direct contravention of the assessor's recommendations by a panel who was not involved in the assessment.

managing toilet needs

LAs should consider the adult's ability to access and use a toilet and manage their toilet needs.

being appropriately clothed.

LAs should consider the adult's ability to dress themselves and to be appropriately dressed, for instance in relation to the weather to maintain their health.

Two relevant 2016 ombudsman decisions include:

- A finding[93] that it is maladministration for a LA to fail to recognise the importance to an adult's personal dignity of wearing clean, presentable and appropriate

[90] Complaint no. 15 011 661 against London Borough of Hammersmith & Fulham 21 July 2016 para 24.
[91] Complaint no. 15 015 721 against Birmingham City Council 7th September 2016.
[92] Complaint no. 15 017 591 against Brighton & Hove City Council 30th August 2016.
[93] Complaint no. 15 011 661 against London Borough of Hammersmith & Fulham 21 July 2016 para 24.

clothes (a complaint concerning a visually impaired adult who needed support to sort her clothes so that she did not wear stained or inappropriate clothing);

- A complaint[94] concerning a council's decision that a person had a need for help with dressing but not to an evening visit to help undress. The report held that it was logical to expect a person who needs assistance with dressing to need assistance with undressing. Being appropriately dressed for bed is equally as important as being dressed in day clothes

being able to make use of the home safely

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.

maintaining a habitable home environment.

whether the condition of the adult's home is sufficiently clean and maintained to be safe. A habitable home is safe and has essential amenities. An adult may require support to sustain their occupancy of the home & to amenities, such as water, electricity, gas.

A 2016 ombudsman report[95] concerned an adult who had been told by assessor that the council 'no longer fund domestic work generally' and that he was not eligible because he could afford a cleaner: that the Care Act was "about what people can do for themselves".

In finding maladministration the ombudsman held that the adult had an eligible need. Therefore he was entitled to receive such a service. The Care Act says "The local authority must also establish whether the individual wants to have their eligible needs met by the local authority. If the individual wishes to arrange their own care and support, the authority does not have to meet those needs".

developing & maintaining family / relationships

whether the adult is lonely or isolated, either because their needs prevent them from maintaining the personal relationships they have or because their needs prevent them from developing new relationships.

accessing /engaging in work, training, education or volunteering

whether the adult has an opportunity to apply themselves and contribute to society through work, training, education or volunteering, subject to their own wishes in this regard. ... includes physical access to any facility & support with participation in the relevant activity.

making use of necessary facilities or services in the local community including public transport and recreational facilities or services

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. LAs do not have responsibility for the provision of NHS

[94] Complaint no. 15 014 893 against Dorset County Council 1st September 2016.
[95] Complaint no. 15 014 893 against Dorset County Council 1st September 2016.

services such as patient transport, however they should consider needs for support when the adult is attending healthcare appointments. [96]

A 2016 ombudsman complaint[97] concerned a disabled person who needed support with every aspect of his personal care. This need also existed when he had hospital outpatient visits – which could take up to 8 hours – during which he needed support in order to be able to eat, drink and go to the toilet. His care support was cut for a number of reasons, including the fact that 'transport to medical appointments and hospital is the NHS responsibility'; that and that it was the NHS' duty to fund this.

In finding maladministration the ombudsman stated that the 'council is correct in saying the cost of transport to medical appointments is the NHS' responsibility, but the Care Act Guidance says councils have to consider the needs for support when the adult is attending healthcare appointments and the Council's failure to consider this is fault'.

carrying out any caring responsibilities the adult has for a child

LAs should consider any parenting or other caring responsibilities the person has. The adult may for example be a step-parent with caring responsibilities for their spouse's children.

It follows that in childcare proceedings that involved a disabled parent, the court will require a CA 2014 assessment of his or her needs to be available. In *Bristol CC v. S*[98] (2015) this did not occur and the court observed that 'there appears to be a profound lack of knowledge of the responsibilities that arise under the Care Act 2014'.

'two or more'

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 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 revised 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[99] provides further advice on this question.

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[96] 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)

[97] Complaint no 15 015 000 against Barnsley Metropolitan Borough Council 27th July 2016.

[98] *Bristol CC v. S* His Honour Judge Wildblood, Q.C. 20th May 2015 BS15C00174 para 10.

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

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 revised Statutory Guidance at para 6.106 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

The examples in the SCIE guide[100] 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 revised Statutory Guidance at para 6.106 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[101] 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

[100] 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
[101] 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

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 revised Statutory Guidance states (para 6.115):

> 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 urgent[102] – is carried forward into the new regime (section 19(3)). The revised Statutory 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).

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 Eligibility Regulations[103] 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.

Significant

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 revised Statutory Guidance at para 6.125 – 6.126 reiterates the comments made in relation to adults – and the SCIE Guidance[104] makes no distinction between adults in need and carers in when explaining how the word should be interpreted – accordingly reference should be made to the discussion above.

Carer impacts / outcomes

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

(a) the carer's physical or mental health is, or is at risk of, deteriorating;

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[102] 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.
[103] The Care and Support (Eligibility Criteria) Regulations 2015.
[104] Social Care Institute for Excellence (SCIE) on line guidance - The *Care Act 2014: What does significant impact mean?* at www.scie.org.uk/care-act-2014/assessment-and-eligibility/process-map/

(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 revised Statutory Guidance provides amplification of what is encompassed by these impacts / outcomes (para 6.123) although the carers criteria ultimately leave considerable discretion to the assessor and their professional opinion. A detailed analysis of these impacts / outcomes is provided in L Clements 'Carers and their Rights' 6th edition (2016)[105] to which reference should be made.

Unable to achieve (carer)

Regulation 3(3) defines 'unable' in similar terms to that for adults in need (see above) except the final ground (reg 2(3)(d)) of being deemed unable if it 'takes significantly longer than would normally be expected' is omitted. The precise significance of this has yet to be determined but it has been suggested that this would mean that carers would not be eligible simply because it took them significantly longer than normal to do their house cleaning because of their caring responsibilities.[106] In such a case, however, carers could simply state that without such support they would be unable to continue caring.

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 6.118). 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.

The revised Statutory Guidance addresses some of the implications of this requirement, explaining that where the carer is eligible for support but the adult being cared is not – and accordingly 'does not have their own personal budget or care plan' (para 11.42) – the carer could (for example) request a direct payment, and use that to commission their own replacement care from an agency (para 11.44). It then states (para 11.45):

[105] L Clements *Carers and their Rights* 6th edition (Carers UK 2015) at www.lukeclements.co.uk/publications/ para 5.30 et seq.
[106] See Belinda Schwehr Your questions answered about assessing carers under the Care Act Community Care 9th June 2016

> If such a type of replacement care is charged for… then it would be the adult needing care that would pay, not the carer, because they are the direct recipient of the service.

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.[107] 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 remain relevant.[108] 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.[109] In relation to the use of panels, the revised Statutory 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. …

Reports from assessors that are required to go to a 'panel' must include a recommendation from the assessor as to her or his professional opinion as to what care is required.[110] A 2016 ombudsman's report,[111] when noting that a panel rejected an assessor's identification of the adult having eligible needs for support three times a week with showering, washing her hair and dressing afterwards, observed (para 20):

> I am not persuaded that this panel was purely looking at compliance with the Care Act and cost effectiveness. If this was its remit, it failed to do this adequately. It is possible Miss X's needs could be met in other ways but with proper care and support planning in consultation with Miss X. Not through a decision in direct contravention of the care manager's recommendations by a panel who was not involved in the assessment. I found the Council was at fault in the way it dealt with this "funding application".

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[107] 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

[108] 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

[109] 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'.

[110] Complaint no. 15 020 384 against London Borough of Bromley 7th September 2016.

[111] Complaint no. 15 017 591 against Brighton & Hove City Council 30th August 2016.

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 contained no duty to meet carers' eligible needs (just a power)[112] nor (in general) did it 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 (albeit in only for self funders who are not in care homes). Where an individual's needs (ie a carer or an 'adult in need') meet the eligibility criteria then there is 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 (and are not in / or seeking care home accommodation).

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.'[113] 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.

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 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 revised Statutory Guidance requires that they 'must be given a record of their needs or carer's assessment' (para 6.96)[114] and also their final care plan (para 10.87).

Care and support planning – principles

Section 25 details what must be in every care and support plan[115] (ie for a carer or an adult 'in need') and this duty is analysed in the revised Statutory 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 …;

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[112] 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.

[113] 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.

[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] 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.

- 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 pre-Care Act requirements for care and support plans continue – but they are now statutory creatures rather than requirements of Department of Health guidance. Existing case law concerning care plans remains relevant – particularly so, given that it places great emphasis on the importance of local authorities following guidance.[116]. In *R v Islington LBC ex p Rixon* (1997)[117] 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.

It will be maladministration to fail to provide sufficient detail in an assessment and care plan.[118] In *R (J) v Caerphilly CBC*[119] 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 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.[120]

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 almost every local authority was already doing this – it has made no practical difference.

The revised Statutory 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 10.20) 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 revised Statutory 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. ….

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[116] *R v Islington LBC ex p Rixon* (1997–98) 1 CCLR 119 at 128, QBD.
[117] (1997–98) 1 CCLR 119 at 128, QBD.
[118] Complaint no 15 015 067 against Kent County Council 26 August 2016.
[119] [2005] EWHC 586 (Admin); (2005) 8 CCLR 255. This case is discussed in detail at para 10.73.
[120] Local Government Ombudsman complaint number 13 002 982 against Birmingham City Council 12 March 2014.

NICE has issued a Quality Standard highlighting 'high-priority areas for quality improvement' in relation to the provision of home care for older people.[121] It contains six care planning 'statements' addressing:

1. The provision of a care plan that identifies how their personal priorities and outcomes will be met.
2. The provision of a care plan that identifies how their home care provider will respond to missed or late visits.
3. The provision of home care services by a consistent team of home care workers who are familiar with the person's needs.
4. The requirement that care visits are at least 30 minutes long 'except when short visits for specific tasks or checks have been agreed as part of a wider package of support'.
5. The requirement that there is a review of the outcomes of the care plan within 6 weeks of starting to use the service and then at least annually.
6. The requirement that home care providers have practice-based supervision discussions with home care workers at least every 3 months.

Care and support plans must be 'clear'. A 2016 ombudsman report[122] concerned a severely disabled applicant's support plan listed as one of the outcomes as being able to 'manage financial matters and assist with correspondence and communication as necessary'. His support plan stated he was to have 156 hours of advocacy available each year to help with all finances, bills and paperwork.

The CA 2014 advocacy service did not feel the advocate should be doing anything other than advocacy and therefore declined to provide the service. Maladministration by not making it clear that the need was not for advocacy but letter reading and help with finances and bills.

It is self-evident that care and support must meet eligible needs. A 2016 ombudsman report[123] concerned a young man with Down's Syndrome who was assessed as having substantial needs including an outcomes to form 'peer group relationships' and prevent isolation. A supported housing placement was identified which was considered suitable because it had a resident of a similar age. The local authority subsequently withdrew this offer, having found a cheaper placement but this was occupied by older people. The social worker however had noted that 'considering [Mr Z's] needs I do not believe another placement could be found at a lower cost to the one identified.' In finding maladministration the ombudsman held that Care plans 'should not only cover how a person's physical needs will be met. They should also address the person's social needs and emotional wellbeing.'

Carer input into adults 'in need' care plan

In relation to support provided by a carer – the revised Statutory 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.

[121] National Institute for Health and Care Excellence (NICE) quality standard QS123 *Home care for older people* (NICE 2016). The standard is endorsed by the Department of Health – see Health and Social Care Act 2012 s234.
[122] Complaint no. 14 013 726 against Surrey County Council 3rd June 2016.
[123] Complaint no. 15 019 312 against London Borough of Barking & Dagenham 08 June 2016.

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:

> 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 revised Statutory Guidance re-emphasise 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:[124]

> 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 revised Statutory Guidance (para 11.38) 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' carer's assessment identifies her as eligible for support due to her additional child care responsibilities.[125] 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 revised Statutory 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)

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[124] 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?'

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

A 2016 ombudsman report[126] concerned an adult with significant leaning difficulties who lived with his parents. His care package had for many years included 50 days of replacement care to enable his parents to have a break. On review this was reduced to 14 days although his needs had not changed and the sustainability of his parents in maintaining their support was recorded as at risk. In finding maladministration the ombudsman held that the council had to provide an explanation as to the reasons for the reduction: that it 'needs to show what circumstances have changed to warrant this reduction in respite provision'. In the ombudsman's opinion it was not acceptable for the council to state that it would offer emergency respite if the need arose:

> The parent's need for 'weekends away and a little social life are not emergencies but part of a planned sustainable support regime'. The Council's assessment does not address these sustainability issues and the guidance says the impact on the carers' daily lives and non caring activities must be included.

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 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 revised Statutory 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 were able to provide to support carers under the pre-Care Act are continued under the new regime. As noted above the range of support under section 8 is wide. The revised Statutory Guidance (para 11.41) provides illustrative examples of the types of support that are envisaged for carers:

[126] Complaint no 15 013 201 against Sefton Metropolitan Borough Council 23rd August 2016.

> 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), regulations[127] and guidance in large measure replicate the pre-Care Act legal position. This means that previous case law and Ombudsman decisions are of continued relevance.

The relevance of local authority financial difficulties

Para 10.27 of the revised Statutory Guidance makes clear that pre-Care Act case law concerning the relevance of an authority's financial position remains – namely that although authorities can 'take into reasonable consideration' of their finances, they 'must comply' with their legal obligations.[128] 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 revised Statutory 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 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 revised Statutory 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 is made by the adult in need or a carer) and section 27(4) requires a reassessment if they believe that that circumstances have changed materially. The revised Statutory Guidance creates an expectation that the

[127] The Care and Support (Direct Payments) Regulations 2014.
[128] Ie the position identified by the House of Lords in *R v Gloucestershire County Council ex p Barry* 1 CCLR 40; [1997] 2 All ER 1; and reiterated by the Supreme Court in *R (KM) v. Cambridgeshire County Council* (2012) [2012] UKSC 23.

care and support plans will 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 revised Statutory Guidance requires that reviews (like assessments) must 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 revised Statutory 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?

A note concerning criteria for challenging reductions in care packages is available at www.lukeclements.co.uk/resources/ ('Reductions in Services'). It refers to a 2016 ombudsman report that reminded authorities that they must not assume a carer is willing or able to provide any care – including additional care arising from a reduction in the care package. It will be maladministration for such a reduction to occur without assessing the carer and explicitly clarifying (and recording) whether she/he is 'able and willing' to provide the additional care.[129]

The revised Statutory 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 are 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 services[130] and a power to charge for non-residential care[131] (including carers' services[132]). 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 appears that there has been little material change to local authority charging policies – although reference to the well-established Charging for Residential Accommodation Guidance (CRAG) ceases (as it has been 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.[133] The revised Statutory 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

[129] Complaint no. 15 020 384 against London Borough of Bromley 7th September 2016.
[130] National Assistance Act 1948, section 22.
[131] Health and Social Services and Social Security Adjudications Act 1983, section 17.
[132] Carers and Disabled Children Act 2000, section 8 (which amended the 1983 Act above, inserting s17(2)(f)).
[133] See also The Care & Support (Charging and Assessment of Resources) Regulations 2014 reg 5.

cover any administration costs incurred' (para 8.59) – but local authorities cannot 'charge people for a financial assessment, a needs assessment or the preparation of a care and support plan' (para 8.60).

The revised Statutory Guidance makes much of the fact that the charging regimes of residential and non-residential care are now governed by 'a single legal framework' (para 8.1): however they are dealt with differently by the regulations and guidance. Authorities now have a discretion to charge residential care accommodation (it was previously a duty). It appears that authorities have continued to impose charges – albeit that they will have to develop a policy on this and consult on it – which will, in itself, be a not insignificant administrative obligation.[134]

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 are 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'.[135]

Charging 'principles'

The revised Statutory Guidance states (para 8.2) that a single set of principles conditions local authority approaches to charging, namely to:

- ensure that people are not charged more than it is reasonably practicable for them to pay;
- be comprehensive, to reduce variation in the way people are assessed and charged;
- be clear and transparent, so people know what they will be charged;
- promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control;
- support carers to look after their own health and wellbeing and to care effectively and safely;
- be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs;
- apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings;
- encourage and enable those who wish to stay in or take up employment, education or training or plan for the future costs of meeting their needs to do so; 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: under the pre-Care Act regime this prohibition was contained in the statute.[136] The advice by the Select Committee[137] that the prohibition be retained in statute (or at least in regulations) was rejected.

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 will start charging carers for

[134] LGA and ADASS *Joint consultation response Care Act: regulations and guidance* (August 2014) at para 31.
[135] LGA and ADASS *Joint consultation response Care Act: regulations and guidance* (August 2014) at para 30.
[136] S17 Health and Social Services and Social Security Adjudications Act 1983.
[137] Joint Committee on the Draft Care and Support Bill, 'Draft Care and Support Bill' Stationery Office (2013) HL Paper 143 HC 822 para 196.

services (as has occurred[138]). The revised Statutory Guidance anticipates this problem, but given that it is statutory in origin – is able to do little more than attempt 'damage limitation', stating (para 8.50):

> Local authorities are not required to charge a carer for support and indeed in many cases it would be a false economy to do so. …. 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 8.22 - 8.26). Most obviously this will apply to people who are wealthy and don't want the 'indignity' of being assessed – but nevertheless do wish to have the local authority care manage their support plan (see below). The revised Statutory 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' (para 8.23).

The upper capital limit remains at £23,250 and the lower limit at £14,250. Notional interest continues to be charged on capital falling between these figures on the same basis as under the previous legal regime. The personal expense allowance continues – and the same services must be provided without charge as previously – 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. The LGA has a range of advice guides / toolkits / template letters concerning aspects of the new charging regime.[139]

Major reforms to the charging regime – particularly the capital allowances – are expected when (and 'if') the 'cap on costs' reforms are brought into force in 2020.

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 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% greater than the 'relevant rate' of interest for the period.[140] The right to a deferred payments is subject to a number of conditions including a maximum capital allowance of £23,750 (reg 2(2)(c)). The Department of Health (together with the LGA and ADASS) has issued guidance concerning deferred payment agreements[141] and the government allocated additional funding to cover the cost of new arrangements.[142]

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[138] See for example (in relation to Redbridge LBC) D Patient 'Carers charge 'would force vulnerable into poverty'' in Epping Forest Guardian 4 March 2015 and in relation to Enfield LBC *Charges for community care services for people living at home* (2015)

[139] LGA Charging for care and support www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6522471/ARTICLE#programme

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

[141] Department of Health *Charging for care and support* at www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6522471/ARTICLE#programme

[142] at £108.5m for 2015-16 - 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/webwatch_for_CK_only/2014/201407/Consultation_document.pdf accessed 11th August 2014

NHS interface (section 22)

A number of amendments were made to the Care Bill to ensure that the boundary between local authority responsibilities and the NHS (the so called 'NHS Continuing Care' boundary as defined in the *Coughlan* Court of Appeal judgment[143]) remained unchanged. The phrasing of section 22 appears to achieve this aim, and the Minister has confirmed that:[144]

> 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 statement[145] but in large measure these have been removed from the final guidance – or remain in heavily qualified terms.

Regulation 7 of the Assessment Regulations[146] 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 regulations[147] 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).

As noted below, the Care Act obligation to provide independent advocacy (section 67) applies to assessments determining eligibility for NHS Continuing Healthcare funding[148] as it does to Care Act assessments.[149] In such cases the stipulation that the duty only arises if there is no other appropriate representative available (section 67(5)) does not apply if there is (a) disagreement on a 'material issue' between the local authority and the person and (b) the local authority and that person agree that advocacy support is in the person's best interests. If the local authority and the NHS consider that the person is not eligible for NHS continuing healthcare funding then (subject to the best interest requirement) the duty arises. If however the local authority disagrees with the NHS over eligibility, then the local authority would be obliged to trigger its inter-authority dispute process.[150] In either case, given the complexity of the NHS continuing healthcare process, the presumption must be that it would be in a person's best interest to have advocacy support.

Even for those who do not come within the parameters of this right, 2015 SCIE guidance[151] advises (page 8):

> Historically this arrangement has often been difficult for people who use services, their carers and friends to understand and be involved in. Local authorities and clinical commissioning groups will therefore want to consider the benefits of providing access to independent advice or independent advocacy for those who do not have substantial difficulty and/or those who have an appropriate person to support their involvement.

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[143] *R v. North and East Devon health authority ex p Coughlan* [2000] 2 WLR 622: [2000] 3 All ER 850.
[144] Public Act Committee Report 16 January 2014 (page 205/208).
[145] See L. Clements 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/
[146] The Care and Support (Assessment) Regulations 2014 SI 2827.
[147] See The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 SI 2996 Part 6 (regulations 21 - 22).
[148] If it is 'is likely to' result in the NHS making funding the person in a hospital for a period of 28 days or more; or a care home for a period of 8 weeks or more - The Care and Support (Independent Advocacy Support) (No. 2) Regulations 2014 reg 4 (2)(a).
[149] See the revised Statutory Guidance para 7.22.
[150] The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 SI 2996 reg 22.
[151] Social Care Institute for Excellence *commissioning independent advocacy: Independent Advocacy under the Care Act 2014* (SCIE 2015).

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 pre-CA 2014 requirement (in relation to direct payments) –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 reassured by this response. The revised Statutory 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.

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.[152] In support of this approach the revised Statutory 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).

A 2015 Ombudsman report concerning Cornwall Council[153] has confirmed the legal position – namely that the hourly rates on which personal budgets / direct payments are assessed must not be arbitrary and that the calculations must be shared with adults in need / carers. Where the individual lacks the necessary mental capacity to manage a personal budget (and to employ personal assistants) then the budget must be costed on the basis that an agency would have to be used.

The Act requires (it appears[154]) local authorities to include in a support plan a personal budget for carers. The revised Statutory Guidance (at 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 revised Statutory 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

[152] 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.
[153] Report on Complaint against Cornwall Council (13 006 400) 26 February 2015
[154] Section 25 distinguishes between 'adults' and 'carers' but it would appear that the reference in section 25(1)(e) (the duty to include a personal budget) is intended to include both 'adults' and 'carers'.

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.

Direct Payments (sections 31-33)

The Care Act provides for an almost identical 'direct payments' regime to that under the previous regime and the detail is again to be found in the regulations[155] and the revised Statutory Guidance. There are two material changes.

1. 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 can be made 'if the local authority considers it is necessary to do so'[156] – and the payment can cover either the cost of meeting the adult's need or the cost of providing 'administrative and management support or services' for the person to whom the direct payments are made.

   In relation to this latter category, the revised Statutory Guidance (para 12.36) explains that:

   > This is allows people to pay a close family member living in the same household to provide management and/or administrative support to the direct payment holder in cases where the local authority determines this to be necessary. This is intended to reflect the fact that in some cases, especially where there are multiple complex needs, the direct payment amount may be substantial.

2. The second change (which has now been postponed until 2020[157]) is that direct payments will be available for residential care placements. . The local authorities who were piloting this programme will however be able to continue making such payments if they so choose.[158]

A 2016 ombudsman's report[159] concerned an adult in need who requested that she have a direct payment (rather than the services being commissioned by the local authority). Instead of responding swiftly to this request, the authority stated that it would have to first undertake a review: action that the ombudsman considered to be maladministration.

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 –

[155] The Care and Support (Direct Payments) Regulations 2014.
[156] The Care and Support (Direct Payments) Regulations 2014 reg 3(2).
[157] In late January 2016 the Government announced that it had decided to postpone the 'national rollout of direct payments in residential care' until 2020 - see www.local.gov.uk/web/guest/care-support-reform/-/journal_content/56/10180/7643648/ARTICLE.
[158] These are listed in Schedule 2 to the Regulations – and see also 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.
[159] Complaint 15 011 661 against London Borough of Hammersmith & Fulham 21 July 2016 para 22.

and so (as now) an individual would have to make a complaint/ go to the Ombudsman if a problem occurs.[160]

Sections 37 – 38 are replete with detailed procedural obligations – but in essence they provide that where a local authority (the 1st local authority) is providing 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 revised Statutory 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.

Two ombudsman's reports illustrate some of the difficulties arsing in practice, concerning this duty

- A 2016 ombudsman complaint[161] concerned an ordinary residence dispute between to councils – which included allegations that a letter had not been received when the disabled person moved to the new authority. The ombudsman reports states that the 'records held by the councils show a lack of interest in ensuring one or the other took responsibility for Mr Y's care needs. … . Both councils lost sight of the key priority which was the wellbeing of Mr Y. Council A's evidence of attempts to communicate with Council B do not relieve it of the responsibility to fund Mr Y until the dispute was resolved.
- A 2016 ombudsman complaint[162] concerned a disabled person who moved to a new council area. Although the new authority were notified that the family were to move on the 31st August, it failed to undertake an assessment until the 27th August. The new social worker recommended that the he needed the same package of care as previously and this was supported by his manager. On the 23rd November the council's panel reduced this substantially and the new package was backdated to the 31st August. In finding maladministration the ombudsman noted that there was no evidence the panel considered (a) Mr B's previous assessment, nor (b) the impact on Mr B's parents and primary carers. The maladministration was compounded by the council's failure to fund Mr B's existing level of care from the date he moved into the area until it made a decision on the level of funding it would provide.

Cross border placements

A problem that has only been partially resolved concerns individuals who move to live in Wales, Scotland and Northern Ireland. Schedule 1 to the Act sets out the basic ground rules and these are considered in further detail in revised Statutory Guidance (chapter 21) which states that the Schedule and the chapter have been agreed by the '4 administrations of the UK (England, Scotland, Wales and Northern Ireland)' (para 21.6). The difficulties will arise in relation to disputes. A brief (one page) protocol setting out 'Principles of Cross-Border Continuity of Care within the United Kingdom' has been agreed which aims:

[160] 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.
[161] Complaint nos 15 012 618 and 15 009 591 against Oxfordshire County Council and Barnet LBC 16 August 2016.
[162] Complaint no. 15 019 587 against Isle of Wight Council 9th August 2016.

> to maintain the adult's wellbeing and prevent them from falling into crisis; ensure that the adult is at the centre of the process; and that responsible authorities should work together and share information in a timely manner to ensure needs are being met both on the day of the move and subsequently.

The 'ordinary residence' implications for people who move across national borders are considered in the next section.

Ordinary residence (section 39 – 41)

The pre-Care Act law concerning the determination of a person's 'ordinary residence' is not disturbed by the new legislation – with one exception. Apart from factoring in the impact of Supreme Court judgment in *R (Cornwall Council) v Secretary of State for Health*[163] (noted above) the case law concerning the notion of 'ordinary residence' 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'.[164]

The Care Act continues to provide for 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 legislation[165] extends this rule to include not only care home accommodation, but also shared lives scheme accommodation[166] and supported living accommodation.[167] 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)).

The 2014 Statutory Guidance was considered insufficient to explain the scope of the 'can only be met' provision (for example where a 'home care' plan was feasible but more expensive than a residential care placement). An undertaking was given to clarify this question[168] and this is now found at para 19.30 of the revised Statutory Guidance. This is set out below and the additional two sentences are in italics (but not the original):

> Need should be judged to be 'able to be met' or of a kind that 'can be met only' 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. *Where the outcome of the care planning process is a decision to meet needs in one of the specified types of accommodation and it is the local authority's view it should be assumed that needs can only be met in that type of accommodation for the purposes of 'deeming' ordinary residence. This should be clearly*

[163] *R (Cornwall Council) v. Secretary of State for Health* [2015] UKSC 46. The case concerned an adult who lacked the capacity to decide where to live. As a child, Wiltshire CC placed him with foster carers in South Gloucestershire – where he remained at the time of the hearing (his parents, with whom he had limited contact, lived in Cornwall). The Court held that he was ordinarily resident in Wiltshire.
[164] See para 19.14 revised Statutory Guidance and *Shah v London Borough of Barnet* [1983] 1 All ER 226.
[165] Section 39(1)(a) and The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014, reg 2.
[166] Defined in The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014, reg 4.
[167] Defined in The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014, reg 5.
[168] See HM Government *Update on final Orders under the Care Act 2014*' at www.gov.uk/government/uploads/system/uploads/attachment_data/file/413386/Guidance_and_Orders_Note_-_final.pdf

> *recorded in the care and support plan.* The local authority is not required to demonstrate that needs cannot be met by any other type of support. 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 payment[169] 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 regulations[170] provides for an updated dispute process – in which, as at present the Department of Health will make the final determination. The process also covers disputed ordinary residence for the purposes of Mental Health Act 1983, s117 (see below). An additional difficulty concerns the fact that in Wales the deeming rule does not extend to shared lives or supported living accommodation.[171]

The extension of the ordinary residence 'deeming rule' to shared lives schemes and supported living accommodation is also reflected in the Care & Support (Choice of Accommodation) Regulations – which bring these schemes within the ambit of the choice of accommodation options available to individuals – where the local authority is proposing a placement in either a shared life scheme or in supported living accommodation – and the department of Health (together with the LGA and ADASS) has issued guidance concerning these new obligations.[172]

Ordinary residence and individuals who move across-borders.

As noted above, Schedule 1 of the 2014 Act and chapter 21 of the revised Statutory 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 revised Statutory 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). In the succeeding paragraphs it then 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 para 21.78 a 'case study' example is given of an elderly person moving from England to Scotland. Everything goes smoothly in this hypothetical example – possibly because it avoids reference to the financial implications of such a move.

Problems have been identified in relation to the interpretation of section 39(1). A literal interpretation could have resulted in a significant number of inter-authority disputes due to the use of the present tense ('the adult is living'). An amending Order and Regulations have

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[169] 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.
[170] The Care and Support (Disputes Between Local Authorities) Regulations 2014 SI 2829.
[171] For an overview of the Social Services and Well-being (Wales) Act 2014 - see www.lukeclements.co.uk/whats-new/
[172] Department of Health *Choice of Accommodation* at www.local.gov.uk/documents/10180/5756320/Guidance+on+choice+accommodation+AM.pdf/d31f02f7-7e89-46b9-8bda-4c021047731c

been issued to address this issue.[173] The Department of Health 2015 guidance note[174] accompanying the Order advises that:

> the ordinary deeming principles' only apply from the date a person living in specified accommodation receives care and support under the Act … [they] do not apply when a person is living in a specified type of accommodation (such as a care home) before they begin to receive care and support from the local authority.

Safeguarding (sections 42 – 47))

The Act provides local authorities with very little in terms of substance, to enhance their safeguarding powers. As a leading commentator has observed, the content is 'minimal' defining only 'the infrastructure … that must exist'.[175] The safeguarding chapter in the 2014 Statutory Guidance was considered unsatisfactory by many and lacking 'legal literacy'[176] and sadly this concern has also been levelled against the 'disappointing' revised Statutory Guidance.[177]

The Act places on a statutory footing some of the safeguarding obligations that were previously only located in guidance (principally the 'No Secrets' guidance[178]) – for example the duty to make enquiries / decide what action should to be taken. The new policy guidance (that replaces 'No Secrets') is to be found in chapter 14 of the revised 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 revised Statutory Guidance (at para 14.17) provides a 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';
- 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';

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[173] The Care and Support (Miscellaneous Amendments) Regulations 2015 SI 644 reg 4, and see also The Care Act 2014 (Transitional Provision) Order 2015 SI 995, para 6.
[174] Update on final Orders under the Care Act 2014 para 14(iv).
[175] See for example, Gary Fitzgerald 'It is not enough to simply reflect the wording of the legislation' in Community Care March 31, 2016
[176] Lucy Series *Care Act 2014: Consultation on Draft Guidance & Regulations* (2014) http://thesmallplaces.wordpress.com
[177] See for example, Gary Fitzgerald 'It is not enough to simply reflect the wording of the legislation' in Community Care March 31, 2016
[178] 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*.

- 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 revised Statutory Guidance contains additional advice concerning self-neglect – suggesting that it:

  > may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.

  While there is difficult line to tread in such cases in cases where significant harm is resulting from the self-neglect, it will be maladministration for an authority to fail to investigate – to fail to appreciate that there is a 'balance to be struck between an individual's autonomy and dignity'.[179]

  Concern has been expressed about the failure of the revised Statutory Guidance to distinguish between self-neglect that is 'a chosen lifestyle' and that is 'caused through external factors, such as a loss of income or the death of a relative'. [180]

The Act (section 42) places the duty to make enquiries on the local authority where abuse is suspected.[181] Para 14.68 of revised Statutory Guidance requires that the authority then decide what should then be done – ie if the investigation be done by the social care / health provider or commissioner

Uncertainty over the scope of the section 42 duty calls for significantly more detailed guidance. For example,[182] a literal interpretation would suggest that the safeguarding duty does not arise in relation to a person who, although having no care and support needs, is a victim of financial abuse / undue influence and unable to protect themselves. Likewise it would appear that that there is no general duty to make enquires where a person, who has been the victim of historic abuse (possibly by a local authority care worker) but the abuser has been suspended.

Section 44 provides for Safeguarding Adult Reviews of historic abuse – but this duty only arises if the person has died or 'has experienced serious abuse or neglect' which the revised Statutory Guidance describes as of a severity that the adult 'would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect' (para 14.163).

Although the guidance makes it clear that there is a power to have a review in other situations, the advice it gives is troubling, for at least two reasons.

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[179] Health Service Ombudsman and the Local Government Ombudsman *Report about the care and support provided to a vulnerable person living independently in the community* 4 July 2011 HC 1355 (The Stationery Office 2011) para 115

[180] See for example, Gary Fitzgerald 'It is not enough to simply reflect the wording of the legislation' in Community Care March 31, 2016

[181] Accessible at www.cqc.org.uk/sites/default/files/20140416_safeguarding_adults_-_roles_and_responsibilities_-_revised_draf....pdf

[182] Examples taken from – Gary Fitzgerald 'It is not enough to simply reflect the wording of the legislation' in Community Care March 31, 2016.

Firstly, the ambiguity as to what us meant by reduced 'quality of life'. On one level this could be relatively minor – for example fearfulness of venturing into public because of an unpleasant previous incident. However the guidance uses this phrase in the context of a description that refers to death; death 'but for an intervention'; and 'permanent harm'. The second (but associated) reason for concern relates to overshadowing impact of these terms and the risk that they imply that the threshold for a section 44 review is 'very serious harm or neglect'. This cannot be the case. Although not every episode of historic neglect or abuse will require investigation, there is a positive obligation on public authorities to investigate past abuse with a view to ensuring that those responsible are identified and appropriately punished.[183] There must also be a public law duty on authorities to identify what has occurred so that they are able to learn from the facts with a view to avoiding any repetition.

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 Act[184] 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 Act[185] contains (in addition) a power of removal. Not only are such powers absent from the English Act, the previous 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 discussion about whether safeguarding is or is not a statutory function[186] - 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'.[187]

Safeguarding is of course a difficult subject for the guidance to address – since it remains 'a complex mishmash of legislation, guidance and ad hoc court interventions':[188] 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 revised Statutory 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 Series suggesting that the original 2014 Statutory Guidance lacked 'legal literacy'[189] – and the revisions in the 2016 version do little to address these failings.

During the debate on the Care Bill the Minister[190] argued that there was no need for

[183] *Đorđević v. Croatia* (2012) Application no. 41526/10 24th July 2012.
[184] Social Services and Well-being (Wales) Act 2014 s127.
[185] Adult Support and Protection (Scotland) Act 2007, ss 7, 8, 11 & 14.
[186] 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.
[187] 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.
[188] *The Mental Health Trust v DD* (2015) [2015] EWCOP 4 (Cobb J) para 23.
[189] Lucy Series *Care Act 2014: Consultation on Draft Guidance & Regulations* (2014) http://thesmallplaces.wordpress.com
[190] The Minister of State, Department of Health (Norman Lamb) House of Commons Public Bill Committee 4th February 2014 Hansard 609 – 610.

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'[191] 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).

Safeguarding as a route to eligibility

As noted above, there is a significant problem with the way the Eligibility Regulations[192] fail to identify an inability on the part of the person to 'keep safe' as an eligible need in itself (unlike the Welsh Act[193]). 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 revised 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 action is 'required to protect the adult … authorities … should take appropriate action. In some cases, safeguarding enquiries may result in the provision of care and support'. At para 7.26 the revised Statutory Guidance advises 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'.

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)[194] 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 and 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.[195]

Đorđević v. Croatia (2012)[196] concerned the harassment by school children of an adult with learning disabilities and his mother, with whom he lived. The police and authorities were

[191] 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
[192] The Care and Support (Eligibility Criteria) Regulations 2015.
[193] The Social Services and Well-being (Wales) Act 2014 section 32(1)(b) addresses this issue directly.
[194] [2009] EWCA Civ 286.
[195] *X, Y & Z v. UK* Application no. 32666/10 by 5 July 2012.
[196] Application no. 41526/10 24th July 2012.

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).[197]

Human Rights Protection (section 73)

The Care Act extended the previous Human Rights Act 1998 protection for care home residents who are 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. The human rights protection now includes individuals (ie carers or adults in need) who receive care / support from a registered care provider in their own homes or the community and also covers '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. Restriction (2) (the existence of an appropriate representative) does not however apply to some 'hospital discharge' and 'NHS continuing care' disputes and these exceptions are considered further in this briefing under these subject headings.

The revised Statutory Guidance (para 3.9) defines advocacy as 'supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need'. Advocacy can be central to achieving well-being – particularly in identifying an individual's views, wishes, feelings and beliefs – and maximising their control over their day-to-day life (CA 2014, s1).

In relation to the general advocacy duty the revised Statutory Guidance states at para 7.4:

> 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

[197] [2015] EWCOP 4 (Cobb J).

> 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 revised Statutory 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 4 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 7.20) 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 obligation to provide independent advocacy applies to all Care Act assessments: accordingly the duty is engaged in relation to most assessments for the purposes of hospital discharge or to ascertain eligibility for NHS Continuing Healthcare funding.[198] Even for those who do not come within the parameters of this right (see below) the 2015 SCIE guidance[199] advises:

> Historically this arrangement has often been difficult for people who use services, their carers and friends to understand and be involved in. Local authorities and clinical commissioning groups will therefore want to consider the benefits of providing access to independent advice or independent advocacy for those who do not have substantial difficulty and/or those who have an appropriate person to support their involvement.

The Care and Support (Independent Advocacy Support) Regulations[200] 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 advised 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'.[201] The Social Care Institute for

[198] If it is 'is likely to' result in the NHS funding the person in a hospital for a period of 28 days or more; or a care home for a period of 8 weeks or more - The Care and Support (Independent Advocacy Support) (No. 2) Regulations 2014 reg 4 (2)(a) – and see also the revised Statutory Guidance para 7.21.
[199] Social Care Institute for Excellence *commissioning independent advocacy: Independent Advocacy under the Care Act 2014* (SCIE 2015).
[200] The Care and Support (Independent Advocacy Support) (No. 2) Regulations 2014 SI 2889.
[201] Lucy Bonnerjea *Advocacy and the Care Act* PowerPoint (Department of Health 2014).

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'.[202]

Dr Lucy Series, when commenting favourably on the advocacy provisions and the draft guidance suggested that what was being required went beyond advocacy and encompassed a duty of 'support and the duty to involve'.[203] Her paper also highlighted 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 were at least 6 reasons why the Care Act advocate would be 'far superior' to the IMCA – one being that advocates under the 2014 Act were to be better paid – being allocated 17 hours per referral compared with the 8 hours allocated to IMCA's.

There is evidence to suggest that the CA 2014 arrangements by which local authorities are required to refer individuals to advocates by local authorities is not working well and research suggests that this is due to the lack of understanding of this duty by frontline social services staff.[204]

R (SG) Haringey LBC (2015)[205] concerned a refugee with severe mental health problems, spoke no English, was illiterate and had significant memory difficulties. The local authority refused Care Act 2014 support after an assessment which was completed without consideration of the need for an advocate. In striking down the decision the court held that it was a:

> 'paradigm case where such an advocate was required, as in the absence of one the claimant was in no position to influence matters'

Hospital Discharge (section 74)

Section 74 and Schedule 3 and the associated regulations[206] contain provisions designed to encourage social services to speed up the discharge of patients who no longer require care in an acute hospital[207] although, as the revised Statutory Guidance notes at para 15.43, 'the majority of delayed discharge days are attributable to the NHS'. Schedule 3 enables a hospital to serve on the relevant social services department an 'assessment' notice advising that a named patient is likely to be ready for discharge on a specified date. Within 2 days of receiving this notice the social services department must undertake an assessment of the patient's needs and an assessment of any person caring for the patient (reg 8).

Before issuing the assessment notice, the NHS body must 'consult the patient, and where it is feasible to do so, any carer that the patient has'[208] and the notice must state that this has been done and whether the patient / the patient's carer has objected to the giving of the assessment notice'.[209] As noted below, a refusal by the patient (or the carer, if the discharge is dependent upon their involvement) has the effect of absolving the local authority from the liability to pay the discharge penalty.

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[202] 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/.
[203] Lucy Series *Care Act 2014: Consultation on Draft Guidance & Regulations* (2014) http://thesmallplaces.wordpress.com.
[204] K Newbigging, J Ridley & J Sadd *Commissioning Care Act Advocacy* Birmingham University Dec 2016.
[205] [2015] EWHC 2579 (Admin) at para 40 Mr John Bowers QC, sitting as Deputy High Court Judge.
[206] The Care and Support (Discharge of Hospital Patients) Regulations 2014 SI 2823.
[207] Maternity care, mental health care, palliative care, intermediate care and care provided for recuperation or rehabilitation are excluded from the definition of acute care.
[208] Care Act 2014, para 1(4) Schedule 3.
[209] The Care and Support Discharge of Hospital Patients) Regulations 2014 SI 2823 Reg 3(f)(iii).

The NHS may issue a 'discharge' notice giving at least one day's notice of the required discharge, and if after this the patient cannot be discharge for the 'reason alone'[210] that the local authority has not carried out the relevant assessments or put in place arrangements 'for meeting some or all' of the identified eligible needs, then it is liable to make a payment to the NHS (as at 2015 of £155 or £130 per day depending on whether it is a London Borough).

A major change with the Care Act regime is that reimbursement is no longer mandatory:[211] Schedule 3 para 4(1) merely stating that in such cases 'the NHS body responsible … may require the relevant authority to pay the specified amount … .' In this context the revised Statutory Guidance advises (para 15.41) that this possibility 'is intended to act as an incentive to improve joint working between the NHS and local government, but should not be seen in isolation' and at Annex G para 39 'that NHS bodies should not use reimbursement as the first approach to address any local difficulties around delayed transfers of care' and that:

> While reimbursement remains available for use by the NHS body, they and local authorities are encouraged to use the provisions on the discharge of hospital patients (such as the issue of assessment and discharge notices) to seek to focus on effective joint working so as to improve the care of those people whose needs span both NHS and local authority care settings …

As under the pre-Care Act regime, if the local authority has assessed and put in place arrangements for meeting some or all of the patient / carers needs, then a refusal by the patient or carer of such a package has the effect of absolving social services from its liability to pay the NHS for a delayed discharge - because the delay is not solely attributable to a social services failure.[212]

As with the previous system there appears to be no statutory provision that enables a local authority to require the discharge notice to be withdrawn if the NHS has itself failed to do something crucial – eg to provide social services with an OT or other relevant assessment when serving the assessment notice. Not infrequently the NHS staff will simply forget to serve the notices on admission or at an early stage and only realise the omission when the patient is ready for discharge – at which point the two notices are served simultaneously. Whilst 2 days may be adequate for patients with straight forward after care needs – this may not be feasible for patients with complex aftercare requirements.

The process as drafted is 'one-sided' and makes no allowance for NHS omissions of this kind – even though (as the revised Statutory Guidance acknowledges) the majority of delayed discharge are attributable to NHS failures. At the very least the NHS assessment notice should be accompanied by a checklist confirming that all the relevant papers (ie OT assessments etc) are attached.[213]

As noted above, the obligation to provide independent advocacy (section 67) applies to hospital discharge assessments as it does to other Care Act assessments.[214] In such cases the stipulation that the duty only arises if there is no other appropriate representative available (section 67(5)) does not apply, if there is: (a) disagreement on a 'material issue' between the local authority and the person and; (b) the local authority and the person agree that advocacy support is in the person's best interests. If the person disagrees with a local authority decision that they are ready to be moved to another hospital or that they should be

[210] Schedule 3 para 4(2).
[211] As it was under the Community Care (Delayed Discharges etc.) Act 2003 s6(2).
[212] As the delay does not result from the local authority's failure – that 'reason alone' – Schedule 3 para 4(2).
[213] Currently this is not required by The Care and Support Discharge of Hospital Patients) Regulations 2014 SI 2823, reg 3.
[214] If it is 'is likely to' result in the NHS making funding the person in a hospital for a period of 28 days or more; or a care home for a period of 8 weeks or more - The Care and Support (Independent Advocacy Support) (No. 2) Regulations 2014 reg 4 (2)(a) – and see also the revised Statutory Guidance para 7.22.

discharged to a care home for an extended period,[215] then (subject to the best interest requirement) the duty arises. Given the many problems that arise on disputed hospital discharges (and the section 1 assumption that the 'individual' is best placed to judge their well-being) the presumption must be that in such situations it would be in a person's best interest to have advocacy support.

Hospital Discharge and carers

A 2016 ombudsman's report[216] highlights the requirement, not only to involve carers in the hospital discharge process but also that the duty to assess a main carer before the discharge occurs is a requirement of CA 2014, s10. In the ombudsman's opinion it was also important for the carer to have been at the assessment.

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)). On release, however, 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 17.48).[217] This is a presumption that appears to be easily rebutted, as the revised Statutory Guidance notes (para 17.50)

> In situations where an offender is likely to have needs for care and support services on release from prison or approved premises and their place of ordinary residence is unclear and/or they express an intention to settle in a new local authority area, the local authority to which they plan to move should take responsibility for carrying out the needs assessment.

Problems will inevitably occur with local authorities reluctant to accept responsibility for prisoners – especially if they are 'expressing an intention' to settle in a new area. The suggestion that in such cases the 'receiving' authority' should undertake the assessment is unrealistic. What will presumably happen is that the prison social work team will undertake the preliminary assessment work and only when the proposed care and support plan has reached a relatively advanced stage – will the 'receiving' authority' then be required to complete the process.

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 revised Statutory Guidance para 17.12). 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 17.17 states 'they must carry out an assessment as they would for someone in the community'.

New statutory appeals process (section 72)

[215] ibid.
[216] Complaint no 16 003 456 against Surrey County Council 8 Sept 2016 and see also complaint no 15 014 893 against Dorset County Council 1st September 2016.
[217] Para 17.48 advises that the deeming provisions in section 39 of the Care Act 2014 do not apply to people who are leaving prison

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:[218]

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 system[219] which sought to narrow considerably the issues on which complaints could be made; have as the 'independent element 'reviewers' (appointed by the local authority) who it appeared would not routinely meet the complainant – and who could only make recommendations – with the final decision being made by the local authority. In July 2015 the Government announced that the implementation of the new appeals process would be delayed.[220]

s117 Mental Health Act 1983 (section 75)

The duty on health and social care bodies to provide support services under s117 remains and is distinct – ie not covered by the Care Act. This means that the assessments to determine eligibility for section 117 aftercare support derive from the duty under the NHS & Community Care Act 1990, section 47 and so this section survives the general repeal of pre-Care Act legislation.[221] This in turn means that the eligibility criteria (discussed above) do not apply to such assessments.

Under the pre-Care Act regime 'after-care services' were not defined by the 1983 Act. The Care Act however inserted a new subsection (6) 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 regulations[222] to introduce a limited 'choice of accommodation' for persons subject to s117[223] and also to confirm that people eligible for s117 support can 'top-up' their care and support packages.[224]

In relation to ordinary residence the revised Statutory Guidance (para 19.43) makes clear 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

[218] Minister of State (Norman Lamb) Public Bill Committee (Bill 123) 2013-2014 4th February 2014 p585 (The Stationery Office 2014)
[219] 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
[220] Written Statement of 17 July 2015 the Parliamentary Under Secretary of State, Department of Health, Lord Prior of Brampton.
[221] See The Care Act 2014 and Children and Families Act 2014 (Consequential Amendments) Order 2015..
[222] The Care and Support and After-care (Choice of Accommodation) Regulations 2014.
[223] See *R (Wiltshire) v Hertfordshire CC* [2014] EWCA Civ 712 19 para 20.
[224] See revised Statutory Guidance Annex A: Choice of accommodation and additional payments para 39.

> 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)

Section 117 and CA 2014 ordinary residence interface

Many individuals entitled to support under MHA 1983 s117 will also have CA 2014 support needs .Since the Acts take a different approach to ordinary residence there is the risk the authority responsible for the support needs under the 2014 may be different to the authority responsible for the provision of care and support under s117. This problem is addressed by the CA 2014 s39(4) which provides that an adult who is being provided with accommodation under s117 is to be treated for the purposes of the CA 2014 'as ordinarily resident in the area of the local authority in England or the local authority in Wales on which the duty to provide the adult with services under that section is imposed'.[225]

[225] Ie i.e. the local authority in whose area the person was ordinarily resident immediately before being detained for treatment under the 1983 Act.

Young Carers, Disabled Children, and Parent Carers

Although the primary purpose of Part 1 of the Care Act 2014 was 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 came into force in April 2015.

The amendments to Children and Families Act 2014 were made at a 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').

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 revised 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.[226] 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 revised 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 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 of the revised Statutory Guidance 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':

[226] 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.

> 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 revised Statutory 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 revised Statutory Guidance is unequivocal in stating that the transition assessment process should begin from year 9[227] (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 revised Statutory Guidance (para 16.15) concerning the timing of a transition assessment. It concerns a 15 year old disabled child who attends an education 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

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

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 terms[228] 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 terms[229]) 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)).

[228] 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.
[229] 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 support arrangements

Parent carers in general

The Children & Families Act 2014, section 97 amends the Children Act 1989[230] to oblige local authorities to assess parent carers[231] 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.

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'.[232] 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'[233] and must also have regard to:[234]

- the well-being of the parent carer ('well-being' has the same meaning as the Care Act 2014 section 1[235]), 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 remain relevant. A key ombudsman's report[236] 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 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)).

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[230] By adding s section 17ZD and section 17ZE.
[231] referred to in the Care Act 2014 as 'child's carers' – sections 60 – 62 above.
[232] Children Act 1989, section 17ZD(2).
[233] Children Act 1989, section 17ZD(9).
[234] Children Act 1989, section 17ZD(10).
[235] Children Act 1989, section 17ZD(11).
[236] Public Service Ombudsman (Wales) Complaint No. B2004/0707/S/370 against Swansea City Council 22 February 2007 see in particular paras 78, 133 &137.

There is in addition a strategic duty on 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 carers[237] - but adults who care for a disabled child – but who do not have parental responsibility[238] 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, AND 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 revised Statutory Guidance to the Care Act highlights the importance of support for people such as grandparents who are providing care (para 6.121) - 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.[239] 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 1989[240] 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 came 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 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.

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[237] 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).

[238] 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.*

[239] See The Care Act 2014 and Children and Families Act 2014 (Consequential Amendments) Order 2015.

[240] By inserting a new section 17ZA.

The Young Carers' (Needs Assessments) (England) Regulations 2015[241] 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 explained that a "whole family approach" 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 parties[242] 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.

[241] SI 527
[242] 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,[243] 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 reviewed[244] 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 revised Statutory 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 16.20) 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 in the revised Statutory Guidance being (para 16.21):

> … 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 16.22) 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'.

[243] 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.
[244] ie be treated as a 'needs assessment under s60 Care Act 2014'.