The Care Act 2014

A guide to efficient and effective interventions for implementing the Care Act 2014 as it applies to carers

Version 2 – Updated December 2018

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Charity number - 299154

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Introduction

Four years on from the introduction of the Care Act, the second version of this document aims to both provide guidance for local authorities on effectively and efficiently delivering these carer elements of the Care Act and capture the direction of travel of local authorities concerning many aspects of their work with carers. It does so by bringing together a summary of the key section of the statutory guidance relating to carers with existing good practice and effective operating models from across the country that can help fulfill the requirements and expectations of the Act. This refreshed document includes a selection of updated and new practice examples as well as results from a recent survey of local authority carers leads completed by the ADASS Carers Policy Network.

The original version of this document responded to feedback from local authorities and others who have said that, whilst they support the fact that carers are “mainstreamed “ in the guidance, it would be helpful to have a reference document that pulls the parts of the statutory guidance that are about carers into one place.

Following the introduction of the Care Act many councils have adapted and changed practices in order to be compliant. In the ADASS Carers Policy Network survey, 63% of councils said they had taken the opportunity to do new things or commission services differently. 9% said that they were already compliant but had to recommission differently due to budget pressures and meeting Care Act requirements. This contrasts with 20% who said that they were already compliant and their practices have remained largely similar since the introduction of the Act.

This guide reproduces sections of the statutory guidance for the Care Act where necessary to bring out points of particular relevance to carers, but it does not replace the guidance in its totality and as such it does not negate the need to refer to the statutory guidance. This is because much of the Care Act applies equally to carers and the person or people they care for, and as such much of the content about people with a care and support need will be relevant to a carer with a support need. For ease of reference links to further reading in the statutory guidance, plus links to and other materials to support implementation of the Care Act, are provided in each chapter.

Evidence continues to show that carers face significant challenges - Almost three quarters (72%) of respondents to the Carers UK State of Caring 2018 survey who are currently providing care said they had suffered mental ill health such as stress or

depression as a result of caring, while well over half (61%) said their physical health had worsened as a result of caring[1]. Furthermore, Over a third of carers (37%) describe their financial situation as 'struggling to make ends meet', while a further 20% say they are in or have been in debt as a result of caring.[2]

The Care Act has meant many changes for councils; from how they assess carers to the type of support they are providing.

This new version of this document follows a renewed focus on carers at national Government level following the introduction of the cross-Government Carers Action Plan in June 2018 which outlined work which will be completed from 2018 to 2020.

"Government is committed to supporting carers to provide care as they would wish, and to do so in a way that takes account of their own health and wellbeing, access to education, employment and life chances.

However, some solutions reach beyond the health and care system, and indeed beyond the influence of Government. We also need businesses, local communities, the voluntary sector and individuals to play their part in addressing these challenges to make sure that caring is everybody's business.

At the root of this is the need to raise the profile of carers and caring – so that all of us recognise and value the contribution carers make within our families, communities, workplaces and society."

The Care Act 2014, alongside the Children and Families Act 2014, represented a new legal framework providing new rights and entitlements to carers. Local authorities continue to implement this vision and it is hoped that this guide will support them in their work developing innovative practices that both efficiently and effectively support carers.

Note: For the purpose of this document the sections taken directly from the statutory guidance are indicated by a shaded box like this one. The full guidance is available online

ADASS Carers Policy Network Survey
A survey was sent to Local Authorities Carers Leads in June 2018 through the ADASS Carers Policy Network. Forty seven Local Authorities across the nine regions of England responded to the survey. Comments and responses are included in this document to indicate the direction of travel in practice since the implementation of the Care Act. These responses have been anonymised where appropriate.

[1] Carers UK (2018) State of Caring 2018
[2] Carers UK (2018) State of Caring 2018

CONTENTS

General Responsibilities and Universal Services		Page
Chapter 1:	Promoting wellbeing	4
Chapter 2:	Preventing, reducing or delaying needs	5
Chapter 3:	Information and advice	10
Chapter 4:	Market shaping and commissioning of adult care and support	15
First Contact and Identifying Needs		
Chapter 6:	Assessment and eligibility	22
Charging and Financial Assessment		
Chapter 8:	Charging and financial assessment	31
Person-centred care and support planning		
Chapter 10:	Care and support planning	35
Chapter 11:	Personal budgets	40
Chapter 12:	Direct payments	44
Chapter 13:	Review of care and support plans	47
Adult safeguarding		
Chapter 14:	Safeguarding	49
Integration and partnership working		
Chapter 15:	Integration, cooperation and partnerships	54
Chapter 16:	Transition to adult care and support	62
Chapter 18:	Delegation of local authority functions	65
General Responsibilities and Universal Services		
Chapter 19:	Ordinary residence	68
Chapter 20:	Continuity of care	68

General responsibilities and universal services

Chapter 1
Promoting Wellbeing
(see page 1 of the statutory guidance)

The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. Throughout this guidance document, the different chapters set out how a local authority should go about performing its care and support responsibilities.

Underpinning all of these individual "care and support functions" (that is, any process, activity or broader responsibility that the local authority performs) is the need to ensure that doing so focuses on the needs and goals of the person concerned.

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

The wellbeing principle applies in all cases where a local authority is carrying out a care and support function, or making a decision, in relation to a person. For this reason it is referred to throughout this guidance. It applies equally to adults with care and support needs and their carers.

The statutory guidance provides further detail about:

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

This document does not discuss wellbeing as a stand-alone chapter. Because the duty to promote wellbeing when exercising a care and support function applies equally to carers, all of the examples discussed below are ways of promoting wellbeing.

Chapter 2
Preventing, reducing or delaying needs
(see page 7 of the statutory guidance)

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

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

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

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

Carers and prevention

Carers play a significant role in preventing the needs for care and support for the people they care for, which is why it is important that local authorities consider preventing carers from developing needs for care and support themselves. There may be specific interventions for carers that **prevent, reduce or delay** the need for carers' support. These interventions may differ from those for people without caring responsibilities. Examples of services, facilities or resources that could contribute to preventing, delaying or reducing the needs of carers may include but is not limited to those which help carers to care effectively and safely – both for themselves and the person they are supporting, for example:

- timely interventions or advice on moving and handling safely or avoiding falls in the home, or training for carers to feel confident performing basic care tasks;
- look after their own physical and mental health and wellbeing, including developing coping mechanisms;
- make use of adaptations, equipment IT and assistive technology;
- make choices about their own lives, for example managing care and paid employment;
- find support and services available in their area;
- access the advice, information and support they need including information and advice on welfare benefits and other financial information and about entitlement to carers' assessments (see chapter 6).

As with the people they care for, the duty to prevent carers from developing needs for support is distinct from the duty to meet their eligible needs (see chapter 6). While a person's eligible needs may be met through universal preventative services, this will be an individual response following a needs or carer's assessment. Local authorities cannot fulfill their universal prevention duty in relation to carers simply by meeting eligible needs, and nor would universal preventative services always be an appropriate way of for meeting carers' eligible needs.

The statutory guidance provides further detail about:

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

Efficient and effective interventions to fulfill these duties

Across the country there are many excellent examples of preventative services. Key themes in good preventative services include:

- importance of **identifying carers** who are not already in touch with services, especially via cooperation with NHS bodies such as general practices
- building links with **public health** services, recognising that carers are often at greater risk of developing health problems than the general population
- providing bespoke **advice** to help carers better manage their caring role and access support
- a **dedicated team** for prevention can be helpful

Respondents to the ADASS Carers Leads Survey were asked if they had adopted any new strategic shifts in a number of areas to meet section 2 requirements. Almost all areas have significant advice and information offers for carers in their area and see this as an important strategic priority. Many respondents felt that digital is an area of growth for councils more widely than just their work within adult social care and this is evident by the increasing range of use of digital resources. An example is the use of social media, online directories and advice pages which are much more common now.

Carers' learning and development was a strategic focus for many areas, often forming a key part of their commissioned services, but delivered in many ways and at times in partnership with other services. Many respondents expected this to get bigger in the future as a key part of their prevention strategy.

There are many examples across the country of how local authorities and their partners in health have got to grips with promoting wellbeing and providing services which may prevent the need for ongoing care and support.

Section 15 of this document has further examples of how health and social care can work together to identify and support carers.

Carers Wakefield and District 'Looking After Me' Programme
'Looking After Me' is a 4 week life coaching programme run by Carers Wakefield and District where carers have the opportunity to identify their aspirations and personal goals, and be supported to identify and take steps towards achieving something meaningful and important for themselves. The programme is funded by The Big Lottery People's Project and is delivered by a life coach/occupational therapist (an ex-carer and volunteer at Carers Wakefield & District) who understands the pressures that carers face, the need for them to feel valued/important and to make time do something to maintain their own health and

wellbeing so that they can continue to provide care for their loved ones. Carers are encouraged /supported to:

- Take control of their situation.
- Find their inner strength
- Step out of their comfort zone.
- Grow self-esteem, confidence and resourcefulness.
- Challenge negative thoughts, beliefs & assumptions.
- Take action to maximise their quality of life & achieve goals.

'Looking After Me' runs on a rolling basis, is delivered in various locality based venues across the district which are accessible to carers. It is delivered by a facilitator but also uses peer support to enable participants to achieve.

It is evident from evaluations that the programme has a positive impact on carers' lives. Carers report that they feel valued and they are given permission to identify what they would like to achieve for themselves. To date 60 carers will have benefitted from the programme.
http://www.carerswakefield.org.uk/

Working Carers Employers Community – Carers Leeds and Leeds City Council
Carers Leeds and Leeds City Council are working with employers from across Leeds covering all sectors and sizes to improve support for working carers. The Working Carers Employers Forum exists to exchange best practice and learn from each other, work through challenges collectively and try out new ideas and innovations in a safe environment.

Leeds City Council have identified funding for three years from 2017/2018 to:

- To further raise awareness of working carers issues with employers in Leeds to improve the identification of and support for working carers
- To work with new and existing employers and working carers to identify and provide practical ways to advise and support them
- To further develop a community of proactive employers in Leeds

http://www.carersleeds.org.uk/supporting-working-carers/
Further examples of good practice with working carers is in section 3

Community based carer passports and discount card schemes
Carer Passports offer an opportunity for community-based recognition of carers while offering them a route into support and appreciation for their caring role. Carer Passports are essentially a record which identifies a carer in some way and sets out an offer of support, services or other benefits in response. Whilst carer passports can exist in many contexts, including workplaces and schools, in a community setting they tend to involve discounts provided by local shops/businesses.
They are an effective tool in prevention because the discounts aspect encourages people to identify themselves as a carer to the organisation organising the scheme, often a carers centre, thereby linking themselves in for further support. Organisations who are interested in setting up a scheme can access resources and templates online.
https://carerpassport.uk/community

Carers in Hertfordshire have a well-established Carer Passport discount card which offers over 400 discounts to the 12,000 carers who have been issued a card. 55% of the card holders are also accessing support or advice from Carers in Hertfordshire.
http://www.carersinherts.org.uk/how-we-can-help/carer-services/carers-discount-passport

Links to further examples

The **Social Care Institute for Excellence** has developed the Prevention Library, which highlights emerging practice and research in the provision of prevention services in adult social care.
http://www.scie.org.uk/prevention-library/

Macmillan Cancer Support has produced guidance and e-learning for health professionals on identifying cancer carers and where to signpost to support.
www.macmillan.org.uk/supportingcarers
http://learnzone.org.uk/courses/course.php?id=309

The **North East Lincolnshire Carers Strategy Group**, designed, developed and produced a carers animation to identify hidden carers across NEL. This inventive method of identification has been very effective locally in improving identification. The animation is available to view on the homepage of the North East Lincolnshire Carers Support Service website
https://www.carerssupportcentre.com/north-east-lincolnshire/

Carers Northumberland operates Carers Clinics in GP surgeries which enable the early identification of carers through training of practice staff. For example, Care Navigators, who are generally reception staff, are trained to signpost patients to activities to avoid social isolation or to carers organisations, or to social care depending on their circumstances. Carers Northumberland also held information points in GP surgeries to encourage carers to register with their local carers centre and allowed GPs to make direct referrals. In 2016/17 the project identified 390 carers.
http://www.carersnorthumberland.org.uk/our-services/carer-clinics/

Plymouth is one of a number of areas which is working on a localised model of health support with their wellbeing hubs which are currently being extended across the area. Each hub is designed to allow quick access to advice, information and support and prevent needs escalating. The local carers service will be working with the hubs to ensure information for carers is available. There are future plans to hold carer-specific drop-ins and peer support groups within the hubs.
https://www.newdevonccg.nhs.uk/news/wellbeing-hubs-launch-in-plymouth-103584

Calderdale Council commissions Making Space to run a monthly support group for female black/minority ethnic carers of people with mental health needs called Sukoon Group. This need for this group was identified as these carers were particularly isolated and has resulted in increased confidence, enhanced well-being, reduced isolation, anxiety and depression for participants.
https://makingspace.co.uk/services/centres/calderdale-mental-health-carer-support

Chapter 3

Information and advice

(see page 23 of the statutory guidance)

Local authorities are responsible for ensuring that all adults including carers in their area with a need for information and advice about care and support are able to access it. This is a very broad group, extending much further than people who have an immediate need for care or support. It will only be achieved through working in partnership with wider public and local advice and information providers. People (carers included) who are likely to need information and advice include, but are not restricted to:

- people wanting to plan for their future care and support needs;
- people who may develop care and support needs, or whose current care and support needs may become greater. Under the duty of prevention in Section 2 of the Act, local authorities are expected to take action to prevent, delay and/or reduce the care and support needs for these people (see chapter 2 on prevention);
- people who have not presented to local authorities for assessment but are likely to be in need of care and support. Local authorities are expected to take steps to identify such people and encourage them to come forward for an assessment of their needs (see chapter 2 on prevention);
- people who become known to the local authority (through referral, including self-referral), at first contact where an assessment of needs is being considered (see chapter 6 on assessments);
- people who are assessed by local authorities as currently being in need of care and support. Advice and information must be offered to these people irrespective of whether they have been assessed as having eligible needs which the local authority must meet (see chapter 6 on assessments);
- people whose eligible needs for care and support the local authority is currently meeting (whether the local authority is paying for some, all or none of the costs of meeting those needs) (see chapter 10 on care and support planning);
- people whose care and support or support plans are being reviewed (see chapter 13 on reviews of care and support plans);
- family members and carers of adults with care and support needs, (or those who are likely to develop care and support needs). Under Section 2 of the Act, local authorities are expected to have regard to the importance of identifying carers and take action to reduce their needs for support (see chapter 6 on assessments);
- adults who are subject to adult safeguarding concerns (see chapter 14 on safeguarding);
- people who may benefit from financial information and advice on matters concerning care and support. Local authorities must have regard to the

importance of identifying these people, to help them understand the financial costs of their care and support and access independent financial information and advice including from regulated financial advisers (see paragraph 3.49);
- and, care and support staff who have contact with and provide information and advice as part of their jobs.

Carers and information and advice

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

- breaks from caring;
- the health and wellbeing of carers themselves;
- caring and advice on wider family relationships;
- carers' financial and legal issues;
- caring and employment;
- caring and education; and,
- a carer's need for advocacy.

The statutory guidance provides further detail about:

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

Efficient and effective interventions to fulfill these duties

There is evidence nationally of examples of information and advice services which have been developed. Key themes in providing good information and advice include:

- **Information and advice** should have a focus on meeting a broad range of carers needs;
- A **range of organisations** can be used to ensure appropriate access to information and advice and reaching hidden carers;
- Providing opportunities for **web based**, telephone and face to face provision of information can improve access to information for carers;
- Meeting carers information needs and providing **appropriate sign posting** can assist carers in managing their caring role.

Examples

Carers UK Digital Resource for Carers
The Carers UK Digital Resource for Carers brings together a number of digital products and online resources, to help organisations including local authorities provide comprehensive information and support for carers. The Digital Resource includes e-learning programmes, access to Jointly (a care coordination app) and a carers rights guide. The resource can help service providers deliver on their Care Act prevention duties by providing local carers with advice and information before they reach crisis point.
https://www.carersuk.org/for-professionals/carersuk-products/digital-resource-for-carers

Several authorities use Carers UK's Digital Resource for Carers combining a range of different information based resources to help complement those commissioned locally. Surrey County Council led this approach, looking to provide information at population wide-level.

"There are over 108,000 carers in Surrey and as budgets get tighter we need to work smarter in reaching out to them. Embedding digital as part of service transformation will allow us to provide greater levels of support to more carers - more effectively and more cost effectively. Critically, the Digital Resource for Carers will help local authorities meet their Care Act duties on information and advice, prevention and wellbeing, and deliver on the NHSE and ADASS Memorandum of Understanding to support carers across health and social care." **–** John Bangs, Surrey County Council

Advice and Information services in Richmond
In the London Borough of Richmond, a carers' hub service has been commissioned to provide a range of information and advice since 2012. The Carers Hub Service, which was originally commissioned in 2012, is led by Richmond Carers Centre with 6 subcontracted organisations delivering specialist services including dementia, addiction, financial, BAME and neurological conditions. The service is performance monitored, and as of October

2017 has reported that across the range of organisations, they are in touch with 437 young carers and 1701 adult carers.

All carers registered with Richmond Carers Centre receive information and advice in the form of a quarterly electronic or hard copy of newsletter. Information and advice requests are monitored and these show that the number of information requests received for period August 2016 to July 2017 (year 5 of service) was 4485 and the number of people accessing benefits advice was 255. 451 Adult carers have accessed 940 individual emotional support sessions, and 283 adult carers have participated in 109 group support sessions. 469 adult carers accessed 2929 breaks and 264 participated in 39 training and education sessions. 157 young carers accessed 331 breaks delivered through a range of group leisure activities.
http://www.richmondcarers.org

Links to further examples

London Borough of Newham provides guidance to practitioners on the importance of an effective approach to providing information, advice, guidance screening and signposting.
http://londonadass.org.uk/wp-content/uploads/2014/10/FactSheet-2-Good-Practice-IAG-Screening-Signposting.pdf

The **Social Care Institute for Excellence** has developed seven e-learning modules which are aimed at anyone who comes into contact with people with dementia. The learning material covers a general introduction to the disease and the experience of living with dementia. However, the SCIE website states that this e-learning course has not been updated since January 2009. It may not reflect current policy but still provides valuable practice guidance. SCIE is currently developing a new awareness course and a much bigger course focused on person-centred care skills, is in development but will not be available until 2019.
http://www.scie.org.uk/publications/elearning/dementia/index.asp

A carers toolkit has been produced by **Think Local Act Personal** to help local areas address the requirements of the Care Act and associated statutory guidance in relation to the provision of information and advice. It is geared towards officers and especially council officers responsible for reviewing information and advice, and for developing a new strategy. The toolkit will also be of interest to all organisations that provide information and advice around care and support.
http://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/Information-and-Advice-Strategy-Toolkit/

Carer Passports, explained in more detail in chapter 2, can be used as a useful tool to link carers into advice and information to support them in their caring role.
https://carerpassport.uk/

Advice and Information for working carers

The majority of respondents to the ADASS Carers Policy Network survey reported having increased their work on carers and employment in the last few years. For a few respondents this included the council becoming more supportive of working carers in their own workforce, for example by implementing training for managers or setting up a carers group. A third of respondents are not yet working with local employers but wanted to develop these connections in the future. Most councils recognised providing targeted help to keep carers in work as an area for development although some already incorporated this into their assessment process.

Employers for Carers

Leeds City Council holds an 'umbrella' membership of Employers for Carers which is a national network of employers who are committed to working carers and is backed up by the specialist knowledge of Carers UK. Umbrella membership means that small and medium enterprises (SME) in Leeds can benefit from membership under the 'umbrella' of Leeds City Councils membership and have free access to the network resources.

Through Employers for Carers Umbrella Membership, Surrey County Council has been able to increase the number of local employers they are engaged with from 3 to 25 over the last 12 months, including a range of diverse organisations.

Employers for Carers has helped Lincolnshire Council develop its 'System Led Support for Carers' – helping reach more carers earlier, and aiming to support resilience in employment. Through this project, delivered by local charity EveryOne, the council has been able to engage with a wide range of employers. The project builds on their existing offer of the local 'Carers Quality Award' which works with local businesses and services to help offer a 'Carer-Friendly' service. Lincolnshire is now in the process of signing up public sector Health organisations and District Councils, as part of taking a 'System Led Approach to Supporting Carers'. Lincolnshire Council has successfully signed up 27 SME's in the last 12 months, with an estimated reach to 475 employees.
https://www.employersforcarers.org/

Chapter 4

Market shaping and commissioning of adult care and support

(see page 41 of the statutory guidance)

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

4.43. When considering the sufficiency and diversity of service provision, local authorities should consider all types of service that are required to provide care and support for the local authority's whole population, including, for example:

- support services and universal and community services that promote prevention;
- domiciliary (home) care;
- homes and other types of accommodation care;
- nursing care;
- live-in care services;
- specialist care;
- support for carers;
- re-ablement services;
- sheltered accommodation and supported living;
- shared lives services;
- other housing options;
- community support;
- counselling;
- social work;
- information, brokerage, advocacy and advice services;
- direct payment support organisations

4.52. Since 2007 there has been a duty on local authorities and latterly clinical commissioning groups, through health and wellbeing boards, to undertake Joint Strategic Needs Assessments (JSNA). JSNA is a process that assesses and maps the needs and demand for health and care and support, supports the development of joint Health and Wellbeing Strategies to address needs, understands community assets and informs commissioning of local health and care and support services that together with community assets meet needs.

4.53. Market shaping and commissioning intentions should be cross-referenced to JSNA, and should be informed by an understanding of the needs and aspirations of the population and how services will adapt to meet them. Strategies should be informed and emphasise preventative services that encourage independence and wellbeing, delaying or preventing the need for acute interventions. Statutory guidance on JSNA and Joint Health and Wellbeing Strategies was published in March 2013. The ambition is for market shaping and commissioning to be an integral part of understanding and delivering the whole health and care economy, and to reflect the range and diversity of communities and people with specific needs, in particular:

- people needing care and support themselves (through for example, consumer research);
- carers;
- carer support organisations;
- health professionals;
- care and support managers and social workers (and representative organisations for these groups);
- relevant voluntary, user and other support organisations;
- independent advocates;
- wider citizens;
- provider organisations (including where appropriate housing providers); and other tiers of local government.

4.54. A co-produced approach will stress the value of meaningful engagement with people at all stages, through design, delivery and evaluation, rather than simply as 'feedback'. Local authorities should publish and make available their local strategies for market shaping and commissioning, giving an indication of timescales, milestones and frequency of activities, to support local accountability and engagement with the provider market and the public.

4.69. Local authorities (through an engagement process, in concert with commissioners for other services where appropriate) should understand and articulate the characteristics of current and future needs for services. This should include reference to underpinning demographics, drivers and trends, the aspirations, priorities and preferences of those who will need care and support, their families and carers, and the changing care and support needs of people as they progress through their lives. This should include an understanding of:

- people with existing care needs drawn from assessment records;
- carers with existing care needs drawn from carers' assessment records;
- new care and support needs;
- those whose care and support needs will transition from young people's services to adult services;
- those transitioning from working-age adults to services for older people;
- people whose care and support needs may fluctuate;

- people moving to higher needs and specialised care and support; and those that will no longer need care and support.

The statutory guidance provides further detail about:

The principles which should underpin market-shaping and commissioning activity:

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

Efficient and effective interventions to fulfil these duties

Across the country, local authorities adopt a range of approaches to ensure that their local market meets the needs of carers. Key themes in effective market shaping and commissioning include:

- Maximising **pooled budget** arrangements across health and care for the commissioning of carers services can ensure a joined up approach to developing a diverse market locally
- Enhancing links with **public health intelligence** and utilising the Joint Strategic Needs Assessment can drive the commissioning of a broader range services to meet carers outcomes
- Adopting an approach to **engaging and involving** carers ensures that local market position statements are coproduced and more likely to result in a flexible market place

Commissioning services

When commissioning services most councils who responded to the ADASS Carers Policy Network survey have a competitive tendering process based on their required outcomes. Most councils reported that these processes are open, in line with the rest of the council's processes and comply with the EU Public Contracts Regulations 2018. In some areas smaller level commissioning may be done on a grants basis for just a year. Very few councils had rolling contracts and the vast majority commission services for 3-5 years upfront followed by a further 2 years or +1+1 arrangement.

Hillingdon Carers Partnership

In Hillingdon, there is an aggregated commissioning model where a partnership of organisations (Hillingdon Carers, Hillingdon Young Carers, Alzheimers Society, Hillingdon Mind, Carers Trust Thames and Harlington Hospice) are commissioned to deliver support for carers. The organisations have a central database, share posts across organisations and deliver many projects jointly.

The vision of the partnership is to provide a single, integrated, borough-wide service that provides high quality, specialist and consistent support to carers of all ages. Working together, the organisations improve carers' experiences of help, advice and support by ensuring that:

- Carers now only tell their story once and all relevant services wrap around – there is no more sign-posting, just active referral across the Partnership and beyond
- All carers receive a Carers Assessment at the first point of contact – a CA has replaced previous registration processes across all partners. Social Services still conduct joint-needs assessments and those where the carer or care-recipient is under 18.
- The number of services available to carers has trebled over the last few years based on priorities set by carers.

Working jointly has brought significant cost saving advantages as they are able to jointly tender for support contracts (IT, audit, telephony) using their collective buying power.

Last year, for the first time, identification of new carers topped 1,000 in 12 months due to improved communication and coordination – identification rate now stands at 28% (from 14% in 2014) and about 37% for young carers.
http://www.hillingdoncarers.org.uk/123

Involvement of carers in market shaping

When asked how carers' needs for services are considered during the 'shaping the market' for care services, many respondents reported that they involve carers as experts by experience in many areas of decision making. Common methods of involvement included having local carers panels or forums and running consultations and surveys to capture opinions. Other councils also mentioned reviewing GP patient survey information and requiring contracted partners to demonstrate a consultative or co-production approach.

Croydon Carers Strategy

In the development of their 2018-2022 Carers Strategy, Croydon Council engaged carers to gain their opinions and ideas on how to improve life for carers locally.

From 2015 to 2017 the Council completed a series of pieces of research designed to better understand the needs of carers, to understand what was working well and identify areas for improvement. In 2016, two methods of data collection were utilised: an online and paper survey and seven focus groups. From this work, a series of recommendations were developed.

In the production of the strategy, a total of 329 carers and professionals were engaged through 22 workshops. This was made of 111 carers and professionals attending 13 workshops to coproduce the themes, ideas on service provision and commissioning. They helped to identify gaps in the current system that have informed the development of this strategy.

Once the draft report was complete a further 9 focus groups were held where the strategy was reported back to the community in order to provide them with an opportunity to comment on any areas. 95 carers and professionals attended these workshops which were held with various groups such as; the Carers Partnership Group, Adult Social Care & NHS staff, working carers, parent carers, black & minority ethnic carers, and carers of people with dementia.

https://www.croydon.gov.uk/sites/default/files/articles/downloads/Croydon%27s%20Carers%27%20Strategy%202018-2022.pdf

Further Examples of involvement of carers include:

- **Carers Voice Somerset**
  http://www.somerset.gov.uk/organisation/partnerships/carers-voice-somerset-partnership-board/
- **Cornwall Carers Forums**
  https://www.supportincornwall.org.uk/kb5/cornwall/directory/service.page?id=DFueuq88WGE

Carers' Learning and Development

For many councils, learning and development is a key part of the services they commission as it is recognised that that it can play a large role in prevention by improving carers' wellbeing. Almost all councils responding to the ADASS survey had some form of carers learning and development but there was a large variety about the type and delivery of training on offer. Many areas have practical training for carers such as moving and handling and first aid and some also offered wellbeing training.

West Sussex Carers Wellbeing Programme

West Sussex offers a variety of e-learning and face to face training as part of their Carers Wellbeing Programme. Many subjects are offered in venues across the county including wills and power of attorney, relaxation techniques and healthy relationships. Carers are able to view the upcoming training schedule and make bookings online. https://www.carerssupport.org.uk/our-services/carer-learning-and-wellbeing-programme/

Telecare and telehealth

Telecare and telehealth are considered by many to be an important way to support carers to carry on their caring role but with challenges in some areas over take-up. Areas which have adopted this approach often had telecare call centres linked to emergency card schemes and alarm systems e.g. GPS trackers or carers assist pagers.

Cornwall Council technology trials

Cornwall Council is running trials of a number of different TEC (Technology Enabled Care) products. Some of these directly support the cared-for (Brain in Hand, AutonoMe, Pebble or Alfi/Footprint) and some support both the carer and cared for person (3 Rings, Canary, Just Checking). Their trials of Just Checking, an activity monitoring system, have investigated the use of the tool as proportional support, considering how the council can meet needs in more creative and less risk averse ways. The initial results indicate that the system is helpful in ensuring that support is deployed at the right time and the council is considering further roll out. The council is now looking to trial the use of further technology including Alexa, Amazon Echo, video entry systems, Hive and smart phones.

Further useful resources

Skills for Care have developed a number of resources to help adult social care staff working with carers.

These are available: http://www.skillsforcare.org.uk/Skills/Carers/Carers.aspx and include:

- The **common core principles for working with carers**. This describes the behaviours that carers would like to see from professionals who are working with them**.**
- **Carers Matters – Everybody's Business**. A resource to help employers and staff better understand the needs of carers through the learning and development of staff.
- **Dementia: workers & carers together / Dementia & carers: workers' resources.** Offers practical guidance for the social care workforce on supporting family and friends who are carers of people with dementia. (http://www.skillsforcare.org.uk/Documents/Topics/Supporting-carers/Dementia-worksandcarerstogether.pdf)
- Guides to develop the skills of those who carry out carers' assessments.
    - **Carers and communities:** gives those who work with carers an overview of ways in which practice can strengthen the ties between carers and their community and why this can lead to better outcomes for all: http://www.skillsforcare.org.uk/Document-library/Skills/Carers/Carers-and-communities.pdf
    - **Assessing carer's needs:** helps those working with carers and families to take a whole family approach to a carers' assessment and support planning: http://www.skillsforcare.org.uk/Document-library/Skills/Carers/Assessing-carers-needs.pdf

First contact and identifying needs

Chapter 6
Assessment and eligibility
(see page 75 of the statutory guidance)

Where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of needs for support, local authorities must carry out a carer's assessment. Where an adult provides care under contract (e.g. for employment) or as part of voluntary work, they should not normally be regarded as a carer, and so the local authority would not be required to carry out the assessment.

There may be circumstances where the adult providing care, either under contract or through voluntary work, is also providing care for the same adult outside of those arrangements. In such a circumstance, the local authority must consider whether to carry out a carer's assessment for that part of the care they are not providing on a contractual or voluntary basis. There may also be cases where the person providing care does so as voluntary work or under contract, but the nature of their relationship with the person cared for is such that they ought to be considered as a "carer" within the scope of the Act. The local authority has the power to carry out an assessment in such cases, if it judges that there is reason to do so.

Carers' assessments must seek to establish not only the carer's needs for support, but also the sustainability of the caring role itself, which includes both the practical and emotional support the carer provides to the adult. Therefore, where the local authority is carrying out a carer's assessment, it must include in its assessment a consideration of the carer's potential future needs for support. Factored into this must be a consideration of whether the carer is, and will continue to be, able and willing to care for the adult needing care. Some carers may need support in recognising issues around sustainability, and in recognising their own needs. This will allow local authorities to make a realistic evaluation of the carer's present and future needs for support and whether the caring relationship is sustainable. Where appropriate these views should be sought in a separate conversation independent from the adult's needs assessment.

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

What is the national eligibility threshold for carers?

Carers can be eligible for support in their own right. The national eligibility threshold for carers is also set out in the Care and Support (Eligibility Criteria) Regulations 2014. The threshold is based on the impact a carer's needs for support has on their wellbeing.

In considering whether a carer has eligible needs, local authorities must consider whether:

- the needs arise as a consequence of providing necessary care for an adult;
- the effect of the carer's needs is that any of the circumstances specified in the Eligibility Regulations apply to the carer; and
- as a consequence of that fact there is, or there is likely to be, a significant impact on the carer's wellbeing.

A carer's needs are only eligible where they meet all three of these conditions.

Whole family approach

6.65. The intention of the whole family approach is for local authorities to take a holistic view of the person's needs and to identify how the adult's needs for care and support impact on family members or others in their support network.

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

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

6.68. The local authority must also identify any children who are involved in providing care. The authority may become aware that the child is carrying out a caring role through the assessment of the person needing care or their carer, or informed through family members or a school. Identification of a young carer in the family should result in an offer of a needs assessment for the adult requiring care and support and, where appropriate, the local authority must consider whether the child or young carer should be referred for a young carer's assessment or a needs assessment under the Children Act 1989,112 or a young carer's assessment under section 63 of the Care Act. Local authorities should ensure that adults' and children's care and support services work together to ensure the assessment is effective – for example by sharing expertise and linking processes.

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

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

6.70. An assessment should take into account the parenting responsibilities of the person as well as the impact of the adult's needs for care and support on the young carer.

6.71. Local authorities must also consider whether any of the caring tasks the child is undertaking are inappropriate. They should consider how supporting the adult with needs for care and support can prevent the young carer from undertaking excessive or inappropriate care and support responsibilities. A young carer becomes vulnerable when their caring role risks impacting upon their emotional or physical wellbeing or their prospects in education and life. This might include:

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

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

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

6.73. When a local authority is determining whether the tasks a child carries out are inappropriate, it should also take into account the child's own view wherever appropriate.

The statutory guidance provides further detail about:

- The purpose of needs and carers' assessments; refusal of assessment; first contact and relevant safeguarding, advocacy and capacity duties; supporting the person's involvement in the assessment; taking a preventative approach and looking at a person's strengths;
- The importance of appropriate and proportionate assessment, including supporting the person through the process, enabling supported self-assessment, combining assessments and referring to NHS Continuing Healthcare where appropriate;
- Taking into account the wider picture by considering fluctuating needs and the impact on the whole family;
- The importance of having assessors appropriately trained and with the experience and knowledge necessary to carry out the assessment, including specialist assessments for those who are deafblind;
- Carrying out integrated assessment where a person has other needs, for example where the person also has health as well as care and support

needs; keeping records and delegating assessments;
- The eligibility framework to ensure that there is clarity and consistency around local authority determinations on eligibility

Efficient and effective interventions to fulfill these duties

Across the country, there are many excellent examples of how local authorities have approached their assessment and eligibility duties. Key themes include:

- Understanding who is best placed to provide assessments within a local area can ensure a **proportionate approach** to carers assessments
- Exploring the actual cost of assessments can be used to inform local approaches to **delegating** some or all assessment functions
- Using local and national protocols can assist authorities in adopting a 'no wrong door approach' ensuring that the needs of **young carers** and their families are met
- **Whole family approaches** can be key to maximising the impact of resources and identifying opportunities to support carers;
- Appropriate protocols between **adults and children's** services can provide a smooth pathway for assessment and support of identified young carers
- Providing and using **assessment tools** which link to the impact of caring on wellbeing: as per the eligibility regulations can assist in ensuring practice is applied consistently;
- Consideration should be given to **integrated assessments** (for example with Health) where other needs are identified to reduce the need for multiple assessments.

When asked about how they conduct carers assessments 63% of respondents said that all statutory carers assessments are conducted in house. 20% of respondents contract out assessments including eligibility decisions and 22% take advice from the contracted organisation but make eligibility decisions themselves.

For those who completed assessments in-house, this was likely to be because the council felt it better allowed for a whole family approach to be applied, whereas some who outsourced assessments said that carers in their area wanted a specialist organisation (like a carers organisation) to carry them out. Some chose to keep complex assessments in-house and contracted out low-level or less complex assessments.

In areas where some assessments are done in-house and others are contracted out, practices varied as to how they made this distinction. Most often, it was assessments for carers who care for someone who is known to the local authority already which are done in-house whereas carers who were new to the local authority who are assessed externally.

However in other local authorities, it was the level of complexity, the presence of a conflict of interest or the need for a second opinion which influenced whether it was completed in house or not. Some areas had developed practices where professionals outside the adult social care team or the commissioned service complete assessments. For example, in some areas staff in the local Mental Health Trust are able to assess adults in receipt of their services.

In general, councils are confident that they are applying the carers eligibility criteria correctly. Examples of practices being used to ensure correct application include:

- Systematically embedding the eligibility criteria into assessment tools allowing assessors to go through the sections one by one
- Development of an eligibility matrix
- Reviewing eligibility guidance on an annual basis following changes to Care Act guidance

Practices regarding joint assessments are varied and councils have different ways of ensuring they comply with the Care Act, although most respondents mentioned the importance they place on giving choice to the carer. When the carer requests it or the council feels it is appropriate, councils will offer a separate assessment but many will complete assessments jointly in the first instance to allow this to be done holistically. In some areas, even when a separate assessment is requested, the same person will complete both assessments to ensure that any care and support plans are aligned. Some authorities are looking to develop this area as there are some discrepancies between the experiences of carers who have joint and separate assessments.

Doncaster assessments

In Doncaster, Local Authority staff in community led support teams complete low level assessments that include assessments for carers. These community teams underpin the adult carer service and seek to identify and support carers by activating a fast response allowing for an early intervention and prevention model to be applied.

Their assessment tool is person centred and outcome focussed and time has been invested in developing staff to aid their carer understanding and approach. This has included staff training sessions, engaging with extended leadership groups to strengthen carer message, and using carer e-learning packages. This has been successful in enabling carers to access the support they need quickly and proactively.

Lincolnshire mixed methods approach to assessments

In Lincolnshire, the council has a range of formats for the assessment, appropriate to the presenting need of the carer. A telephone based service is offered alongside a community based service. This mixed methods approach gives carers a choice although more complex cases, young adult carers and end of life carers are routed directly for face to face assessments. Carers enter the service through the call centre, but get support from the

community based provider who may be better placed to meet their need. The benefits of this approach are that we are able to help a high volume of carers quickly and can offer a range of talking to carers in ways that will best suit the person. However the telephone offer helps reach all corners of a large rural county, and can reach housebound carers easily and cost effectively, avoiding travel costs.

The council works hard to have a consistent approach as part of their mixed methods offer of carers' assessments. Both providers access the same case management database. The quality assurance system also includes six weekly case review meetings with both providers; regular case led reflective practice sessions; and a single lead practitioner who oversees the quality of all carer assessments and authorises personal budgets.

Whole Family Approach

The Care Act introduced a number of reforms to the way that care and support for adults with care needs are met. It requires local authorities to adopt a whole system, whole council, whole family approach, coordinating services and support around the person and their family. The intention of the whole family approach is for local authorities to take a holistic view of the person's needs, in the context of their wider support network. The approach must consider both how the adult or their support network or the wider community can contribute towards meeting the outcomes they want to achieve and whether or how the adult's needs for care and support impacts on family members or others in their support network.

The whole family approaches guide encourages practitioners to think family, the importance of a proportionate approach to assessment and the power to join up assessments.
https://www.local.gov.uk/sites/default/files/documents/care-act-and-whole-family-6e1.pdf

The memorandum of understanding which has been developed by the Associations of Directors of Adult Social Services and Children's Services, highlights key principles to ensure that the should be **'no wrong doors'** for young carers and their families. The memorandum commits departments to work together locally, adopting a whole system, whole family approach to providing support for young carers and their families. The principles underpin good practice including the recognising that the presence of a young carer in the family should always constitute an appearance of need and should trigger either an assessment or the offer of an assessment to the person needing care.
http://londonadass.org.uk/wp-content/uploads/2014/10/No-wrong-doors-final-MOU-March-2015-.pdf

Many councils were confident that they are applying a 'whole family approach' to assessments because of local training, joint working between staff working with adults and young carers and having a 'think family' approach across all work with carers. One council has a prompt within their IT system which reminds practitioners to follow a whole family approach.
Lots of survey respondents said that support planning for young carers is part of a whole

family holistic approach involving, for example, a multi-agency family plan and team around the family meetings. For many councils, planning support for young carers following an assessment involves categorising them depending on the level of care they are providing. These categories reflect different levels of support which are provided and can change as the young carers' needs change.
For example in one Local Authority there are 3 tiers:

- Tier 1 – young carer is coping and functioning well, requiring low level support;
- Tier 2 – young carer experiencing problems relating to their caring role;
- Tier 3 – young carer entrenched in their role as primary carer, requiring high levels of support.

Doncaster Metropolitan Borough Council's whole family approach

Doncaster Metropolitan Borough Council has continued to deliver their carers assessment function directly and have worked to ensure that their assessment processes are Care Act compliant. The assessment form is based on the principles of a whole family approach with the recognition of multiple caring arrangements and joint assessment. The assessment process embraces the content of the eligibility regulations by focusing on the impact of caring on wellbeing. The purpose is to ensure a consistent approach and identifies other professionals who may be able to contribute to the assessment. Carer identified needs and outcomes form a main part of the assessment form.
http://www.doncaster.gov.uk/services/adult-social-care/carersoffer
http://www.londonadass.org.uk/wp-content/uploads/2014/10/Carers-assessment-Doncaster.pdf

There is further information about whole family approaches to care and support planning in Chapter 10.

Self-assessments

Just over half of respondents offer a self-assessment in paper format. This isn't necessarily part of their normal offer to carers but considered it a part of being flexible and adaptable. 37% of councils offer an online self-assessment for carers and many are planning to introduce this in the future. Some councils have other online options including screening tools and general contact forms which offer an online route into support.

Liverpool Council's self-directed assessments

Liverpool City Council's carer assessment process embodies the spirit of the Care Act embracing prevention, reducing impact of the caring role on carers and improving carers' health and wellbeing. What makes Liverpool's approach effective and efficient is that it places a strong emphasis on self-directed assessment.

Referrals can be made by any organisation or carers can self-refer. Once a referral has been made the case is allocated to a carers development worker (CDW) who sends out an information pack and guidance on completing the self-supported assessment. The CDW will complete the form with the carer if that is the carer's request. The self-supported assessment aims to place the carer at the centre of the assessment process. It is not a test to check ability to care and focuses on impact of the caring role as opposed to number of hours or duties undertaken. Once the self-directed assessment is received the CDW will visit the carer to arrange to develop their support plan which has been designed as a tool to assist with prompting conversation between the CDW and the carers about how the carer can best be supported. The Carers Self Supported Assessment form can be found online: https://forms.liverpool.gov.uk/contour-forms/carers-self-directed-assessment-ext/

The guidance can be found here: https://www.liverpool.gov.uk/media/2810/carers-self-directed-assessment-guidance-notes2012.pdf

Liverpool has produced a series of documents which demonstrate how services for carers can be delivered effectively and efficiently including a carer's assessment form. https://forms.liverpool.gov.uk/contour-forms/carers-self-directed-assessment-ext/

Southampton online self-assessment tool
Southampton uses an online electronic self-assessment tool. It is in its second iteration with improvements from the original in 2015. If there are any issues, these can be addressed over the phone. In 2017/18 they had 300 carers complete an assessment this way, which represented 100% of the assessments completed in the area. https://www.southampton.gov.uk/health-social-care/adults/adult-social-care/carers-assessment.aspx

East Sussex online carers assessment form
In East Sussex carers can download the Carers Assessment form online - there is online guidance on the website alongside the form and contact details for the council and local carers centre if help is needed. https://www.eastsussex.gov.uk/socialcare/carers/assessment/.

Assessing young carers

One third of respondents said that they outsource young carers assessments to a commissioned service and for some this is the same service as adults, for others it is a specialised young carers service. For those who have kept assessments in house, some have specific youth workers who would complete assessments whereas some say that the assessment would be done by the team who is working with the cared for person.

Some areas are starting to involve schools in the assessment process and one area said that they are hoping that schools will be able to complete young carers' assessments in the future. In another council the initial assessment involves the parent/carer of the young person, but a second stage of the assessment involves seeing the young carer at school

so that they have the opportunity to talk away from the cared for person.

MACA-YC18 (Multidimensional assessment of caring activities), PANOC-YC20 (Positive and negative outcomes of caring) and the my star outcomes tool are all popular assessment tools.

Some also mentioned using:

- Saul Becker screening tools
- the same tools as with adults
- an adapted version of the general 'child in need' assessment
- their own tools developed by the council/young carers service

60% of respondents are using the 'No Wrong Doors Policy' and many others still apply this approach but don't have the official policy in place. All other respondents were aspiring to have this in place in the future.

'We have a single point of access for Carer Support, one phone number for the whole county, so this enables the right door to be chosen first time and the ping-ponging of referrals is no-longer a significant issue.' Survey respondent

Half of councils are currently recording how many of their young carers are not in education, employment or training (NEET) and others acknowledged that this is an area for development.

Further useful resources

Carers UK publishes a guide to Carers Assessments which is updated annually. The guide covers a range of areas including assessments, eligibility for support, whole family approach and young carers.
https://www.carersuk.org/help-and-advice/practical-support/getting-care-and-support/carers-assessment

Skills for Care published a useful report which contains valuable information from carers about their experiences which can help local authorities consider workforce issues in relation to carers' assessments from the carers' perspective.
http://www.skillsforcare.org.uk/Document-library/Skills/Carers/Carersassessments.pdf

Social Care Institute for Excellence (SCIE) has developed a range of resources to support local authority staff, social workers and others involved in assessment and eligibility
http://www.scie.org.uk/care-act-2014/assessment-and-eligibility/

Charging and financial assessment

Chapter 8
Charging and financial assessment
(see page 133 of the statutory guidance)

Charging for support to carers

8.49. Where a carer has eligible support needs of their own, the local authority has a duty, or in some cases a power, to arrange support to meet their needs. Where a local authority is meeting the needs of a carer by providing a service directly to a carer, for example a relaxation class or driving lessons, it has the power to charge the carer. However, a local authority must not charge a carer for care and support provided directly to the person they care for under any circumstances.

8.50. 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. When deciding whether to charge, and in determining what an appropriate charge is, a local authority should consider how it wishes to express the way it values carers within its local community as partners in care, and recognize the significant contribution carers make. Carers help to maintain the health and wellbeing of the person they care for, support this person's independence and enable them to stay in their own homes for longer. In many cases of course, carers voluntarily meet eligible needs that the local authority would otherwise be required to meet. Local authorities should consider carefully the likely impact of any charges on carers, particularly in terms of their willingness and ability to continue their caring responsibilities. It may be that there are circumstances where a nominal charge may be appropriate, for example to provide for a service which is subsidised but for which the carer may still pay a small charge, such as a gym class. Ultimately, a local authority should ensure that any charges do not negatively impact on a carer's ability to look after their own health and wellbeing and to care effectively and safely.

8.51. While charging carers may be appropriate in some circumstances, it is very unlikely to be efficient to systematically charge carers for meeting their eligible needs. This is because excessive charges are likely to lead to carers refusing support, which in turn will lead to carer breakdown and local authorities having to meet more eligible needs of people currently cared for voluntarily. As an example, work carried out by Surrey County Council found that if even 10% of people with care and support needs in families supported by carers presented to the council with eligible needs as a result of carer breakdown, the resulting cost would be three times the current total budget for carer support.

8.52. Local authorities may also wish to consider whether charging is proportionate when light touch carers assessments are undertaken for small scale help. There is a risk that financial assessments might become the most costly part of the process and something that is administratively burdensome.

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

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

The statutory guidance includes further information about:

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

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

Efficient and effective interventions to fulfill these duties

Across the country, there are some examples of how local authorities have approached charging and financial assessment. Key themes include:

- The **economic case for investing** in carers should be underpinned by effective modelling in order to assist authorities in determining their approach to charging;
- Recognise and value the **important role** that carers play in supporting the sustainability of the current care system

Local authorities can and most do, charge for care provided to individuals. However, most authorities do not charge for providing support to carers as they regard this as counterproductive in supporting carers. However, if a local authority does decide to charge a carer then it must carry out a financial assessment to decide whether the carer can afford to pay. In cases where the support to the carer involves providing care to the person being cared for, the law says that the carer cannot be charged.

A short factsheet has been developed for local authorities to use in considering whether to put in place a policy of charging carers. It makes the case that charging would be a false economy because it would lead to increased "carer breakdown" and the costs of replacing the care provided by those carers would outweigh the income from charging.
https://www.adass.org.uk/media/6199/economic-case-investment-530.pdf

Examples of cost-benefit analysis

Surrey County Council

Surrey County Council Adult Social Care provides support to just over 25,000 people on any given day. It also funds services to over 13,000 carers a year, funded via a Joint Carers Commissioning Group at a cost of just over £5 million per year. In around 10,000 of these cases, neither the adult service user or carer receive any direct support from Adult Social Care. A cost modelling exercise has been undertaken to look at the impact of ceasing carers' support and the financial consequence. The model estimates that, if these carers' services were withdrawn, 10,000 of these carers would be left unsupported, and up to 40% could break down within a few months. Not all cared for people would necessarily seek help from the Council and not everyone eligible for help would take up services. However, if just 10% were eligible and took up publicly funded services, the model suggests a whole-year cost of over £14.7 million a year for replacing the care provided.

Surrey has also completed a further cost benefit analysis of their support for Young Carers. Their short paper, produced in collaboration with Ecorys has demonstrated the estimated benefits from supporting young carers in Surrey. It was estimated that Surrey Young Carers potentially avoided the taxpayer spending just under £3million (£2,736,954) over the course of one year by avoiding young carers becoming Child in Need status. Compared to the costs of delivery of Surrey Young Carers in 2015/16 (£925,767), this leaves a return on investment of almost £3 (£2.96) for every £1 spent on the service.

London Borough of Newham

London Borough of Newham adopted an approach to determine the actual cost of care provided by carers to understand the economic contribution of carers to the social care system. Newham identified the cost of the annual carers allocation to support the continuation of unpaid care (including respite) and demonstrated that from the sample of 35, there was a £110,344 reduction in cost because of the need being met by the carer. This shows that, for every £1.00 invested in carers, there is a potential equivalent reduction in local authority cost of £5.90 (£4.90 net reduction), therefore illustrating the importance of carers and their role in supporting social care.

When asked about charging for carers services, 87% of survey respondents stated that their council doesn't charge carers for services and they have no plans to. The minority who did charge for some services said there are grants available. Some respondents included statements about the value of carers to their local area.

'Carers save the nation and [our council] a great deal of money and most of the support

carers receive is typically modest in scale. The cost of undertaking financial assessments would be disproportionately high and would make no economic sense.' Survey respondent

'In [our council] we recognise and value carers who we see as key partners in the delivery of services. We understand the support they provide is invaluable. Carers are instrumental in helping support a great number of local people and without their support health and social care would be under greater pressure.' Survey respondent

Person-centred care and support planning

Chapter 10
Care and support planning
(see page 169 of the statutory guidance)

10.1. Care and support should put people in control of their care, with the support that they need to enhance their wellbeing and improve their connections to family, friends and community. A vital part of this process for people with ongoing needs which the local authority is going to meet is the care and support plan or support plan in the case of carers (henceforth referred to as 'the plan').

10.2. The person must be genuinely involved and influential throughout the planning process, and should be given every opportunity to take joint ownership of the development of the plan with the local authority if they wish, and the local authority agrees. There should be a default assumption that the person, with support if necessary, will play a strong pro-active role in planning if they choose to. Indeed, 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.

10.3. The personal budget in the plan will give everyone clear information regarding the costs of their care and support and the amount that the local authority will make available, in order to help people to make better informed decisions as to how needs will be met. The ability to meet needs by taking a direct payment must be clearly explained to the person in a way that works best for them, so that they can make an informed decision about the level of choice and control they wish to take over their care and support. This should mean offering the choice more than once in the process and enabling that choice by providing examples of how others have used direct payments, including via direct peer support, for example from user-led organisations.

The statutory guidance provides further detail about:

- When to undertake care and support planning;
- What it means to "meet needs", and considerations in deciding how to meet needs;
- How to undertake care and support planning, and support planning;
- Production of the plan;
- Involving the person;
- Authorising others (including the person) to prepare the plan;
- Care planning for people who lack capacity;
- Minimising and authorising a deprivation of liberty (DOL) for people who lack capacity;

- Combining plans;
- Sign-off and assurance;
- Protecting property of adults being cared for away from home.

Efficient and effective interventions to fulfill these duties

A number of authorities have developed their approaches to care and support planning. The key themes emerging from the examples include:

- The importance of linking the **outcomes** identified within the assessment process with the support plan development
- Encouraging carers to be at the **centre of the support planning** process, identifying how they want their outcomes to be met
- When meeting the needs of multiple people in the same family, there is benefit in producing a **combined support plan** with a joint person budget here
- Where a range of needs exist and opportunities arise, maximise **joint care planning** with health

Whole family approaches to care and support planning

Adopting a whole-family approach to developing a plan can provide new opportunities to achieve best outcomes for the whole family. Where there are multiple family members requiring care and support and multiple support plans the plans should not be developed in isolation. Where it is not possible to combine plans they should at very least be coordinated.
https://www.local.gov.uk/sites/default/files/documents/care-act-and-whole-family-6e1.pdf

Examples of where combined plans can be useful are:

- Mutual caring where both people involved have needs and also caring responsibilities;
- People in receipt of local authority and NHS health care;
- Where budgets are pooled.
- Carers (including young carers) and person with support need;

Many councils use a whole family approach to care and support planning as well as assessments. When asked what kinds of additional services have been provided to adults in order to alleviate young carers' responsibilities, councils mentioned providing respite and assistive technology as well as putting emergency plans in place and making referrals to social care and occupational therapy. A few respondents mentioned that their area focuses on helping families to build a wider support network so that there are other people to rely

on and not just the immediate children in the family. Care and support planning may be focused on critical times for a family to enable young carers to get to school on time.

Many authorities have adopted good practice in this area demonstrating different approaches to working in a whole systems way. Given the requirements of the Care Act around early intervention and prevention, it is essential all local authorities look at their current practice and seek to develop approaches which are pro-active and cross the care and health system. Further, they must also consider how universal services can be accessed in different ways in their area.

Liverpool City Council's care and support planning

Liverpool City Council commission an external organisation to undertake the development of their care and support plans. The plan is designed to be completed by the carer and carers development worker and is designed to ensure it meets the requirements of the local authority in terms of reporting, quality and outcomes. The plan is designed to ensure the appropriate outcomes are considered and identifying how these will be met. A health and wellbeing scale is included alongside a focus on how broader carer outcomes will be met and supported. The plan links directly to the allocation of resources to meet the identified needs and outcomes and approval processes.
http://londonadass.org.uk/wp-content/uploads/2014/10/Liverpool-Carers-Support-Plan.pdf

Think Local Act Personal Resources

Delivering Care & Support Planning has been developed by Think Local Act Personal (TLAP) with people who use services, families and carers to show what good care and support planning looks like in practice.

It is backed up with examples from councils across England that are leading the way in this area. The guide describes what people want in a care and support planning process and the elements that need to be in place to make this happen. There are also a set of recommendations for councils so that they can be both Care Act compliant and person-centred in their approach.
http://www.thinklocalactpersonal.org.uk/Latest/Resource/?cid=10464

This guidance has more recently been enhanced by the production of an online tool on integrated care and support planning
https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/

Case study examples

Case Study 1

Paul is a 21 year old university student and has been the main carer for his father Greg for three years. Paul was finding it difficult to maintain his relationships and his own support networks with his friends. He wanted a break to recharge his batteries and spend time with his friends to keep up his social life alongside his studies and caring role. Paul wanted to go on holiday with his friends and requested support for his father when he goes away.

He was providing substantial assistance, especially in the evening and over the weekend and was providing 15 hours support to his father each week.

Paul wanted to continue caring for his dad as long as he was also supported to have a break when he needed one. Following the outcome of both assessments, Greg's package of support and support plan were amended to ensure that replacement care was provided.

Paul was given a personal budget to reflect his needs as a carer and the outcomes he wanted to achieve. Paul used his personal budget to go on holiday with his friends.

This break allowed Paul to spend time with his friends and maintain his own social support network. He felt the break had significantly improved his wellbeing allowing him to maintain his studies and continue his caring role for his father.

Paul – *'Being able to spend a few days away from looking after my Dad gave me a chance to relax. I was confident he was safe and well looked after so I didn't have to worry'*

Case Study 2

Harry is the carer for his wife Margaret who has dementia and significant care and support needs. Whilst Margaret has daily support from commissioned carers three times a day, Harry provides substantial care and support the remainder of the time. Harry has very little time to himself outside of his caring role and was starting to feel stressed by the situation and wanted to have some time to himself.

In the past, Harry used to enjoy playing the organ and found it to be a good means of relieving stress. He had said he would like to take this hobby up again but Margaret does not like any noise in the house and becomes distressed.

Following a carers assessment, Harry was awarded a personal budget and supported with developing his support plan.

Harry chose to meet his identified outcomes through the purchase of an organ and a pair of headphones so that he could enjoy his hobby without creating any noise in the family home. Harry found this to be a good way of unwinding, and over time improved his wellbeing and reduced his stress levels improving his ability to maintain his caring role.

Harry – '*It's great to have a chance to unwind and have a bit of me time. I feel less stressed and more able to carry on looking after my wife.'*

Case Study 3[3]

Barbara is 69 and looking after her mother Eleanor who is 93 and has dementia. Eleanor lives with her daughter and can still manage most of her own personal care with a bit of help, but cannot be left alone at home as her memory problems are now quite significant and she also struggles with mobility and has fallen a number of times.

Barbara wanted to take a break to have some time to herself but Eleanor had in the past been adamant that she only wanted Barbara looking after her, meaning this hadn't been possible. Barbara was exhausted and at breaking point meaning her own mental health was suffering.

After an assessment of both of their needs, it was clear that a solution needed to be found as the situation was unsustainable.

Barbara worked with a local carer support organisation to agree that a care support worker, Linda, would come to visit them in their home over a number of weeks, to help whilst they were both there, explaining that she was there to help Barbara. Linda had been carefully chosen as a good match for this role based on Eleanor's interests – Eleanor and Linda shared an interest in piano playing which helped with them giving something to talk about together.

Over a number of weeks, Eleanor got to know Linda, all three spent time and went out on short trips together, and when Barbara felt happy with it, and with Eleanor's agreement that she would be back soon, Barbara tried nipping out to the shops for half an hour whilst Linda stayed with Eleanor. Over time, Eleanor's trust was built and Barbara could leave her mother with Linda for up to three hours at a time.

Barbara – *'It's great having Linda come round to support with mum because I don't have to feel guilty about wanting a break. I enjoy have time to myself and I come back from my time away feeling refreshed.'*

[3] This example case study is also included within The Care Act and Whole-Family Approaches document which can be found at http://www.local.gov.uk/documents/10180/5756320/The+Care+Act+and+whole+family+approaches/080c323f-e653-4cea-832a-90947c9dc00c

Chapter 11
Personal Budgets
(see page 187 of the statutory guidance)

Use of a carer's personal budget

11.36. Specific consideration should be given to how a personal budget will be used by carers. The Act specifies that a carer's need for support can be met by providing care to the person they care for. However, decisions on for whom a particular service is to be provided may affect issues such as whether the service is chargeable, and who is liable to pay any charges. It is therefore important that it is clear to all individuals involved whose needs are intended to be met by a particular type of support, to whom the support will be provided directly, and therefore who may pay any charges due. Where a service is provided directly to the adult needing care, even though it is to meet the carer's needs, then that adult would be liable to pay any charge, and must agree to do so. Section 14 of the Act makes clear that where the needs are met by providing care and support direct to the adult needing care, the charge may not be imposed on the carer.

11.37. Decisions on which services are provided to meet carers' needs, and which are provided to meet the needs of the adult for whom they care, will therefore impact on which individual's personal budget includes the costs of meeting those needs. Local authorities should make this decision as part of the care planning process, in discussion with the individuals concerned, and should consider whether joint plans (and therefore joint personal budgets) for the two individuals may be of benefit.

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

11.39. "Replacement care" may be needed to enable a carer to look after their own health and wellbeing alongside caring responsibilities, and to take a break from caring. For example, this may enable them to attend their own health appointments, or go shopping and pursue other recreational activities. It might be that regular replacement care overnight is needed so that the carer can catch up on their own sleep. In other circumstances, longer periods of replacement care may be needed, for example to enable carers to have a longer break from caring responsibilities or to balance caring with education or paid employment. In these circumstances, where the form of the replacement care is essentially a homecare service provided to the adult needing care that enables the carer to take a break, it should be considered a service provided to the cared-for person, and thus must be charged to them, not the carer.

11.40. The carer's personal budget must be an amount that enables the carer to meet their needs to continue to fulfill their caring role, and takes into account the outcomes that the carer wishes to achieve in their day to day life. This includes their wishes and/or aspirations concerning paid employment, education, training or recreation if the provision of support can contribute to the achievement of those outcomes. The manner in which the personal budget will be used to meet the carer's needs should be agreed as part of the planning process.

11.41. Local authorities must have regard to the wellbeing principle of the Act as it may be the case that the carer needs a break from caring responsibilities to look after their own physical/mental health and emotional wellbeing, social and economic wellbeing and to spend time with other members of the family and personal relationships. Whether or not there is a need for replacement care, carers may need support to help them to look after their own wellbeing. This may be, for example, a course of relaxation classes, training on stress management, gym or leisure centre membership, adult learning, development of new work skills or refreshing existing skills (so they might be able to stay in paid employment alongside caring or take up return to paid work), pursuit of hobbies such as the purchase of a garden shed, or purchase of laptop so they can stay in touch with family and friends. Carers' personal budgets where the adult being cared for does not have eligible needs.

11.42. The Act makes clear that the local authority is able to meet the carer's needs by providing a service directly to the adult needing care. However, there may be instances where the adult being cared for does not have eligible needs, so does not have their own personal budget or care plan. In these cases, the carer must still receive a support plan which covers their needs, and how they will be met. This would specify how the carer's needs are going to be met (for example, via replacement care to the adult needing care), and the personal budget would be for the costs of meeting the carer's needs.

11.43. The adult needing care would not receive a personal budget or care plan, because no matter what the service is in practice, it is designed to meet the carer's needs. However, it is essential that the person requiring care is involved in the decision-making process and agrees with the intended course of action.

11.44. In situations such as these, the carer could request a direct payment, and use that to commission their own replacement care from an agency, rather than using an arranged service from the local authority or a third party. The local authority should take steps to ensure that the wishes of the adult requiring care are taken into account during these decisions. For example, the adult requiring care may not want to receive replacement care in this manner.

11.45. If such a type of replacement care is charged for (and it may not be), then it would be the adult needing care that would pay, not the carer, because they are the direct recipient of the service. This is in part why it is so important that the adult needing care agrees to receive that type of care. The decisions taken by the carer and adult requiring

care and charging implications should be agreed and recorded in the support plan. If a dispute arises and the person refused to pay the charge, the local authority must, as far as it is feasible, identify some other way of supporting the carer.

11.46. For the purposes of charging, the personal budget which the carer receives must specify the costs to the local authority and the costs to the adult, based on the charging guidance (see chapter 8). In this case, "the adult" refers to the carer, because they are the adult whose needs are being met. However, in instances where replacement care is being provided, the carer should not be charged; if charges are due to be paid then these have to be met by the adult needing care. Any such charges would not be recorded in the personal budget, but should be set out clearly and agreed by those concerned.

The statutory guidance provides further detail about:

- The personal budget;
- Elements of the personal budget;
- Elements of care and support that are excluded from the personal budget;
- Calculating the personal budget;
- Agreeing the final budget;
- Use of the personal budget;
- Use of a carer's personal budget;
- Carers' personal budgets where the adult being cared for does not have eligible needs;
- Appeals/disputes

Efficient and effective interventions to fulfill these duties

A number of authorities have developed their approaches to personal budgets and how they may need to be amended to meet the duties within the Care Act. The key themes that have emerged include:

- Effective use and administration of personal budgets can improve choice and flexibility and impact positively on individual outcomes;
- A clear and transparent process for establishing the personal budget should be in place to ensure that both practitioners and individuals are clear about how the budget is calculated
- Budgets must meet the sufficiency principle and be administered in a timely way
- Maximise opportunities for integrating personal health and care budgets for individuals, to ensure minimal monitoring arrangements and duplication

Just under half of respondents to the ADASS CPN survey said that they have a Resource Allocation System for carers, although 3 of these were pilot schemes still in evaluation stage. These RAS offer an indicative budget which is then personalised and amended in a care plan. iIt should be noted that use of any RAS needs to be flexible enough to meet

individual needs. Those who don't use a RAS, often said their decisions are done on a case by case basis based on outcomes and the necessary budget to achieve this. One local authority had moved to a more flexible system after it found the RAS did not provide the flexibility to tailor support to carers' needs.

When asked about their processes with carers' personal budgets, all respondents' answers included reference to developing and costing a plan after assessment and then a form of validation. Some had boards or panels that have to approve decisions, for others it is at staff (council or commissioned service) discretion until a certain level.

Examples

Think Local Act Personal tool for personal budgets

The TLAP Personal Budgets Minimum Process Framework is an interactive tool. It is designed to help improvement officers and managers working in Councils, and their partner organisations, deliver Care Act compliant lean social care systems and processes which relate to personal budgets. It also addresses other common issues related to delivering the best outcomes for personal budget holders.

http://www.thinklocalactpersonal.org.uk/Personal-Budgets-Minimum-Process-Framework/

East Sussex whole family budget

In East Sussex, a whole family budget is available. Applications for this can be made by a professional supporting any member of the family. Supporting needs assessment evidence is needed to meet the criteria. This is a one-off allocation and can be made by a direct payment or direct purchase of goods or services.'

https://www.eastsussex.gov.uk/socialcare/carers/fpb/

Chapter 12

Direct Payments

(see page 203 of the statutory guidance)

Direct payments are monetary payments made to individuals who request to receive one to meet some or all of their eligible care and support needs. The legislative context for direct payments is set out in the Care Act, Section 117(2C) of the Mental Health Act 1983 (the 1983 Act) and the Care and Support (Direct Payments) Regulations 2014.

Direct payments have been in use in adult care and support since the mid- 1990s and they remain the Government's preferred mechanism for personalised care and support. They provide independence, choice and control by enabling people to commission their own care and support in order to meet their eligible needs.

Direct payments, along with personal budgets and personalised care planning, mandated for the first time in the Care Act, provide the platform with which to deliver a modern care and support system. People should be encouraged to take ownership of their care planning, and be free to choose how their needs are met, whether through local authority or third-party provision, by direct payments, or a combination of the three approaches.

For direct payments to have the maximum impact, the processes involved in administering and monitoring the payment should incorporate the minimal elements to allow the local authority to fulfill its statutory responsibilities. These processes must not restrict choice or stifle innovation by requiring that the adult's needs are met by a particular provider, and must not place undue burdens on people to provide information to the local authority. An effective monitoring process should also go beyond financial monitoring, and include aspects such as identifying wider risks and issues, for example non- payment of tax, and provision of employers' liability insurance where this is appropriate.

The local authority also has a key role in ensuring that people are given relevant and timely information about direct payments, so that they can make a decision whether to request a payment, and, if doing so, are supported to use and manage the payment appropriately. The route to a direct payment is for a person to request one, but the local authority should support the person's right to make this request by providing information and advice as detailed above. People must not be forced to take a direct payment against their will, but instead be informed of the choices available to them.

The statutory guidance provides further detail about:

- Making direct payments available;
- Considerations for adults with and without capacity;
- Administering, monitoring and reviewing direct payments;
- Using the direct payment;

- Paying family members;
- Short-term and long-term care in a care home;
- Becoming an employer;
- Direct payments and hospital stays;
- Direct payments for local authority services;
- Direct payments in the form of pre-payment cards;
- Harmonisation of direct payments;
- Terminating direct payments.

Efficient and effective interventions to fulfill these duties

A number of local authorities have developed good practice and efficient processes for administering direct payments. Key themes in good practice approaches to direct payments include:

- Processes for administering direct payments should be simple and proportionate whilst also ensuring that **risks are enabled** and managed;
- Direct Payments provide an appropriate mechanism for delivering flexible **personalised care** and support;
- Information on direct payments and their benefits should be available and **promoted**.

Pre-paid Cards

Prepaid cards offer a resolution to problems generally associated with direct payments including:

- Transferring funds;
- Monitoring and auditing funds against agreed support plans;
- Reclaiming unspent funds and managing fraud.

Prepaid cards enable good care and effective monitoring to be carefully balanced. Funds can be uploaded to the card and then spent in a similar way to a debit card. This includes the setup of Direct Debits, standing orders, online payments and cash withdrawals. The cards cannot become overdrawn as there is no credit element associated with the cards.

In most cases carers can have a companion card which can allow access to a defined pot of funding as part of the cared for person's personal budget. They can also have a card in their own right for Carers' assessed services.

Service users can monitor and manage their funds through an online portal or via a telephone banking facility. Service users no longer have to submit bank statements and the high volume of paperwork traditionally associated with receiving a Direct Payment.

Funds can be uploaded to the cards in an instant, 24/7, to deal with emergencies and accounts can be suspended if a problem is identified.

Other benefits include:

- Service users no longer need to open a separate bank account;
- Prepaid card available to both service users and carers;
- Emergency payments can be made instantly;
- Monitoring Officers work is less bureaucratic and can be targeted;
- Focus on service user outcomes and not on completing financial monitoring forms;
- Any discrepancies not in accordance with the care plan is addressed in a timely fashion;
- Safeguarding of individuals including earlier identification of potential financial abuse;
- Claw back of fund becomes much easier as both the cards and any unspent funds remain the property of the Local Authority;
- Missing service user contributions are automatically notified.

Over 100 councils are using prepaid cards to deliver direct payments and other services. The National Prepaid Card Network website (www.prepaidnetwork.org.uk) explains that transferring money in this way enabled a careful balance of good care and effective monitoring. Their online guide includes case studies from Camden, Brent & Derbyshire County Council.
https://prepaidnetwork.org.uk/web-cont1001/uploads/Guide-to-the-use-of-Prepaid-Cards-2nd-edition.pdf

In the ADASS survey, there was a variety of practice in relation to the use of pre-paid cards for carers. Given that carers' personal budgets will generally be far smaller than those of a person needing care, pre-paid cards may not be the most efficient mechanism. As such, there are mixed approaches with some using pre-paid cards, other authorities prefer to pay money directly to carers.

Links to further information

Carers UK's guide to direct payments has useful information for carers
https://www.carersuk.org/help-and-advice/practical-support/getting-care-and-support/direct-payments

HMRC has a number of resources which can help direct payment recipients to understand their responsibilities
https://www.gov.uk/browse/employing-people

Chapter 13
Review of care and support plans
(see page 223 of the statutory guidance)

Ensuring all people with a care and support plan, or support plan have the opportunity to reflect on what is working, what is not working and what might need to change is a an important part of the planning process. It ensures that plans are kept up to date and relevant to the person's needs and aspirations, will provide confidence in the system, and mitigate the risk of people entering a crisis situation.

The review process should be person-centred and outcomes focused, as well as accessible and proportionate to the needs to be met. The process must involve the person needing care and also the carer where feasible, and consideration must be given whether to involve an independent advocate who local authorities are required to supply in the circumstances specified in the Act.

Reviewing intended outcomes detailed in the plan is the means by which the local authority complies with its ongoing responsibility towards people with care and support needs. The duty on the local authority therefore is to ensure that a review occurs, and if needed, a revision follows this. Consideration should also be given to authorising others to conduct a review – this could include the person themselves or carer, a third party (such as a provider) or another professional, with the local authority adopting an assurance and sign-off approach.

The review will help to identify if the person's needs have changed and can in such circumstances lead to a reassessment. It should also identify other circumstances which may have changed, and follow safeguarding principles in ensuring that the person is not at risk of abuse or neglect. The review must not be used as a mechanism to arbitrarily reduce the level of a person's personal budget.

The statutory guidance provides further detail about:

- Review of the care and support plan, support plan;
- Keeping plans under review generally;
- Planned and unplanned review;
- Considering a request for a review of a care plan, support plan;
- Considering a review;
- Revision of the care and support plan, support plan;
- Timeliness and regularity of reviews.

Efficient and effective interventions to fulfill these duties

The key themes emerging from good practice in this area include:

- Processes for reviewing care and support plans should be proportionate and take into consideration risk and fluctuating needs;
- Consideration should be given to the method of review and making a range of review options available;
- Review processes should be person-centred and outcome focused;
- The review and revision of the care and support plan should be intrinsically linked especially where it relates to a change in circumstances or presenting need;
- At the assessment and support planning stages, consideration should be given to timing of the first review and subsequent reviews.

Links to further examples

Newham risk management and enablement guidance
London Borough of Newham has practice guidance for staff on key issues to consider when facilitating risk enablement. Three case study examples are included within the practice guide.
http://londonadass.org.uk/wp-content/uploads/2014/10/FactSheet-7-LBN-Risk-Management-and-Risk-Enablement.pdf

Adult safeguarding

Chapter 14
Safeguarding
(see page 231 of the statutory guidance)

Carers and safeguarding

14.35. Circumstances in which a carer (for example, a family member or friend) could be involved in a situation that may require a safeguarding response include:

- a carer may witness or speak up about abuse or neglect;
- a carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with; or,
- a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others.

14.36. Assessment of both the carer and the adult they care for must include consideration of both their wellbeing. Section 1 of the Care Act includes protection from abuse and neglect as part of the definition of wellbeing. As such, a needs or carer's assessment is an important opportunity to explore the individuals' circumstances and consider whether it would be possible to provide information, or support that prevents abuse or neglect from occurring, for example, by providing training to the carer about the condition that the adult they care for has or to support them to care more safely. Where that is necessary the local authority should make arrangements for providing it.

14.37. If a carer speaks up about abuse or neglect, it is essential that they are listened to and that where appropriate a safeguarding enquiry is undertaken and other agencies are involved as appropriate.

14.38. If a carer experiences intentional or unintentional harm from the adult they are supporting, or if a carer unintentionally or intentionally harms or neglects the adult they support, consideration should be given to:

- whether, as part of the assessment and support planning process for the carer and, or, the adult they care for, support can be provided that removes or mitigates the risk of abuse. For example, the provision of training or information or other support that minimises the stress experienced by the carer. In some circumstances the carer may need to have independent representation or advocacy; in others, a carer may benefit from having such support if they are under great stress or similar; and
- whether other agencies should be involved; in some circumstances where a criminal offence is suspected this will include alerting the police, or in others the primary healthcare services may need to be involved in monitoring.

14.39. Other key considerations in relation to carers should include:

- involving carers in safeguarding enquiries relating to the adult they care for, as appropriate;
- whether or not joint assessment is appropriate in each individual circumstance;
- the risk factors that may increase the likelihood of abuse or neglect occurring; and
- whether a change in circumstance changes the risk of abuse or neglect occurring.

A change in circumstance should also trigger the review of the care and support plan and, or, support plan.

The statutory guidance provides further detail about:

- Adult safeguarding – what it is and why it matters;
- Abuse and neglect:
- Understanding what they are and spotting the signs;
- Reporting and responding to abuse and neglect;
- Carers and adult safeguarding;
- Adult safeguarding procedures;
- Local authority's role and multi-agency working;
- Criminal offences and adult safeguarding;
- Safeguarding enquiries;
- Safeguarding Adults Boards;
- Safeguarding Adults Reviews;
- Information sharing, confidentiality and record keeping;
- Roles, responsibilities and training in local authorities, the NHS and other agencies.

ADASS safeguarding review paper

The ADASS review paper on carers and safeguarding explores issues around improving practice and securing desired outcomes for:

- Carers speaking up about abuse or neglect within the community or within different care settings;
- Carers who may experience intentional or unintentional harm from the person they are trying to support or from professionals and organisations they are in contact with;
- Carers who may unintentionally or intentionally harm or neglect the person they support.

Included are seven key messages arising from the review:
http://static.carers.org/files/carers-and-safeguarding-document-june-2011-5730.pdf

Case Study 4

Vivian is a 73 year old woman who was diagnosed with dementia in 2013. John, her son, who is 50, was divorced last year and as a result moved into his mother's home. He works from home as an IT consultant and is the main carer for his mother.

Vivian is able to move around the home fairly independently: using a walking stick. She manages her own personal care requirements by using the equipment provided by the community Occupational Therapist (Bath board). John confirmed that he supported his mother with the shopping, cleaning, laundry and meal preparation. He had become overwhelmed with the situation and stated that it is difficult to witness his mother's memory loss, repetitive questions and anxiety.

John confirmed that his mother had recently wandered out of the house at midnight. He contacted the GP and Vivian was being reviewed by a psycho-geriatrician. He felt under a "great deal of strain" with the caring role and was reaching out for advice and support. He indicated that there had always been 'tension' between him and his mother.

John stated that when his mother had wandered he took her inside the home and was "so angry" that he "yelled at her and punched a hole in the wall." He asserted that he would "never hit" his mother. He expressed feelings of frustration and reported the situation was "suffocating… he was exhausted… and was frequently yelling at his mother."

Client and carer's desired outcomes:

Vivian: *"I keep forgetting things…. My son gets upset… I want my son to be happy. I don't want to go into a home."*

John: *"I want to look after my mother, yet I need help to do this. I want to feel I am in control of my emotions, and able to manage without getting angry all of the time."*

Issues identified	Intervention	Outcome
Mental and emotional wellbeing: Risk Assessment conducted.	- 1:2:1: Assessment and support for Vivian: Referred to the Alzheimer's Society and is now attending weekly groups. - John was referred to counselling. - John explored and adopted relaxation techniques. - John has accessed self-help websites. - John was provided with a	- Vivian reported she enjoyed getting out of the house and meeting people. - Emotional support provided to Vivian. This is ongoing and the situation will be monitored. - John feels more confident as he understands and can deal with dementia better. - John has attended his first counselling session. He

	Carer's Assessment and respite options. - 1:2:1 meeting outside of the family home for emotional support – whilst Vivian was at the Alzheimer's Society.	stated he had initially struggled with the concept. - 1:2:1 session provided to John: provision of information and support is ongoing to both John and Vivian - A family conference was held with the GP and Social Worker.
Social interaction: Mrs A	- Alzheimer's Society: attending a community group, luncheon group and an art class.	- Vivian has attended the weekly groups and enjoyed her time away from home socialising. This also provided space for her son to have time for himself. Attending the groups has reduced the levels of tension in the home.
Physical health needs	- The GP is reviewing Vivian and her medication has been changed. - John has had sensors fitted in the home so that he will be alerted should his mother wander / be away from her bed for too long at night. He is also looking into new digital forms of AT e.g. voice recognition software and is using an app to organise care.	- A follow-up appointment had been made and Vivian's situation is being monitored closely. - John believes the situation is less worrying, and he is continuing to explore other forms of Assistive Technology to support his mother and himself.
Carer's Support	- Assessment and information provided: - learning online and in groups in understanding and responding to dementia - digital online forum and online resources to access 24 hour help - local carers' organization contacts - - local breaks services in additional to the Alzheimer's Society local group	- John arranged a sitting service for his mother. He reported he was able to go to the football for the first time in a year; which was "great." - John has joined an online carers' group.
Financial	- John was immediately given	- Vivian is now in receipt of

	the link to online benefits information and tools - A referral to the local benefits advice service.	Attendance Allowance and her benefits were maximised. She now receives a Council Tax Discount in addition. - John has now looked into costs and planning for the future.
Hair, beauty and dental requirements.	- Local College: Hair and Beauty school. - List of dentists – appointment for a check- up and new dentures.	- John took his mother to the local college where students cut her hair and she had a manicure. Vivian said she "thoroughly enjoyed" the experience and wants "a massage next time." - Vivian had new dentures fitted.
Safeguarding Adults	- The approach to safeguarding Vivian was to involve both parties in a conversation (family conference) about the situation and to ensure the family had access to support, information and resources.	- John and his mother are able to contact the social worker and seek ongoing support, as they require it. - Vivian said her son is "happier." - John stated he feels "calmer" and enjoys going to the football.

6 week: Follow–up review comments:

Vivian: *"Very nice, you're good and you listened to me….. Thank you….I am glad I did not have to move into a home."*

John: *"I know so much more than I did before; about dementia, myself and my mother…It's nice to have a back-up, and information. It is good we both have regular breaks and time apart."*

Integration and partnership working

Chapter 15
Integration and partnership working
(see page 283 of the statutory guidance)

For people to receive high quality health and care and support, local organisations need to work in a more joined-up way, to eliminate the disjointed care that is a source of frustration to people and staff, and which often results in poor care, with a negative impact on health and wellbeing. The vision is for integrated care and support that is person-centred, tailored to the needs and preferences of those needing care and support, carers and families.

Sections 3, 6 and 7 of the Act require that:

- local authorities must carry out their care and support responsibilities with the aim of promoting greater integration with NHS and other health-related services;
- local authorities and their relevant partners must cooperate generally in performing their functions related to care and support; and, supplementary to this,
- in specific individual cases, local authorities and their partners must cooperate in performing their respective functions relating to care and support and carers wherever they can.

The statutory guidance provides further detail about:

Integrating care and support with other local services;

- Strategic planning;
- Integrating service provision and combining and aligning processes;
- Cooperation of partner organisations;

General duty to cooperate;

- Who must cooperate;
- Cooperation within local authorities;
- Cooperating in specific cases;

Working with the NHS;

- The boundary between the NHS and care and support;
- Delayed transfers of care from hospitals;

Working with housing authorities and providers;

Working with welfare and employment support.

Efficient and effective interventions to fulfill these duties

As local authorities work together with their health colleagues, a number of themes are emerging including:

- Opportunities to undertake **joint or aligned assessments and care planning** processes should be maximised
- **Information governance protocols** should facilitate the sharing of identified and agreed key health and care data to facilitate person centred care

Leeds Commitment to Carers
The Leeds Carers Partnership, a wide ranging group of organisations across the public/private/voluntary sectors, has created the Leeds Commitment to Carers – a vision of what Leeds will look like if it is the best city for carers. This was in response to the NHSE Carers Toolkit and is designed to be a public facing version of the memorandum of understanding. Teams, organisations, employers etc. are asked to think about when, where and how they might come across carers – what they do well and what they could do better. They are asked to identify up to three actions that will mean they are better at identifying, recognising and supporting carers. The Leeds Council Health and Wellbeing Board have endorsed the commitment to carers.
http://www.carersleeds.org.uk/leeds-commitment-to-carers/
https://www.carersleeds.org.uk/the-leeds-carers-partnership/

Working with the NHS

Since the publication of the publication of the NHS Commitment to Carers in 2014, NHS England has continued to assert the importance of supporting carers. In the 2018-2019 NHS Mandate it is stated that

"Carers should routinely be identified and given access to information and advice about the support available."

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf

This is further to the NHS Commitment to Carers published in April 2014 and the NHS Five Year Forward View, in which it is noted that:

"The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. We will find new ways to support carers, building on the new rights created by the Care Act…." (p13).
http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Under the Care Act, local authorities have responsibilities to promote integration with health services in order to "improve the wellbeing of adults with care and support needs and carers; prevent or delay needs for support; and improve the quality of care and support". It is well-recognised that working in an integrated way is ensuring that services

are effective and efficient as gaps are being closed and duplication of effort reduced as well as better use of existing resources. This approach is built upon understanding carers and their needs and what they are saying to frontline workers such as social workers and GPs.

When asked if their council had a Memorandum of Understanding with local CCGs, most councils said that they either have an MOU or another way of jointly working together. For example, respondents mentioned having:

- Shared strategic principles at STP level
- Joint commissioning arrangements
- Joint carers vision
- Joint carers strategy
- Section 75 agreement

Respondents were further asked if they are using the Carers Memorandum of Understanding developed by NHS England[4] by using the baseline questionnaire to support joint work. 23% of respondents said they are using it and 26% said that they aren't currently using it but are considering it in the future. 44% said no because they have a number of other joint initiatives.

Doncaster Carers Strategic Oversight group

In Doncaster the Carers Strategic Oversight group is made up of a wide variety of stakeholders including health/CCG. This group has worked with GP surgeries, looking at how health services can better identify carers and signpost to carers' services as a baseline. This group reviews the local carers strategy on a quarterly basis to enable progress to be evidenced and solutions found where there are challenges.
http://www.doncaster.gov.uk/services/adult-social-care/carers-strategy

Referrals into Health

Survey respondents were asked if there is an agreed pathway process for direct referral into health if an individual's carer's assessment flags that there are health and wellbeing concerns. Just under half of respondents said they have no agreed pathway and just signposting. Some of these said that under the exceptional circumstances they would refer someone by writing to their GP, for example, if they felt the carer would be unable to do so for themselves.

[4] https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf

For those who have referral routes, all respondents mentioned the importance of obtaining the carer's consent in this process. Practice varied across councils with some having direct referrals into services including carers counselling and others holding regular meetings with GP practices where cases of concern can be discussed.

West Sussex Carer Health Team

In West Sussex the usual care pathway involves making direct referrals to the dedicated Carer Health Team. The Health Team works directly with carers and aims to reduce the health impacts of coping with a caring role. The team works closely with other services and provides information and advice on specific health conditions, as well as practical advice on the caring environment (safe lifting and handling, healthy eating, risk minimisation).
https://www.sussexcommunity.nhs.uk/services/servicedetails.htm?directoryID=22403

Integration in North East Lincolnshire

North East Lincolnshire CCG is an integrated health and adult social care commissioner and the CCG is also in partnership with NEL Council as a union. There is an integrated single point of access for mental health, health and care. Therefore when needs are presented at point of contact the appropriate referrals are made.
http://www.northeastlincolnshireccg.nhs.uk/data/uploads/publications/market-position-statement-2017-version-final-20180316.pdf

Referrals from Health into Social Care

Survey respondents were asked about formally agreed referral processes from health into social care at primary level, in pharmacies, in mental health services and other services such as dentists.

- At primary care level, only a few respondents said that they have no specific route, although some did say that the approach is not consistent across their area. For councils who do have clear routes, they often involve GPs and either involve training current GP staff to better identify carers or have specific carers support workers who are based in the GP surgeries.
- For the vast majority of respondents there is signposting only in pharmacies, rather than a direct referral process. This was recognised as an area to work on. Even in areas where referrals can be made, councils reported that this rarely happens.
- About a quarter of respondents said that staff within the mental health trust are able to complete carers assessments. However, for most respondents, it is still council staff or the commissioned service who complete the assessments and the mental health trust is able to refer in.
- Most offer signposting only from other health services such as dentists although it is widely recognised that this is an area for development.

Surrey Carers Prescription

A whole systems online secure referral portal called Surrey NHS Carers' Prescription has been developed by Surrey County Council and 5 local CCGs in partnership with Surrey Independent Living Council; Action for Carers Surrey and the Surrey Carers and NHS Providers Network. It is used by all 125 GP practices including 5 Acute Trusts, 3 Community Providers; 1 Mental Health Trust and 5 Hospices in Surrey to securely refer carers to voluntary sector support. This provides a simple practical system for busy clinical staff to make referrals at the first point of contact. This is in effect a form of social prescribing for carers. In addition, the system also enables GP Practices to make one off support payments of up to £300 to have a break

The online form is quick for health staff to complete and has resulted in referrals rising from a few hundred to over 6,000 a year and it is still rising. The new portal puts carers in touch with services that can give them information and advice or even provide them with a short break from caring. Carers have been amazed to get a follow up call from the local carers support service within 24 hours of visiting their GP. For the Carer the prescription provides a quick pathway for help through both the statutory and voluntary sector. The system also provides Carers with on line resources around their caring role. To date, the service has supported over 25,000 carers and over 36,588 services delivered to them as a result.
http://www.actionforcarers.org.uk/professionals/general-practitioners/surrey-gp-carers-prescription/
www.surreynhscarersprescription.org.uk

East Sussex Healthy Living Pharmacy Programme

The Healthy Living Pharmacy Programme in East Sussex acts as a gateway for identifying carers and signposting for support. As part of the programme pharmacy staff will undertake the 'Care Awareness Training for professionals delivered by the local carers' centre.
http://communitypharmacyss.co.uk/eastsussexlpc/east-sussex-county-council-escc/healthy-living-pharmacies-hlp-across-escc/

Torbay Carer Recognition Tool

In Torbay, their Carer Recognition Tool can be used to support direct referrals in from opthalmologists , dentists and this will soon be expanded to include hearing aid specialists.
https://www.torbayandsouthdevon.nhs.uk/about-us/news-and-publications/news/2018/07/the-carers-recognition-tool-14161/

North Tyneside Referral Process

In North Tyneside, there is an online referral process and the MemoryClinic , Care Plus, Talking Therapies and Stroke Information Service all refer direct to the Carers' Centre.
https://www.northtynesidecarers.org.uk/professionals/referring-to-the-centre

Hospitals

When asked about how referrals into social care work at hospital discharge, almost all survey respondents mentioned their general hospital social work team who are able to complete assessments if carers are identified. Some respondents also said that there are

specific carers support workers in the hospitals or that there commissioned service has a presence in the hospital in a dedicated carers space.

Collection of data on carers in hospital was highlighted as an area of improvement for almost all respondents. Many respondents said that they do not have any local evidence on how supporting carers prevents admission or readmission to hospital but that there is a move in some areas to recording readmission and the reason for it. Only one respondent said that their local hospital records admissions that are due to carer breakdown or carer issues although almost all respondents agreed that this would be useful, especially in commissioning decisions.

'It would be extremely useful. This would enable health and social care to examine these admissions, see what support needed to be in place to avoid admission and the reasons why this was not done. This would also help us identify gaps in service provision which would help with shaping the market.' Survey respondent

Some respondents have local evidence/data/case records that look at supporting smoother hospital discharge when the carer is involved and supported. Respondents from areas where staff from commissioned carers' services are based in hospitals are most likely to have a strong evidence basis, whereas others had more anecdotal evidence.

Carer Passports and John's Campaign in Surrey

In Surrey, all NHS Providers have mechanisms in place to involve carers in smoother hospital discharge and reduce the risk of hospital re-admission. Many use the carers passport scheme to help identify carers and provide practical support to carers during hospitalisation of the person they care for. All acute providers are signed up to John's Campaign to allow unrestricted visiting hours and, where a carer chooses to continue to care whilst the person they care for is in hospital, staff work with them to ensure both patient and carer receive the support they require. Carer specific questions are also now included in the discharge process. In the 2017-18 annual hospital carers support service survey, 56% of carers who responded felt having had a carers support service had resulted in a more effective/successful hospital discharge and 50% felt the service they had received had helped reduced the risk of a hospital re-admission.

https://carerpassport.uk/hospitals

https://johnscampaign.org.uk/

West Sussex Hospital Teams

In West Sussex there are Carer Support Workers all acute and community hospitals provide support for carers and collect outcome data.

https://www.carerssupport.org.uk/our-services/hospital-teams/

Plymouth hospitals

In Plymouth, carers workers are based in the hospital trust for 2 days a week, the carers service meets regularly with the hospital discharge team and social work advanced

practitioner managers with a remit for hospital discharge are representatives to the Carers Partnership Board
https://www.plymouthhospitals.nhs.uk/carers

Carers in Bedfordshire Hospital Lounges
Carers in Bedfordshire operates Hospital Lounges run by staff support workers and volunteers. Carers are able to take a break from the busy hospital setting and find out information from a selection of national and local organisations.
https://www.carersinbeds.org.uk/how-we-can-help/hospital-lounges/28-how-we-can-help/carers-lounge/50-carers-lounges

Better Care Fund (BCF)
There are a number of good practice examples of interventions for carers that have featured in Councils' previous Better Care Fund Plans. These have focused on supporting people so that they can continue in their role as carers and avoid hospital admissions. These include:

- Information, Advice and Advocacy;
- Assessment;
- Emotional and physical support;
- Training;
- Access to services to support wellbeing and improve independence.

Examples of BCF Plans

Nottingham Example	
Key Elements	Projected Impact
Programme aims to provide integrated and comprehensive carer services Universal advice and support services for end of life respite to be rolled out to all eligible carers Community Carers Hub acting as a one-stop-shop for accessing support services Community Carers Hub responsible for coordinating direct referrals to the pre-eligibility Respite Service	Evidence drawn from internal reports and academic reviews: • Nottingham Carers Reference Group • York University 2010 meta review of Carers services Outlined impact includes: • Effective support for carers looking after those with long-term conditions • Reduced residential and nursing care admissions

Greenwich Example	
Key Elements	Projected Impact
Aims to provide integrated support to carers	Evidence drawn from the National Strategy for Carers and LTC NICE clinical guidelines (Stroke etc.)
Push to identify un-assessed carers using existing health care services	Reduction in Length of Stay resulting from supported discharge:
Extends current support to include the provision of emotional and practical support	NEL admissions reduction resulting from end of life care support
Provides initial carer assessments and tailored carer support planning	Prevention of carer breakdown - reducing need for residential care
Introduction of Carers' Emergency Support Service to prevent unnecessary admissions to residential care	Prevention of carer breakdown - reduce unnecessary emergency admission to hospital

Lambeth Example	
Key Elements	Projected Impact
Aims to provide holistic support services to carers	Evidence drawn from national guidelines:
Carers' Hub provides access to independent advice, advocacy, information and assessment.	National Carers Strategy Carers' Strategy (England) 2008-2018
Carers' Breaks Service enables service users and carers to access short breaks	
Respite for Carers program offers tailored packages based need	

Chapter 16
Transition to adult care and support
(see page 303 of the statutory guidance)

Carers and transition

16.20. Preparation for adulthood will involve not only assessing how the needs of young people change as they approach adulthood but also how carers', young carers' and other family members' needs might change. Local authorities must assess the needs of an adult carer where there is a likely need for support after the child turns 18 and it is of significant benefit to the carer to do so. For instance, some carers of disabled children are able to remain in employment with minimal support while the child has been in school. However, once the young person leaves education, it may be the case that the carer's needs for support increase, and additional support and planning is required from the local authority to allow the carer to stay in employment.

16.21. The SEN code of practice sets out the importance of full-time programmes for young people aged 16 and over. For instance, some sixth forms or colleges offer five-day placements which allow parents to remain in employment full time. However, for young people who do not have this opportunity, for example if their college offers only three- day placements, transition assessments should consider if there is other provision and support for the young person such as volunteering, community participation or training which not only allows the carer to remain in full time employment, but also fulfills the young person's wishes or equips them to live more independently as an adult (SEN Code of Practice chapter 8 on preparation for adulthood, and chapter 4 of this guidance on market shaping).

16.22. Local authorities must also assess the needs of young carers as they approach adulthood. For instance, many young carers feel that they cannot go to university or enter employment because of their caring responsibilities. Transition assessments and planning must consider how to support young carers to prepare for adulthood and how to raise and fulfill their aspirations.

16.23. Local authorities must consider the impact on other members of the family (or other people the authority may feel appropriate) of the person receiving care and support. This will require the authority to identify anyone who may be part of the person's wider network of care and support. For example, caring responsibilities could have an impact on siblings' school work, or their aspirations to go to university. Young carers' assessments should include an indication of how any care and support plan for the person(s) they care for would change as a result of the young carer's change in circumstances. For example, if a young carer has an opportunity to go to university away from home, the local authority should indicate how it would meet the eligible needs of any family members that were previously being met by the young carer.

The statutory guidance provides further detail about:

- Integrating care and support with other local services;
- Strategic planning;
- Integrating service provision and combining and aligning processes;
- Cooperation of partner organisations;
- General duty to cooperate;
- Who must cooperate;
- Cooperation within local authorities;
- Cooperating in specific cases;
- Working with the NHS;
- The boundary between the NHS and care and support;
- Delayed transfers of care from hospitals;
- Working with housing authorities and providers;
- Working with welfare and employment support.

The Social Care Institute for Excellence (SCIE) have produced specific best practice guidance on transition for young carers and adult carers under the Care Act.
http://www.scie.org.uk/care-act-2014/transition-from-childhood-to-adulthood/

In the ADASS Carers Policy Network Survey many areas reported having relatively long transition phases to ease young carers into adult services. For example, specific support for young adult carers up until age 25. A few appeared to have stricter cut offs at age 18. In general, support during transition was highlighted as an area for development by many councils. This is an area of good practice which DHSC is currently looking to develop.

Examples

Cornwall Council's flexible transition programme

Cornwall Council developed a flexible transition programme for young adult carers, based on what carers in this age range were telling them they need. Young adult carers wanted to access the same or similar support to that they had as young carers (predominantly less formal) and to maintain peer support. In effect this meant creating a longer transition, from 16-25. The council has found that young adult carers are now having Carers Assessments as an adult, but at a time they are ready and they can still access the peer support they need, through newly formed groups. Approximately 40-50 new young adult carers are now identified per annum which is a significant change from previous years where the numbers were single figures at best.
https://www.supportincornwall.org.uk/kb5/cornwall/directory/service.page?id=DpW6IBqhS9o

Hillingdon Carers Supported Transition project

Hillingdon Carers has recently secured continuation funding, from the council, for their Supported Transition project for young adult carers. In its first three years, the project successfully supported 96% participants into further education, employment, training, apprenticeships or higher education. Staff work closely with Social Care staff and would refer young adult carers for re-assessment if they identified a need. They also work closely with both Targeted and Universal Youth Services and many of the young adult carers they support will access some of Hillingdon Carers' programmes.

Chapter 18
Delegation of local authority functions
(see page 337 of the statutory guidance)

Part 1 of the Care Act sets out local authorities' functions and responsibilities for care and support. Sometimes external organisations might be better placed than the local authority itself to carry out some of its care and support functions. For instance, an outside organisation might specialise in carrying out assessments or care and support planning for certain disability groups, where the local authority does not have the in-house expertise.

External organisations might also be able to provide additional capacity to carry out care and support functions.

The Care Act allows local authorities to delegate some, but not all, of their care and support functions to other parties. This power to delegate is intended to allow flexibility for local approaches to be developed in delivering care and support, and to allow local authorities to work more efficiently and innovatively, and provide better quality care and support to local populations.

As with all care and support, individual wellbeing should be central to any decision to delegate a function. Local authorities should not delegate its functions simply to gain efficiency where this is to the detriment of the wellbeing of people using care and support. Local Authorities retain ultimate responsibility for how its functions are carried out.

Delegation does not absolve the local authority of its legal responsibilities. When a local authority delegates any of its functions, it retains ultimate responsibility for how the function is carried out. The Care Act is clear that anything done (or not done) by the third party in carrying out the function, is to be treated as if it has been done (or not done) by the local authority itself. This is a core principle of allowing delegation of care and support functions.

The statutory guidance provides further detail about:

- Overview of the policy;
- Local authorities retain ultimate responsibility for how its functions are carried out;
- Importance of contracts;
- Which functions may not be delegated;
- The difference between outsourcing a legal function and activities relating to the function;
- Conflicts of interest.

Efficient and effective interventions to fulfill these duties

The Care Act allows local authorities to delegate some of their care and support functions to other parties:

- Local Authorities **retain ultimate responsibility** for how its functions are carried out;
- In addition to efficiency considerations, individual wellbeing should be central to any decision to delegate a function;
- Consideration should be given to the nature and **quality of the contracting and monitoring arrangements** for any function a local authority chooses to delegate;
- Local Authorities should consider imposing conditions on their contracts with delegated parties to mitigate against the risk of any potential conflicts;
- The Care Act does not allow the delegation of certain functions namely:
    - Integration and Cooperation;
    - Adult Safeguarding;
    - Power to charge.

In the spirit of facilitating more flexible arrangements to enable local authorities to meet local needs, the Care Act sets out provision for the delegation of some of its care and support functions. It is recognised that in some cases, local authorities may determine that outside organisations might be best placed to deliver a specific area of care and support. It may also be recognised that outside organisations may have the appropriate skills and capacity to deliver these functions more effectively or efficiently than the local authority directly.

There may be occasions where it is determined that external organisations might be better-placed than the local authority to carry out some of its care and support functions. This may be when the external organisations specialise in carrying out assessments for carers or specific other disability groups. As part of the decision making process, Local Authorities may develop an economic case for delegating functions, which should also take into account the cost of the additional contract monitoring required to ensure that the local authority duties are carried out effectively. Other factors to be considered include:

- the use of information technology and reporting requirements to the local authority
- detailed processes including any requirement for decision making by the local authority at any part of the pathway (where specific elements have not been delegated);
- Required skills, training and competencies of staff undertaking the functions;
- Expected standards and outcomes to be delivered by the external organisation;
- How complaints will be handled, managed and reported.

Where assessments have been outsourced, practices to ensure that eligibility decisions are Care Act compliant varied across councils who responded to the ADASS survey. Many

councils said they completed regular audits and made sure decisions were verified by a manager. Others have ongoing contract meetings with the commissioned service, have local authority staff based in the commissioned service or check assessments when they lead to a personal budget. One council said their regular reviews include monthly 'dip sampling' by a quality assurance team.

Examples

Devon County Council's approach to commissioning

In Devon, the introduction of the Care Act prompted the council to change their commissioning arrangements to ensure that staff members in the local carers centre had the skills to be able to complete statutory functions delegated to them such as carer assessments and care and support plans. In local listening events carers had also told the council that well trained staff was an important requirement for them.

As part of their commissioning arrangements, the council requires all carers centre staff to complete safeguarding training, basic digital skills training and the care certificate forms a key part of their induction. The carers centre must complete a regular workplace development plan which is then agreed by the council. The council more recently introduced a specification that the staff member who manages carer support including assessments should be a qualified social worker experienced in Local Authority social work and their deputy must be a qualified and experienced occupational therapist. Devon Council finds that this approach reduces the demand on other statutory bodies because the Carers Centre is able to respond to problems presented by carers.

These staffing requirements sit alongside a rigorous programme of quality assurance including regular reporting, quarterly contract meetings and monthly meetings between the council, carers centre and care provider. The council also checks all decisions to issue a personal budget and randomly samples other assessments to ensure quality.

Social work practice pilots

The social work practice (SWP) pilots tested proposals to allow local authorities to delegate some of their functions relating to looked-after children to independent organisations. This independent report on the SWP pilots includes findings on:

- the advantages and disadvantages of the different models employed;
- the impact of SWP pilots on children, their carers and their families;
- the impact of the SWP model on the children's social care workforce;

The report can be found at:
https://www.gov.uk/government/publications/social-work-practices-report-of-the-national-evaluation

Moving between areas

Chapter 19

Ordinary residence

(see page 343 of the statutory guidance)

Chapter 20

Continuity of care

(see page 357 of the statutory guidance)

As with all care and support, individual wellbeing should be central to any decision to delegate a function. Local authorities should not delegate its functions simply to gain efficiency where this is to the detriment of the wellbeing of people using care and support.

Local Authorities retain ultimate responsibility for how its functions are carried out.

Delegation does not absolve the local authority of its legal responsibilities. When a local authority delegates any of its functions, it retains ultimate responsibility for how the function is carried out. The Care Act is clear that anything done (or not done) by the third party in carrying out the function, is to be treated as if it has been done (or not done) by the local authority itself. This is a core principle of allowing delegation of care and support functions.

“Ordinary residence” is crucial in deciding which local authority is required to meet the needs in respect of adults with care and support needs and carers. Whether the person is “ordinarily resident” in the area of the local authority is a key test in determining where responsibilities lie between local authorities for the funding and provision of care and support.

Ordinary residence is not a new concept – it has been used in care and support for many years. However, there have been in the past and will continue to be cases in which it is difficult to establish precisely where a person is ordinarily resident, and this guidance is intended to help resolve such situations.

Carers and ordinary residence

19.6. The test for ordinary residence, which determines which local authority would be responsible for meeting needs, applies differently in relation to adults with needs for care and support and carers. For adults with care and support needs, the local authority in which the adult is ordinarily resident will be responsible for meeting their eligible needs. For carers, however, the responsible local authority will be the one where the adult for whom they care is ordinarily resident.

Continuity of care

People with care and support needs may decide to move home just like anyone else, such as to be closer to family or to pursue education or employment opportunities, or because they want to live in another area. Where they do decide to move to a new area and as a result their ordinary residence status changes (see chapter 19 on ordinary residence), it is important to ensure that care and support is in place during the move, so the person's wellbeing is maintained.

In circumstances where a person is receiving local authority support and moves within their current local authority (for example, moving between homes in the same area), they would remain ordinarily resident within that authority and it must continue to meet their needs.

Where the person chooses to live in a different local authority area, the local authority that is currently arranging care and support and the authority to which they are moving must work together to ensure that there is no interruption to the person's care and support.

The continuity of care chapter sets out the process local authorities must follow to ensure that the person's care and support continue, without disruption, during and after the move. These procedures also apply where the person's carer is receiving support and will continue to care for adult after they have moved.

The statutory guidance provides further detail about:

For ordinary residence:

- How ordinary residence affects the legal framework in the Care Act;
- How to determine ordinary residence;
- Determining ordinary residence when a person moves into certain types of accommodation out of area;
- Disputes between authorities, and the process for seeking a determination by the Secretary of State for Health or appointed person;

For continuity of care:

- Making an informed decision to move to a different local authority; confirming intention to move; supporting people to be fully involved in the process;
- What local authorities take into account when they are planning the move with people;
- How to ensure continuity of the person's care if the second local authority has not carried out an assessment ahead of the day of the move;
- What happens if a person does not move.

ADASS have reviewed their cross border protocol for assessment of adult carers who live in a different local authority area to that of the adult with care and support needs they care

for. http://londonadass.uk/wp-content/uploads/2014/10/Cross-border-assessment-of-carers-draft.pdf

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Updated by the ADASS Carers Policy Network