THE CARE ACT 2014

Response to the Department of Health consultation on the draft regulations and guidance for implementation of part 1 of the Act 2015/16

LONDON BOROUGH OF RICHMOND UPON THAMES

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1. INTRODUCTION

This document sets out the London Borough of Richmond upon Thames' (LBRuT) response to Department of Health (DoH) consultation on the draft regulations and guidance of the Care Act which come into effect in April 2015.

The Care Act Implementation Programme in Richmond has been divided into five project areas; 1) Funding, 2) Prevention, Information and Advice, 3) Community Offer, 4) Safeguarding and 5) Market Shaping. Where appropriate, project managers have taken responsibility for formulating the responses relating to their area of work. Responses have also been collated from the wider Council.

LBRuT is committed to engaging with local residents and we have undertaken a number of consultation activities with service-users, carers, the local voluntary and community sector and the general public about some of the areas covered in this consultation. Where possible, the information collected has been incorporated into this response document to help ensure that the views of the local population are taken into consideration. Additionally, information collected will help shape the way that the Act is implemented in Richmond following the publication of the final regulations and guidance.

External consultation activities undertaken were;

- Workshops with the Care Act Coproduction Group (service-users and carers)
- Discussions with residents who have learning disabilities at three local social events
- A survey aimed at the local Voluntary Sector
- Outreach sessions and survey facilitated by Healthwatch Richmond on behalf of the Council
- A Care Act public consultation event facilitated by Healthwatch Richmond on behalf of the Council
- Workshops with the Public Information Group
- Discussions at the Care Home Provider Forum

(Please see 'Appendix A- Consultation Methodology', for full details of consultation activities).

This response includes responses to the specific consultation questions as well as a number of general comments and key issues. Questions that were not a priority for LBRuT or where there was no comment have not been included. As a result of wider consultation, some questions include feedback from more than one respondent and the origin of each response has been indicated within the text. Where there is a single response, this represents the view of LBRuT.

2. KEY ISSUES FOR LBRuT

Funding the changes

The reforms and new burdens in 2015/16 should be fully funded. It should not be underestimated how the Care Act conveys a different view of the role of the Council in providing care and creates additional expectations. New responsibilities, such as that to provide support for self-funders, will place additional pressure on existing staff and financial resources. Funding allocations should fairly reflect regional cost variations, as well as accurately taking into account the number of self-funders and carers who will have new entitlements under the Care Act.

Funding Care Issues

- **Deferred Payments:** We support the proposal to introduce universal deferred payments; however it would be preferable to delay implementation until 2016 to bring this in line with the other social care funding reforms. This would allow adequate time for the development of appropriate local financial systems appropriate for all the funding reforms and to ensure information and advice services are in place for all elements of the funding reforms.

- **Debt Recovery:** With the repeal of powers to place a unilateral charge on properties under HASSASSA 1983 we are concerned that this will impact on councils' ability to protect public funds in cases where it has not been possible to achieve cooperation with a service user or their relatives to carry out a financial assessment or to obtain payment of contributions. Whilst there are powers to take recovery action through the courts to obtain a judgement and a charging order, this will result in additional costs to councils which we do not believe have been taken into account when allocating resources to councils. We would welcome changes to the guidance which give councils sufficient powers to take legal recovery action without having to take repeated action where a person's debt relating to their care costs continues to increase.

Non-funding Issues

- **Eligibility:** There are concerns that the proposed eligibility criteria are set at a lower threshold to the current substantial level under the FACS criteria meaning more people will be eligible for services. We urge the Department to ensure the final drafting of the eligibility criteria ensures that the new criteria remains in line with the current definitions of substantial needs, taking into account feedback from councils who have carried out testing.

- **Integration:** There are concerns that the guidance on integration and partnership does not go far enough to require integrated working. Particularly in relation to guidance on integration with the NHS, the guidance should set clearer pathways and deliverables that local authorities can work towards in order to make integration a reality rather than an aspiration. It would be useful if tools to support local integration were produced or if existing tools that are supported by DoH were referenced in the guidance.

- **Model of Care:** The spirit of the Act promotes the social model of care and support and the regulations and guidance reflect this in many respects. However, this is contrasted with some elements of a more medical model.

Examples include the discussion of conditions and the descriptions of preventative services as ‘primary, secondary and tertiary’. This can create difficulty in implementing the true spirit of the Act.

Key issues arising from wider consultation

- **Communications campaign:** A consistent message received throughout the consultation activities related to the desire to see simple, clear and, transparent messages that explain the Act. We are aware that the DoH plan to release a national communications campaign starting autumn 2015 and it is important that this includes tools and information that can be adapted and used by local authorities <u>and</u> the voluntary sector in order to promote consistent and simple messages about the Act and ensure people are well informed. For example, we asked residents if they were in a situation where they had assets and required care, would they approach the local authority for a care account in order to take advantage of the cap on funding. Many who said they would not do this thought it would be unlikely that they would know about the cap if they were not already receiving council services. The biggest area of concern was regarding changes to the funding of care, particularly the cap on care costs and deferred payments. This is a particular area where clear, simple and, consistent messages will be needed.
- **Funding:** The Act was generally supported but it was questioned where the money for changes would come from and how local authorities would deal with an increased demand on services, particularly at a time of efficiency to meet a reduction in public funding.

3. GENERAL DUTIES AND UNIVERSAL SERVICES

Well-being

Question 1. Does the draft guidance provide local authorities with the information they need to embed wellbeing into the way that they work?

The guidance sets out a definition for well-being but this is fairly broad and interpretation will inevitably be based on subjective judgement. The key-principles, however, are helpful.

Preventing, reducing and delaying needs

Question 3. Is the description of prevention as primary, secondary or tertiary, a helpful illustration of who may benefit from preventative interventions, when and what those interventions may be?

The terms primary, secondary and tertiary are rather jargon-based, although such a differentiation is necessary. The wording under secondary and tertiary headings is a little confusing. The heading “Reduce: secondary prevention/early intervention” is followed immediately by point 2.7 which refers to “help slow down”, and “Delay: tertiary prevention” refers in 2.8 to “reduce need”. The essence of the content is understood but it would be logical to adjust this anomaly.

Question 4. Is the list of examples of preventative 'services, facilities or resources' helpful? What else should be included?

LBRuT Response: The list of examples of services, facilities and resources are helpful. The following could also be included: luncheon clubs, Careline/Lifeline service, financial advice/benefits checks, signposting to meals services.

Voluntary sector survey: *7 out of 10 respondents to the survey felt that the list of examples was helpful. Respondents were also asked to give examples of preventative services, facilities or resources and responses loosely reflected the types of examples given in the guidance. The most common suggestions were information and advice as a preventative service in itself, peer support and the ability to meet others in a similar situation. Areas identified as missing were:*

- *Richmond Carers Centre - Preventative services specifically for carers. The guidance should acknowledge that unpaid carers are often the first line of preventing the escalation of need for those they care for.*
- *Richmond Borough Mind – Prevention is focused on older people and physical health. They would like to see an example that illustrates the importance of social contact and relationships within the community as a preventative service for people under secondary and tertiary mental health services.*

Outreach and public consultation event: *People were asked about the services that would help delay or reduce the development of needs for care and support and help people to remain in their own homes or continue caring. Again, a common response related to good communication, information and advice about services and knowledgeable staff such as social care staff, GPs and pharmacists. The importance of support groups, peer support and advocacy groups were also frequently mentioned and these are often a source of information for their users. Other examples included:*

- *Support within the home individuals and carers such as help with maintaining the home, cleaning and gardening*
- *Financial advice and understanding of legal issues around care*
- *GPs keeping an awareness of people who may need care and information from GPs.*
- *Good hospital discharge planning (which also includes the carer)*
- *Mechanisms for raising concerns about neighbours/ people in the community who may not have family*
- *Community transport services*
- *Services to avoid social isolation*
- *Support groups*

Information and advice

Question 5. Views are invited about how local authorities should co-ordinate and target information to those who have specific health and care and support needs.

LBRuT's response: (including views of the Public Information Group; network of local voluntary sector organisations): *Information provision should be broken down into clusters, e.g. 1) general information, 2) information for service users, carers, families, 3) professionals 4) voluntary/third sector, 5) GPs, etc. Information to be consistent and easily interpreted. Local authorities should work with representatives of all the above groups to ensure the right information is provided in the right way and using established networks. A cohesive network to be formed and maintained, building a* *community "hub" of information/distribution list/point for printed information as well as electronic provision.*

Care Act Coproduction Group: *Were asked to consider how the local authority might target information for people with specific health and care and support needs:*

- *Information should remain multi-channel and not rely too heavily on electronic communications. Richmond User Independent Living Scheme found that 50% of its members preferred paper-based communication. Printed material available in accessible formats.*
- *GP involvement is paramount in providing information and advice. GPs should make better use of the GP intranet and more use of Patient Participation Groups/ Networks. (The guidance does suggest working with partners such as GPs, but it would be helpful if this duty was reciprocal.)*
- *Information prescriptions are a great idea*
- *Other areas suggested for targeting information were; through local shops, supermarkets, post offices and faith groups.*

Learning disabilities: *The residents with learnings disabilities who we spoke to tended to find information and advice about services (including that of partner agencies such as housing), through existing support networks. The role of social workers and care workers was key, as were networks established through voluntary organisations such as MENCAP. The provision of such services should be considered in the guidance.*

Voluntary sector survey: *Consistent messages and branding are crucial, and communications to be available at a range of outlets and through the use of existing information directories. GPs surgeries were mentioned specifically.*

- *A single point of access, or single phone number and website as a starting point for further information.*
- *Local authorities should work with a number of organisations who communicate with service users. A 'train the trainer' approach could be taken with the voluntary sector with regards to communicating the changes of the Care Act specifically.*
- *Disseminating information through networks and regular bulletins*
- *To target carers it is important to engage with local employers and business networks on the importance of supporting carers in employment.*

Outreach and public consultation event: *People were asked about how they find information about service asides from the Local Authority.*

- *Friends and family and existing support networks. Relationships and word of mouth are a key way people find out about services.*
- *Local charities and voluntary sector organisations (such as Healthwatch Richmond) and support groups*
- *Advice centres such as Citizens Advice Bureau*
- *The internet (although many emphasised this should not be the only way)*
- *Within the local community- shop notice boards etc.*
- *GPs, (including leaflets and information in waiting rooms)*
- *NHS providers*
- *Police*

Question 6. Does the guidance provide sufficient clarity about the active role that the local authority should play to support people's access to financial

information and advice that is independent of the local authority, including regulated financial advisors?

LBRuT response: *It was felt that the guidance was sufficiently clear about the local authority's role in supporting access to financial advice.*

Voluntary sector survey: *5 out of 10 respondents thought the guidance was sufficiently clear. 2 felt it was not and 2 were not sure. Richmond Advice and Information on Disability (Richmond AID) felt that the local authority should have a role in facilitating access to financial support but the guidance around this was not as clear as they would have liked. There is a role for the voluntary sector in offering financial advice services.*

Care Home Providers Forum: *Providers were asked how the Council could help them ensure that people have access to good financial advice before entering a care home. It was suggested that the council could provide a list of nominated and approved financial advice providers.*

Market shaping and commissioning

Question 7. Does the statutory guidance provide a framework to support local authorities and their partners to take new approaches to commissioning and shaping their local market?

Further clarity would be useful around examples of best practice of the differing models of outcome based commissioning. There should also remain an emphasis on ensuring good practice and clear standards in delivering care and services.

Clarification that new models of commissioning will not automatically lead to a reduction in costs or usage of resources and may need initial investment to build skills.

Should be a stronger emphasis on workforce development in particular increasing the skills base of commissioners to develop and shape local markets and implement new models.

Question 8. Are there any further suggestions of case studies or tools that can assist local authorities in carrying out their market shaping and commissioning activities?

LBRuT response: *Toolkits to take forward Outcome Based commissioning on already successful models would assist local authorities. This could include contracting documents, Outcome sets and measures. Examples of preventative services which have delivered evidenced efficiencies and improved outcomes would also be useful.*

Voluntary sector survey: *We asked how the local authority should engage with the local voluntary and community sector as a part of the market shaping duties:*

- *Coproduction of the service specification*
- *Ongoing involvement in quality assurance*
- *Consider how the public is informed about ongoing service delivery. For example, performance information could be published.*
- *The process needs to be explicit and understood by all*
- *Supporting smaller-providers: smaller providers may find it difficult to be involved in the process if it is cumbersome. Payment by outcome may be problematic for smaller providers due to the need for up-front investment.*

- *Different options for procurement should be part of this work, and those that support smaller, voluntary sector organisation should be fully explored.*
- *Business mentoring or training for smaller voluntary and community sector providers. Provider forums to help share best practice.*
- *Piloting innovative approaches: mechanisms for the piloting of small scale innovative services to enable the development of new services.*

Care Home Providers Forum: *workforce development will be an important part of Market Shaping. The Council could help attract skilled care staff to the borough through on-going recruitment with financial incentives for service or employment schemes such as child care vouchers.*

Managing provider failure and other service interruptions

Question 9. We invite views on the entry criteria to the market oversight regime, and whether and how they could be made simpler for residential care providers.

The draft guidance outlines the criteria to be applied before a provider falls within the market oversight regime. Separate criteria apply to community services (non-residential) and residential services.

Non-residential - this is based upon one of three criteria applying:-
1) 30,000 hours per week: 2) 2,000 service users per week 3)800 service users each receiving on average at least 30 hours per week
The 30,000 hour threshold is high – such providers will have turnovers in excess of £22.5m. In our view it is not these providers that are likely to fail, it is more the medium size providers where the risks are greater. We would recommend a lower threshold of 20,000 hours per week.
It is very unlikely that the third criteria will apply, the criteria is based upon a minimum number of services users (800) with each service-user receiving on average 30 hours of care per week. With the exception of a specialist live in care provider, this criteria will not be met by any provider. Even if it applies, the provider would be providing 24,000 hours of care per week, this is close to 30,000 hour threshold. We would recommend this criteria is deleted.
One accepts that appropriate criteria are set so that CQC resources are directed to areas of higher risks. The area of highest risk is a local provider which operate across a handful of adjoining authorities, a criteria should be included covering this situation. For example "a provider operating across four adjoining authorities and is providing on average 2,000 hours per week across each authority."

Residential – this is based upon one of two criteria applying:-
1) 2,000 beds (national provider); 2) 1,000-2,000 beds (regional provider) either operating across 16 local authorities or 3 local authorities in each local authorities the provider is providing 10% or more of the total provision.
The area of highest risk is a provider which operate across a handful of adjoining authorities or providing specialist services that would be difficult to replace. An organisation having 1,000 beds is likely to have a turnover in excess of £30m; risks are greater for providers below this. A criteria should be included covering this situation. A lower threshold of 600 should be used.

Question 10. We invite views on the approach to defining business failure by reference to insolvency situations.

The lists are typically those used in a contract and are notification of events that have already occurred. This list is reasonable in terms of instigating a local authority *temporary duty of care for until one of these events have occurred the company is still trading.*

In leading up to one of these events CQC may have advance notification of or information that suggests it is highly likely one will occur. The guidance makes reference of the trigger for CQC "to contact authorities is that it believes the whole of the regulated activity in respect of which the provider is registered is likely to fail, not parts of it. It is not required to make contact with authorities if, say, a single home owned by the provider in the regime is likely to fail because it is unprofitable and the CQC is not satisfied that this will lead to the whole of the provider's regulated activity becoming unable to continue. When and how to involve local authorities is a decision for CQC in the light of what it considers is the best course of action to maintain continuity of care for those receiving services"

A more specific requirement on CQC to inform should be included to inform a local authority in all instances as soon as practical once CQC has come to a view that a regulated activity (or branch/home) is to cease trading or close. The guidance should support better, reciprocal sharing of information.

Question 11. We also invite views on the insolvency situations listed, e.g. are they appropriate and clear. Should other situations be covered?

The situations listed are appropriate.

4. FIRST CONTACT AND IDENTIFYING NEEDS

General comments: *It should be emphasised that the eligibility criteria marks a substantial shift in the way assessments are carried out, particularly in the notion that all needs are assessed in the first instance, and then assessed in terms of what needs will be met. This is a huge cultural shift and it may be helpful to acknowledge this within the guidance.*

Needs assessments and carer's assessments

General Points: Wider consultation: *A number of points about how to make an assessment as straight forward as possible were picked up through outreach sessions and the public event. The appropriate training, quality and knowledge of an assessor was a key theme and the ability of the assessor to listen and be empathetic. Other common themes included the need for service-users and carers to be fully informed of the process throughout the assessment and appropriate access to an advocate.*

Question 13. What further circumstances are there in which a person undergoing assessment would require a specialist assessor? Please describe why a specialist assessor is needed, and what additional training is required above the requirement for the assessor to be appropriately trained to carry out the assessment in question.

LBRuT's Response: *The requirement for a specialist assessor in the case of deaf blind individuals could be expanded to include sensory loss. Often individuals with Autistic Spectrum conditions would require a specialist assessor and this is an omission in the guidance. The guidance states that assessors require 'sufficient expertise'; this would need to include sufficient knowledge about the implications of specific health conditions such as neurological conditions.*

The Care Act Coproduction Group: *Identified assessing individuals with autistic spectrum conditions requiring specialist assessor. Despite reference to other relevant acts throughout the guidance, such as the Mental Capacity Act, the guidance makes no reference to the Autism Act. The assessor's specialist knowledge should not only* *focus on the medical conditions, but the impact of the condition on the assessment process.*

Eligibility

Questions 14. Do the draft eligibility regulations, together with powers to meet other needs at local discretion, describe the national eligibility threshold at a level that will allow local authorities to maintain their existing level of access to care and support in April 2015? If you believe they don't please explain your reasons for this.

LBRuT Response: *Additional clarity in the regulation and guidance is required;*

- *The guidance and regulation should clarify whether the impairment should be of permanent nature e.g. not a broken leg.*
- *The concept of wellbeing will be subjectively interpreted by individuals and staff; this puts at risk the notion of fairness and portability.*
- *The way eligibility is set out in 3 conditions/criteria (a, b, c), some of them are quite subjective and make applying the criteria difficult in terms of equality and fairness.*
- *The guidance states that fluctuating needs should be taken into consideration, but does not define at which point we must assess needs. Would eligibility be determined on the basis of the worse day, the best day? How would you identify the middle point?*

The criteria, as set out, look similar to the current 'moderate' FACS banding and therefore there will be an increase of people eligible for services. For example, in paragraphs 6.87(b) and (c)- the qualification of an adult being unable to achieve 'one or more' of the following outcomes would equate to the 'moderate' banding.

Question 15. Do you think that the eligibility regulations give the right balance of being outcome- focused and set a threshold that can be easily understood, or would defining "basic care activities" as "outcomes" make this clearer?

LBRuT's response: *Basic care activities cannot be described as outcomes and we must ensure that the distinction between what is an activity and what is an outcome remains clear. The eligibility regulations are complex. The clarification point about what constitutes being unable to do something actually makes it confusing and adds complexity especially as the requirement is to measure eligibility before any informal care or natural support is taken into account.*

The Care Act Coproduction Group: *Felt that the outcomes, as defined in the guidance, could be open to local interpretation. From a service-user point of view, it may not be clear enough to what extent these outcomes apply. For example, what constitutes "necessary facilities"? Does this include cultural or religious facilities? This may result in the service-user being unaware that they may be entitled to care and support or being unwilling to access the support they need. It was noted that, particularly in relation to individuals with autistic spectrum conditions, defining these activities as outcomes could create the danger of an individual having appeared to have achieved an 'outcome' because their care and support needs (defined as 'basic care activities') are being met. To withdraw the support in these circumstances would result in the individual's needs increasing. The group supported a change in wording of some care activities which seemed too simplistic. For example, a service-user may be physically able to dress but may need support in selecting appropriate clothing.*

Question 16. Do the current definitions of "basic care activities" include all the essential care tasks you would expect? If not, what would you add?

LBRuT's response: *Essential care is covered. The term 'toileting' should be replaced with 'using the toilet'.*

The Care Act Coproduction group: *Identified shopping and managing personal finances as basic care activities that are missing. In addition, the group identified the ability to partake in faith/ beliefs. This could be specified as part of the outcome 'To access necessary facilities or services in local community including recreational facilities or services'.*

Learning disabilities: *We asked residents with learning disabilities about what 'activities' councils should consider with regards to who might require services. The ability to travel independently/ use public transportation should be included as a basic care activity or as an outcome. This would mean transport authorities taking responsibility. The importance of friendships and socialising were emphasised. The outcome of 'maintaining…personal relationships' could be expanded to include 'forming' relationships.*

Question 17. Are you content that the eligibility regulations will cover any cases currently provided for by section 21 of the National Assistance Act 1948?

The guidance is not clear enough in terms of the local authority's responsibility to individuals who are subject to provisions under Section 115 of the Immigration and Asylum Act 1999.

Question 18. Does the guidance adequately describe what local authorities should take into consideration during the assessment and eligibility process? If not, what further advice or examples would be helpful?

Issues relating to eligibility have been identified above and apply here. The assessment process, as set out is quite prescriptive. This helps with national consistency but contrasts with the Act's principal of proportionality and not taking a 'one size fits all' approach.

Independent advocacy

Question 19. We would welcome views on further specific circumstances where the advocacy duty should apply. In particular, we welcome views on the potential benefits and disadvantages of providing independent advocacy for people for people receiving care jointly from adult social care and the NHS.

Voluntary sector survey: *Responses highlighted the importance of independent advocacy. Comments relating to the guidance :*

- *An advocate should be provided when the 'appropriate person' requests it or when there is a disagreement with the local authority/ NHS and the appropriate person*
- *There does not appear to be a definition of when a person would have 'substantial difficulty' in being involved with the assessment and support planning process, which leaves it open to interpretation*
- *The guidance should make clear that carers must be willing to take on the role of advocate or 'appropriate person'.*

- *Robust guidance around the discretionary provision of an independent advocate and the factors that should be considered would provide a better approach to identifying specific circumstances where the duty should apply.*

5. CHARGING AND FINANCIAL ASSESSMENT

General comments and areas of concern:

Deferred Payments
We support the proposal to introduce universal deferred payments, however it would be preferable to delay implementation until 2016 to bring this in line with the other social care funding reforms. This would allow adequate time for the development of appropriate local financial systems appropriate for all the funding reforms and to ensure information and advice services are in place for all elements of the funding reforms.

The new requirements of Deferred Payment Agreements, having regard to the Consumer Credit Act, will require highly trained financial assessment officers to ensure that proper information is made available to people when considering a Deferred Payment Agreement. Councils will require adequate funding to recognise the additional complexity of financial assessment work as well as the increased volume of work.

The draft guidance is unclear about how the personal allowance of £144 per week would work under the revised Deferred Payment Scheme and it should be clarified that this higher amount of personal allowance does not reduce the amount paid by the individual towards their care home fees as the effect of this allowance is to increase the level of the debt payable under the Deferred Payment Agreement.

Consistent Charging Arrangements
We welcome that some flexibility is allowed under the draft charging guidance, however we would urge the Department to limit local discretion with regard to calculating the level of means-tested support available, in order to achieve much greater consistency for citizens across different local authority areas. The greater consistency achieved for charging policies will make it easier for information and advice services, including national publicity campaigns regarding the cap on care costs and extended means test. This would be consistent with the intention of supporting portability of services.

Deprivation of Assets/Gifts
We believe the draft guidance may be too widely open to interpretation, resulting in additional costs to the public purse. There is an opportunity to strengthen guidance in this area to reduce the potential loss to public funds in a minority of cases where someone intends to claim state funding where they should not otherwise be entitled. We do not believe that there are sufficient powers to investigate financial circumstances where there is cause to believe that assets/income have not been fully declared.

With regard to gifts, we would encourage further clarification on what is acceptable as a gift and suggest that a limit is set in line with HMRC limits for gifts, currently set at £3,000 per annum.

Further guidance on the treatment of pensions in the financial assessment is needed with regard to the new flexibilities for individuals to withdraw funds from their pension pot as a lump sum. Guidance would ensure that individuals are not unfairly penalised *as a result of decisions made around their pension as well as protecting the public purse against people wishing to deprive themselves of assets.*

Debt Recovery

We acknowledge that it has been necessary to repeal the powers to place a unilateral charge on properties under HASSASSA 1983. We are, however, concerned that this will impact on councils' ability to protect public funds in cases where it has not been possible to achieve cooperation with a service user or their relatives to carry out a financial assessment or to obtain payment of contributions. This would apply in cases where someone may decline the offer of a Deferred Payment Agreement, whilst refusing to pay their towards their care costs. There is a missed opportunity within the guidance to strengthen guidance for councils to maximise recovery of contributions. Whilst there are powers to take recovery action through the courts to obtain a judgement and a charging order, this will result in additional costs to councils which we do not believe have been taken into account when allocating resources to councils. We would welcome changes to the guidance which give councils sufficient powers to take legal recovery action without having to take repeated action where a person's debt relating to their care costs continues to increase. Where court action is necessary, it should be possible to obtain a judgement to recover care costs up to the value of the lifetime cap as well as the assessed contribution towards daily living costs.

Choice of Accommodation and Additional Payments (Top Ups)

We welcome the choice provided to individuals and ability to make additional payments relating to their choice of accommodation. It is likely, however, that there will be an increase in these arrangements, as self-funders request the Council to assist with making arrangements for their care. We would request powers to undertake credit checks on third parties who agree to enter into a top up arrangement with the Council and greater powers to ensure recovery of top up payments. Clearer guidance for councils would be welcomed as well as tools to ensure the agreements are robust.

Property/Assets held overseas

Guidance on property and assets held overseas would be welcomed. This is a complex area and with increase mobility within and outside the European Union, councils are dealing more frequently with people with care needs who hold property/assets overseas. This is likely to apply in cases where someone who has purchased a retirement property overseas returns to the UK or where an older person who comes to the UK to reside with their family develops care needs. Greater powers to place a legal charge over property held abroad and power to investigate the level of assets held abroad would protect the public purse from providing funding where the individual is able to pay for their care as they progress to the funding cap.

Other disregards

Question 25. Do you think these bonds should be taken account of in the financial assessment? What are the risks and costs to local authorities and individuals?

We agree that bonds should be taken into account in the financial assessment as this would be consistent with the treatment of capital/savings in the assessment. This would ensure that people are not encouraged to take out particular products which are not suitable for their needs or used as a vehicle to avoid paying towards their care.

Question 26. Should pre-paid funeral plans be disregarded and if so should there be a limit to the size of plan that can be disregarded? If so, how much?

We agreed that prepaid funeral plans should be disregarded with the amount disregarded set at the average cost of a funeral in the UK.

Choice of accommodation and additional payments

Question 28. What are the risks of the expansion of the additional cost provisions so that the person can meet this cost themselves (to both local authorities and the person)? How can any risks be mitigated by regulations and guidance?

There are increased risks to councils and these could be mitigated by clear guidance to councils and a toolkit so that councils adopt best practice to ensure that individuals are given clear information and can plan appropriately for their care costs.

Pension reform

Question 29. What do you think the impact of the increased pension flexibilities might be for social care charging for people and local authorities? How can any risks be mitigated via regulations and guidance?

The increased pension flexibilities provide an element of risk, as someone choosing to take a lump sum from their pension may not fully understand the implications for their financial assessment and paying for their care. There are risks that people could withdraw capital and seek to deprive themselves of their capital. This potential risk around pensions should be covered in the section on deprivation in the guidance and regulations.

Deferred payment agreements

General comment: *During outreach sessions and public consultation, discussions around deferred payments promoted residents' concern about 'losing their home', and many worried about not having anything to pass on to their children.*

Question 30. Should the eligibility criteria for deferred payment agreements be extended to include people in extra care housing or supported living arrangements? Do you have evidence of the likely demand for deferred payment agreements from people whose needs are met in these types of accommodation?

We would welcome discretion for councils to offer a Deferred Payment where there may be a need in individual circumstances. We are not aware of particular demand for deferred payment agreements for people in supported living or extra care housing. Locally we have had several cases where people receiving care services at home have owned more than one property and would have benefitted from being able to have a Deferred Payment Agreement as they did not have sufficient liquid assets to pay towards their care.

Question 31. Do you think we should seek to introduce a scheme which is compliant with Sharia law at a later date?

Yes, however any scheme must not result in a higher or lower charge for services received.

Question 32. Do you agree that the maximum LTV for deferred payment agreements should fall between 70 and 80%? Do you have any evidence to support a particular amount within that range?

Yes. A LTV of 7% would be in line with LTV ranges applied for other financial products and buy to let mortgages.

Question 33. Do you agree that people should be able to keep a proportion of any rental income they earn on a property they have secured a deferred payment agreement on? Are there other ways people could be incentivised to rent out their houses?

LBRuT response: *No, we do not agree that people should keep a proportion of rental income they earn under a Deferred Payment Agreement, as there is sufficient incentive from the DPA scheme to encourage take up and there are other incentives available to help encourage people to keep their property in use (e.g. empty property grants to help bring empty homes back into use). As it is proposed to allow an increased Personal Allowance of £144 per week, retaining further rental income would not be necessary.*

Outreach sessions and public consultation event: *Residents were asked whether they would consider renting their home as part of the DPA agreement, and what might incentivise residents to rent their homes. The response was mixed, some saw renting out their property as a viable option to help cover care costs whilst others were uncomfortable with the idea. The main concern arose from the burdens of becoming a landlord. Some mentioned help in renting from family members, but many felt they might be more willing if a management service was on offer, including help with removal and affordable storage. It was suggested that this could be something the local authority could offer. In addition, advocacy, advice and support services around renting were mentioned. Generally, respondents wanted assurances that their home would be looked after. Some felt that they would prefer to sell their property and did not see an issue in doing so if they had moved into residential care.*

Question. 35, Do you agree that local authorities should be required to accept any legal charge on a property as security for a deferred payment agreement when they are required to enter into one and not just a first charge?

No, we do not agree.

Question. 36. In line with the recommendations of the Independent Commission on Funding of Care and Support, do you agree that the interest rate should be set so that it is reasonable for people, cost neutral to local authorities and as such that it does not create incentives for people to apply for deferred payments when they are not needed?

Yes, we agree and feel strongly that a national interest rate should be set. This would be equitable and also easier to explain to people.

Question. 37. Do you agree that there should be a different interest rate for deferred payment agreements made at the local authority's discretion? If so, what should the maximum rate be?

Yes, this would reflect the additional risk borne by the Local Authority. This should be set equivalent to the rate set by the County Court.

6. PERSON-CENTRED CARE AND SUPPORT PLANNING

Care and support plans

Question 38. Does the guidance on personalisation fully support and promote a care and support system that has personalisation at its heart?

The Act and guidance does try very hard to place personalisation at the heart of the care and support system. However, there are some contradictions. For example, it requires that service-user and carer are in control but requires the local authority to ensure, check and confirm arrangements. It is unclear where the focus was intended to be.

Question 39. Does the guidance on personalisation support integration of health and care (and any other state support)?

The guidance supports the concept, but the focus is on 'shoulds' rather than 'musts' means this guidance is not strong enough to deliver integration. An example of this is in the guidance on combining support plans.

The guidance sets out integration in aspirational terms and not practical terms and the duty lies with the local authority and not on the NHS or health authorities.

The guidance on integration in transitions cases is more detailed with more example processes set out and this approach would be helpful in other areas. Particularly, paragraph 163.9 creates reciprocal duties which isn't reflected in chapter 15. The reciprocal responsibility for working together should be extended.

Question 40. Does the guidance support care and support workers to do their job effectively?

This question is unclear. If this refers to the creation of a care and support plan to guide care then, yes, there are some helpful paragraphs in the guidance. If the question relates to the delivery of the care and support following the creation of the plan then the guidance is less helpful.

Personal budgets

Question 41. Is this definition clear and does it conform to your understanding of intermediate care and reablement? Is there any way it can be improved?

Yes it does conform to current understanding of the types of intermediate care and reablement, however there are some problems with the definition:
- *Identifying reablement as a social care service is confusing and it should be clearer that this should be an integrated delivery.*
- *The guidance fails to define a short term intervention that relates to MH conditions and it would appear that this is excluded from the definition. For example should IAPS be included in the definition of reablement?*

Question 42. Does excluding the cost of reablement/intermediate care from the personal budget as defined above:
- **Create inconsistencies with the way that reablement/intermediate care is provided in NHS personal health budgets?**
- **Affect the provision of reablement/intermediate care for people with mental health problems?**

The exclusion could create inconsistencies in relation to personal health budgets and the guidance does need to be stronger in its reference to its impact on this.

Question 43. Are the ways in which different Personal Budgets can be combined sufficiently clear?

Yes, it is sufficiently clear

Direct Payments

Question 44. Will the easing of the restriction to pay family members living in the same household for administration/ management of the direct payment increase uptake of direct payments? Will this create implementation issues for local authorities?

LBRuT response: *No, it is not likely to increase the uptake of direct payments. The easing of the restriction is likely to cause more difficulty and confusion and is at odds with other aspects of the provisions such as the restriction on paying a person in the same household to deliver care. It is better to have a range of support services available to help people with the specifics of a direct payment to help make it simple to administer.*

The Care Act Coproduction Group*: The easing of this restriction is unlikely to increase the uptake of direct payments. Many carers/family who manage a direct payment find it to be a substantial administrative duty, and, if struggling, payment is unlikely to help.*

Question 45. The draft direct payment regulations decreases the time period to conduct a review of the direct payment from 12 months to 6 months – is this workable?

Reducing the time period of a review is not proportionate as the frequency of a review should be based on risk. If an arrangement has been working well for a sufficient period time there is no reason to conduct a 6-monthly review. This conflicts with taking a light-touch approach and putting the individual in control.

Question 46. The draft regulations seek to ensure choice is not stifled and the direct payment is not monitored excessively – is it strong enough to encourage greater direct payment use, but workable for local authorities to show effective use of public monies?

LBRuT response: *The guidance encourages a light touch approach and this should result in direct payments being a more attractive option for service-users. Locally, we already use this approach and it is working well.*

The Care Act Coproduction Group: *The perceived complexity of managing a direct payment was the biggest barrier to greater direct payment use. A light-touch approach would help reduce this and importance was placed on advice and support services such as that offered through the voluntary sector. Greater use could be encouraged if:*

- *There was greater awareness of direct payments and the benefits*
- *There was a great awareness of the help and support*
- *If hospitals allowed personal assistants to administer basic care whilst the service-user was admitted*

7. INTEGRATION AND PARTNERSHIP WORKING

Integration, cooperation and partnerships

(Responses to questions 47 and 48 resulted from discussions with Care Act leads in SW London*).*

Question 47. Does the draft statutory guidance provide a framework that will support local authorities and their partners to make integration a reality locally?

It is useful for existing practice to be brought together however, there is disappointment about the lack of 'musts' in this area and the lack of specific deliverables that all local authorities must work towards. The guidance could go further in providing clear pathways in exactly what should be implemented. In relation to integration with the NHS, it should be acknowledged that the centrality of the NHS impedes local decision making and could therefore hamper integration.

Question 48. Are there any ways the guidance can better support cooperation locally?

There are some areas that should be included for the guidance to better support cooperation:

- *There is little clarity about sanctions if local authorities or relevant partner fails to cooperate other than that it 'could be subject to judicial review' (paragraph 15.28). This will inevitably lead to different local interpretation.*
- *There was no direct reference to Section 75 and its role in integration.*
- *There was very little in the guidance about joint commissioning as a key mechanism for achieving integration and cooperation*
- *Data sharing is a key part of integrating and should be addressed within the guidance*.

The boundary with the NHS

Question 49. Is the description in the guidance of exceptions to provision of healthcare (which effectively sets out the boundary between NHS and local authority responsibilities) sufficiently clear and does it maintain the current position on the boundary?

The description of exceptions is not sufficiently clear to maintain the current position on the boundary, they need to be sharper and more specific, otherwise the issue is open to interpretation. Clarity will reduce the likelihood of debate between health and social care professionals regarding where the responsibility lies. The patient/service user will also benefit as time will be saved and the risk of paying for a service if the guidance has been interpreted incorrectly will be reduced.

Question 50. Is there any danger that the legal barrier could be interpreted as a barrier to integration? Are there specific examples where it would be helpful to clarify?

Yes, there is a risk that the legal barrier will have an impact on integration, although the legal barrier exists already and services have co-existed (although not integrated). The need is for clarity in definitions, and further examples to illustrate responsibilities will be helpful (NHS Continuing Healthcare is an obvious example but there is little ambiguity owing to the National Framework and specific criteria). For instance, point 15.31 could be clarified further as this is open to interpretation.

Delayed transfers of care

Question 51. Will any of these changes affect the working of delayed discharge processes in ways not discussed in the guidance?

Retaining the reimbursement element to a large extent runs counter to partnership working as it seeks to assign blame. A better approach would be better to focus on patient outcomes rather than days delayed and social services and health responsibilities.

Working with housing authorities and providers

Question 53. Could local authorities' duties in relation to housing be described more clearly in the guidance?

LBRuT Housing team: *We welcome the acknowledgement of the importance of housing to an individual's health and wellbeing. Also welcomed is the requirement to provide information and advice on issues such as housing options and adaptations that may reduce the need for care. The guidance should however be more specific in describing local authority duties with regard to housing; including duties with regard to allocations, homelessness and house conditions. The guidance could also be expanded to provide greater detail and more examples or case studies. These could include issues such as the importance of the Housing Health and Safety Rating system to health and wellbeing. The guidance could also examine potential housing problems that Local Authorities may face in meeting care needs, such as landlords in the private rented sector refusing adaptations for properties or asking their tenants to leave, by serving notice, when they have requested work to be carried out*.

Question 54. Are the links to prevention, integration, co-operation, information and advice, market shaping and assessments adequate?

LBRuT Housing team: *We welcome the requirement for local authorities to provide advice on relevant housing and housing services and the inclusion of housing as part of the care assessment. Much of the housing section regarding integration and prevention only refers to 'may' rather than 'should' consider housing issues, outlining the benefits of housing services only. This approach (where there is not a requirement to engage) may risk losing the resources of housing providers/services in supporting a person's care and limit the potential benefits of joint commissioning.*
In terms of market shaping the guidance could be more specific with regard to assessing the needs in an area for supported and older people's accommodation.

Whilst the guidance quite rightly outlines the importance of housing to health and social care it does not require practitioner's to really consider housing issues (apart from housing advice and care assessment processes), they 'may' consider it. Where housing has not historically been seen by practitioners as of importance there is a risk that housing remains a 'Cinderella service' in relation to health and wellbeing. This may not create the 'step change' required by the Care Act to bring better integration of services for the benefit of residents.

The guidance also does not consider the issue of co-operation in Large Scale Voluntary Transfer (LSVT) authorities, where the housing stock has been transferred to a housing association. In these circumstances a local authority is reliant on Registered Providers for affordable housing and it is important that there is a requirement to consider co-operation in these circumstances. It is recommended this issue is addressed within 15.23.

Further the guidance does not particularly stress the role of RPs in supporting tenants with health and wellbeing, focusing mainly on the role of Local Authorities. The role of RP's and benefits of engagement with RPs could be strengthened. As an example RPs carry out significant work to get tenants back into work and training, which could meet a person's care needs such as addressing social isolation. RPs may also offer tenancy support services, such as assisting vulnerable people to maintain their tenancies.

Question 55. How could guidance on the legal boundary between care and support and general housing responsibilities be improved?

LBRuT Housing team: *The guidance could be strengthened by providing case studies or examples of where the main housing duties are likely or may interact with care and support requirements. For non-housing practitioners it would also be useful to outline some of the key housing duties e.g. Part V1 (allocation of housing) and V11 (homelessness) of the Housing Act 1996 and the Housing Act 2004, regarding house conditions.*

Clarification of 'grey areas' between housing and care and support should be used in the guidance. For example if someone with high care needs was accepted as homeless by a local authority and a subsequent duty to rehouse agreed – but due to their care needs they were temporarily placed into residential care. There would still be a housing duty towards the homeless household which could (over the longer term) be discharged through offering appropriate accommodation, such as extra care housing. The duty to provide accommodation would be discharged as the applicant gains a tenancy and care and support needs are also met.

Transition to adult care and support

Question 57. Is the guidance clear enough that the term 'significant benefit' is about the timing of the assessment? Is the guidance precise enough to ensure that 'significant benefit' is not open to misinterpretation and that people who should be assessed are assessed at the right time for them?

The guidance should be more explicit about what 'significant benefit' means. It would be helpful if the guidance was more explicit in stating that transition assessments should start at age 16 or less. Paragraph 16.12 specifies year 9 for individuals with special education needs, this should be extended to everyone in transitions who is likely to need care in the future. The guidance should make clear that there needs to be sufficient time to undertake future planning and sufficient time to for the individual to engage the relevant partner agencies such as housing.

Question 58. Are the descriptions in the guidance of people's rights to transition assessments and continuity of care beyond 18 sufficiently clear?

Yes, with guidance around special education needs having most clarity. The guidance is less clear for disabled children and looked after children who may also have care needs (specifically autistic spectrum conditions). Perhaps a subheading 'rights to an assessment' will make this clearer to the reader. We would welcome greater clarity around the rights for young carers.

Delegation of local authority functions

Question 63. Are there any core principles or requirements that local authorities should always place on contractors when delegating care and support functions?

LBRuT include in all specifications principles around dignity, choice and control, safeguarding and human rights. This approach is taken jointly by health and social care commissioners.

8. ADULT SAFEGUARDING

(Responses questions 65-70 also provided by representatives of South West London and St George's Mental Health NHS Trust (SWLSTG) as a member of Richmond's Safeguarding Adults Board.)

Question 65 Are there any other types of behaviour that should be explicitly stated in the guidance? Are there any that should be removed?

SWLSTG: *The following to be included:*

- *Psychological abuse as defined under Prevent/Radicalisation and, psychological abuse in the context of domestic violence when decisions are made under duress.*
- *Physical abuse including medication errors*
- *Cyber-bullying*

Question 66. Are there additional possible members of SABs that we should add?

LBRuT response: *It would be more in keeping with the spirit of the Act for members of service-user and carer advocacy groups to be listed under 'must be represented'.*

SWLSTG*: Community leaders and faith groups*

Question 68. Would it be useful to append a draft template for the strategic plan for SABs to use if they wish?

It was felt by LBRuT and SWLSTG that this would be helpful. SWLSTG, feels that a common template for organisations that work across a number of boroughs would enhance partnership working.

Question 69. Is there anything we could add to improve how managers and practitioners view and participate in Safeguarding Adults Reviews?

LBRuT response: *It is idealistic to suggest that individuals involved should not be fearful of Safeguarding Adults Reviews. The guidance could be strengthen by being clear that the reviews should be about learning and improving rather than blame and fault finding.*

SWLSTG: *NHS practitioners would increase participation if safeguarding was better integrated with SI/RCA processes with better understanding of the respective qualities of the two processes. Need for sharing of NHS skills already available: there are highly skilled investigators already undertaking RCA, IMR and SCR tasks: safeguarding needs to make better use of those resources. Safeguarding focus on process and bureaucracy does not present it as useful or effective. NHS has existing highly developed risk assessment tools that should be respected, not replaced.*

Question 70. Are there other areas of information sharing that need to be spelt out in this section?

SWLSTG: *A template for information sharing has been developed by Met Police. A similar model would be good for all SABs to follow, looking for commonality across boundaries.*

9. MOVING BETWEEN AREAS

Ordinary residence

Question 71. Are the definitions of the types of accommodation as cited in the regulations too wide? Are they workable and clear?

The definitions of types of accommodation are wider than definitions currently used and are too wide. The care home case-study is useful, but care homes are the area that local authorities are likely to already be clear about. The guidance should also give an example relating to supported living or shared lives.

Question 72. Do the guidance and regulations about ordinary residence disputes provide enough clarity to settle ordinary residence disputes between two or more local authorities? Are there other scenarios that it would be helpful for the guidance to consider?

It would be useful to give some guidance around how long local authorities should attempt to resolve a dispute for before it is referred to the secretary of state. Currently disputes can run on for years, with no incentive to absolve. At times this can be at great cost, including legal cost, without any benefit to the service-user.

Question 73. Which authority should be responsible for meeting the needs of an adult or carer when two authorities in dispute, or another authority cannot come to an agreement on who should be the lead authority? Do you agree with the regulations as currently set out in the regulations?

Yes, we agree with the regulations as currently set out.

Continuity of care

Question 74. What further circumstances should be considered when carers and people with care and support needs want to move?

The current circumstances are sufficient.

Cross-border placements

Question 75. Do the regulations provide for an effective dispute resolution procedure?

We believe they do.

Question 76. In particular, in setting out the process for local authorities to follow when making a cross-border residential care placement, are there any gaps or omissions in the guidance in terms of key issues that need to be addressed before a placement can successfully take place?

Paragraph 21.51 states that the first authority retains responsibility for reviews and amendment of the support plan. It would be helpful is the guidance was stronger in terms of encouraging reciprocity around reviews.

Question 78. Would it be helpful for the guidance to be supplemented by best practice guidance? If so, what issues and scenarios will it be important for best practice guidance on these placements to cover?

Yes it would be helpful. Best practice guidance should cover the exceptional cases of cross boarder placements. For example, guidance would have been useful in a situation in which a young person in a foster-care moved with his foster parents and on reaching adult-hood was not offered adequate support from the local authority in the country in which the foster parents became resident.

10. OTHER AREAS

Registers

Question 79. Should certification of certificate of vision impairments (CVIs) be extended senior ophthalmologists, or should this continue to be carried out by consultant ophthalmologists as is currently the case?

Yes, certification should be extended to senior ophthalmologists as well as consultants. They are fully competent to undertake this and their additional involvement will increase certification accessibility for people who are sight impaired or severely sight impaired

Question 80. Should we seek the patient's consent to pass their contact details to Royal National Institute of Blind People (RNIB), as well as to the local authority, as part of the CVI process in order for RNIB to offer advice and support?

LBRuT Response: *No, the NHS should not seek the patient's consent to pass their details to the RNIB as NHS staff may not have the time or the knowledge to provide details of what the RNIB can offer. Because NHS staff should in any case pass a copy of the Certificate to the Local Authority (LA), LA staff should already routinely inform patients/service users about the RNIB and give them RNIB's contact details. To consolidate this, they should now ensure that they always give RNIB contact details to the patient/service user. If the patient/service is unable to make the initial contact, LA staff should offer do this on their behalf.*

Voluntary sector survey: *8 of the 10 respondents felt that the patient's consent should be sought. Whilst it was felt that voluntary sector organisations such as RNIB can be of enormous support to service-users the general response was that people should be given the choice about who holds information about them regardless of personal circumstances. Richmond Council for Voluntary Service saw giving people a choice about what they would like to happen as being key to promoting a person-centred approach.*

The transition to the new legal framework

Question 82. Are there other considerations around preparation for implementation of the April 2016 elements of the Care Act on which national guidance would be helpful?

We welcome involvement/consultation in developing guidance. Guidance to be provided ahead of autumn 2015 when we could start to assess for care accounts.

11. ANNEXE B

Proposals on the extension of licence exemption of nursing care

Question 83. Do you think that providers of NHS Continuing Healthcare and NHS-funded nursing care should continue to be exempt from the requirement to hold a licence from Monitor?

Yes, the current arrangement is adequate and there is no clear benefit in any additional overview from Monitor.

Question 84. Should providers NHS Continuing Healthcare and NHS-funded nursing care services be subject to those services being designated CRS?

No, CQC will regulate providers anyway and Local Authorities have effective existing links. Being designated CRS would be no guarantee of protection from provider failure, and in any case if a provider were to fail the key issue at this point would be the actions taken by CCG's and Local Authorities in response.

Response coordinated by Rachel Kidd
Project Support Officer (Graduate Trainee)
On behalf of London Borough of Richmond upon Thames

12. APPENDIX A – CONSULTATION METHODOLOGY

As part of Richmond's ongoing consultation and engagement around the Care Act, we organised a number of consultation activities relating to areas covered in the Department of Health consultation on the Care Act draft regulations and guidance. The activities are set out below.

1. **Name: Care Act Coproduction Group**
   People involved: A group of service-users and carers covering a range of client groups
   Approximate numbers: 10 members of the coproduction group, additional 10 responses social clubs.

   Details: The Care Act Coproduction Group was recruited to work with the Council throughout the implementation of the Care Act. We held two two-hour sessions relating to the regulations and guidance. Members were given briefings on the relevant areas if guidance prior to meetings. As part of Coproduction Group work, we attended three additional sessions at social clubs to gather feedback from residents with learning disabilities.
   Areas discussed: Information and advice, Assessments, Eligibility and, Direct Payments

2. **Name: Voluntary Sector Survey**
   People involved: Local community and voluntary sector organisations
   Approximate numbers: 12 responses in total, 10 that represented local organisations

   Details: The Voluntary Sector Survey was hosted on the Council's consultation portal for 4 weeks and promoted via the Council's mailing list, voluntary sector forum meetings Richmond Council for Voluntary Sector's news bulletin. The survey contained links to the relevant guidance. We received responses from the following organisations: Richmond Carers' Centre, Addiction Support and Care Agency (ASCA), Richmond Users Independent Living Services (RUILS), Richmond Council Voluntary Service (RCVS), POhWER, Ethnic Minorities Advocacy Group (EMAG), Richmond MENCAP, Richmond Advice and Information on Disability (Richmond AID), Richmond Borough Mind and, Richmond User and Carer Group.
   Areas discussed: Independent advocacy, Certificate of vision impairment, Market shaping and commissioning, Preventing, reducing and delaying needs and, Information and advice.

3. **Name: Outreach sessions and survey**
   People involved: local advocacy groups/ networks, the general public
   Approximate numbers: 36 respondents to the survey, 8 advocacy groups attended (reaching 118 people)

   Details: The survey and outreach sessions were hosted by Healthwatch Richmond on behalf of the Council, they were held at; Age UK (Twickenham), Age UK (Whitton), Ethnic Minorities Advocacy Group (EMAG), Richmond Carers Centre, FiSH Neighbourhood Care and, Richmond User Independent Living Scheme (RUILS). The outreach sessions included a briefing and discussion. The survey explored the same questions and was promoted by Healthwatch.

Areas discussed: Preventing, reducing and delaying needs, Information and advice, Deferred Payments and, Care Accounts*

4. **Name: Healthwatch Care Act Public Consultation Event**
   People involved: Public event: members of the public, service-users, carers, voluntary sector professionals.
   Approximate numbers: 65

   Details: Healthwatch Richmond hosted a public event regarding the Care Act on behalf of the Council. The event included a presentation, outlining the main changes of the Care Act given by Assistant Director Adult and Community Services, Derek Oliver. Round table discussions were then facilitated.
   Areas discussed: Preventing, reducing and delaying needs, Information and advice, Deferred Payments and, Care Accounts*

5. **Name: Public Information Group**
   People involved: Voluntary sector organisations and stakeholders
   Approximate numbers: 12 organisation represented

   Details: Discussion session relating to information and advice. The group will continue to work as a steering group throughout the implementation for ‘information and advice’ requirements of the Act
   Areas discussed: Information and advice

6. **Name: Care home Providers Forum**
   People involved: Care home providers
   Approximate numbers: 7 providers represented

   Details: Presentation regarding the Care Act held at the forum with opportunity afterwards to comment on specific areas.
   Areas discussed: Provider Assurance re provider failure, Financial advice and, Workforce

* Care accounts were not part of the current DoH consultation, but we felt it was important to take this opportunity to gain some insight into how service-users and members of the public would respond to the cap.

Internal engagement and partnership working regarding the consultation included:

- Care Team Managers Workshops regarding the guidance and consultation questions
- Continued work with the JCC
- Consultation with the housing team regarding questions on working with housing authorities and providers
- Consultation with members of the SAB regarding questions on safeguarding