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The Care Act - 2014

Care Act - Summary of key areas

Modernises over 60 years of care and support law into a single statute.
Much already in practice but not in statute

•Clarifies entitlements to care and support and puts the focus on personalisation

•Provides a national minimum eligibility criteria

•Carers on same legal footing as person cared for.

•Reform of how care and support is funded

•Promotes wellbeing and preventing or delaying needs, rather than only intervening at crisis point.

Wellbeing

Key principle. What does it mean?

- Personal dignity
- Physical and mental health, emotional wellbeing
- Protection from abuse and neglect
- Control over daily life
- Social and economic wellbeing
- Domestic, family and personal relationships

1. Information and advice

- Provide an information and advice on services – prevention, health, housing, befriending, employment, specialist help (dementia).
- How to access local services
- Aim to provide online info and advice service by Jan 2015.
- Independent Advocacy and signposting to independent financial advice to help people plan their future care and support
- How people can raise concerns about the safety or wellbeing of someone who has care and support needs
- Service must be accessible, proportionate, target key access points (hospital, application for disability benefit payments, Housing etc)

2. Preventing needs for care & support:

- Reduce, prevent or delay the development of support needs for both adults and carers
- Consider availability of social capital (VCS, communities etc to help keep people well and independent.
- How to identify support needs– customer service centres, GP's, via housing, hospital admission, AA applications
- ***Primary***: information, healthy lifestyles, isolation, safer neighbourhoods
- ***Secondary***: aim to prevent risk of developing needs. Identify people at risk of specific health conditions (stroke, falls). Minor adaptations. Carers support
- ***Tertiary***: regaining independent living skills - PRRT, Community beds, Carer breaks, community equipment

3. Changes to eligibility: 2015

- Categories of critical/substantial/Mod/Low – replaced/new focus on ability to carry out basic care activities and dignity which impact on the person's well-being. (ability to get up out of bed and dressed and move around their house)
- Carer's eligibility criteria.

  Councils will have a new duty to carry out a needs assessment for all carers (no longer dependent on the cared-for person meeting eligibility criteria). - Potentially increases demand

- Transition

  The Act also refers to smooth transition to adulthood - Duty to assess young people, and carers, before they reach 18 years.

- Cross Border issues: Continuity of Care

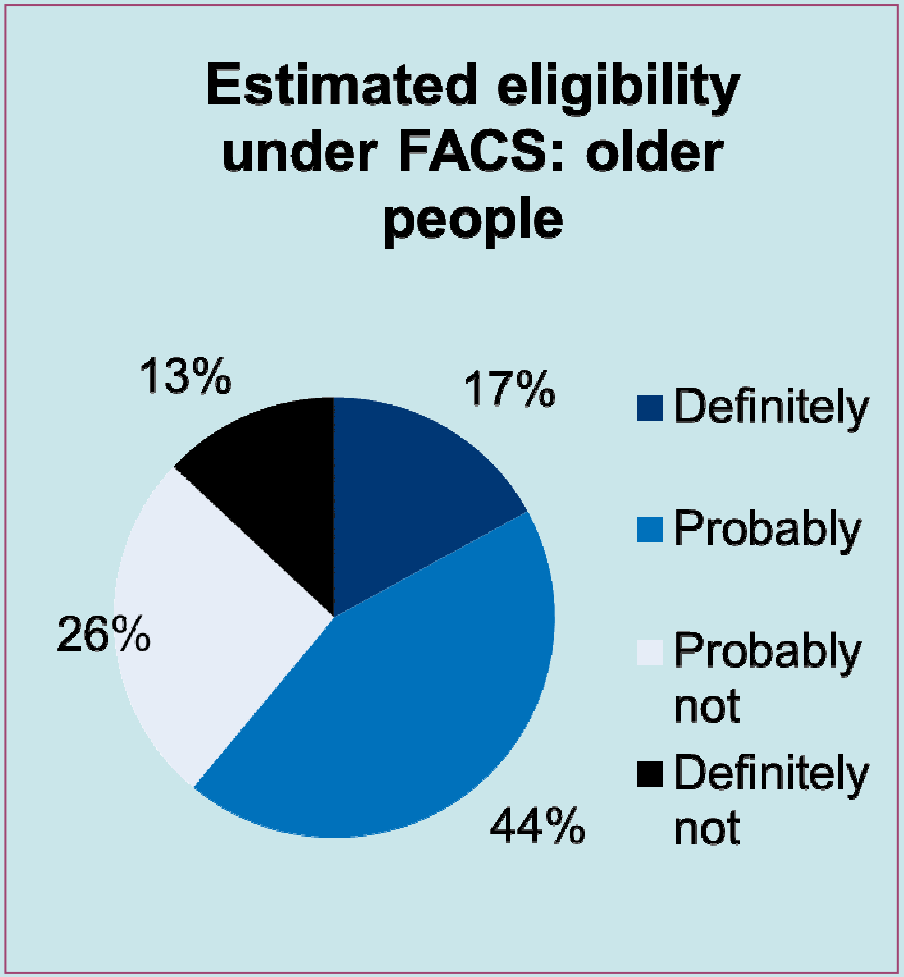
Eligibility criteria: 2015

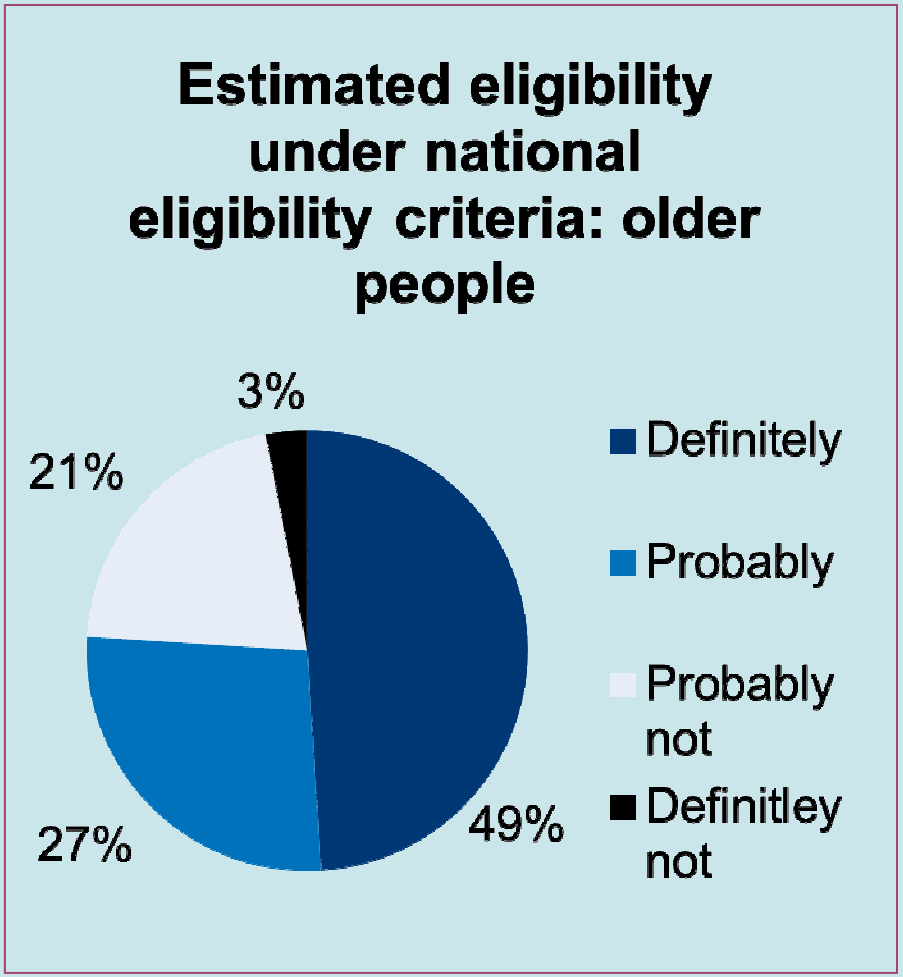
- Relate to physical or mental impairment or illness
- Likely to be significant impact on wellbeing
- Unable to achieve 2 or more outcomes with impact on wellbeing

Outcomes:

- Managing and maintaining nutrition
- Personal hygiene
- Toilet needs
- Being appropriately clothes
- Ability to be safe at home
- Maintaining a habitable environment
- Developing or maintaining personal relationships
- Accessing work, education, training
- Accessing public services – transport, recreational facilities
- Caring responsibility for child

Eligibility: Research





4. Assessment

- Local authority responsibilities for assessments are currently set out in a number of different laws.

- At the moment, they tend to focus on what service should be provided, rather than on what the person actually needs or wants.

- *'We want a care and support system built around the individual. We therefore need change, so that assessments focus on what the person wants to achieve'.*

Assessment / personalisation

- Personal Budgets included in legislation for the first time - indicative budget to meet care needs
- Right to request a Direct Payment to meet care needs so people have more flexibility and choice over how care is to be met.
- Encourage flexibility/innovation in care solutions, not menu driven
- People to be involved in the process of assessment and arranging care solutions, incl. self assessment

Assessment / personalisation (cont)

- Duty to undertake reviews and individuals right to request a review.
- Ensure better information and advice, on care and paying for care.
- Ensure there is a range of appropriate services and information for those not eligible for LA support
- Prevention and support at early stage not crisis point
- Support people self plan how future needs will be met
- Must take a whole family approach

Assessment: questions

- What more should we be doing to encourage the ‘wider community’ to take a greater role in the care of vulnerable people?
- Social Care is everyone's business
- How can we manage demand to make the whole system sustainable?

5. Carers

- LA must assess whether a carer has needs (or will do), irrespective of level of need and their finances
- Assessment must focus on outcomes, wellbeing, impact on daily living, whether carer wishes to work or participate in education/ training / recreation
- Not required to assess if refused, or if safeguarding risk, or there is lack of capacity
- Carers needs can be met by providing support to client
- Carers involvement in review and reassessment

6. Funding reform - April 2016

Key principles

- Cap on costs of care: Care accounts - everyone will know what they have to pay towards the cost of meeting their eligible needs for care and support.
- People will be helped to take responsibility for planning and preparing for their care needs in later life.
- More financial support to people by increasing the upper level of the means test for people entering residential care to £118k (up from £23k).

Important changes and risks

- Introduction of a cap on costs to be set at £72,000 (for people of State Pension age or over), but excludes 'hotel costs' (for a residential cost of £500pw, perhaps 50% may be determined as hotel costs).

- Potential loss of income which ASC relies on to fund care (but Government state that the Care Act will be fully funded) as no contribution for young people entering adulthood with eligible care need & Lower cap for adults of working age (yet to be determined)

Funding reform

- ‘Care account’ starts from April 2016, **if** they have been assessed as eligible for social care.

- Anyone can request an assessment to see if they qualify under new national eligibility criteria and funding arrangements (October 2015)
  If not assessed as eligible - then continue to meet own cost of care

- If they are eligible - only local social care rates for care are met – not that which may be paid over LA residential rate
  Risk:Anticipated that awareness of changes will create extra demand for social work and financial assessments.

Deferred Payments

- People who have faced the risk of having to sell their home in their lifetime to pay for care home fees will have the option of a deferred payment (April 2015).

7. Market Shaping: Care Act

Ensure market can meet the needs of all

- Contracting focus on outcomes, wellbeing and quality
- Promoting choice
- Help people pool DP's
- Support sustainability
- Working with partners and people who use care
- Market intelligence and facilitation
- Workforce development and pay
- Dealing with Provider failure and temporary duties of LA

8. Safeguarding

- Putting ASC on similar footing to Children Social Care - Independent Chair, statutory SAB – Designated Adult Safeguarding Manager
- Making Safeguarding personal and outcome focused
- Must publish annual strategic plan and consult local Healthwatch and local community
- Duty to carry out enquiries if someone in need of care & support experiences abuse and unable to protect self
- Safeguarding Adult Reviews when abuse or neglect
- Training for workforce by all partners
- Common agreement on confidentiality

9. Integration and co-operation

- Duty to promote integration
- Aligns with Better Care Fund (BCF)
- Using JSNA to plan (risk stratification)
- Integrated management/provision (LD, AMH, PRRT)
- Duty for partners to cooperate when specific needs identified (housing, continuing health care etc)
- Housing important for wellbeing, independence and adequacy tp prevent escalation of needs.

10. Delegation:

- No:
  - ❑ Integration and cooperation
  - ❑ Adult Safeguarding
  - ❑ Power to charge

- Yes:
  - ❑ All other functions incl specialist assessment and support planning.
  - ❑ LA retains statutory responsibility
  - ❑ Monitoring of delegated functions through contracts.

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Better Care Fund

Better Care Fund

- A pooled budget deployed for social care and health
- A jointly agreed plan CCG and LA
  - *'To be used to support ASC services in each LA which has a health benefit'.*
  - *'Flexibility to determine how this investment in social care services is best used'*
  - *'LA to agree with Health how funding is best used within social care'*

- 19 September 2014 submission of final plan
- Full Implementation by 1 April 2015
- Consultation: 'whilst the proposals at a formative stage'

Aim of the Better Care Fund Plan

Supports the Joint Health and Wellbeing vision and strategic objectives, through:

- The creation of a single health and social care system
- A single commissioning vehicle and integrated service delivery
- People will experience integrated care that:

  - Is personalised and promotes independence
  - Does not duplicate assessments for individuals and efficiently manages resources
  - Is in the right place at the right time by the right staff

Our Progress Toward Integration

A long history of collaborative working in Portsmouth:

- Integrated Commissioning Board and Integrated Commissioning Unit
- Health and Social Care Partnership with providers to improve systems for better customer experience and efficiency

Substantial reconfiguration and delivery of new models of integrated care already in place:

- Integrated Continuing Health Care assessment and contracting
- Integrated management of complex patients across GP locality clusters
- Integrated rehabilitation services - PRRT and community beds

This has achieved:

- Low rates of delayed discharge
- Reductions in non-elective admissions
- Significant downward trends in residential care admissions

BCF outcomes for service users

- Say it once – Trusted Assessment, reducing duplication
- Improved health & wellbeing
- Maintaining independence for longer
- Reducing social isolation and more early intervention
- Improved access to services and good information
- Reducing time between identification of need and delivery of service
- Reduced hospital admissions and readmissions

Work-streams

- Analysis of need and demand profiling
  specific conditions, probability of admission, costs of care etc

- Commissioning planning processes
  VFM, Quality, Market Shaping – what we need

- Single point of access: Integrated Locality Teams
  GP, social care, community nurses, geriatrician, OPMH, VCS
  Care co-ordination provided through a named worker
  A single personalised care plan
  Rapid response to avoid unnecessary admissions- hospital or care

- Joint IT infrastructure and Information Governance

- Workforce - to include 7 day working, key worker role, workforce development and education, co-location

- Communication and engagement with public

- Greater role for VCS – in care navigation and support

- Review of Bed Based Provision & Reablement
  - Integrated community delivery model across services.
  - Ensure a minimum length of stay as possible.
  - Undertake discharge planning at point of admission to hospital
  - Shift emphasis from ‘step-down’ beds to ‘step up’ in community setting Support “people to do things for themselves
  - Domiciliary care services to deliver reablement focused care.

Measuring Success

- Reducing number of permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care and maintaining performance
- Focus on avoidable emergency admissions
- Patient / service user experience
- Proportion of adult social care users that have as much social contact as they would like

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Deprivation of Liberty Safeguards (DoLS)

DoLS

Legal framework to comply with article 5 ECHR for those;

- Over 18 years
- Needing residential or hospital care
- Lacking capacity to consent (MCA 2005), for example due to Dementia or Learning disability
- Prior to March 2014 applied only to those objecting to the arrangements that restricted their liberty
- Referral to Court of Protection for disagreements

- Following court judgement in March 2014 (“Cheshire West”)
- DoLS now applies to those ‘Under continuous supervision and Control and not free to leave’, regardless of lack of objection
- 5 specific assessments carried out by an approved doctor and a specially trained social worker
- Most importantly- “Best Interests Assessment” must be carried out to safeguard individuals interests.

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- Referrals – huge increase – “Cheshire West”
- 2013-14 - 90
- 2014-15 so far 358 to 30 November 2014.
- Costs 13/14: 18k
- Costs 2014 to date= £187k
- The full year projected spend for DOLS for 14/15 is £461k and rising
- Issues – payment of doctors, need to train more BIA’s, reviewing, legal challenges.
- In addition – people in supported accommodation or in their own home with care may also be deprived of liberty.
- Impact on community teams for assessment and budgets.

- Under DoLS – the Coroner has to hold an inquest if the person dies, regardless of circumstances of the death – now classed as a death in custody. The wait for a slot for an inquest is up to 5 months.