

The Care Act 2014 in England

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Abstract

The Care Act 2014 introduced historic changes to the system of adult social care in England by imposing new legal responsibilities on local authorities. The focus on the wellbeing of individuals, personalisation, preventing, reducing and delaying the need for care and support were some of the significant changes. The act, for the first time, gave carers a legal right to receive assessment and support for specific needs, and it introduced new national eligibility criteria. The statute has implications for the safeguarding of vulnerable adults, managing the care markets, promoting cooperation, the integration of services within the local authority departments and between the authority and the health agencies. The Act also introduced changes to how and when people are required to contribute towards the cost of their care. The reforms are intended to improve the cost-effectiveness of the care system and to manage the increasing demands for care demands in an ageing population. However, the implementation of some aspects of the legislation has been impaired by the current policy of fiscal austerity.

Key words: Care Act 2014, social care reforms in England, social care prevention, care integration, formal and informal care, social care costs, social care eligibility criteria

Słowa kluczowe: Ustawa o opiece zdrowotnej 2014, reforma opieki społecznej w Anglii, prewencja w opiece społecznej, integracja służby zdrowia i pomocy społecznej, formalna i nieformalna opieka, koszty opieki społecznej, kryteria przyznawania pomocy społecznej

Introduction

The Care Act 2014 (the Act) represents the most significant legislative change to the care and health sector in England¹ since the establishment of the welfare state. The previous laws stretched back to the Beveridge reforms,² particularly the National Assistance Act 1948 (NAA) which at the time was ground-breaking legislation. The NAA established a social safety net for those who did not pay their national insurance contributions, such as the homeless and the physically disabled. It provided assistance for elderly people who required additional benefits to attain subsistence living and obliged the local authorities to provide accommodation for individuals who were in need of care and assistance which was not otherwise available. Local authorities were required to promote the wellbeing of disabled people and to grant financial assistance to the voluntary organisations which provided recreational facilities or meals. Over the intervening years the NAA was amended and complemented so that a piecemeal system of social care legislation had devel-

oped which was complex and difficult to navigate [2, 3]. However, social care had been a neglected service in the post-war welfare state. It was then means-tested and funded predominantly by non-ring-fenced grants from central government, with substantial differences between councils as each independently decided which services to fund and for whom³ [4]. The social care services had remained under-developed and the provision was dominated by institutional approaches incapable of delivering an adequate service and individual person-centred assistance, in line with their growing aspirations, to live a more fulfilling life [5, 6]. In mid-2000 critical voices were raised about the failure of the social care system to meet the needs of individuals equitably, or to support people in such a way as to enable them to have a full and purposeful life. Concerns were growing amongst politicians over the financial sustainability of the care system, particularly because of the pressures resulting from the increasing life expectancy and the ageing population. Consecutive Governments agreed that the care system in England was inadequate, unsustainable and likely to fail

the increasing number of people needing care unless radical reforms were introduced [7–9]. A major project to reform adult social care legislation was undertaken by The Law Commission between 2008 and 2011 (see **Appendix 1** for the social care reform timeline). The Commission's final report was very significant as it recommended that the earlier social care Acts should be repealed and replaced with a unified adult social care statute [10]. The report proposed far more than just a simplification of the law, it suggested fundamental reforms to how it worked by prioritising people's well-being, their needs and goals and putting them in control of their care and support. In response to the Commission, the Government produced a white paper *Caring for our Future* [11] and a draft Care and Support Bill in 2012, which included 66 of the 76 recommendations in the report [12]. A Joint Committee was established to scrutinise the proposals, and many of its recommendations were adopted when the Care Bill was introduced to Parliament in 2013 [13].

A significant amount of primary and secondary legislation was repealed when the Care Act 2014 came into force in 2015. The goals of the Act were to produce a unified, modern and consistent legal framework which would help service users, carers and providers to understand if social care services could, or should, be provided, and would put people in control of their care and support [14, 15]. The Act identifies the local authority's seven general responsibilities: 'promoting individual well-being'; 'preventing the need for care and support'; 'promoting the integration of care and support with the health services'; 'providing information and advice'; 'promoting diversity and quality in the provision of services'; 'co-operating⁴ generally' and 'co-operating in specific cases'. The Act introduced a greater emphasis on personalisation, wellbeing and prevention as the local authorities are required to help individuals to lead healthy lives, thereby reducing the chance that care is needed in the future. There is a greater importance on providing information and advice to assist members of the public to make informed choices for their care and support arrangements. The Act gave new rights to carers, putting them on the same legal footing as the individuals for whom they care. Under the Act all carers are entitled to an assessment of their needs and those who are found to have eligible needs have the legal right to receive support for those needs. The statute has introduced national eligibility criteria for publicly funded social care and support, which aim to guarantee a fairer system of national eligibility. The way in which the local council completes assessments was changed and the focus changed from only providing services to one achieving the outcomes that individuals want to attain in their lives. The Act has introduced changes to when and how people are asked to contribute towards the costs of their care, putting greater emphasis on protecting vulnerable individuals from abuse and neglect, and it has introduced greater regulations for service providers. Statutory implementation guidance to the legislation is expected to drive the policy and the practice of local councils in England.⁵ The Act is a lengthy piece of legislation which addresses many

issues. The sections below give an overview of the major changes in the following areas: care personalisation and choice; the wellbeing principle; prevention; information and advice; care integration and collaboration across agencies; promoting diversity and quality of services; unpaid carers; assessing needs and new eligibility criteria; adult safeguarding and advocacy. Finally, this paper briefly discusses how financial austerity in England has impacted the Care Act implementation to date.

Personalisation and choice

Apart from simplifying previous legislation, the main aim of the Act is to ensure that the legal provisions of adult social care (ASC) are able to disseminate contemporary health and care cultures. To achieve this, the rhetoric of personalisation and user choice has a vital place in the legislation. The basic principle of personalisation is that care and support should be individualised and tailored to a person's specific needs and thereby give individuals greater independence, choice and control over their life [16, 17]. Although the emphasis on personalisation is not new, the Act placed personalisation on a statutory footing for the first time. The Act placed the concept of a personal budget⁶ (PB) into the legislation, and the guidance notes that PBs are a vital part of the aspiration to deliver personalised care. Individuals eligible for services, including carers, have a legal entitlement to a PB. Although the Act makes similar provisions regarding direct payments (DPs)⁷ as did the previous legislation, there is a slight softening of the previous restriction that DPs could not be used to pay for care provided by a relative living in the same household. However, following the Act, such arrangements can be made if the local council considers it necessary. In addition, from 2020 a DP will also be nationally available for residential care placements. The person-centred emphasis of the Act is evident in the broad statutory principles that underpin it, including those relating to wellbeing, prevention and the assessment of needs [16].

Wellbeing

A major focus of the Act and the fundamental emphasis running through the legislation is changing the duty of local authority's from one of providing services for specific clients to that of promoting the wellbeing of adults in their jurisdiction. The latest implementation guidance asserts that the wellbeing principle shall be at the centre of the care system. The wellbeing obligation applies to every action undertaken by a local authority when carrying out any of their care and support functions. It applies equally to decisions on the local authority's social care budget and when it comes into contact with people who have eligible needs, as well as to those who do not have eligible needs, if such people come into contact with the local authority in another way.

The statutory implementation guidance explains the concept of wellbeing by identifying nine areas for wellbeing: an individual's dignity; mental and physical health and emotional wellbeing; social and economic

well-being; protection from abuse; control over day-to-day life; participation in work, training, education or recreation (which could be of special importance to carers); domestic, family and personal wellbeing; suitability of accommodation; the persons' contribution to society. The guidance emphasises protection from abuse, noting that wellbeing cannot be promoted 'without establishing a basic foundation where people are safe and their care and support is on a secure footing'. However, as the eligibility criteria do not include 'keeping safe' as an outcome, it could be argued that being protected from 'abuse and neglect' will not be an eligible need [19]. The statute recognises that individuals are best placed to assess their own wellbeing. It highlights the importance of individuals participating fully in decisions regarding the care and support they receive and it emphasises the need to ensure that any limitations imposed on individual rights by councils are justified. However, the Act has been criticised for failing to declare an explicit standard of wellbeing as the areas listed above are considered to be too vague and broad. It was also noted, that although the wellbeing principle places clients in a strong position in the process of needs assessment, the guidance does not clarify how local authorities will move from the individuals' views to their own views in decisions about eligibility. The lack of clarity in relation to the concepts of wellbeing as well as the different values and interests of the individual stakeholders can result in different perceptions of wellbeing and need. Councils have already been legally challenged over their interpretation of the wellbeing principle [20, 21]. It can, however, be considered that the broad areas related to wellbeing reflect aspects beyond the basic activities of daily life and they provide an opportunity to think more holistically about what contributes to an individual's wellbeing [19].

Prevention

Prevention and early intervention have been a prominent focus of policy in England for several decades, with the core assumption that preventative services will promote an individual's quality of life, health and independence and will result in a reduced demand for high cost services [6, 22–24]. Despite the longstanding advocacy of prevention, it was only the Care Act which imposed a legal responsibility on councils with adult social care responsibility to provide prevention. Councils now have a statutory duty to prevent and delay the development of an individual's need for care and support [15]. The implementation guidance notes that the duty to consider if, or how, people's needs could be reduced or delayed should be the intention at every interaction with an individual. Even if the person's needs are not to be met by the local authority, the council must still provide information and advice about what can be undertaken to prevent, delay, or reduce the development of those needs. Councils also have a new duty to identify the services, facilities and resources already available in their local area which are required to meet this new duty with regard to specific groups of adults.

The Act embraces a broad definition of prevention, encompassing social inclusion, empowerment, health, social and economic wellbeing. According to the statute, preventative approaches should view an individual's life holistically, and seek to develop the individuals' resilience and self-reliance. It also recognises that the preventative model developed by each local authority may be different because of their distinctive local needs, aspirations, partnerships and community resources. Subsequent statutory guidance recognised that achieving the prevention objectives requires the involvement of a wide range of services, including public health, the local NHS, transport, leisure and housing services. Wider community resources are also expected to be part of the overall preventative offer, including local support networks and facilities provided by the voluntary and community sectors.

In the context of financial austerity in England, and the lack of any substantial additional money to implement the Care Act, there have been concerns that the new duty of prevention can be implemented, particularly in the short-term. According to a budgetary survey on the state of finance for adult social care, in recent years council spending on prevention has declined in cash terms [25]. To invest in preventative services without additional funding would mean reducing investment in the other existing services. In principle, investing in prevention would mean less funding for services which address more critical needs and it has been noted that this is not currently feasible. There could be still a long-term value in making prevention a statutory responsibility, because it would create an expectation that preventative interventions will be developed. Therefore, if and when, local authorities have greater resources, the new prevention duty may provide a significant impetus for them to develop preventative services. Consequently, the Act may significantly contribute to a cultural change in social care from one which intervenes only when a crisis occurs, to one which focuses on preventing the crisis occurring [19, 20].

Information and advice

The Act re-emphasised the duty of councils to provide adults and carers with information about the care and support that is available. The provision of information and advice covers a wide range, including peoples' choices regarding providers, how to access support and how to raise concerns about safeguarding. This duty relates to prevention, finances, health, housing, employment and it applies to the entire population residing in the local authority's area, not only to those individuals with needs for care and support, or to those already known to the system. Under the Act, local authorities have an obligation to facilitate access to independent financial information and advice to enable people to make well-informed decisions about how they pay for their care immediately, or in the future. In doing so, councils are expected to understand, co-ordinate and make effective use of other statutory, voluntary and/or private sector information and advice resources within their local area or nationally [26]. However, concerns have been expressed

that the provision of independent financial advice may result in more people receiving guidance on action they can take to avoid making contributions to the cost of care [27].

In providing information and advice, local authorities must consider the needs of the wide range of people with whom they communicate, and therefore, the service must be provided in various formats. As information is increasingly available only on the internet, the inevitable consequence could be that considerable sections of the population may be excluded – many of whom are disproportionately in need of care and support such as the elderly and those with significant learning difficulties. The updated statutory guidance addresses these concerns and notes that the requirement in the Act to provide information and advice cannot be met entirely through the use of electronic media. It is anticipated that the provision will include face-to-face contact, which may be provided by the council, or by organisations in the private and voluntary sector.

Care integration and cooperation

It has been recognised that people are not well served by a complex and fragmented health and social care system that is difficult to understand and navigate [11, 28, 29]. The Department of Health and the National Health Services England (NHS) have introduced a range of initiatives to support the local areas developing plans for integration within healthcare settings and between health and social care. For example, the Better Care Fund (BCF), announced in June 2013, established pooled budgets between health and social care services to support transformation towards integrated care from April 2015 [30]. In 2014, the NHS England's Five Year Forward View launched "New Models of Care" for different types of integrated care. The new model emphasised the importance of the integration of care between primary and acute health, mental health and social care, whilst engaging with communities, voluntary and third sector organizations [31]. As part of the current focus on care integration at the macro level, the Act imposes further obligations on public bodies to cooperate and integrate services. The statute imposes a general duty to cooperate and a specific duty to cooperate in particular areas when it is requested by a council. Moreover, councils must promote greater integration with the NHS and the various local government departments (e.g. housing, leisure, transport or public health which are under the local authorities' governance). The requirement for cooperation and integration applies to councils' responsibilities in relation to general care and support functions for adults and carers, including duties related to prevention, providing information and advice and shaping the market of service providers. Legislation prior to the Act placed an obligation on social services to notify other relevant bodies, e.g. housing or health, if a corresponding need was identified during care assessment, however, there was no duty on the notified bodies to respond to such a request. The Act not only enables social services to request help for adult social care, but such help must be provided

by other public agencies unless it would be incompatible with their duties, or have an adverse consequence on their functions; however, in the latter case, the public body must provide reasons why it cannot provide the assistance requested.

Policies have increasingly highlighted the importance of patient data and information sharing between different departments in local authorities, as well as between the local authorities and the health services [32]. The Act further regulates information sharing⁸ which requires local authority departments to ensure that data are used appropriately and legally in establishing systems for information sharing in multi-disciplinary and/or multi-agency teams. The statutory guidance notes that, for example, housing and adult social care officers should share information and collaborate, since suitable housing is important to prevent or delay a person's need for social care and support. Collaboration between social care and health is required, for example, to facilitate the discharge of patients with support needs from NHS hospitals to local authority for their continuing care and support.

Promoting diversity and quality in provision of services

The marketisation of social care services was formalised in England in the 1990s and currently the bulk of services is provided by private for-profit and not-for-profit providers [33]. The Act encouraged local government commissioners to expand high quality care options for service users, imposing an obligation on local authorities to develop care markets that deliver sustainable high-quality care. Inadequate funding, however, has been a significant obstacle to the aspiration of developing a diverse care market and high quality care. Care commissioners in England were reported as requiring providers to deliver high quality care, whilst continually cutting the fees paid and depressing the providers' profit margins to very low levels, thereby jeopardising the viability of care provision and the providers financial sustainability [34, 35]. In the preparation of the Act, it was noted that there should be mechanisms to require councils to take into account the actual care costs when deciding the rates to be paid to providers [13]. However, there are no such provisions in the Act. The statutory guidance notes, that because local authorities have a significant influence on the market, the commissioning processes are an important way in which they can effectively shape the market. It is hoped that such guidance will ensure that the fee levels are more transparent, which may prompt further concerns about the levels of fees received by providers, and may lead to lawsuits in this field if providers decide that the fees paid by local authorities are too low to permit the delivery of high quality care [19, 27]. The pressure on providers to reduce their fees impacts directly on the social care workforce. The statutory guidance highlights that when councils are commissioning services, they must guarantee that the fees paid to providers are sufficient to enable at least the minimum wage to be paid to their employees, the appropriate payments to be made for the time spent travelling between appointments and for the provision for staff training.

Another problem caused by local care commissioners forcing prices down is the possibility of the market being dominated by large providers able to compete on cost. Although large companies can operate at lower unit cost if and when they fail, significant numbers of individuals can be left without care.⁹ To a degree, the statutory guidance addresses this concern, as it requires commissioning procedures to encourage a variety of different providers, including voluntary organisations, user-led organisations, and small businesses. Moreover, the Act assigned responsibility for evaluating the financial sustainability of care providers, which would be difficult to replace in the event of failure, to the Care Quality Commission (CQC), the independent regulator for health and social care services in England [15].

Unpaid carers

The Act has an important implication for carers.¹⁰ It imposes a legal requirement on local authorities to undertake the assessments of carers, removing the previous requirement that a carer needed to provide substantial amounts of care on a regular basis to be eligible for assessment. In the foreword to the consultation document, Norman Lamb, the then Minister of State for Care and Support, noted that the Act is 'a landmark moment for carers. For the first time, they will be put on the same legal footing as the people for whom they care' [14]. Prior to the implementation of the Act, carers had the right to request an assessment only if they provided a substantial amount of care on a regular basis and if the local authority was carrying out an assessment of the cared-for person [10]. The criteria for the assessment of a carer have not only been broadened, but the statute has imposed a new legal duty on local authorities to provide support to meet the carer's needs, even if the cared-for person is not eligible for services. Prior to the current legislation, carers did not have a legal right to receive support, although local authorities were required to provide services to meet the needs of some carers e.g. when the carer's employment was at risk. Councils could provide support to carers at their discretion, however, this meant that access to support for carers was dependent on the affluence of their local council.

The legal duty to provide prevention, reduce or delay the need for support and promote wellbeing introduced by the Act also applies to carers. These requirements relate not only to people who already provide care, but also to those who may be about to take on a caring role, or who do not currently need support. Local authorities are also obliged to consider cooperating with other agencies, such as the NHS, to identify carers. The implementation guidance gives examples of interventions that could support carers, such as assistive technology, access to information and advice, developing the knowledge and skills to care effectively and the training to carry out the basic tasks for health care. It also notes that local prevention interventions could be designed to help carers to 'have a life of their own alongside caring', to have breaks from caring, to develop mechanisms to cope with the stress associated

with caring and be aware of their own needs [39]. An early report on local authorities implementation of their Care Act prevention duties found that carers were most often provided with information and advice services, but that many Councils were focusing their work on people with care needs, rather than the carers [39]. However, as with other areas, the Care Act may well create the expectation that councils will develop a more wide-ranging and comprehensive support system for carers, at least in the longer-term, when they have greater financial resources available to address the needs of carers. To date, voluntary organisations have been filling the gap by providing significant support for carers, and local authorities, after assessing carers' needs, may refer, or direct, carers to a voluntary organisation for on-going support [40, 41].

Assessing needs and eligibility criteria

The Act placed the eligibility criteria for publicly funded social care services on a statutory footing, not only for adults in need but, also for the first time, for carers. The new eligibility regulations differ from the pre-Care Act situation, under the Fair Access to Care Services (FACS) guidelines, in two important ways. Firstly, the Care Act introduced national minimum levels of eligibility, where previously the minimum eligibility thresholds were determined by each local authority.¹¹ The FACS suffered from wide and diverse interpretation, leading to inconsistencies in the provision, the so called 'post-code lottery' of eligibility. The aims of the new eligibility criteria are to be more transparent and to guarantee a minimum level of needs which have to be met throughout the country, although councils can meet other needs that are below the national threshold [9, 42]. Additionally, the FACS led to assessments that were unduly standardised, service-driven and neglected some groups of people¹, whereas the new regulations take a more user-led and outcomes-focused approach. The Act demands that the assessment of an individual's needs focuses on the outcomes that they wish to achieve in everyday life and the statutory implementation guidance explains that 'promoting well-being does not mean simply looking at a need that corresponds to a particular service' but requires 'a genuine conversation about a person's need for care and support' [38]. It has been noted that the value of an outcome-based approach is its ability to support people in attaining the things in life that they most value, but which are often overlooked by a service-focused approach [10, 43].

Although the commitment in the Act to support the perspective of service users is valuable, there are questions as to whether it can be achieved as comprehensively as described in the legislation. The guidance regarding assessment and eligibility notes that an assessment must be person-centred, involving the individual and any carer for that adult, however, the final decision about an individual's need will remain with the council. Concerns have been voiced that despite the introduction of the new national criteria, in the current financial climate, the final judgements about an individual's need is likely to depend

on the financial resources available in the local authorities to meet the eligible needs [16, 20].

The Act introduced a new obligation on councils to consider how they identify the needs which are currently unmet and to develop strategies to improve the provision of services to meet such needs. To-date, there is no comprehensive assessment of what occurs when individuals are not eligible for publicly funded services, partly because it is difficult to identify and measure unmet needs. However, research indicates that between 2005 and 2013 there was a steady reduction in the number of people receiving publicly funded services and the reduction of 31% was particularly serious for older adults [44]. Some of this reduction may reflect a reduction in the need for care, or an increase in the population's wealth leading to more people paying privately for care. However, an increasing number of elderly people with complex health conditions could suggest there is an increase in unmet needs and concerns were raised whether local authorities have the skills and resources to fulfil their new duty to identify such needs [45, 46].

Someone who has a sufficiently high need to be eligible for publicly funded care, may still be required to fund some or all of their care. The capital limits for charging remained the same as under the previous legislation, namely the capital and savings below £14,250 are disregarded in the assessment of the liability to pay for care, but people having capital and savings greater than £23,250 may need to fund their own care. The Act introduces some changes to means testing, which are not due to come into effect until 2020, when people with less than £118,000 in savings will be entitled to some financial support to meet their care costs, but on a sliding scale. Some services still must be provided free of charge, these include reablement for up to 6 weeks, or access to community equipment such as aids and minor adaptations. The Act opened the possibility for self-funders being charged for the costs incurred by councils when making arrangements to meet their needs, for example, the costs of negotiating or managing a contract with a provider. However, local authorities cannot charge for assessments or the preparation of care plans. Under the pre-Care Act legislation, councils had a duty to charge for residential care and the Act gives councils the power, but not the duty, to continue charging for residential services. It has been noted that to date not much has changed in councils' charging policies [19]. In the Act, the government set a lifetime cap of £72,000 on the private contributions to care costs. The cap and changes to the means test were due to come into effect in 2016, but were later delayed until April 2020. The cap was based on the principle of introducing greater fairness, by setting people a maximum level of responsibility to pay for their care whilst protecting individuals from incurring 'catastrophic' care costs, but also to encourage people's financial responsibility and planning [9]. The cap will, however, only apply to direct care costs, and the costs of accommodation in residential care will still be the responsibility of individuals. The new statute also specifies that councils have a duty to offer deferred payment agree-

ments. However, a local authority may refuse to accept deferred payment unless it obtains an adequate guarantee that the deferred amount will be paid in due course. The Act clarifies that such a guarantee may include a property deposit or a guarantee from a third party that the money will be paid. Universal deferred payments are an attempt to balance the requirement that people use their housing wealth to pay for their care costs, but ensuring that they are not forced to sell their home to meet the costs of care during their lifetime. The deferred payment scheme has been, however, criticised for protecting housing assets and giving a privilege to home owners; whereas people who do not own a property, but have financial resources above the threshold of £23,250, will be immediately required to pay for the care. Conversely, deferred payments reinforce the expectation of using housing assets across the life-cycle, including paying for care, rather than assuming that housing will be kept intact as an inheritance for the next generation [47].

Adult safeguarding and advocacy

The Act puts safeguarding adults into law for the first time and following the new legislation, councils must make enquiries if there is any reason to believe that an adult is being, or is at risk of being, abused or neglected. Following such an enquiry, local authorities need to establish whether any action is required to stop or prevent abuse or neglect, and by whom such action should be taken. Furthermore, councils have new legal duties to establish a safeguarding adults' board (SAB), including key stakeholders such as the Police, the NHS and other relevant bodies, which could undertake safeguarding investigations. The safeguarding regulations have been criticised for providing little, if any, new powers for councils to protect people from abuse, as the Act only defined the infrastructure to create the SAB and the power of enquiry by councils, but it requires individuals to provide information. The earlier versions of guidance for statutory implementation were also criticised for not being sufficiently precise in defining what is meant by abuse, however, the definition of abuse has been expanded in the revised guidance published in 2017.¹² It has been pointed out that the inclusion of such items as self-neglect as a form of abuse, with the lack of any clear guidance to help practitioners distinguish between self-neglect and a chosen lifestyle, is still a shortfall in the revised guidance [48]. Overall, commentators have indicated that the safeguarding section in the Act is unsatisfactory because it fails to provide any substantial new powers for councils and the various versions of the statutory guidance fail to offer any clear principles for the assessment of abuse [19, 49].

Fiscal challenges

It has been argued that the Act's aspiration, to ensure that social care meets the fundamental care needs throughout the course of life, requires significant additional financial resources to support its implementation. Overall, the various new duties introduced by the Act are

likely to require greater expenditure. For example, the new obligations to assess and address the eligible needs of carers reduces the threshold at which carers might expect support, which is likely to increase the burden on local authorities [16]. Similarly, scepticism was expressed about the ability of councils to fulfil their new obligation to invest in preventative services, particularly given the scale of the budget reductions being experienced by local authorities [27]. In 2016, a budget survey revealed that only 36% of the Directors of Adult Social Care in English local authorities were fully confident of being able to provide all the statutory services for 2016/17. However, when the services demanded by the Care Act are included, the percentage of Directors who thought they could provide the required services in 2017/2018 falls to just 8% [25]. The Act was introduced at a time of severe financial pressure on councils, which are facing a reduction of 40% in central government funding over the lifespan of the parliament. Moreover, it is predicted that by the end of the decade, the funding available for local government could shrink by as much as 66% [27, 50, 51]. A Local Government Association report in 2015/2016 highlighted that more than half the councils anticipated that a degree of service reduction would be needed to balance the budget [50]. Such reductions in services and funding do not automatically imply that there has been a failure in fulfilling the councils' statutory duties, however, there has been some indication that providers are struggling to maintain care quality standards while sustaining their financial viability [46, 52]. One of the promises of the Act is that councils will be able to achieve more with less. Enhanced system efficiency and improved quality of care should be achieved by investing in wellbeing, prevention, personalisation, better commissioning and integrated care. Conversely, councils appear to have little confidence in the central government's assumptions that the legal reforms will lead to savings [50]. It was noted that if central government cannot provide adequate funding to support the reforms, it should make it clear that the responsibility to fund care rests on individuals and their families, and further incentives should be created for people to plan for their future care needs. Equally, it was suggested that some of the new duties and rights created by the Act should be revised to make sure that people's expectations are more realistic, and reflect what local authorities can afford to provide [20, 46].

Discussion

The Care Act 2014 is the most significant piece of legislation in the social care sector for more than 60 years. It aims to shift attention away from local authority-led services, which often overlooked people's individual needs, and to put service users in control of their care, focusing on the person's individual care needs, choices and aspirations. The Care Act merged the previous laws on adult social care into a single entity and modernised legislation in line with the contemporary emphasis on individuals' wellbeing, personalisation, prevention and integration. While some of the significance attributed to the

Act by ministers has been reduced by delaying the cap on care costs until 2020, the legislation has influenced the working practices of councils [53]. The implementation of the Act, at least in the short-term, seems to have been hampered by the statute having been introduced at a time of significant fiscal pressure on local budgets. It will, however, take time for the wide-ranging effects of the Care Act to become more visible. Where the Act was criticised for providing merely cosmetic changes, for example, in relation to prevention or safeguarding, the Act can, in the longer-term, contribute to changes in practice and culture. The shift from the duty of only providing services to one of meeting the needs of individuals and carers; with the focus on improving wellbeing, preventing or delaying the need for support, as well as across-agency collaboration, are the essential parts of the hope of delivering long-term savings by improving the cost-effectiveness of the care system. Investing in these areas and fully utilising any existing public and community resources, may well be the answer to the ambitious plans to deliver high quality care at lower cost and to contribute to the sustainability of the care system in the era of an ageing population and the consequent increase in demand for care.

Notes

¹ The Care Act generally applies only to local authorities in England. However, some provisions extend to other parts of the United Kingdom (e.g. in relation to cross-border placements, certain provisions on provider failure or provisions on the Health Research Authority).

² The aftermath of the First World War heightened demands for social reforms in Britain and in 1942, a committee, led by Liberal politician William Beveridge, published the Beveridge report, which identified five 'Giant Evils', which needed to be tackled for a better society: poverty, disease, ignorance, squalor, idleness. To address these issues, Beveridge proposed setting up a welfare state with social security, a national health service, free education, council housing and full employment. After the war, the Labour government adopted the Beveridge proposals and implemented many social policies, which became known as the Welfare State. These policies included the Family Allowances Act 1945, National Insurance Act 1946, National Health Service Act 1946, Pensions Act 1947, Children's Act 1948 and NAA 1948 [1].

³ In contrast, the National Health Service (NHS England) is predominantly free of charge at the point of delivery. The NHS is funded by National Insurance contributions and from general taxation and its budget is ring-fenced.

⁴ The Care Act states that councils must co-operate with each of its relevant partners and each relevant partner must co-operate with the authority in providing care and support services.

⁵ There has been a series of subsequent amendments to the Care Act statutory implementation guidance; most recently, in February 2017, the revised statutory guidance was published in electronic form. The list of changes made to the Care Act Guidance are provided online by the Department of Health.

⁶ Personal budgets provide service users a menu of options for the commissioning of their care, with different degrees of

involvement of service users and carers. Since 2011, all new publicly funded users of home care in England have been provided with a PB, which they can take as a direct payment, as a care package managed by a third party on behalf of the user, or as a care package managed by the local authority.

⁷ DPs are the most extreme form of personalised care. They involve cash payments made to individuals, who can use them to meet some, or all, of their eligible care and support needs. DPs were introduced by the 1966 Direct Payments Act which enabled local authorities to make payments for disabled working age adults. The provision was extended in 2000 to include older people, and carers were included in 2001. Since 2003 the local authorities have had a legal duty to provide DPs [18].

⁸ Data sharing is mainly regulated by the Data Protection Act 1998.

⁹ For example, the bankruptcy of Southern Cross in 2011, the largest provider of care homes in England, which had 9% of the market nationally, jeopardised the care of 30,000 residents across 750 care homes [36, 37].

¹⁰ The Act mostly relates to adult carers i.e. people aged 18 and over who provide care for another adult because young carers can be supported under children's laws. Regulations under the Act allow councils to look at the family circumstances when assessing an adult's need for care, ensuring that the situation of a young carer within a family is considered. The Act also contains new rules about working with young carers, or adult carers of disabled children, to plan the transition to adult social care.

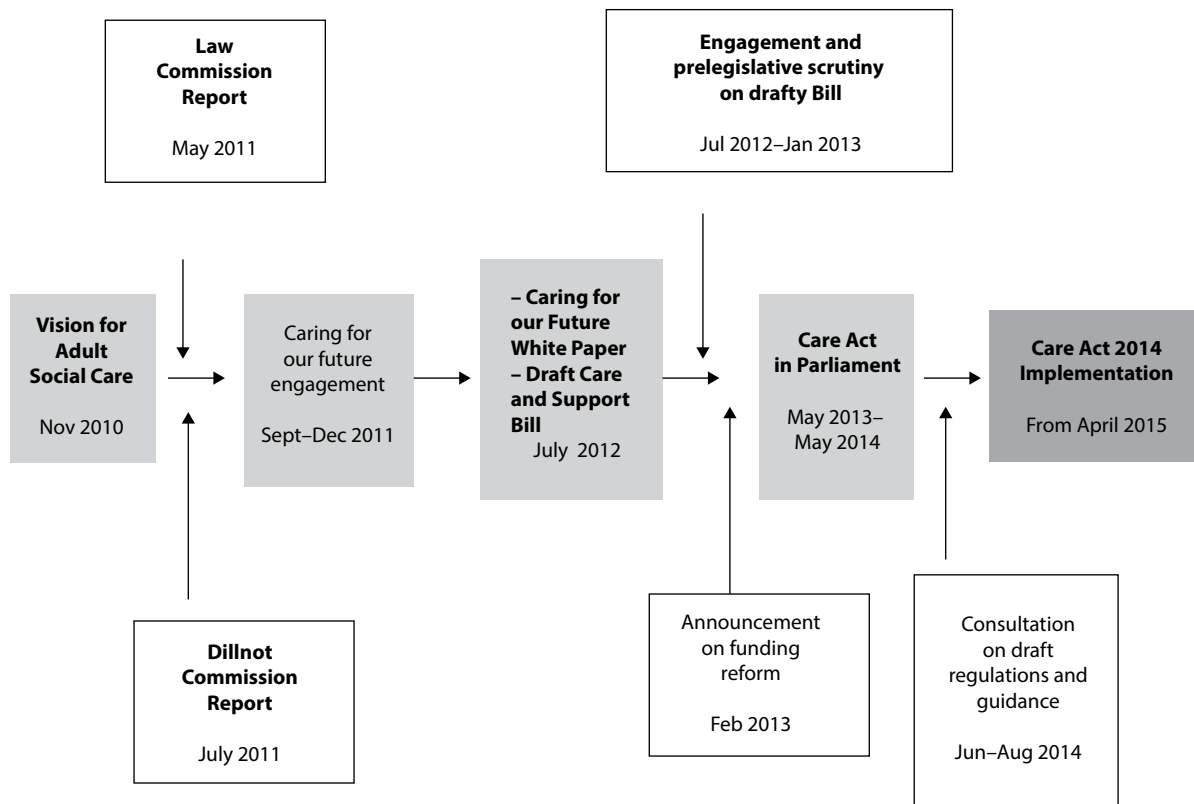
¹¹ According to FACS the needs of assessed individuals were split into one of four categories: critical, severe, moderate or low, in line with their level of risk and potential loss of independence. However, English local authorities had the autonomy to decide which of these categories were entitled to public support according to their financial resources [43].

¹² According to revised guidance, abuse consists of: physical abuse; domestic violence -including psychological and emotional abuse; sexual abuse including inappropriate looking or touching; psychological abuse including 'deprivation of contact, blaming, controlling, cyber bullying, isolation'; financial or material abuse, modern slavery; discriminatory abuse, including forms of 'harassment due to race, gender or gender identity, age, disability, sexual orientation or religion; organisational abuse including 'neglect and poor care practice within an institution or specific care setting, e.g. hospital or care home'; neglect and acts of omission including ignoring medical, emotional or physical care needs, failure to provide access to health, care and support or educational services. Finally, self-neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and actions such as hoarding.

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Appendix 1. *The Care Act 2014: Timeline for social care reforms.*
 Source: Own work.