Care Act: Regulations and Guidance

Herefordshire Council Consultation Response

August 2014

Herefordshire Council welcomes the opportunity to respond to the consultation on the Care Act regulations and guidance as we fully support the movement towards a more person-centered approach which aims to rebalance the focus of care and support away from crisis management to preventative interventions.

We have had sight of the joint ADASS and LGA consultation response and also the County Council's Network response and concur with their contributions. This response is specifically by Herefordshire Council and reflects on how the regulations and guidance particularly impact on our county and also relays specific technical issues raised by members of staff.

This response is divided in two parts – an overall response followed by more detailed sub-responses to particular areas of the draft regulations and guidance.

Overall response

Whilst we welcome the Care Act and the regulations and guidance, the changes required of local authorities by the regulations and guidance will have significant financial implications on Herefordshire Council – both in terms of implementation costs and the increased costs going forward. We are deeply concerned that neither the cost implications nor time required for robust implementation have been fully considered by national government.

Local modelling of the financial implications of the Care Act indicate costs of at least £2.3m for the changes to be implemented in 2015/16, yet the indicative funding allocation we are set to receive is £1.5m (Source LGA finance team allocation model), of which £1.0m is expected to come directly to the local authority, with £0.5m to be received from the Better Care Fund (BCF). This represents a budget shortfall of £0.8m. Furthermore, £458k of our local funding allocation is identified within the BCF but locally this is only to be released if the CCG can release savings. Whilst the government has published details relating to the distribution of Care Act funding from within the BCF, the lack of further information on specific BCF funding streams (e.g.. eligibility, carers, advocacy) is restricting our ability to ensure this BCF funding for the implementation of specific aspects of the Care Act are allocated. In addition we currently estimate the further changes to be implemented in 2016/17 will create an additional £4.4m pressure.

The financial challenge presented by the Care Act is particularly concerning when the changes required by the Care Act regulations and guidance are considered within the broader context facing Herefordshire Council. The timescales for implementation are a further big concern as

the regulations and guidance are substantial in size and it is essential we properly understand the detail. Until the regulations and guidance are finalised we cannot properly proceed with implementing the changes required; time-wise this is will be extremely challenging if new systems are required to be set up to deal with assessments and if any commissioning of services is required.

Even before the implementation of the Care Act, the council faces a significant financial challenge in meeting increasing demand for services with decreasing resources. Meeting current demand is already an enormous strain on resources; the additional pressures in the system which the Care Act will generate will worsen the budget position for the council over the coming years. Whilst this has implications generally for implementation of the Care Act, it particularly impacts on our ability to rebalance the focus of care and support away from crisis response towards prevention and early intervention.

As with other councils, we have significant concern regarding the implications of the number of people paying for their own care who might approach the council for an assessment under the new system so as to limit the care costs they have to meet. However, as a rural county these concerns are exacerbated further in Herefordshire. Herefordshire has a higher than average aging demographic (22.5% aged 65 years and older compared to 17% nationally) and is also a popular retirement destination, and subsequently has a noticeably higher than average self-funder market (for instance 74% of nursing home placements are made by privately funding individuals, compared to 48% nationally). As Herefordshire has much higher than average numbers of self-funding individuals, the council is therefore very likely to experience a much higher than average increase in demand for assessments, yet we are not currently set to receive any additional funding or support to cope with this and so this will place further strain on our budget.

In addition, our rural context places additional strain on resources to fund care and support as services must be delivered and made accessible to a large, scattered population dispersed over a large geographic area. Nearly half of the county's population live in villages, hamlets and isolated dwellings, making Herefordshire one of the most rural counties in England. Not only are there challenges of access to services, there are challenges for market development and the ability of providers to meet changes in demand, such as due to the remote and rural nature of the county creating difficulties in staff recruitment and retention. Yet again, whilst we welcome the principles introduced by the Care Act and the regulations and guidance, the specific nature of the challenges faced by rural authorities in implementing the changes required are not currently adequately reflected in funding allocations.

We are aware of the recent launch of the consultation on the funding allocations for new social care duties and will of course feed our thoughts and concerns into this process too.

Sub-response A: commissioning related duties

Regulations and Guidance being responded to:

- *Preventing, reducing or delaying needs*
- *Information and advice*
- *Market shaping and commissioning of adult care and support*
- *Integration, cooperation and partnerships*
- *The Care and Support (Preventing Needs for Care and Support) Regulations 2014*
- *The Care and Support (Provision of Health Services) Regulations 2014*
- *The Care and Support (Discharge of Hospital Patients) Regulations 2014*

1. General observations and comments

1.1. The objective of the Care Act's to rebalance the focus of care and support on preventing and delaying needs away from solely supporting those at crisis point is welcomed, however without additional funding to meaningfully resource it local authorities will struggle to redirect their limited resources away from meeting those with the greatest and most urgent needs. .

1.2. Successful implementation of the Act and the supporting statutory guidance is predicated on increased integration with health-services to provide a more person-centered approach to care and support. This is welcomed locally as it corresponds with our ambitions to increase integration in Herefordshire. However, the Department of Health should recognise that effective integration takes time as structural, cultural and financial barriers must first be addressed. Our previous experiences locally have shown that when these barriers are not fully considered integration is neither effective nor sustainable.

1.3. The ambitions outlined in the Market Shaping guidance to create a market of vibrant, responsive, quality services with appropriately paid, trained and qualified staff are welcomed, as is the requirement for local authorities to have regard to cost-effectiveness and value for money. Balancing these two requirements, in the context of increasing demand and constrained resources, is becoming increasingly challenging for local authorities. For rural authorities such as Herefordshire, this difficulty is amplified as providing services to a sparse population distributed over a wide geographical area presents additional challenges to provider growth and development, particularly micro-business and community and voluntary enterprises.

1.4. Whilst it clearly has a pivotal role to play, the local authority alone cannot shape and direct local markets and services – other commissioners, particularly the Clinical Commissioning Group and service users have an important role to play too. The current guidance on Market Shaping does not reflect this.

1.5. Similarly, the guidance does not adequately recognise that most preventative services tend not to be provided by adult social care but are part of the wider local provision of universal services and community infrastructure (e.g. leisure services, transport). The guidance should be revised to reflect the key role of local authorities in enabling, supporting and facilitating the local preventative offer and the prevention duty should be extended beyond the local authority to the wider system, such as GPs and primary care.

1.6. In addition to 1.5 above, the lack of clarity of what is a care and support preventative service and what is part of the wider general offer of preventative services will pose a challenge to local authorities in relation to charging. How will local authorities be expected to differentiate which preventative services are adult social care (and therefore chargeable) and which are part of the wider offer locally? Furthermore, the current lack of clear guidance on what is the boundary between a preventative service and a care and support service will have implications on how care accounts are calculated.

1.7. To establish and maintain a comprehensive information and advice service as outline in the guidance on Information and Advice will require a substantial amount of investment. Repeatedly throughout the chapter long lists of examples of what local authorities will need to consider are outlined, for example appropriate communication channels (paragraph 3.19), the range of services information and advice should be on (paragraph 3.23), where information should be provided (paragraph 3.24). To achieve all this by April 2015 with very limited funding will be extremely challenging and we do not believe the Department of Health has fully considered the scale of this task.

2. Where the regulations and guidance are helpful

2.1 Explanation of the three-tiers of prevention in the guidance (2.6-2.8) is a welcome step to establishing a common-language and understanding nationally about the different types of preventative approach. It is important that a shared understanding of tiers of prevention is developed in conjunction with health services if local authorities and CCGs are to successfully jointly fund and commission preventative services. Equally, the clarification of the difference between intermediate care and reablement in regulations and statutory guidance (2.9-2.11) is appreciated.

2.2 The definitions of market shaping, commissioning, procurement and contracting in the Guidance on Market shaping (4.5-4.9) is useful in giving clarity both on how these concepts are different from each other and how they inter-relate.

2.3 It is encouraging that the guidance on Prevention and Integration recognises the importance of housing in promoting the wellbeing of an individual.

3. Technical details or specific areas where refinement is required

3.1 A clear definition of ‘co-production’ (e.g. as used in guidance 4.49) would be helpful as this is becoming an increasingly popular term with a growing range of interpretations.

3.2 The guidance on information and advice does not adequately recognise the key role local partners also have to play in providing and sign-posting to information and advice.

3.3 Market shaping guidance (4.68) requires local authorities to include an analysis of those self-funding individuals who are likely to move to state funding in the future. Whist we agree with the principle and understand the requirement, it seems that proper consideration has not been given to the scale this task presents to local authorities, as by nature most ‘self funders’ currently have no contact with the local authority. Estimating the numbers of self-funders, particularly those in the community is very challenging and providers are under no obligation to share their numbers of privately-funding individuals with the local authority.

3.4 The guidance on prevention repeatedly refers to ‘prevention intervention’. This is quite a medical concept that does not adequately capture the range of nature of preventative services, particularly those at the universal ‘prevent’ end of the spectrum. Furthermore, the concept of an intervention is contrary to the attempt in the guidance to emphasise that prevention is not a one-off activity.

3.5 It should be made clearer in paragraph 2.31 of the guidance on Prevention, that the list given is not an exclusive list but merely some examples.

3.6 Guidance on delayed transfers of care is very mechanistic and process driven. In comparison to much of the rest of the guidance and the Care Act, which attempts to drive forward the personalisation agenda, the delayed transfers of care guidance seems far less person-centered.

3.7 Clarification is needed on whether the assessment should include a consideration of the role of carers - Paragraph 2.39 of the guidance on Prevention states that as part of the assessment process the local authority should take into account ‘the role of any support from family, friends of others that could help them to achieve what they wise for from day-to-day life’. This appears to contradict paragraph 6.8 in the guidance on Assessment, which states ‘an assessment must seek to establish the total extent of needs before the local authority considers the person’s eligibility for care and support and what types of support can help meet those needs’.

3.8 The ‘Money Management’ section of the guidance on Information and Advice (3.41) requires more detail and elaboration. Money management is crucial to supporting an individual to maintain their independence and it is disappointing that it only warrants a single paragraph in the guidance with no specific requirement set out.

3.9 Greater clarity and differentiation is required between the terms information and advice.

4. Questions and suggestions to the Department of Health

4.1. There is a need for a greater evidence base on what the benefits of prevention are and which approaches are most effective. Examples of best practice and research would be welcomed as this would support local authorities in ensuring they are targeting their limited resources most efficiently. It will also support local authorities in their discussions with colleagues in health in agreeing joint funding for preventative services.

4.2. We agree that local authorities should ‘consider emerging best-practice on outcomes-based commissioning’ (4.14) and hope that there will be national work to support the collation and dissemination of this. For example, further research and best-practices examples of how to successfully implement ‘payments-for-outcomes’ mechanisms would be useful.

4.3. As the term implies, engaging with ‘hard-to-reach individuals and groups’ (Guidance 4.57) is notoriously difficult. To support local authorities in this, it would be helpful for the Department of Health to develop an approach to facilitate increased sharing of examples of successful approaches from across the country.

Sub-response B: assessment, eligibility, planning and review

Regulations and Guidance being responded to:

- *Assessment and eligibility*
- *Care and support planning*
- *Review of care and support plans*
- *Transition to adult care and support*
- *The Care and Support (Assessment) Regulations 2014*
- *The Care and Support (Eligibility Criteria) Regulations 2014*
- *The Care and Support (Children's Carers) Regulations 2014*

5. General observations and comments

5.1. At points the guidance on assessment and eligibility is unnecessarily repetitious, for instance paragraphs 6.11 and 6.91 are virtually identical.

5.2. We welcome the intention to set national eligibility at a level consistent with the current level of substantial. However, we urge the Department of Health to ensure that this is actually the case in the regulations and guidance. If the new eligibility threshold is more generous (as it currently appears it may be), there will be significant cost implications to Herefordshire Council and many other local authorities.

6. Where the regulations and guidance are helpful

6.1 Creation of clear eligibility criteria is welcomed.

6.2 The inclusion of carers in the guidance alongside service users, rather than as a separate consideration, is welcomed as this re-emphasies the integral and important role that carers play.

6.3 Explanation of what is meant by 'unable' in the assessment and eligibility guidance, paragraph 6.87, is helpful in ensuring the eligibility criteria is understood and applied correctly, although as with many terms in the guidance, this may still be open to a degree of subjective interpretation.

6.4 It is positive that recognition is given to individuals with fluctuating needs and that local authorities should consider this when conducting an assessment (as outlined in paragraph 6.89 of the assessment and eligibility guidance, section (3)(3) of the assessment regulations and also (2)(3) of the eligibility regulations).

7. Technical details or specific areas where refinement is required

7.1. The concept of 'significant' impact, as included in 2.(1)(c) in the eligibility regulations is vague and open to a wide degree of interpretation

7.2. Co-production as an approach to assessment, as mentioned in 6.34 and 6.36 in the assessment and eligibility guidance, requires defining to ensure a consistent understanding of the term.

7.3. The case study example on pages 86 and 87 of the assessment and eligibility guidance is not helpful – it is not clear how it illustrates judgment of 'significant impact on wellbeing' and is more like an exercise of spot the difference.

7.4. It is not clear in 6.51 whether the local authority must offer a supported self-assessment or not. The first sentence states 'local authorities ***can*** offer individuals a supported self-assessment, but the second sentence states 'the local authority ***must*** offer the individual the choice of a supported self-assessment.

7.5. Paragraph 6.68 of the assessment guidance in relation to NHS Continuing Healthcare requires further clarification. The guidance states the 'local authority may provide or arrange healthcare services where they are simply incidental or ancillary to doing something else to meet needs for care and support'. Whilst this is true for those assessed as eligible for care and support from the local authority, those with NHS Continuing Healthcare eligible needs should have all services arranged through the NHS. This requires clarification in the guidance, particularly as the paragraph is in the NHS Continuing Healthcare section.

Sub-response C: paying for care

Regulations and Guidance being responded to:

- *Charging and financial assessment*
- *Deferred payment agreements*
- *Personal Budgets*
- *Direct Payments*
- *The Care and Support (Charging and Assessment of Resources) Regulations 2014*
- *The Care and Support (Deferred Payment) Regulations 2014*
- *The Care and Support (Personal Budget Exclusion of Costs) Regulations 2014*
- *The Care and Support (Direct Payments) Regulations 2014*
- *The Care and Support and Aftercare (Choice of Accommodation) Regulations 2014*

8. General observations and comments

Recovery of Debts

8.1. We understand why Section 22 of HASSASSA, the power of a local authority to place a legal charge, has been removed, but we do not believe the financial implication of this upon local authorities has been adequately considered. Removal of Section 22 will increase local authorities' exposure to bad debts and create a cost pressure when those debts have to be pursued through the courts.

Charging and Financial Assessment

8.2. The guidance uses terminology that is unhelpful such as regularly and small. Can the guidance be more specific to clarify policy intention. For example, "the LA **MUST** regularly re-assess a person's ability to meet the cost of care" Is this at least once every 12 months or more frequently? Another example is with light-touch assessments. "where the LA charges a small or nominal amount for a particular service which a person is clearly able to meet ". What is small or nominal? Whilst the light touch approach is welcomed some further examples of the level and types of charges that would meet this criteria would be helpful.

8.3. The ability to charge an administration fee to people with assets above the limit who want the council to arrange care is welcomed but clarification around what costs can be recovered through the admin fee would be helpful. In addition to the needs assessment and financial assessment, the Council will incur additional costs in not only setting up the arrangements but ongoing costs relating to raising invoices etc.

Deferred Payments

8.4. We recognise that implementing a Mandatory Deferred Payment Scheme will ensure consistent approach nationally but further guidance is needed around financing care provision when a person lacks capacity and where there are delays in obtaining deputyship through COP, especially as LA Deputyship is not a statutory function.

9. Where the regulations and guidance are helpful

Deferred Payments

9.1 The quantifying of what the local authority can lend and how to calculate this is welcomed. Regulations 5(3) (a) (i) refer to a limit of '70-80% of the value of the land'. **This should be set at a single figure to ensure consistency across all local authorities.**

9.2 Clarification on what the administration costs for Deferred Payment Agreements should consist of is welcomed.

Charging and Financial Assessment

9.3 The guidance has helped to clarify a number of areas where policy intention was previously unclear, for example the ability to charge temporary residents in a care home under fairer charging if appropriate, and the treatment of backdated benefit awards when calculating charges.

9.4 The proposed changes to the 12 week property disregard give councils more flexibility.

10. Technical details or specific areas where refinement is required

Deferred Payments

10.1. Clarification is needed on whether the Department of Health believes the responsibility for updating the value of assets in the Deferred Payment Agreement sits with the local authority or the individual.

10.2. Clarification is needed on how often the value of assets in the Deferred Payment Agreement should be updated. Will the content of the statements be prescriptive?

10.3. The Regulations on Deferred Payment Agreements (9) refers to an interest range of between 3.5-5%. This should be a single standard rate applied by all local authorities. A 'range' is not helpful. The interest rate should be set at a fixed percentage above the base rate.

10.4. An explanation of how interest on Deferred Payment Agreements should be calculated. There will need to be a consistent approach across all local authorities. If this is compound – what formula is to be used to calculate – e.g. daily balance (as for mortgage interest), or applied annually.

Recovery of Debts

10.5. Guidance on debt recovery policy and practice would be welcomed. Are there plans to make provision for recovery through attachments to DWP benefits /pensions when s22 is removed?

Charging and Financial Assessments

10.6. Clarification of the treatment of residential respite in a direct payment is welcomed but there appears to be conflicting guidance around how income is treated when a person is a temporary resident in a care home, including when having respite. Schedule 1 Part paragraph 10 states that if an adult is a temporary resident then any attendance allowance or care component of DLA is to be disregarded. These incomes would not be disregarded under fairer charging. Further clarity on how this will apply including examples would be helpful.

Schedule 1 part 1 (para 2) defines what housing related costs MUST be disregarded from income. This definition includes service charges, water and fuel charges and insurance. Under current fairer charging guidance, costs for water and fuel charges and contents insurance would not be treated as "housing related" costs. This is because a person's basic income support allowance would be expected to cover these costs. Any excessively high costs for water and fuel usage as a result of a person's disability would be treated as a "disability related expense" DRE .i.e. only the excess costs allowed. It appears that application of this new disregard under the care act could result in a person getting an allowance for these costs twice. I.e. once as a disregard against income and twice in the basic income support allowance. It would be helpful if you could clarify how these disregards relate to basic income allowances. **Application of these disregards as stated in the Care Act will result in a reduction in what the council currently charges people towards care costs.**

10.7. Charging and Assessment of Resources Part 2 para 7 (1) states how the minimum income guarantee amount should be specified. Para 7(1) (a) refers to Schedule 2 of the Income Support Regulations to determine the applicable amount. Having looked at Schedule 2 of the Income Support Regulations it is not clear how the applicable amount should be arrived at in circumstances where the person is a member of a couple and is the only person receiving the care or service. Should the applicable amount be calculated based on a single person allowance or half of a couples allowance? Paragraph 7 (1) (a) appears to suggest that if the person receiving the care is a member of a couple then the couple rate should be used, however when determining the income of the person getting the care an equal share of any joint income should be used. Further clarification and examples would be helpful.

11. Questions and suggestions to the Department of Health

11.1. We have heard that by charging interest this will create a requirement on local authorities to register with the FSA. Can the Department confirm if this is the case?

11.2. What happens if CHC funding is awarded during the deferred payment period, will the regulations enable the deferred debt to be suspended?

11.3. When setting the interest rate for DPA's, will the DoH be taking into consideration the rates generally charged by banks and other lenders? If the rate is lower than other lenders where is the incentive to buy financial products from other financial service providers?

11.4. Further clarification on the treatment of war pensions when local schemes are in place for HB and Council Tax rebates would be welcomed. The guidance says the financial assessment should take this into account, but does that mean if the LA has a local scheme that disregards 100% of that income under HB/CTB that the assessment for charging for care should follow suit?.

11.5. The charging guidance states the LA has no power to do a joint assessment, previous fairer charging guidance stated a joint assessment could be done if the result was more beneficial to the service user. Can you clarify that under the care act joint assessments for people living at home will no longer apply even if it is in the person's interest?

Sub-response D: safeguarding, advocacy & provider failure

Regulations and Guidance being responded to:

- *Safeguarding*
- *Managing provider failure and other service interruptions*
- *Independent advocacy*
- *The Care and Support (Business Failure) (England and Wales and Northern Ireland) Regulations 2014*
- *The Care and Support (Independent Advocacy) Regulations 2014*

12. General observations and comments

12.1. We have reflected on the consultation responses submitted by the West Midlands Regional Adult Safeguarding Network and also Solihull Safeguarding Adults Board and many of our thoughts, observations and concerns are in line with what has already been stated.

12.2. It is pleasing to see that the Making it Personal approach and the notion that safeguarding is everyone's business is embedded throughout the guidance.

12.3. Cooperation is a welcome theme in the guidance, but there is very little actual 'teeth' to ensure all partners cooperate. It is a shame there are not formal regulations on safeguarding to ensure consistency and accountability, particularly in relation to information sharing. The guidance is clear the local authority must make enquiries and decide what needs to be done and by whom, but the local authority is not able to compel anyone else to do what the SAB decides to be done. Greater emphasis is needed in the safeguarding guidance on the responsibilities of key partners.

12.4. The use of case studies in the guidance on safeguarding is very helpful in principle – however, many of the case studies are weak and for certain areas that would benefit from a case study there are none (e.g. information sharing). For instance, the case study on carer strain (p.194) makes no reference to police involvement and thereby implies that it is acceptable for the police to not be involved in circumstances such as those given.

12.5. Mental Capacity Act Deprivation of Liberty Safeguards (DOLs) are not mentioned at all in the Safeguarding Guidance. The SAB should have oversight of DOLs in its area and this should be reflected in the guidance.

12.6. The guidance on safeguarding seems poorly structured and confusing at times. A glossary would be helpful in ensuring greater consistency in the use of terms.

13. Where the regulations and guidance are helpful

13.1. It is useful that the safeguarding guidance gives clarity that actual mistakes and misunderstandings (e.g. in commissioning or case management) need not always automatically be labelled as 'safeguarding' if they simply are genuine errors.

13.2. It is positive that the government recognises the importance of advocacy and the increasing demand for advocacy, and has therefore made it statutory.

14. Technical details or specific areas where refinement is required

14.1. Much greater clarity is required in relation to information-sharing and safeguarding – particularly with regards to the roles, responsibilities and when and how the power to call on others to provide information can be applied.

14.2. In relation to safeguarding, a case study of the relevance of the section 45 duty would be useful.

14.3. All core members should be required to financially support the SAB – this should not be optional as currently stated in paragraph 14.105.

14.4. The safeguarding guidance is very poor in relation to power of entry. More guidance, supported by case studies, would be extremely useful in this area.

14.5. Paragraph 14.103 identifies the formulation of guidance on dealing with complaints and grievances as a role of the SAB. Whilst we agree the SAB may have a role to play in developing an approach shared by partners, it should be stated clearly that it is not the role of the SAB to deal with complaints and grievances as these are matters for individual partners.

14.6. Paragraph 14.113 does not give any explanation of what is meant by 'multi-agency training'. Neither is it clear what levels of training are intended nor what the core skills required by staff are.

14.7. Why is the Chief Officer of Police specified as a core member, but the level of representation from the other core member organisations is not specified?

14.8. A more comprehensive definition of prevention and safeguarding principles should be provided and consistently referred to throughout the guidance. The principles are outlined in 14.3 and 14.4, but not to a standard as comparable to that previously produced by government.

14.9. No guidance is provided on the framework for enquiries, with the inference that this is left to local discretion. This is inconsistent when compared to *Working together to*

safeguard children. Furthermore, no guidance is provided on how to proceed in relation to large scale investigations.

14.10. Paragraphs 14.111 and 14.153, which outline the skills required of SAB members, should be cross-checked to ensure they are aligned and consistent.

14.11. Institutional abuse is currently poorly defined in the guidance. The creation of statutory guidance provides a good opportunity to establish a standard definition of the term as this does not exist currently.

14.12. In relation to advocacy, the guidance does not define 'substantial difficulty' very clearly or consistently – this will be vulnerable to a wide degree of subjective interpretation.

15. Questions and suggestions to the Department of Health

15.1. As demand for independent advocates is likely to increase for all local authorities, a more coordinated national approach to independent advocates should be considered – such as the establishment of a national register. This would support workforce development and training and would also be useful for local authorities when sourcing independent advocates for out-of-county cases.

15.2. A draft, optional, template for the SAB strategic plan would be welcomed (consultation question 68)

Sub-response E: other

Regulations and Guidance being responded to:

- *Delegation of local authority functions*
- *Sight registers*
- *Ordinary residence*
- *The Care and Support (Ordinary Residence) Regulations 2014*

16. Technical details or specific areas where refinement is required

16.1. In the guidance on delegation, there appears to be an error in paragraph 8.16 which refers to '22.15 above'. Should this read 18.15 above?

16.2. The second to last sentence in paragraph 18.23 on delegation (*'…as well as handling and those funds')* does not make sense

16.3. Greater consistency is needed between the regulations on ordinary residence and the associated guidance, particularly in relation to the definitions and terminology of different types of accommodation.

16.4. With regard to sight registers (consultation question 80), it would be more appropriate for patients to be asked consent to share their details with the local society for the blind, rather than the RNIB specifically.

17. Questions and suggestions to the Department of Health

17.1. Whilst we understand and do not necessarily disagree with the test for ordinary residence for carers (as outlined in guidance 19.6), we would urge the Department of Health to consider how the new entitlement for carers to an assessment in their own right reconciles with the unchanged requirement that a carers ordinary residence is determined by where the person they care for is ordinarily resident.