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# **Micro-Commissioning in Adult Social Care, NHS Continuing Healthcare/ Funded Nursing Care and Mental Health Aftercare: Principles of Consistent, Pragmatic and Ethical Decision Making For Staff**

**North East Lincolnshire Council  
and  
Humber and North Yorkshire Integrated Care Board  
(at North East Lincolnshire Place)**

**Strategic framework on maintaining independence  
for those with care needs**

<b>Document Title:</b>	Micro-Commissioning in Adult Social Care, Continuing Healthcare/ Funded Nursing Care and Mental Health Aftercare: principles of consistent, pragmatic, and ethical decision making
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# 1 Introduction

This policy provides the framework within which micro-commissioning decisions are taken regarding allocation of adult social care, NHS continuing healthcare (CHC)/ funded nursing care (FNC), and mental health aftercare, in North East Lincolnshire (NEL).

## 1.1 Integrated structures

Via an agreement under s75 of the National Health Service Act 2006 ('the NHS Act'), NEL Council ('the Council') delegated some adult social care responsibilities to the Humber and North Yorkshire Integrated Care Board at North East Lincolnshire Place ('the ICB'). The Council and ICB commission providers to deliver social care functions. The ICB commissions (as well as delivers some) health functions. Care Plus Group (CPG), Navigo and Focus Independent Adult Social Work (Focus) deliver micro-commissioning functions on behalf of the Council and/ or ICB.

Duties under the Care Act 2014 ('the Care Act') are primarily directed at local authorities. CHC duties are directed at ICBs. Mental health aftercare duties deriving from the Mental Health Act 1983 (MHA) are shared. Given the integrated arrangements in North East Lincolnshire, and for ease of reference, where duties are referred to in this policy they will be referred to as duties imposed on the ICB (acting either on its own behalf and/ or as the Council's delegate).

## 1.2 Integrated plans

The Integrated Care Strategy creates the framework for plans at Place. It sets out an ambition for 'everyone in our population to live longer, healthier lives', by taking a life course approach. Similarly, the refreshed Council plan 2023 – 2026 sets out an intention for NEL to be a place "where citizens of all ages live active, healthy and independent lives". The Council plan vision for adults is that "all adults in North East Lincolnshire will have healthy and independent lives with easy access to joined up advice and support, helping them to help themselves"; it uses the life course structure to frame priorities, adding 'Care well' to ensure carers' needs are prioritised.

The local delivery plan for adults, as part of the Integrated Care Strategy, focuses on the following areas:

- 1 Starting well: supporting young disabled people to transition to adulthood with the right support as close to home, families and communities as possible
- 2 Living well: supporting working age adults to live as independently as possible
- 3 Aging well: supporting older people to live as independently as possible, for as long as possible in their own homes
- 4 Caring well: supporting carers who are looking after family members, friends and neighbours
- 5 Dying well: supporting those reaching the end of life to do so in a dignified way, wherever possible with support at home.

## 2 Scope and definitions

### 2.1 Scope

This policy sets out the principles intended to inform micro-commissioned activity:

- for those aged 18 and over
- undertaken on the ICB's behalf
- whether via the Care Act, NHS Act or s117 of the MHA; and
- regardless of which organisation employs the practitioner undertaking that activity.

#### 2.1.1 Adult social care

Access to adult social care and support is determined by the provisions of the Care Act. The Care Act prescribes that care and support is accessed via assessment, determination of eligibility and determination of ordinary residence. Procedures which support delivery of assessments and determinations of eligibility and ordinary residence are set out elsewhere.

#### 2.1.2 CHC/ FNC

Via a process similar to that which underpins access to support via the Care Act, access to CHC and FNC is determined by:

- the NHS Act 2006 (as amended by the Health and Social Care Act 2012)
- the NHS Commissioning Board and Clinical Commissioning Groups' (Responsibilities and Standing Rules) Regulations 2012 (amended by the 2013 and 2016 'Standing Rules') ('the Standing Rules')
- the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care and Decision Support Tool (both published March 2018, revised July 2022) – incorporating Practice Guidance ('the Framework')
- NHS England Who Pays? Determining responsibility for payments to providers 2013 (amended 2022).

These documents form the backdrop for the ICB's 'Continuing Healthcare Overarching Policy'. It can be found at: <https://www.northeastlincolnshireccg.nhs.uk/publications-1/> The principles in this policy are intended to reflect, not replace, those in the Overarching Policy, and other relevant documents.

This policy has been developed with awareness of the boundaries set out within the Coughlan and Grogan judgements (R v North and East Devon Health Authority, ex parte Coughlan (1999) and R v Bexley NHS Trust, ex parte Grogan (2006)) and the national Parliamentary Commissioner's decisions on complaints about CHC.

#### 2.1.3 Mental health aftercare

Entitlement to aftercare begins when a person is detained in hospital for treatment under a relevant section of the MHA. The duty to provide after-care is triggered when the person ceases to be detained and leaves hospital, and is determined via assessment.

After-care support is defined as that which has both of the following purposes:

- a) meeting a need arising from or related to the person's mental disorder; and
- b) reducing the risk of a deterioration of the person's mental condition (and so reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder).

These are referred to here as ‘the s117 purposes’. There must be a clear (although not necessarily causal) connection between the person’s needs and their mental disorder for the need to come within this definition/ s117 purposes. Needs related to general wellbeing are insufficient (Mental Health Act Manual, twentieth edition, Jones, 1-1170, p521).

NEL’s approach to provision of aftercare can be found here:

<https://livewell.nelincs.gov.uk/adult-health/>.

## 2.2 Definitions

The term ‘care practitioners’ is used throughout this policy to denote staff directly interfacing with members of the public: individuals with needs, carers, families and representatives.

The term ‘care and support’ is used throughout this policy to describe the provision of services or other activity to adults in need of care, and adult carers of adults in need of support, regardless of the legal framework via which they are supported. The term ‘eligible care and support needs’ is used throughout this policy to denote needs deemed eligible via the application of criteria within the Care Act, NHS Act or s117 of the MHA, and associated guidance, Framework and regulations; again, it is intended to include reference to the eligible support needs of adult carers of adults.

‘CHC’ means a package of on-going care that is arranged and funded solely by the NHS where an adult has been found to have a ‘primary health need’. Such care is provided to meet needs for NHS funded inputs under the NHS Act that have arisen as a result of disability, accident or illness as defined by statute. FNC means the funding provided by the NHS to homes providing nursing to support provision of nursing care by a registered nurse.

‘Micro-commissioning’ is defined as commissioning packages of support for individuals. Micro-commissioning is undertaken where:

- An individual is assessed as meeting the Care Act’s test of eligibility and
  - they are ordinarily resident in North East Lincolnshire (or are present here, but of no settled residence), and
  - there is either a) no charge for the care and support offered, or b) there is a charge and
    - the individual has assets under or at the upper capital limit (UCL), established via financial assessment (either a light touch or full financial assessment)
    - the individual has assets above the UCL, but asks the ICB to meet their needs (NB the ICB is not required to meet needs where it is anticipated those needs will be met by a care home placement – subject to the next bullet point)
    - the individual lacks capacity and there is no one to make arrangements for them (i.e. no-one authorised under the Mental Capacity Act 2005 to act as the individual, or otherwise willing to make any other reliable arrangement in their own name for the individual)
- An individual is assessed as not meeting the Care Act’s test of eligibility but a decision is taken to exercise discretionary powers under the Care Act (or other legislation) to provide care and support
- An individual is assessed as eligible/ qualifying for CHC support (i.e. has been assessed as having a primary health need), or for FNC, and that individual is
  - provided with primary medical services by GP practices in North East Lincolnshire, **OR**



- usually resident in North East Lincolnshire and not provided with primary medical services by a GP practice in North East Lincolnshire (see further NHS Act 2006 and ‘Who Pays? Determining responsibility for payments to providers’)
- An individual is assessed as eligible for a jointly funded NHS and social care package
- An individual is assessed as entitled to aftercare under s117 of the MHA and was ordinarily resident in North East Lincolnshire immediately prior to being detained.

NB Ordinary residence is established by reference to different rules, depending on whether a social care, CHC or s117 entitlement is being considered. The Care Act’s test for ordinary residence, which determines which local authority would be responsible for meeting needs, applies differently in relation to adults with needs for care and support and carers. Both health and social care legislation make provision for meeting the needs of carers or cared-for persons in an emergency, whether or not eligibility or ordinary residence has been determined. There are some restrictions necessitated by immigration status. A guide to supporting individuals who have no recourse to public funds can be found here: [NRPF Network | Introduction](#)

For the purpose of this policy, micro-commissioning activity includes (but is not limited to) making arrangements for:

- Care within a registered care home (with or without FNC), including respite, short stay and permanent stay
- Care at home or in the community, including in supported living settings and extra care housing accommodation
- Day care services
- Use of direct payments (and other mechanisms for delivering personal budgets and personal health budgets). Detail regarding the local approach to direct payments can be found within the Direct Payments Policy at: <https://www.northeastlincolnshireccg.nhs.uk/publications-1/>

In addition to micro-commissioned activity, all care practitioners must provide those for which the ICB is responsible with appropriate information, advice and signposting (particularly with regard to accessing preventative opportunities and community resources).

### **3 Purpose and aims**

The ICB wishes to ensure a holistic approach to micro-commissioning social care, CHC/ FNC provision and mental health aftercare, drawing on a shared set of principles and values (despite differing legislative origins). Whilst health services are free at the point of delivery and adult social care is not, public law principles apply to both.

#### **3.1 driving quality, affordable care**

The purpose of this policy is to ensure provision of the best possible quality of care for those for whom the ICB is responsible, distributed on a transparent, equitable and affordable basis.

The ICB’s ambition is to influence and drive the pace of change in its local market, leading to:

- a sustainable and diverse range of care providers (including those which offer registered nursing)
- continuously improving quality and variety, and

- innovative and cost-effective outcomes that promote the wellbeing of those in need of care and support in North East Lincolnshire.

In addition to the ICB's contractual monitoring and the Care Quality Commission's regulatory monitoring of providers, provision of commissioned care and support is overseen by the Market Intelligence and Failing Services Group ('the MIFS Group'). The MIFS Group protects the interests of those with needs in circumstances where providers are finding it difficult to deliver safe and quality services. The MIFS Group ensures the regular flow of information with regard to such providers, pooling and analysing intelligence collectively.

The MIFS Group will take appropriate action in response to any failing or interrupted service, including a temporary suspension of referrals until difficulties are remedied. The MIFS Group policy and procedure can be found at:

<https://www.northeastlincolnshireccg.nhs.uk/publications/> (under the heading Adult Services Publications and Policies).

Intelligence regarding provision of care and support should be logged using this link:

<http://chintel.northeastlincolnshireccg.nhs.uk/Home/InformUs>.

The ICB considers the strengths (or asset) based approach relevant to all forms of micro-commissioning. The policy is intended to support delivery of the local practice framework which can be read here: <https://livewell.nelincs.gov.uk/wp-content/uploads/2023/12/12882-Practice-framework.pdf>

### **3.1 Objectives and key considerations**

This document offers clarification to micro-commissioning staff. In particular it is intended to ensure recognition of the following:

#### **3.1.1 the financial context in which micro-commissioning activity takes place**

The adult social care budget is agreed annually by the Council's cabinet and is limited. Similarly, the NHS is tasked with delivering better outcomes for patients within limited resources. Health and social care budgets are constrained and the ICB expects budgets to be managed with regard to National Audit Office (NAO) guidance.

The ICB expects care practitioners to:

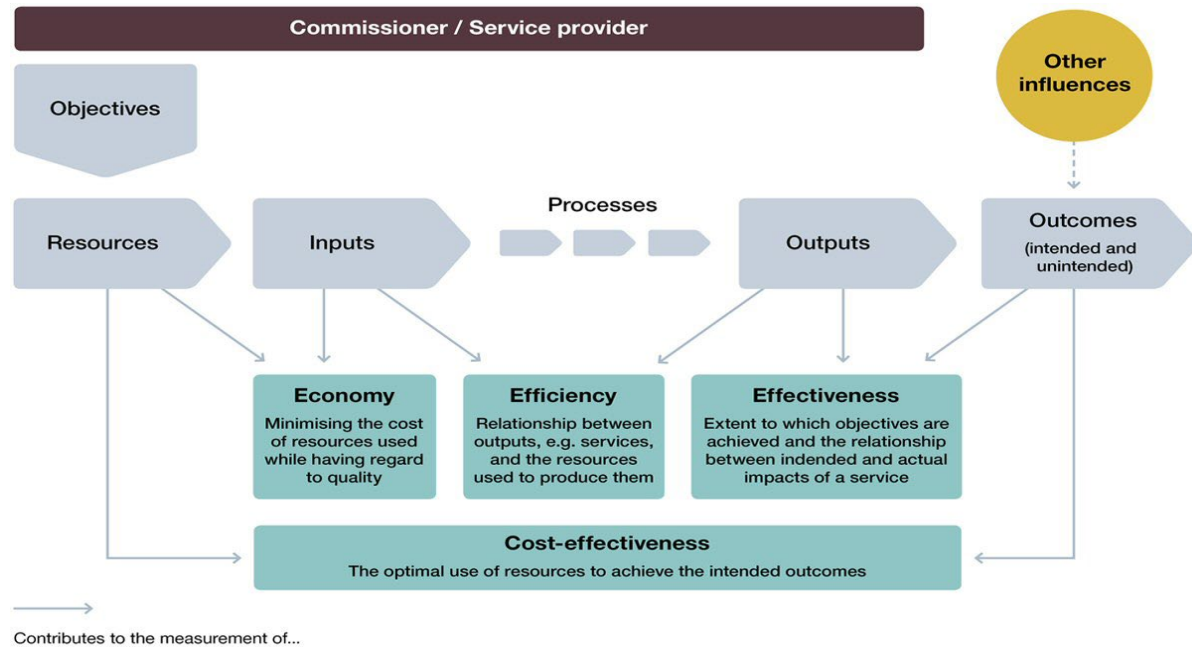
- Meet the eligible needs of those for whom the ICB is responsible within the available budget (subject to considerations of exceeding the budget where the law compels it)
- Meet the eligible needs of those for whom the ICB is responsible, with regard to the NAO Successful Commissioning Guide (guidance on securing value for money in public spending - see below)
- Operationalise this policy in ways that are consistent with meeting the objectives contained herein, in compliance with the law.

The NAO defines value for money as 'the optimal use of resources to achieve the intended outcomes', and uses three criteria when assessing value for money:

- Economy: minimising the cost of resources used or required (inputs) – spending less
- Efficiency: the relationship between the output from goods or services and the resources to produce them – spending well; and

- Effectiveness: the relationship between the intended and actual results of public spending (outcomes) – spending wisely.

The below diagram shows how costs effectiveness is supported by the NAO's "3 Es" (economy, efficiency and effectiveness) and the relationship between inputs and outputs when considering value for money.



For further guidance, go to: <https://www.nao.org.uk/successful-commissioning/>

The ICB wishes to impress on care practitioners the financial context in which allocation of resources takes place. This wish to make clear the reality of budgetary constraints does not indicate a lack of awareness on the part of the ICB (or Council) of the requirement to meet eligible need where a legal duty to do so arises, irrespective of financial limitations.

### 3.1.2 the legal context in which micro-commissioning activity takes place

The legislative context for micro-commissioning is set out in the Care Act, NHS Act (via the CHC Framework), and s117 of the MHA plus associated regulations and guidance.

This policy is not intended to give a full account of the legal position, but rather to offer highlights likely to be of particular relevance to micro-commissioning practitioners.

All references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching to them.

#### 3.1.2.1 public law principles and decision making

Application of legislation (and local policy) is always subject to public law. Care practitioners are expected to take decisions in a way that is compliant with public law duties and principles. Care practitioners must ask themselves the following when making micro-commissioning decisions:

- Legality – is the proposed decision reflective of legislative obligations, and within the limits of the discretion allowed by law (taking into account all relevant considerations and ignoring irrelevant ones)?
- Rationality – is the proposed decision reasonable and proportionate in all the circumstances? Does it maintain a proper balance between the interests of the adult to which the decision relates, and those of ‘the State’ (i.e. in this context, the ICB)?
- Procedural propriety – has the decision making process ensured that the adult affected by the decision (and/ or their representative) has had a fair opportunity to participate in it? Have any views expressed by the affected adult (and/ or their representative) been properly taken into account? Have any procedural rules in relevant legislation been complied with (advance notice, copies and involvement, for instance)?

The implications of not taking into account all relevant considerations (see ‘Legality’ above) when making public law decisions were helpfully summarised by the judge in *R v London Borough of Merton* [2017] EWHC 1519 (Admin), paragraphs 53 to 55:

- First, where there are specific factors *required by law* to be taken into account, a failure to take account of such factors will necessarily vitiate the decision
- Secondly, there are other factors which *may* be taken into account (or indeed which others or the court itself would have taken into account). In such a case, a failure to take such factors into account will not vitiate the decision
- Thirdly, there is a class of factors which *ought* to be taken into account. Here a failure to take account will vitiate. Such factors have variously been described as “relevant” or “clearly relevant” or “so obviously material” to the exercise of the particular discretion that they ought to be taken into account.

The Merton case challenged the Care Act needs assessment which formed the basis of a decision to move JF, an adult with autism and severe learning difficulties, to a new residential placement. At paragraph 47 the judge noted, “the Needs Assessment must specify what JF’s needs are and it must do so on a rational basis. If the Assessment failed to assess the impact of JF’s needs for care and support upon the factors of wellbeing listed in section 1(2) of the [Care] Act, then it is an unlawful assessment. Likewise, if it failed to assess the outcomes that JF wishes to achieve in day-to-day life, and whether, and if so to what extent, the provision of care and support could contribute to the achievement of those outcomes, it is unlawful. If it fails to have regard to the matters specified in [the Care Act Assessment] Regulation[s] 3(2) . . . ., it is unlawful. If the [assessor] failed to have regard to the wishes and preferences of [JF] (expressed here to a degree by the Guardians, his parents), then it is unlawful. If it is neither appropriate nor proportionate then it is unlawful”.

In commenting further on the need for decision makers to act reasonably, the judge states at paragraphs 37 and 38 that “Two reasonable persons can perfectly reasonably come to opposite conclusions on the same set of facts without forfeiting their right to be regarded as reasonable. The proof required to show unreasonableness must be convincing. The claimant must demonstrate an error or errors of reasoning which rob the decision of its logic”. The intensity of the court’s review will depend upon the impact of the decision; given the individual’s permanent vulnerability and dependency upon care and support in the Merton case, the intensity of the review required was deemed high. This high intensity review is likely to apply to many of the individuals considered via application of this policy.

Whilst the Merton case relates to decision making under the Care Act, the way in which public law principles have been applied throughout the judgement may be equally pertinent for decisions made under the NHS Act or s117 of the MHA.

The risk of decisions being successfully challenged can be mitigated by clear statements giving reasons for the exercise of professional judgement, based on public law principles.

Care practitioners are reminded that as a matter of public law, a policy provides a starting point, and a framework for the application of professional decision making to each adult's individual circumstances; this policy is not intended to fetter discretion.

### **3.1.2.2 the Care Act 2014**

The Care Act requires care practitioners to deliver on a range of duties, underpinned by the wellbeing principle set out in s1 of the Act, in working to serve the local population. This requires care practitioners to navigate and weigh a variety of factors, including having regard to the key principles associated with wellbeing (see the Care Act's Statutory Guidance, 1.14). Having 'regard to' is likely to mean approaching consideration of all the circumstances of an individual's case with rigour and an open mind, and consciously directing the mind to obligations within the Care Act. This extends to the practitioner ensuring that they glean sufficient information to enable themselves to have due regard for the individual's wellbeing, in all the circumstances. The concept of 'having regard to' does not mean that consideration of wellbeing *excludes* consideration of all other factors, but failure to consider it appropriately would constitute grounds to vitiate any relevant decision (Davey, R (On the Application Of) v Oxfordshire County Council [2017] EWHC 354 (Admin), paragraph 136). Considerations of the wellbeing principle must be balanced, reasoned and evidenced.

Although not specifically mentioned in the way wellbeing is defined, wellbeing is intended to cover the key components of independent living as expressed in the UN Convention on the Rights of Persons with Disabilities (CRPD). Paragraphs 1.18-1.19 of the Care Act's Statutory Guidance state that the Act and its use of the concept of wellbeing is intended to be clearer than the CRPD, and to focus on the outcomes that matter to individuals, rather than using the relatively abstract term 'independent living'. Article 19 of the CRPD (living independently and being included in the community) does not impose any additional obligations, beyond those arising under the Care Act (Davey, paragraphs 44-49 and 153).

The wishes of the disabled person may be a primary influence, but they do not amount to an overriding consideration (Davey, para 49). For example, in a case in which it was alleged (amongst other things) that rights under CRPD were potentially infringed by a local authority, the UK Supreme Court noted that "in choosing the services that should be provided, an authority has a very wide discretion, as long as the identified needs are met"; whilst service user preferences as to how their needs might be met are material considerations, local authorities are entitled to have regard to their resources "so long as the authority meets the particular need, and gives proper regard to other policy obligations, it is always open to it to meet that need by provision of a cheaper service" (R(D) v Worcestershire CC [2013] EWHC 2490 at paragraph 19.3 and 19.5). Regard for resources remains subject to public law duties (see above), i.e. a cheaper offer must also be a lawful one.

### **3.1.2.3 the Children and Families Act 2014**

The Children and Families Act 2014 created a single system for children and young people with special educational needs and disabilities (SEND). The system of coordinated assessments and an Education, Health and Care Plan applies from birth and can be in place up to the person's 25<sup>th</sup> birthday (or the end of the academic year in which they turn 25). The Act also includes provisions for young carers and parent carers.

Having carried out a transition assessment, care practitioners must give an indication of which needs are likely to be regarded as eligible needs so the young person and /or the parent /carer understand the care and support they are likely to receive once children's services cease. Where a transition assessment identifies needs that are likely to be eligible, care practitioners should consider providing an indicative personal budget so that young people have an idea of how much funding might be available to meet their care and support needs when they enter adults' services.

The NICE quality standard covers the period before, during and after a young person moves from children's to adults' services in all settings where transitions from children's to adults' health or social care services take place. NICE transition standard can be found here: [Overview | Transition from children's to adults' services | Quality standards | NICE](#)

Some individuals will be entitled to the benefit of statutory functions under the Children Act 1989, the Children and Families Act and the Care Act. This may be most likely for (but is not limited to) a young person in transition from children's to adult services (this includes young carers in transition and adult carers of young people in transition).

The Care Act's duty of cooperation makes explicit the requirement to ensure the cooperation of children and adult's services, particularly in order to smooth the transition from the former to the latter. The Framework too, states that eligibility for CHC should be identified early on, and provides a timetable designed to ensure that plans are in place before the young person's 18th birthday.

Practitioners from children and adult services (both health and social care) are expected to work together to ensure that outcomes and best value are maximised

For further guidance on support under the Care Act for those in transition, refer to the Statutory Guidance chapter 16. Similar guidance, as it applies to health-related support in transition, can be found within the National Framework for Children and Young People's Continuing Care, 2016.

Local aspirations and expectations in respect of preparation for adulthood, along with information about the local offer can be found here: <https://sendlocaloffer.nelincs.gov.uk/preparing-for-adulthood-and-transition-to-adult-life/>

#### **3.1.2.4 the Mental Capacity Act 2005 (MCA)**

Although statutory decisions are not decisions made by the individual seeking services, that individual's consent to the implementation of any such decision, or their refusal, is subject to the principles of the MCA; as such, the MCA underpins all micro-commissioning functions.

The MCA recognises that each individual is unique and will have different aspirations for their care. To reflect this diversity, the MCA is underpinned by key principles which enable a flexible approach to decision-making. Used well, these principles empower individuals to make their own decisions and protect those who lack capacity to do so. It also offers protection for care practitioners taking decisions on behalf of those who lack capacity.

Local MCA policy requires that care practitioners proactively consider an adult's capacity, and record whether they are acting in reliance on the statutory presumption of capacity, or where this is not appropriate, proceed to undertake a capacity assessment. Care practitioners must carefully identify the decision against which capacity is being assessed, and the factors relevant to it (i.e., what salient points the adult needs to understand, retain, use/ weigh in respect of that decision, in addition to being able to communicate that decision).

Care practitioners must show through their assessments, care plans and associated records how individuals are supported to maintain some control over their lives and to be involved in decisions about how their care is provided, as far as they are able. This includes consideration of less restrictive care options. Supporting individuals in a way that is reflective of the MCA's principles will include provision of statutory advocacy (via the MCA, Care Act, or MHA) where appropriate. Practitioners must evidence their consideration of statutory advocacy, including evidencing consideration of whether the informal support available to an individual is appropriate.

MCA principles are vitally important in determining, for example, whether a refusal of services is a capacitous refusal, or an incapacitous refusal which should be over-riden in the best interests of the individual, using the MCA for protection.

Care practitioners' attention is drawn to the case of Jackie Maguire (R (on the application of Maguire) v HM Senior Coroner for Blackpool and Fylde and Ors [2023] UKSC 20) which emphasises the importance of coordinated planning to ensure that incapacitous individuals with a history of refusing necessary care are nevertheless supported to access it. For more information on North East Lincolnshire's expectations in response to Jackie Maguire's case, please visit the local MCA policy at:

<https://www.northeastlincolnshireccg.nhs.uk/publications-1/>

### **3.1.2.5 the Equality Act 2010 (EqA)**

Anti-discriminatory practice is a fundamental part of ensuring an ethical basis for care provision, and critical to the protection of individual dignity. The EqA protects those receiving care from being treated unfairly on named grounds known as the 'protected characteristics'. The protected characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race (including ethnic or national origins, colour or nationality)
- religion or belief (including lack of belief)
- sex
- sexual orientation.

Direct discrimination occurs when an individual is treated less favourably than another in similar circumstances on the grounds of a protected characteristic. Indirect discrimination occurs when a condition or requirement is applied equally to everyone but some are unable to comply because of a protected characteristic; this is unlawful unless the condition or requirement is objectively justifiable. The EqA also prohibits harassment and victimisation.

The EqA applies to all delivering public services; following the principles within the EqA will enable care practitioners to ensure that individuals receive support that is respectful, inclusive and effective, and that they are able to access help which meets their needs and takes into account any which may arise as a result of one or more protected characteristics.

The Local Government Ombudsman (LGO) has helpfully summarised key EqA's requirements of care providers (and care practitioners) as being to:

- anticipate the needs of potential disabled service users; and

- make reasonable adjustments to enable disabled people to access services in a way that is as close as possible to the standard offered to the public at large. (<https://www.lgo.org.uk/decisions/adult-care-services/assessment-and-care-plan/20-000-835>).

### **3.1.2.6 the NHS Act 2006/ the Standing Rules/ the Framework**

Eligibility for CHC is determined by identification of a primary health need, by reference to four key characteristics of need (nature, intensity, complexity and unpredictability). Whilst the concept of wellbeing is not as developed in the Framework when compared with the Care Act, its practice guidance (paragraph 3.3) specifically references consideration for impact of need on wellbeing, to help identify the nature of the need. Consideration for wellbeing is therefore crucial for all practitioners.

As with social care, the process of CHC related decision making should be person centred. This means placing the individual, their perception of their support needs, and their preferred models of support at the heart of the assessment and care-planning process. When deciding how needs are met, the individual's wishes and expectations of how and where the care is delivered, should be documented and taken into account, along with the risks of different types of provision. Access to resources should be considered in a way that is fair and consistent.

Establishing that an individual's primary need is a health need requires a clear, reasoned decision, based on evidence of needs from a comprehensive assessment. A good quality assessment looks at all the individual's needs 'in the round', drawing on those who have direct knowledge of the individual and their needs. Care planning for needs to be met under CHC should not be carried out in isolation from planning to meet other needs. It is expected that, wherever possible, a single, integrated and personalised care plan will be developed.

### **3.1.2.7 the Human Rights Act 1998 (HRA)**

The HRA requires UK courts to give effect to a large part of the European Convention on Human Rights (ECHR). The HRA declares that it is unlawful for a public authority to act in a way which is incompatible with the ECHR. Convention rights include freedom from inhuman or degrading treatment (Art. 3), the right to freedom and security of person (Art. 5), the right to respect for private and family life (Art. 8) and freedom from discrimination (Art. 14). Article 8 rights to private and family life are particularly relevant where choices are being made regarding whether to support an individual in their own home, or in a residential setting. Interference with Convention rights must not be arbitrary or excessive, but must be necessary and proportionate to the legitimate aim pursued.

For example, in the case of an individual with a neurogenic bladder who needed to urinate frequently, it was contended that her right to live a dignified life under ECHR Article 8 required continued provision of a night-time care worker. The European Court of Human Rights agreed that this individual's needs could be met by provision of incontinence pads from the NHS; some interference with her rights was necessary and proportionate in the context of the legitimate aim of preserving public budgets (i.e., the local authority's budget). The implication is that Article 8, and perhaps by analogy the wellbeing principle, do not 'trump' properly made, proportionate decisions regarding allocation of scarce resources between service users. It should be noted that the local authority in this case went to considerable lengths to attempt to agree alternative forms of service provision with the individual (*McDonald v UK* 37 BHRC 130).



It is also worth noting that Article 8 of the ECHR does not guarantee individuals a right to a home, or the right to stay in their own home no matter what the cost of meeting their needs might be. Case law indicates however that it is not acceptable to make it a condition of meeting an individual's needs that they move from their own house/ flat into another house/ flat that they must rent or buy in order to have occupation rights. A similar approach might be taken to the notion of having live-in care in one's own home, or an employee to whom one owes legal duties: these are not services that can be foisted on an unwilling person/ property owner, even if it would save the ICB money, but these services may be funded with consent.

### **3.1.2.8 The Mental Health Act 1983 (MHA)**

Much help provided by local authorities for people with mental health problems is delivered via the Care Act. A small minority receive their services under s117 of the MHA; s117 imposes a duty for both local authorities and the NHS to provide (or arrange for provision of) services for people who have been detained under, and then discharged from, certain sections of the MHA. Aftercare services are those which meet need arising from or related to an individual's mental disorder and reduce the risk of deterioration in their mental health condition. Such services can therefore include micro-commissioned care. Once the duty under s117 has arisen, and services are provided, they must continue to be provided until such time as the ICB is satisfied that the need for such services no longer exists. Aftercare services are provided without charge.

The MHA Code of Practice offers some guidance on provision of aftercare. Local expectations can be found here: <https://livewell.nelincs.gov.uk/adult-health/>

### **3.1.2.9 the NHS Constitution**

The aim of the Constitution is to safeguard the principles and values of the NHS. The ICB is required by law to take account of the Constitution in its decisions and actions. The ICB must, in the exercise of its functions, act with a view to securing health services that are provided in a way which promotes the Constitution, and promotes awareness of it among patients, staff and members of the public.

The principles and values within the NHS Constitution are reflective of those in the Care Act, particularly in s1 (setting out the wellbeing principle). There are some obvious differences regarding the way NHS principles might apply to delivery of social care; for example, social care is not delivered free at the point of access, but is means tested. However, many NHS principles are equally pertinent, such as 'aspiring to the highest standards of excellence and professionalism', and 'providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources'.

The rights and responsibilities in the Constitution generally apply to everyone entitled to receive NHS services (including CHC and mental health), and to NHS staff. Whilst the Constitution may not apply directly to local authorities in which social care functions are not delegated, in North East Lincolnshire it is expected that its principles and values will apply to all micro-commissioning. Equally, whilst not all staff to whom this policy applies are NHS employees, each staff member is expected to consider how the Constitution's principles/ values might apply in their own setting.

## **3.3 The general principles against the backdrop of which the allocation of resources takes place**

### **3.3.1 Meeting needs v providing services**

The core purpose of care and support is to meet need in a way that helps adults to achieve the outcomes that matter to them. The concept of 'meeting needs' under the Care Act signifies

a shift from previous duties to 'provide services' and recognises that everyone's needs are different. Whilst the NHS is more likely to use the language of 'services', this refers to anything that can be commissioned or bought which will meet the individual's care and support needs.

There is no duty to achieve the outcomes that matter to adults; rather the duty is to assess whether the provision of care and support can contribute to achievement of those outcomes (see Davey, R (On the Application Of) v Oxfordshire County Council [2017] EWHC 354 (Admin), at paragraph 21; this is a Care Act case, but its principles are likely to be broadly applicable to CHC provision, which stipulates 'due regard' for the individual's preferred outcomes). Care practitioners are expected to take an asset-based approach in supporting individuals to consider how to achieve the outcomes that matter to them. Care practitioners **must** consider what else, other than (or in addition to) the provision of commissioned care and support, might help an individual to achieve their outcomes.

As with social care assessments, CHC assessments will include consideration of the individual's abilities as well as difficulties, reflect their views and aspirations, and focus on improved outcomes. Where a person qualifies for CHC, the package provided is that which the ICB assesses is appropriate to meet all of the individual's assessed health and associated care and support needs. Eligibility for CHC places no limits on the settings in which support can be offered or on the type of service delivery. Care practitioners should adopt creative, flexible approaches that reflect best practice. The package provided should maximise personalisation and individual control, and reflect the individual's preferences, as far as possible. The care planning process should also provide support for self-care so that people can self-manage their condition(s), where appropriate, and prevent deterioration.

Provision of mental health aftercare should support individuals in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital. Care planning is undertaken in partnership with the individual with needs, taking into account their needs and wishes. Plans should include proactive, preventative strategies to avoid deterioration in mental health, and set out how the individual will be supported to achieve their goals.

There are a range of options for meeting need, including referral to relevant and suitable universal or community resources, provision of 'traditional' commissioned services, use of direct payments to allow the individual to purchase their own care and support, or a combination of these. Care practitioners' reasons (in conjunction with those given by the individual) for rejecting other possible options, and choosing the one selected as being an effective, appropriate and reasonable way to meet need, must be evidenced.

Regardless of the legislative framework, whatever options are chosen in agreement with the individual, care practitioners must be satisfied that they are an effective, appropriate and reasonable way of meeting eligible needs and identified outcomes (see the Framework; regarding reasonableness, and the Care Act's Statutory Guidance 10.31/ 10.47. Regarding transparency and accountability in meeting need, see the MHA Code of Practice 34.3).

Where an individual is assessed as lacking capacity to contribute to choosing which options best meet their needs, care planning must be undertaken on the basis of the person's best interests, within the meaning of the MCA. Decisions should be made in ways that are less restrictive of the individual's rights and freedoms. Any restriction must be in the person's best interests, necessary to prevent harm to them, and represent a proportionate response to the likelihood and severity of that harm. North East Lincolnshire's MCA Policy offers a suite of tools to support capacity assessment and best interests decision making.

For further guidance regarding capacity, refer to the MCA, the Care Act's Statutory Guidance 10.59 – 10.72, and/ or the Framework's practice guidance paragraphs 5.6 – 10.5.

### **3.3.2 Wellbeing and the whole family approach**

Care practitioners are expected to consider how best to promote wellbeing when carrying out any of their functions under the Care Act, in respect of an individual. The Care Act describes wellbeing as relating to a number of areas, including (for example) control by the individual over the care and support they receive, the ability to engage in personal relationships and suitability of living accommodation. When considering wellbeing, the importance of independence should not exclude consideration of other factors. Care practitioners will need to weigh all factors in agreeing how to meet eligible need. There is no hierarchy, and all aspects of wellbeing should be considered in the round, as they relate to the individual.

The concept of wellbeing is not explored in detail in the Framework, although the importance of promoting it, and its impact on needs, is mentioned. The 'key elements of a person-centred approach' to CHC assessment and care planning are arguably less developed, but not unlike the Care Act's key principles and standards. CHC models must maximise personalisation and individual control, and reflect individual preferences, as far as possible.

A codified or defined concept of wellbeing does not feature in the MHA Code of Practice (which details expectations around mental health aftercare). However, aspects of wellbeing such as physical, psychological, emotional, cultural, spiritual and social needs (including housing, occupation and finance), are referenced. Having regard to the Care Act's concept of wellbeing when planning mental health aftercare is likely to support application of the MHA Code of Practice.

The assessment and care and support planning process, will identify how needs impact on wellbeing, and how resources could help the individual achieve their desired outcomes. This is an opportunity to consider holistically the individual's needs and preferences in the context of their wider support network. Utilising the whole family approach necessitates consideration of how the individual's needs impact on the wellbeing of those around them.

All care practitioners should be proactive in identifying carers and be sensitive to the level of support they need and desire. The Framework makes reference to being considerate of the impact of the adult's needs on others (including the risks posed to others by the adult's needs) and carefully considering whether the caring role is appropriate and sustainable. Involving the adult's carer(s) and family in decisions about care and treatment is a core component of the Framework and the Care Act. Similarly, the MHA Code notes that mental health aftercare planning should not place undue reliance on carer contributions.

Care practitioners will often have to undertake difficult balancing exercises when considering the key principles and standards associated with wellbeing, to which the Care Act states they must have regard. For example, the individual's wishes may sometimes conflict with those of their friends and family who are involved in caring for them. Consideration must be given to the needs of carers, and to the sustainability of the caring relationship.

Care practitioners are not entitled to *assume* that carers will provide care, but can create a care plan around what carers voluntarily agree to provide. The level/ type of support provided by a carer must be agreed with both the individual and carer and clearly recorded

in the individual's care plan. It must be made clear to the carer that they can request a review of the care they deliver at any time if they wish to withdraw the support they offer – carers cannot be forced to provide care which they are unwilling or unable to provide. Care practitioners should ensure that carers are not placed under unreasonable expectations. In directing their minds towards what is reasonable, practitioners are expected to consider all available evidence including evidence provided by carers themselves (R (on the application of Ali Raja and Ali Hussain) v London Borough of Redbridge [2020] EWHC 1456 (Admin)).

Practitioners may find the following guide on the whole family approach useful:

<https://www.local.gov.uk/sites/default/files/documents/care-act-and-whole-family-6e1.pdf>

### **3.3.3 Balancing outcomes and best value**

In determining how (rather than whether) to meet eligible needs, the law entitles the ICB to take into account its financial resources. It must also comply with its related public law duties, including ensuring that its available funding is sufficient to meet the needs of the entire local population i.e. the ICB must be cognisant of the impact that meeting individual needs has on the overall budget. The Care Act states that determination of how to meet need (rather than whether) may reasonably be balanced with consideration of budgetary requirements. The Framework also states that ICBs can take comparative costs and value for money into account when determining the model of support to be provided. Budgetary considerations include promoting independence and preventative interventions to reduce and delay needs, which in turn, reduces future demand on the ICB's budget.

When making micro-commissioning decisions under the Care Act, care practitioners are expected to evidence how they have *had regard to* the wellbeing factors set out at s1(3) of the Act when balancing outcomes and best value. The breadth of the meaning of wellbeing set out within the Care Act, and the obvious tensions between individual wellbeing (i.e. those with needs) and collective wellbeing (the requirement for budgets to support an entire community) heightens the importance of care practitioners evidencing reasoned and reasonable decision-making processes when determining how to meet need.

CHC packages should be high quality, offer choice and value for money, and be focused on outcomes. The Framework (paragraphs 177, 293, and practice guidance 49.1) recognises that a model of support preferred by an individual may be more expensive than other options; taking comparative costs and value for money into account when determining the model of support should include consideration of the following when doing so:

- The cost comparison of alternative models must be based on the genuine/ actual costs incurred in supporting an individual with their specific needs (and not on an assumed standard cost)
- Where an individual prefers to be supported in their own home, the actual costs of doing this should be identified on the basis of the individual's assessed needs and agreed desired outcomes
- Cost must be balanced against other factors in the individual case, such as the significance of their desire to continue to live in a family environment (Art.8 of the ECHR has considerable weight in any such decision to be made; for example, removing an individual from their family home may constitute an interference with family life and so must be justified as necessary and proportionate).

All decisions should be taken on a case-by-case basis, weighing up the total costs of different potential options for meeting needs; cost is a relevant factor in deciding between suitable alternative options for meeting needs. This does not necessarily mean choosing the

cheapest option, but the one which delivers the best outcomes for the best value in relation to the adult and the available budget at any given time. Consideration should also be given to treating similar cases in the same way in the interests of equity, within any one financial accounting period. Whilst not the sole, or necessarily primary consideration, financial matters are a key factor in reaching a conclusion on how to meet need.

For further guidance, refer to the Care Act's Statutory Guidance 10.27, and the Framework.

### **3.3.4 principles of public life**

As public servants, those undertaking micro-commissioning decisions on behalf of the ICB are expected to operate in accordance with the Seven Principles of Public Life, as set out within 'Standards Matter: a review of best practice in promoting good behaviour in public life' (published by the Committee on Standards in Public Life, 2013). These are:

- ✓ Selflessness: Holders of public office should act solely in terms of the public interest
- ✓ Integrity: Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships
- ✓ Objectivity: Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias
- ✓ Accountability: Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this
- ✓ Openness: Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing
- ✓ Honesty: Holders of public office should be truthful
- ✓ Leadership: Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

For more information, refer to: <https://www.gov.uk/government/publications/standards-matter-thirteenth-report-of-the-committee-on-standards-in-public-life>

This policy is also intended to draw the attention of practitioners to the principles of good administration espoused by the Parliamentary and Health Services Ombudsman ([Principles of Good Administration | Parliamentary and Health Service Ombudsman \(PHSO\)](#)) and by the Local Government Ombudsman ([Principles of Good Administrative Practice - Local Government and Social Care Ombudsman](#)).

## **4 Policy**

### **4.1 residential care**

Care in a residential setting represents an important option for those who prefer it, or whose needs can best be met within it. Care home placements are a vital component in the menu of choice on offer in North East Lincolnshire.

The ICB wishes to clarify its position regarding the respective merits of care home placements, when compared with care in an individual's own home. The ICB acknowledges that the concept of independence is a core part of the wellbeing principle outlined in the Care Act, and reflective of the objectives it has set out in the ICB Strategy/ Council Plan.

However, whilst supporting people to live as independently as possible for as long as possible remains a guiding principle for local provision, the ICB recognises that independence at home is not appropriate for all. It is not the ICB's policy to maintain such independence at all costs (i.e., financial cost or cost to wellbeing or cost to the legitimate expectations of paid carers for environmental safety) without regard to other factors. The ICB's approach is one of balancing the best interests of the individual with financial imperatives (see sections 3.1 - 3.3 above, regarding objectives and key considerations).

Where a care practitioner proposes to support an individual via a care at home (domiciliary) package that equates to a higher cost than the equivalent suitable available residential placement fee (including the costs of any carers' support and respite, but excluding the additional costs associated with two care worker calls), the practitioner must provide a rationale as to why this is justified (by reference to the factors set out within legislation, guidance, and this policy; see further 4.6.2 below), and present their case to the Individual Commissioning Approval and Advice Panel (ICAAP) and/ or the CHC Decision Forum for ratification. Similarly, where the cost of a residential placement is higher than the equivalent level of care available from a domiciliary package, the ICB expects the matter to be presented to ICAAP/ the CHC Decision Forum. The comparative costs of models of care provide a trigger for comprehensive consideration of options, but such is not intended as a blanket policy of not funding above a specific level.

## **4.2 supported living accommodation**

Supported living is a concept that was developed as an alternative to institutional care for people with disabilities. The supported living aspiration is that wherever possible, all people with disabilities, regardless of the level or type of disability, are able to make choices about how to live their lives, even if they do not make choices in conventional ways.

Supported living provision in North East Lincolnshire has been developed partly in response to the Winterbourne View scandal, and the resulting Government pledge to ensure appropriate community-based services for those with learning disabilities and/or autism. The ICB's policy position is to meet the needs of those for whom it is responsible within North East Lincolnshire as a first preference (where this is appropriate to meet individual need). The ICB accepts that where needs will be met under the Care Act, or MHA s117, this preference is subject to the rights set out within the Care and Support and Aftercare (Choice of Accommodation) Regulations 2014.

The person's benefits entitlement may need to be ascertained as part of prudent care planning with regard to rent and other property-based expenditure.

When considering supported living care practitioners must ensure the individual has the necessary mental capacity to enter into the required tenancy agreement, or if not, that they have a legally appointed representative to act on their behalf. In addition, practitioners must ensure that arrangements are in the best interests of the person after consideration of any less restrictive options. Appropriate protocols must be followed where deprivation of liberty issues might arise.

The ICB's expects practitioners and providers to focus on outcomes, personalisation and wellbeing, strengthening preventative support in the community to avoid crises and help support people to be active members of their communities. Services must comply with national policy and current best practice. Relevant CQC guidance has been revised and can be found here: [Right support right care right culture \(cqc.org.uk\)](https://www.cqc.org.uk/publications-and-reports/2023/04/2023-right-support-right-care-right-culture); it has links to the [national service model](#), the [national improvement plan](#) and [guidance](#).

### **4.3 extra care housing**

As with Supported Living, 'Extra Care Housing' (ECH) is a concept: those in ECH schemes have their own self-contained home, designed to support them to live independently and to self-care (as much as possible) for longer. They have legal rights to occupy their home underpinned by housing law, marking a clear distinction between ECH and residential care. For more information go to: <http://www.housinglin.org.uk/>

Working with partners the ICB opened its first ECH scheme for older people (aged 55+) in 2015, to provide 60 flats with care and support. A further such scheme providing 60 flats opened in 2020, and more schemes are in development.

The development and effective use of ECH is crucial in the ICB's plans for reshaping care provision for the increasing numbers of individuals with needs living in North East Lincolnshire, enabling them to live independently for longer in high quality, purpose-built accommodation, in their own community.

Issues regarding adequacy of benefits, tenancy validity, mental capacity, consideration of any less restrictive care arrangements and deprivation of liberty, mentioned above in the context of supported living, are equally pertinent to ECH.

Applications for ECH are considered regularly by the ECH Allocation Panel in accordance with agreed criteria. Expressions of interest can be made directly to either Strand Court or Burchester Court, or via the Single Point of Access (01472 256256).

### **4.4 choice of accommodation**

#### **4.4.1 choice of accommodation and top-up payments in adult social care**

Service provision in any setting must meet eligible needs, and be appropriate to the individual. The Care Act directs that where the care planning process has determined that an individual's care and support needs are best met in a care home, in supported living or ECH accommodation, they are entitled to choose their preferred accommodation, subject to certain conditions.

Where an individual is assessed as having care and support needs which require one of the above types of accommodation, they have a right to choose between different providers of that type of accommodation, if:

- the accommodation is suitable to their assessed needs
- the accommodation would not cost the ICB more than the amount specified in their personal budget for accommodation of that type (the personal budget amount usually equates to the ICB's standard rate for that accommodation)
- the accommodation is available; and
- the provider of the accommodation is willing to enter into a contract with the ICB to provide accommodation on the ICB's terms. In the case of a contracted placement the care may or may not be integral to the contract, and thus part of the price.

At least one appropriate vacant option must be available within the individual's personal budget, and *more* than one should be able to be identified, pursuant to Care Act guidance.

An individual must also be able to choose alternative options, including a more expensive setting than the amount identified for the provision of accommodation in their personal budget. Where the choice for a more expensive option is exercised, the care practitioner must arrange for the individual to be placed there, provided a third party or in certain circumstances the individual in need of care and support, is willing and able to pay the

additional cost (a 'top-up'). Choice of accommodation only applies to more expensive options if:

- the care practitioner is satisfied that the person paying the top-up is willing and able to do so for the likely duration of the individual's stay in the chosen accommodation
- the person paying the top-up enters into a written agreement with the ICB in which they agree to pay it.

Where choice rights do not apply, care practitioners must set out in writing why this is the case, and offer suitable alternatives (along with provision of information regarding the complaints procedure, and when/ if the decision may be reviewed).

In the context of choosing a setting, if a capacitous individual unreasonably refuses lawful options, care practitioners are entitled to consider that the Care Act duty to meet need has been discharged. The practitioner must inform the individual in writing that as a result, they will need to make their own arrangements. This is an option of last resort. Where a refusal arises from an individual's relatives, the care practitioner must consider whether the refusal amounts to a challenge to the legality or suitability of the alternative offered, or an obstruction of the individual's right to State-made arrangements. If the refusal by a relative amounts to such an obstruction, a referral to the Safeguarding Adult's Team may be required. Such refusal should not be accepted without further enquiry. In the case of a challenge to the legality or suitability of the offer (which is more likely), referral to the care practitioner's line manager will be necessary.

In North East Lincolnshire, compliance with Care Act duties in respect of top-ups is supported via use of the Top-ups Toolkit, which can be found via:

<https://livewell.nelincs.gov.uk/adult-social-care/choosing-adult-social-care-accommodation-and-paying-a-top-up/>

#### **4.4.1.1 defaulting on top-up payments in adult social care**

Defaulting on payment of the top-up may result in the individual's accommodation placement being terminated and alternative accommodation arranged. Where top-up payments default, the ICB will generally (acting via practitioners):

- negotiate with the accommodation provider to remove the top-up
- where this is not possible, move the individual to a room within the same accommodation that does not attract a top-up
- where this is not possible, move the individual to alternative accommodation that does not attract a top-up.

As always, cost is a relevant factor in deciding between suitable alternative options for meeting needs. This does not necessarily mean choosing the cheapest option, but the one which delivers the best outcomes for the best value in relation to the individual and the available budget at any given time.

Individuals who no longer have a person willing and able to pay the top-up, and/ or they are no longer able to pay it themselves (where certain circumstances apply), will generally only be enabled to remain in accommodation that attracts such a payment in exceptional circumstances. In deciding whether the circumstances are exceptional, care practitioners will weigh up the impact of any move on the individual's health and wellbeing (including consideration of their desired outcomes) against the cost of funding a more expensive placement, in conjunction with relevant stakeholders e.g., the individual's GP. This will



include identification of potential risks to the individual of any move, and the reasonable steps that may be taken to mitigate them. Concerns expressed by the individual and/ or their representative will be taken into account in assessing impact and risk. In broad terms, the higher the cost of the placement the greater the individual impact/ risk may need to be for it to become inappropriate to move the individual. Where a move is indicated, sufficient time must be allowed to enable the individual and/ or their representative to engage with the choices available. Practitioners are also reminded to consider MCA requirements and advocacy where relevant.

Arrangements for a different room or alternative accommodation will only be made after a) an assessment of need, b) an assessment of impact/ risk re health and wellbeing (including consideration of outcomes), c) identification of suitable alternative accommodation to meet assessed eligible need, carried out in accordance with Care Act requirements. This includes providing opportunities for input from the individual and/ or their representative, and relevant stakeholders. In making their assessments, care practitioners will take into account best practice guidance on managing the risks associated with moving care home, such as that in the Age and Aging Report 2011: <https://academic.oup.com/ageing/article/40/5/534/46619>. Such guidance reminds practitioners that any proposal to move an individual engages their rights under the ECHR (in particular Arts 2 and 8). Practitioners must actively consider as part of their impact assessment the positive obligations imposed by the ECHR, and ensure that any interference with rights is necessary and proportionate in pursuance of a legitimate objective.

Care practitioners will attend ICAAP for a comprehensive discussion of the individual's situation before any decision regarding exceptional circumstances is made.

#### **4.4.2 choice of accommodation and s117 of the MHA**

All references to a personal budget in this section are taken to include the local mental health aftercare usual cost guideline (when arranging s117 aftercare under the MHA). Whilst there are differences in approach to choice of accommodation and top-ups where care is being provided under s117 of the MHA, broadly, the same principles apply and a capacitous adult cannot be prevented from spending their own money on meeting their own or their relative's needs, as they deem appropriate.

Defaulting on a top-up for a placement made as part of mental health aftercare provision will be managed in the same way as set out at 4.4.1.1 above, paying particular attention to the impact of any move on the individual's mental health.

#### **4.4.3 choice of accommodation and individuals funding their own social care**

The ICB has negotiated a standard rate with providers. Where an individual able to fund their care arranges their own placement in accommodation that costs more than the ICB's standard rate, and the individual subsequently becomes entitled to means tested support, the ICB will follow the approach set out above in relation to top-up defaults. In other words, and on the assumption that there is no other person willing and able to pay the difference between the individual's funded rate and the ICB's standard rate on behalf of the individual, the ICB will generally (acting via practitioners):

1. negotiate with the accommodation provider to pay no more than the ICB's standard rate for the existing room
2. where this is not possible, move the individual to a room within the same accommodation that does not attract more than the ICB's standard rate

3. where this is not possible, move the individual to alternative accommodation that does not cost more than the ICB's standard rate.

Individuals who are no longer able to fund their own care, and have no one willing and able to pay the difference between the rate the individual has been paying and the ICB's standard rate, will generally only be enabled to remain in accommodation which costs more than the ICB's standard rate in exceptional circumstances. As set out above (4.4.1.1) in deciding whether the circumstances are exceptional, care practitioners will weigh up the impact of any move on the individual's health and wellbeing (including consideration of their desired outcomes) against the cost of funding a more expensive placement, in conjunction with relevant stakeholders e.g., the individual's GP. This will include identification of potential risks to the individual of any move, and the reasonable steps that can be taken to mitigate them. Concerns expressed by the individual and/ or their representative will be taken into account in assessing impact and risk. In broad terms, the higher the cost of the placement the greater the individual impact/ risk may need to be for it to become inappropriate to move the individual. Where a move is indicated, sufficient time must be allowed to enable the individual and/ or their representative to engage with the choices available. Practitioners are also reminded to consider MCA requirements and advocacy where relevant.

Arrangements for a different room or alternative accommodation will only be made after a) an assessment of need, b) an assessment of impact/ risk re health and wellbeing (including consideration of outcomes), c) identification of suitable alternative accommodation to meet assessed eligible need, carried out in accordance with Care Act requirements. This includes providing opportunities for input from the individual and/ or their representative, and relevant stakeholders. In making their assessments, care practitioners will take into account best practice guidance on managing the risks associated with moving care home, such as that in the Age and Aging Report 2011: <https://academic.oup.com/ageing/article/40/5/534/46619>. Such guidance reminds practitioners that any proposal to move an individual engages their rights under the ECHR (in particular Arts 2 and 8). Practitioners must actively consider as part of their impact assessment the positive obligations imposed by the ECHR, ensuring any interference with rights is necessary and proportionate in pursuance of a legitimate objective.

Care practitioners will attend ICAAP for a comprehensive discussion of the individual's situation before any decision regarding exceptional circumstances is made.

For further guidance, refer to the Care Act's Statutory Guidance Annex A, the Care and Support and Aftercare (Choice of Accommodation) Regulations 2014.

#### **4.4.4 choice of accommodation (social care/ mental health aftercare) and settings/ providers with which the ICB has no contract**

Choice of accommodation should not be limited to settings/ providers with which the ICB already contracts. However, an individual's chosen provider must be willing to contract on the ICB's terms and conditions for choice of accommodation rights to apply.

The ICB's approach to more expensive social care placements is set out at 4.4.1.1 (in respect of defaulting on top-up payments) and 4.4.3 (in respect of individuals funding their own care). A similar approach on these topics is taken to s117 placements (4.4.2). This section sets out the ICB's approach where no contract is in place between the ICB and the individual's chosen provider.

The ICB will not generally support the placement of individuals in settings/ with providers with which it has no contract. However, where prior to the ICB's involvement the individual is already accommodated in a setting/ with such a provider, the ICB will:

1. use its best endeavours to agree a contract on its terms and conditions, at least in relation to the relevant individual
2. where this is not possible, move the individual to alternative accommodation, in a setting/ with a provider with which the ICB does have a contract.

Individuals will only be enabled to remain with a non-contracted provider in exceptional circumstances. Care practitioners will undertake a similar weighing up exercise as described at 4.4.1.1 and 4.4.3, taking into account the factors listed therein. Of particular relevance in this context may be the risks to the individual of staying in a placement over which the ICB may have limited influence and oversight, due to the lack of a contractual relationship. The standard of care available to the individual from a non-contracted provider, the provider's record of CQC inspections and latest CQC rating will be factors to take into consideration.

Where a move is indicated, the steps at 4.4.1.1 and 4.4.3 will be followed (i.e. no moves will be undertaken without an assessment of need, an assessment of impact/ risk, and identification of a suitable alternative) and the matters set out therein taken into account. Again, all discussions and decision making will involve ICAAP.

#### **4.4.5 choice of accommodation and particular CHC considerations**

Whilst eligibility for CHC does not mean an absolute right to a particular care home, or to care within the individual's own home, individuals should be offered only suitable options for consideration. Care practitioners should be prepared to discuss with individuals the clinically related advantages or disadvantages of each option. Whilst the starting point for decision-making should be the individual's preferences within what is clinically suitable, there may be a range of reasons why such preferences cannot be met (including funding constraints).

The CHC care package provided should meet the individual's health and associated social care needs as identified in their care plan. The decision to purchase additional private care services, or higher cost care, should always be a voluntary one for the individual.

Individuals may choose a residential home which is more expensive than the amount specified in their personal budget, provided it is possible to separately identify and deliver the NHS-funded elements of the service. Additional sums to be paid must relate to extra services or facilities, or an identifiably different standard with regard to the environment, or care ratios preferred by the individual, rather than merely to meet assessed needs which the NHS is obliged to meet. The financial arrangement for payment of additional sums is entirely a matter between the individual making the payments and the relevant provider and should not form part of any financial agreement between the ICB and the provider.

There may be circumstances where care practitioners should contemplate paying a higher than usual CHC cost, where the need is for identified clinical reasons. The Framework (paragraph 285) gives other examples of where paying higher costs should be considered, including where the individual has lived in a higher cost home for many years and would suffer significant detriment if moved. Where significantly higher costs are requested, and where there is no acceptable clinical rationale, CHC practitioners have a responsibility to consider alternative options.

The matters set out at 3.1 – 3.3 above should be taken into account, including comparative costs and value for money considerations. Where there is no justification for funding a higher cost placement, care practitioners will follow the approach set out at 4.4.1/3 above i.e., negotiation, relocation within the home, or as a last resort, relocation outside of the home). In addition to the matters at 4.4.1/3 above, care practitioners should note the Framework's (paragraph 288) reference to developing a transition care plan between the existing and new provider which identifies key needs and preferences, and how specific needs and risks will be managed during the transition process. For further guidance see the Framework (paragraph 270 onwards).

As noted at 4.4.4 above in respect of social care funded placements, the ICB will not generally support the placement of individuals in settings/ with providers with which it has no contract. The ICB will follow the approach set out at 4.4.4 above in respect of CHC placements, taking into account the requirements of the Framework (for example, by developing a transition plan, as referenced in the preceding paragraph).

The ICB expects any decisions on higher cost placements or placements with non-contracted settings or placements, to be presented to ICAAP/ the CHC Decision Forum before a decision is made.

Decisions regarding accommodation provision should be provided in writing, with reasons. Where an individual wishes to dispute a decision, they should do this via the ICB's complaints process.

## **4.5 out of area placements**

### **4.5.1 out of area placements in adult social care/ mental health aftercare**

It is the ICB's intention to facilitate a range of quality local provision, able to meet a variety of needs within North East Lincolnshire. However, choice of accommodation made under the Care Act or s117 of the MHA must not be limited to those settings or providers with which the ICB already contracts, or those that are within its geographical boundary. Individuals must be able to make a genuine choice across provision which is appropriate to their needs.

If an individual chooses to be placed in a setting that is outside the ICB's area, the Care Act states that the care practitioner must still arrange for their preferred care (subject to the conditions set out at 4.4.1 above). In responding to requests for out of area placements, care practitioners should *have regard to* the cost of care in the chosen area when setting the individual's personal budget. The personal budget is defined as the cost to the ICB of meeting the individual's care and support needs which it is required (or chooses) to meet. The practitioner should take into consideration circumstances where this cost to the ICB may need to be adjusted to ensure that needs are met.

Care and support should improve connections to family, friends and community. Maintenance of relationships with important others will be a priority outcome for many individuals. Where it is agreed that *needs* should be met by an out of area placement nearer to the individual's important others, arrangements should be made to effect this, and the personal budget should be adjusted to reflect the usual cost of care in the area in which the individual's needs are to be met.

Conversely, whilst care practitioners must do everything they can to take into account individual circumstances and reasonable preferences when arranging care, there may be occasions when preferences cannot be met (subject to the conditions set out within the Choice of Accommodation Regulations). Lack of any suitable setting where the needs *can* be met, for instance, would negate a right to choose a preferred area.

Where an out of area placement is an individual's desire, rather than a necessity to meet their needs, the individual still has a right to choose that out of area accommodation, and again care practitioners must *have regard* to the cost of accommodation in the area when setting the personal budget. Whilst regard for individual circumstances might justify departure from ICB expectations, the ICB expects that in most cases in which an out of area placement relates to a 'want' rather than an assessed eligible need, the personal budget will be calculated on the basis of no more than the usual cost to the ICB of providing accommodation in North East Lincolnshire ('the ICB's standard rate'). This may mean that unless a third party (or in certain circumstances the individual in need of care and support) is able and willing to pay the additional cost (i.e. the difference between the ICB's standard rate and the full contractual cost of the desired out of area accommodation), an out of area placement is unlikely to reflect an appropriate balance between outcomes and best value. Care practitioners are expected to evidence how they have *had regard* to the factors set out at s1(3) of the Care Act when approaching decisions on out of area placements.

NB all out of area placements must be approved by ICAAP before a final decision is made.

#### **4.5.2 out of area placements and particular CHC considerations**

There may be circumstances where an individual requests an out of area placement, at a higher cost than the ICB would usually meet for the person's needs. Such cost may be reasonable taking into account the market rates in the locality of the placement, established in liaison with the ICB where the placement is located. In such circumstances care practitioners should consider whether there are particular circumstances that make it reasonable to fund the higher rate, for example, because the location of the placement is close to family members who play an active role in the life of the individual. If making such a placement is required to meet need, the higher amount should be paid. Where a more expensive placement out of area is merely desired (for example: "I've no connections there but I've always rather fancied retiring to Bournemouth") rather than necessary to meet need, it is unlikely that such a placement would represent an appropriate balance between outcomes and best value.

Formal choice rights do not apply to CHC. However, such placements may be considered at the ICB's discretion where the individual or other reliable source is able and willing to pay the difference between the ICB's standard rate (defined above) and the full contractual cost of the desired out of area accommodation.

NB all out of area placements must be approved by the CHC Decision Forum before a final decision is made.

### **4.6 care at home (domiciliary care)**

#### **4.6.1 choice of care at home**

There is no legal right in the Care Act, CHC Framework or MHA for a service user to compel the ICB to discharge its duties to meet need through a particular preferred provider. Direct payments enable a person, capacitous or otherwise, (in the latter case as long as there is a suitable third party to take on the role of the Authorised Person) to exercise choice through taking on personal responsibility for commissioning, if so desired.

The ICB has adopted a lead provider model to support viability and sustainability in the local domiciliary care market. The default position is that care practitioners will call upon the lead provider responsible for the geographical area within which the individual requires support. This will promote consistency and efficiency in service provision. It is accepted that use of the geographically relevant lead provider will not be appropriate in all circumstances.

The following exceptions to the default position can be considered:

- Where temporary provider capacity issues necessitate care practitioners calling on alternatives. In such circumstances, first consideration should be given to micro-commissioning with another lead provider, or an approved provider
- Where there are particular personal circumstances which result in an individual not wishing to use the geographically relevant lead provider e.g., due to family issues or previous difficulty with that provider. Again, it is expected that care practitioners will micro-commission with another lead provider in the first instance, or an approved provider.

Exceptions will be agreed with the care practitioner's head of service or the Chair of ICAAP/ CHC Decision Forum (depending on who may be available in the circumstances).

#### **4.6.2 higher cost care at home – first considerations**

In all cases, care practitioners must consider what care can best meet an individual's needs, and what budget reasonably reflects the costs of meeting those needs. Those costs must be based on actually available options. As already noted at 4.1, where a practitioner proposes to support an individual via a care at home package that equates to a higher cost than the equivalent suitable available residential placement fee (including the costs of any carers' support and respite, but excluding the additional costs associated with two care worker calls), the practitioner must provide a rationale as to why this is justified (by reference to the factors set out within legislation, guidance, and this policy), and present their case to ICAAP and/ or the CHC Decision Forum for ratification.

**For the avoidance of doubt, all decisions in this section (4.6.2, 4.6.2.1, 4.6.2.2 and 4.6.2.3) will be taken in conjunction with ICAAP and/ or the CHC Decision Forum.**

Blanket or arbitrary approaches must be avoided. The comparative costs of models of care – care at home v residential care – simply provide a trigger for comprehensive consideration of options. The focus in this section is on appropriate considerations where the cost of available care at home is higher than available residential care.

The default position for all support planning is the promotion of independent living. However as noted at 4.1, independent living may not be appropriate in all circumstances. Where, for example, an individual cannot be safely and cost effectively accommodated in their own home, it may be that only residential care options are viable.

The strong presumption in favour of independent living which arises from Art.8 is the starting point for local decision-making, but does not exclude consideration of other factors.

Decisions regarding care setting will be taken:

- a) following thorough assessment of individual needs, combined with consideration of the impact of those needs on the health and wellbeing of the individual (and on that of their relevant others, e.g., family members, carers etc) and the degree to which care and support can help the individual to achieve their desired outcomes
- b) on the basis of clear evidence regarding actual cost comparisons of available options i.e., regarding the difference in cost between an available care home and an available care at home package, which meet the individual's needs; and
- c) with regard for enabling independence for as long and as fully as possible, and in a way that recognises the desirability (at least in some cases) of living with a level of risk. In seeking to balance independence with safety, practitioners will be particularly mindful of rights under the ECHR and CPRD (especially Arts 8 and 19

respectively), consideration of less restrictive approaches as required by the MCA (where relevant), and the objectives in the ICB Strategy/ Council Plan.

In conjunction with the above, decisions will be directed by professional judgement of risk – to the individual’s safety and to their wellbeing. Emphasis will be on holistic, sensible risk appraisal, which does not strive to avoid all risk, but seeks a proper balance which tolerates manageable or acceptable risks as the price to be paid to achieve another ‘good’ i.e., to promote individual wellbeing. Although the following statement was made in the context of care arrangements amounting to a deprivation of liberty, the judicial sentiments expressed may be equally pertinent to decisions about all care: “What good is it making someone safer if it merely makes them miserable?” (In the matter of MM, [2007] EWHC 2003 (Fam)). Whilst an individual’s wishes, feelings and preferences will not be determinative, they will be a crucial factor to be taken into account in all decision making.

The considerations in this section apply equally to those with and without relevant decision-making capacity. Where individuals lack relevant capacity, best interests decisions will be made in accordance with the MCA’s s4 ‘checklist’, taking account of this policy.

#### **4.6.2.1 risk and refusing to support care at home**

In *Community Care and the Law*, Luke Clements offers useful guidance where practitioners are seeking to work with individuals to manage the risk attached to them remaining at home (sixth edition, paragraph 2.38). He quotes Department of Health guidance from 2007 which states in relation to negligence that “an individual who has the mental capacity to make a decision and chooses voluntarily to live with a level of risk, is entitled to do so. The law will treat that person as having consented to the risk and so there will be no breach of the duty of care by professionals or public authorities. However the local authority remains accountable for the proper use of its public funds, and whilst the individual is entitled to live with a degree of risk, the local authority is not obliged to fund it” (paragraph 2.26).

The starting point for decision making is the individual’s needs, impact on health/ wellbeing and desired outcomes, on the basis that capacitous individuals may choose to live with some level of risk. However, where outcomes and risks to an individual and/ or their relevant others cannot be appropriately managed and balanced within the available budget (taking into account the actual costs of providing support to the individual and to any informal carer, and excluding the additional costs associated with two care worker calls), individuals will be offered a residential placement. Such an offer will be accompanied by cogent reasons underpinning the decision to make this offer. This includes a clear explanation of how decisions have been reached as to the level of personal budget offered.

In the context of balancing independence with cost effectiveness, Clements (*supra*, at 2.51) references the case of *R (Khana) v Southwark LBC* [2001] EWCA Civ 999. Here the court noted that a certain degree of risk taking is often acceptable to preserve independence and/ or avoid family breakup; however, where an authority concludes that an individual’s needs can only be met in full time residential care, and “makes a corresponding offer, and where the assessment and the reasonableness of the offer cannot be challenged as such, then the local authority has in my judgement satisfied its duties under the legislation” (paragraph 56). This was a pre-Care Act/ Framework case, but its principles are likely to remain relevant.

It should be noted that before any capacitous individual can be regarded as having sufficient information to choose to accept or reject the offer of a residential placement, the individual must be provided with clear details of all the practicable support that would or might be available if they continue to refuse the offer, and remain in their own home. It is not possible to find that an individual lacks capacity to choose unless they have been provided

with the information they need to make an informed decision, and all reasonable steps have been taken to maximise the prospect of them being able to make an informed decision.

Again, the considerations in this section apply equally to those with and without relevant decision-making capacity. Where individuals lack relevant capacity, best interests decisions will be made in accordance with the MCA's s4 'checklist', taking account of this policy. Care practitioners may wish to refer to the case of Manuela Sykes for guidance on approaching an incapacitous individual's wish to accept the risks of staying at home ([\[2014\] EWCOP B9](#)). Of particular interest – in respect of capacitous as well as incapacitous individuals - may be the judgement's references to planning for critical periods of a trial of care at home to establish viability, in section 10, 'Summary' (from inception of the trial, to the review of it at one month, and 4-6 months).

#### **4.6.2.2 using the costs of a residential placement towards care at home**

It is not likely to be unlawful in a public law sense to refuse to meet an individual's needs in their own home (even though it would be possible if money were no object), as long as there is another appropriate and lawfully defensible way of meeting need (*A Local Authority v X* [2016] EWCOP 44) and human rights and mental capacity issues are grappled with.

The X case suggests that the law does not necessarily support offering an individual the cost of the cheaper method (nursing care in a residential setting) for use in a more expensive setting (X's own home) without regard to *how the individual would use that cost*. As the court noted in the X case, "if the local authority are unwilling or unable to fund a safe package of care within his own home, there is no other person who can, or will do so, the required safe level of care simply will not be available for him in his home" (paragraph 26). The court went on to suggest that X could ask what minimum and lesser level of care the local authority would be willing to fund if X returned home, but warned that the authority may refuse to fund care on the basis proposed by X, if they considered the situation so unsafe that they would not be willing to participate in it (paragraph 27).

Where a capacitous individual rejects and/ or objects to the offer of a residential placement, taking into account their wishes and feelings, consideration will be given to the following:

- a) on the basis of a thorough assessment of need and impact (including taking into account the individual's desired outcomes), the minimum safe level of care at home on which the individual could reasonably and desirably (by reference to the considerations set out in legislation, guidance, and this policy) manage. Safe levels of care will be considered by reference to the nature and strength of the evidence of the risk of harm (i.e., its likelihood and seriousness) to the individual and any relevant others, such as an informal carer living in the same home. In collating such evidence, practitioners may approach those interested in the individual's welfare (with consent) personally and/ or professionally, to secure a rounded, comprehensive assessment. The availability of wider resources in the form of (for example) GP support, district nursing, equipment and occupational therapy, community matron support, assistive technology and voluntary sector help such as Meals on Wheels, will also be factored into the assessment
- b) the difference between the residential placement offered, and the minimum safe level of care at home, both in terms of its value, and the quantity, quality and type of care available;
  - i. With regard to the financial difference, whether there is any individual willing and able to meet that difference, and if so, whether that represents a suitable and sustainable option. NB suitability and sustainability will be judged by



practitioners. Potential contributors may be required to evidence the affordability of their contribution for the foreseeable duration of the individual's receipt of care at home (or any reasonable, shorter period), and to sign a written agreement which recognises each party's responsibilities and the implications for the individual should contributions cease (based on the approach to top-ups in residential accommodation, which can be found at <https://livewell.nelincs.gov.uk/adult-social-care/>)

- ii. With regard to the difference in quantity, quality and type of care available, whether there is any individual willing and able to deliver that care informally i.e., not in a paid, professional capacity, and if so, whether that represents a suitable and sustainable option. NB although suitability and sustainability will be judged by practitioners, no assumptions must be made as to a carer's willingness. The cost and availability of appropriate training and support to enable a willing person to deliver informal care will be considered. Understanding the impact on the informal carer, and the sustainability of the caring relationship will be crucial; such will be subject to careful assessment, care planning (including contingency planning) and regular review.

Note that "Before a local authority seeks to invoke the court's powers to compel a family to place a relative in a residential care home, the court is entitled to expect that the authority will have made a genuine and reasonable attempt to carry out a full assessment of the capacity of the family to meet the relative's needs in the community" (LLBC v TG, JG and KR 1997-8 1 CCLR QBD referenced by Clements, supra at 2.43/44. This was a pre Care Act/ Framework and pre MCA case, but its principles are likely to remain relevant).

Again, the considerations in this section apply equally to those with and without relevant decision making capacity. Where individuals lack relevant capacity, best interests decisions will be made in accordance with the MCA's s4 'checklist', taking account of this policy.

#### **4.6.2.3 refusing to fund care at home: next steps**

Care practitioners are urged to avoid an excessive focus on risks. However, where the considerations above do not result in care practitioners feeling satisfied that the individual can remain at home with an acceptable level of risk (having taken into account all available options in the individual's particular circumstances), and the individual and/ or their relevant others continue to reject/ object to the reasonable offer of a residential placement, then a referral will be made via ICAAP and/ or the CHC Decision Forum for a director level opinion. This is to ensure that all possible alternatives have been explored before further action is taken. Drawing on legal advice and making whatever other enquires the director considers necessary, the director may decide that:

- a) Where the individual is capacitous, the ICB will not consider itself under any obligation to fund a situation which care practitioners do not reasonably believe to be safe or within acceptable margins of risk, and may regard itself as having discharged its obligations to the individual while the refusal is maintained. In some circumstances, the ICB may seek the sanction of the court before regarding itself as discharged. In all cases, the individual's situation will be kept under regular review and the offer repeated in the hope that in time, the individual may be more willing to accept it. The regularity of the review will be directed by the level of risk of harm to the individual and/ or their relevant others, such as an informal carer living in the same home
- b) Where the individual is incapacitous, the ICB will make an application to the Court of Protection for:

- i. An order giving effect to its best interests decision (where the individual has no appointed decision makers) to move the individual to a residential placement; or
- ii. An order that, notwithstanding the decision of an appointed decision maker not to move the individual to a residential placement, such a move is in fact in the individual's best interests.

Care practitioners are reminded that the high-risk protocol (accessible via <https://www.safernel.co.uk/information-for-practitioners/safeguarding-adults/>) should be utilised where a capacitous individual's situation directs it. The protocol is applicable to highly complex cases where other mechanisms for risk management may have failed, and in respect of which a) a high-risk panel may reduce the risk of serious harm and/ or b) provide enhanced opportunity for formal consultation with wider professionals.

NB funding will only be refused, and/ or court applications will only be made, where there appears to be no other way of resolving the matter, and efforts to reach agreement by consensus have failed. These situations are anticipated to be exceptional, and every effort must be made to work with individuals to avoid them. Where such is unavoidable, the ICB will make its position clear, in writing, and with reasons.

#### **4.7 intermediate care, reablement and recovery**

Promotion of preventative interventions (commissioned or otherwise) on every appropriate occasion is crucial to supporting the citizens of North East Lincolnshire to remain healthy and independent for as long as is possible. Intermediate care and reablement support services are free at the point of delivery in accordance with the regulations below, for up to six weeks (these support services may be provided for longer than six weeks, but not necessarily without charge). Exit from such services should not be automatically linked to the pre-planned duration but should be properly considered by practitioners.

The Care and Support (Preventing Needs for Care and Support) Regulations 2014 define intermediate care and reablement as facilities or resources which —

- a) consist of a programme of services, facilities or resources
- b) are for a specified period of time; and
- c) have as their purpose the provision of assistance to an adult to enable them to maintain or regain the ability needed to live independently in their own home.

The Care Act's Statutory Guidance quotes the National Audit of Intermediate Care's four categories of intermediate care:

- crisis response – services providing short-term care (up to 48 hours)
- home-based intermediate care – services provided to people in their own homes by a team with different specialities, but mainly health professionals such as nurses and therapists
- bed-based intermediate care – services delivered away from home, for example, in a community hospital; and,
- reablement – services to help people live independently, provided in the person's own home by a team of mainly care and support professionals.

Intermediate care services provide a link between places such as hospitals and individual's homes, and between different areas of the health and care and support system – community services, hospitals, GPs etc. Local intermediate care provision comprises:

- Specialist bed-based care at Cambridge Park Community Inpatient Unit

- Enhanced recovery beds providing rehabilitation, reablement, recovery and further assessment
- Intermediate care at home – supporting individuals to access reablement and rehabilitation in their own home.

NICE (National Institute for Health and Care Excellence) guidance (NG74) states that care practitioners should assess individuals for intermediate care if it is likely that specific support and rehabilitation would improve their ability to live independently and they:

- are at risk of hospital admission or they have been in hospital and need help to regain independence, or
- are living at home and having increased difficulty with daily living through illness or disability.

Individuals must not be excluded from intermediate care based on whether they have a particular condition such as dementia or live in particular circumstances such as residential care or temporary accommodation.

The Care Act's Statutory Guidance distinguishes intermediate care from the provision of short-term care in residential accommodation; it states that temporary care could be for a number of reasons such as providing respite for a carer.

A temporary resident is defined (for charging purposes only) as a person whose need to stay in a care home is *intended* to last for a limited period of time and where there is a plan to return home. The individual's stay should be unlikely to exceed 52 weeks, or in exceptional circumstances, unlikely to substantially exceed 52 weeks. A decision to treat an individual as a temporary resident must be agreed with them and/or their representative and written into their care plan.

For further guidance, refer to the Care Act's Statutory Guidance, chapter 2 (especially 2.12 – 2.14) and Annex F.

#### **4.8 day care opportunities**

Following a re-modelling exercise, day care services may look different from the way in which they were previously configured, and may not cater for all on the same basis as before; however, the ICB's expectation is that sufficient day care sessions have been retained to meet current eligible demand.

It should be noted that day care opportunities are not suitable for all individuals. The ICB's expectation is that care practitioners will look to services within the community to support individual need, subject always to a needs analysis, with new referrals to day care opportunities being the exception rather than the rule.

#### **4.9 personal budgets and direct payments**

While different regimes govern the use of health and social care funding, the Department of Health and Social Care is clear that consistent principles should be applied within local policies for personal budget (including personal health budget) expenditure, to support people to make decisions that are right for them.

The personal budget is the mechanism that, in conjunction with the care and support plan, enables individuals to exercise greater choice and control over how their needs are met. It is vital that the process used to establish the personal budget is transparent so that individuals are clear how and by what method their budget is calculated, so they can have confidence

that the allocation is correct and sufficient to meet needs. The Care Act's statutory guidance states that the most important principles in setting the personal budget are transparency, timeliness and sufficiency (paragraph 11.24). Practitioners are reminded that "any failure to provide a transparent budget in a care and support plan represents a prima facie breach of [Care Act] duty which in my judgment would be susceptible to legal challenge by way of [Judicial Review]" (R (on the application of CP) v North East Lincolnshire Council [2019] EWCA Civ 1614, paragraph 79). NHS guidance reiterates the importance of sufficiency and transparency in calculating personal budgets (see for example Guidance on the Legal Rights to Personal Health Budgets, 2019, paragraph 5.1).

There are various ways in which personal budgets may be managed and delivered to individuals. The term 'direct payment' is used in this section to refer to delivery of either a personal budget for social care, or a personal health budget; this includes budgets delivered via s117 of the MHA. When determining with an individual how to meet needs, care practitioners must inform them which (if any) of their needs may be met by a direct payment. This information should assist the individual to decide whether they wish to request a direct payment to meet some or all of their needs.

However the individual's needs are to be met, the care practitioner must satisfy themselves that it is an appropriate way of doing so (appropriateness is for the care practitioner to determine, taking into account all relevant factors). When an individual requests a direct payment, whether this is appropriate to meet need must be determined with reference to the matters set out within this policy, including by reference to outcomes and value for money. Reference must also be made to the local Direct Payment Policy which can be accessed at <https://www.northeastlincolnshireccg.nhs.uk/publications-1/> and provides greater detail regarding the matters practitioners are expected to take into account.

#### **4.10 supporting those with assets above the financial limit**

The Care Act clarifies legislative responsibilities in respect of those who must fund their own care and support needs because they have assets above the financial limits set out within the Care and Support (Charging and Assessment of Resources) Regulations 2014. The following are particularly pertinent (with Care Act section reference numbers):

- The duty to promote wellbeing applies when carrying out any function under part 1 of the Care Act in respect of an individual. The duty applies equally to those who have no eligible needs and regardless of resources (see s1)
- The duty to provide/ arrange for preventive services applies to all adults including those without current or eligible need and regardless of resources. Those with assets above the financial limit are entitled to access intermediate care and reablement support services to meet need (see s2 and the Care and Support (Preventing Needs for Care and Support) Regulations 2014)
- Information and advice provision must meet the needs of the whole population, not just those who are in receipt of commissioned services. Access to information and advice (including financial information and advice) is fundamental to making well-informed care and support choices (see s4)
- The duty to ensure the care and support market provides a variety of high-quality services is intended to benefit any person wishing to access those services (see s5)
- All adults with an appearance of need for care and support and carers with an appearance of need for support are entitled to an assessment, regardless of the level of their resources, or need (see s9)

- Assuming that an individual is assessed as having eligible care and support needs, and is ordinarily resident in North East Lincolnshire (or is present here, but of no settled residence), those with assets above the financial limit who are seeking access to chargeable services can ask the ICB to meet their needs. Care practitioners must accede to this request unless it is anticipated that the needs of the person with assets above the financial limit will be met by a care home placement (NB there is an administration charge for making the requested care at home arrangements on behalf of anyone capacitous who has assets above the financial limit). Where an individual lacks capacity to arrange their own care and support (whether within a care home or otherwise) and has no one authorised and/ or willing to make arrangements for them, care practitioners must arrange to meet their needs (see s18, and the Care Act's Statutory Guidance 8.13, 8.55 and 8.56). Practitioner requirements when making care home placements under s18(4) are set out at Appendix Two
- Safeguarding duties apply to all adults with care and support needs who are experiencing (or at risk of experiencing) abuse or neglect, and who as a result of their care and support needs, are unable to protect themselves (see s42)
- There is a duty to ensure needs for care and support are met temporarily where a registered care provider fails in the circumstances set out within the Care and Support (Business Failure) Regulations 2014 (see s48)
- The duty to arrange for an independent advocate applies for all adults on assessment, care planning, care plan revision, or safeguarding enquiry or review, where the adult has substantial difficulty in being involved in these processes and has no one appropriate to support them (see s67 and 68 and the Care and Support (Independent Advocacy Support) (No. 2) Regulations 2014).

North East Lincolnshire's Charging Policy which sets out the principles and framework within which access to chargeable social care and support services is determined, can be found at: <https://www.nelincs.gov.uk/health-wellbeing-and-social-care/adult-social-care/>

#### **4.11 dispute resolution and decision making**

Care practitioners must take all reasonable steps to agree with individuals how to meet their needs (taking 'all reasonable steps' does not equate to a duty to reach agreement at any cost; Davey, paragraph 158). Efforts to reach agreement should be carefully documented. The care practitioner's role is to ensure that the care plan sufficiently meets needs, is appropriate, and represents the best value for money and maximisation of outcomes for the individual.

In the event that the plan cannot be agreed with the individual, or any other person involved, the care practitioner should state the reasons for this and the steps which must be taken to ensure that the plan is signed-off. This may require going back to earlier elements of the planning process. Individuals must not be left without support while a dispute is resolved. If a dispute still remains, and the care practitioner feels that all reasonable steps have been taken to address the situation, they should direct the individual to the local complaints procedure. It is not appropriate to suspend service provision whilst a complaint is made.

Practitioners are reminded that part of ICAAP/ the CHC Decision Forum's role is to offer advice on challenging cases. There are also a number of decisions listed in this policy which must involve ICAAP and/ or the CHC Decision Forum; such decisions are generally those which involve fine balancing of best value with individual outcomes, including in particular managing higher levels of risk. The ICB wishes to be clear that ICAAP/ the CHC Decision Forum is not intended as a mechanism to create barriers or set arbitrary cost limits on packages of support, in any setting, but aims to ensure that all appropriate matters have

been taken into account before an apparently riskier or costlier option is endorsed. Director level opinion – as set out at 4.6.2.3 above – is sought on the same basis, where necessary.

ICAAP's Terms of Reference can be found at:  
<https://www.northeastlincolnshireccg.nhs.uk/publications/>

## **4.12 policy application: case studies and conclusion**

### **4.12.1 Case study commentary**

Case studies are offered at Appendix One, as a means of promoting discussion amongst care practitioners, and as examples to which the principles within this policy can be applied as part of those discussions.

Could cases like Mrs X, Mrs A and Mr B be approached differently or re-evaluated? The ICB recognises that care practitioners must be free to exercise professional judgment, based on all the circumstances. However, in situations like that of Mrs X, Mrs A and Mr B, if the service user and family feel that residential accommodation is the best option, and this also represents best value for money over the long term, the ICB expects its micro-commissioners to make a pragmatic and reasoned choice.

Cases like those of J, and K and L, demonstrate that the increased costs to the ICB necessitated by direct payments can be justified where significantly better outcomes for individuals are achieved than might be possible via commissioned services. Whether a direct payment is appropriate for an individual will depend upon all the circumstances of the case; however, where outcomes and value for money cannot be appropriately balanced, practitioners are expected to make a reasoned and pragmatic choice, which may sometimes result in direct payments being refused.

Care practitioners must always record the way in which they have exercised their judgement, and the factors taken into account in arriving at a conclusion.

### **4.12.2 Conclusion**

The ICB is most mindful of the difficult tasks of decision making faced by care practitioners each day, and the lengthy array of factors which must be considered by them. It is intended that this policy should lighten the weighty burden of deliberations, whilst ensuring that the highest standards of service are met within North East Lincolnshire.

Decision making will often necessitate making tough choices, not all of which will be welcome to the individuals affected by them. It can also be difficult for care practitioners to make choices that they may feel uncomfortable with, due to an historic culture or practice of perceived restrictions.

## **5 Training**

This policy will be drawn to the attention of all relevant individuals as part of the implementation process (see 7 below).

## **6 Impact analysis**

### **6.1 Equality**

This policy has been created with due regard for the ICB's public sector equality duty under the Equality Act 2010, s149. All staff connected with the implementation of this policy, in the exercise of their public functions, must also have due regard to the matters within s149(1).

An Equality Impact Assessment (EIA) has been conducted with regard to this policy. Two areas of concern have been identified: whilst the policy itself is unlikely to have an impact on grounds of race, it is recognised that some nationalities may have difficulties understanding the policy due to limited English Language skills. Similarly, whilst the policy itself is unlikely to have an impact on grounds of disability, it is recognised that those with sensory impairments or with specific communication needs may have difficulties accessing the policy. Mitigating actions are set out within the EIA.

### **6.2 Bribery Act 2010**

The Bribery Act 2010 is relevant to this policy. Under that Act it is a criminal offence:

- To bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so; and
- To be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so
- To bribe a foreign public official - A person will be guilty of this offence if they promise, offer or give a financial or other advantage to a foreign public official, either directly or through a third party, where such an advantage is not legitimately due
- For commercial organisations to fail to embed preventative bribery measures. This applies to all commercial organisations which have business in the UK. Unlike corporate manslaughter this does not only apply to the organisation itself; individuals and employees may also be guilty.

These offences can be committed directly or by and through a third person, when considering whether to offer or accept gifts and hospitality and/or other incentives.

Anyone with concerns or reasonably held suspicions about potentially fraudulent activity or practice should refer to the Local Anti-Fraud and Corruption Policy and contact the Local Counter Fraud Specialist.

## **7 Implementation**

This policy will be disseminated via key individuals within the Council, the ICB, CPG, Navigo, Focus and FPC with the expectation that each will cascade the information within it amongst their relevant teams. Providers will be expected to ensure that it is available electronically to their staff. The policy will be further communicated through team briefings, and training sessions, led by each provider's key individuals.

Each organisation delivering micro-commissioning functions will create operational procedures to support their staff in delivering on this policy.

Breaches of this policy may be investigated and may result in the matter being treated as a disciplinary offence under the ICB's disciplinary procedure, or that of the organisation which employs the staff member in breach.

This policy is publicly available at: <https://www.northeastlincolnshireccg.nhs.uk/publications-1/>.

## 8 Policy monitoring and review

This policy will be reviewed in 3 years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in law/ guidance, as instructed by the senior manager responsible for this policy.

## 9 References and links to other documents

External documents:

1. European Convention on Human Rights
2. UN Convention on the Rights of Persons with Disabilities
3. The NHS Constitution
4. The Care Act 2014, Statutory Guidance and supporting Regulations
5. The Children and Families Act 2014
6. The Health and Social Care Act 2012
7. The Equality Act 2010
8. The Bribery Act 2010
9. National Health Service Act 2006
10. The Mental Capacity Act 2005 and Codes of Practice
11. The Human Rights Act 1998
12. The Mental Health Act 1983 and Code of Practice
13. The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care and Decision Support Tool (both published March 2018, revised July 2022)
14. Who Pays? Determining Responsibility for Payments to Providers (NHS England 2013) – amended 2022 ([NHS England » Who Pays?](#))
15. Guidance on the Legal Rights to Personal Health Budgets, NHSE and NHSI 2019 (<https://www.england.nhs.uk/wp-content/uploads/2014/09/guidance-on-the-legal-rights-to-personal-health-budgets.pdf>)
16. NHS Commissioning Board and Clinical Commissioning Groups' (Responsibilities and Standing Rules) Regulations 2012 (amended by the 2013 and 2016 'Standing Rules')
17. Personal Health Budget's Guide: Integrating Personal Budgets, Myths and Misconceptions (Department of Health, 2012)
18. Enforced relocation of older people when Care Homes close: a question of life and death?, Jolley, Jeffreys, Katona and Lennon, in Age and Aging, 2011
19. National Audit Office Successful Commissioning Guide (guidance on securing value for money in public spending) (<https://www.nao.org.uk/successful-commissioning/general-principles/value-for-money/assessing-value-for-money/>)

Internal Documents:

20. Direct Payments Policy; this can be found at <https://www.northeastlincolnshireccg.nhs.uk/publications/>
21. Mental Capacity Act 2005 and Deprivation of Liberty Policy; this can be found at <https://www.northeastlincolnshireccg.nhs.uk/publications/>
22. ICAAP terms of reference can be found at <https://www.northeastlincolnshireccg.nhs.uk/publications/>
23. S117 Memorandum of Understanding can be found at: [ ]].



## 10 Appendixes

### Appendix One: Real Life Case Studies

**Study One:** Mrs X is in her eighties and lives alone in her pre-war terraced house. Mrs X has had a number of falls, and sometimes suffers from confusion (although she has not lost capacity). Mrs X is in receipt of a substantial domiciliary care package, and has a pendant system from Carelink.

Mrs X is supported by her children and their spouses, all of whom work full-time. Family members have received an increased number of calls from Carelink and other emergency services, when Mrs X has fallen. This often seems to be in the middle of the night, contributing to Mrs X's confusion. Supporting Mrs X is leading to family disagreements regarding which of them offers her the most time; the extent of their input is causing some to feel stressed and is impacting on their work.

When lucid, Mrs X has expressed an interest in residential accommodation; her family also feel this would be in her own, and their best interests. Mrs X's care practitioner advises that there are other options which could be explored to support Mrs X at home, and suggests her family seek support via the Carers' Support Service. Consequently, Mrs X stays at home, and the situation continues until the next review.

**Study Two:** Mrs A has lived in her own home for the last 10 years following the death of her husband. She has two sons. Five years ago she had a stroke and needed a domiciliary care package for key times during the day. She managed with this level of support and the help of her family.

Mrs A had a further stroke 2 months ago, following which she was admitted to hospital and then to respite care for 6 weeks. Mrs A no longer has capacity but her family state that they would like their mother to return home. In order to go home, Mrs A needs a domiciliary care package of 5 calls per day and requires 2 workers for lifting and handling. This amounts to a cost of £550 per week, whereas her indicative budget is £310.

On returning home, Mrs A has become fully dependent on care workers and is not able to mobilise without them. The family now feel that Mrs A is isolated, and due to a recent job change within the family, they cannot visit her as often. Mrs A's quality of life has deteriorated rapidly.

**Study Three:** Mr B is in his eighties, and suffers from multiple long-term conditions. Mr B is wheelchair bound, and needs help with all aspects of his personal care including feeding and toileting. Mr B lives at home alone.

Mr B is cared for mainly by his daughter, Ms C. Ms C also works part-time and her caring responsibilities place significant strain on her. Even with input from his daughter, Mr B still needs a substantial package of care. Mr B and Ms C express a wish for Mr B to move into residential care.

Whilst the cost of Mr B's package is reduced by his daughter's contribution to his care (falling just under the cost of residential care), when the support package offered to his daughter is also taken into account, the overall cost of supporting them is in excess of the cost of residential care.

**Study Four:**

J was an avid motorcyclist, competing in amateur competitions and embracing a biker's lifestyle. He worked as a mechanic and spent most of his evenings working on his bikes, riding them with his club, or socialising with club mates. In his early 30s J was knocked off his bike, and suffered serious injury. He now needs a wheelchair.

J lives alone in an adapted bungalow; he has no family or lasting relationships. He needs assistance to bathe and get in and out of bed, and is frustrated that the support offered to him does not match his lifestyle – requiring him to go to bed at regular times, and earlier than he would like. Over time J reduced his social activities and contact with friends; he became depressed and contemplated suicide.

J requested a direct payment to employ two Personal Assistants who are better able to assist him later in the evening. This has enabled J to re-engage with his club. His mates have adapted a side-car so he can still go on evening rides, and one of his Personal Assistants has even joined the club. J helps his mates out with mechanical advice, and he has been able to find a sense of purpose and contribution that keeps his depression away. This would not have been possible without a direct payment.

**Study Five:**

K and L are two young men with learning disabilities, both requiring personal support. They are great friends, and both are passionate about gardening. K and L collaborated by putting their direct payments together to employ a Personal Assistant who was able to provide some personal support and assistance. This additional support and assistant was crucial to enabling K and L to launch their own gardening business.

The business is now thriving, and K and L have developed so much that they no longer need the support. They are recruiting staff directly. K and L feel that their direct payment was the turning point in becoming independent.

## **Appendix Two: placing clients (P) with assets above the upper capital limit (UCL) in a residential setting**

### **1 Background: the law**

- 1.1 Access to adult care and support is determined by the provisions of the Care Act 2014. The Care Act prescribes that care and support is accessed via assessment, determination of eligibility and determination of ordinary residence. For the purposes of this practice note, it is assumed that P has been assessed as eligible, and determined as ordinarily resident in North East Lincolnshire (note: urgent need may be met regardless of whether an assessment has been completed/ eligibility and ordinary residence have been determined).
- 1.2 The Care Act s18(4) provides that a local authority (LA) must meet the needs of a P with assets above the UCL where they:
- lack relevant mental capacity (within the meaning of the Mental Capacity Act 2005 (MCA)), and
  - have no one to make their care arrangements.
- 1.3 In seeking to support such a P in a residential setting, the LA will –
- Assess needs, eligibility, and mental capacity with regard to relevant decision(s)
  - Make a micro-commissioning decision regarding the range of possible placements suitable to meet P's needs, and therefore what to offer for P
  - With relevant others (as required by the MCA s4), make a best interests decision regarding which of the placements is the most appropriate one to accept on P's behalf; this best interests decision will include consideration of P's health and welfare, *and financial*, best interests
  - Reflect decision making in a care plan (ensuring that deprivation of liberty considerations are acted on)
  - Make the placement (by contracting with the provider)
  - Ensure a mechanism is in place for paying P's fees to the care home
  - Review P's needs assessment/ plan and financial assessment no less than annually.

For more information on LAs' legal duties owed to those with assets above £23,250, see Appendix Two B and One C.

In North East Lincolnshire, the LA's duties are largely discharged by the Humber and North Yorkshire Integrated Care Board at North East Lincolnshire Place and/ or Focus Independent Adult Social Work (Focus).

### **2 A note on deputyship**

2.1 Where P lacks relevant mental capacity and has no one to make their care arrangements, the LA may also act, or make an application to the Court of Protection to act, as Property and Finance (P&F) Deputy. It is less common for the Court to appoint Health and Welfare (H&W) Deputies. This guidance is written on the basis that a) the LA does not hold H&W deputyship – and therefore (strictly speaking) does not have the authority to make decisions about how P's care needs should be met (including whether or not they should receive care in a residential setting) – but that b) most decisions as to P's care needs are likely to have financial implications/ be inextricably linked with P's financial resources, which fall clearly within the P&F Deputy's area of authority.

2.2 Where the LA is appointed as P&F Deputy, the approach described at 1.2 above is slightly different; the officer appointed as P&F Deputy will be involved throughout, and in particular, regarding the following steps:

- c) the lead practitioner and the P&F Deputy will make the best interests decision together in conjunction with any relevant others (as required by the MCA s4)
- e) the lead practitioner will make the placement in conjunction with the P&F Deputy (the Deputy is responsible for costs/ financial commitment arising from the placement)
- f) The P&F Deputy will access P's resources to ensure that care fees are paid (it may be that the LA pays in the first instance and recovers monies from P later if there is delay accessing their account(s))
- g) The P&F Deputy must be involved in P's financial assessment, and should be given the opportunity to be involved in P's needs assessments.

*NB: the Care Act imposes an obligation to meet the eligible needs of those with assets above the UCL, not only where they lack capacity to make their own arrangements and have no one to make them for them, but also where (outside of a residential setting) they ask the LA to make their arrangements for them (s18(3)). Situations arising outside of a residential setting are not considered further in this appendix.*

### **3 Making a placement: local expectations**

3.1 Where P falls within s18(4), i.e. has assets above the UCL, lacks relevant mental capacity, and has no one to make their care arrangements, the LA assumes a legal responsibility for P they would not otherwise have done. In effect, the LA has the same comprehensive level of duty towards a P in this cohort, as it would for a P who has assets below the UCL. The only difference between the two cohorts is where the money comes from to pay P's fees.

In addition to considering P's health and welfare, practitioners should remember P's financial best interests. This includes securing the best deal for P, and considering (where relevant) long term financial implications for P.

#### **3.2 Ps for whom we are not deputy: requirements of practitioners**

Due to lacking relevant capacity, P cannot enter into a contract for care, or give instructions for such to be entered into on their behalf; the LA (acting via focus) therefore enters into the contract for P's placement.

When making a placement for P, practitioners should:

- 3.2.1 Act in P's best interests – both in terms of health and welfare and financial best interests. This includes:
- Considering the sustainability of any proposed arrangements for P. Given the likely duration of P's stay in a care home, what offers the best balance of quality (the best P can afford) with stability (P may have to move to a less costly arrangement if/ when their assets drop below £23,250)
  - For reasons of confidentiality, practitioners will not disclose P's level of assets unless asked. If not asked for disclosure, it is assumed P will be placed on the LA contract at LA fee rate, as a P for whom the LA is responsible, in the same way as any other P for whom the LA is responsible
  - If practitioners are asked to confirm whether P has assets above the UCL, they must answer truthfully without disclosing more information than is requested. Where it is established that P is able to meet the full costs of their care, practitioners should still seek to negotiate the best fee rate for P – P is the LA's legal responsibility just as much as other Ps we place with assets under the UCL
  - If P will need to pay a higher fee rate than the LA's contract rate, be clear as to the following -
    - Given the higher fee rate P will pay, are there additional services/ features/ facilities available to P, e.g. entitlement to a larger room? If so, ensure these are specified in writing

- But for the fee rate and any additional services/ features/ facilities negotiated for P's benefit, in every other respect P is placed on the LA's contract (and therefore entitled – as a minimum – to the level of service set out within that contract and accompanying specification, on the same terms and conditions). The contract between the ICB (on the Council's behalf) is intended to include all those for which the LA is legally responsible – this includes those Ps lacking relevant capacity who have no one to make their care arrangements
    - a clause has been drafted for you to use when arranging P's placement at fee rates higher than the LA's fee rate (Appendix Two A)
- 3.2.2 Consider the practicalities of accessing P's funds. In the short term it may be that if funds cannot be accessed, the LA must meet the costs of P's care and seek later reimbursement. Many P's falling within this category will have no one with the legal authority to access their funds. In this case, a referral should be made to the deputyship team for consideration of how an application might be made to the Court of Protection to gain access to P's funds. This will enable the LA to recoup any sums paid on P's behalf.

### **3.3 Ps for whom we are deputy: requirements of practitioners**

Due to lacking relevant capacity, P cannot enter into a contract for care, or give instructions for such to be entered into on their behalf; the P&F Deputy enters into the contract for P's placement. The deputyship team may ask that care practitioners make arrangements on their behalf.

When making a placement for Ps for whom we are deputy, the best interests requirements set out at 3.2.2 apply (i.e. appropriately protecting P's confidentiality, negotiating the best fee rate for P where required, securing additional services/ features/ facilities where possible, and recording any agreements/ the basis of the contract). The primary difference is that the P&F Deputy will already have access to P's funds, and is responsible for contracting with the home. This means that practitioners must liaise with the deputyship team before making a placement to agree who will make the arrangements. Collaboration between care practitioners and the deputyship team is required.

### **4 P's falling within s18(4) who have already been placed**

When you undertake an annual review for any P who falls within s18(4), please use that as an opportunity to consider:

- a) The basis on which P is accommodated i.e. it is clear who is responsible for the care home placement contracted on P's behalf. For example, it may be that P initially contracted on their own behalf when they had capacity, or someone no longer involved in P's life contracted on their behalf. Consider whether there is evidence that P (or someone on their behalf) had contracted for additional services and whether P is actually receiving those additional services
- b) The home needs to know that P is our responsibility, and therefore covered by the ICB's contract (you can use the clause at Appendix Two A to let them know). This entitles P - as a minimum – to the level of service set out within that contract and accompanying specification, on the same basis, excepting perhaps for fees
- c) In conjunction with the deputyship team where relevant, consider whether the placement remains in P's best interests – in both the health/ welfare, and financial sense.

## **Appendix Two A: clause for use when arranging P's placement, or clarifying the basis of P's existing placement**

1 The ICB has a contract and specification with [ *name of care home* ] which covers commissioned placements for residents of North East Lincolnshire and those residents who are registered with a NHS North East Lincolnshire GP practice residing or looking to reside in an ICB commissioned Care Home.

2 The contract and specification is intended to include those to whom the ICB owes a duty to meet need, or in respect of whom it has exercised a power to meet need. The ICB understands itself to be responsible for meeting the care needs of [ *name of P* ]. This person is therefore included in the ICB's contractual arrangements with your home and entitled to benefit – as a minimum – from the level of service set out within that contract and accompanying specification.

3 [The following services or facilities or items have been agreed for P, in addition to those from which they benefit as part of ICB's contract/ specification with your home:

- *List*
- *List*
- *List etc* ]. *Delete if not applicable*

4 The fee agreed for P is £[ *insert amount* ]. This amount may not be increased unless it has been agreed with relevant staff members at focus.

5 [To support this person, the ICB is working with Sarah Savage at Focus Independent Adult Social Work, who acts as deputy for property and finances.] *Delete if not applicable.*

### **Notes for use:**

1. Don't forget to enter the name of P's care home
2. Don't forget to enter P's name!
3. Delete this clause if not relevant – there may be no additional services etc to which P is entitled
4. Insert the fee applicable for P. The focus staff members in question might be P's key worker, member of the deputyship team or both, as relevant
5. Delete this clause if not relevant. If Sarah is acting as deputy, it will be helpful to ensure that the home know that she is doing so
6. Feel free to add anything else that you think the home needs to know about P. A copy of P's capacity assessment and best interests decision relating to their placement should be shared with the home.

## **Appendix Two B: extract from Care Act statutory guidance (local emphasis) as at 08 11 23 re those with assets £23,250>**

8.13 A person with more in capital than the upper capital limit can ask their local authority to arrange their care and support for them. Where the person's needs are to be met by care in a care home, the local authority may choose to meet those needs and arrange the care, but is not required to do so. In other cases, the authority must meet the eligible needs if requested. However, these people are not entitled to receive any financial assistance from their local authority and in any case, may pay the full cost of their care and support until their capital falls below the upper capital limit.

**Definitions: self-funder –**

Someone to whom, following assessment of needs and establishment of O/R, is identified as able to meet the full cost of their care AND either a) has capacity and i) does not request our assistance in making care and support arrangement, or ii) requests our assistance in making care and support arrangements in a care home, but we decline to exercise our discretion to assist them or b) lacks capacity but has someone appointed to make the arrangement for them.

**Definitions: full-cost payer –**

Someone to whom, following assessment of needs and establishment of O/R, is identified as able to meet the full cost of their care AND either a) has capacity and requests our assistance in making care and support arrangement outside of a care home, or ii) requests our assistance in making care and support arrangements in a care home, and we exercise our discretion to assist them or b) lacks capacity and has no one appointed to make arrangement for them.

**Duties: self-funder**

- Assessment of care and support needs. Applies regardless of need, finances and ordinary residence
- Financial assessment. NB this obligation is triggered where the LA thinks that if it were to meet need, it would exercise its discretion to charge for services/ support provided to meet need (see s17); the obligation can be avoided (i.e. the LA can be treated as having carried out the financial assessment) if Regulation 10(3) applies: “A local authority is to be treated as having carried out a financial assessment in an adult’s case and being satisfied on that basis that the adult’s financial resources exceed the financial limit where—
  - (a) with the consent of the adult, the authority has not carried out a financial assessment in accordance with these Regulations; but
  - (b) the authority is satisfied from the evidence available to it that the adult’s financial resources do exceed the financial limit.”

The individual’s right to request a full financial assessment is reserved (see SG 8.26).

**Duties: full-cost payer**

- Assessment of care and support needs. Applies regardless of need, finances and ordinary residence
- Financial assessment. See NB above re when this obligation is triggered (s17)/ avoided (Regulation 10(3))
- Care and support plan
- Making care and support arrangements
- Annual review/ possible revision of care and support plan.

Summary: we assume the full range of responsibilities for an individual with assets over £23,250 where a) they have capacity and have requested that we make the arrangements for them and either i) we are obliged to do so (because their needs will be met outside of a care home), or ii) we exercise our discretion to make arrangements for them regardless of setting, or b) they lack capacity to make their own arrangements and have no one appointed to make arrangements for them.

**Appendix Two C: extracts from Care Act statutory guidance (local emphasis) as at 08 11 23 re brokerage**

10.15 The local authority may also consider whether it can effectively meet a person’s needs by ‘brokering’ a service on behalf of an individual in certain cases. ‘Brokering’ services are

commonly offered by organisations which are independent of the local authority, and may be accessed by any person wishing to find care. However, the local authority may also provide such support where it meets a person's needs. 'Brokering' would involve the local authority supporting an individual to make a choice about the provider of their care, and to enter into a contract with that provider. The local authority would not need to hold the contract with the provider, but would be required to assure itself that the chosen provider and terms of the contract were appropriate to meet the person's needs. Note- where P lacks capacity and has no one to act for them, there is no one but the LA to hold the contract.

10.16 The local authority would remain under the duty to meet a person's eligible needs, and so would need to be satisfied both that this was an effective way of meeting those needs, and that the person was in agreement to this approach being used. It is likely that 'brokering' would only be an effective way of meeting a person's needs in exceptional circumstances, for example where a person is fully funding their own care and wishes to retain control of the contract with their provider, but wants the local authority to meet their needs and the local authority has agreed to do so. If there is a risk that a person's needs would not be met effectively by means of 'brokering', the local authority should discount it as an option and proceed with other ways of meeting that person's needs, such as direct commissioning of services from a provider. In considering such an option, the local authority should also have regard to the likelihood of the person continuing to be willing and able to manage such arrangements in the future, including their ability to pay the charges due (for example, to mitigate against a future loss of capacity or disposal of their assets, such that the local authority may be required to take over the contract with the provider). The local authority would continue to support the person in meeting any other needs, offering ongoing support and keeping the arrangements under review to ensure that the needs were met. The person would have a care and support plan as usual.

10.17 The individual's position in this approach would in some respects be akin to a person who had taken a direct payment to commission their own services, in that they would hold their own contract with a provider whilst the local authority is under a duty to meet their needs.

10.18 The difference would be that in the case of a direct payment, the money for commissioning the service comes from the local authority, whereas in the case of 'brokering' it comes from the individual directly. This option, therefore, would only likely be of use for meeting the needs of people who are fully funding their own care but ask the local authority to meet their eligible needs, and who are not using alternative arrangements such as an individual service fund.