Adult Social Care Policy Framework

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Owner:	**Assistant Director- Personalisation, Quality and Safeguarding**		
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Role	**Name**	**Approval Date**
Assistant Director Personalisation, Quality and Safeguarding	Julie Bateman	23.10.2015

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Contents

We will on request produce **this policy / procedure, or particular parts of it, in other languages and formats, in order that everyone can use and comment upon its content.**

Important Note:

In March 2016, the Department of Health published the refreshed edition of the Care and Support statutory guidance. It is available at https://www.gov.uk/guidance/care-and-support-statutory-guidance. The statutory guidance supports implementation of part 1 of the Care Act 2014 by local authorities, the NHS, the police and other partners.

The new edition supersedes the version issued in October 2014, which requirements were taken in account at the time the Adult Social Care Policy Framework has been developed in 2015.

*The new guidance is being published as an online document on Gov.UK. The new format is intended to be **read online** and has improved navigation and search functionality.*

Not all chapters have been revised and some have only received minor clarifications to improve understanding following feedback from the sector. The table indicates where changes have been made and provides more detail on the more significant changes.

Foreword

To support the delivery of the requirements of the Care Act 2014, the Council has developed this policy framework to provide transparency for staff, service users, carers, the general public and partner organisations. This policy framework is underpinned by practitioner guidance which gives clear direction to staff tasked with implementing the provisions of the Care Act 2014.

1.1 The policy framework reflects and underpins Supporting Lives Connecting Communities, the new model of social work/social care implemented in Suffolk to support the most responsive, efficient and effective use of the Council's resources.

The policy framework covers the statutory duties of Suffolk County Council as Local Social Services Authority, as set out in the Care Act 2014: some of a general nature and that apply to the population as a whole; others are specific and relate to people with care and support needs and / or their carers. The policy framework also indicates where the Council has legal powers under the Act, how it intends to exercise those powers, either for the benefit of the population of Suffolk generally, or in relation to people with care and support needs.

2.0 Council priorities

2.1 The vision for Suffolk County Council is:

Adult and Community Services will ensure adults of all ages and abilities who live in Suffolk have opportunities to access leisure activities, learning or work that assist them to develop and sustain their economic, health and social well-being, remain independent, and exercise choice and their right to dignity in a safe environment.

2.2 Adult and Community Services roles and aims are:

- Improving health and emotional well-being
- Improving quality of life
- Improving choice and personal control
- Improving employability and skills
- Providing freedom from discrimination and harassment
- Helping people live with dignity and respect.

2.3 We know that there are some key challenges, including more support for vulnerable people within their own homes and the rising numbers of older people. These will need a radical rethink in the way we provide services.

3.0 Wellbeing

3.1 Wellbeing

3.1.1 Local authorities have a duty to promote wellbeing when carrying out any of their care and support functions in respect of a person ("***the wellbeing principle***"). The wellbeing principle applies in all cases where a local authority is providing non-assessed 'universal' services available to the local population as a whole, as well as when carrying out a care and support function, or making a decision in relation to a person.

3.2 What is wellbeing?

3.2.1 "Wellbeing" is a broad concept, which may include any or all of the following:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing

- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society.

3.2.2 There is no hierarchy and all will be considered of equal importance. The individual aspects of wellbeing or outcomes listed above are those specifically set out in the Care Act 2014 and are most relevant to people with care and support needs and carers.

3.3 Promoting wellbeing in Suffolk

3.3.1 Wellbeing covers an intentionally broad range of the aspects of a person's life and will encompass a wide variety of specific considerations depending on the individual.

3.3.2 A local authority can promote a person's wellbeing in many ways: it involves actively seeking improvements in a person's wellbeing. How this happens will depend on an individual's circumstances: including the person's needs, goals and wishes, and how these impact on their wellbeing.

3.3.3 The promotion of wellbeing will underpin the Council's provision of 'universal' non-assessed services, aimed at the local population as a whole, such as the provision of information and advice.

3.4 Wellbeing throughout the care and support function

3.4.1 The promotion of wellbeing underpins the Council's care and support functions. The Care Act 2014 removes the duty for local authorities to provide particular services, instead placing the emphasis on 'meeting needs'. This recognises that everyone's needs are unique and personal to them and that care and support can be provided in a number of different ways.

3.4.2 When undertaking any care and support function, the Council will act to promote an individual's wellbeing. The Council will consider each case on its own merits, taking into account what the person wants to achieve, and how any action undertaken may affect the wellbeing of the individual.

3.4.3 There are a number of key principles and standards that the Council will conform to in carrying out the care and support function:

- The assumption that the individual is best-placed to judge their own wellbeing
- The individual's views, wishes, feelings and beliefs should be taken into account

- The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist
- The need to ensure that decisions are made having regard to all the individual's circumstances and all the information relevant to that decision
- The importance of the individual participating as fully as possible in decisions about them and being provided with the information and support necessary to enable the individual to participate
- The importance of achieving a balance between the individual's wellbeing and that of any friends or relatives who are involved in caring for the individual
- The need to protect people from abuse and neglect
- The need to ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary for achieving the purpose for which the function is being exercised.

4.0 Prevention

4.1 Preventing, reducing or delaying need

4.1.1 The Care Act 2014 requires that the care and support system works to actively promote wellbeing and independence, and seeks actively to prevent people reaching a crisis point. This requires that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence and prevents need or delays deterioration wherever possible.

4.2 What is prevention?

4.2.1 The term "prevention" or "preventative" measures can cover many different types of support, services, facilities or other resources. There is no one definition for what constitutes preventative activity and this can range from wide-scale whole-population measures aimed at promoting health, to more targeted, individual interventions aimed at improving skills or functioning for one person or a particular group or lessening the impact of caring on a carer's health and wellbeing.

4.2.2 "Prevention" or "preventative" measures is often broken down into three general approaches. Services can cut across any or all of these three general approaches and as such the examples provided under each approach are not to be seen as limited to that particular approach. Prevention should be seen as an ongoing consideration and not a single activity or intervention.

4.2.3 These measures are:

Prevent: These are services, facilities or resources provided or arranged that may help an individual avoid developing needs for care and support, or

help a carer avoid developing support needs by maintaining independence and good health and promoting wellbeing.

Reduce: These are more targeted interventions aimed at individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down or reduce any further deterioration or prevent other needs from developing. In order to identify those individuals most likely to benefit from such targeted services, local authorities may undertake screening or case finding, for instance to identify individuals at risk of developing specific health conditions or experiencing certain events (such as strokes, or falls), or those that have needs for care and support which are not currently met by the local authority. Targeted interventions should also include approaches to identifying carers, including those who are taking on new caring responsibilities.

Delay: These are interventions aimed at minimising the effect of disability or deterioration for people with established or complex health conditions, (including progressive conditions, such as dementia), supporting people to regain skills and manage or reduce need where possible. The Care Act 2014 requires that local authorities must provide or arrange services, resources or facilities that maximise independence for those already with such needs, for example, interventions such as rehabilitation/reablement services, e.g. community equipment services and adaptations and the use of joint case-management for people with complex needs.

4.3 Carers and prevention

Carers play a significant role in preventing the needs for care and support for the people they care for, which is why it is important that local authorities consider preventing carers from developing needs for care and support themselves.

4.4 The focus of prevention in Suffolk

4.4.1 *Supporting Lives, Connecting Communities* (SLCC) is the operating model for all Adult and Community Services (ACS) in Suffolk and has been designed in particularly with the aim of:

- helping people to stay more independent, for longer
- providing a better response to everyone, as well as those for whom the County has a statutory duty to support
- improving personalisation, so that people have greater choice and control over how they meet their needs
- strengthening partnership with community-based services and resources to facilitate a ‘whole community’ approach to improving choice and control
- developing a more preventative approach, to avoid people’s health and social care needs from escalating wherever possible.

4.4.2 **Promoting wellbeing:** The promotion of wellbeing underpins the Council’s provision of ‘universal’ non-assessed services aimed at the local population

as a whole as well as all 'assessed' care and support functions provided to people with care and support needs.

4.4.3 **Holistic approach for individuals:** The Council will look at an individual's life holistically. This will mean considering any care and support needs in the context of the person's skills, ambitions and priorities. This will include consideration of the role a person's family or friends can play in helping the person meet their goals. This is not creating or adding to their caring role but including them in an approach supporting the person to live as independently as possible for as long as possible.

With regard to carers, the local authority will consider how they can be supported to look after their own health and wellbeing and to have a life of their own alongside their caring responsibilities.

4.4.4 **Developing resilience and promoting individual strength:** The Council is committed to developing and delivering preventative approaches to care and support. The Council recognises that individuals are not passive recipients of support services and will therefore design care and support systems based around the individual, enabling them to achieve their goals. By ensuring people have choice and control over the support they may need, and access to the right information at the right time, enables people to stay as well as possible, maintain independence and caring roles for longer. This approach will include consideration of a person's strengths and their informal support networks as well as their needs and the risks they face. It recognises the value of voluntary and community groups and other resources of the local area.

4.4.5 **A local approach to preventative support:** The Council will provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers. This approach may involve a range of Council departments and services, as well as those provided via voluntary groups and health and housing organisations.

4.4.6 **Identifying services in local areas:** The Council recognises the importance of identifying the services, facilities and resources that are already available in their area, which can support people to prevent, reduce or delay needs, and which forms part of the overall local approach to preventative activity.

4.4.7 **Promoting diversity and quality:** The Council will promote diversity and quality in provision of care and support services, and ensure that a person has a variety of providers to choose from.

4.4.8 **Working with partners to focus on prevention:** The Council recognises that preventative actions will often be more effective when action is taken at a local level, with different organisations working together to meet the needs of the individual.

4.4.9 **Integration of care and support provision:** the Care Act 2014 requires local authorities to ensure the integration of care and support provision, including prevention with health and health-related services. This responsibility includes a particular focus on integrating with partners to prevent, reduce or delay the need for care and support.

4.4.10 **Identifying those who may benefit from preventative support:** The Council will seek to identify and target those individuals who may benefit from particular types of preventative support. In developing such approaches, the Council will consider the different opportunities for coming into contact with those people who may benefit from preventative support, including where the first contact may be with another professional outside the local authority.

4.4.11 **Information and advice provision:** The Care Act 2014 requires local authorities to establish and maintain a service for providing people with information and advice relating to care and support. This service will include information and advice about preventative services, facilities or resources, so that anyone can find out about the types of support available locally that may meet their individual needs and circumstances, and how to access them.

4.4.12 **Helping people access preventative support:** The Council recognises that a preventative approach requires a broad range of interventions, as one size will not fit all.

4.4.13 **Information regarding services provided:** Where a person is provided with any type of service, or support as a preventative measure, the Council will provide such information as is necessary to enable the person to understand:

- what needs the person has or may develop and why the intervention or other action is proposed
- the expected outcome for the action proposed and any relevant timescale in which those outcomes are expected and
- what is proposed to take place at the end of the measure (for instance, whether an assessment of need or a carer's assessment will be carried out at that point).

4.4.14 **Assessment for care and support needs:** The person concerned must agree to the provision of any service or other step proposed by the Council.

Where the person refuses, but continues to appear to have needs for care and support (or for support, in the case of a carer), then the Council will proceed to offer the individual an assessment.

4.5 Prevention and the care and support function

4.5.1 In assessing whether an adult has any care and support needs or a carer has any needs for support, the Council will consider whether individual would benefit from the preventative services, facilities or resources provided by the local authority or which might otherwise be available in the community. As part of this process, the Council will consider the person's own capabilities and the potential for improving their skills, as well as the role of any support from family, friends or others that could help them to achieve what they wish for from day-to-day life.

4.5.2 If a person is provided with care and support or support as a carer by the local authority, the Council will provide them with information and advice about what can be done to prevent, delay, or reduce their needs as part of their care and support plan or support plan. This will take into consideration the person's strengths and the support from other members of the family, friends or the community.

4.5.3 Regardless of whether or not a person is ultimately assessed as having needs which are to be met by the Council, the Council will provide information and advice in an accessible form, about what can be done to prevent, delay, or reduce development of their needs.

4.5.4 This will ensure that all people are provided with targeted, personalised information and advice that can support them to take steps to prevent or reduce their needs, connect more effectively with their local community, and delay the onset of greater needs to maximise their independence and quality of life.

4.6 Charging for preventative support

4.6.1 The Care Act 2014 specifically exempts the following preventative services from the Council's financial charging policy:

- Minor aids and adaptations, up to the value of £1,000
- Up to 6 weeks of reablement care.

5.0 Information and advice

5.1 Information and advice

5.1.1 Information and advice is fundamental to enabling people, carers and families to take control of, and make well-informed choices about their care

and support and how they fund it. Not only does information and advice help to promote people's wellbeing by increasing their ability to exercise choice and control, it is also a vital component of preventing or delaying people's need for care and support.

5.2 New statutory duties established under the Care Act 2014

5.2.1 Under the Care Act 2014 local authorities must: *"establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers"*.

5.2.2 This duty to establish and maintain an information and advice service relates to the whole population of the local authority area, not just those with care and support needs or in some other way already known to the system.

5.2.3 The local authority must ensure that information and advice services cover more than just basic information about care and support including:

- prevention of care and support needs
- finances
- health
- housing
- employment
- what to do in cases of abuse or neglect of an adult .

5.2.4 The Care Act 2014 also states that local authorities must provide independent advocacy to facilitate the person's involvement in the care and support assessment, planning and review processes where an individual would experience substantial difficulty in understanding, retaining or using information given, or in communicating their views, wishes or feelings and where there is nobody else appropriate to provide support.

5.3 The focus of information and advice in Suffolk

5.3.1 The Council's Information and Advice Strategy can be found here: Adult and Community Services Information and Advice Strategy

5.3.2 The Council also invites ongoing feedback and comments via Suffolk Infolink. There is an email address (Infolink@suffolk.gov.uk) for this purpose and we ask practitioners and call centre staff to let the Council know if they or their clients have found difficulty finding information, or gaps in the provision.

5.3.3 The SCC website Suffolk Infolink Help for Adults supports Suffolk residents in getting information and advice about local services and organisations to help people live independently.

5.3.4 Moreover, at Tier 1 under the SLCC model of care and support, our ACS practitioners will offer information and advice, including signposting. The assessment conversation we have with people who contact the Council for help will provide personalised, accessible information and advice, or signpost to other sources of help, advice or information.

5.3.5 Our SLCC approach allows our practitioners to make connections into their communities and capture the wealth of societies, clubs and services within the community and link people to them. Tier 1 is for everyone in Suffolk, no matter how straightforward or complex their situation.

5.3.6 We do this by connecting and signposting the person to what is nearby in their local community:

- working in partnership with voluntary organisations and other important services such as GPs, housing and hospitals
- working with service-user led organisations so the customer voice is heard
- making processes easy for all who use them
- building on people's strengths and thinking creatively with the customer about the outcomes would want to achieve and how can achieve them
- supporting and encouraging the customer to have greater choice and control about the sort of help and support wanted.
- And, most importantly, promoting the person's wellbeing and taking this into account in all our decision-making.

5.3.7 Throughout our SLCC model of work we are putting significant effort into the development of a social care offer, an offer which proactively targets people who may be at risk of requiring social care services in order to inform them about ways in which they can make themselves more resilient to any risk to their independence and improve their overall wellbeing.

5.4 Independent financial information and advice

5.4.1 The Council recognises that financial information and advice is fundamental to enabling people to make well informed choices about how they pay for their care. It is integral to a person's consideration of how best to meet care and support needs, immediately or in the future.

5.4.2 Financial information and advice can be specialist and complex. The Care Act 2014 places a duty on local authorities to ensure that people have help in accessing independent financial advice, whist recognising that it is not appropriate for local authorities to provide this service directly.

5.4.3 The Council recognises the importance of identifying those who may benefit from financial advice or information as early as possible.

5.4.4 The Council provides the following information on the following:

- care charges
- ways to pay
- money management
- making informed decisions
- accessing independent financial advisors.

Suffolk Infolink Advice

5.4.5 Where a person lacks capacity, the Council will establish whether a person has a deputy appointed by the Court of Protection or a person with Lasting Power of Attorney or Enduring Power of Attorney acting on their behalf.

6.0 Integration, cooperation and partnerships

6.2.1 Integration, cooperation and close partnership working seeks to improve patient and service user experience and outcomes by minimising barriers between organisations and services and by delivering care that is tailored to meet the needs of those in need of care and support, their carers and families.

6.2.2 Examples of partnership and co-operation in Suffolk include the Better Care Fund, Health and Wellbeing Board, Out of Hospital Teams in Waveney and the Integrated Health and Care Model in Ipswich and East Suffolk and West Suffolk and here is link to: Suffolk Health and Wellbeing Board Care and Health Review. The Integrated Health and Care Model approach is currently being tested in two early adopter sites in Sudbury and East Ipswich (IP3/4) as part of the wider 'Connect' project with a longer term view to roll out the model across the whole of East and West Suffolk. For further information please see the website dedicated to the Connect project: www.connectsuffolk.co.uk/ .

6.2 Working with the NHS, housing providers and welfare and employment support

6.2.1 The Council is committed to working with the NHS to plan the safe and timely discharge of discharge of NHS patients from acute hospital settings to local authority care and support. Practices relating to patient discharge will be established on a collaborative basis

6.2.2 Housing is recognised as a crucial health-related service and when integrated with care and support services it improves the quality of services offered and the promotion of health and wellbeing. There are clear boundaries in law between a local authority's care and support function and housing functions but this does not prevent co-operation or joined up working, or the provision of specific housing-related services to support the preventative agenda and person-centred delivery of care.

6.2.3 The Council will work with partners to provide information and advice to help people to make well informed choices relating their health and social care needs and to help them navigate the system effectively.

7.0 Care market shaping and provider failure

7.1 Care market shaping and provider failure

7.1.1 High-quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers. The role of the local authority is critical to achieving this, both through the actions it takes to directly commission services to meet needs and the broader understanding and interactions it facilitates with the wider market, for the benefit of all local people and communities.

7.1.2 Interruptions, and the possibility of interruptions to care and support services causes uncertainty and anxiety for people receiving service, their carers, family and friends. It is vital, therefore that the care and support markets remain robust and that provisions are made to minimise the impact of service interruptions on the individuals concerned.

7.2 New statutory duties established under the Care Act 2014

7.2.1 The Care Act places new duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways.

7.2.2 Local authorities have a vital role in ensuring that universal services are available to the whole population and where necessary, tailored to meet the needs of those with additional support requirements (for example housing and leisure services).

7.2.3 Interruption to care and support services can arise from a number of different causes. The Care Act 2014 gives local authorities the power to intervene in order to minimise the impact of an interruption to care and

support services on the individuals receiving service, their carers, family and friends.

7.3 What is care market shaping?

7.3.1 Care Market shaping means the local authority collaborating with relevant partners and stakeholders, including people with care and support needs, carers and families, to facilitate the whole market in its area for care, support and related services. This includes services arranged and paid for by the state through the authority itself, those services paid by the state through direct payments, those services arranged and paid for by individuals from whatever sources (sometimes called 'self-funders') and services paid for by a combination of these sources. Market shaping activity should stimulate a diverse range of appropriate high quality services (both in terms of the types, volumes and quality of services and the types of provider organisation) and ensure the market as a whole remains vibrant and sustainable.

7.3.2 The core activities of market shaping are to engage with stakeholders to develop understanding of supply and demand and articulate likely trends that reflect peoples' needs and aspirations, and, based on evidence, to signal to the market the types of services needed now and in the future to meet them, encourage innovation, investment and continuous improvement. It can also include working to ensure that those who purchase their own services are empowered to be effective consumers, for example by helping people who want to take direct payments make informed decisions about employing personal assistants.

7.4 The focus of care market shaping in Suffolk

Adult and Community Services (ACS) Market Position Statement which sets out Council's vision for the care and support of people living in the county, as well as our commissioning intentions can be found at following links:

Suffolk County Council Market Position Statements or

Suffolk County Council Service Provider information

Suffolk County Council commissioning and de-commissioning intentions

7.5 What is provider failure?

7.5.1 Provider failure occurs when a provider is unable to exercise its normal day-to-day duties, due to a specific set of circumstances, such as:

- the appointment of an administrator
- a receiver is appointed
- a winding up order is made

- an application for bankruptcy is submitted
- the charity trustees of the provider become unable to pay their debts
- CQC suspend a service
- a service is disrupted owing to 'force majeur' for example flood, fire or other emergency situation,
- a provider withdraws services from the market.

The Care Act 2014 outlines a specific set of duties that local authorities should exercise in the event of provider failure.

7.6 The focus of provider failure in Suffolk

7.6.1 Not all instances of provider failure will trigger local authority intervention. If service provision remains uninterrupted and the needs of the people using that service are still met, there is no need for local authority intervention. Should provider failure lead to a temporary or permanent service interruption however, the Council has a temporary duty to intervene.

7.6.2 This temporary duty applies regardless of whether:

- there is a contract in place between the provider and the Council
- the people affected pay for their own care
- other local authorities had made the arrangements to provide service

7.6.3 The Council will intervene to ensure the needs of the individuals affected continue to be met.

7.6.4 The Council will seek to minimise the disruption to the people receiving care. The Council will aim to provide as similar a service as is possible, whist recognising that the Council has discretion about how those needs will be met and it may not be possible or necessary to arrange for the exact same combination of services that were previously supplied.

7.6.5 In deciding how an individual's needs will be met, the Council will involve the person concerned and carer that the person has, or anyone the person asks the authority to involve. If the individual lacks capacity to do that, the Council will involve anyone who appears to have an interest in the person's welfare.

7.6.6 Where the provider is subject to the Care Quality Commission (CQC) oversight regime, the Council will work with the CQC to prepare to develop a remedial action plan in preparation for exercising this temporary duty.

7.6.7 In the event of service disruptions occurring that are not triggered by business failure, the Council may still chose to exercise these temporary duties if the disruption is likely to cause urgent needs of the individuals receiving that service.

7.6.8 The Council will examine the consequences of any actions in planning whether and how to respond. Particular consideration will be given to how any actions will impact on the likelihood of the service continuing, given that some actions may increase the risk of causing business failure.

7.6.9 These duties do not apply to anyone receiving Continuing Health Care, and the NHS remains responsible for intervening in the event of provider failure.

7.7 Charging in the event of provider failure

7.7.1 Care and support services are not always provided free and charging for some services is vital to ensure affordability.

7.7.2 The Care Act 2014 states that a local authority may charge a person for the costs of arranging alternative services, where the individual concerned is funding the costs of their own care. The Council will only seek to recover costs incurred in arranging the alternative care in order to ensure this service is cost neutral to the local tax payer.

7.7.3 In the event that the service was arranged by another local authority, the Care Act 2014 allows the cost of arranging alternative services to be recharged to the placing authority.

7.7.4 Additional transport and removal charges may also apply, in addition to the arrangement costs incurred by the Council. These will be discussed and agreed on an individual basis with the person concerned, or their representative. The underlying principle remains:: there should be no cost to the local tax payer for the provision of this service.

7.7.5 The Council will not charge for the provision of information and advice to the person as a result of provider failure.

7.7.6 This charging mechanism does not apply to people who are receiving care that is paid partially or fully by the Council.

8.0 Adult safeguarding

8.1. Safeguarding

8.1.1 Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect.

8.2 What is adult safeguarding?

8.2.1 The Care Act 2014 defines safeguarding as *protecting an adult's right to live in safety, free from abuse and neglect*.

8.2.2 Adult safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of abuse and neglect
- as a result of their care and support needs, is unable to protect themselves from the risk or experience of abuse and neglect.

8.2.3 Safeguarding involves people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

8.2.4 Adult safeguarding aims to:

- stop abuse or neglect wherever possible
- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- support adults in making choices and having control about how they want to live
- promote an approach that concentrates on improving life for the adults concerned
- raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult
- address what has caused the abuse or neglect.

8.2.5 The Care Act 2014 stipulates that local authorities must:

- make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect
- set up a Safeguarding Adults Board (SAB)
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR)
- co-operate with each of its relevant partners in order to protect the adult.

8.2.6 There are six key principles that underpin all adult safeguarding work:

Empowerment: People being supported and encouraged to make their own decisions and informed consent.
"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

Prevention: It is better to take action before harm occurs.
"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

Proportionality: The least intrusive response appropriate to the risk presented.
"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

Protection: Support and representation for those in greatest need.
"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

Partnership: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

Accountability: Accountability and transparency in delivering safeguarding.
"I understand the role of everyone involved in my life and so do they."

8.3 The focus of adult safeguarding in Suffolk

8.3.1 The Council is committed to safeguarding individuals from abuse and neglect and links to the Adults Safeguarding Framework and policy for Adult Safeguarding in Prisons can be found here:

Suffolk Prisons Safeguarding Policy

9.0 Assessment of care and support needs

9.1 Assessment of care and support needs

9.1.1 The assessment process is one of the most important elements of the care and support system. The assessment is one of the key interactions between a local authority and an individual, whether an adult needing care, or a carer. The process must be person-centred throughout, involving the person and supporting them to have choice and control.

9.2 What is an assessment?

9.2.1 The assessment process provides a framework to identify any level of need for care and support so that local authorities can consider how to provide a proportionate response at the right time, based on the individual's needs.

9.2.2 The assessment process starts from when local authorities begin to collect information about the person, and will be an integral part of the person's journey through the care and support system as their needs change. It should not just be seen as a gateway to care and support, but should be a critical intervention in its own right, which can help people to understand their situation and the needs they have, to reduce or delay the onset of greater needs and to access support when they require it.

9.3 Supporting Lives, Connecting Communities

9.3.1 The aim of the assessment is to identify what needs a person may have and what outcomes they are looking to achieve to maintain or improve their wellbeing. The outcome of the assessment is to provide a full picture of an individual's needs so that a local authority can provide an appropriate response at the right time to meet a person's needs. This might range from offering guidance and information to arranging for services to meet those needs.

9.3.2 In Suffolk this is achieved through the Supporting Lives, Connecting Communities model which was implemented in 2014 which underpins the responsibilities required by the Council under the Care Act.

9.3.3 **The assessment conversation we have with people who contact the Council for help will:**

- Provide personalised, accessible information and advice, or signpost to other sources of help, advice or information.
- Let the person know if there are any immediate services that can help.
- Help the person to identify their care and support needs and the changes they want to make in their life and to identify the best ways in which they can make these changes.
- Offer timely and appropriate reablement and preventative support first before considering ongoing support.
- Discuss what support could help sustain the person if they are a carer.
- Continue to give advice throughout the assessment process about other agencies or services that could meet their needs.

9.3.4 **Ensuring assessments are appropriate, proportionate and timely**
Appropriate means that you should ensure the assessment process is adapted to the person's circumstances, needs (e.g. communication needs and level of complexity) and preferences. It will include:

- **Face-to-face.** This may for example be appropriate if there are any communication needs, or other people who need to be present (e.g. another professional).
- **Telephone.** This may for example be appropriate if there are no communication needs, the level of needs is not complex and the individual is capable and able to express themselves by phone.
- **A joint assessment.** Where relevant agencies work together to avoid the person undergoing multiple assessments and where joint working will deliver better outcomes.
- **A combined assessment.** Where an adult's assessment is combined with a carer's assessment.

9.3.5 **Proportionate** means that the assessment is only as extensive, in-depth and detailed as it needs to be to establish an accurate picture of the needs of the individual or a carer. This will link to the severity, complexity, risks and overall extent of the person's needs.

9.3.6 **Timeliness** means that assessment should be carried out in a timely way but it may take time for strategies and interventions to have a positive effect or for fluctuating needs to be accurately assessed.

9.4 Cases where a person lacks capacity

9.4.1 Putting the person at the heart of the assessment process is crucial to understanding the person's needs, outcomes and wellbeing and delivering better care and support. The Council will involve the person being assessed in the process as they are best placed to judge their own wellbeing.

9.4.2 The Council recognises that an individual may be unable to request an assessment or may struggle to express their needs.

9.4.3 In these situations the Council will carry out "supported decision making", helping the person to be as involved as possible in the assessment. The Council will seek to find someone appropriate and independent to support and represent the person, for the purpose of facilitating their involvement.

9.4.4 Where there is a family member or friend who is willing and able to facilitate the person's involvement effectively, and who is acceptable to the individual and judged appropriate by the Council, they may be asked to support the individual in the assessment process.

9.4.5 Where there is no one thought to be appropriate for this role – either because there is no family member or friend willing and available, or if the individual does not want them to be a part of the assessment – the Council will appoint an independent advocate.

9.5 Needs assessment

9.5.1 The Council will seek to identify an individual's care and support needs via the assessment process. In doing so, the Council will consider whether the individual's needs impact on their wellbeing beyond the ways identified by the individual.

9.5.2 During the assessment process the Council will seek to identify and record where any needs are being willingly met by a carer, although the Council is not required to meet those needs.

9.6 Carers assessments

9.6.1 Where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of needs for support, the Council will offer to carry out a carer's assessment.

9.6.2 A carers' assessment will seek to establish not only the carer's needs for support, but also the sustainability of the caring role itself, which includes both the practical and emotional support the carer provides to the adult. This will allow the Council to make a realistic evaluation of the carer's present and future needs for support and whether the caring relationship is sustainable.

9.6.3 The carer's assessment will consider the outcomes that the carer wants to achieve in their daily life, their activities beyond their caring responsibilities and the impact of caring upon those activities.

9.6.4 There may be circumstances where an adult providing care, either under contract or through voluntary work, is also providing care for an individual outside of those arrangements. In such a circumstance, the Council will consider whether to carry out a carer's assessment for that part of the care they are not providing on a contractual or voluntary basis.

9.7 Refusal of assessment

9.7.1 An adult with possible care and support needs or a carer may choose to refuse to have an assessment. In such circumstances the Council is not required to carry out an assessment. However, where it is identified that an adult lacks mental capacity and that carrying out a needs assessment would be in the adult's best interests, the Council is required to do so. The same applies where the Council identifies that an adult is experiencing, or is at risk of experiencing, abuse or neglect.

9.7.2 In instances where an individual or a carer has refused an assessment but at a later time requests one, the Council will ensure one is carried out.

9.8 Safeguarding

9.8.1 If it appears during the assessment process that the person is experiencing, or at risk of, abuse or neglect, the Council will carry out a safeguarding enquiry and decide with the adult in question what action, if any, is necessary and by whom.

9.8.2 The decision to carry out a safeguarding enquiry does not depend on the person's eligibility, but will be taken wherever there is reasonable cause to think that the person is experiencing, or is at risk of, abuse or neglect.

9.8.3 Where the actions required to protect the adult can be met by the Council, appropriate action will be taken. In the majority of cases the response will involve other agencies, such as the police, a change of accommodation or action by the CQC.

9.9 Focus on preventing needs

9.9.1 The assessment and eligibility process underpins the Council's preventative agenda. Throughout the assessment process the Council will seek to identify needs that could be reduced, or where escalation could be delayed through the use of specific preventive services, or relevant information and advice.

9.10 Considering the person's strengths and capabilities

9.10.1 During the assessment process, the Council will consider what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve. This will include the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help.

9.11 A whole family approach

9.11.1 During the assessment process, the Council will consider the impact of the person's needs for care and support on family members or other people the authority may feel appropriate. This will require the Council to identify anyone who may be part of the person's wider network of care and support.

9.11.2 In considering the impact of the person's needs on those around them, the Council will consider whether or not the provision of any information and advice would be beneficial to those people they have identified.

9.12 Young carers

9.12.1 During the assessment process, the Council will seek to identify any children who are involved in providing care. Identification of a young carer in the family will result in an offer of a needs assessment for the adult requiring care and support and, where appropriate, the Council will consider whether the child or young carer should be referred for a young carer's assessment or a needs assessment under the Children Act 1989 or a young carer's assessment under the Care Act 2014.

9.12.2 When assessing the young carer, the Council will consider:

- The impact of the person's needs on the young carers wellbeing, welfare, education and development
- Whether any of the caring responsibilities the young carer is undertaking are inappropriate.

9.13 Supported self-assessment

9.13.1 A supported self-assessment is an assessment carried out jointly by the adult with care and support needs or carer and the Council. It places the individual in control of the assessment process to a point where they themselves complete their assessment form.

9.13.2 Whilst it is the person filling in the assessment form, the duty to assess the person's needs, and in doing so ensure that they are accurate and complete, remains with the Council. This may involve the Council seeking consent to obtain the views of those who are in regular contact with the person self-assessing.

9.13.3 Before offering a supported self-assessment, the Council will first ensure that the individual has capacity to fully assess and reflect on their own needs. If a person is felt to lack capacity, the Council will carry out a capacity assessment. If this shows that the individual lacks capacity, a self-assessment will not be offered.

9.13.4 Where an individual lacking capacity does not have the support required from a carer or family member who is willing and able to facilitate the person's involvement effectively and who is acceptable to the individual and judged appropriate by the Council, an independent advocate will be arranged to assist them in their self-assessment.

9.13.5 Once assured that the self-assessment has accurately captured the person's needs, the Council will decide whether the individual meets the national eligibility criteria. Although the Council and the individual are working jointly to ascertain needs and eligibility, the final decision regarding eligibility will rest with the local authority.

9.13.6 In all cases, the Council will inform the person of their eligibility judgement and why the local authority has reached the eligibility determination that it has.

9.14 Combining assessments

9.14.1 The assessment of an adult and a carer may be combined, where both parties agree. If either of the individuals concerned does not agree to a combined assessment, then the assessments must be carried out separately.

9.15 Integrated assessments

9.15.1 The Council may carry out an assessment jointly with another organisation in relation to the person concerned, provided that person agrees. The exact form of integrated assessment will depend on the individual's circumstances, it may involve working together with relevant professionals on a single assessment or it may include putting processes in place to ensure that the person is referred to another agency for assessment.

9.16 NHS continuing healthcare

9.16.1 Where it appears that a person may be eligible for NHS continuing healthcare, the Council will notify the local Clinical Commissioning Group, as the ultimate responsibility for arranging and monitoring these services rests with the NHS.

9.17 Assessing people who have visual and hearing impairment

9.17.1 If a person has full or partial visual and hearing impairment that causes "difficulties with communication, access to information and mobility" a specialist assessment will be carried out by a trained assessor.

9.18 Record keeping

9.18.1 Once completed, the Council will provide a copy of the assessment to the person being assessed.

9.19 Delegating assessments

9.19.1 The Council may choose to delegate responsibility for the majority of its care and support duties to other organisations. If an assessment is carried out by another organisation, it should be treated as having been carried out by the Council.

9.20 Eligibility criteria - adults

9.20.1 The Council will comply with the national eligibility criteria which sets a minimum threshold for adult care and support needs and transparency on what level of need is eligible.

9.20.2 The assessment will be used to identify how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing. In considering whether an adult with care and support needs has eligible needs, the Council will consider whether:

- The adult's needs arise from, or are related to, a physical or mental impairment or illness
- As a result of the adult's needs the adult is **unable** to achieve **two or more** of the following outcomes
  - managing and maintaining nutrition
  - maintaining personal hygiene
  - managing toilet needs
  - being appropriately clothed
  - being able to make use of the adult's home safely
  - maintaining a habitable home environment
  - developing and maintaining family or other personal relationship
  - accessing and engaging in work, training, education or volunteering
  - making use of necessary facilities or services in the local community including public transport and recreational facilities or services
  - carrying out any caring responsibilities the adult has for a child
- As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing.

9.20.3 The council must meet an adult's needs where they meet all three of these conditions and may provide care and support to an adult if their needs to not meet all of these needs.

9.20.4 At times when an individual might be found to have needs that are not eligible, the Council may use its discretion in supporting the person and this may mean that under the SLCC model the practitioners may use their own professional judgment and their expertise to identify the most effective "tier 1 and tier 2" services and support available to the person. Workers will offer information and advice and signpost the individual to our partner organisations and voluntary community services as appropriate.

9.21 Eligibility criteria – carers

9.21.1 Carers can be eligible for support in their own right. The Council will comply with the national eligibility criteria which sets a minimum threshold for carer support and provides transparency on what level of need is eligible.

9.21.2 The assessment will be used to identify how a person's needs affect their ability to achieve relevant outcomes and how this impacts on their wellbeing.

9.21.3 In carrying out an assessment to determine a carers eligible needs, the Council will consider whether:

- the needs arise as a consequence of providing necessary care for an adult
- the carer is **unable** to do **any** of the following as a result of their caring duties:
    - carrying out any caring responsibilities the carer has for a child
    - providing care to other persons for whom the carer provides care
    - maintaining a habitable home environment in the carer's home (whether or not this is also the home of the adult needing care)
    - managing and maintaining nutrition
    - developing and maintaining family or other personal relationships
    - engaging in work, training, education or volunteering
    - making use of the necessary facilities or services in the local community, including recreational facilities or services
    - engaging in recreational activities.
- as a consequence of that fact there is, or there is likely to be, a significant impact on the carer's wellbeing.

9.21.4 The council must meet a carer's needs where they meet all three of these conditions and may provide care and support to an adult if their needs to not meet all of these needs.

9.21.5 In Suffolk we have a countywide strategy which is owned by the Carers Partnership Board and is co-produced and now includes SLCC, Joint Strategic Needs Assessment (JSNA) and the Carers Review. A new strategy for 2016 onwards will be co-produced with our partners and other stakeholders over the course of 2015.

9.21.6 There is also an action plan which gives some responsibility and governance to the Board and includes potential future joint commissioning activities of SCC and the CCGs.

9.21.7 Please see the attached links regarding carers in Suffolk for more information:

Suffolk Family Carers Strategy

9.21.8 Our approach to support Suffolk carers is offered via Supporting Lives , Connecting Communities, the same model of work we have for the cared for.

9.21.9 Supporting Lives Connecting Communities gives the strategic context for the delivery of services by the County. It focuses service delivery in three

tiers with a focus on preventative intervention which enables people to live their lives in a sustainable way, without the need for statutory services (tier one delivery). The SLCC approach describes these tiers as:

Tier 1 - Help to help yourself: Accessible, Friendly, Quick, Information, Advice, Advocacy. Universal services to the whole community, Prevention
Tier 2 - Regain independence, minimal delays, no presumption about long-term support, goal focused
Tier 3 - On-going support for those who need it: Self-directed, personal budget based, choice and control, highly individualised.

9.21.10 Our model of work prescribes a preventative approach for carers and aims to reduce or delay the need for care and support and promote independence from statutory services. The SLCC model is based upon a proactive, preventative and personalised approach, hence it offers carers the choice and control to lead healthy and fulfilled lives.

9.21.11 The model enables identification of carers earlier and aims to promote carers wellbeing. Prevention will be enhanced through a focus on a community based approach, as SLCC aims to connect its communities. Support aims to be more personalised and based upon carers own strengths, capacity, knowledge and networks.

9.21.12 Based on analysis of the current effectiveness of support for carers and a commissioned piece of research (Joint Strategic Needs Assessment) our Suffolk assessment of the areas of most significance in effectively supporting Carers are:

- The provision of good quality information and advice – sustaining the caring role
- Providing a break from the caring role
- The provision of emotional support/counselling.

9.22 Next steps

9.22.1 The Council will provide the outcome of the eligibility determination to the individual who has been assessed using the EDR –Eligibility Decision Records.

9.22.2 Where the individual has no eligible needs, the Council may still provide relevant information and advice about what can be done to meet or reduce the person's needs and what can be done to prevent or delay the development of needs in the future.

9.22.3 If a person is found to have some eligible needs, the Council will::

- Agree with the adult which of their needs are being met through other support networks, such as a carer or a local support group
- Agree with the adult which of their needs are to be met by the Council and begin the support planning process
- Arrange for a financial assessment to determine whether the person should contribute towards their care and support services

9.23 Transition to the new legal framework

9.23.1 This policy relates to duties established under the Care Act 2014 which came into effect from the 1st April 2015.

9.23.2 Individuals who have received an assessment under the previous legislation will not be required to be re-assessed purely because of the new legal framework, however any assessments or re-assessments started on or after the 1st April 2015 will be carried out in line with the new duties and responsibilities established in the Care Act 2014.

9.23.3 This applies equally to individuals with care and support needs and carers.

10.0 Advocacy

10.1 Advocacy

10.1.1 Local authorities are required to involve people in decisions made about them and their care and support. No matter how complex a person's needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions. Where someone has substantial difficulty in being involved in the decision-making process, the Care Act 2014 establishes a duty for local authorities to provide an independent advocate to support their involvement as fully as is possible.

10.2 What is advocacy?

10.2.1 The role of the independent advocate is to support and represent the individual and to facilitate their involvement in the key processes and interactions with the local authority and other organisations as required.

10.2.2 The ultimate aim is for people's wishes feelings and needs to be at the heart of the assessment, care planning and review processes.

10.3 Advocacy and the duty to involve

10.3.1 The Council will arrange an independent advocate to facilitate the involvement of a person in their assessment, in the preparation of their care

and support plan and in the review of their care plan, as well as in safeguarding enquiries and SARs if two conditions are met. These are:

- That if an independent advocate were not provided then the person would have substantial difficulty in being fully involved in these processes
- There is no appropriate individual available to support and represent the person's wishes who is not paid or professionally engaged in providing care or treatment to the person or their carer

10.3.2 Many of the people who qualify for advocacy under the Care Act will also qualify for advocacy under the Mental Capacity Act 2005. The Council supports the view that the same advocate can provide support as an advocate under the Care Act and under the Mental Capacity Act.

10.4 Judging 'substantial' difficulty in being involved

10.4.1 The statutory guidance issued under the Care Act 2014 guidance states a "substantial difficulty" might be found in anyone of the following areas:

- Understanding relevant information
- Retaining information
- Using or weighing the information as part of the process of being involved
- Communicating their views, wishes and feelings.

10.5 When the duty to provide independent advocacy applies

10.5.1 The duty to provide independent advocates applies to the following:

- Assessing needs for care and support
- Adult safeguarding
- Care and support reviews.

10.5.2 **Assessing needs for care and support:** From the point of first contact, request or referral (including self-referral) for an assessment, the Council will involve the person in the process. The Council will initially consider the best way of involving the person in the assessment processes, which is appropriate and proportionate to the person's needs and circumstances.

10.5.3 Where the Council considers that a person has "**substantial difficulty"** in engaging with the assessment process, then they must consider whether there is anyone appropriate who can support the person be fully involved. This might for example be a carer, family member or friend. If there is no one appropriate, then the Council will arrange for an independent advocate. This applies equally to:

- A needs assessment
- A carer's assessment
- The preparation of a care and support plan or support plan

- A review of care and support plan or support plan
- A child's needs assessment
- A child's carer's assessment
- A young carer's assessment
- Adult safeguarding

10.5.4 As part of the assessment and the care and support plan, the Council will have regard to the need to help protect people from abuse and neglect, and will assist the person to identify any risks and ways to manage them.

10.5.5 The Council will also have regard to ensuring that any restriction on the person's rights or freedom is kept to the minimum necessary. Restrictions will be carefully considered and frequently reviewed. Any potential deprivation of liberty will be authorised, either by a the local authority authorising this using its powers under the Deprivation of Liberty Safeguards, or by an order from the Court of Protection made under the Mental Capacity Act.

10.5.6 Where it appears that a person may be eligible for NHS Continuing Health Care (NHS CHC) funding the Council will notify the local Clinical Commissioning Group (CCG). Where an individual is deemed not eligible for NHS CHC, the Council retains the duty to carry out an assessment of needs where a person has an appearance of needs and a duty to meet those eligible needs identified. In doing so, the Council will consider the need for an independent advocate to support the person's involvement in that assessment.

10.5.7 Under the Mental Health Act 1983 (MHA) certain people, known as 'qualifying patients', are entitled to the help and support from an Independent Mental Health Advocate (IMHA). Section 117 of the MHA places a duty on the NHS and the Council to provide aftercare, which will usually involve a joint assessment.

10.5.8 Those people who do not retain a right to an IMHA, whose care and support needs are being assessed, planned or reviewed will be considered for an advocate under the Care Act 2014.

10.5.9 **Care and support reviews:** The Council will involve the person, their carer and any other individual that the person wants to be involved in any review of their care and support plan and take all reasonable steps to agree any changes. In doing so, the Council will consider whether an advocate is required to facilitate the person's involvement in the review of a care and support plan and, if appropriate, appoint an advocate.

10.6 Involvement from friends, family and others

10.6.1 The council will consider the most appropriate action, dependent on the specific circumstances of the individual in question.

10.6.2 If the Council decides that they are required to appoint an independent advocate as the person does not have friends or family who can facilitate their involvement, the Council will still consult with those friends or family members when the person asks them to.

10.6.3 There may be some cases where the local authority considers that a person needs the support of both a family member and an advocate.

10.6.4 It is the Council's decision as to whether a family member or friend can act as an appropriate person to facilitate the individual's involvement. In considering the appointment of an independent advocate, or the involvement of a family member or friend, the Council will apply the following principles:

- It cannot be someone who is already providing the person with care or treatment in a professional capacity or on a paid basis (regardless of who employs or pays for them).
- The person's wish not to be supported by a particular individual should be respected. In such a case the Council must be satisfied that it is in the person's best interest in order to overrule this wish.
- The appropriate individual is expected to support and represent the person and to facilitate their involvement in the process.

10.6.5 It is the Council's responsibility to communicate this decision to the individual's friends and family where this may have been in question and whenever appropriate. The overall aim should be for people who need advocacy to be identified and when relevant, receive consistent support as early as possible and throughout the assessment, the care and support planning and the review processes.

10.6.6 The Council may be carrying out assessments for two people in the same household. If both people agree to have the same advocate and if the Council considers there is no conflict of interest between the individuals or either of the individuals and the advocate, then the same advocate may support and represent the two people.

10.7 Exceptions and special circumstances

10.7.1 In general, a person who has substantial difficulty in being involved in their assessment, plan and review, will only become eligible for an advocate where there is no one appropriate to support their involvement. The exceptions are:

- Where the exercising of the assessment or planning function might result in placement in NHS-funded provision in either a hospital for a period exceeding four weeks or in a care home for a period of eight weeks or more and the Council believes that it would be in the best interests of the individual to arrange an advocate
- Where there is a disagreement, relating to the individual, between the Council and the appropriate person whose role it would be to facilitate the individual's involvement, the Council and the appropriate person agree that the involvement of an independent advocate would be beneficial to the individual

10.8 Who can act as an independent advocate

10.8.1 The Care Act 2014 contains some specific regulations and guidance relating to independent advocates, which is endorsed by the Council, as detailed below.

10.8.2 An independent advocate must not be working for the Council, or for an organisation that is commissioned to carry out assessments, care and support plans or reviews for the local authority.

10.8.3 In certain circumstances, in addition to their role under the Care Act, an advocate **may** assist an individual to develop their own care or support plan if requested to by the individual, but they cannot be the person to authorise the support plan or to approve care and support plans or reviews on behalf of the Council.

10.8.4 Nor can an advocate be appointed if they are providing care or treatment to the individual in a professional or a paid capacity.

10.8.5 The Council recognises that an advocate must have the following attributes, in order to comply with the legal requirements outlined in the Care Act 2014:

- A suitable level of appropriate experience:
- Appropriate training
- Competency in the task
- Integrity and good character
- The ability to work independently of the local authority or body carrying out assessments, planning or reviews on the local authority's behalf
- Arrangements for regular supervision

10.9 The role of an independent advocate

10.9.1 The Council recognises that acting as an independent advocate for a person with a substantial difficulty in engaging with care and support or safeguarding processes includes:

- Assisting a person to understand the assessment, care and support planning and review and safeguarding processes
- Assisting a person to communicate their views, wishes and feelings
- Assisting a person to understand how their needs can be met by the local authority or otherwise
- Assisting the person to make decisions about their care and support arrangements
- Assisting the person to understand their rights under the Care Act
- Assisting a person to challenge a decision or process made by the local authority

10.9.2 In line with the Care Act 2014 guidance, the Council will support this by allowing independent advocates to examine and take copies of relevant records in certain circumstances. This mirrors the powers of an Independent Mental Capacity Advocate (IMCA).

10.9.3 In terms of safeguarding there are some particular important issues for advocates to address. These include assisting a person to::

- Decide what outcomes/changes they want
- Understand the behaviour of others that are abusive/neglectful
- Understand which actions of their own may expose them to avoidable abuse or neglect
- Understand what actions that they can take to safeguard themselves
- Understand what advice and help they can expect from others, including the criminal justice system
- Understand what parts of the process are completely or partially within their control
- Explain what help they want to avoid reoccurrence and also recover from the experience

10.10 Representing

10.10.1 The advocate must write a report outlining their concerns for the Council, and the Council has a duty to convene a meeting with the advocate to consider the concerns and provide a written response to the advocate following the meeting.

10.10.2 The ultimate goal of this representation is to secure a person's rights, promote the individual's well-being and ensure that their wishes are taken fully into account.

10.11 The Council's role in supporting an independent advocate

10.11.1 The Council recognises that an advocate's duty is to support and represent a person who has substantial difficulty in engaging with Council processes.

10.11.2 The Council will take into account any representations made by an advocate, and provide a written response to a report from an advocate which outlines concerns about how the Council has acted or what decision

has been made or what outcome is proposed. The Council agrees that the advocate's role incorporates 'challenge' on behalf of the individual.

10.12 Availability of advocacy services in Suffolk

10.12.1 The Council is committed to ensuring sufficient provision of independent advocacy services in the county, in order to meet the obligations established under the Care Act 2014.

10.12.2 We commission statutory and independent advocacy services for people within Suffolk.

10.12.3 Suffolk County Council commissions statutory and non-statutory independent formal advocacy services for people in Suffolk.

10.12.4 Formal advocacy is:

- delivered by Total Voice Suffolk, a partnership of charity and voluntary sector organisations in the county
- focused, time-limited support for individuals across Suffolk
- available to adults aged 18 or over who live in Suffolk, or who access health and social care services here.

10.12.5 Formal advocacy can support people:

- facing important decisions about their lives or care during periods of disability or ill health
- wanting to explore their the options at each stage of the complaints procedure about NHS funded services
- who need help to be fully involved in their assessment, review, planning and safeguarding (and their family carers)
- qualifying under the Mental Health Act 2007 for Independent Mental Health Advocacy
- with a mental health condition who need specialist Mental Health Advocacy
- who lack mental capacity subject under the Mental Capacity Act 2005 but have no one to speak for them, such as family or friends, about decisions regarding serious medical treatment or a move to other accommodation or when an application to deprive them of their liberty has been made
- living in those Care UK homes purchased from the council and/or their family members
- with a learning disability who are parents and are facing child protection proceedings

- with a learning disability who are moving from NHS accommodation to supported living (and their family carers).

10.12.6 If you or someone you care for need help with any of the above, or if you want to find out more about advocacy, please contact Total Voice Suffolk,

Telephone: 01473 857631
Fax: 01473 858806
Email: tvspartnership@voiceability.org

10.12.7

Informal/Community advocacy: We are also supporting the development of less formal advocacy in local communities by providing training, support and mentoring to charities and community groups. This means they can gain an understanding of both formal and informal advocacy, and deliver informal advocacy through their volunteers or paid support workers.

10.12.8 This is a pilot being developed in collaboration with Suffolk Community Advocacy which is led by three local organisations: ACE Anglia Ltd, Anglia Care Trust and The Befriending Scheme.

10.12.9 Suffolk Community Advocacy works closely with Total Voice Suffolk. It also provides awareness training to organisations and community groups about advocacy and the advocacy requirements of the Care Act.

Telephone: 01449 674657
Email: info@suffolkcommunityadvocacy.org

11.0 Support planning

11.1.1 A vital part of the care and support process for people with ongoing needs is the “care and support plan” or “support plan” in the case of carers.

12.1.1 The individual concerned will be given every opportunity to take joint ownership of the development of the plan. The plan ‘belongs’ to the person it is intended for, with the local authority role to ensure the production and sign-off of the plan to ensure that it is appropriate to meet the identified needs.

11.2 What is support planning?

11.2.1 Once an individual has been assessed as having eligible needs, and ordinary residence established, a period of support planning will take place which will detail how that person’s needs will be met.

11.2.2 The plan should contain an indication of the personal budget that has been identified to give everyone involved clear information regarding the care and supports costs and the amount that the local authority will make available. Including the personal budget helps people to make better informed decisions as to how needs will be met.

11.2.3 The guiding principle in the development of the plan is that the process should be person-centred and person-led, in order to meet the needs and outcomes of the person in ways that works for them as an individual and their family.

11.3 Meeting needs

11.3.1 The concept of "meeting needs" is intended to be broader than a duty to provide or arrange a particular service. Because a person's needs are specific to them, there are many ways in which their needs can be met. The purpose of the care and support planning process is to agree **how** a person's needs should be met, and therefore how the Council will discharge its duty, or its power, to do so.

11.3.2 **How needs can be met:** There are a number of broad options for how needs could be met, and the use of one or more of these will depend on the individuals specific circumstances. These are:

- The Council directly providing some type of support
- The Council arranging for a care and support provider to provide some type of support
- The Council making a direct payment, to enable the person to purchase their own care and support
- Some combination of the above
- The Council 'brokering' a service on behalf of the individual in specific cases, for example with people who are financially assessed as being able to pay for their own care. This would involve the Council supporting the individual to select and enter into a contract with a provider. The contract would be held with the individual, not by the Council.

11.3.3 When determining how to meet someone's needs, the Council will take into consideration the individual's preferences and consider the person's goals in approaching the authority for support and the level or nature of support desired.

11.3.4 The Council recognises that eligible needs can sometimes be met by services or arrangements beyond the provision or arrangement of services by local authorities. Needs may be met via a carer, a community provision or another institution, other than the Council. In such a case, the eligible needs will be included in the support plan, but these services may not be

included in any support arrangements commissioned or arranged by the Council. However, they will be regularly reviewed by the Council alongside the other arrangements to ensure their continued suitability.

11.3.5 Whilst the Council is committed to joint working with the NHS and housing partners, the Council will not directly provide or arrange any services that these organisations are legally obliged to provide.

11.3.6 **Non-eligible needs:** Under certain circumstances, the Council may choose to meet some non-eligible needs. Where the Council chooses not to meet any non-eligible needs, the Council will provide a written explanation for this decision.

11.4 Changing the way needs are met

11.4.1 The Council is committed to meeting the eligible needs of the people receiving care and support. In recognising the importance of family and community networks, where eligible needs can be met by support from family carers or engagement with community networks and activities, these will be reflected in the support plan and will reduce the need for support funded and/or arranged by the Council.

11.4.2 Further information on how the Council will work with adults and their carers to ensure that their assessed eligible needs are met can be found at Suffolk Infolink.

11.5 Producing care and support plans

11.5.1 The Council is committed to ensuring care and support plans are person-centred and to ensure the individual has every reasonable opportunity to be involved in the planning. The Council will involve the person the plan is intended for, the carer (if there is one) and any other person the adult requests to be involved.

11.5.2 The Council is committed to including the following key elements in a care and support plan:

- The needs identified by the assessment:

- Whether, and to what extent, the needs meet the eligibility criteria
- The needs that the authority is going to meet, and how it intends to do so
- For a person needing care, for which of the desired outcomes care and support could be relevant
- For a carer, the outcomes the carer wishes to achieve, and their wishes around providing care, work, education and recreation where support could be relevant

- The personal budget
- Information and advice on what can be done to reduce the needs in question, and to prevent or delay the development of needs in the future
- Where needs are being met via a direct payment, the needs to be met via the direct payment and the amount and frequency of the payments

11.5.3 During the support planning process, the Council will give consideration to the extent to which the needs or a person's other circumstances may mean that they are at risk of abuse or neglect. The planning process may bring to light new information that suggests a safeguarding issue, and therefore lead to a requirement to carry out a safeguarding enquiry.

11.5.4 **Carer involvement:** The person may have assessed eligible needs which are being met by a carer at the time of the plan – in these cases the Council will seek to involve the carer in the planning process. Provided the carer remains willing and able to continue caring, the local authority is not required to meet those needs. However, the Council will record the carer's willingness to provide care and the extent of this in the plan of the person and also the carer, so that the authority is able to respond to any changes in circumstance more effectively.

11.5.5 Where the carer also has eligible needs, the Council may suggest the production of a joint support plan. Both parties will need to agree with this approach before a joint plan is undertaken.

11.5.6 **Direct payments:** In developing the plan, the local authority must inform the person which, if any, of their needs may be met by a direct payment. More detail can be found in policy statement "12.0 Direct payments".

11.5.7 **Mental capacity:** The Mental Capacity Act 2005 (MCA) requires local authorities to assume that people have capacity and can make decisions for themselves, unless otherwise established. Every adult has the right to make his or her own decisions in respect of his or her *care and support plan*, and must be assumed to have capacity to do so unless it is proved otherwise.

11.5.8 The Council endorses the view that a person must be given all practicable help to make the specific decision before being assessed as lacking capacity to make their own decisions.

11.5.9 Where an individual has been assessed as lacking capacity to make a particular decision, then the Council will commence care and support planning in the person's best interests under the meaning of the MCA.

11.5.10 Where individuals have difficulty in being actively involved with the planning process, the Council will seek to involve any person who appears to the authority to be interested in the welfare of the person. Where individuals have no family or friends who are able to facilitate the person's involvement in the plan, the Council will arrange for an independent advocate to represent and support the person's involvement.

11.5.11 This duty arises if the person would, without the representation and support of an independent advocate, experience substantial difficulty in any of the following:

- Understanding relevant information
- Retaining relevant information
- Using or weighing that information as part of the process of being involved
- Communicating their views, wishes or feelings

11.5.12 **Combined care and support plans:** Depending on the specific circumstances of the individual concerned, the Council may recommend the production of a joint care and support plan. The plan can only be combined if all parties to whom it is relevant agree and understand the implications of sharing data and information. The combination of plans should aim to maximise outcomes for all involved. The Council is legally obliged to obtain consent from all parties involved before undertaking a joint care and support plan. During this process, the Council will work with partners to establish a lead organisation for the combined plan.

11.6 Care and support plan - sign-off and assurance

11.6.1 The Council will take all reasonable steps to agree with the person concerned the manner in which the plan details how needs will be met, before signing-off the plan.

11.6.2 Where a care and support plan is created by the person, a third party or jointly with other organisations, the Council's role includes overseeing and providing guidance for the completion of the plan and ensuring that the plan sufficiently meets needs, is appropriate and represents the best balance between value for money and maximisation of outcomes for the person.

11.6.3 In the event that the Council prepares the plan on behalf of the person or delegating this to a third-party, it will reflect the best interests of the person throughout.

11.6.4 Where possible sign-off should occur when the person, any third party involved in the preparation of the plan and the Council have agreed on the

factors within the plan, including the final personal budget amount and how the needs in question will be met.

11.6.5 Where an independent advocate has been used, they will not be asked to sign-off the plan, as this remains the responsibility of the Council.

11.6.6 The Council recognises the importance of the care and support plan and will ensure timely completion, proportionate to the needs that are to be met. The Council is also committed to ensuring that the planning process does not unduly delay needs being met.

11.6.7 Upon completion of the plan, the Council will give a copy of the final plan to the person for whom the plan is intended and any other person they request to receive a copy, including their independent advocate if they have one and the person agrees.

11.7 What is a personal budget?

11.7.1 The personal budget calculation forms a key part of the care and support planning process.

11.7.2 The personal budget sets out the overall sum of money that will be available to meet a person's eligible needs. The individual can then exercise choice and control over the way their eligible needs are met through their care and support plan.

11.7.3 Some, or all, of the personal budget can be taken as a direct payment to enable the individual to directly purchase care and support services. See the Direct Payment Policy Statement for further details.

11.7.4 Key benefits of a personal budget are:

- Knowing, before care and support planning begins, an estimate of how much money will be available to meet a person's assessed needs and, with the final personal budget, having clear information about the total amount of the budget, including proportion the local authority will pay, and what amount (if any) the person will pay
- Being able to choose from a range of options for how the money is managed, including direct payments, the local authority managing the budget and a provider or third party managing the budget on the individual's behalf (an individual service fund), or a combination of these approaches
- Having a choice over who is involved in developing the care and support plan for how the personal budget will be spent, including from family or friends
- Having greater choice and control over the way the personal budget is used to purchase care and support, and from whom.

11.7.5 The Council is committed to ensuring the personal budget calculation is transparent and robust so people have confidence that their allocation is correct and therefore sufficient to meet their eligible care and support needs.

11.7.6 The personal budget will contain:

- The cost to the Council of meeting a person's eligible needs
- Any financial contributions the individual must make towards the cost of their care and support services

11.7.7 The personal budget will not contain

- Any preventative services deemed to be 'free at point of delivery' (such as occupational therapy and assistive telecare equipment and reablement services)
- Any top-up fees paid by the individual or a third-party
- Any administration charges applicable for the arranging of care and support services for people who have financial resources above the financial limit

11.7.8 These items will be presented separately but alongside the personal budget. This ensures that the personal budget remains transparent, timely and sufficient to meet the individual's eligible needs.

11.8 Personal budgets for carers

11.8.1 In line with the principles of the Care Act 2014, the Council has a duty to promote wellbeing, and will support carers to look after their own physical and mental health and emotional wellbeing, social and economic wellbeing and to spend time with other family members and personal relationships.

11.8.2 To support this objective, carers will receive a personal budget. The personal budget calculation forms a key part of the carers support planning process.

11.8.3 The personal budget sets out the overall sum of money that will be available to meet the carers eligible needs. The carer can then exercise choice and control over the way their eligible needs are met through support plan.

11.8.4 Some, or all, of the personal budget can be taken as a direct payment to enable the carer to directly purchase support services. See the Direct Payment Policy Statement for further details.

11.9 Reviewing the care and support plan

11.9.1 Keeping care and support plans under review is an important part of the process and is essential to ensure the plan remains relevant to their goals and aspirations.

11.9.2 A care and support plan review will cover these broad elements, as appropriate::

- Have the person's circumstances and/or care and support or support needs changed?
- What is working in the plan, what is not working and what might need to change?
- Have the outcomes identified in the plan been achieved or not?
- Does the person have new outcomes they want to meet?
- Could improvements be made to achieve better outcomes?
- Is the person's personal budget enabling them to meet their needs and the outcomes identified in their plan, and
- Is the current method of managing it still the best one for what they want to achieve, e.g. should direct payments be considered?
- Is the personal budget still sufficient to meet the person's needs?
- Are there any changes in the person's informal and community support networks which might impact negatively or positively on the plan?
- Has there been any changes to the person's needs or circumstances which might mean they are at risk of abuse or neglect?
- Is the person, carer, independent advocate satisfied with the plan?

11.9.3 A review of a care and support plan might be triggered by:

- A planned review – where a date is agreed with the individual during the care and support planning process
- An unplanned review – instigated due to a change in need or circumstances of the individual concerned, such as an unplanned hospital admission
- A requested review – where the individual or their carer or other interested party requests a review of the persons care and support plan.

11.9.4 It will be a 'light-touch' review designed to ensure that the care and support plan is working as intended and help identify any minor adjustments needed.

11.9.5 The Council is committed to ensuring that reviews are proportionate to the needs and circumstances of the individual concerned. Where conditions are progressive and a person's health is deteriorating, frequent reviews may be scheduled.

11.9.6 The right to request a review applies to all parties interested in a person's wellbeing, not just the person receiving care.

11.9.7 In considering whether to undertake a review the Council will involve the person, carer and anyone else the person requests to be involved where feasible. The Council will seek to identify those who may have significant difficulty in being fully involved in the decision to review and when there is no appropriate person who can represent or support their involvement and consider the duty to provide independent advocacy.

11.9.8 Where a decision is made not to conduct a review following a request, the Council will set out the reasons for not accepting the request in a format accessible to the person, along with details of how to pursue the matter if the person remains unsatisfied.

11.10 Revising the care and support plan

11.10.1 Where a decision has been made following a review that a revision is necessary, the Council will inform the person, or a person acting on their behalf of the decision and what this will involve. Where the person has substantial difficulty in being actively involved with the review, and where there are no family or friends to help them being engaged, an independent advocate must be involved.

11.10.2 When revising the plan the Council will involve the person, their carer and any other persons the adult may want involved and their advocate where the person qualifies for one. The Council will take all reasonable steps to agree the revision. The revision will, wherever possible, follow the process used in the assessment and care planning stages. Indeed, the Council will, if satisfied that the circumstances have changed in a way that affects a care and support or support plan, carry out a needs or carer's assessment and financial assessment and then revise the plan and personal budget accordingly.

11.10.3 In some cases the review will confirm that the care and support plan remains relevant and represents the best and most effective way of meeting a person's eligible needs.

11.10.4 In other cases the review will result in changes to the plan, either because a person's needs have changed, or because there are new and more effective ways of meeting an individual's needs.

11.10.5 The review process will be fundamentally the same as the one followed to establish the initial care and support plan. This will include the following

- The person's wishes and feelings should be identified as far as possible and they should be supported to be involved
- The revision should be proportionate to the needs to be met
- Where the plan was produced in combination with other plans, this should be considered at the revision stage
- The person, carer or person acting on their behalf should be allowed to self-plan in conjunction with the local authority where appropriate
- The development of the revised plan must be made with the involvement of the adult/carer and any person the adult asks the authority to involve
- Any additional elements that were incorporated into the original plan should be replicated in the revised plan where appropriate and agreed by all parties
- There needs to be clarity in the sign-off process, especially where the revised plan is prepared by the person and the local authority

11.10.6 Particular attention will be given if the revisions to the plan propose increased restraints or restrictions on a person who does not have the capacity to agree them. This may become a deprivation of liberty, which requires appropriate safeguards to be in place.

11.10.7 In all cases, the Council will consider whether an independent advocate may be required to facilitate the person's involvement in the revision of the care and support plan.

11.10.8 Where there is an urgent need to intervene, the Council will consider implementing interim packages to urgently meet needs while the plan is revised. In doing so, the Council will endeavour to work with the person to avoid such circumstances arising wherever possible by ensuring that any potential emergency needs are identified as part of the care and support planning stage and planned for accordingly.

11.11 Transition to the new legal framework

11.11.1 This policy relates to duties established under the Care Act 2014 which came into effect from the 1st April 2015. Individuals who have received an assessment under the previous legislation will not be required to be re-assessed purely because of the new legal framework, however any re-assessments started on or after the 1st April 2015 will be carried out in accordance with the new duties and responsibilities established in the Care Act 2014.

11.11.2 Equally, any care and support plans created prior to the 1st April 2015 will only be revised following a re-assessment brought about by a change to an individual's needs or circumstances.

11.11.3 This applies equally to individuals with care and support needs and carers.

12.0 Direct payments

12.1.1 Direct payments provide independence, choice and control by enabling people to purchase their own care and support in order to meet their assessed eligible social care needs.

12.2 What is a direct payment?

12.2.1 A direct payment is a monetary payment made to individuals who request one in order to meet part or all of their eligible care and support needs. Direct payments enable people to take control over their care planning, giving them choice over the way their needs are met.

12.3 Promoting direct payments in Suffolk

12.3.1 The Council will ensure that information about direct payments is universally available. The information will cover::

- What direct payments are
- How to request one including the use of nominated and authorised persons to manage the payment
- Explanation of the direct payment agreement and how the local authority will monitor the use of the direct payment
- The responsibilities involved in managing a direct payment
- The responsibilities involved in being an employer
- Making arrangements with social care providers
- Signposting to local organisations (such as user-led organisations and micro-enterprises) and the local authority's own internal support, who offer support to direct payment holders, and information on local providers
- Case studies and evidence on how direct payments can be used locally to innovatively meet needs

12.3.2. Information about direct payments is available on the following pages:

Suffolk Infolink Direct Payments information

Suffolk Infolink advice page

12.3.3 A request to receive a direct payment can be made at any time, and the Council will ensure a timely response.

12.3.4 The steps taken after a request for a direct payment depends on whether the person making the request has been assessed as having capacity to make a decision about direct payments or not.

12.4 Who can receive direct payments

12.4.1 The steps taken after a request for a direct payment depends on whether the person making the request has been assessed as having capacity to make a decision about direct payments or not.

12.4.2 **Adults with capacity:** The Council will ensure that the person requesting a direct payment meets all four of the following conditions:

:

- The adult has capacity to make the request, and where there is a nominated person, that person agrees to receive the payments
- The Council is not prohibited by regulations from meeting the adult's needs by making direct payments to the adult or nominated person (for example prisoners are disbarred from receiving direct payments)
- The Council is satisfied that the adult or nominated person is capable of managing direct payments either by himself or herself, or with whatever help the authority thinks the adult or nominated person will be able to access
- The Council is satisfied that making direct payments to the adult or nominated person is an appropriate way to meet the needs in question

12.4.3 **Adults lacking capacity:** When an adult with eligible needs lacks the capacity to request a direct payment, an authorised person may request that the Council meets some or all of the needs by making a direct payment to the authorised person. A person is authorised for this purpose if::

- They are authorised under the Mental Capacity Act 2005 to make decisions about the adult's needs for care and support
- A person authorised under the Mental Capacity Act 2005 agrees with the Council that another person is a suitable person to receive the direct payment
- Where there is no person authorised under the Mental Capacity Act 2005, the Council considers that the person is suitable to receive the direct payment.

12.4.4 The Council will ensure the following:

- The authorised person will act in the adult's best interests in arranging for the provision of care and support for which the direct payments under this section would be used
- The authorised person is capable of managing the direct payment by himself or herself, or with whatever help the authority thinks the authorised person will be able to access
- Making direct payments to the authorised person is an appropriate way to meet the needs in question

12.4.5 Where accepted, the decision to provide direct payments will be recorded in the care plan or support plan. The individual will be asked to sign a direct payment agreement with the Council outlining the appropriate use of the payment, to ensure effective use of public money.

12.4.6 Where declined, the person or persons making the request will be notified by the Council in writing, explaining why the request was declined. The Council will also provide information about how the decision can be appealed through the local complaints process.

12.4.7 Where a request has been declined, the Council will continue the care planning process so it can seek to agree with the individual concerned how best to meet their needs without the use of direct payments.

12.4.8 Carers who have had an assessment and are eligible to receive social care support have a right to request some or all of their needs are met by direct payments.

12.4.9 Carers can also request to administer a direct payment on behalf of the person they care for, provided that they have given consent.

12.5 Direct payment exceptions

12.5.1. Direct payments are designed to be used flexibly and innovatively and there should be no unreasonable restriction placed upon the use of this payment, as long as it is being used to meet eligible care and support needs, with the following exceptions.

12.5.2 A direct payment cannot be used to pay for care from a close family member or partner living in the same household, although the Care Act 2014 allows people to pay a close family member living in the same house to provide management or administrative support to the direct payment holder, in cases where the Council deems this necessary. This recognises that the management and administration of a large direct payment can be complex and time consuming, although it is not intended that this be seen as income replacement. The family member receiving this payment will have significant tax and employment implications and may impact on any other benefits received.

12.5.3 Direct payments cannot be made to people subject to a court order for a drug or alcohol treatment program or similar schemes.

12.5.4 Direct payments are not available to people serving a custodial sentence. This includes people residing in prison, approved premises and other bail accommodation.

12.5.5 A Direct Payment cannot currently be used to pay for long-term care home placements, although they can be made to enable people to purchase for themselves a short stay in care homes, provided that the stay does not exceed a period of four consecutive weeks in any 12-month period.

12.5.6 Direct payments should not be used to pay the Council for in-house provider services, such as day care. However they can be used to pay for services provided by other local authorities.

12.6 Administering direct payments

12.6.1 The individual receiving direct payments will be required to set up a dedicated bank account that will only be used for receiving the direct payment and making appropriate payments. The Council will pay direct payments net of any assessed financial contribution. Any contribution due

as a result of a financial assessment must be paid into the dedicated direct payment bank account.

12.6.2 The Council is accountable for the effective use of public money, and will therefore periodically review how direct payments are being used to ensure it is in keeping with the agreed care and support plan. The Council will require evidence to be submitted to show how the direct payment is being spent. In most cases, this will be a request for bank statements and records of payments to and from the direct payment account.

12.6.3 The initial review is likely to be a 'light touch' review, to take place within the first six months of the first payment, to ensure that the individual is able to manage direct payments effectively, and experiencing no initial issues. If this review raises concerns or requires actions that impact on the care and support plan, a full review would be initiated.

12.6.4 The Council will seek to recover any unspent direct payments.

12.7 Employment and direct payments

12.7.1 Where direct payments are used to employ a personal assistant, or other staff, the Council will work with the individual to ensure that there are adequate contingency plans in place to ensure their needs are met in the event of the personal assistant being absent. These will be detailed in the care and support plan.

12.7.2 Where an individual chooses to use direct payments to employ someone, they will be responsible for all costs of employment, including redundancy payments. To facilitate the employment of personal assistants and other staff, the Council has a commissioned support and payroll organisation to assist people with using their Direct Payment and becoming employers. A personal assistant register is available for Suffolk residents to assist in finding care staff.

12.7.3 The Council will ensure that the individual has sufficient information and guidance in regards to having the correct insurance cover in place. The Council will therefore factor these costs into the direct payment calculation.

12.7.4 Becoming an employer carries with it certain responsibilities and obligations, in particular to HMRC. The Council will provide the individual with relevant information about this so they can make an informed choice when deciding to take up a direct payment.

12.7.5 The Council retains the right to make periodic checks to make sure any PAYE income tax and National Insurance contributions are deducted from an employee's pay is in turn paid over to HMRC, and that employment payments do not breach the national minimum wage and conform to pension requirements if eligible.

12.7.6 The government has designated certain types of work in the care sector as 'regulated activity'. The vast majority of care assistants employed via direct

payments will be doing 'regulated' work. People who are employed via direct payments must be prepared to apply for a Disclosure and Barring certificate if they are undertaking 'regulated activity'. This is a legal requirement. The responsibility of this lies with the employee.

12.8 Terminating direct payments

12.8.1 The decision to terminate direct payments can be taken by either the Council or the individual receiving them. There are a number of reasons why direct payments may be terminated. These reasons include, but are not limited to:

- The person to whom direct payments are made, whether to purchase support for themselves or on behalf of someone else, may decide at any time that they no longer wish to continue receiving direct payments
- The person no longer appears to be capable of managing the direct payments or of managing them with whatever support is necessary
- Direct payments should be discontinued when a person no longer needs the support for which the direct payments are made
- There may be circumstances in which the Council discontinues direct payments temporarily. The Council will discuss with the person, their carer, and any other person how best to manage this
- The Council will discontinue payments if the person fails to comply with a condition imposed under regulations to which the direct payments are subject or if for some reason the Council no longer believes it is appropriate to make the direct payments
- The deliberate misuse of direct payments by the person to whom direct payments are made, or their representative

12.8.2 In the event that direct payments are terminated, the Council will work with the individual concerned to agree an arranged care and support provision. The Council will conduct a revision of the care and support plan to ensure that it remains appropriate to meet the needs in question.

12.8.3 If direct payments are discontinued, some people may find themselves with ongoing contractual responsibilities or having to terminate contracts for services (including possibly making employees redundant). The Council will take reasonable steps to make people aware of the potential consequences if direct payments end, and any obligations they may have.

12.8.4 Where the person has lost the capacity to manage the direct payment and there is no-one else to manage the payment on their behalf, or where a person needs additional support to terminate arrangements, the Council will consider whether it needs to step in or provide support to ensure that any contractual arrangements are appropriately terminated to ensure that additional costs are not incurred.

12.9 Policy review

12.9.1 This policy will be reviewed annually. An early review may be triggered by any national or local developments that impact on this policy.

13.0 Ordinary residence

13.1 Ordinary residence

13.1.1 It is critical to the effective operation of the care and support system that local authorities can identify which people they have responsibilities towards: and that people know which council to contact when they need care and support.

13.1.2 A local authority only has a duty to meet needs in respect of an adult who is "ordinarily resident" in their area, or is present there but has no settled residence elsewhere.

13.2 What is ordinary residence?

13.2.1 Ordinary residence is one of the key tests which must be met to establish whether a local authority is required to meet a person's eligible needs.

13.2.2 For adults with care and support needs, the local authority in which the adult is ordinarily resident will be responsible for meeting their eligible needs. For carers, however, the responsible local authority will be the one where the adult for whom they care is ordinarily resident.

13.2.3 There may be some cases where the carer provides care for more than one person in different local authority areas. Where there is more than one local authority involved, those authorities should consider how best to cooperate on and share the provision of support.

13.2.4 Ordinary residence is not a new concept – it has been used in care and support for many years. However, there have been in the past and will continue to be cases in which it is difficult to establish precisely where a person is ordinarily resident. The Care Act 2014 seeks to provide clarity and limit such situations occurring. The Act contains all the necessary powers for joint assessments and support planning, plus the duties to co-operate to provide a mechanism for one of the authorities in a case like this, to require the cooperation of the other, if needed.

13.2.5 The concept of ordinary residence has been tested in the courts. The leading case is that of Shah v London Borough of Barnet (1983) which established that an ordinary resident "*abode[s] in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration*" .

13.3 Ordinary residence throughout the care and support function

13.3.1 The Council will determine whether an individual is ordinarily resident in their area following the needs or carer's assessment, and after determining whether a person has eligible needs.

13.3.2 In cases where ordinary residence is not certain, the Council will meet the individual's needs first, and then resolve the question of residence subsequently.

13.3.3 In most cases, establishing a person's ordinary residence is a straightforward matter. However, this may not always be the case. There will be circumstances in which ordinary residence is not as clear cut, for example when a person spends their time in more than one local authority area, or moves between areas. Where uncertainties arise, the Council will always consider each case on its own merits, but will ensure that the person's needs are met, whilst seeking to resolve the question of residence.

13.4 Cases where a person lacks capacity

13.4.1 All issues relating to mental capacity should be decided with reference to the Mental Capacity Act 2005, under which it must be assumed that adults have the capacity to make their own decisions, including decisions relating to their accommodation and care, unless it is established to the contrary.

13.4.2 The test for capacity is specific to each decision at the time it needs to be made, and a person may be capable of making some decisions but not others.

13.4.3 For people who lack capacity to make decisions about their accommodation, an alternative approach is appropriate because a person's lack of mental capacity may mean that they are not able to voluntarily adopt a particular place. The Council will make a decision on the ordinary residence of persons who lack capacity on the basis of all the relevant circumstances and the current case law.

13.5 People with no settled residence

13.5.1 People who have no settled residence, but are physically present in the local authority's area, will be treated by the Council in the same way as those who are ordinarily resident in Suffolk.

13.6 Ordinary residence when arranging accommodation in another area

13.6.1 There may be some cases where the Council considers it appropriate for an individual's care and support needs to be met by the provision of accommodation in the area of another authority. In line with the Care Act 2014 guidance, the Council abides by the principle that the person placed 'out of area' is deemed to continue to be an ordinarily resident, and does not acquire an ordinary residence in the 'host' or second authority. The Council therefore retains responsibility for meeting the person's needs where it places a person in:

- nursing and residential care homes
- supported living and extra care housing
- shared living schemes

13.6.2 Depending on the specifics of the case, the Council may choose to initiate an agreement to allow the authority where the accommodation is located to carry out functions on its behalf. This may particularly be the case where the accommodation is located some distance away, as some functions can be performed more effectively locally.

13.6.3 Should the accommodation provider change the type of care which it provides, in the event of the person remaining living at the same property and their needs continue to be met by the new service, then ordinary residence will not be affected and the duty to meet those needs will be retained by the Council.

13.6.4 In the event that the individual moves accommodation of their own volition, without the Council making the arrangements, their ordinary residence would be where the new accommodation is situated.

13.7 NHS accommodation

13.7.1 A person for whom NHS accommodation is provided is to be treated as being ordinarily resident in the local authority where they were ordinarily resident before the NHS accommodation was provided. This means the Council retains responsibility for the person's care, and support does not transfer to the area of the hospital, if this is different from the area in which the person lived previously.

13.8 Mental health after-care

13.8.1 The duty to commission or provide mental health after-care rests with the Council in the event that the person concerned was ordinarily resident in Suffolk immediately before they were detained under the 1983 Act.

13.9 Temporary absences

13.9.1 Having established ordinary residence in a particular place, this should not be affected by the individual taking a temporary absence from the area. The Council will therefore retain responsibility for meeting the care and support needs of an individual, even in the event of a temporary absence.

13.9.2 The Council also recognises that in certain circumstances an individual may be temporarily residing in the county when experiencing an urgent need for care and support. In such a situation, the Council will work with the individual in question to ensure their eligible needs are met, and will work with the local authority where the person is ordinary resident to ensure continuity of care.

13.10 People with more than one home

13.10.1 The purpose of the ordinary residence test in the Act is to determine which single local authority has responsibility for meeting a person's eligible needs, and this purpose would be defeated if a person could have more than one ordinary residence.

13.10.2 If a person appears genuinely to divide their time equally between two homes, the Council would work with the other local authority to establish (from all of the circumstances) to which of the two homes the person has the stronger link. If this is found to be the Council, it would provide or arrange care and support to meet the needs during the time the person is temporarily away at their second home, as well as when there are residing in Suffolk.

13.11 People who arrange and fund their own care

13.11 1 People who self-fund and arrange their own care and move to Suffolk, and then find that their funds have depleted, can apply to the Council to have their needs assessed. If it is decided that they have eligible needs for care and support, the person's ordinary residence will be Suffolk, and not their previous local authority.

13.11.2 Resolving ordinary residence disputes: The Council will take all reasonable steps to resolve a dispute with another local authority. In doing so, the Council will continue to work with the individual in question to ensure that their eligible care and support needs are met.

14.0 Continuity of care

14.1 Continuity of care

14.1.1 People with care and support needs may decide to move home the Care Act recognises that it is important to ensure that care and support is in place during the move, so the person's wellbeing is maintained.

14.1.2 Where the person chooses to live in a different local authority area, the local authority that is currently arranging care and support and the authority to which they are moving must work together to ensure that there is no interruption to the person's care and support. This duty equally applies where the person's carer is receiving support, and will continue to care for the adult after they have moved.

14.1.3 The overriding principle is that the person with care and support needs will be able to move with the confidence that arrangements to meet their care needs will be in place the day of the move. Close co-operation between local authorities is crucial to achieving this.

14.2 Moving out of Suffolk

14.2.1 The continuity of care process begins when someone receiving care and support services notifies the Council that they intend to move to another local authority area. Once notification is received, the Council will work with the new local authority to begin transferring responsibility for managing the persons care and support needs.

14.2.2 The Council recognises there will be situations where a person may lack capacity to make a decision about a move, but the individual's family may wish to move the adult closer to where they live. In such situations, the

Council will support the individual to be involved in the decision-making process, which will involve a capacity assessment, and where necessary take 'best interest' decisions. An independent advocate may be appointed to help the individual participate in the decision-making process.

14.2.3 Once the intention to move has been verified as genuine, the Council will provide the new local authority area with:

- A copy of the person's most recent care and support plan
- A copy of the most recent carer's support plan if the person's carer is moving with them
- Where relevant, a copy of the persons Transition Assessment and associated transition plan
- Any other information relating to the person or the carer (whether or not the carer has needs for support), that the second authority may request

14.2.4 Where the Council has funded specialist equipment or adaptations, this equipment may be taken to the new location by the individual, should it still be required, if this is the persons preference, and the Council and the other local authority agree this is the most cost effective solution. Otherwise, arrangements will be made for recycling or disposal on the day of the move. Where the person is the subject of an authorisation granted under the Deprivation of Liberty Safeguards the managing authority of the Suffolk Care Home which is to provide them with accommodation will have to submit a new referral for a Deprivation of Liberty to the Council and the Council will ensure that the provider is aware of this.

14.3 Moving into Suffolk

14.3.1 The Council will make information about care and support services available individuals who are considering moving into the county, to help inform the decision.

14.3.2 On receiving notification from another local authority that someone with care and support needs intends to move to Suffolk, the Council may undertake steps to verify that the intention is genuine. This might include::

- Establish and maintain contact with the person and their carer to keep abreast of their intention to move
- Continue to liaise with the other local authority to get their views on the persons intention
- Liaise with family members, carers and other relevant parties to confirm their intention

14.3.3 Once intention has been verified, the Council will provide the individual with information about the care and support options available in Suffolk. This may include::

- Support for carers

- Information about the local care market and organisations that could meet their needs
- The Council's charging policy, highlighting any charges that might be relevant to the individual

14.3.4 The Council will work with the other local authority and the individual in question to begin a new needs assessment. Where a person lacks capacity to be fully involved in the assessment or care planning process, and there is no suitable person that can assist, the Council will provide an independent advocate to assist.

14.3.5 The Council will also consider whether the person might be moving to be close to a new carer. If so, the carer will be offered an assessment.

14.3.6 The Council will keep the other local authority, the individual and their carer abreast of steps being taken to arrange the necessary care and support from the day of the move.

14.3.7 In line with other policy statements, the Council's needs assessment will consider where information and advice and preventative services can help prevent, reduce or delay the individuals needs from escalating.

14.3.8 On completing the needs assessment and determining whether the individual or carer has eligible needs, the council will involve the individual or carer in the development of the care and support plan, taking all reasonable steps to agree the plan.

14.3.9 The Council recognises that local market conditions and ways of meeting need can mean personal budgets vary significant between local authorities. An explanation for any variation will be explained during the support planning process

14.3.10 The Council's care and support plan will include arrangements starting on the day of the move, and will need to be agreed between the individual and/or carer, the Council and the other local authority to ensure continuity of care.

14.3.11 Any requirements for specialist equipment or adaptations will be identified in the support planning process. Where equipment has been provided by the other local authority, the Council will work with the other local authority and the individual to ascertain whether the most cost effective and practical option would be to use the existing equipment or to organise and install new equipment.

14.3.12 Equally, if the individual has a piece of equipment on long-term loan from the NHS, the Council will notify the relevant NHS organisation and discuss the best and most practical option for ensuring the persons needs continue to be met.

14.3.13 If the person also has health needs, the Council will make relevant arrangements with the local Clinical Commissioning Group (CCG) to ensure that those needs are appropriately assessed. Depending on the specific circumstances of the individual, this may be via a joint assessment.

14.4.14 In the event that the Council has been unable to carry out a needs assessment prior to the move into Suffolk, it is committed to meeting the needs and outcomes identified in the adult's care and support plan, carried out by the local authority previously responsible for. The Council will involve the individual and/or the carer and any relevant independent advocate, as well as any other individual that either person requests, in deciding how to meet the care and support needs in the interim period.

14.4.15 When meeting an individual's needs ahead of carrying out an assessment, the Council will have regard to the following matters::

- Their care and support plan provided by the other local authority
- The outcomes the individual wants to achieve
- The individual's preferences and views

14.5.16 In the event of the individual's circumstances being significantly different as a result of the move, the Council will consider the impact on their wellbeing of the following::

- Any carer support
- The suitability of the new accommodation
- Any existing requirements for equipment and adaptations
- Access to services and facilities
- Access to other types of support
- Where the person makes use of universal services

14.5.17 Where the person is the subject of an authorisation granted under the Deprivation of Liberty Safeguards by the Council, the Council will ensure that the new local authority is aware of this fact so that they can ensure that, if appropriate, the new provider submits a referral for a Deprivation of Liberty to the appropriate Authority.

14.4 When the adult does not move or the move is delayed

14.4.1 Where there has been a delay because of unforeseen circumstances, the Council will maintain contact with the person to ensure that arrangements are in place for the new date of the move. This applies to people moving in and out of Suffolk.

14.4.2 If the person's move is delayed and they remain resident in Suffolk, the Council will remain responsible for meeting the person's and the carer's needs, until such time as they move.

14.4.3 If the individual does not move out of Suffolk, the Council will remain responsible for meeting the persons care and support needs.

14.4.4 If the person does not move into Suffolk, they remain the responsibility of the other local authority.

15.0 Preparation for Adulthood (Transition to adult care and support)

15.1 Suffolk's Vision:

All young people in Suffolk having experiences of adolescence that enable them to become as independent, connected, healthy and confident in adulthood as they can be.

15.1.1 To support this vision Suffolk has produced some good practice guidance in the Suffolk practice framework (Preparation for adulthood). Please see link: Practice Framework.

15.2 Transition to adult care and support

15.2.1 Effective person-centred transition planning is essential to help young people and their families prepare for adulthood. Transition to adult care and support comes at a time when a lot of change can take place in a young person's life. It can also mean changes to the care and support they receive from education, health and care services, or involvement with new agencies such as those who provide support for housing, employment or further education and training.

15.3 What are Transition Assessments?

15.3.1 The purpose of carrying out Transition Assessments is to provide young people and their families with information so that they know what to expect in the future and can prepare for adulthood. Transition Assessments will also allow local authorities to better understand the needs of people in their population, and to plan resources and commission services for young people and carers accordingly. The Transition Assessments carried out by the Council will be completed using the adult assessment process.

15.3.2 Transition Assessments are applicable to three specific groups of people:

- Children and young people with care and support needs approaching adulthood
- Young carers who are approaching adulthood
- Adult carers of children and young people with care and support needs approaching adulthood

15.4 When Transition Assessments should be carried out

15.4.1 The Transition Assessment will help a young person and their family with information so they know what to expect in the future and can prepare for adulthood.

15.4.2 Transition Assessments will take place at the right time for the young person or carer and at a point when the Council can be reasonably confident about what the young person's or carer's needs for care or support will look like after the young person in question reaches the age of 18. This will normally happen within a young person's 16th year and before they are $17^{1}/_{2}$ although the Council recognises that every young person and their family are different and, as such, Transition Assessments should take place when it is most appropriate for them.

15.4.3 The Council will carry out a Transition Assessment for anyone in the three groups when there is a "significant benefit" to the young person or carer in doing so, and if they are likely to have needs for care or support after turning 18.

15.4.4 This applies equally to those who are already receiving children's services, and to anyone who is likely to have needs for adult care and support after turning 18.

15.4.5 In establishing a "significant benefit" to the individual, the Council will consider whether the young person or carer is likely to have a need for care and support as an adult.

15.4.6 Factors that may contribute to establishing a significant benefit to assess includes, but is not limited to the following:

- The stage they have reached at school and any upcoming exams
- Whether the young person or carer wishes to enter further/higher education or training:
- Whether the young person or carer wishes to get a job when they become a young adult
- Whether the young person is planning to move out of their parental home into their own accommodation
- Whether the young person will have care leaver status when they become 18
- Whether the carer of a young person wishes to remain in or return to employment when the young person leaves full time education
- The time it may take to carry out an assessment
- The time it may take to plan and put in place the adult care and support
- Any relevant family circumstances
- Any planned medical treatment
- Whether services provided by Children's social care prior to 18 are planned to continue even if the funding and case responsibility changes

15.4.7 For young people with special educational needs (SEN) who have an Education, Health and Care (EHC) plan under the Children and Families Act, preparation for adulthood must begin from year 9. The Transition Assessment will be undertaken as part of one of the annual statutory reviews of the EHC plan, and will inform a plan for the transition from children's services to adult care and support services.

15.4.8 For care leavers, the Council will consider using the statutory Pathway Planning process as the opportunity to carry out a Transition Assessment where appropriate.

15.4.9 The Council will seek to minimise the disruption to the child and their family when undertaking a Transition Assessment, for example by combining multiple appointments where possible and avoiding stressful times, such as exam periods.

15.4.10 A young person or carer, or someone acting on their behalf, has the right to request a Transition Assessment.

15.4.11 The Council will consider such requests and whether the likely need and significant benefit conditions apply – and if so it must undertake a Transition Assessment.

15.4.12 Where this does not apply, the Council may refuse to undertake a Transition Assessment on that basis, and will provide the reasons for this in writing in a timely manner. It may also provide supporting information and advice on what can be done to prevent or delay the development of needs for support.

15.4.13 Where someone is refused (or they themselves refuse) a Transition Assessment, but at a later time makes a request for an assessment, the Council will again consider whether the likely need and significant benefit conditions apply, and carry out an assessment if so.

15.5 Adult and young carers

15.5.1 Preparation for adulthood will involve not only assessing how the needs of young people change as they approach adulthood but also how carers', young carers' and other family members' needs might change. The Council will assess the needs of an adult carer where there is a likely need for support after the child turns 18 and it is of significant benefit to the carer to do so.

15.5.2 The Council also has a duty to offer to assess the needs of young carers as they approach adulthood. Transition Assessments and planning will be used to consider how to support young carers to prepare for adulthood and how to raise and fulfil their aspirations.

15.5.3 The Transition Assessment will consider the impact on other members of the family (or other people the Council may feel appropriate) of the person

receiving care and support. This will require the Council to identify anyone who may be part of the person's wider network of care and support.

15.5.4 Young carers' assessments should include an indication of how any care and support plan for the person(s) they care for would change as a result of the young carer's change in circumstances.

15.6 Key features of a Transition Assessment

15.6.1 In line with other policy areas, Transition Assessments will take into account the following:

- Current needs for care and support and how these impact on wellbeing
- Whether the young person or carer is likely to have needs for care and support after the child in question becomes 18
- If so, what those needs are likely to be, and which are likely to be eligible needs
- The outcomes, views and wishes that matter to the young person or carer in question
- The needs of the individual to ensure the Transition Assessment remains proportionate
- As assessment of the persons strengths and capabilities
- Where joint assessments might be undertaken with input from a range of professionals and interest groups to help the person achieve the outcomes that matter to them
- Where relevant information and advice can be provided to support the transition process, including general information about adult care and support, as well as more specific information relevant to the individuals circumstances

15.6.2 Transition Assessments of young and adult carers will also consider whether the carer:

- Is able to care now and after the young person in question turns 18
- Is willing to care now and will continue to after 18
- Works or wishes to do so
- Is or wishes to participate in education, training or recreation

15.6.3 Where possible, the Council will look to use existing assessments and related information to inform the Transition Assessment. For example, a young person with special educational need (SEN) may have an Education, Health and Care (EHC) plan under the Children and Families Act 2014. This could be used to inform the Transition Assessment.

15.7 Capacity and consent

15.7.1 The Council will require the consent of the young person or carer in question to undertake a Transition Assessment, where they have mental capacity and are competent to agree.

15.7.2 Where a young person or carer lacks mental capacity or is not competent to agree, the Council must be satisfied that an assessment is in their best

interests. Everyone has the right to refuse a Transition Assessment, however the Council will undertake an assessment regardless if it suspects that a young person is experiencing or at risk of abuse or neglect.

15.7.3 The right of young people to make decisions is subject to their capacity to do so as set out in the Mental Capacity Act 2005. The underlying principle here is to ensure that those who lack capacity are supported to make as many decisions for themselves as is possible, and that any decision made or action taken on their behalf, is done so in their best interests. This is a necessity if the Transition Assessment is to be person-centred.

15.7.4 For young people below the age of 16, the Council will need to establish a young person's competence using the test of 'Gillick competence' (whether they are able to understand a proposed treatment or procedure). Where the young person is not competent, a person with parental responsibility will need to be involved in their Transition Assessment – or an independent advocate provided if there is no one appropriate to act on their behalf (either with or without parental responsibility).

15.7.5 The Council will provide an independent advocate to facilitate the involvement in the Transition Assessment where the person in question would experience substantial difficulty in understanding the necessary information or in communicating their views, wishes and feelings – and if there is nobody else appropriate to act on their behalf.

15.7.6 This duty applies for all young people or carers who meet the criteria, regardless of whether they lack mental capacity as defined under the Mental Capacity Act.

15.8 Co-operating with partner organisations and other professionals

15.8.1 The Council will cooperate with relevant partners, and the Care Act 2014 makes this duty reciprocal. Children's services and adults' services will work together to pass on relevant knowledge and to help build new relationships in advance of transition.

15.8.2 The Council will cooperate with relevant external agencies and partner organisations including local GP practices, housing providers and educational institutions. Again, this duty is reciprocal. This cooperation is crucial to help ensure that assessments and planning are person-centred. Furthermore, local health services or schools are vital to identifying young people and carers who may not already be in contact with local authorities.

15.8.3 The Council will consult with the young person and their family to discuss what arrangements they would prefer for assessments and reviews, and will seek to ensure that all relevant partners are involved in transition planning where they are involved in the person's care and support.

15.8.4 Equally, the Council is committed to ensuring involvement in transition planning led by another organisation, for example a child and adolescent

mental health service, where there are also likely to be needs for adult care and support.

15.8.5 Where possible, and of benefit to the individual, a Transition Assessment may be combined with any other assessment carried out jointly with, or on behalf of, another body.

15.8.6 Often there is a natural lead professional involved in a young person's care. The Council may consider formalising this by designating a named person to co-ordinate the Transition Assessment and planning across different agencies.

15.9 What happens after the Transition Assessment

15.9.1 Having carried out a transition assessment, the Council will give an indication of which needs are likely to be eligible needs (and which are not likely to be eligible) once the young person in question turns 18, to ensure that the young person or carer understands the care and support they are likely to receive and can plan accordingly.

15.9.2 The different systems and legislative frameworks for children's and adult care and support mean that there will be circumstances in which needs that were being met by children's services may not be eligible needs under the adult system.

15.9.3 The Council will therefore ensure that families are able to understand what support they are likely to receive when the young person or carer is in the adult system, and that the transition period is planned and managed as far in advance as is practical and useful to the individual to ensure that there is not a sudden gap in meeting the young person's or carer's needs.

15.9.4 Where the Transition Assessment identifies needs that are likely to be eligible, the Council will provide an indicative personal budget, so that young people, carers and their families are able to plan their care and support before entering the adult system.

15.9.5 For any needs that are not eligible under the adult statute, the Council will provide information and advice on how those needs can be met, and how they can be prevented from getting worse. Information and advice must be accessible and proportionate to whoever needs it and must consider individual circumstances.

15.9.6 Where a person has eligible needs, the Council will work with the individual to create a person-centred transition plan that sets out the information in the assessment, along with a plan for the transition to adult care and support.

15.9.7 The Council will ensure that the Transition Assessment and plans should be reviewed regularly to take into account changes both in circumstances and desired outcomes.

15.9.8 In the case of an adult carer, where the Council has identified needs through a Transition Assessment which could be met by adult services, it may meet these needs under the Care Act 2014 in advance of the child being cared for turning 18.

15.9.9 If the Council decides to meet the adult carer's needs through adult services, as for anyone else under the adult legislation, the adult carer will receive a support plan and a personal budget.

15.10 After the young person or carer turns 18

15.10.1 There is no obligation on the Council to implement the move from children's social care to adult care and support as soon as someone turns 18. The exact point of transition will be decided by the Council, taking into account the specific circumstances of the individual. It might be that the move to adult services will begin at the end of a school term or another similar milestone. In many cases, planning will be a staged process over several months or years.

15.10.2 If the Council is to meet the young person's or carer's needs under the Care Act 2014 after they have turned 18 the Council will undertake the care planning process as for other adults – including creating a care and support plan and producing a personal budget. The Council will ensure that this happens early enough that a package of care and support is in place by the time a young person is $17^{1}/_{2}$, ready for the time of transition, ensuring that there is no gap or disruption in care and support when young people and carers move from children's to adult services.

15.10.3 The Council will continue to provide services until the relevant steps have been taken. These steps are::

- Concluding that the individual **does not** have needs for adult care and support
- Concluding that the person **does** have such needs and begins to meet some or all of them
- Concluding that the person does have such needs but decides they are **not eligible** for adult care and support

15.10.4 The Council will use the Transition Assessment to reach the appropriate conclusion.

15.10.5 In certain circumstances, the Council may conclude that the young person should continue to receive support from children's services.

15.10.6 Where a young person or carer is not deemed to have needs or meets eligibility criteria, the Council will state the reasons in writing.

15.11 Safeguarding after the age of 18

15.11.1 Where someone is over 18 but still receiving children's services and a safeguarding issue is raised, the matter will be dealt with as a matter of

course by the adult safeguarding team. Where appropriate, they will involve the local authority's children's safeguarding colleagues as well as any relevant partners (e.g. police or NHS) or other persons relevant to the case.

15.12 Ordinary residence and the transition to Higher Education

15.12.1 It is an important aspect of transition planning to confirm as early as possible where someone will be ordinarily resident as an adult.

15.12.2 Where a young person is intending to move to a higher or further education institution which is out of the area where they were receiving children's services, they will usually remain ordinarily resident in the area where their parents live (or the local authority area which had responsibility for them as a child).

15.12.3 Where a young person or carer wishes to attend a higher or further education institution, the Council will help them identify a suitable institution as part of transition planning (if they have not done so already). Once an offer has been accepted, the Council will ensure the relevant institution is made aware as soon as possible of the young person's or carer's needs and desired outcomes and discuss a plan for meeting them.

15.12.4 The objective should be to ensure that there will be an appropriate package of care and support in place from the day the young person or carer starts at the institution.

15.13 Transition from children's to adult NHS Continuing Health Care

15.13.1 The Council will work with the local Clinical Commissioning Group (CCG) to have systems in place to ensure that appropriate referrals are made whenever either organisation is supporting a young person who, on reaching adulthood, may have a need for services from the other agency.

15.13.2 The Council will comply with national best practice for the timing of transition steps, as follows:

- Children's services should identify young people with likely needs for NHS CHC and notify the relevant CCGs when such a young person turns 14
- There should be a formal referral for adult NHS CHC screening at 16:
- There should be a decision in principle at 17 so that a package of care can be in place once the person turns 18 (or later if agreed more appropriate).

15.13.3 Where a young person has been receiving children's continuing health care from a relevant CCG, it is likely that they will continue to be eligible for a package of adult NHS CHC when they reach the age of 18. The Council will seek to involve the CCG to ensure and appropriate and timely transfer of responsibility.

15.14 Transition to the new legal framework

15.14.1 This policy relates to duties established under the Care Act 2014 which came into effect from the 1st April 2015.

15.14.2 The Council will assume that any transition assessments conducted before the 1st April 2015 comply with the new legal framework. However, the Council may seek to review and update any transition assessments to ensure compliance with the new legal framework on an individual basis.

15.14.3 Any assessments or re-assessments started on or after the 1st April 2015 will be carried out in compliance with the new duties and responsibilities established in the Care Act 2014.

15.14.4 This applies equally to individuals with care and support needs and carers.

16.0 Prisoners

16.1 Prisoners

16.1.1 People in custody or custodial settings who have needs for care and support should be able to access the care they need, just like anyone else. In the past, the responsibilities for meeting the needs of prisoners have been unclear, and this has led to confusion between local authorities, prisons and other organisations. This has created difficulties in ensuring people's eligible needs are met.

16.1.2 Prisoners can often have complex health and care needs and experience poorer health and mental health outcomes than the general population. Evidence demonstrates higher prevalence among the adult prison population of mental illness, substance misuse and learning disabilities than in the general population.

16.1.3 This policy relates to people in prisons, approved premises and other bail accommodation.

16.2 New statutory duties established under the Care Act 2014

16.2.1 The Care Act 2014 the Council a new duty to ensure that people in custody or custodial settings who have needs for care and support should be able to access the care they need.

16.2.2 The Council is committed to providing the same level of care and support to all adults in custody, as the rest of the population. The Council recognises the principle of equivalence of care, which forms the basis for this policy. This is critical in ensuring that those in need of care and support achieve the outcomes that matter to them, and that will support them to live as independently as possible at the end of their detention. In addition to ensuring that an individual's needs are met, this will contribute to the effectiveness of rehabilitation and improve community safety.

16.2.3 Prisons are required to enter into a memorandum of understanding with their local social services authority.

16.3 Who this applies to

16.3.1 The Council is responsible for the assessment of all adults who are in custody in their area and who appear to be in need of care and support, regardless of which area the individual came from or where they will be released to. If an individual is transferred to another custodial establishment in a different local authority area this responsibility will transfer to the new area.

16.3.2 People bailed to a particular address in criminal proceedings are, like those in prison or approved premises, treated as ordinarily resident in Suffolk: therefore the Council has a duty to assess for eligible needs, care planning including the establishment of a personal budget, and the provision or arrangement of relevant care and support.

16.3.3 Where prisoners have previously been detained under sections 47 and 48 of the Mental Health Act 1983 and transferred back to prison, their entitlement to section 117 aftercare will be dealt with by the Council in the same way as it would be in the community, apart from any provisions which are disapplied in custodial settings, which are set out in more detail below.

16.3.4 If the person was ordinarily resident in Suffolk immediately before being detained in hospital, the Council will be responsible for the after-care while the person is in prison and upon their release from prison. If the person was not ordinarily resident in any area immediately before detention, the Council will become responsible for that individual if they are discharged to, or choose to reside in, Suffolk. The Council will be jointly responsible for after-care with NHS England while the person is in prison.

16.4 Assessment of need

16.4.1 Where the Council is made aware that an adult in a custodial setting may have care and support needs, it will carry out an assessment as it would for someone in the community.

16.4.2 The Council will identify and consider the extent and nature of need before taking into account the environment in which the individual lives.

16.4.3 Where practical, the Council may choose to combine a needs assessment with any other assessment it is carrying out, or it may carry out assessments jointly with, or on behalf of another body, for example prisoners' health assessments.

16.4.4 The Council will aim to conduct assessments of those who appear to have care and support needs promptly following receipt of the referral from managers of custodial settings or the prison's health providers. The Council recognises that people in a custodial setting have a right to self-refer for an assessment and the Council will work with the managers of the custodial setting to consider how to facilitate and respond to self-referrals.

16.4.5 The council will provide appropriate types of care and support prior to completion of the assessment where it is clear the person has urgent needs.

16.4.6 If someone in a custodial setting refuses a needs assessment the local authority is not required to carry out the assessment, subject to the same conditions as in the community

That is, this does not apply if:

- the person lacks the capacity to refuse and the local authority believes that the assessment will be in their best interests
- the person is experiencing, or is at risk of, abuse or neglect

16.4.7 Once the council has assessed an individual in custody as needing care and support it will then determine if some or all of these needs meet the eligibility criteria.

16.4.8 Where an individual does not meet the eligibility criteria, the Council will provide written information about:

- What can be done to meet or reduce needs and what services are available
- What can be done to prevent or delay the development of needs for care and support in the future.

16.4.9 Where non-eligible needs are identified the Council will provide information and advice to the individual on how those needs can be met, and how they can be prevented from getting worse. The Council recognises that it is good practice to copy this information to managers of custodial settings (with the person's consent) as this may be relevant to how the individual is managed in the custodial setting.

16.4.10 The Council recognises that prisoners, especially those serving long sentences, may develop eligible needs over time. Individuals in custodial settings, like people in the community, may benefit from low level preventative support and information and advice that will help them maintain their own health and wellbeing. The Council will consider how best to provide information and advice to both individuals and establishments on what can be done to prevent or delay the development of care and support needs.

16.4.11 While it may not always be possible or appropriate to involve family members directly in assessment or care planning, the Council will ask the individual being assessed whether they would like to involve others in their assessment or care planning.

16.4.12 Where it is not possible to involve families directly, the Council will ask the individual concerned whether they would like others to be informed that an

assessment is taking place, the outcome of that assessment and whether they should see the care and support plan.

16.5 Charging and assessing financial resources

Those in custodial settings will be subject to a financial assessment to determine how much they may pay towards the cost of their care and support, as they would be in the community.

16.5.1 The Council will consider the use of “light touch” assessments where a person is unlikely to be required to contribute towards the cost of their care and support.

16.5.2 Should the person not meet the eligibility threshold for support by the council, but they wish to purchase care services, this request should be referred for decision to NOMS.

16.6 Next steps after assessment

16.6.1 The Council will ensure that all relevant partners are involved in care and support planning and take part in joint planning with health partners.

16.6.2 Where the Council is required to meet needs it must prepare a care and support plan for the person concerned and involve the individual to decide how to have their needs met.

16.6.3 The Council will speak to others concerned with the person’s health and wellbeing, as appropriate, including enabling access to regime services such as libraries and education.

16.6.4 During the support planning process the Council will make it clear to the individual in question the range of care options available, paying regard to those provisions which are specifically disapplied under the Care Act 2014. The plan will contain the elements defined in the Care Act 2014, including the allocated personal budget. This will ensure that the person is clear about the needs to be met, the cost attributed to meeting those needs and how, if applicable, the custodial regime limited the individual’s choice and control.

16.6.5 The Council will request that consent is given so that individual care plans are shared with other relevant providers of custodial and resettlement services including custodial services, probation service providers including Community Rehabilitation Companies, prison healthcare providers and managers of approved premises. For residents of approved premises, the Council will liaise with the responsible Offender Manager in probation services.

16.6.6 For those assessed as being in need of equipment or adaptations to their living accommodation to meet their needs, the council will discuss with their partners in prisons, approved premises and health care services where responsibility lies.

16.6.7 Where this relates to fixtures and fittings (for instance a grab rail or a ramp), it will usually be for the prison to deliver this. But for specialised and moveable items such as beds and hoists, then it may be the Council that is responsible. Aids for individuals are the responsibility of the Council, whilst more significant adaptations would the responsibility of the custodial establishment.

16.6.8 The Council will regard and confirm with the specialist guidance on responsibility of custodial services for equipment aids and adaptations issued by NOMS.

16.6.9 The Council may commission or arrange for others to provide care and support services, or delegate the function to another party, in line with the duties established under the Care Act 2014. In doing so, the Council will make sure that any other party commissioned to provide care and support is aware of the policies and procedures to be followed when working in a custodial environment.

16.6.10 The Council will ensure that care and support plans for those in custodial settings will be subject to the same review processes as all other plans, and will seek to review an individual's care and support plan each time they enter custody from the community, or are released from custody.

16.6.11. The Council will co-operate with hospital staff and prison health service providers and commissioners to prevent delays in discharge from hospital and support a timely return to custody.

16.7 Disapplied provisions

16.7.1 The right to a choice of accommodation does not apply to those in a custodial setting except when an individual is preparing for release or resettlement in the community. Release into an approved premises amounts to moving from one custodial setting to another.

16.7.2 Direct payments may not be made to people in custodial settings. Individuals in bail accommodation and approved premises who have not yet been convicted are entitled to direct payments, as they would have been whilst in their own homes.

16.7.3 It is not the intention of the Care Act that any prisoner, resident of approved premises or staff in prisons or approved premises should take on the role of carer as defined by the Care Act 2014 and should therefore not in general be entitled to a carer's assessment.

16.8 Continuity of care and support when an adult moves

16.8.1 Individuals may be moved between different custodial settings. In such cases, the Council will be notified by the Governor of the prison or a representative that the adult is to be moved or is being released to a new area as soon as practicable.

16.8.2 If this is a move to a custodial setting or release into the community in Suffolk, then the Council will remain responsible for meeting the individual's care and support needs. Where the new custodial setting or the community, if being released, is in a different local authority area, the Council will inform the second authority of the move once it has been told by the prison.

16.8.3 In the event that this is a move from another local authority into Suffolk, the Council will continue to meet the needs of the individual via their existing care and support plan, until such time as it is able to carry out its own assessment of need.

16.9 People leaving prison – ordinary residence

16.9.1 The council will start from a presumption that they remain ordinarily resident in the area in which they were ordinarily resident before the start of their sentence.

16.9.2 In situations where an offender is likely to have needs for care and support services on release from prison or approved premises and their place of ordinary residence is unclear and/ or they express an intention to settle in Suffolk, the Council will take responsibility for carrying out the needs assessment.

16.9.3 Given the difficulties associated with determining some offenders' ordinary residence on release, the Council will work with the probation provider (NPS or CRC) to initiate joint planning for release in advance.

16.10 Information sharing

16.10.1 The Council will ensure the security of information held on people who are in custodial settings, and will develop agreements consistent with policies and procedures of Ministry of Justice and the National Offender Management Service (NOMS) and with relevant legislation to enable appropriate information sharing on individuals, including the sharing of information about risk to the prisoner and others where this is relevant.

16.10.2 Where the Council is providing care and support for a person in the community and that person is subsequently remanded or sentenced to custody, or bailed to an approved premises, or required to live in approved premises as part of a community sentence, the Council will share details of the most recent assessment and care and support plan to the relevant custodial setting and the local authority in which it is based so that care and support may continue.

16.10.3 The council will work with prisons and or prison health services to develop timely referrals for needs assessment, when someone they believe has care and support needs arrives at their establishment. Either party may use this information sharing mechanism to request co-operation to support working in an individual case.

16.11 End of life care

16.11.1 The Council will work with the prison healthcare provider to ensure that the care and support needs of the prisoner are met throughout the period of end of life care.

16.12 NHS Continuing Healthcare

16.12.1 NHS Continuing Healthcare is a package of support that is wholly funded by the NHS. If during the needs assessment, care planning or review process someone appears eligible for NHS Continuing Healthcare, the Council will ensure a referral to the local Clinical Commissioning Group for assessment.

16.13 Safeguarding adults at risk of abuse and neglect

16.13.1 The Care Act 2014 establishes that prisons, approved premises and other bail accommodation is responsible for ensuring that it has clear safeguarding policies and procedures that are explained to all visiting staff.

16.13.2 The Council is committed to providing support and guidance to prison and probation staff in individual cases, although it does not have the legal duty to lead enquiries in any custodial setting.

16.14 Transitions from children's to adult care and support

16.14.1 The Council will ensure that appropriate arrangements are in place to identify young people who have, or are likely to have eligible needs for care and support residing in Young Offender Institutions, Secure Children's Homes, Secure Training Centres or other places of detention, and provide a Transition Assessment when appropriate.

16.14.2 If a young person was receiving Council support and services as a care leaver, this status remains unchanged whilst they are in custody. The Council retains responsibility for providing leaving care services during his/her time in custody and on release.

16.15 Independent advocacy support

16.15.1 Adults in custody are entitled to the support of an independent advocate during needs assessments and care and support planning and reviews of plans if they would have significant difficulty in being involved in the process. The Council has a duty to arrange an independent advocate, as they would for an individual in the community.

17.0 Charging and financial assessments

17.1 Charging and financial assessments

17.1.1 The Care Act 2014 provides a single legal framework for charging for care and support. Where a local authority arranges care and support to meet a person's needs, it may charge the adult, except where the local authority is required to arrange care and support free of charge. The new framework is intended to make charging fairer and more clearly understood by everyone.

17.1.2 **Suffolk's charging policy for 2015/2016:**
Please see the link to the current charging policy: SCC charging policy

17.2 Carrying out a financial assessment

17.2.1 The Council has a duty to arrange care and support for those people with eligible needs. Care and support services are not always provided free and charging for some services is vital to ensure affordability. The Care Act 2014 continues to allow local authorities to make a charge for the provision of certain services, facilities or resources.

17.2.2 The Council is committed to ensuring that people should only be required to pay what they can afford. To this end, it will:

- ensure that people are not charged more than it is reasonably practicable for them to pay
- be clear and transparent, so people know what they will be charged
- promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control
- support carers to look after their own health and wellbeing and to care effectively and safely
- be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs
- apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings
- encourage and enable those who wish to stay in or take up employment, education or training or plan for the future costs of meeting their needs to do so
- ensure there is sufficient information and advice available in a suitable format to make sure a person, or their representative can understand any contributions they are asked to make
- make the person and/or their representative aware of the availability of independent financial information and advice.

17.3 General charging rules

17.3.1 Following a person's needs assessment, a financial assessment will be offered. The financial assessment will be used to determine an individual's ability to contribute towards the costs of their care and support services. The financial assessment process requires the individual being assessed to provide some key financial information which is used to determine a person's ability to pay towards the costs of care and support services.

17.3.2 If an individual is financially assessed as being above the "upper capital limit" they will be required to pay the full cost of their care and support services - less any exclusions listed in the section below. The Council also reserves the right to charge an administrative fee to cover costs incurred in arranging the care and support services (see appendix 1 for current administrative fees).

17.3.3 If an individual has capital below the upper capital limit they will be financially assessed to determine how much they can afford to contribute towards the cost of their care and support services.

17.3.4 If the individual receiving a financial assessment fails to provide the necessary financial information, the Council will assume that they are above the “upper capital limit” and they will be charged accordingly.

17.3.5 To promote openness and transparency, the Council will provide a copy of the completed financial assessment to the individual who has been assessed.

17.3.6 The financial assessment will be regularly reviewed in conjunction with the individual who has been assessed. This is likely to be on an annual basis, but will depend on the circumstances of the individual concerned, and may be brought forward at the request of the Council or the individual as a result of a change in circumstances.

17.3.7 The Council will ensure that local charging mechanisms do not exceed the maximums established under the Care Act 2014.

17.3.8 The Council has no power to assess couples or civil partners according to their joint resources. Each person will therefore be treated individually.

17.3.9 The financial assessment will seek to establish a person’s capital (predominantly property and savings, although the care Act 2014 confirms there are specific rules for certain types of financial asset).

17.3.10 The financial assessment will also seek to establish a person’s level of income, although earnings from any current employment will be disregarded in order to encourage people to take up or remain in employment. The financial assessment is different depending on whether the person being financially assessed is receiving care in their own home or in a residential or nursing home. This is covered in the relevant sub-sections of the charging policy.

17.3.11 Following the pension reforms that take effect from April 2015, where a person chooses to withdraw funds from their pension pot and manage this directly, the Council may treat this as capital, under the rules established under the Care Act 2014.

General charging rule exemptions

17.3.12 The Care Act 2014 specifically exempts the following services from the Council’s financial charging policy:

- Minor aids and adaptations, up to the value of £1,000
- Up to 6 weeks of reablement care
- Care and support provided to anyone with Creutzfeldt-Jacob Disease

- After-care services and / or support provided under Section117 of the Mental Health Act 1983
- Any service or part of service which the NHS is under a duty to provide, including Continuing Healthcare and the NHS contribution to Registered Nursing Care
- More broadly, any services which a local authority is under a duty to provide through other legislation may not be charged for under the Care Act 2014
- Assessment of needs and care planning may also not be charged for, since these processes do not constitute “meeting needs”.

Establishing capacity

17.3.13 The Council will establish whether a person has capacity to take part in the financial assessment. If the person lacks capacity, the Council will seek to find out whether the person due to be financially assessed has any of the following appropriate people to be involved::

- Enduring Power of Attorney (EPA)
- Lasting Power of Attorney (LPA) for Property and Affairs
- Lasting Power of Attorney (LPA) for Health and Welfare
- Property and Affairs Deputyship under the Court of Protection
- Any other person dealing with that person’s affairs (e.g. someone who has been given Appointee-ship by the Department for Work and Pensions (DWP) for the purpose of benefits payments).

17.3.14 If the person lacks capacity and does not have an appropriate person with authority to be involved in their affairs, it may be appropriate to appoint a Property and Affairs Deputyship. This can be applied for by family members or the local authority (if there are no family members) to the Court of Protection. While this may take some weeks, it can then enable the person appointed to access information about bank accounts and financial affairs.

Light-touch financial assessments

17.3.15 In certain circumstances, the Council may opt to offer a ‘light-touch’ rather than a full financial assessment. These circumstances would include, but are not limited to, the following:

17.3.16 *Where a person has significant financial resources, and does not wish to undergo a full financial assessment for personal reasons, but wishes nonetheless to access local authority support in meeting their needs. In these situations the local authority may accept other evidence in lieu of*

carrying out the financial assessment and consider the person to have financial resources above the upper limit

17.3.17 Where the local authority charges a small or nominal amount for a particular service (e.g. for subsidised services) which a person is clearly able to meet and would clearly have the relevant minimum income left, and carrying out a financial assessment would be disproportionate

17.3.18 When an individual is in receipt of benefits which demonstrate that they would not be able to contribute towards their care and support costs. This might include income from Jobseeker's Allowance.

17.3.19 There are a number of circumstances in which the Council would be satisfied that there is sufficient evidence that a person is able to afford any charges due, including but not limited to::

- The individual owning property clearly worth more than the upper capital limit, where they are the sole owner or it is clear what their share is
- The individual having savings clearly worth more than the upper capital limit
- The individual having sufficient income left following the charge due

17.3.20 Before offering a 'light-touch' financial assessment, the Council will take steps to ensure that the individual concerned is willing, and will continue to be willing, to pay all charges due. Where a person does not agree to this, a full financial assessment will be offered.

17.3.21 When deciding whether or not to undertake a light-touch financial assessment, the Council will consider both the level of the charge it proposes to make, as well as the evidence or other certification the person is able to provide. It will inform the person when a 'light-touch' assessment has taken place and make clear that the person has the right to request a full financial assessment should they so wish, as well as making sure they have access to sufficient information and advice, including the option of independent financial information and advice.

Deprivation of assets

17.3.22 Deprivation of assets refers to a situation where an individual has *intentionally* deprived or decreased their overall assets in order to reduce the level of financial contribution paid towards their care and support services.

17.3.23 If, whilst undertaking a financial assessment, the Council identifies a situation where deprivation of assets may have occurred, the Council will decide how best to proceed. Depending on the individual's circumstances, options may include:

- Charging the individual concerned as if this deprivation has not occurred,
- Treating the individual concerned as possessing the notional difference between the two asset values, and charging accordingly
- Recovering care costs from the individual(s) who received the asset

Charging for care and support in a person's home

17.3.24 These charging arrangements apply to any setting for meeting care and support outside of a residential or nursing home.

17.3.25 The Council recognises that a person who receives care and support outside of a residential or nursing home will also need to pay their daily living costs (such as rent, food and utilities). This means that after charging, a person will be left with the minimum income guaranteed amount), equivalent to Income Support plus a buffer of 25%.

17.3.26 In addition, where a person receives benefits to meet their disability needs that do not meet the eligibility criteria for local authority care and support, the charging arrangements should ensure that they keep enough money to cover the cost of meeting these disability-related costs.

17.3.27 Where someone requiring care and support in their own home has the financial means to fully fund their own support, depending on their specific circumstances, the Council will offer to broker the individual's care, or may provide information and advice in order to help them arrange the care themselves. The Council reserves the right to charge an administration fee to recoup costs incurred in arranging care for self-funders (see appendix 1 for current administrative fees).

Charging for care and support in a residential or nursing home

17.3.28 Where a local authority is responsible for meeting an individual's needs by arranging a residential or nursing care placement, the Council is responsible for contracting with the relevant provider.

17.3.29 The Council is committed to working with providers to promote quality, choice and value for money. Where market capacity allows, the Council will offer a choice of accommodation options. Depending on the individual's circumstances and wishes, this may involve a more expensive setting, which in the majority of cases, would require a 'top-up' fee from the person requiring care, or a third party.

17.3.30 In the event that the individual receiving the care is required to make a financial contribution, the Council will support the individual to identify options of how best to pay any appropriate charges, which will be collected via a specific arrangement between the Council and the individual receiving care. The Council will be responsible for paying the provider.

17.3.31 Where someone requiring residential or nursing care has the financial means to fully fund their own support, depending on their specific circumstances the Council will either offer to broker the individual's care, or may provide information and advice in order to help them arrange the care themselves. The Council reserves the right to charge an administration fee to recoup costs incurred in arranging care for self-funders (see appendix 1 for current administrative fees).

Residential and nursing home 'top-up' fees

17.3.32 In the event of a 'top-up' fee being required to obtain the person's choice of accommodation, the Council will ensure that the person paying is willing and able to meet this additional cost for the duration of the agreement, recognising that this may be some time in the future.

17.3.33 The Council will provide the person paying the 'top-up' with sufficient information and advice to ensure that they understand the terms and conditions of the arrangement. This may include the promotion of guidance from an independent financial advisor.

17.3.34 The person paying the 'top-up' fee will be required to enter into a written agreement with the Council, which will include confirmation of::

a. the additional amount to be paid
b. the amount specified for the accommodation in the person's personal budget
c. the frequency of the payments
d. to whom the payments are to be made
e. provisions for reviewing the agreement
f. a statement on the consequences of ceasing to make payments
g. a statement on the effect of any increases in charges that a provider may make
h. a statement on the effect of any changes in the financial circumstances of the person paying the 'top-up'
i. The 'top-up' fee agreement will be periodically reviewed, in light of expected provider fee increases for example, in order to assess continuing affordability.

17.3.35 The person whose needs are to be met by the accommodation may themselves choose to make a 'top-up' payment only in the following circumstances:

- where they are subject to a 12-week property disregard
- where they have a deferred payment agreement in place with the local authority. Where this is the case, the terms of the agreement should reflect this arrangement
- where they are receiving accommodation provided under S117 for mental health aftercare.

Choice of accommodation and mental health after care

17.3.36 Section 117 of the Mental Health Act 1983 enables a person who qualifies for after-care support to express a preference for particular accommodation, where accommodation forms part of their after-care package of support.

17.3.37 The Council is committed to involving the individual concerned in the care planning process. An adult has the right to choose accommodation provided:

- the preferred accommodation is of the same type that the local authority has decided to provide or arrange
- it is suitable for the person's needs
- it is available
- where the accommodation is not provided by the local authority, the provider of the accommodation agrees to provide the accommodation to the person on the local
- authority's terms

17.3.38 Under section 117 of the Mental Health Act 1983, after-care support is provided free of charge to the recipient, however in the event that the cost of the person's preferred accommodation is more than the local authority would normally pay to meet the person's needs, the Council will still arrange the care provided that the person or a third party is willing and able to pay the additional cost.

Charging for carers support

17.3.39 The Council will not charge a carer for services provided to the person they care for. However, in certain circumstances, a partner organisation may charge a carer to cover the costs of services provided.

Transition to the new legal framework

17.3.40 This policy relates to duties established under the Care Act 2014 and came into effect from the 1st April 2015.

17.3.41 Individuals who have received an assessment under the previous legislation will not be required to be re-assessed purely because of the new legal framework, however any re-assessments started on or after the 1st April 2015 will be carried out in line with the new duties and responsibilities established in the Care Act 2014.

17.3.42 Equally, any care and support plans created prior to the 1st April 2015 will only be revised following a re-assessment brought about by a change to an individual's needs or circumstances.

17.3.43 This applies equally to individuals with care and support needs and carers.

Appendix *1 Capital limits, fees and charges*

Upper capital limit: £23,250
Lower Capital limit: £14,250
Administrative fees: £75

18.0 Deferred payments

18.1 Deferred payments

18.1.1 A deferred payment agreement can provide additional flexibility for when and how someone pays for their care and support. The establishment of the universal deferred payment scheme will mean that people should not be forced to sell their home in their lifetime to pay for their care. By entering into a deferred payment agreement, a person can 'defer' or delay paying the costs of their care and support until a later date.

18.1.2 The scheme is universally available throughout England and all local authorities are required to offer such a scheme to people who meet certain key criteria.

18.2 What is a deferred payment?

18.2.1 A deferred payment is a financial arrangement which allows an individual who requires permanent residential or nursing care to delay the costs of their care until a later date.

18.2.2 The deferred payment agreement is a contractual arrangement between the Council and the individual where the Council agrees to meet the costs of their care on a temporary basis, secured against the value of the person's home.

18.2.3 The care costs are then paid back to the Council by the individual (or a third party on their behalf) at a later date once the property is sold. This offers flexibility for the person by allowing them to sell their home when they choose to do so.

18.2.4 Deferred payments are available to anyone who meets the deferred payment eligibility criteria as detailed within this policy.

18.3 Information and advice on Deferred Payments

18.3.1 The Council recommends that independent financial advice is sought by an individual before making decisions about their financial future, which includes the consideration of a deferred payment scheme.

18.3.2 The Council will offer guidance to individuals on how to access independent financial advice and note the existence of regulated financial advice.

18.3.3 Links to the currently available information and practitioner guidance can be found on the Suffolk Infolink Deferred Payments Frequently Asked Questions

18.4 Mental Capacity for Deferred Payments

18.4.1 The law works on the principle that everyone is assumed to have capacity to make decisions for themselves if they are given enough information,

support and time. It protects their right to make their own decisions and to be involved in any decisions that affect them.

18.4.2 The Council recognises that an individual's capacity must be judged according to the specific decision that needs to be made, even though someone may be making what seems to be an unwise decision (even if they have an illness or disability) this does not necessarily mean they lack capacity.

18.4.3 There are legal safeguards that must be followed when making a decision on behalf of some who lacks the capacity to make the decision – it must be done in their 'best interest'.

18.4.4 A person is unable to make a decision if they cannot:

- Understand the information relevant to the decision
- Retain that information
- Use or weigh that information as part of the process of making the decision, or communicate the decision

18.4.5 If a person's mental capacity is in doubt then if a relative or solicitor has a lasting power of attorney, which includes authority to make such decisions for them, which may include whether or not to choose the option of a deferred payment.

18.4.6 If a relative or carer cannot act as an advocate and where there is no Power of Attorney or the holder of the Power of Attorney is can no longer appropriately in that role, then an independent advocate must be provided and a Court of protection order considered.

18.5 Who to offer deferred payments to

18.5.1 The deferred payment scheme is available to those people who meet the three eligibility criteria detailed below:

- The person must have needs that are to be met via the provision of care in a care home
- The person must have less than (or equal to) £23,250 in financial assets, excluding the value of the property
- The person's property is not disregarded, i.e. it is not occupied by a spouse or dependent relative

18.5.2 The Council can also exercise its discretion and may offer Deferred Payments to individuals in permanent residential/nursing care, who do not meet all of the deferred payment eligibility criteria above.

18.5.3 Examples of when the Council may exercise its discretion on a case-by-case basis, and can include but are not limited to:

- Where a person has assets which cannot be realised quickly and converted to cash

- Where a person would like to use the wealth tied up in their property to fund more than just their core care costs and purchase affordable 'top-ups'
- Whether an individual has any other accessible means to help meet their care fees and/or they are narrowly not eligible given the criteria listed above
- The Council can also consider applications for Deferred Payments where a person is renting their Supported Living/Extra Care Accommodation and they still own their previous main residence

18.6 Refusing a deferred payment

18.6.1 There are certain circumstances where the Council may refuse to offer a deferred payment, even if the individual meets the above eligibility criteria. These circumstances include:

- Where the Council is unable to secure a first charge on the property, which can include but is not limited to:
  - unregistered property,
  - non-agreement by joint owners
  - mobile homes
  - some leasehold property
  - property abroad
  - uninsurable property
  - property with a mortgage charge attached
- Where someone is seeking a top up and/or
- Where a person does not agree to the terms and conditions of the agreement, for example a requirement to insure and maintain the property
- Deferred payment agreement cannot be entered into to finance mortgage payments on Support living accommodation.
- Where a person wishes to defer an amount larger than they can provide security for.

18.7 How much can be deferred

18.7.1 A person should in principle be able to defer the entirety of their care costs (subject to any contribution required from the person's income). The Council will need to consider both security and sustainability:

- Can adequate security be provided for the deferred payment agreement? This requirement for 'adequate security' will normally be fulfilled by securing the deferred payment agreement against a property.
- Is the amount or size of the weekly deferral requested sustainable given the intended length of deferral and equity available to repay i.e. will the care costs mount up over time to be more than the security available to repay?

18.7.2 Three elements will determine how much a person may need to defer:

- The amount of equity a person has available in their form of security

- The amount a person is contributing to their care costs from other sources, including income, savings or a third-party
- The total care costs a person will face, including any top-ups the person might be seeking.

18.8 The equity limit

18.8.1 An 'equity limit' is the total amount that can be deferred. The amount deferred cannot rise above this agreed equity limit. The equity limit will leave some equity remaining in the security used for the deferred payment agreement – this will both act as a buffer to cover any subsequent interest payments, and will provide a small 'cushion' in case of small variations in value of the security.

18.8.2 If the person intends to secure their deferred payment agreement with a property, the Council must secure a valuation of the property. People may request an independent assessment of the property's value, in addition to the Council's valuation.

If an independent assessment finds a substantially differing value to the Council's valuation, the Council and the individual seeking a deferred payment will discuss and agree an appropriate valuation prior to proceeding with the agreement.

18.8.3 Where a property is used as security to offer a deferred payment agreement, the equity limit is set at:

- The value of the property
- Minus ten percent,
- Minus the lower capital limit.

18.8.4 The Council will, when someone is approaching the point at which they have deferred 70% of the value of their security, review the cost of their care with the person. The Council will:

- Discuss when the person might be eligible for any means tested support
- Discuss the implications for any top-up they might currently have and
- Consider jointly whether a deferred payment agreement continues to be the best way for someone to meet these costs

18.8.5 The council may also seek to re-value the security

18.8.6 The Council will not allow additional amounts to be deferred beyond the equity limit, and will refuse to defer care costs beyond this. Interest may/will still accrue beyond this point, and administrative charges may still be deferred.

18.9 Financial contribution

18.9.1 The share of care costs that a person intends to defer will be determined based on the amount they will be paying from income or other sources. A person may also contribute from payments by a third party (including any

contributions available from a financial product) or from their savings. The sustainability of a person's contributions from their savings should be considered.

18.9.2 Contributing to care costs from another source would be beneficial for a person as it would reduce the amount they are deferring and this would reduce their overall debt to the local authority. However, the Council will not compel a person to contribute to their deferral from these sources.

18.9.3 The Council will require a contribution towards fees from a person's income, but will not leave the person with less than the disposable income allowance [£144 per week (2015/16 allowance]. A person may choose to keep less of their income than the disposable income allowance should they wish.

18.9.4 If a person decides to rent out their property during the course of their deferred payment agreement, the Council will permit that person to retain a percentage of any rental income they possess.

18.10 Care home costs (top-ups)

18.10.1 Where an individual meets the criteria and the Council is able to offer a deferred payment agreement, the Council will allow someone the opportunity to defer their 'core' care costs.

18.10.2 Before considering the deferred payment scheme through the Council, an individual should have an understanding of what their likely care costs will be. If the individual is considering residential/nursing care accommodation which is above the agreed rate with the commissioned providers for the Council (therefore above the Expected to Pay Rate - EPR), the customer may wish to consider a top-up in order to meet their preferred accommodation option.

18.10.3 Therefore, in choosing to make a top-up to their 'core' care costs, a customer would need to make additional payments in order to meet the costs of the preferred accommodation option.

18.10.4 The deferred payment scheme offered by the Council can consider the option for a customer to defer their full care costs, which can include any top ups for the preferred accommodation option.

18.10.5 The Council will consider requests for top-ups, but have the discretion whether or not to agree to and the amount of a given top-up. The Council will accept any top-up deemed to be reasonable given considerations of affordability, sustainability and available equity within the security for the deferred payment.

18.10.6 If the Council is satisfied that a person or a nominated third party is able and willing to pay the additional cost of the preferred accommodation option for the period during which the Council expects to meet the adult's needs,

the person agreeing to pay will enter into a written agreement with the Council for the additional costs.

18.10.7 When a top up is agreed the Council will pay the full amount to the residential/nursing home provider and recover the top-up amount from the customer.

18.10.8 The Council will administer top-ups in accordance with the duties set out in the Care and Support and Aftercare (Choice of Accommodation) regulations 2014.

18.11 Property Valuation

18.11.1 Where an individual intends to secure their deferred payment agreement with a property, the Council will arrange for a valuation of the property usually during the 12 week property disregard. The Council will instruct an appropriate professional to provide a current market valuation.

18.11.2 The individual may request an independent assessment of the property's value (in addition to the Council's valuation). If an appropriate independent assessment finds a substantially differing value to that of the Council's, the Council and person will discuss and agree an appropriate valuation prior to proceeding with the agreement.

18.11.3 The value of the property or security will be revalued as follows:

- On an annual basis from the date of the original valuation and
- When the amount deferred is between 50%-70% of the value of the security to assess any potential change in the value (and consequently the person's 'equity limit' should be reassessed in turn). After this revaluation, the Council will revalue the security periodically to monitor any potential further changes in value. If in either case there has been any substantial change the local authority should review the amount being deferred as well, as set out in the section "how much can be deferred" above
- More frequently if individual circumstances deem that necessary.

18.11.4 Where a property is being considered as the form of security for a deferred payment, the individual will need to consider how they plan to use, maintain and insure the property if they would like to take out a deferred payment agreement with the Council.

18.11.5 Consideration should be made by the customer for how to rent out the property, prepare it for sale, or to leave it vacant for a period of time. The Council will signpost people to more specialist organisations who can provide further advice, for example, information about their legal responsibilities as landlords and their obligations to any potential tenants.

18.12 Obtaining Security

18.12.1 In order to enter into a deferred payment agreement, the Council must have adequate security in place. In line with Care Act 2014 the Council requires a legal mortgage charge on a property via the Land Registry i.e. a “1st charge”.

18.12.2 Where a property is jointly owned, the Council will request all owners consent and agreement to a charge on the property.

18.12.3 All owners will need to be signature of the charge and deferred payment agreement. The agreement will require the co-owner(s) to agree to the sale of the property for the purpose of repaying the debt due to the Council.

18.12.4 The Council can also use its discretion to agree other forms of adequate security, in places where a legal charge on a property cannot be secured. These can include, but are not limited to:

- A 3rd party guarantor – subject to the guarantor offering an adequate form of security
- A solicitors undertaking letter
- A valuable object such as a painting/work of art
- An agreement to repay the amount deferred from the proceeds of a life insurance policy

18.12.5 The Council has full discretion in individual cases to refuse a deferred payment agreement if it is not satisfied that adequate security is in place.

18.13 Interest rate and administration charge

18.13.1 The Council will recover the costs of administering the deferred payments scheme in line with the Department of Health guidance for the Care Act. This national guidance outlines how Local Authorities should intend to operate a cost neutral deferred payment agreement scheme.

18.13.2 The Deferred Payment Scheme provided by the Council includes an administration charge for costs associated with the arrangement and on-going management of a deferred payment agreement. The Council also applies a rate of interest to the agreed amount deferred to cover the cost of lending.

18.13.3 The administration charges and interest for a deferred payment can be added on to the total amount deferred as they are accrued, although a person can request to pay these separately if they choose. The Council’s deferred payment agreement explains that all fees deferred, including any interest and administrative charges incurred, must be paid in full by the person entering into the agreement.

18.13.4 Prior to entering into a deferred payment agreement with the Council, information will be made available on the rate of interest that will be charged on a deferred amount. The person will also be informed of when interest rates are likely to change.

18.13.5 The rate of interest applied to deferred amounts will be reviewed on a regular basis and will be maintained in accordance with the guidance for the national maximum rate as detailed within the Department of Health guidance for the Care Act. The same rate of interest will be applied to all deferred payment agreements with the Council and on review, any changes to the rate of interest will be applied to all the agreements the Council has entered into.

18.13.6 The interest charged on the deferred amount will accrue on a compound basis. An interest charge that is compounded means that the interest is initially calculated on the agreed loan amount, but also then on the accumulated interest for each period thereafter. Interest will continue to accrue on a compound basis until the deferred amount, along with all accrued interest and incurred administration charges, are repaid to the Council in full.

18.13.7 The approach to charge interest on a compound basis for deferred payments is in line with the Department of Health guidance for the Care Act.

18.13.8 Interest can accrue beyond the point where the equity limit is reached. It can also accrue after when the person has died up until the point at which the deferred amount is repaid to the Council. If the Council cannot recover a possible debt for an agreement and seeks to pursue this through the County Court system, the Council may consider charging the higher County Court rate of interest.

18.13.9 The administration charge a person will be liable to pay through entering into a deferred payment agreement with the Council includes costs associated with the arrangement and on-going management of the agreement.

18.14 Ending a deferred payment

18.14.1 The Council retains the right to terminate a deferred payment agreement. In deciding to end a deferred payment agreement the Council will consider the person's individual circumstances, and the Council's overarching duty to promote the individuals wellbeing. Circumstances where a deferred payment might be terminated include:

- When a person's total assets fall below the level of the means-test and the person becomes eligible for local authority support in paying for their care
- Where a person no longer has need for care in a care home (or where appropriate supported living accommodation)
- If a person breaches certain predefined terms of their deferred payment agreement and the Council's attempts to resolve the breach are unsuccessful and the contract has specified that the authority will stop making further payments in such a case

- If, under the charging regulations the property becomes disregarded for any reason and the person consequently qualifies for local authority support in paying for their care, including but not limited to:

    - where a spouse or dependent relative (as defined in charging regulations) has moved into the property after the agreement has been made, where this means the person is eligible for local authority support in paying for care and no longer requires a deferred payment agreement
    - Where a relative who was living in the property at the time of the agreement subsequently becomes a dependent relative (as defined in charging regulations). The local authority may cease further deferrals at this point

18.14.2 The Council will not exercise the power to terminate a deferred payment if a person would, as a result, be unable to pay any tariff income due to the local authority from their non-housing assets.

18.14.3 The Council will also cease deferring further amounts when a person has reached the 'equity limit' that they are allowed to defer): or when a person is no longer receiving care and support in either a care home setting or in supported living accommodation. This also applies when the value of the security has dropped and so the equity limit has been reached earlier than expected.

18.14.4 The Council will provide a minimum of 30 days advance notice that further deferrals will cease: and will provide the person with an indication of how their care costs will need to be met in future.

18.15 Transition to the new legal framework

This policy relates to duties established under the Care Act 2014 which came into effect from the 1st April 2015. Direct Payment agreements made under previous legislation will remain in force.