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|   |  | Internal Ref: | CCGNELC.CFAssmnt |
| Review date | March 2021 |
| Version No. | V4 (2020/21) |

North East Lincolnshire

Council

**Charging and Financial Assessment for**

**Adult Care and Support Services**

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| **Document Title:** | Charging and Financial Assessment forAdult Care and Support Services |
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| **Version No:** | V4 |
| **Latest Version Issued:** | June 2020 |
| **Supersedes:** | All previous Charging and Financial Assessment for Adult Care and Support Services policies  |
| **Date of Next Review:** | March 2021 |

**Index**

|  |  |
| --- | --- |
| **Topic** | **Page**  |
| Introduction | 2 |
| Scope and definitions | 2 |
| Policy Purpose/ aims | 2 |
| Policy  | 4 |
| * Key points to charging regardless of setting
 | 4 |
| * Charging for permanent care and support in a care home
 | 5 |
| * Key points to financial assessment when entering a care home permanently
 | 6 |
| * Charging for temporary care and support in a care home
 | 6 |
| * Charging for care and support outside of a residential setting
 | 7 |
| * Disability Related Expenditure
 | 9 |
| * Charging for carers
 | 10 |
| * Requesting council support to meet eligible needs
 | 10 |
| * Deprivation of Assets
 | 11 |
| * Recovery of Debt
 | 11 |
| * Appeal panel
 | 11 |
| Summary of Publications | 12 |
|  |  |
| Annex A – Direct Payment Policy |  |
| Annex B – Recovery Process |  |
| Annex C – Disability Related Expenditure  |  |
| Annex D – Schedule of Fees |  |

1. **INTRODUCTION**

This Policy provides the framework within which charging and financial assessment is undertaken in North East Lincolnshire. It should be read in tandem with the policy entitled “Micro-Commissioning in Adult Social Care, Continuing Healthcare and Funded Nursing Care: principles of consistent, pragmatic, and ethical decision making” which can be found at <https://www.northeastlincolnshireccg.nhs.uk/> (‘the Micro-commissioning Policy).

Via an agreement under s75 of the National Health Service Act 2006, North East Lincolnshire Council (NELC) delegated adult social care responsibilities to the North East Lincolnshire Clinical Commissioning Group (CCG).  The CCG commissions a number of providers to deliver social care functions on behalf of NELC for which it acts as delegate; this includes

* delivery of micro-commissioning functions by Care Plus Group (CPG), Navigo and focus independent adult social work (focus); and
* charging, financial assessment and collection functions by focus.

Whilst the functions to which this Policy relates will be carried out primarily by the CCG and/ or focus, as charging policy is a reserved matter, only NELC will be referred to throughout.

*Note to reader: the reference to the Micro-commissioning Policy is new. The Micro-commissioning Policy has been in existence since 2016 in its current form, but previously was not cross-referenced with the charging policy. By cross-referencing to the Micro-commissioning Policy, we hope to make sure the policies are applied coherently together.*

1. **SCOPE AND DEFINITIONS**

This Policy applies to all adults (those aged 18 and over) that receive chargeable care and support services. It will be referenced and applied by all staff undertaking charging activity on behalf of NELC, regardless of which organisation employs them.

Charging activity includes (but may not be limited to):

* providing information about charges for care and support
* undertaking financial assessment, review or collection
* undertaking associated administrative tasks, such as arrangements for putting in place, or for monitoring:
* packages of care and support for those otherwise ineligible for such help from NELC
* direct payments
* deferred payment agreements.

The term ‘care and support’ is used to describe the provision of services or other activity to adults in need of social care and support. The term ‘eligible care and support needs’ is used to denote adult social care needs deemed eligible via the application of criteria within the Care Act 2014 (‘the Care Act’) associated statutory guidance and regulations.

1. **PURPOSE AND AIMS**

The Policy’s aim is to produce a consistent and fair framework for charging and financial assessment for all adults who receive or may receive chargeable care and support services, applied on an equitable and transparent basis.

In particular, the Policy is intended to recognise:

3.1 The **financial context** within which charging activity takes place.

The adult social care budget is agreed annually by NELC cabinet and is limited. To ensure best value management of public budgets, NELC intends that its charging activity will be undertaken on the basis of full cost recovery wherever possible and appropriate. This intention is reflective of the Care Act, which directs local authorities to consider the long-term sustainability of their approach to charging.

In considering best value, NELC pays particular regard to National Audit Office (NAO) guidelines. The NAO defines value for money as ‘the optimal use of resources to achieve the intended outcomes’, and uses three criteria when assessing value for money:

* Economy: minimising the cost of resources used or required (inputs) – spending less
* Efficiency: the relationship between the output from goods or services and the resources to produce them – spending well; and
* Effectiveness: the relationship between the intended and actual results of public spending (outcomes) – spending wisely.

The NAO criteria should be applied to all adult care and support functions undertaken on NELC’s behalf, including charging activity.

*Note to reader: it has been NELC’s policy for some time to charge on the basis of full cost recovery wherever possible and appropriate. For consistency, the NAO criteria which features in the Micro-commissioning Policy has been added.*

3.2 The **legal context** within which charging activity takes place.

3.2.1 The Care Act 2014

The Care Act provides the framework for charging for care and support. It enables local authorities to decide whether or not to charge adults when arranging to meet their needs, and when arranging support for carers. The Care Act also lists functions and services for which local authorities are not permitted to charge.

Where a local authority intends to charge, the Care Act permits it to undertake an assessment of an adult’s financial resources (either a full or a light touch assessment). Financial resources include income and capital. The financial assessment determines the level of an adult’s resources, and the amount (if any) which the adult may be likely to be able to contribute towards the cost of their care and support. The assessment will ensure that the level of financial contribution calculated is within an adult’s means, and leaves them with the guaranteed minimum level of income set annually by government. Financial assessments are updated annually to take account of changes in circumstances.

The detail of how charges apply is different depending on whether an adult receives care and support in a care home, in their own home, or in another setting. However, the Care Act’s overarching principle in relation to charging is that adults should only be required to pay what they can afford. The Care Act’s accompanying statutory guidance gives further details of the principles which local authorities must take into account when making decisions on charging. NELC has due regard for those principles when drafting and applying this Policy.

3.2.3 The Mental Capacity Act 2005 (MCA)

NELC is mindful that although charging decisions are not decisions made by the adult seeking care and support, each adult’s consent to participate in charging activity (for example, a financial assessment), or their refusal, is subject to the principles of the MCA.

Where the adult lacks capacity to consent to charging activity, NELC will seek consent and participation from appointed representatives where available, such as

* An attorney appointed via an Enduring Power of Attorney (EPA)
* An attorney appointed via a Lasting Power of Attorney (LPA) for property and affairs
* A deputy for property and affairs appointed by the Court of Protection
* Any other person dealing with the adult’s financial affairs (e.g. a person selected as ‘appointee’ by the Department for Work and Pensions (DWP) for the purpose of benefits payments).

Persons appointed as representatives via any of the above mechanisms will be asked to evidence it by providing a full copy of the document appointing them. Copy evidence will be lodged with the adult’s records.

*Note to reader: asking for evidence of a person’s appointment is a requirement of our Mental Capacity Act policy; reference has been added here for consistency.*

Where there is no person appointed to act on behalf of an incapacitous adult in respect of charging activity, NELC will seek to involve relevant others such as health and welfare attorneys/ deputies with the aim of:

1. Facilitating the involvement of the adult in charging activity
2. Making relevant best interests decisions on behalf of the adult
3. Considering whether an application should be made to the Court of Protection to appoint a property and affairs deputy.

In the absence of any appropriate person to support the involvement of an incapacitous adult in charging activity, NELC may consider the involvement of an advocate where this appears to be in the best interests of the adult.

1. **POLICY**

4.1 **Key points applicable to charging regardless of setting**

To access care and support, adults must meet the Care Act’s eligibility criteria. Only where an adult has eligible needs for care and support need will a financial assessment be required.

Financial assessment (either a full assessment or light touch) is the mechanism for determining the level of an adult’s resources. An adult with capital over the upper capital limit, or who refuses a financial assessment, will be required to pay the full cost of their care and support.

The financial assessment will refer to the Care Act Statutory Guidance for all disregards in respect of income and capital when making a determination of the individual’s financial resources.

Where following financial assessment an adult is deemed to be able to afford to make a contribution to their care, contributions are payable from the date care begins. If there is a delay in conducting the financial assessment for any reason, contributions will still be payable from the date services began. Where a financial assessment has been delayed, adults may be invoiced retrospectively to bring their contributions up to date.

There are circumstances in which an adult may be offered a light touch financial assessment, where undertaking a full financial assessment may be disproportionate to the cost of care and support services.

Once the financial assessment has been concluded, the adult will be informed of the weekly amount they must contribute towards their care and support costs. Adults will not be charged more than the amount determined by the financial assessment; this will be the amount that the law says they can afford.

All financial assessments will be reviewed with the adult or their representative on an annual basis or when a change in circumstances occurs. If the adult’s contribution will increase as a result of the review, the increase will apply from the Monday following the review. If the adult’s contribution decreases as a result of the review or change, it will be backdated to the Monday before the review took place. A review will be proportionate to the circumstances: it may be face to face, over the telephone or by post.

Adults or their representatives are responsible for informing NELC of any changes in their financial circumstances. This includes informing NELC of additional benefits being awarded. If the Council is not notified immediately of any changes, the financial reassessment will be backdated to the date of the change and/ or the additional benefit was awarded. Notification of change should be directed to the Community Care Finance at focus (contact details can be found on the adult’s notification of charge).

4.2 **Charging for permanent care and support in a care home (residential care)**

Adults will only be supported to access residential care where a care assessment identifies that this is where their eligible needs are best met.

NELC will charge for care and support delivered in a care home on a permanent basis. Adults will be made aware no later than admission to the care home, of the maximum amount of funding NELC makes available towards the care and support delivered there. This maximum amount is known as NELC’s ‘Standard Rate’. The Standard Rate is the sum agreed between NELC (via the CCG) and residential care providers each year. The Standard rate for the current year can be found at Appendix D. The adult will make any assessed contribution to the standard amount directly to the care home, and NELC will pay the remainder directly to the care home.

NELC’s approach to micro-commissioning care home placements is set out in detail in the Micro-commissioning Policy at paragraphs 4.4 and 4.5. This includes NELC’s approach to choice of accommodation and top-ups and out of area placements. A brief summary only is offered here, as follows:

Choice of accommodation and top-ups: the right to choose a placement more expensive than NELC’s Standard Rate only applies where a third party or in certain circumstances the adult in need of care is able and willing to pay the additional cost (a ‘top-up’), and

* NELC is satisfied that the person paying the top-up is willing and able to do so for the likely duration of the adult’s stay in the chosen accommodation (the person paying the top-up will be required to provide evidence of affordability and sustainability)
* the person paying the top-up enters into a written agreement with the CCG (on behalf of NELC) in which they agree to pay it. Further information on the content of the written agreement can be found in the Top-ups Toolkit at [https://www.**services4**.**me**.uk/](https://www.services4.me.uk/)

Not paying the top-up may result in the adult’s accommodation placement being ended and alternative accommodation arranged. Further information on NELC’s approach to defaults in top-up payments can be found within the Micro-commissioning Policy and Top-ups Toolkit.

Out of area placements: If an adult chooses to be placed in a setting outside North East Lincolnshire, arrangements will be made, subject to the choice of accommodation/ top-ups conditions set out above. In such cases, NELC will *have regard to* the cost of care in the chosen area when setting the maximum sum it will make available to meet the adult’s needs. Further detail is offered in the Micro-commissioning Policy.

*Note to reader: for consistency, more detail has been added here by copying information from our Micro-commissioning Policy and our Top-ups Toolkit.*

Universal Deferred Payment Agreement

Adults that own a property or other valuable asset, over which security (a legal charge) can be taken, may be eligible to defer care costs against the value of the property/ asset. This is known as a Deferred Payment Agreement. NELC will make universal deferred payment agreements available under the national ‘Universal Deferred Payment Agreement Scheme’ providing the eligibility criteria has been met. Details of North East Lincolnshire’s Deferred Payment Scheme can be found here: <https://www.nelincs.gov.uk/wp-content/uploads/2016/02/NELCCG-Deferred-Policy-1.pdf>.

**Key points to a financial assessment when entering a care home permanently**

The financial assessment will take into account:

* Income
* Capital
* The value of any assets.

Evidence of income, capital and assets may be required when completing the assessment.

NELC will take into consideration any mandatory disregards of income, capital and property as defined in the Care Act regulations and statutory guidance. It will also take into account the amounts the law says adults must be allowed to retain from their income. These are known as ‘Personal Expenditure Allowance’ (PEA) and ‘Disposable Income Allowance’ (DIA). These amounts are dependent upon the adults’ financial circumstances, and are set annually by the Department of Health and Social Care.

NELC will undertake a financial and benefits check for adults as part of their financial assessment.This may include signposting and referring for additional benefits.

4.3 **Charging for temporary care and support in a care home (respite)**

NELC will charge for care and support delivered in a care home on a temporary basis.

Following an assessment of an adult’s eligible care and support needs, a decision may be taken that they would benefit from a temporary stay in a care home. A temporary resident is defined as an adult whose need to stay in a care home is intended to last for a limited period of time and where there is a plan to return home. The adult’s stay should be unlikely to exceed 52 weeks, or in exceptional circumstances, unlikely to substantially exceed 52 weeks.

For the first eight weeks of a temporary stay, NELC will charge adults a flat rate. After the first eight weeks, a full financial assessment will take place.

There are four flat rates; NELC decides which of these rates an adult will pay depending on what benefits they receive, and their level of resources (money and investments). Details of the four flat rates can be found at [ ]. The flat rates will increase each year. Charges for temporary stays will be increased by the same percentage as the increase in the Standard Rate agreed between NELC (via the CCG) and residential care providers each April.

*Note to reader: the text in red is subject to consultation. NELC has not increased the flat rates for several years, and is consulting on whether or not people agree that they should be increased to catch up and keep up with increased costs, and over what period. Whether this text appears in the final policy is subject to the outcome of the consultation.*

Adults that have a temporary stay that becomes permanent will be assessed for a permanent stay at the date permanency is confirmed and their care and support plan is amended. The financial assessment for temporary stays will completely disregard the adult’s main or only home where the individual intends to return to that home.

If the temporary stay falls under “Extended Respite” (anything longer than a stay of eight weeks) NELC will ensure that payments made by the adult to keep and maintain their home, such as rent (unless housing benefit is in payment), water rates and insurance premiums are disregarded.

Contributions to the cost of all temporary stays are payable from the date care commences.

A new light touch financial assessment will be required in each financial year in which an adult requires temporary accommodation in a care home.

4.4 **Charging for care and support outside of a residential setting, including an adult’s own home (domiciliary care)**

NELC will charge for care and support delivered in other care settings including an adult’s own home.

If more than one care worker is required to carry out the same service at the same time (for example, the adult needs two care workers simultaneously to support safe moving and handling), the maximum the adult will pay is the full cost of the first care worker and 50% of the cost of the second care worker.

NELC has a range of flat rates for day care, transport and laundry services. You can view these at: Appendix D. NELC increase these charges every year by reference to the rate of inflation.

*Note to reader: the text in red is subject to consultation. NELC has not increased the flat rates for several years, and is consulting on whether or not people agree that they should be increased to catch up with inflation, and to keep pace with inflation in future. Whether this text appears in the final policy is subject to the outcome of the consultation.*

A personal budget is the sum NELC makes available to meet the adult’s needs. Adults have the option to use their personal budget for NELC commissioned services or to take it as a direct payment, or a combination of both. NELC has a Direct Payments Policy that sets out the criteria for care and support being managed using direct payments. This can be found at Annex C.

*Note to reader: the direct payment policy is not part of the current consultation.*

Key points to a financial assessment outside of a residential setting

NELC will undertake a financial assessment to determine the amount an adult can contribute towards the costs of their care and support based, as a minimum, on income, capital and housing costs. Where the adult is in receipt of a qualifying benefit, Disability Related Expenditure (DRE) will also be considered.

Where the adult receiving care and support has capital at or below the upper capital limit, but more than the lower capital limit, they will be charged £1 per week for every £250 in capital between the two amounts. This is called “tariff income”. For example, if an adult has £5,000 above the lower capital limit, they are charged a tariff income of £20 per week.

When assessing what an adult can afford to contribute to the cost of their care, NELC will ensure that the adult retains at least the ‘Minimum Income Guarantee’ (MIG). This retained income level is designed to promote independence and social inclusion and is intended to cover basic needs such as purchasing food, after housing costs have been taken into consideration. NELC uses the MIG figures provided annually by the Department of Health and Social Care.

*Note to reader: the text in red is subject to consultation. NELC currently allows an amount which is more generous than the nationally set MIG figure, and is consulting on whether to stop doing so. Whether this text appears in the final policy is subject to the outcome of the consultation.*

Property other than the adult’s main or only home will be included within the financial assessment as a capital asset. The only exception to this rule is where the adult is taking steps to occupy premises as their home. In this case the asset value will be disregarded for a maximum of 26 weeks.

Direct housing costs (rent, mortgage interest, council tax) will only be taken into account as part of the financial assessment where the adult is liable for such costs, i.e. where the adult is a party to a tenancy agreement or mortgage. For adults living with family members, the housing benefit non-dependent deduction rate will be taken into account as part of a financial assessment. Unless the adult is directly liable (a party to the tenancy agreement or mortgage), no further allowance above the level of the housing benefit non-dependent deduction rate will be taken into account.

Where funds are held in trust, the financial assessment will seek to determine whether income received or capital held in trust should be included or disregarded. Copies of trust documents (e.g. Trust Deed, Will Settlement etc.) are required as part of the financial assessment.

The Care Act requires that financial assessments are completed for adults as individuals. Where capital is held and income is received on a joint basis, then it is assumed that each person is entitled to 50% of that capital/ income. A couple is defined (for administration of their financial affairs) as two people who are married or in a civil partnership, or living together as if they are married or in a civil partnership.

NELC has no power to assess couples according to their joint resources. Each adult must therefore be treated individually. However, NELC takes an approach to the minimum income guarantee (MIG) which takes account of the fact that the adult is living as part of a couple. This means that an adult who is living as part of a couple will be left with a lower MIG than an adult who is living alone. This is because people who are living as a couple are often sharing resources and expenses, which may mean that they are better off than those who live alone.

*Note to reader: the text in red is subject to consultation. NELC currently allows an amount which is more generous than the nationally set MIG figure, and is consulting on whether to stop doing so. Whether this text appears in the final policy is subject to the outcome of the consultation.*

Adults will be encouraged to set up a standing order to pay their contribution or alternatively will receive an invoice on a 4 weekly basis in arrears.

Where an adult has capital in excess of the upper capital limit and is therefore required to meet the full costs of their care, they are still entitled to request that NELC arrange their services. NELC will charge an annual fee for arranging services. See 4.6 below.

**4.5 Disability Related Expenditure (DRE)**

The Council understands from the Care Act’s statutory guidance that DRE can be defined as relating to:

* needs not met by the Council
* reasonable additional costs directly related to a person’s disability, or necessitated by their disability.

Adults in receipt of care outside of a residential setting (care or nursing home) and are in receipt of disability benefits (Attendance Allowance/Disability Living Allowance and Personal Independence Payment), will be asked whether they want any relevant expenditure to be considered as DRE. Agreed DRE is taken into account as part of the financial assessment.

When considering what to allow as DRE, the Council will use the adult’s care plan as a starting point. It can be difficult to quantify the additional costs directly related to a person’s disability in the context of expenses which many people meet, regardless of whether they have a disability. NELC has largely adopted the guidance set out by the National Association of Financial Assessment Officers (NAFAO) in developing an approach to DRE. This can be found at [ ]. With regard to the following common expenses, NELC anticipates that reasonable additional costs directly related to the person’s disability can be met within the following limits:

* social activities up to a maximum of £50 per week
* gardening up to a maximum of £15 per week
* window cleaning up to a maximum of once per month.

The above figures are those which NELC has calculated are sufficient to meet the majority of requests for DRE allowances in respect of social activities and gardening. Higher claims must be accompanied by a clear rationale as to why this is justified (by reference to the factors set out within legislation, guidance, and the Micro-commissioning Policy), and submitted to the Appeal Panel (see 4.10 below). There is no intention to set arbitrary limits, but rather to ensure that all appropriate matters have been taken into account before apparently costlier claims are endorsed.

*Note to reader: the text in red is subject to consultation. NELC does not currently set limits on amounts for DRE for social activities, gardening and window cleaning, and is consulting on whether to start doing so. Whether this text appears in the final policy is subject to the outcome of the consultation.*

NELC will generally not allow DRE where:

* a reasonable alternative is available at lesser cost. For example, an individual funding a private day care placement at a higher cost than NELC’s day care provision will only be allowed DRE to the value of NELC’s provision
* costs should be met by other agencies, such as the NHS. This applies to therapies such as physiotherapy, chiropody and incontinence pads.

NELC retains flexibility to take into account individual need. It will consider DRE allowances outside of this policy where individual circumstances may warrant departure from it, via its Appeal Panel (see 4.10 below).

DRE will only be allowed if the adult is in receipt of a qualifying benefit and receipts are provided to evidence expenditure.

Any private care or support that is put forward as part of an adult’s DRE must be identified on the care and support plan.

Only costs incurred by the adult will be considered as part of the assessment as allowable disability related expenditure.

4.6 **Charging for support to carers**

NELC does not currently charge carers for any support they receive as it recognises the vast contribution carers make towards sustaining the health and social care system.

4.7 **Requesting Council support to meet eligible needs**

The Care Act allows local authorities to charge an administration fee for arranging care and support for someone in their own home when they have capital above the upper capital limit.

NELC charges an administration fee, which is due for payment when the care and support package has been arranged.  This fee is to cover the costs involved in arranging care and support. An ongoing administration fee of the same amount is payable annually thereafter, at the time of the individual’s financial assessment. This fee is charged every year regardless of changes to the care and support received.

Fees will be reviewed on an annual basis. The current fee can be viewed at Appendix D.

*Note to reader: the text in red is linked to the consultation. NELC currently charges an administration fee of £50, and is consulting on increasing the charge to £170 per annum. The text that appears in the final policy is subject to the outcome of the consultation.*

4.8 **Deprivation of assets (deprivation of capital and/ or income)**

Deprivation of assets is the disposal of income and/ or capital (property and investments) in order to avoid or reduce care charges. Disposal can take the form of transfer of ownership or conversion of an asset into a different type of asset that is disregarded as part of a financial assessment. In all cases, it is up to the individual to prove to NELC that they no longer possess the asset.

NELC will determine whether to conduct an investigation into whether deprivation of assets has occurred. Following the investigation, where NELC decides that an adult has deliberately deprived themselves of an asset in order to avoid or reduce a charge for care and support, NELC will charge the adult as though they still owned the asset or income. NELC will require evidence to satisfy it that any transfer of assets was not a deprivation of assets.

NELC recommends that any adult wishing to dispose of an asset seeks legal advice before doing so in order to avoid any financial implications relating to care and support charges.

4.9 **Recovery of Debt**

The Care Act consolidates local authorities’ powers to recover money owed for arranging care and support for an adult. These powers can be exercised where an adult refuses to pay the amount they have been assessed as being able to pay, or have been asked to pay (where the cost of care and support is less than their assessed contribution).

The powers granted to local authorities for the recovery of debt extend to the adult or their representative, where they have misrepresented or have failed to disclose (whether fraudulently or otherwise) information relevant to the assessment of what the adult can afford to pay.

NELC is committed to recovering all monies owed to it in order to maximise income to sustain services for the local community.

NELC will approach the recovery of debt reasonably and sensitively and will only take court action as a last resort. The financial assessment team will work with adults and/ or their representatives to prevent debts from occurring. NELC’s debt recovery process for recovering monies due for care and support costs can be found at Annex C.

All debt that arises from 1st April 2015 must be recovered within 6 years from when the sum became due to NELC.

4.10 **The Appeal Panel**

The Appeal Panel considers appeals from adults or their representatives against charges, formal complaints relating to charging, or regarding decisions of the Risk and Quality Panel. The Appeal Panel comprises a CCG financial representative, a charging policy expert, and representatives of both adult social care and customer care teams. The Appeal Panel uses generic guidance from the Local Government Ombudsman and Parliamentary and Health Service Ombudsman when considering its responses to appeals, complaints and decisions. The Appeal Panel’s Terms of Reference can be found towards the end of the list of documents on the CCG’s publications page: <https://www.northeastlincolnshireccg.nhs.uk/publications/>

*Note to reader: information about the appeal panel is a new addition. The panel has been around for some time, but we thought people would like to know more about it.*

1. **Summary of Publications**

The following publications have been referred to in the compilation of this policy:



The Care Act 2014

The Care Act 2014 Regulations

The Care Act 2014 Care and Support Statutory Guidance

The Mental Capacity Act 2005

Micro-Commissioning in Adult Social Care, Continuing Healthcare and Funded Nursing Care: principles of consistent, pragmatic, and ethical decision making – local policy

Mental Capacity Act 2005 and Deprivation of Liberty Policy – local policy

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**Annex A**

North East Lincolnshire

Council

**Direct Payments Policy for**

**Adult Care and Support Services**

**THIS POLICY IS UNDER REVIEW; IT DOES NOT FORM PART OF THE CURRENT CONSULTATION**

**Contents**

|  |  |
| --- | --- |
| **Topic** | **Page**  |
| Introduction | 2 |
| Making Direct Payments available  | 2 |
| Assessing capacity and making Direct Payments available to persons with and without capacity  | 2 - 3 |
| Administering Direct Payments, monitoring and reconciliation  | 3 - 4 |
| Using Direct Payment  | 4 |
| Discontinuation and termination of Direct Payments  | 4 - 5  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
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|  |  |
|  |  |
|  |  |

**1. Introduction**

1.1 Direct payments are monetary payments for people to meet some or all of their eligible care and support needs. The legislative context for direct payments is set out in The Care Act 2014, Sections 31 to 33, Mental Health Act Section 117 (2C) and Care and Support (Direct Payments) Regulations 2014.

**2. Making direct payments available**

2.1 North East Lincolnshire Clinical Commissioning Group (CCG) has a key role in ensuring that people are provided with relevant and timely information about direct payments, so that they can decide whether to request direct payments to fund their care and support costs.

2.2 Information will be made available during the support planning stage setting out the following:

* What direct payments are



* How to request a direct payment, including the use of nominated and authorised persons to manage the payment



* Explanation of the direct payment agreement
* The responsibilities involved in managing a direct payment and being an employer



* Making arrangements with social care providers
* Signposting to local organisations, and support organisations who can offer advice and support about employing staff
* The requirements of keeping accurate records and monitoring arrangements

2.3 People that wish to receive some or all of their personal budget via direct payments must request to do so. Direct payments are the Governments’ preferred method of administering care and support costs. The worker will encourage people to consider direct payments, and how they could be used to meet needs. No one will be forced to take a direct payment but will be informed of all of the choices available to them, following an assessment of their eligibility for care and support.

2.4 Where a person requests a direct payment after the support planning stage or between care and support reviews, then the review will be brought forward to accommodate the request for a direct payment.

2.5 It must be determined that a person has the capacity to request direct payments, or whether a person’s capacity is likely to fluctuate. Where a person lacks capacity to request a direct payment, an authorised person can request the direct payment on their behalf. Capacity decisions should be recorded in the assessment or support plan.

* 1. The following terms will be used as follows:
* Nominated Person is anyone who agrees to manage a direct payment on behalf of the person with care and support needs
* Authorised Person is someone who agrees to manage a direct payment for a person who lacks capacity according to the Mental Capacity Act 2005.

**3. Assessing capacity and making direct payments available to a person with and without capacity**

3.1 Where a person requests a direct payment, then an assessment of capacity must be made on a case by case basis. An individual will not be assumed to have or to lack capacity because they have a particular condition or illness.

3.2 Direct payments will be made to a nominated person specifically where requested by the person with care and support needs, and where the person has capacity. Where this is the case, the nominated person should be involved at any appropriate stage of the support planning. The nominated person should receive information and advice regarding direct payments and the additional legal obligations and responsibilities in acting in the person’s best interests.

3.3 Where it is deemed that a person has capacity to request a direct payment, The Care Act 2014 states that consideration should be given to each of the following conditions. A failure of one of the

conditions would result in the direct payment being declined. The conditions are:

* The person has capacity to request a direct payment and where there is a nominated person, that person agrees to receive payments
* There is no prohibition by regulations under section 33 from meeting the person’s needs by making direct payments to the person or nominated person
* It is determined that the person or nominated person is capable of managing direct payments on their own, or with whatever support they can access
* It is determined that making direct payments to the person or nominated person is an appropriate way to meet the needs in question.

3.4 In cases where the person requiring care and support lacks capacity to request direct payments, an authorised person can request a direct payment on their behalf. There are five conditions that must be satisfied as laid out in The Care Act 2014, section 32. Failure to meet any of the conditions would result in the request being declined. The conditions are:

* Where an authorised person is **not** authorised to act under the Mental Capacity Act 2005, but there is at least one person who is authorised under the Mental Capacity Act 2005, that person **must** support the authorised person’s request
* There is no prohibition by regulations under Section 33 from meeting the person’s needs by making direct payments to the authorised person
* It is expected that the authorised person will act in the person’s best interests in arranging for the provision of care and support for which direct payments would be used
* It is determined that the authorised person is capable of managing direct payments by himself or herself, or with whatever support they will need to access
* It is deemed that making direct payments to the authorised person is an appropriate way to meet the needs in question.

3.5 Where a direct payment is provided, this will be recorded in the person’s support plan. Where a direct payment request is refused, the person making the request will be provided with an explanation in writing, setting out the rationale behind the decision and how the person making the request can appeal. The decision should refer to the relevant conditions within the Care Act 2014 that have not been met. The support planning process should continue to ensure that the person’s needs are being and continue to be met.

3.6 Where requests are made to support aftercare under section 117 of the Mental Health Act 1983, full consideration must be given as to whether direct payments are the most appropriate way to meet those needs.

3.7 It must also be determined that the person, authorised or nominated person, is able to manage the direct payment, with whatever support is deemed necessary. Information on organisations and sources of support to assist in the management of direct payments will be provided.

 **4. Administering direct payments, monitoring and reconciliation**

4.1 It must be determined that the direct payment is being used to meet eligible care and support costs. Direct payments must be administered within the terms and conditions of the DP1 agreement under which direct payments are made. Care management will review direct payments initially at the 6-8 week review and then at least annually.

4.2 Any ‘on-costs’ associated with employment, such as recruitment, training, and employers liability insurance will be included in the amount paid as a direct payment. The Individual will then become the employer and responsible for the payment of employment costs. These may be paid as one off payments or incorporated into the regular monthly payment.

4.3 Where redundancy costs arise, these will be approved through the Risk and Quality panel and paid by the CCG.

4.4 Direct payments will be paid net of any client contribution. Where the person has been advised that they have to contribute towards their care and support through their direct payment, then the person should arrange to make this payment into the direct payment account on a weekly or monthly basis.

*Individuals who receive a direct payment so that they can arrange their own care and support will receive ‘net’ payments into their direct payment account 4 weekly in advance. Individuals must pay their assessed contributions to the direct payment account, so that when the direct payment amount and the individual’s assessed contribution are added together, they provide enough money to meet the needs set out in the individual’s care plan. A direct payment may be suspended or terminated and commissioned services provided if the individual does not pay their contribution to their direct payment account. Non-payment of assessed contributions to the direct payment account may also result in the Council initiating debt-recovery processes. Relocated from charging policy.*

4.5 The direct payments allocation will be paid into a bank account. This must be a separate account for the sole purposes of administering the direct payment. All direct payment accounts (including third party supported accounts) will be monitored and reconciled during regular financial audits.

4.6 The monitoring of accounts will ensure that where the person has employment responsibility and liabilities such as tax and national insurance, that these costs are being met from the direct payment.

4.7 The purpose of reconciling the direct payment account is to ensure that there are sufficient funds available to meet the person’s care and support needs and that the funds have been spent appropriately in meeting those needs. It is intended that the monitoring and reconciliation of accounts is as unobtrusive as possible.

4.8 Where it is identified that the direct payment has been misused or misappropriated, action will be taken to recover the funds. If fraud is suspected, the matter will be reported to the police for investigation.

4.9 Where a person has not fully used their direct payment money, or has purchased services that meet their care and support needs at an advantageous cost, the CCG retains the right to reclaim any excess amount. The person will be notified in advance of any amount identified, which will then be reclaimed.

4.10 Where funding from other public bodies is agreed, such as the NHS, then integrated budgets paid to and managed through a single account, will be monitored by the CCG.

**5. Using direct payments**

5.1 Direct payments are intended to be used flexibly and innovatively, and no unreasonable restriction should be placed on the use of the payment, as long as it is used to meet eligible care and support needs, detailed in the support plan.

5.2 Direct payments can be used for the purchase of short stays in residential care providing that the stay does not exceed a period of four consecutive weeks (28 days) in any 12 month period.

5.3 Regulations specify that where direct payments are used to purchase short breaks in residential care, and where the interim period between two stays is less than four weeks, then these two stays should be added together. The total of these stays should also not exceed four weeks. In both cases, no further residential care can be purchased using direct payments until 12 months have elapsed since the start of the four week period. Alternative funding arrangements would need to be agreed at this time.

5.4 Regulations do allow direct payments to be used to purchase short breaks in residential care where stays are four weeks and less, and are separated by four weeks, and do not exceed four weeks when added together. In this case, a person can use their direct payment to purchase short breaks in residential care throughout the year.

5.5 Direct payments may be considered for people requiring non-residential care services that live permanently in a care home. Similarly a person may have temporary access to direct payments to try independent living.

5.6 Direct payments cannot be used to pay for care and support provided by the Council/ CCG. There may be cases however, where the person wishes to make a one-off purchase of care or support from the Council / CCG (such as short break). In these circumstances, it would be appropriate for the person to use their direct payment for this purpose.

**6. Discontinuation and termination of direct payments**

6.1 People entering hospital should consider how best to use their direct payment at that time, especially where they are an employer and suspension of the direct payment could necessitate a break in the employment contract. The person should explore how their care and support needs as well as their health needs are met at this time. They may discuss with the hospital, the possibility of the personal assistants visiting the person in hospital to help with personal care matters.

6.2 Where the nominated or authorised person requires a hospital stay, then it must be ensured that the person continues to have their care and support needs met. This may be through a temporary nominated or authorised person, or through short term commissioned care and support.

6.3 Where a person, nominated or authorised person decides that they no longer wish to receive a direct payment, it must be determined that no outstanding liabilities remain before terminating the agreement. Where contracts of employment require terminating, then this should be done in a timely manner to avoid additional costs. A review of alternative care and support provision would be arranged

6.4 The direct payments must cease where a person advises, or no longer appears capable of managing them with necessary support.

6.5 The direct payments must cease where the person no longer needs the care and support for which the payment was made available.

6.6 The direct payments must cease where the person, nominated or authorised person fails to comply with the any of the terms and conditions of use.

6.7 The direct payments will cease where a person, nominated or authorised person loses capacity to consent. If the loss of capacity is considered temporary then payment can continue providing someone is willing to continue managing the payment on their behalf. The situation will be closely monitored and capacity will be reviewed before discontinuing payment or entering into an agreement with another person.

6.8 The direct payment will cease if the person receiving it dies.

6.9 When the direct payment ceases, an exit audit will be undertaken; all information and paperwork relating to the direct payment account must be made available to the finance team. Once all outstanding expenses have been determined and paid, any money remaining in the direct payment account must be returned to the CCG.

**Annex B**

**Recovery Process**

**DEBT RECOVERY FOR ADULT SOCIAL CARE**

Standing Order is preferred method of payment as money is more of a guarantee.

Financial Assessment completed for services to ascertain means to pay.

Invoice for client contributions generated via ContrOcc and interfaced directly into E-Financials.

Refer to case management for care review/risk assessment. If debts, direct payments should not be offered.

When the account reaches 14 days overdue NELC will issue standard reminder letter 1 requesting payment.

After a further 7 days (21 days overdue) NELC issue standard reminder letter 2 and Adult Social Care Staff contact the client/representative by phone to discuss full repayment or a payment plan. If a payment plan is agreed it must be at the highest repayment possible and clear the debt within a reasonable timescale. If progress is not made a Service Review will be generated.

Is advice required from CAB/CAS?

If payment plan is arranged, Visiting Officer will monitor account to make sure agreement is adhered to.

If repayment cannot be agreed by telephone, Visiting Officer to arrange home visit to discuss any issues and a repayment plan with client/representative.

Won’t Pay

If it becomes clear payment will not be made, Visiting Officer to refer case back to CCG for recovery action.

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Can’t Pay

Visiting Officer to signpost to relevant agencies for debt advice and keep regular contact with client/representative in order to achieve full repayment.

**Any payment plans needs to be timely and efficient to make repayment plans effective.**

If respite received and there is a debt within 12 months, refer to CMT to see if this can be stopped.

Worker to be notified via workflow on SystmOne re debt amount in order to assist process.

At this point, Visiting Officer to explore all payment options including charge on property and report back to Senior.

If arrangement fails, client/representative may need to be visited.

If client has a property, contact legal for a restriction to be placed.

If arrangement cannot be met then case needs to be referred back to CCG/focus for decision on whether or not further action will be taken.

Further recovery action in line with the debt recovery strategy for Adult Social Care.

Offer of instalment plan available at all times unless adequate savings

If legal restriction can be placed, complete relevant paperwork.

Legal to provide regular feedback to CCG and focus to review on a regular basis.

**Annex C - Disability Related Expenditure**

**NAFAO GUIDE TO DISABILITY RELATED EXPENDITURE 2019/20**

|  |  |  |
| --- | --- | --- |
| **Item** | **Amount** | **Evidence** |
| All fuel | Difference between actual annual bill and figures given below (which represent “normal costs”), divided by 52 Single in flat and terraced £1421.11 Couple in flat and terraced £1873.02 Single in semi-detached £1509.43 Couple in semi-detached £1987.72 Single in detached £1835.18 Couple in detached £2418.99  | Last 4 quarterly bills for all types of fuel  |
| **Notes:**  If bills not retained, copies to be provided within 28 days. If not provided within this timescale the allowance will apply from the date that the evidence is provided.Winter Fuel and Cold Weather Payments should not be taken into account.  |
| Community or Personal Alarm | Actual cost unless included in Housing Benefit or Supporting People Grant | Bills from provider |
| **Notes:**For couples where only 1 service user still allow actual cost  |
| Communication Aids  |   | Reference in the Support Plan to communication needs  |

|  |  |  |
| --- | --- | --- |
| Privately arranged care | Actual cost (up to a maximum of £14.64 per hour) if Social Worker confirms requirement as part of the Support Plan and Council supported care is reduced accordingly | Signed receipts, for at least 4 weeks using a proper receipt book  |
| Private Domestic Help | Actual cost (up to a maximum of £14.64 per hour) if Social Worker confirms requirement as part of the Support Plan and Council supported care is reduced accordingly | Signed receipts, for at least 4 weeks using a proper receipt book |
| **Notes:** Allowances will not normally be given in relation to care or domestic assistance provided by spouse or partner, other close relative or anyone else living in the same household. A close relative is defined as parent, parent-in-law, aunt, uncle, grandparent, son, daughter, son-in-law, daughter-in-law, step-son, step-daughter, brother, sister or spouse or partner of any of these.  |
| Laundry / Specialist Washing Powder  | £3.85 per week | Support Plan will have identified an incontinence problem. Identify more than 4 loads per week |
| Bedding | Continence service may provide Protective mattress Covers – check local provision | Receipts for a minimum 6 month period |
|  Dietary | Discretionary as special dietary needs may not be more expensive than normal | Details of special purchases |
| Clothes or Shoes |   | Reference within the Support Plan to abnormal wear and tear of clothing or need for specialist clothing. |
| Gardening | Discretionary based on individual costs of garden maintenance. *Note local policy – costs only allowable once per month – subject to outcome of consultation* | Signed receipts, for at least 4 weeks using a proper receipt book |
| **Notes:** Allowances will not normally be given in relation to redecoration or gardening provided by spouse or partner, other close relative or anyone else living in the same household. A close relative is defined as parent, parent-in-law, aunt, uncle, grandparent, son, daughter, son-in-law, daughter-in-law, step-son, step-daughter, brother, sister or spouse or partner of any of these.  |
| Wheelchair | Actual costs divided by 500 (10 year life) up to a maximum of £4.01 per week manualUp to a maximum of£9.74 per week powered | Evidence of purchase. No allowance if equipment provided free of charge |
| Powered Bed | Actual costs divided by 500 (10 year life) up to maximum of £4.43 per week | Evidence of purchase if available |
| Turning Bed | Actual costs divided by 500 up to a maximum of £7.76 per week | Evidence of purchase if available |
| Powered reclining chair | Actual costs divided by 500 up to a maximum of £3.52 per week input | Evidence of purchase if available |
| Stair lift | Actual costs divided by 500 up to a maximum of £6.27 per week | Evidence of purchasewithout DFG input |
| Hoist  | Actual cost divided by 500 up to a maximum of £3.07 per week | Evidence of purchase without DFG input |
| Notes: Allowance based on purchase costs over average life expectancy Other specialist equipment should be supported by Support Plan, receipt or estimate provided and referred to the Charging Appeal Panel for a decision Disabled Facilities Grant (DFG)  |
| Transport | Discretionary based on costs that are greater than those incurred by an able bodied person | Evidence in the Support Plan of the need for specialist transport |
| **Notes:** Mobility Allowance cannot be included in the normal financial assessment as an income, but the statutory guidance states that transport costs should be allowed if necessitated by illness or disability, including costs of transport to Day Centres, over and above the mobility component of DLA or PIP, if in payment and available for these costs. This implies that transport costs do not need to be allowed if Mobility Allowance is considered available to meet such costs.  |

**Appendix D – schedule of costs for 2020-2021**

Standard rate for residential care – AT LEAST £491.75

Short or temporary residential stay AT LEAST –

 Lower rate - £83.02

 Mid rate - £105.84

 Higher rate - £135.24

Day care full day – AT LEAST £32.16

Day care half day – AT LEAST £16.08

Transport per journey – AT LEAST £5.36

Laundry per week – AT LEAST £5.24

Administration fee for arranging care and support for someone in their own home when they have capital above the upper capital limit - £170 per annum.

*Note to reader – all of the above items in red text are subject to consultation. The text and figures that appears in the final policy are subject to the outcome of the consultation. The figures preceded by the words ‘at least’ will not be known until after the consultation closes (****April******2020)****. These fees will be increased by the current rate of inflation which is relevant at that time – the Council does not know what the rate of inflation will be at the time that a revised policy is likely to come into effect (****June 2020)*** *and so these figures are indicative only.*

*This page was subject to minor amendment/ clarification on 04 02 2020. .*