Micro-Commissioning in Adult Social Care, Continuing Healthcare and Funded Nursing Care: Principles of Consistent, Pragmatic, and Ethical Decision Making For Staff

North East Lincolnshire Council and North East Lincolnshire Clinical Commissioning Group strategic framework on maintaining independence for those with care needs

(previously known as the ‘Placement Policy’)

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

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**Target Audience:** NELC, CCG, Care Plus Group, Navigo, focus independent adult social work and Yarborough Clee Care.  
This policy applies to all staff who are responsible for micro-commissioning adult social care, continuing healthcare, or nursing resources to meet need, and to staff overseeing micro-commissioning decisions.

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Any locally held old paper copies of the Placement Policy must be destroyed. When this document is viewed as a paper copy, the reader is responsible for checking that it is the most current version. This can be checked on the CCG intranet.
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1. INTRODUCTION

This policy is owned by the North East Lincolnshire Clinical Commissioning Group (CCG). It provides the framework within which micro-commissioning decisions are taken regarding allocation of adult social care, NHS continuing healthcare (CHC) and funded nursing care (FNC), in North East Lincolnshire. This document should be read in tandem with the 3 year plan set out within the area’s Adult Social Care Strategy 2015. The Strategy can be found at http://www.northeastlincolnshirecwa.uk/market-position-statement-mps/north-east-lincolnshire-strategic-plans/.

This document replaces the Adult Social Care Procedure, Placement 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 CCG. As an integrated commissioner, the CCG commissions a number of providers to deliver health and social care functions on its behalf; this includes delivery of micro-commissioning functions by Care Plus Group (CPG), Navigo, and focus independent adult social work (focus).

Whilst duties under the Care Act 2014 are primarily directed at local authorities, given the integrated arrangements in North East Lincolnshire, where such duties are referred to in this policy they will be referred to as duties imposed on the CCG (acting as NELC’s delegate).

2. SCOPE & DEFINITIONS

This policy sets out the principles intended to inform the micro-commissioned activity undertaken on the CCG’s behalf in respect of a) adult social care and b) NHS CHC and FNC. This policy applies to all staff undertaking or reviewing this activity, whether employed by the CCG, Care Plus Group, Navigo, focus independent adult social work or Yarborough Clee Care.

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

The term ‘care and support’ is used throughout this policy to describe the provision of services or other activity to adults in need of social care and support, and adult carers in need of support. The term ‘eligible care and support needs’ is used throughout this policy to denote adult social care needs deemed eligible via the application of criteria within the regulations under the Care Act 2014; again it is intended to include reference to the eligible support needs of adult carers.

Access to adult care and support is determined by the provisions of the Care Act 2014. The Care Act prescribes that care and support is accessed via assessment, determination of eligibility and determination of ordinary residence. Procedures which support delivery of assessments and determinations of eligibility and ordinary residence are set out elsewhere.

‘CHC’ means a package of on-going care that is arranged and funded solely by the NHS where an adult has been found to have a ‘primary health need’. Such care is provided to meet needs for NHS funded inputs under the NHS Act 2006 that have arisen as a result of disability, accident or illness as defined by statute. FNC means the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse.

Via a process similar to that which underpins access to support via the Care Act 2014, access to CHC and FNC is determined by:
- the NHS Act 2006 (as amended by the Health and Social Care Act 2012)
- the NHS Commissioning Board and Clinical Commissioning Groups’ (Responsibilities and Standing Rules) Regulations 2012 (amended by the 2013 ‘Standing Rules’)
- the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (November 2012) and Decision Support Tool (both as revised) – incorporating Practice Guidance
- NHS England Who Pays? Determining responsibility for payments to providers 2013

Reference to the ‘Regulations’, ‘Framework’ and ‘Ops Model’ will be made throughout this policy. These documents form the backdrop against which the CCG’s ‘Joint Funding Principles and Practice for NHS Continuing Healthcare and Social Care’ must be considered. The principles within this policy should also be applied to ‘Joint Funding Principles and Practice for NHS Continuing Healthcare and Social Care’.

Whilst health services are provided free at the point of delivery (and adult social care is not), the principles set out within this document are applicable when allocating CHC or FNC resources, or considering delivery of personal health budgets. The principles within this document are intended to reflect, not replace, those within the documents referred to in the preceding paragraph: the CCG wishes to ensure a holistic approach to micro-commissioning social care, CHC and FNC provision, drawing on a shared set of principles and values (despite differing legislative origins). Public law principles apply to provision of both health and social care.

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

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

- An individual is assessed as meeting the Care Act’s test of eligibility and
  - they are ordinarily resident in North East Lincolnshire (or are present here, but of no settled residence), and
  - there is either a) no charge for the care and support offered, or b) there is a charge and
    - the person has assets under or at the upper capital limit (UCL), established via financial assessment (either a light touch or full financial assessment)
    - the person has assets above the UCL, but asks the CCG to meet their needs (NB the CCG is not required to meet needs where it is anticipated those needs will be met by a care home placement – subject to the next bullet point)
    - the person lacks capacity and there is no one to make arrangements for them (i.e. no-one authorised under the Mental Capacity Act 2005, or otherwise willing to make any other arrangement in their own name for the person).
- An individual is assessed as not meeting the Care Act’s test of eligibility but a decision is taken to exercise discretionary powers under the Care Act (or other legislation) to provide care and support
- An individual is assessed as eligible for CHC support (i.e. has been assessed as having a primary health need), or for FNC, and that individual is
  - provided with primary medical services by GP practices who are members of the CCG, OR
• usually resident in North East Lincolnshire and not provided with primary medical services by a member of any CCG
  (see further National Health Service (NHS) Act 2006 and ‘Who Pays? Determining responsibility for payments to providers’)
• An individual is assessed as eligible for a jointly funded NHS and social care package.

NB determination of ordinary residence under the Care Act applies differently in respect of carers. Both health and social care legislation makes provision for meeting the needs of carers or cared-for persons in an emergency, whether or not eligibility or ordinary residence has been determined. There are some restrictions necessitated by immigration status.

For the purpose of this policy, micro-commissioning activity includes (but is not limited to) making arrangements for:
• Care within a registered care home (with or without FNC), including respite, short stay and permanent stay
• Care at home or in the community, including in supported living settings and Extra Care Housing accommodation
• Day care services
• Use of direct payments (and other mechanisms for delivering personal budgets and personal health budgets).

In addition to arranging care and support, CHC or FNC provision via micro-commissioned activity, all care professionals must provide those for which the CCG is responsible with appropriate information, advice and signposting (particularly with regard to accessing preventative opportunities and community resources).

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

3. POLICY PURPOSE & AIMS

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

The CCG’s ambition is to influence and drive the pace of change in its local market, leading to:
• a sustainable and diverse range of care providers (including those which offer registered nursing)
• continuously improving quality and variety, and
• innovative and cost-effective outcomes that promote the wellbeing of those in need of care in North East Lincolnshire.

Supporting Best Quality Care
Via its Quality Framework the CCG seeks to reward providers offering innovation, investment and continuous improvement in the services they deliver, by payment of an increased premium. It is expected that providers offering higher quality care will be in greater demand, so further incentivising them to deliver services which meet the requirements of the local market.
In addition to the CCG’s contractual monitoring and the Care Quality Commission’s regulatory monitoring of providers, provision of commissioned care and support, CHC and FNC services is overseen by the Market Intelligence and Failing Services Group (‘the MIFS Group’). The MIFS Group protects the interests of those with needs in circumstances where providers are finding it difficult to deliver safe and quality services. The MIFS Group ensures the regular flow of information with regard to such providers, pooling and analysing intelligence collectively. The MIFS Group will take appropriate action in response to any failing or interrupted service, including a temporary suspension of referrals until difficulties are remedied. The MIFS Group policy and procedure can be found here.

Information regarding the status and Quality Framework rating of providers can be found at: http://chintel.northeastlincolnshireccg.nhs.uk/Home/InformUs. Intelligence regarding providers should also be logged using this link.

OBJECTIVES AND KEY CONSIDERATIONS
This document offers clarification to micro-commissioning staff in light of changes to the law. In particular it is intended to ensure recognition of the following:

3.1 The financial context within which the allocation of resources takes place.

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

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

The NAO defines value for money as ‘the optimal use of resources to achieve the intended outcomes’, and uses three criteria when assessing value for money:
- Economy: minimising the cost of resources used or required (inputs) – spending less
- Efficiency: the relationship between the output from goods or services and the resources to produce them – spending well; and
- Effectiveness: the relationship between the intended and actual results of public spending (outcomes) – spending wisely.

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

Key legal provisions include:

3.2.1 The Care Act 2014

The Care Act 2014 introduces major reforms to the legal framework for adult social care: to the funding system, to the duties of local authorities and to the rights of those in need of care and support. It gives additional rights to support for carers and increases duties towards those who fund their own care. The potential impact on commissioners’ finances and on their working practices is very significant.

The Care Act requires care practitioners to deliver on a range of duties, underpinned by the wellbeing principle, in working to serve the local population. This requires practitioners to navigate and weigh a variety of factors, including having regard to the key principles associated with wellbeing (see the Care Act’s Statutory Guidance, 1.14). Having ‘regard to’ is likely to mean approaching consideration of all the circumstances of an individual’s case with rigour and an open mind, and consciously directing the mind to obligations within the Care Act. This extends to the practitioner ensuring that they glean sufficient information to enable themselves to have due regard for the individual’s wellbeing, in all the circumstances. The concept of ‘having regard to’ does not mean that consideration of wellbeing excludes consideration of all other factors. Considerations must be balanced, reasoned and evidenced.

Although not specifically mentioned in the way that wellbeing is defined, wellbeing is intended to cover the key components of independent living as expressed in the UN Convention on the Rights of People with Disabilities (CRDP). Again, such rights do not automatically outweigh other considerations. For example, in a case in which it was alleged (amongst other things) that rights under CRDP were potentially infringed by a local authority, it was noted by the UK Supreme Court that “in choosing the services that should be provided, an authority has a very wide discretion, as long as the identified needs are met”; whilst service user preferences as to ways in which their needs might be met are material considerations, local authorities are entitled to

For further guidance, go to: https://www.nao.org.uk/successful-commissioning/
have regard to their resources “so long as the authority meets the particular need, and gives proper regard to other policy obligations, it is always open to it to meet that need by provision of a cheaper service” (R(D) v Worcestershire CC [2013] EWHC 2490 at paragraph 19.3 and 19.5). Regard for resources remains subject to public law duties (see 3.2.8), i.e. a cheaper offer must also be a lawful offer.

3.2.2 The Children and Families Act 2014.

The Children and Families Act 2014 is intended to transform the system for disabled children and young people, and those with special educational needs. The reforms create a system from birth to age 25, through the development of coordinated assessments, and a single Education, Health and Care Plan. The Children and Families Act also includes provisions for young carers and parent carers.

Some individuals will be entitled to the benefit of statutory functions owed under the Children Act, the Children and Families Act and the Care Act. This may be most likely for a young person in transition from children’s to adult services (this includes young carers in transition and adult carers of young people in transition). The Care Act’s duty of cooperation makes explicit the requirement to ensure the cooperation of children and adult’s services, particularly in order to smooth the transition from the former to the latter. The revised Framework states that eligibility for CHC should be identified early on, and provides a timetable designed to ensure that plans are in place before the young person’s 18th birthday. Staff from children and adult services (both health and social care) are expected to work together to ensure that outcomes and best value are maximised.

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

3.2.3 The Mental Capacity Act 2005 (MCA)

Care Practitioners are asked to remember that the principles of the MCA underpin all adult social care, CHC and FNC activity, including micro-commissioning functions. MCA principles are vitally important to ensuring person-centred care, and when supporting individuals to make choices about their care, in so far as they are able.

The MCA recognises that each individual is unique and will have different aspirations for their care. To reflect this diversity, the MCA is underpinned by key principles which enable a flexible approach to decision-making. Used well, these principles empower individuals to make their own decisions and protect those who lack capacity to do so. Care practitioners must show through their assessments, care plans and associated records how individuals are supported to maintain some control over their lives and to be involved in decisions about how their care is provided, as far as they are able. This includes consideration of the least restrictive care options. Supporting individuals in a way that is reflective of the MCA’s principles will include provision of statutory advocacy (via the MCA, Care Act or Mental Health Act 1983 - MHA) where appropriate. Practitioners must evidence their consideration of statutory advocacy, including evidencing consideration of whether the informal support available to an individual is appropriate.

3.2.4 The Equality Act 2010

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

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

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

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

3.2.5 The Human Rights Act 1998 (HRA)

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

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

It is worth noting that Article 8 of the ECHR does not guarantee individuals a right to a home, or the right to stay in their own home no matter what the cost of meeting their needs might be. Case law indicates that it is not acceptable to make it a condition of meeting an individual’s needs that they move from their own house/flat into another house/flat that they must rent or buy in order to have occupation rights.
3.2.6 National Framework and Practice Guidance for CHC/ FNC

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

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

3.2.7 The NHS Constitution

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

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

The rights and responsibilities in the Constitution generally apply to everyone who is entitled to receive NHS services, and to NHS staff. The Constitution is clearly applicable to the delivery of CHC/ FNC services. Whilst the Constitution may not be directly applicable to delivery of care and support in local authorities in which such functions are not devolved, in North East Lincolnshire it is expected that the principles and values in the Constitution will apply to delivery of all services commissioned by the CCG (where relevant – see examples in above paragraph). Equally, whilst not all staff to whom this policy applies are employed by the NHS, each staff member is expected to consider how the Constitution’s principles/values might apply within their own setting.

3.2.8 Public Law Principles and Decision Making

In addition to legislative duties, care practitioners are expected to take decisions in a way that is compliant with public law duties and principles. Care practitioners must ask themselves the following questions when making micro-commissioning decisions:

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

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

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

3.3.1 Meeting needs v providing services

The core purpose of care and support is to meet need in a way that helps people achieve the outcomes that matter to them. The concept of ‘meeting needs’ under the Care Act 2014 signifies an important shift from previous duties to ‘provide services’ and recognises that everyone’s needs are different, in particular any that may arise as a result of one or more protected characteristics. The Care Act intends to encourage diversity regarding the ways in which needs are met, and a focus on how to meet each individual’s specific needs, rather than simply considering what service they will ‘fit into’.

Care practitioners are expected to take an asset-based approach in supporting individuals to consider how to achieve the outcomes that matter to them. It is entirely permissible to regard a person’s eligible care and support needs as capable of being met without recourse to commissioned services, or even expenditure. Care practitioners **must** consider what else, other than (or in addition to) the provision of commissioned care and support, might help an individual to achieve their outcomes. There are a range of options for meeting need, including referral to universal or community resources, provision of ‘traditional’ commissioned services, use of direct payments to allow the individual to purchase their own care and support, or a combination of these. Reasons for rejecting other possible options, and choosing the one selected as being an effective, appropriate and reasonable way to meet need, must be evidenced.

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

Whatever options are chosen in agreement with the individual, care practitioners must be satisfied that they are an effective, appropriate and reasonable way of meeting eligible needs and identified outcomes (see the Framework page 105 - 106; regarding reasonableness, refer to the Care Act's Statutory Guidance 10.31/ 10.47).
Where an individual is assessed as lacking capacity to contribute to choosing which options best meet their needs, care planning must be undertaken on the basis of the person’s best interests, within the meaning of the MCA. Decisions should be made in ways that are the least restrictive of the individual’s rights and freedoms. Any restriction must be in the person’s best interests, necessary to prevent harm to them, and represent a proportionate response to the likelihood and severity of that harm.

For further guidance regarding capacity, refer to the MCA, the Care Act’s Statutory Guidance 10.59 – 10.72, and/ or the Framework pages 19 - 20.

3.3.2 Consideration of wellbeing and the whole family approach

Care practitioners are expected to consider how best to promote wellbeing when carrying out any of their care and support functions under the Care Act, in respect of an individual. The Care Act describes wellbeing as relating to a number of areas, including (for example) control by the individual over the care and support they receive, the ability to engage in family and personal relationships and suitability of living accommodation. There is no hierarchy, and all aspects of wellbeing should be considered in the round, as they relate to the individual.

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

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

The concept of wellbeing is not explored in detail within the Framework, although the importance of promoting it, and its impact on needs, is mentioned; the ‘key elements of a person-centred approach’ to CHC assessment and care planning are arguably less developed, but not unlike the Care Act’s key principles and standards. The Framework also makes reference to being considerate of the impact of the individual’s needs on others (including the risks posed to others by the individual’s needs); involving the individual’s carer(s) and family in decisions about care and treatment is a core component of the Framework.

When considering wellbeing, the importance of independence should not exclude consideration of other factors. Care practitioners will need to weigh all factors in agreeing how to meet eligible need.

3.3.3 Balancing outcomes and best value

In determining how (rather than whether) to meet needs, the law entitles the CCG to take into account its financial resources. It must also comply with its related public law duties, including ensuring that its available funding is sufficient to meet the needs of the entire local population i.e. the CCG must be cognisant of the impact that meeting individual needs has on the overall budget. The Care Act states that determination of how to meet need (rather than whether) may reasonably be balanced with consideration of budgetary requirements. This includes promoting
preventative interventions to reduce and delay needs, which in turn, reduces future demands on the CCG’s budget.

Care practitioners should take decisions on a case-by-case basis, weighing up the total costs of different potential options for meeting needs; cost is a relevant factor in deciding between suitable alternative options for meeting needs. This does not necessarily mean choosing the cheapest option, but the one which delivers the best outcomes for the best value in relation to the individual and the available budget at any given time balanced against the policy to treat similar cases in the same way in the interests of equity, within any one financial accounting period (see also the reference at 3.1, regarding the potential for legal compulsion to exceed the budget). Whilst not the sole, or necessarily primary consideration, financial matters are a key factor in reaching a conclusion on how to meet need.

The Ops Model states that CHC packages should be high quality, offer choice and value for money, and be focused on outcomes. The Framework notes that in some situations a model of support preferred by the individual will be more expensive than other options; it confirms that CCGs can take comparative costs and value for money into account when determining the model of support to be provided but should consider the following when doing so:

a) The cost comparison of alternative models has to be on the basis of the genuine/actual costs incurred in supporting a person with the specific needs in the case (and not on an assumed standard cost)
b) Where a person prefers to be supported in their own home, the actual costs of doing this should be identified on the basis of the individual’s assessed needs and agreed desired outcomes.
c) Cost has to be balanced against other factors in the individual case, such as an individual’s desire to continue to live in a family environment.

The social care case law examples given at 3.2.1 and 3.2.5 were decided prior to the advent of the Care Act, and it is as yet unknown how similar such cases might be decided under the new law. It is likely that given the breadth of the meaning of wellbeing set out within the Care Act, and the obvious tensions between individual wellbeing (i.e. those with care and support needs) and collective wellbeing (the requirement for budgets to support an entire community), litigation will increase. This heightens the importance of care practitioners evidencing reasoned and reasonable decision making processes when determining how to meet need.

For further guidance, refer to the Care Act’s Statutory Guidance 10.27, and the Framework pages 107 - 108.

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

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

For more information, refer to:

4. POLICY

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

The CCG wishes to clarify its position regarding the respective merits of care home placements, when compared with care in an individual’s own home. The CCG acknowledges that the concept of independence is a core part of the wellbeing principle outlined within the Care Act 2014, and reflective of the objectives it has set out within the ‘Healthy Lives, Healthy Futures’ programme for change.

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

4.2 SUPPORTED LIVING ACCOMMODATION
Supported living is a concept that was developed as an alternative to institutional care for people with disabilities. The main principles of supported living are that people with disabilities own or rent their home or have their own tenancy, and have * a measure of control over the support they get and who they live with (if anyone). The supported living aspiration is that wherever possible, all people with disabilities, regardless of the level or type of disability, are able to make choices about how to live their lives, even if they do not make choices in conventional ways.

Supported living provision within North East Lincolnshire has been developed partly in response to the Winterbourne View scandal, and the resulting Government pledge to ensure appropriate community placements for those with autism and/or learning difficulties. The CCG’s policy position is to meet the needs of those for whom it is responsible within North East Lincolnshire as a first preference (where this is appropriate to meet individual need). The CCG accepts that this preference is
subject to the rights set out within the Care Act’s Choice of Accommodation Regulations 2014.

When considering supported living for an individual, care practitioners must ensure that the individual has the necessary mental capacity to enter into the required tenancy agreement, or if not, that they have a legally appointed representative to act on their behalf. In addition, when considering the care arrangements within a supported living setting, practitioners must ensure that such arrangements are those which are the least restrictive, and follow the appropriate protocols where deprivation of liberty issues might arise.

Re supporting people with learning disabilities and/ or autism, NHS England, Directors of Adult Social Services and the Local Government Association have produced a service model for commissioners, which can be found at: https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

4.3 EXTRA CARE HOUSING

As with Supported Living, ‘Extra Care Housing’ (ECH) is a concept rather than a housing type, or the name of a service, as such. A key part of the concept is that those within ECH schemes have their own self-contained home, designed to enable them to self-care for longer. They have legal rights to occupy their home underpinned by housing law, marking a clear distinction between ECH and residential care. For more information go to: http://www.housinglin.org.uk/

Working with partners the CCG opened its first ECH scheme for frail elderly people in July 2015, to provide 60 flats with care and support. Further schemes are in development; five schemes are intended to provide a total of 300 ECH flats by 2018.

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

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

Applications for ECH are considered on a quarterly basis by the ECH Allocation Panel in accordance with agreed criteria.

4.4 CHOICE OF ACCOMMODATION

Placements in any setting must meet eligible needs, and be appropriate to the individual. The Care Act directs that where the care planning process has determined that an individual’s care and support needs are best met in a care home, or in a placement (not a tenancy) in supported living or ECH accommodation, they are entitled to choose their preferred accommodation, subject to certain conditions.

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

- the accommodation is suitable to their assessed needs
- the accommodation would not cost the CCG more than the amount specified in their personal budget for accommodation of that type
- the accommodation is available; and
- the provider of the accommodation is willing to enter into a contract with the CCG to provide accommodation on the CCG’s terms.

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

An individual must also be able to choose alternative options, including a more expensive setting than the amount identified for the provision of accommodation in their personal budget for care and support. Where the choice for a more expensive option is exercised, the care practitioner must arrange for the individual to be placed there, provided a third party or in certain circumstances the individual in need of care and support, is willing and able to pay the additional cost (a ‘top-up’). Choice of accommodation only applies to more expensive options if:
- the care practitioner is satisfied that the person paying the top-up is willing and able to do so for the likely duration of the individual’s stay in the chosen accommodation
- the person paying the top-up enters into a written agreement with the CCG in which they agree to pay it.

Defaulting on payment of the top-up may result in the individual’s accommodation placement being terminated and alternative accommodation arranged.

Within North East Lincolnshire, compliance with Care Act duties in respect of top-ups is supported via use of the Top-ups Toolkit. The Toolkit can be found at: https://www.services4.me.uk/ within the information, advice and guidance section.

Where choice cannot be accommodated, care practitioners must set out in writing why this is the case, and offer suitable alternatives (along with provision of information regarding the complaints procedure, and when/ if the decision may be reviewed). Where a capacitated individual unreasonably refuses alternatives, care practitioners are entitled to consider that the duty within the Care Act to meet need has been discharged. The practitioner must inform the individual in writing that as a result, they will need to make their own arrangements. This is an option of last resort. Where a refusal arises from an individual’s relatives, the care practitioner must consider whether the refusal amounts to a challenge to the suitability of the alternative offered, or an obstruction of the individual’s right to State-made arrangements. If the refusal by a relative amounts to such an obstruction, a referral to the Safeguarding Adult’s Team may be required. In the case of a challenge to the suitability of the offer (which is more likely), referral to the care practitioner’s line manager will be necessary.

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

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

Whilst eligibility for CHC does not mean an absolute right to a particular care home, or indeed to care within the individual’s own home, individuals should be offered suitable options for consideration. Care practitioners should consider with individuals the clinical consequences of each option. Whilst the starting point for consideration should be the individual’s preferences, there may be a range of reasons why such preferences cannot be met (including funding constraints).

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

There may be circumstances where care practitioners should contemplate paying a higher than-usual CHC cost, where the need is for identified clinical reasons. The matters set out at 3.1 – 3.3 above should be taken into account, including comparative costs and value for money considerations. Decisions regarding accommodation provision should be provided in writing, with reasons given. Where an individual wishes to dispute a decision not to pay for higher-cost accommodation, they should do this via the CCG’s complaints process.

For further guidance see the Framework pages 117 - 119.

4.5 OUT OF AREA PLACEMENTS

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

If an individual chooses to be placed in a setting that is outside the CCG’s area, the Care Act states that the care practitioner must still arrange for their preferred care (subject to the conditions set out at 4.4 above). In responding to requests for out of area placements, care practitioners should have regard to the cost of care in the chosen area when setting the individual’s personal budget. The personal budget is defined as the cost to the CCG of meeting the individual’s care and support needs which it is required (or chooses) to meet. The practitioner should take into consideration circumstances where this cost to the CCG may need to be adjusted to ensure that needs are met.

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

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

Where an out of area placement is an individual’s desire, rather a necessity to meet their needs, the individual still has a right to choose that out of area accommodation, and again care practitioners must have regard to the cost of accommodation in the area when setting the personal budget. Whilst regard for individual circumstances might occasionally justify departure from CCG expectations, the CCG expects that in most cases in which an out of area placement relates to a ‘want’ rather than an assessed eligible need, the personal budget will be calculated on the basis of the usual cost to the CCG of providing accommodation in North East Lincolnshire (‘the CCG’s usual rate’). This means that unless a third party (or in certain circumstances the individual in need of care and support) is able and willing to pay the additional cost (i.e. the difference between the CCG’s usual rate and the full contractual cost of the desired out of area accommodation), an out of area placement is unlikely to reflect an appropriate balance between outcomes and best value.

Out of Area placements and particular CHC considerations
There may be circumstances where an individual requests an out of area placement, at a higher cost than the CCG would usually meet for the person’s needs. Such cost may be reasonable taking into account the market rates in the locality of the placement, established in liaison with the CCG where the placement is located. In such circumstances care practitioners should consider whether there are particular circumstances that make it reasonable to fund the higher rate, for example, because the location of the placement is close to family members who play an active role in the life of the individual. If making such a placement is required to meet need, the higher amount should be paid. Where a more expensive placement out of area is merely desired (for example: “I’ve no connections there but I’ve always rather fancied retiring to Bournemouth”) rather than necessary to meet need, it is unlikely that such a placement would represent an appropriate balance between outcomes and best value. However, such placements may be considered where there is a reliable source able and willing to pay the difference between the CCG’s usual rate (defined above) and the full contractual cost of the desired out of area accommodation).

NB all out of area placements must be approved by the Risk and Quality Assurance Panel (R&Q).

4.6 DOMICILIARY CARE
There is no legal right in the Care Act for a service user to compel the CCG to discharge its duties to meet need through a particular preferred provider. Direct Payments enable a person, capacitated or otherwise, (in the latter case as long as there is a suitable third party to take on the role of the Authorised Person) to exercise choice through commissioning, if so desired.

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

The following exceptions to the default position can be considered:
• Where temporary provider capacity issues necessitate care practitioners calling on alternatives. In such circumstances, first consideration should be given to micro-commissioning with another lead provider

• Where there are particular personal circumstances which result in an individual not wishing to use the geographically relevant lead provider e.g. due to family issues or previous difficulty with that provider. Again, it is expected that care practitioners will micro-commission with another lead provider in the first instance.

For further information, please refer to the Domiciliary Care Referrals Pathway at Appendix A.

4.7 INTERMEDIATE CARE, REABLEMENT AND RESPIE
Promotion of preventative interventions (commissioned or otherwise) on every appropriate occasion is crucial to supporting the citizens of North East Lincolnshire to remain healthy and independent for as long as is possible.

The Care and Support (Preventing Needs for Care and Support) Regulations 2014 define intermediate care and reablement as facilities or resources which —
(a) consist of a programme of services, facilities or resources
(b) are for a specified period of time; and
(c) have as their purpose the provision of assistance to an adult to enable them to maintain or regain the ability needed to live independently in their own home.

The Care Act’s Statutory Guidance quotes the National Audit of Intermediate Care’s four categories of intermediate care:
• crisis response – services providing short-term care (up to 48 hours)
• home-based intermediate care – services provided to people in their own homes by a team with different specialities, but mainly health professionals such as nurses and therapists
• bed-based intermediate care – services delivered away from home, for example, in a community hospital; and,
• reablement – services to help people live independently, provided in the person’s own home by a team of mainly care and support professionals.

Intermediate care services provide a link between places such as hospitals and people’s homes, and between different areas of the health and care and support system – community services, hospitals, GPs etc.

The Statutory Guidance appears to distinguish intermediate care from the provision of short term care in residential accommodation; it states that temporary care could be for a number of reasons such as providing respite for a carer.

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

For further guidance, refer to the Care Act’s Statutory Guidance, chapter 2 (especially 2.12 – 2.14) and Annex F.
4.8 DAY CARE OPPORTUNITIES
Following a re-modelling exercise, day care services may look different from the way in which they were previously configured, and may not cater for all on the same basis as before; however, the CCG’s expectation is that sufficient day care sessions have been retained to meet current eligible demand.

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

4.9 PERSONAL BUDGETS AND DIRECT PAYMENTS
There are various ways in which personal budgets may be managed and delivered to individuals. The term ‘direct payment’ is used in this section to refer to delivery of either a personal budget for care and support, or a personal health budget.

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

Direct payments may represent an important aspect of choice and control for some individuals, leading to better outcomes from their care provision. However, the gateway to receiving a direct payment must always be through a request from the individual, and no one must be forced to take a direct payment against their will – they are not appropriate for all individuals.

When determining with an individual how to meet needs, care practitioners must inform them which (if any) of their needs may be met by a direct payment. In addition the individual should be provided with information and advice regarding the usage and administration of direct payments (including requirements of monitoring and review, and the obligations of becoming an employer - where this is relevant). This information should assist the individual to decide whether they wish to request a direct payment to meet some or all of their needs.

However the individual’s needs are to be met, the care practitioner must satisfy themselves that it is an appropriate way of doing so (appropriateness is for the care practitioner to determine, taking into account all relevant factors). When an individual requests a direct payment, whether this is appropriate to meet need must be determined with reference to the matters set out within this policy, including by reference to outcomes and value for money. Care practitioners should be mindful that control over everyday life (including over the way that care is received) is an aspect of wellbeing, and that the additional control represented by use of a direct payment may be particularly valued by some individuals.

Consideration should be given to whether the personal budget is sufficient where needs will be met via a direct payment, for example where the recipient requires support to manage the direct payment, or to ensure that the legal obligations associated with becoming an employer are complied with. Additional costs associated with direct payments are only justified on the basis that the direct payment is an appropriate way for an individual to meet their needs.

4.9.1 Support for managing direct payments
Where the care practitioner is satisfied that a direct payment is an appropriate way to meet need, and that the requester is a capacitated person, they must
also be satisfied that the individual is able to manage the direct payment themselves, or with whatever help they are able to access. They may not have a friend or relative willing to take on the responsibility as a nominated helper. Care practitioners should take all reasonable steps to provide this support, perhaps via organisations such as Pay Packet, Pass or Penderels. Those who need help to manage a direct payment should not automatically be excluded from having one without consideration of support needs.

However, where the individual requesting the direct payment is able to manage it for themselves but chooses not to, the individual will be expected to meet the costs of management support from their own funds (e.g. via Pay Packet, Pass or Penderels).

4.9.2 Employment obligations
Where the care practitioner is satisfied that a direct payment is an appropriate way to meet need, and it is appropriate for the individual to meet need by employing someone, all genuinely unavoidable employment costs must be included in the personal budget (and so in the direct payment). Genuine employment costs will include those which are legally necessary such as recruitment costs, Employers’ National Insurance Contributions, pension costs (where the employee does not wish to opt out), employers’ liability insurance, payroll costs – and wages at the minimum or living wage. The direct payment must be sufficient to meet these costs if it is appropriate for the individual to meet their needs by incurring them. Where a redundancy payment becomes relevant, this will be considered via application to R&Q.

The individual must satisfy the care practitioner that they (or their representative) have the requisite knowledge and expertise to manage their own payroll. If the practitioner is not satisfied, the individual must utilise a reputable payroll provider to ensure that all appropriate matters are attended to. Where the individual (or their representative) is unable to manage the payroll, the costs of a payroll provider will be included in the direct payment.

A request for needs to be met via a direct payment does not mean that there is no limit on the amount attributed to the personal budget. There may be cases where it is more appropriate to meet needs via commissioned services, rather than by making a direct payment: for example, where the costs of an alternate provider arranged via a direct payment would be more than the CCG would be able to arrange the same support for, whilst achieving the same outcomes for the individual. Where an individual simply wishes to replicate a commissioned offer by use of a direct payment – but at higher cost - this is unlikely to represent value for money, unless significantly better outcomes will be achieved via the direct payment route.

Consideration should be focused on the expected outcomes of each potential delivery route. The increased costs to the CCG represented by use of a direct payment may be justified where this is expected to deliver much better outcomes than CCG-commissioned care. Decisions should be based on outcomes and value for money, rather than being purely financially motivated. Where a care practitioner feels that the test of outcomes and value for money does not justify use of a direct payment, their carefully reasoned decision must be recorded and provided in writing to the individual. The decision should set out the reasons by reference to the NHS (Direct Payment) Regulations 2013, or the conditions within the Care Act which have not been met, and confirm what (if anything) the individual could do to obtain a positive decision in future.
Care Practitioners should be aware that when determining whether a personal health budget (PHB) should be made available, regulations make explicit that care practitioners must have regard to whether making a PHB available represents value for money. The Care Act’s Direct Payment Regulations are not similarly explicit; however, as the Care Act’s Statutory Guidance states that decisions regarding direct payments should be based on outcomes and value for money (at paragraphs 11.26 - 11.27), the CCG considers application of value for money criteria to be a proper element of considering whether a direct payment is appropriate to meet need.

For further guidance, refer to the Care and Support (Direct Payments) Regulations 2014, the Care Act’s Statutory Guidance, Chapters 11 and 12, and the Guidance on Direct Payments for Healthcare: Understanding the Regulations. See also the North East Lincolnshire Direct Payments’ Policy (within the Charging Policy).

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

- The duty to promote wellbeing applies when carrying out any function under part 1 of the Care Act in respect of an individual. The duty applies equally to those who have no eligible needs and regardless of resources (see s1)
- The duty to provide/ arrange for preventive services applies to all adults including those without current or eligible need and regardless of resources. Self-funders are entitled to access intermediate care and reablement support services to meet need (see s2 and the Care and Support (Preventing Needs for Care and Support) Regulations 2014)
- Information and advice provision must meet the needs of the whole population, not just those who are in receipt of commissioned services. Access to information and advice (including financial information and advice) is fundamental to making well-informed care and support choices (see s4)
- The duty to ensure the care and support market provides a variety of high quality services is intended to benefit any person wishing to access those services (see s5)
- All adults with an appearance of need for care and support and carers with an appearance of need for support are entitled to an assessment, regardless of the level of their resources, or need (see s9)
- Assuming that an individual is assessed as having eligible care and support needs, and is ordinarily resident in North East Lincolnshire (or is present here, but of no settled residence), those with assets above the financial limit who are seeking access to chargeable services can ask the CCG to meet their needs. Care practitioners must accede to this request unless it is anticipated that the needs of the person with assets above the financial limit will be met by a care home placement (NB there is an administration charge for making the requested home care arrangements on behalf of anyone capacitated who has assets above the financial limit). Where an individual lacks capacity to arrange their own care and support (whether within a care home or otherwise) and has no one to make arrangements for them, care practitioners must arrange to meet their needs (see s18, and the Care Act’s Statutory Guidance 8.13, 8.55 and 8.56)
- Safeguarding duties apply to all adults with care and support needs who are experiencing (or at risk of experiencing) abuse or neglect, and who as a result of their care and support needs, are unable to protect themselves (see s42)
• There is a duty to ensure needs for care and support are met temporarily where a registered care provider fails in the circumstances set out within the Care and Support (Business Failure) Regulations 2014 (see s48)

• The duty to arrange for an independent advocate applies for all adults on assessment, care planning, care review, or safeguarding enquiry or review, where the adult has substantial difficulty in being involved in these processes and has no one appropriate to support them (see s67 and 68 and the Care and Support (Independent Advocacy Support) (No. 2) Regulations 2014).

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

4.11 CLARIFICATION AND DISPUTE RESOLUTION
Care practitioners must take all reasonable steps to agree with individuals how to meet their needs. Efforts to reach agreement should be carefully documented. The care practitioner’s role is to ensure that the care plan sufficiently meets needs, is appropriate, and represents the best value for money and maximisation of outcomes for the individual.

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

Where a care practitioner proposes to support an individual via a domiciliary care package that equates to a higher cost than the equivalent residential fee (including the costs of any carers’ support and respite), the practitioner must provide a rationale as to why this is justified (by reference to the factors set out within legislation, guidance, and this policy), and present their case to R&Q for ratification. Similarly, where the cost of a residential placement is higher than the equivalent level of care available from a domiciliary package, the CCG expects the matter to be presented to R&Q for scrutiny and authorisation. The involvement of R&Q is not intended as a mechanism to set arbitrary cost limits on packages of support, but aims to ensure that all appropriate matters have been taken into account before an apparently costlier option is endorsed. All packages must reflect the cultural change represented by the Care Act, and the overarching financial situation.

It should be noted that before any capacitated individual can be regarded as having sufficient information to choose to accept or reject an offer of a residential placement, the individual must be provided with a clear statement which details all the practicable support that would or might be available if they continue to refuse the offer, and remain in their own home. It is not possible to find that an individual lacks capacity to choose unless the individual has been provided with the information they need to make an informed decision, and all reasonable steps have been taken to maximise the prospect of the person being able to make an informed decision.

4.12 POLICY APPLICATION: CASE STUDIES AND CONCLUSION
The following case studies are offered as a means for promoting discussion amongst care practitioners, and as examples to which the principles within this policy can be applied as part of those discussions.
4.12.1 Real Life Case Studies

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

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

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

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

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

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

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

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

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

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

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

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

**Study Five:**

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

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

4.12.2 Conclusion

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

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

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

Cases like those of J, and K and L, demonstrate that the increased costs to the CCG necessitated by direct payments can be justified where significantly better outcomes for individuals are achieved than might be possible via commissioned services. Whether a direct payment is appropriate for an individual will depend upon all the circumstances of the case; however, where outcomes and value for money cannot be appropriately balanced, practitioners are expected to make a reasoned and pragmatic choice, which may sometimes result in direct payments being refused.
Care practitioners must always record the way in which they have exercised their judgement, and the factors taken into account in arriving at a conclusion.

5. **TRAINING**

This policy will be drawn to the attention of all relevant individuals as part of the implementation process (see 7 below). A session on this refreshed policy has been held with micro-commissioning teams at the CCG, focus, Care Plus Group, Navigo and Yarborough Clee Care, as well as the R&Q Panel.

6. **IMPACT ANALYSES**

6.1 Equality

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

An Equality Impact Assessment (EIA) has been conducted with regard to this policy. In seeking to allocate resources equitably, the policy is largely neutral with regard to Protected Characteristics. A single area of concern has been identified: whilst the policy itself is unlikely to have an impact on grounds of race, it is recognised that some nationalities may have difficulties understanding the policy due to limited English Language skills. Mitigating actions are set out within the EIA.

6.2 Bribery Act 2010

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

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

These offences can be committed directly or by and through a third person and other related policies and documentation (as detailed on the CCG intranet) when considering whether to offer or accept gifts and hospitality and/or other incentives.

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

This policy will be disseminated via key individuals within NELC, the CCG, CPG, Navigo, Yarborough Clee Care and focus with the expectation that each will cascade the information within it amongst their relevant teams. The policy will be lodged on the CCG’s intranet, and micro-commissioning providers will be expected to ensure that it is available electronically to their staff. The policy will be further communicated through team briefings, and on-going training sessions.

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

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

The policy has been the subject of community engagement and will be publically available on the CCG’s website.

8. **MONITORING & REVIEW**

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

9. **REFERENCES AND LINKS TO OTHER DOCUMENTS**

External documents:
1. European Convention on Human Rights
2. UN Convention on the Rights of People with Disabilities
3. The NHS Constitution
4. The Care Act 2014, Statutory Guidance and supporting Regulations
5. The Children and Families Act 2014
6. The Health and Social Care Act 2012
7. The Equality Act 2010
8. The Bribery Act 2010
10. The Mental Capacity Act 2005
12. The Mental Health Act 1983
13. NHS (Direct Payment) Regulations 2013
14. NHS Commissioning Board and Clinical Commissioning Groups’ (Responsibilities and Standing Rules) Regulations 2012 (amended by the 2013 ‘Standing Rules’)
19. ‘Standards Matter: a review of best practice in promoting good behaviour in public life’ (Committee on Standards in Public Life, 2013)

Internal Documents:
22. Adult Social Care Strategy 2015
23. Joint Funding Principles and Practice for NHS Continuing Healthcare and Social Care
24. Failing Services Policy and Procedure, and Market Intelligence and Failing Services Group Terms of Reference
25. Extra Care Housing Allocation Panel Terms of Reference
26. North East Lincolnshire Charging Policy (of which the Direct Payments Policy is a part)
27. North East Lincolnshire Top-ups Toolkit
28. Risk and Quality Panel Terms of Reference

10. APPENDICES
Appendix A – Domiciliary Care Referral Pathway
Appendix B – Equality Impact Assessment
Appendix C - Joint Funding: Principles and Practice for NHS Continuing Healthcare and Social Care
## Appendix A – Domiciliary Care Referral Pathway

### Identify Service User Location

<table>
<thead>
<tr>
<th>Service User Location</th>
<th>West</th>
<th>South</th>
<th>East</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Immingham</td>
<td>Waltham</td>
<td>Sidney Sussex</td>
</tr>
<tr>
<td></td>
<td>Healing</td>
<td>Scartho</td>
<td>Croft Baker</td>
</tr>
<tr>
<td></td>
<td>Freshney</td>
<td>Wolds</td>
<td>Haverstoe</td>
</tr>
<tr>
<td></td>
<td>Yarborough</td>
<td>South</td>
<td>Humberston and New Waltham</td>
</tr>
<tr>
<td></td>
<td>West Marsh</td>
<td>Park</td>
<td></td>
</tr>
<tr>
<td></td>
<td>East Marsh</td>
<td>Heneage</td>
<td></td>
</tr>
</tbody>
</table>

### Designated Lead Providers to Pick Up New Referrals in Their Locality Area:

- **West**: LQCS (Lincolnshire Quality Care Services), Tel: 01469 578444
- **South**: Willow Homecare, Tel: 01472 344222
- **East**: HICA, Tel: 01472 362022

### If Designated Lead Providers Are Unable to Pick Up the New Referral, Referrals Will Be Offered To:

- **Other Lead Providers**: Willow Homecare / HICA
- **LQCS / HICA**
- **LQCS / Willow Homecare**

### If Other Lead Providers Are Unable to Pick Up the New Referral, Referrals Will Be Offered To the Approved Providers:

- **Approved Providers – Only to be Used If None of the Lead Providers Are Able to Pick Up New Referrals**
  - Abbey Homecare (Tel: 01472 897577)
  - Aspects Care (Tel: 07551 158250 or 07551 158249)

Both Abbey Homecare and Aspects Care provide cover across North East Lincolnshire.

Due to complexity of need, one may need to use other than the above providers. There may be clients out of area who have an NEL GP that need an out of area provider.
### Equality Impact Risk Analysis: Micro-Commissioning in Adult Social Care and Continuing Healthcare

<table>
<thead>
<tr>
<th>Policy / Project / Function/Service:</th>
<th>Micro-Commissioning in Adult Social Care, Continuing Healthcare and Funded Nursing Care: Principles of Consistent, Pragmatic, and Ethical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Analysis:</td>
<td>November 2016</td>
</tr>
<tr>
<td>Analysis Rating:</td>
<td>Red</td>
</tr>
<tr>
<td>(See Completion Notes)</td>
<td></td>
</tr>
<tr>
<td>Type of Analysis Performed:</td>
<td>Systematic Policy Analysis</td>
</tr>
<tr>
<td>Please Tick</td>
<td>Consultation</td>
</tr>
<tr>
<td></td>
<td>Meeting</td>
</tr>
<tr>
<td></td>
<td>Service Proposal</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Please list any other policies that are related to or referred to as part of this analysis</td>
<td>Records Management</td>
</tr>
<tr>
<td>Who does the policy, project function or service affect?</td>
<td>Employees</td>
</tr>
<tr>
<td>Please Tick</td>
<td>Service Users</td>
</tr>
<tr>
<td></td>
<td>Applicants</td>
</tr>
<tr>
<td></td>
<td>Members of the Public</td>
</tr>
<tr>
<td></td>
<td>Other (List Below)</td>
</tr>
<tr>
<td></td>
<td>Micro-commissioners</td>
</tr>
</tbody>
</table>
Equality Impact Risk Analysis:

<table>
<thead>
<tr>
<th>What are the aims and intended effects of this policy, project or function?</th>
<th>The policy provides the framework within which micro-commissioning decisions are taken regarding allocation of adult social care, NHS continuing healthcare (CHC) and funded nursing care (FNC) in North East Lincolnshire. The purpose of the policy is to ensure provision of the best possible quality of care for the population of North East Lincolnshire, distributed on a transparent, equitable and affordable basis.</th>
</tr>
</thead>
</table>
| Is any Equality Data available relating to the use or implementation of this policy, project or function? | Yes  
No |
| (See Completion notes) | Where you have answered yes, please incorporate this data when performing the Equality Impact Assessment Test (the next section of this document). |
| List any Consultation e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function | Managers and team leaders within North East Lincolnshire Council, North East Lincolnshire Clinical Commissioning Group, Care Plus Group, Navigo, focus independent adult social work and Yarborough Clee Care have contributed to drafts of the policy. Each of those organisations has distributed it amongst their staff with the request for comments. Engagement on the policy has been undertaken with members of NELC’s Scrutiny Committee, and with members of the public. |
| Financial Analysis | Costs (£m) *  
| Implementation | £  
| Projected Returns | £  
<p>| Projected Savings | £ |</p>
<table>
<thead>
<tr>
<th>Protected Characteristic:</th>
<th>Neutral Impact:</th>
<th>Positive Impact:</th>
<th>Negative Impact:</th>
<th>Evidence of impact and if applicable, justification where a Genuine Determining Reason exists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>x</td>
<td>More older people are in receipt of health and care services than younger people. Women form the largest part of the ageing population, and therefore the way in which adult social care or CHC/ FNC resources are allocated has the potential to impact on women more than men. However, the purpose of the policy is to provide the best possible quality of health and care for the population of North East Lincolnshire – regardless of gender - distributed on a transparent, equitable and affordable basis. In seeking to deliver care equitably, the policy is gender neutral.</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td>x</td>
<td></td>
<td>Whilst the policy itself is unlikely to have an impact on grounds of race, it is recognised that some nationalities may have difficulties understanding the policy due to limited English Language skills.</td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
<td>x</td>
<td>More disabled people are in receipt of health and care services than non-disabled people, therefore the way in which adult social care or CHC/ FNC resources are allocated has the potential to impact on disabled people more than others. However, the purpose of the policy is to provide the best possible quality of health and care for the population of North East Lincolnshire – regardless of disability - distributed on a transparent, equitable and affordable basis. In seeking to deliver care equitably, the policy is disability neutral.</td>
</tr>
<tr>
<td>Religion or Belief</td>
<td></td>
<td>x</td>
<td></td>
<td>There is no impact on grounds of religion or belief.</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td></td>
<td>x</td>
<td>There is no impact on grounds of sexual orientation.</td>
</tr>
</tbody>
</table>
## Equality Impact Risk Assessment Test:

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010*?

<table>
<thead>
<tr>
<th>Protected Characteristic:</th>
<th>Neutral Impact:</th>
<th>Positive Impact:</th>
<th>Negative Impact:</th>
<th>Evidence of impact and if applicable, justification where a <em>Genuine Determining Reason</em> exists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy/ Maternity</td>
<td>X</td>
<td></td>
<td></td>
<td>There is no impact on grounds of pregnancy or maternity.</td>
</tr>
<tr>
<td>Transgender</td>
<td>X</td>
<td></td>
<td></td>
<td>There is no impact on grounds of transgender.</td>
</tr>
<tr>
<td>Marital Status</td>
<td>X</td>
<td></td>
<td></td>
<td>There is no impact on grounds of marital status.</td>
</tr>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td></td>
<td>More older people are in receipt of health and care services than younger people, therefore the way in which adult social care or CHC/ FNC resources are allocated has the potential to impact on older people more than younger people. However, the purpose of the policy is to provide the best possible quality of health and care for the population of North East Lincolnshire – regardless of age - distributed on a transparent, equitable and affordable basis. In seeking to deliver care equitably, the policy is age neutral.</td>
</tr>
<tr>
<td>Deprivation</td>
<td>X</td>
<td></td>
<td></td>
<td>Those in receipt of health and care services are likely to be amongst the most deprived. However, the purpose of the policy is to provide the best possible quality of health and care for the population of North East Lincolnshire, distributed on a transparent, equitable and affordable basis. Careful allocation of resources will contribute to ensuring that those most in need of services continue to receive them.</td>
</tr>
</tbody>
</table>
This Equality Impact Risk Analysis was completed by: Emma Overton, Care and Independence Team, NELCCG

### Action Planning:

As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by *The Equality Act 2010*?

<table>
<thead>
<tr>
<th>Identified Risk:</th>
<th>Recommended Actions:</th>
<th>Responsible Lead:</th>
<th>Completion Date:</th>
<th>Review Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race: some nationalities may have difficulties understanding the policy due to limited English Language skills</td>
<td>As part of the implementation of this policy, staff will be reminded of the potential requirement to access translation services.</td>
<td>Emma Overton</td>
<td>November 2016</td>
<td></td>
</tr>
</tbody>
</table>