Contributions – Paying for Non-Residential Care

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CATEGORY: Finance
KEYWORDS: Contributions
ISSUED BY: Richard Ellis
CONTACT: Nicky Millard

PROCEDURES 01/12 CANCELLED OR AMENDED:

REMARKS:

SIGNED:

DESIGNATION: Assistant Director Adult Services

YOU SHOULD ENSURE THAT:-

- You read, understand and, where appropriate, act on this information
- All people in your workplace who need to know see this procedure
- This document is available in a place to which all staff members in your workplace have access
PURPOSE
To outline Adult Services policy and procedures for contributions to personal budgets for social care services that support people to live at home.
To set out prices charged by Hampshire County Council Adult Services for services delivered by its own establishments.

SCOPE
The contributions policy and procedures apply to all adult non-residential social care services for which the council has discretionary powers to charge. Contributions will not be sought for services excluded by legislation or statutory guidance. See appendix B for a non-exhaustive list of services.

POLICY
The department seeks contributions for services under section 17 of the Health and Social Services and Social Security Adjudication Act (1983) and seeks contributions for direct payments under Community Care, Services for Carers and Social Care Act 2001. See appendix A for the policy statement approved by Hampshire County Council’s Cabinet 28 February 2011.

REFERENCES TO LEGAL, CENTRAL GOVERNMENT AND OTHER EXTERNAL DOCUMENTS, INCLUDING RESEARCH
The National Assistance Act 1948
The Health Services and Public Health Act 1968
The Chronically Sick and Disabled Act 1970
The NHS Act 2006
The Carers and Disabled Children Act 2000
The Health and Social Care Act 2001
Community Care, Services for Carers and Children’s Services (Direct Payments) (England) Regulation 2009 Pursuant to Health and Social Care Act 2001
Charging for Residential Accommodation Guide (CRAG)
Fairer Charging Policies for Home Care and other non-residential Social Services – Guidance for Councils with Social Services Responsibilities – September 2003 Dept of Health
Dept of Health Fairer contributions guidance 2010: calculating an individual’s contribution to their personal budget : Department of Health - Publications
Dept of Health Fairer Contributions Guidance 2009 Easy Read Version
Health and Social Services and Social Security Adjudications Act 1983 – Section 17
Mental Health Act 1983 section 117 – the duty on health and social care services to provide free aftercare to patients previously detained under certain sections of the act

HAMPSHIRE COUNTY COUNCIL ADULT SERVICES DEPARTMENT REFERENCES
Help with care choices in Hampshire

DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer</td>
<td>A person who provides substantial and regular unpaid care</td>
</tr>
<tr>
<td>Chargeable Personal Budget (cPB)</td>
<td>The part of a personal budget for social care (see below) to which the service user may need to make a financial contribution</td>
</tr>
<tr>
<td>Contribution</td>
<td>The payment made by the service user towards their chargeable Personal Budget</td>
</tr>
<tr>
<td>Care Practitioner</td>
<td>The person within Adult Services who assesses service users social care needs and eligibility to receive services and arranges services to meet eligible needs</td>
</tr>
<tr>
<td>The Council</td>
<td>Hampshire County Council</td>
</tr>
<tr>
<td>The Department</td>
<td>Adult Services</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Direct Payment</td>
<td>Payment by the department to service users, or appropriate adult, with which they arrange and pay for services to meet their eligible needs</td>
</tr>
<tr>
<td>Free Crisis Care</td>
<td>Reablement services offered free for up to six weeks to service users at risk of hospitalisation, or at the point of hospital discharge</td>
</tr>
<tr>
<td>Financial Assessment</td>
<td>An assessment of the service user’s finances to determine their maximum contribution (the most they will pay towards their cPB). Includes the offer of information about welfare benefits entitlement and support to claim these</td>
</tr>
<tr>
<td>Financial Assessments and Benefits Team (FAB)</td>
<td>County Treasurer’s team who carry out the financial assessment and calculate the maximum contribution (the most a service user will pay for their care).</td>
</tr>
<tr>
<td>Managed Services</td>
<td>Care services organised and managed for the service user by the department</td>
</tr>
<tr>
<td>Personal Budget for social care</td>
<td>An amount of money agree by the department to meet an individual’s eligible needs. This budget may include money for services that are provided for free by the council.</td>
</tr>
<tr>
<td>Representative</td>
<td>Someone with the legal authority to manage the service users finances. They will have been granted power of attorney, deputyship or Appointeeship. See paragraph 14.5 for further information.</td>
</tr>
<tr>
<td>Respite Care</td>
<td>Gives service users a break from their home circumstances and/or enables a carer to have a break from the caring role. For short term residential respite care this is up to 8 weeks.</td>
</tr>
<tr>
<td>Self Directed Support Assessment.</td>
<td>Assessment and supporting planning of the service user’s needs and how these will be met</td>
</tr>
<tr>
<td>Service User</td>
<td>Someone who has received, or is likely to receive, a social care service from the council</td>
</tr>
<tr>
<td>Telecare</td>
<td>Equipment that senses risks such as smoke, floods and gas and can prompt a service user to take action (such as medication reminders or doors left open).</td>
</tr>
<tr>
<td>Welfare Benefits</td>
<td>The range of benefits provided by the Dept for Work and Pensions.</td>
</tr>
</tbody>
</table>

**ROLES**

Care practitioners in Adult Services will assess individuals needs and eligibility for services and will put care services in place to meet eligible needs. They will advise service users about the Council’s Contributions Policy and refer service users who are eligible for chargeable services to the County Treasurer’s Financial Assessments and Benefits Team (FAB) in Revenue Services.

Revenue Services will undertake the financial assessment in accordance with Dept of Health guidance; issue invoices and receive payments, in accordance with the County Treasurer’s procedures and guidance for staff.

The Devolved Finance Team will provide information and challenge to the Adult Services budget management in relation to the chargeable rates for the Council’s own services; and for income monitoring.

**AUTHORITY TO VARY THE PROCEDURE**

Deputy Director Adult Services
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1. National Context

1.1 The Department of Health (DH) requires that everyone will have a Personal Budget for social care by 2013. The Council is implementing this through Self Directed Support.

1.2 The DH Fairer Charging Guidance sets out how the financial assessment must be carried out; and Fairer Contributions Guidance sets out how an individual’s contribution towards their personal budget is calculated.

2. Hampshire County Council Contributions Policy

Social care is not a free service and national funding arrangements make it clear that contributions from service users to help fund the cost of services are essential to the Council’s financial strategy. A copy of the policy approved by Cabinet on 28 February 2011 is attached as Appendix A.

Service users have the choice to manage their own services, or to ask the Council to do this for them. This does not affect their entitlement to an assessment of needs, nor access to advice and information provided by the Council.

Service users who have a financial assessment which indicates the Council needs to pay for some or all of their services can choose to have a Direct Payment. The policy and this procedure applies equally to all service users who ask the Council to manage their services, use a Direct Payment or use a combination of these.

The policy applies to service users who are ordinarily resident in Hampshire and meet the Council’s eligibility criteria of critical or substantial needs. Service users resident in another council area will be subject to the contributions policy of that authority. Hampshire County Council will recover the full cost from other organisations for services it provides or arranges on their behalf. Appendix C sets out the rates for Hampshire County Council run services. These rates will also apply to service users in Hampshire who use these facilities and pay the full cost of their care services.

Hampshire County Council Adult Services Department aims to promote independence and choice, be fair and equitable and give service users more power and control over their lives. The policy applies to all care services that support people to live at home. The procedures outlined below are to help ensure the Council seeks timely, fair and equitable contributions from service users.

Rates for care services commissioned or provided by the department are reviewed annually and approved by the Executive Member for Adult Social Care as part of the annual budget setting process. This usually happens in January in respect of the forthcoming financial year.

3. Personal Budgets for Social Care and the chargeable Personal Budget

The Department is introducing personal social care budgets which, over time, could include money for all the services it arranges for an individual. As not all services can be charged for
under this policy, there is a need to create a chargeable Personal Budget (cPB) for each service user. This is the amount of money that is used in the calculation of the service users contribution. A non exhaustive list of chargeable and non-chargeable services is included in Appendix B.

Service users can pay the full cost of their cPB or request an assessment of their financial means. The financial assessment will work out their maximum contribution (the most they will pay towards their cPB). There are three possible outcomes from this assessment:

- The service user is assessed as having insufficient money to contribute, so the maximum contribution is nil = the department funds the full cost.
- The maximum contribution is lower than the cPB = the service user pays the maximum contribution and the department funds the balance.
- The maximum contribution is higher than the cPB = the service user pays the full cost.

E.g. cPB = £500 a week. Max contribution = £100 a week. Service user pays £100 a week. The department pays £400 a week.

4 Direct Payments

Where a Direct Payment is made as an alternative to arranging services, a contribution may be required and will be calculated on the same basis. Wherever possible, Direct Payments will be paid net of the service users contribution.

For mixed packages, instead of using waivers, a Disability Related Expense (DRE) is applied to the financial assessment for the amount outlined in the table below, as it has effectively become ‘care services, privately arranged’. This would remove the need to amend waivers but would require social workers to notify FAB of any changes to ‘care services, privately arranged’ in the future, so that the DRE can be appropriately amended (see Section 6 Care Services Privately Arranged).

A FAB visit would only be required if financial circumstances had changed but the financial assessment would need amending to correct the level of ‘care services, privately arranged’ being allowed.

This process should also apply for service users who no longer receive a Direct Payment where there is no Commissioned Care in case Commissioned Care commences in the future.

The table below shows the different scenarios:

<table>
<thead>
<tr>
<th></th>
<th>Direct Payment only</th>
<th>Mixed Package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fin Asst:</strong></td>
<td>Nil</td>
<td>Less than DP</td>
</tr>
<tr>
<td>DP received</td>
<td>Full</td>
<td>Part</td>
</tr>
<tr>
<td>Contribute to Commissioned Care</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>DRE</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
5. The Process

The following process will be followed as quickly as possible to ensure service users make a fair and affordable financial contribution to their care service costs, and receive the information and support they need in order to do so.

5.1 Self Directed Support – the needs assessment stage

The care practitioner will carry out the assessment of needs and eligibility with service users and explain the personal budget for social care. As part of this process, they will take action to ensure service users are aware of the Contributions Policy and are supported to make a fair and affordable contribution to the cost of their services where appropriate. Unless a service user has previously had a financial assessment, the following action will be taken:

Care practitioners must assume the service user’s mental capacity, including to manage financial affairs. Where there is doubt, they will carry out a mental capacity assessment. Section 7, Mental Capacity, gives more information including how to obtain legal responsibility for someone’s finances and the Department’s role.

The care practitioner will take action to establish someone with the legal authority to manage the service user’s finances (their representative) – they will record this information on AIS and include this information in the referral to FAB.

The care practitioner will then explain to the service user or representative:

- Most social care services are not free and the service user may need to contribute towards their chargeable services. Carers are not required to contribute although the service user may contribute towards the cost of the chargeable services they use that benefit the carer.

- Service users can pay the full cost of their chargeable services or have a financial assessment to work out what they should pay. The financial assessment guidelines are determined nationally by the DH and are aimed at ensuring no-one pays more for their care services than they can afford. Please note ‘affordability’ is determined by reference to national welfare benefits rates, rather than local policy. The assessment also includes information about welfare benefits and help to apply for them. A summary of how the financial assessment works is set out in the Making a contribution to your personal budget for social care booklet. Further information about the financial assessment including savings and income is available from the Corporate Services’ Financial Assessments and Benefits Team.

- Service users with more than £23,250 (2012/13) in assessable savings or capital (excluding the home they live in) will need to pay the full cost of their chargeable services.

- The care practitioner will leave a copy of the Making a contribution to your personal budget for social care booklet and Financial Assessment Form SAS10 with the service user/representative. Further information about the policy and paying for care is available on Hantsweb.

- The benefits of a having a financial assessment (unless the service user has more than £23,250 (2012/13) in assessable savings/capital) are that most people find it helpful to have some assistance with understanding how to complete the form. This will ensure that they provide all the important information, for example Disability Related Expenses that may reduce their contribution. Information and help to apply for welfare benefits are also included as part of the assessment.
Where an assessment is declined, FAB can still send information about local groups that can help with benefit claims. This is to ensure service users who are struggling financially but regard the financial assessment as an invasion of privacy are not disadvantaged.

The care practitioner will then:

- Offer to make an appointment with FAB for a home visit to carry out the financial assessment with the service user or representative.
- Telephone FAB (01962 845600) to make an appointment with the service user/representative.
- Ask the service user/representative to **sign the SAS10CR declaration** at the back of the *Making a contribution to your personal budget for social care booklet*.
- Where an assessment is declined, or there is agreement to pay the full cost of their services, ask service user/representative to complete and **sign section 3 of the financial assessment form SAS10**.

As soon as possible after the SDS assessment visit, the care practitioner will:

- Make a referral to FAB – using the AIS profile note and ‘workflow’ link to the FAB team. Even if the service user has declined a referral or is full cost this must be noted and advised to FAB on the referral form.
- Provide the service user/representative with their indicative personal budget for social care. The chargeable Personal Budget is calculated later on in this process. The letter from FAB will inform the service user of both their chargeable Personal Budget and maximum weekly contribution. The MWC is uploaded into AIS Quickview approximately once a month, although it should be borne in mind that this is a snapshot as at the date stated.
- FAB update the cPB in AIS once a month.
- Complete the Support Plan Summary which includes everything to meet the service user’s needs. This can include services that the service user will pay for themselves or extra expenses incurred in order to meet their needs, as set out in their support plan.

**Two carers**

If the support plan summary requires the service user to have 2 carers, regardless of their financial means, the following five measures should be considered by the Care Manager priori to finalising the care package.

i) paying for and arranging a hoist or other equipment; and funding the cost of the second carer until this is in place

ii) paying for and arranging training and support for partner/family member to become the second carer

iii) considering individual circumstances / solutions for service users where the need for a second carer is to meet health and safety requirements of service providers with regard to their liabilities to the service users and their employees, in which case the cost of the second care will not be chargeable.

iv) reviewing with the service user their financial circumstances to ensure they have the means to pay for their care services (this would be targeted at those who decline a financial assessment as they believe they are ‘full cost’) For example:

- Ensuring only ‘eligible’ savings and capital monies are used to pay for care services – people may not be aware that some monies may be excluded.

  Supporting an application for Attendance Allowance where not already received. This is a non-means tested Dept of Work and Pensions welfare benefit for people with disabilities that pays up to £70 per week depending on levels of need (most of
the 754 service users with two carers, who have had a financial assessment, are receiving this benefit.

v) Robust analysis of the specific situation where two carers are required and of the tasks they are required to do: so that two carers are only with service users where there is a specific task to do e.g. actual moving of the service users. This will minimize the time when two carer are required.

5.2 The Financial Assessment

This will involve a Financial Assessment and Benefits (FAB) officer visiting the service user at home to complete a financial assessment, give welfare benefits information and help with claims.

The assessment will follow the DH Fairer Charging guidance and the Councils Contributions Policy to determine the maximum contribution a service user could make to their budget for social care. The DH guidance states contributions towards care service costs should not reduce a service user’s net income to below an amount equal to the basic level of Income Support or the Guarantee Credit of Pension Credit, plus 25%.

The FAB visiting officer will liaise with the care practitioners identifying any possible Disability Related Expense that might have already been taken into account within the support plan summary.

FAB will write to the service user/representative setting out what was taken into account in the financial assessment and the maximum amount the service user may need to pay. This letter also includes the service users chargeable Personal Budget.

If it is not possible to undertake the financial assessment, for example where the assessment is refused or appointments are continuously cancelled, the service user will normally be expected to pay the full cost of their care.

Care practitioners will ensure, where appropriate, the service user/representative confirms they understand that they will either need to pay the full cost of their chargeable services or have a financial assessment to work out how much they should pay, by signing the tear-off form (SAS10CR) at the back of the Making a contribution to your personal budget for social care booklet. The care practitioner will send this form to FAB for action.

5.3 The Panel Process

The business process for calculating the cPB is effectively the Panel process. The Panel process was introduced to provide financial governance and chairs of Panels have responsibility for ensuring that the contributions policy is applied fairly and equitably to all service users using chargeable services, and that the referral to FAB has been made. Provisions Support Officers will provide support, expertise and guidance in completing the Panel documentation to ensure the cPB is calculated accurately.

5.4 Calculating the Service Users Contribution

As the County Council provides some services for free, each service user will have a chargeable services budget, known as their cPB (chargeable Personal Budget). This is the sum of the total cost of all the chargeable services they will use over the year. This sum is then divided into weekly amounts. It is not a reflection of the amount or cost of services used in a particular week.

In order to calculate the actual contribution by the service user, two figures are required:

- the chargeable Personal Budget as calculated by the Panel Form
- the maximum contribution as calculated by FAB’s financial assessment.

The information that is sent through to the Corporate Services’ IT system, A4W, no longer comes directly from AIS provisions. This is because there is a need to first create the chargeable Personal Budget. This is done by using the Panel form process.
Service users will pay the lower of:
- their chargeable Personal Budget (cPB)
- their maximum contribution (the most they have been assessed to pay).

6 Changing the Service Users Weekly Contribution during the year

6.1 National Policy

Fairer Contributions Guidance 2010 is silent on when and whether contributions, once notified to the service user, should vary with the level of service received throughout the year. All DH guidance emphasises that the financial assessment is the mechanism through which contributions are determined and that councils should:

- Have regard to the effect of contributions on a user’s net income which should not be reduced below the levels set out in Fairer Charging guidance. (Income Support basic level or the Pension Credit Guarantee; plus 25%).
- Ensure no-one contributes any more than the financial assessment shows is reasonably practicable for them to pay.

In most cases, a change in the cost or amount of services received will not result in a change in the value of the service user’s contribution. The table below shows how this works.

6.2 Service User Contribution to the cPB

<table>
<thead>
<tr>
<th>Weekly Amounts</th>
<th>cPB of £250</th>
<th>cPB increases by £50 per week</th>
<th>cPB reduces by £50 per week</th>
<th>cPB reduces to £50 per week</th>
<th>cPB reduces to £30 per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>cPB</td>
<td>£250</td>
<td>£300</td>
<td>£200</td>
<td>£50</td>
<td>£30</td>
</tr>
<tr>
<td>Service Users Maximum Contribution</td>
<td>£50</td>
<td>£50</td>
<td>£50</td>
<td>£50</td>
<td>£50</td>
</tr>
<tr>
<td>Service User pays</td>
<td>£50</td>
<td>£50</td>
<td>£50</td>
<td>£50 (= full cost)</td>
<td>£30</td>
</tr>
<tr>
<td>Council pays</td>
<td>£200</td>
<td>£250</td>
<td>£150</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

While the outcome for each service user will be different, it can be seen that there is no direct link between the contribution and the cost of services. The exception will be people who pay the full cost of their services and have asked the Council to arrange them.

6.3 Local Policy

In Hampshire, to recognise that some service users may be financially disadvantaged if their contribution is not recalculated: wherever reasonably practicable, a change in the amount of chargeable services will result in a recalculated cPB (although this will not affect what most service users pay).

Why service users need to pay when services are not received

The majority of service users pay a contribution (based on their finances) towards their services. The Council then ‘tops up’ the difference. Therefore the amount that these service user pay won’t change if their services reduce or are not received. The following is an example of how this works.

The top (solid) line is the total cost of services
The lower (dashed) line is the service users contribution
The County Council funds the bit in the middle – which will go up and down as services are used

For the majority of service users, unless all their services stop completely, they will pay the
same amount each week. This is why we have introduced the 1-4 day rule. This rule is simply intended to reduce the need for people to have to contact us about short temporary changes (defined as up to 4 days) in their care services as these don’t affect what they need to pay. The position for people who fully fund, or nearly fully fund, their services is different as what they pay will be affected by the cost of their services. In is important the chargeable personal budget is very accurately maintained, particularly in such cases.

**For ALL service users**

It’s important to remember that services are meeting assessed needs and are booked for an individual. Where the Council has incurred a cost, it is reasonable to expect the service user to pay their full or partial contribution.

Where a service isn’t received for any reason, the Council will however offer an alternative service. Where the service user cancels the service, this offer will be limited to up to 4 times in a financial year. This could be achieved by re-booking respite care or arranging another day at a day centre, including at one of the Council’s own units.

Bank holidays are another area where service users may think they should pay less. However, the service providers still need to pay staff and buildings costs and build this into their prices. Spreading the annual contribution over 52 weeks also means people won’t pay less when there is a Bank holiday in a particular week.

Refunds should not be made unless the service user pays the full cost of their services and all reasonable steps have been taken to arrange alternative services. In these cases service users should be directed to the Professional Advisory Team.

Every effort has been taken to ensure people are not overcharged for services. All calculations are rounded down to ensure this. This is why figures may not match exactly from the support plan to the chargeable Personal Budget to the service users invoice.

6.4 Changing the chargeable Personal Budget

Changing an AIS provision will not automatically change the cPB. That can only be done by using the Panel forms. The process for ensuring the cPB is changed, when it is appropriate to do so, is set out in full in Hantsnet Learn IT (staff guidance). The care practitioner will change the cPB when:

- an increase in any service takes place for more than 4 days in a row
- any or all services end
- a reduction in any services takes place for more than 4 days in a row
- a break in all services is required (for the whole duration of the break) The cPB does not need to be changed when:
- services increase for 4 or less days in a row*
- services decrease for 4 or less days in a row*

(*Unless the service users is making a full or nearly full contribution to their care costs)

6.5 Cancelling the chargeable Personal Budget

This will in effect make all services non-chargeable and should be authorised by the Panel chair where:

- a cPB has been incorrectly created for a service user for whom the Council has no statutory discretion to seek a contribution (such as those using mental health after care services - Section 117 of the MH Act)
- the service user has refused services on the grounds they are chargeable and there
are significant safeguarding risks in not providing such services.

- there is strong evidence that the service user does not have sufficient means to pay a contribution AND there is no-one with legal responsibility for managing their finances.

Please note this is different to temporarily waiving the client contribution which remains subject to agreement with the Council’s Scheme of Delegation. This states that “waivers for non-residential care charges can be authorised by the budget holder in accordance with Financial regulations. Waivers up to £100 per week can be approved by District Service Manager or equivalent, and over £100 can be approved by Area Director or equivalent”. The usual process should be followed if a temporary waiver is required, a District Service Manager will need to submit a SASS to the FAB team manager.

Financial implications for the Council: Cancelling the cPB will reduce the weekly cost of chargeable services to £0. This will not be the loss of income from the client contribution (as the value of such will not be determined through this process). Careful consideration should be given to the correct procedure to be used and what is recorded for income budget monitoring purposes.

6.5 Making Payments

The Making a contribution to your personal budget for social care booklet sets out when and how service users can pay their contribution [http://www3.hants.gov.uk/adult-services/as-publications/care-at-home-publications.htm](http://www3.hants.gov.uk/adult-services/as-publications/care-at-home-publications.htm).

6.6 Service Users Review of their financial Circumstances

A review of all service users financial assessments will normally be undertaken by FAB every April. This is when the Dept for Work and Pensions sets new rates for welfare benefits. Currently welfare benefits can include money for meeting care needs and this may need to be used to pay the service users contribution.

Where a service user’s financial circumstances change at any point, they should notify the Department as soon as possible, as this may affect what they need to pay. Any amount may need to be backdated if not reported promptly. For example, where income or assets reach the level at which the Council may need to contribute towards the cost of care services; or when a service user’s income or assets increase. Where a care practitioner becomes aware of changed financial circumstances they will request the FAB team to carry out a financial reassessment.

7. Services

Attached as Appendix B is a non-exhaustive list of services that are free/non-chargeable and those that are chargeable, under the current policy. This list will be reviewed annually as part of the Department’s budget setting process. Any variations from or amendments to this list will be agreed by Adult Services DMT.

7.1 Rates for non-residential and residential care services

The Council is both a provider and commissioner of adult social care services. All rates are reviewed annually and approved by the Executive Member for Adult Social Care as part of the annual budget setting process. This usually happens in January, for implementation the following April.

Rates for social care services provided by the Department are based on inflationary increases and occupancy levels. They also include a 10% administration charge. These rates apply to services purchased by service users who have been financially assessed to pay the full cost of their services (the process for determining their contribution is as set out in this procedure); and by other local authorities and health organisations who have service users or patients receiving services provided by the Council.

No VAT is levied on amounts to be paid by other local authorities or those paid by service users assessed to pay the full cost. Rates for services commissioned by the Council are reviewed with the service providers. Information about the rates paid by the Council for
commissioned services is available from AIS or the Contract Support Team. Information about the new Preferred Provider Contract Framework for domiciliary personal care is published on Hantsweb.

7.2 Shared Lives

Shared Lives service users are tenants i.e. they live at home; and are able to claim housing benefit for their housing costs. They pay a set amount towards food and household bills. Social care services provided to people living in Shared Lives homes are covered by the Contributions Policy.

Service users will meet the department’s eligibility criteria and receive personal care and/or support from the resident landlord (the Shared Lives carer) funded by the Council. They will be using chargeable services arranged by the Department. They are not eligible to use Direct Payments as the scheme is provided and registered by the local authority.

All Shared Lives service users will need to either pay the full cost of the chargeable services or have a financial assessment to work out their contribution. The Shared Lives user will be invoiced by the Council for their contribution towards social care.

The agreed weekly amount that is paid to the Shared lives carer by the Council will be net of the rent, food and bills as the service user pays this directly to their carer.

Arrangements for shared lives placements in schemes other than Hampshire’s need to be negotiated with the scheme in question.

7.3 Extra-Care Housing

Extra-Care is designed for people who rent and for those who wish to buy, and meet the schemes eligibility criteria. To rent Extra-Care housing, individuals also need to be on their local district / borough housing register.

Social care services provided to people living in Extra-Care housing are covered by the Contributions Policy. Care practitioners will ensure early referral and close liaison with FAB for service users considering Extra-Care housing as an option for meeting their care needs as there are financial implications that the service user may need to take into account.

The nature of Extra-Care schemes mean that service users who are owner occupiers must carefully assess the implications of moving to property which is either rented, or has a value which may be significantly different to the value of the property they own and will sell. This includes where the service user retains ownership of property as a second home as this will usually result in the service user being assessed as being able to afford to pay the full cost of their care services.

7.4 After Care Services for people previously detained under the Mental Health Act

After care services provided under section 117 of the Mental Health Act 1983 are not chargeable. What constitutes ‘after care’ services is not defined in the Act but would normally include services determined to keep the service user from further hospitalisation. The decision to reduce the chargeable services personal budget in such circumstances rests with the Panel chair.

7.5 Care Services which are privately arranged by the service user

The cost of privately arranged services can be regarded as a Disability Related Expense where it is meeting eligible needs as identified in the SDS (care needs) assessment and needs to be recorded in the support plan summary. The costs of such care will not be included in the personal budget, but the amount can help reduce the service user's financial contribution to other services arranged on their behalf by the Department.

FAB will liaise with the care practitioner to check the support plan summary to establish whether the amount of privately arranged services are meeting assessed eligible needs.

Where this is not confirmed in the support plan summary; and the service user chooses to continue to purchase the service(s), they will not be regarded as a Disability Related Expense.
7.6 LD Transformation

Service users who transfer from one type of service to another need to have the charging implications explained to them and to be referred to FAB for a financial assessment. After the client moves services, those who are using accommodation for long term needs must be CRAG assessed. Those who access respite will be charged through this policy.

7.7 Respite Care

Respite care is defined as giving service users a break from their home circumstances and/or also enabling a carer to have a break from the caring role. For short term residential respite care this is up to 8 weeks and should be entered at the time the provision is put on SWIFT. At this point the cPB should be recalculated.

See Appendix E for the guidance on residential respite care.

The County Council has agreed to provide some respite care and other services to carers free of charge under its Contributions Policy. These are specifically named services for carers, and are set out in the list of services in appendix B. These services will only be provided where the carer provides regular and substantial care, and after an assessment of the carer’s needs.

All other services that provide respite care, including day care and residential services, are chargeable to the service user. The SDS process will identify the needs and the service(s) agreed.

Care practitioners will then record the respite provision in AIS and ensure that a ‘break’ is applied in AIS to the provision of other services during the period of respite care to ensure the Council does not pay for services that are not being used during the period of respite. Care practitioners will also ensure the provision is amended if respite care is no longer required.

To ensure service users contribute fairly, care practitioners will need to ensure the cPB is amended to:

- Exclude the cost of other services, including those provided by the Council, that are not required for the period of respite.
- Remove the cost of any period of respite care that is no longer required.

Guidance for staff on how to change the cPB to this effect is on Hantsnet Learn IT.

Care practitioners will ensure the service users chargeable Personal Budget is amended for the duration of respite care as set out above.

8. Safeguarding the interests of service users

The contributions process gives the council an opportunity and responsibility to safeguard the financial and other interests of service users. It does this in a number of ways:

8.1 Mental Capacity, Attorney, Deputy or Appointee

As part of the SDS assessment where the care practitioner believes a service user may not have capacity to make financial or other decisions, an assessment of ‘capabilities and best interests decision making’ will be undertaken. This will be made using guidance given in the care management practice manual.
If the service user does not have capacity to manage their finances and someone else has legal authority to do so, copies of the relevant documentary evidence must be provided. Care practitioners will obtain this evidence and confirm this on the client electronic record (AIS) and notify FAB on the financial assessment referral form.

*Please note the council cannot, by law, share information with a person who claims to be an Attorney, Deputy or Appointee without obtaining a copy of that authority. Care workers, relatives or friends cannot legally access the person’s income or assets, unless these arrangements are in place.*

Where the care practitioner has concerns that there is a mismanagement of the service user’s finances, they will consider using the council’s safeguarding powers. If there is a concern regarding an appointee, this will be reported by the team manager to the Department for Work and Pensions. If there is a concern over the functioning of an attorney or deputy then this will be reported to the Office of the Public Guardian.

If no legal arrangements exist, a referral to FAB should not be made at this point. Care practitioners will advise and support an appropriate person to make a formal application for:

- **Appointeeship** – suitable if the person only has income from benefits to manage.
- **Lasting Power of Attorney Property and Finance** – granted after 1st October 2007 whilst the service user had mental capacity to create this. This power has to be registered to be valid.
- **Court Appointed Deputy, Property and Finance** – applied for on behalf of the service user who lacks capacity.
- **Enduring Power of Attorney** – granted before 1st October 2007 whilst the person had mental capacity to create this. This power must be registered at the point the person loses capacity to manage their finances.

### 8.2 Client Affairs Team (CAT)

Where necessary and as a last resort, in the absence of any suitable alternative, the Department’s Client Affairs Team will manage some or all of a service user’s financial and property affairs under an authority from the Court of Protection and / or under Appointeeship granted by the Department of Work and Pensions. Normally, this will only occur if there is no friend or relative willing or suitable to undertake these responsibilities.

Where this happens, the care practitioner will remain involved (these matters are outside the capabilities of the FAB team) to liaise with CAT. The CAT team may request assistance from the FAB team in completing the financial assessment.

### 8.3 Suspicion of Abuse

Financial abuse is a significant factor in the abuse of vulnerable adults. Guidelines for dealing with suspected abuse have been agreed across local agencies through the **Safeguarding procedure**. Where financial abuse or the mismanagement of direct payments is suspected then financial records including bank statements will be requested from the person by the Department’s relevant team manager.

Where the Income Collection Team has concerns that a contribution is not being made, then they will inform the care practitioner. Debt can be an indication of financial abuse.

### 8.4 Debt and Arrears

The Council will pro-actively monitor arrears to identify service users who are having difficulties paying and initiate action to help address problems. The Income Collection Team will monitor arrears and inform the Departments’ local team manager where a service user seems to have difficulty paying. This will normally happen after the point at which the third months payment has not been received.

Team managers and care practitioners will consider what action can be taken to avoid
further build up of debt. This may involve discussing the situation with the service user who may not understand recent changes, or a relative with legal authority may have moved away. The team manager is not responsible for collecting the debt, but is responsible for ensuring the service user is safeguarded and that the most up to date information is available to enable the Council to make a decision about the appropriateness of debt recovery. The longer the debt is left the more difficult it becomes to collect. The council will only issue legal proceedings against a person as a last resort.

8.5 Duty to assess and provide services; and refusal to pay

A service user’s financial circumstances have no bearing on whether the Department will carry out a needs assessment. Similarly, the Department cannot withdraw services that meet eligible needs where the service user refuses to pay. However, contributions will be recovered through debt recovery collection processes. This is arranged by the Corporate Services’ Income Collection Team.

8.6 Welfare Benefits Checks

When the FAB team carry out a home visit because a financial assessment has been requested, they will give welfare benefits information and help with claims. This can be for the service user and any affected family members. Where a financial assessment is declined or is not necessary, FAB will not visit, but will signpost service users to their local Department of Work and Pensions office, Citizens Advice Bureau or other local groups that can help with benefit claims.

9 Getting it right, first time

How the various rules governing social care impact upon people individually can be hard to understand, especially during times of anxiety and distress. The council aims to ‘get it right first time’ when collecting financial contributions from people who use social care services and will respond promptly to service users if it gets things wrong.

Most social care services are not automatically provided free to the service user, and many people will need to pay towards the cost of their care services. The SDS (care needs) assessment is personal to the individual; and services are tailored to individual needs. Similarly, the amount contributed is individual to every service user. National guidance requires councils to consider every aspect of an individual’s financial circumstances to ensure they only pay what they can afford.

Having accurate and up to date information about a service user and the services they use is key to this aim. Care practitioners will keep the electronic client records (AIS), such as the contact details of representatives, up to date. This includes orders for services (provisions) including those provided by the Department. Care practitioners, supported by Provisions Support Officers (PSOs) will also ensure panel forms are accurately completed and activated to calculate the chargeable Personal Budget. Panel Chairs will ensure the approval process is prompt and apply waivers to contributions (through reducing the cPB) to ensure wherever possible charges are not made inappropriately to service users: for example, mental health aftercare services and safeguarding placements.

Care practitioners will also make prompt referrals to FAB, immediately following the care needs assessment. Timely financial assessments are essential to reassure service users and ensure that they are able to make informed decisions.

10 Ordinary Residence

The Contributions policy applies to residents of Hampshire. Where a service user, who fully funds their care services, moves from Hampshire, they will be regarded as ordinarily resident in the new location. They should approach their new council for all services, including advice about adult social care and contributions. The policy on ordinary residence gives further information about ordinary residence in Hampshire. Ordinary Residence - Staff Information -
11 Other organisations who purchase services from the council

A formal written agreement will be obtained from the purchasing authority confirming it accepts responsibility for funding the stated service costs.

Purchasing authorities will be invoiced quarterly in arrears for long stays; and as soon as possible after any short stay placement. The amount will be based on the number of sessions booked, rather than the number of sessions used.

Where a service user is absent, the rate will continue until notice is received that the placement is to be terminated. The purchasing authority must give 2 weeks notice of termination or payment in lieu of notice.

Other local authorities and health organisations purchasing care services from the Council will be notified of any changes in writing by the Corporate Services’ Devolved Finance Unit for Adult Services (DFU), as soon as possible following Member approval.

Invoicing will be carried out by the Corporate Service’s Income Collection Team, with the exception of units for people with learning disabilities. Managers of these units will notify purchasing authorities of new rates, issue invoices and deal with queries.

Information to district councils regarding meals on wheels agreement rates will be issued by DFU.

Invoices will clearly identify each service user and the period and number of days charged each billing period. LD units will record each invoice against each service user’s records.

Unit Managers will make periodic checks to ensure invoices are accurate, timely and that the correct rates are used.

12 Compliments and Complaints

Feedback from service users and those who represent them is important to the Council. Tell us what you think provides information about how to make a compliment, complaint, comment or concern about adult social care in Hampshire.

Services users can also request a review of their financial assessment before making a formal complaint by contacting the FAB team.

13 Equalities Impact Assessment

An Equalities Impact Assessment was completed for the Cabinet report ‘Contributions policy framework for Adult Social Care – paying for care at home’ 28 Feb 2011. The findings are included under each proposal and a summary is available on Hantsweb Equality Impact Assessment.

14 Performance Standards associated with this procedure

Prompt referral by care teams for financial assessment; and prompt financial assessment by FAB are crucial for the reassurance of service users; and for the Council’s financial strategy which regards income from charging for services as an important component. Performance across these areas is monitored and action to improve will be taken by both Departments as necessary.

This procedure will be reviewed at least annually by the Deputy Director of Adult Services and Head of Finance.
Appendix A  Hampshire County Council’s Contributions Policy

Hampshire County Council Contributions Policy Framework for Adult Social Care – paying for care at home

The County Council has the power to charge for services under Section 17 of the Health and Social Services and Social Security Adjudication Act (1983) and seeks contributions to Direct Payments under Community Care, Services for Carers and Children’s Services (Direct Payments)(England) Regulations 2009 pursuant to Health and Social Care Act 2001. In respect of temporary residential stays of up to 8 weeks the Council has discretion under Charging for Residential Accommodation Guide (CRAG) not to carry out a financial assessment and to charge an amount it appears reasonable for the resident to pay.

1. Context
1.1 Income from charging for services is an essential component of Hampshire County Council’s financial strategy. National funding arrangements make it clear councils need to collect income locally to fund the full cost of services. This policy is concerned with contributions to be paid towards provision of non-residential care and Direct Payments.

Relevant legislation includes:
The National Assistance Act 1948
The Health Services and Public Health Act 1968
The Chronically Sick and Disabled Persons Act 1970
The NHS Act 2006
The Carers and Disabled Children Act 2000
The Health and Social Care Act 2001
Charging for Residential Accommodation guide (CRAG)

1.2 Legislation permits an authority to recover a reasonable charge for social care from a service user who satisfies the authority that he/she has insufficient means for it to be reasonably practicable for him/her to pay for the service.
1.3 Where the Council makes a Direct Payment as an alternative to making arrangements for direct provision of a service a contribution will be required and calculated on the same basis as when the Council commissions a service.
1.4 The same principles of fairness apply to those who hold personal budgets as those who do not.
1.5 In setting its Contributions Policy and determining the contribution to be paid by an individual the Council cannot be less generous in the treatment of capital than the provisions set out in the national Charging for Residential Accommodation Guide (CRAG).
1.6 The Council will take into account in the financial assessment capital and income unless it is required to be disregarded under legislation or statutory guidance.
1.7 Where permitted discretion to do so the Council charges an amount that appears reasonable for the resident to pay for residential respite care rather than carry out a financial assessment under CRAG.

2. Policy Inclusions
2.1 All adult social care services for which the Council has discretionary powers to charge. See appendix 4 for a non exhaustive list of services. See also Policy Exclusions.
2.2 Direct Payments Scheme

3. Policy Exclusions
3.1 Services for which the Council may not charge under legislation and/or statutory guidance. This includes aftercare services under the Mental Health Act, services provided to people suffering from any form of Creutzfeldt Jacob Disease, intermediate care services and community equipment and minor adaptations.
3.2 Direct access services provided by the voluntary sector and funded by the Council—these services are generally grant funded and have a vital role in preventing or deferring the need for longer term health and social care services.
3.3 All Residential services (of over 8 weeks). These are the subject of a national charging policy administered by councils which councils are obliged to follow.
3.4 Temporary residential services under 8 weeks that are not respite, intermediate or reablement.
3.5 Supporting People funded services which are subject to separate arrangements. Account will be taken of the impact in individual cases where a person receives a service from Supporting People programme as well as other care provision from the Council.

4. Policy Aims
This policy aims to ensure the Council requires contributions towards services that support people living at home on a fair and equitable basis. The policy is based on statutory guidance: Fairer Charging Policies for Home Care and Non-residential Social Services (The Fairer Charging Guidance) issued in 2003. Fairer Contributions Guidance 2010 Calculating an Individual’s Contribution to their Personal Budget.

4.1 Fairness and Equity
A single policy for all non-residential services for which the Council is permitted to charge and temporary residential stays of up to 8 weeks provided as respite ensures people are treated fairly and equitably.
Contributions to a personal budget for social care are determined by financial assessment of an individual’s means. In respect of temporary residential stays of up to 8 weeks the Council has discretion whether to carry out a financial assessment under CRAG or to charge an amount that appears reasonable to the Council.

4.2 Protecting people on low incomes
The financial assessment will ensure that people on low incomes are not put in financial hardship as a result of paying towards their care costs. Advice and support to claim welfare benefit entitlements will be made available to service users and carers.

4.3 Choice and Control
This policy supports the Council’s wider aims to enable greater choice and control over services that meet eligible social care needs. Service users, subject to financial means, contribute to their personal budget for social care. The Council funds the difference. This budget is used to purchase services to meet the users eligible needs. Service users may take this money in the form of a Direct Payment, or ask the Council to arrange services on their behalf, or use a combination of both.

4.4 Promoting prevention and reablement
Services provided or commissioned by the Council include those that prevent or defer the need for more intensive health and social care services. These services will be free for up to 6 weeks, following an assessment of need, to encourage and enable independence. (Other services that support this policy aim are grant funded by the Council and provided by the voluntary sector. These are free to access and can be found on the Council’s Care Choice website.)

4.5 Supporting carers wellbeing and the caring relationship
In order to support people living at home and their carers who require services the Council provides certain services free. These are identified in Appendix 4.

4.6 Provide people with timely, clear and concise information about the costs of their care
The Council will publish its Contributions policy on Hantsweb and provide clear information to service users, carers and the general public in a variety of formats.

5. Service User’s Financial Assessment

5.1 Low Income
‘Low income’ levels are those as set out by the Department of Health (which currently states contributions to care costs should not reduce a services user’s net income below levels of income equal to basic levels of Income Support or the Guarantee Credit of Pension Credit plus 25%). The Council will offer advice on benefits entitlement and assistance with claiming benefits.

5.2 Direct Payments.
The contribution to be made when the service user receives a Direct Payment instead of services is calculated on the same basis as when a service user receives a service commissioned by the Council. Wherever possible Direct Payments will be paid net of client contribution.

5.3 Disability Related Expenses (DRE)
The aim is to allow for reasonable expenditure needed for independent living by the service user. The Council will take into consideration the relevant expenses of each individual service user. The list of possible items is not exhaustive, and examples are given in further information provided to the service user, but expenses should be included in the support plan where it would be more appropriate to do so.

5.4 Income, Capital and Investments
In carrying out a financial assessment, the Council will take into account all relevant income and capital that is not required to be disregarded. Examples of disregarded income include any income from earnings, Winter Fuel Allowance, mobility component of Disability Living Allowance. Treatment of capital including savings. The Council sets an amount:

i Below which capital will not be taken into account when assessing the service user’s contribution.

ii Above which the service user will be expected to pay the full cost of their Personal Budget.

iii The above amounts cannot be less generous to the service user than are set out in CRAG as amended from time to time.

Personal Injury Awards. The Council will take into account all elements (capital and income) of a personal injury award unless they must be disregarded for legal reasons. Deprivation of capital. If someone has deprived themselves of capital or an asset to reduce their contribution, this may be treated as deprivation of funds to pay for care and the contribution will be calculated as if the individual still had the capital or asset.

5.5 Net Assessed Income
The Council will disregard 5% of the net assessed income. This means that 95% of a service user’s net assessed income will be used to calculate the most someone would contribute towards their personal budget.

5.6 Refusal to be assessed
A service user is required to pay the full cost of the service if they refuse to disclose their financial means. Services cannot be withdrawn because a person refuses to pay their contribution to their care costs or the full cost of care where appropriate. The Council will pursue any debt accrued.

5.7 Maximum Weekly Charge
Hampshire County Council no longer has a maximum weekly charge.

6. Carers

6.1 Carer’s legislation requires councils to assess carer’s needs to support their wellbeing and the caring relationship where they are providing regular and substantial care. Carers
benefit from services provided as carers services as well as certain services provided to the cared for person.

The Council gives consideration to meeting the needs of carers through provision:

(i) used directly by the carer – these are defined as 'carers services' and are free under this policy. Such services are identified through the carers assessment of needs and are arranged by the carer using a Direct Payment provided by the Council. The range of possible services is very wide and some examples are given in the appendix.

(ii) used by the cared for person – these are included in the service user’s support plan and will generally be services liable to a service user’s contribution.

6.2 Carer Replacement Scheme including sitting services, and Take a Break voucher scheme are free.

Legislation requires personal care to be excluded from services determined as Carers Services as it is intimate in nature and directly provided to the service user. (There are exceptions to this, where the service user requests help or is in a situation that would cause harm).

7. Joint arrangements with Children’s Services

7.1 Social care legislation in relation to the provision of services to meet the needs of adult and children is complex and the Council is committed to ensuring Adult and Children’s Services work collaboratively to achieve the best possible outcomes for individuals and family groups. In the context of paying for services, those arranged by Children’s Services are free under legislation. Services arranged by Adult Services are subject to this policy. The following clarification is provided:

Parents who are carers of disabled children

People with parental responsibility for a disabled child are entitled to a carer’s assessment. Adult and Children’s Services work together to ensure that the assessment is carried out by the most appropriate person. As set out above, adult social care services directly to the carer are free.

Disabled Parents

Disabled people who are parents are entitled to an adult social care assessment; and to have their needs met where they meet the Council’s eligibility criteria for adult social care. They will be required to make a contribution to their personal budget for social care services, based upon a financial assessment.

Young Carers

Young people under the age of 18 who have caring responsibilities are entitled to an assessment of their needs by Children’s Services. The cared for person is entitled to an adult social care assessment; and to have their needs met where they meet the Council’s eligibility criteria for adult social care. They will be required to make a contribution to their personal budget for adult social care services, based upon a financial assessment.

This policy and accompanying guidance will be monitored and reviewed by the Adult Services Department through learning from complaints, compliments and concerns raised by service users and carers.
## Appendix B – List of chargeable and non-chargeable services (non-exhaustive)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Illustrative Description (this is not a legal definition)</th>
<th>Examples of services in Hampshire. (see Care Choice for more services)</th>
<th>Proposed Contributions Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice and Information*</td>
<td>On the range of social care and support services available, including welfare benefits. These services help guide people towards the right help which can prevent or defer the need for intensive social care. ‘direct access’ advice and support services</td>
<td>HantsDirect contact centre Hantsweb Care Choice Guide to Care publications Community Innovations Teams Community Dev Workers Community Mental Health Teams Advocacy, appropriate adult and, rape and sexual abuse counselling services</td>
<td>Free</td>
</tr>
<tr>
<td>Assessment*</td>
<td>An assessment by the Council to determine an individual’s needs, goals and eligibility for funded care and support.</td>
<td>Hospital Teams Community Teams Community Mental Health Teams</td>
<td>Free</td>
</tr>
<tr>
<td>Carers Assessment*</td>
<td>An assessment by the Council to determine carer’s needs.</td>
<td>Hospital Teams Community Teams</td>
<td>Free</td>
</tr>
<tr>
<td>Carers Services (see also non-res respite)</td>
<td>Provision directly to the carer to enable them to fulfil their caring role.</td>
<td>Direct Payments. Used for example for costs of travel, mobile phone, laundry.</td>
<td>Free</td>
</tr>
<tr>
<td>Carers Emergency planning/support</td>
<td>Emergency plan and up to 48 hours care at home, should an emergency or crisis occur.</td>
<td>Princess Royal Trust for Carers</td>
<td>Free</td>
</tr>
<tr>
<td>Community Equipment*</td>
<td>Aids to daily living such as eating and drinking utensils, grab rails, raised toilet seats or more complex equipment such as beds and hoists.</td>
<td>Equipment Store Sensory Services British Red Cross</td>
<td>Free</td>
</tr>
<tr>
<td>Day Services</td>
<td>Social contact and activities for people who are socially isolated or have difficulty living at home. Also enables the carer to have a break from the caring role.</td>
<td>Available from a number of service providers.</td>
<td>Assessed user contribution to personal budget</td>
</tr>
<tr>
<td>Financial Assessment*</td>
<td>Information and financial assessment to determine the persons contribution to their personal social care budget</td>
<td>Financial Assessments and Benefits Team</td>
<td>Free</td>
</tr>
<tr>
<td>Long term Personal Care at home – day and night time See also Support</td>
<td>For people with long term care needs. Help with intimate personal tasks such as getting into and out of bed, using the toilet, dressing, bathing, eating and personal hygiene.</td>
<td>Available from a number of service providers.</td>
<td>Assessed user contribution to personal budget*</td>
</tr>
<tr>
<td>Meals</td>
<td>Meals provided to people unable to cook for themselves.</td>
<td>Available from a number of service providers. * Fixed amount charged for meals on wheels and meals at some day services.</td>
<td>Charge made for Meals</td>
</tr>
<tr>
<td>Community Mental Health</td>
<td>Assessment and referral</td>
<td>Community Mental Health Teams</td>
<td>Free</td>
</tr>
<tr>
<td>Service Type</td>
<td>Illustrative Description (this is not a legal definition)</td>
<td>Examples of services in Hampshire. (see Care Choice for more services)</td>
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</tr>
<tr>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------</td>
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<td>-----------------------------</td>
</tr>
</tbody>
</table>
| Services                                         | Treatment and care for time-limited disorders  
Treatment and care for complex and enduring needs  
Advice to other professionals                                                                                          |                                                                                          |                             |
| Community Mental Health Support Services         | Prevention and/or reablement on a ‘direct access’ basis. Help to prevent or defer the need for longer term health and social care services. | Commissioned from a number of providers                                                   | Free                        |
| Non Residential Respite Care                    | Support provided to the cared for person, to enable the carer to take a break from the caring role.                       | Only  
Take a Break Voucher Scheme  
Carer replacement scheme  
Sitting Services                                                                 | Free                        |
| Short term residential respite care (up to 8 weeks) | Gives service users a break from their home circumstances; also enables a carer to have a break from the caring role.    | Available from a number of service providers.                                               | Assessed user contribution as part of personal budget |
| Client Affairs                                   | The Council manages service users financial affairs where they lack the mental capacity to do so themselves  
Acting as Deputy  
Acting as Appointee  
Charged for in accordance with Court of Protection rules  
Free                                                                 |                                                                                          |                             |
| Reablement*                                      | Care and support to recover from or live with a disability or illness, by (re) learning skills for daily living. Aims to avoid hospital or long term care admission and support hospital discharge. | Commissioned services:  
Community Response  
Welcome Home  
Time to Think Beds  
Free for up to six weeks                                                                 |                             |
| Safeguarding                                     | The co-ordination of investigations into allegations of the abuse of a vulnerable person  
Community Teams  
Safeguarding Team  
Free                                                                 |                                                                                          |                             |
| Shared Lives                                     | A scheme through which vulnerable adults live with people who are paid carers, offering a home and support in a family environment. | Shared Lives – care and support including respite care  
NB: Service users pay the carer direct for food, utility bills and rent.  
Assessed user contribution to personal budget.                                                                     |                             |
| Support Planning                                 | Setting out agreed goals and a plan of action, including the services to help achieve these.                            | Hospital Discharge Teams  
Community Teams  
Free                                                                 |                             |
| Support (day and night time) See also personal care. | Advice, encouragement and supervision for vulnerable adults who live independently. Includes emotional and psychological support including behaviour management. | Commissioned from a number of service providers.  
Where support work is provided as part of a chargeable service, there will be no additional charge  
Assessed user contribution to personal budget.                                                                     |                             |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Sensory Loss Service</td>
<td>For people with sight, hearing or dual sensory loss. Offers reablement and help prevent or defer the need for longer term care. Provides assessments of need, training and advice about the equipment available.</td>
<td>Provided by the Council</td>
<td>Free</td>
</tr>
<tr>
<td>Occupational Therapy (OT)</td>
<td>For people with a range of people with physical, mental and/ or social problems, either as a result of accident, illness or ageing. Offers reablement and help prevent or defer the need for longer term care. OTs carry out assessments and provide services to help people remain as independent as possible in their own homes.</td>
<td>Provided by the Council</td>
<td>Free</td>
</tr>
<tr>
<td>Telecare Equipment*</td>
<td>Equipment that senses risks such as smoke, floods and gas, pills reminder or phone for help.</td>
<td>Commissioned from a number of service providers.</td>
<td>Free</td>
</tr>
<tr>
<td>Telecare Response Service</td>
<td>Response to the alarm or alert generated by the Telecare equipment.</td>
<td>Commission from a number of service providers.</td>
<td>Assessed user contribution to personal budget - All contributions for Telecare suspended from Oct 1st</td>
</tr>
<tr>
<td>Transport</td>
<td>Transport to access services</td>
<td>Transport arranged or provided by the Council, including to attend day services is chargeable.</td>
<td>Assessed user contribution to personal budget</td>
</tr>
<tr>
<td>Welfare Benefits Advice</td>
<td>Advice and support to claim welfare benefits</td>
<td>Financial Assessments and Benefits Team Hantsweb</td>
<td>Free</td>
</tr>
</tbody>
</table>
Appendix C

<table>
<thead>
<tr>
<th>Questions</th>
<th>Service User Information</th>
<th>Care Practitioner Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My needs have increased and the cost of my services will go up – do I need to pay more?</td>
<td>If you are already paying your maximum contribution, you won’t pay any more. If you aren’t paying your maximum contribution, you will pay more, but only up to your maximum contribution. If you are paying the full cost of your services and want the Council to continue to manage them for you, then you will pay the full cost of the new amount. Further Information: If your financial circumstances have changed (i.e. chosen to pay full cost or saving were above the capital limit), you could have a financial (re) assessment to ensure you would be paying the right amount.</td>
<td>Reassessment due to increased needs has led to increased service costs. cPB needs to be increased via Panel Form application</td>
</tr>
<tr>
<td>2. My partner/carer is unwell and can’t look after me today. I am having different or extra services, will I pay more?</td>
<td>No you won’t pay any more. If we have put personal care services or support work in place or arranged extra day care for 1 – 4 days, the Council will pay for this. If the carer has an emergency plan, then such services are free of charge Further Information: If the situation continues for more than 4 days in a row, it might affect what you pay. Please see answer to question above.</td>
<td>Variation in care services to meet temporary increase in needs No change to cPB needed</td>
</tr>
<tr>
<td>3. I won’t need my services next week as my daughter is coming to visit and will look after me, will I pay less.</td>
<td>You may pay less depending on your contribution and if the break in care is 5 days or more. You will see this in your next invoice (or may be the month after if we are about to send them out)</td>
<td>cPB break to be applied for full term of break in services if 5 days or more Break in care applied in SWIFT</td>
</tr>
<tr>
<td>4. I have not received my services today/recently as:</td>
<td>This won’t be the case as what you pay each week doesn’t change. If you pay a contribution, this is based on what you can afford to pay, and not the cost of the service paid for by the Council. If you are paying the full cost, then please understand that all service users have the option to ask the Council to arrange services on their behalf, or to manage their own services. The Council is managing services for thousands of individuals and cannot manage each arrangement individually. It must be consistent in how it treats all service users who may feel they have paid for care not</td>
<td>Follow up if wellbeing or care quality concerns. No change to cPB needed If situation continues for more than 4 days in a row, then change to cPB may be needed where A service is ended or a break applied Where alternative services are provided for more than 4 days in a row, such as in bad weather, then it may remain reasonable not to change the</td>
</tr>
</tbody>
</table>
The Council is often able to procure services at competitive rates. It also has certain contractual obligations to service providers. The Council may still need to pay the provider or fund the cost of alternative arrangements.

**Further Information**

*While it may not be possible to provide a particular service on a particular occasion, for example due to bad weather and concerns of people’s safety; the Council would be in contact with the individual to check that their essential needs are being met and to put alternative services in place in an emergency.*

*If this situation continues for more than 4 days in a row it might affect what you pay. Please see answer to question 3.*

<table>
<thead>
<tr>
<th>Questions</th>
<th>Service User Information</th>
<th>Care Practitioner Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. A carer does not turn up or stays for shorter period than planned</td>
<td>This is a concern as it’s about the quality of care you are receiving. We would not normally reduce your contribution for a ‘one off’ event, but if it happens regularly please contact us again and we will investigate with the provider. On this occasion it will not affect what you pay.</td>
<td>Follow up if wellbeing or care quality concerns. No change to cPB needed</td>
</tr>
</tbody>
</table>
Appendix D Guidance Note for Adult Services Care Managers and their Managers  November 2011

Contributions Policy for Non-residential Services

This note is in response to a number of concerns from service users and staff about whether the amount service users pay will vary according to the amount of services they receive.

You will know that people who are eligible to have services arranged by the Department, may need to pay a contribution towards the total cost of their chargeable services.

Everyone is entitled to have a financial assessment to work out what they need to pay. Those who do not wish to have a financial assessment will need to pay the full cost of their chargeable services. Service users only pay what they have been financially assessed as needing to pay; and will pay less if the total cost of their chargeable services is a lower amount. This can sometimes be confusing for people who have been used to being charged for individual services. This has led to lots of questions about:

**Does the amount someone pays change if they have less or more care?**

The short answer is: No. This is because what most people pay is based on their financial assessment, not the cost of the individual services they use.

Service users will only pay up to the amount they have been assessed as being able to pay. The Council must pay the rest. (Where someone’s chargeable services cost less than they can afford to pay, the most they will pay is the total cost of those services i.e. they are ‘full cost’)

Most people do not pay the full cost of their services, so if service costs increase or decrease, their contribution is unaffected. The table below explains how this works.

<table>
<thead>
<tr>
<th>Weekly Amounts</th>
<th>CPB of £250</th>
<th>CPB increases by £50 per week</th>
<th>CPB reduces by £50 per week</th>
<th>CPB reduces to £50 per week</th>
<th>CPB reduces to £30 per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>cPB (See the Panel form for this amount)</td>
<td>£250</td>
<td>£300</td>
<td>£200</td>
<td>£50</td>
<td>£30</td>
</tr>
<tr>
<td>Service Users Maximum Contribution (See the FAB Profile note in SWIFT for this amount)</td>
<td>£50</td>
<td>£50</td>
<td>£50</td>
<td>£50</td>
<td>£50</td>
</tr>
<tr>
<td>Service User pays</td>
<td>£50</td>
<td>£50</td>
<td>£50</td>
<td>£50</td>
<td>£30</td>
</tr>
<tr>
<td>Council pays</td>
<td>£200</td>
<td>£250</td>
<td>£150</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

cPB = chargeable element of the personal budget

For those people who pay the full cost of their services, it may seem unfair not to adjust what they pay if they do not receive a service.

However they have asked the Council to arrange services on their behalf.

The Council is managing services for thousands of individuals and cannot manage each arrangement individually. It must therefore be consistent in how it treats all service users who may feel they have paid for care not received.

The Council is often able to procure services at competitive rates. It also has certain contractual obligations to service providers.

There is a degree of flexibility however, if the person paying is paying the full cost of their care and has not received care for 1 – 4 days through no fault of their own eg. Carer hasn’t turned up, short hospital stay, and there is no way to arrange alternative care for the service user, then their contribution can be adjusted. Service users must contact Adult Services on; 08456035630. Service users should be put through to the Professional Advisory Team.

Where a service is not received, and this becomes a frequent occurrence, this will be investigated with the provider as a care quality matter. The Council may still need to pay the service provider and the service user may still need to pay the Council.
Why, when and how does the cPB change?

The business process for changing the cPB is effectively the Panel process. (The Panel process was introduced to provide budget governance).

Why?

As the County Council provides some services for free, each service user now has a chargeable services budget, know as their cPB (chargeable personal budget). This is the sum of the total cost of all the chargeable services they will use over the year. This sum is then divided into weekly amounts. It is not necessarily a reflection of the amount of services used in a particular week.

The information that is sent through to A4W in County Treasurers no longer comes directly from SWIFT provisions. This is because there is a need to first create the chargeable personal budget. This is done by using the Panel form process. Changing a SWIFT provision will not automatically change the cPB. That can only be done by using the Panel forms.

The aim of this guidance is to help ensure changes to the cPB are kept to the necessary minimum, while ensuring fairness and equity for service users and the tax payer.

When?

- There will be some occasions when the cPB needs to be changed. These are when:
  - an increase in services takes place (for more than 4 days in a row) or services end
  - a reduction in services takes place (for more than 4 days in a row) or a break in services is required (for the whole duration of the break) The cPB does not need to be changed when
  - services increase for 4 or less days in a row
  - services decrease for 4 or less days in a row

*There will be a proportionate approach to managing budget approval for care packages through the Panel process, guidance in relation to managing the cPB is that:

- When the decision to increase services for 4 or less days in a row is made through the Panel process, opening the Panel forms will recalculate the cPB and this is not required. The cPB needs to be overwritten to its previous amount.

- When the decision to increase or decrease a service for 4 days or less in a row is not made by using the Panel form process, no action in relation to the cPB is required as it will not have changed.

How?

The business process for changing the cPB is effectively the Panel process.

To create or increase the cPB, the provision must be put on SWIFT, a Panel form completed and submitted to Panel.

If the change will increase services for 4 or less days in a row, and it goes to Panel, the PSO will over-ride the cPB by overtyping the figure in the Weekly NRC Chargeable PB box with the previous cPB amount. (This is to ensure an equitable approach, as the Department does not change the cPB where services reduce by less than 5 days in a row).

The business process for ending, breaking or reducing the cPB is new. It requires care managers to complete a new form. The provision must be changed on SWIFT, the ‘Manage cPB’ form completed and the cPB recalculate button clicked. It does not need to be submitted to Panel.

If the change is for less than 5 days in a row, the provision still has to be changed on SWIFT, but the manage cPB form does not have to be completed.

If the change is for a known break in services, the provision must be changed on SWIFT and the ‘Manage cPB’ form completed: At ‘chargeable personal budget admin’; click create a CPB Break; enter Break Start and End dates, Click Save and then click ‘yes’ to confirm. The cPB will be set to zero and then revert to the weekly cost the day after the end date. PLEASE REMEMBER THIS IS NOT THE PROCESS FOR RESPITE.

If care is ended, then click ‘recalculate CPB’, enter the date after care is ended, then click ‘recalculate’, then click ‘save’ and then click ‘yes’ to confirm. Please ensure you make any relevant comments in the comment box before saving the record.
If care is reduced then click ‘recalculate CPB’, enter the date on which care is reduced, then click ‘recalculate’, then click ‘save’ and then click ‘yes’ to confirm

Further guidance on the Panel process is available in Hantsnet Learn IT. Further guidance in Learn IT on the cPB is available at CPB.

Model answers are suggested overleaf to help care practitioners and managers explain to service users why they will not normally pay any less if their care services are not received.

More detailed guidance for Adult Services staff is on the Departmental procedures page.
Appendix E

Guidance for residential respite care

Introduction
As part of the agreed changes to the Contributions Policy, Residential respite care will be charged for differently. This recognises that such care supports people living at home.

1. Definition of residential respite care
   With the new Contributions Policy a clear definition of residential respite care has been agreed and this will now apply in all circumstances.

   The definition is:
   Short term residential respite care (up to 8 weeks) with a clear start and end date – both dates should be entered at the time the provision is put on SWIFT.

   This is defined as either:
   a) giving a service user a break from their home circumstances and/or
   b) enabling a carer to have a break from the caring role.

   Previously there was some confusion about the definition of residential respite care where some teams understood residential respite to only apply where there was a carer.

   This definition does not include any other type of residential care. These should all be recorded as temporary or permanent stays.

2. Respite care identified as required
   The practitioner will need to agree with the service user that residential respite care is a service that will help them meet their needs and the support plan and support plan summary includes residential respite care.
   See page 35 for flow chart of the process.

3. Does the service user have other non residential chargeable services?
   If so, the residential respite will become part of the overall chargeable Personal Budget (cPB) and will be charged for in the same way as all other non-residential chargeable services.

   If there are no other non-residential chargeable services, see 6 below.

   Recording process
   The residential respite must be included in the support plan summary as with any other provision. Practitioners must choose the care item on Swift – cPB Respite. If there is a carer, tick the carer’s box. You would need to recalculate the cPB once this provision has been entered to ensure it is part of the non residential charging.

4. Does the service user already have a Financial Assessment for non-residential care?
   If so, there is no need to refer the service user to the FAB Team at this stage. However, the practitioner can contact the FAB Team to see if the service user needs a review of their financial assessment.

   If there is no financial assessment for non-residential care, the practitioner must make a referral to the FAB Team.
5. **Panel process for residential respite with other non-residential chargeable services.**
   The normal process for Panel authorisation should be followed. The residential respite provision is included in the cPB.

   Once the Panel has authorised the provision the cPB will be used to calculate the service user’s contribution as normal. Any cost for residential respite will be spread over the following 52 weeks as presently happens with other chargeable care services.

   Now go to 9 below.

6. **Does the service user have residential respite and no other chargeable services?**
   If so, the charging for this will remain under CRAG and there will be no cPB.
   
   **Recording process**
   The residential respite must be included in the support plan summary as with any other provision. Practitioners must choose the care item on Swift – Temporary. If there is a carer, tick the carer’s box.
   This is to ensure that the service user pays their contribution at the time of the respite and the charge is not spread over 52 weeks.

7. **Does the Service user already have a current financial assessment under CRAG?**
   If so, this amount must be recorded on the Client Contribution tab in the provision.

   If there is no financial assessment under CRAG, the practitioner must refer the service user to the FAB Team for a financial assessment

   If in doubt check with the Residential Assessments Team. (see structure chart)

8. **Panel process for respite only.**
   The normal process for Panel authorisation should be followed. The Temporary provision will not create an invoice to the service user as the cPB created will recognise the provision as residential.

9. **Is this respite being provided by an external provider?**
   If so, the practitioner books the placement with the external provider before the placement starts. They must inform the provider that this is a respite placement and the provider does not have to collect a charge. The provision should be put on as gross.

   If the provider sends an invoice to the Adult Service Revenue Team (see structure chart) and there is no authorised Swift provision, the Adult Services Revenue Team will contact the practitioner to ensure a provision is added.

   The Adult Services Revenue Team will know from the care item if the service user is being charged through their cPB or if they need to raise an invoice for the service user’s charge under CRAG.

10. **Is this respite being provided In-House?**
    If so, the practitioner books the placement and informs the provider if this is a cPB respite (respite is part of a support package and is included in a cPB) or a temporary stay (respite is the only chargeable service being provided and is charged under CRAG).

    The provider will send a weekly return to the Financial Assessments Group of all admissions and discharges. This information will be used to confirm if the service user will contribute through their cPB or if invoices should be sent to the service user under CRAG. The Adult Services Business management Information Team will use the information to ensure Swift information is correct.

11. **Process for situations not recorded above.**
a) Programmed respite (see flow chart on page 37)
Currently the practitioner will put a provision on Swift dated at the end of the financial year, covering the number of days agreed for the service user’s respite for the year. The actual stays are recorded on Swift when taken and the appropriate number of days are deducted from the programmed respite.

This practice should continue under the new process, however, the programmed respite provision is part of the cPB where the service user has other chargeable services and the cost of the respite will be spread over the next 52 weeks. N.B. the cPB should not be recalculated at this point as the provisions are only being updated to ensure the provider is paid.

Where the service user does not have other chargeable services the service user is charged under CRAG as in no. 6 above.

Through the year, as they draw down on their programme of respite, if there is any instance where the service user cannot take their planned care, an alternative equivalent should be offered. This can happen up to four times in a year and aims to ensure that there is no surplus programmed care at the end of the year.

The practitioner must ensure that service users clearly understand that the total amount of their programmed respite is included in their cPB which they will be making a contribution towards. If they do not take the full amount of programmed respite care allocated there will be no adjustment and therefore they could be contributing towards services they did not receive.

As the cost of the service will have been calculated in the cPB, it is important to make sure that the amount of programmed respite care reflects the requirements of the service user. Every effort should be made to ensure the programmed respite care is as accurate as possible to avoid services users paying for services they did not need.

b) Orchard Close
Service users using Orchard Close do not need to have a financial assessment as the charge for Orchard Close is a set weekly rate and is not means tested. Any provision is not to be included in the cPB.
The current process is to be followed until further notice.

c) Joint packages
Where a respite provision is jointly funded and agreed with Health, only the social care element should be included in the cPB. Practitioners should choose the ‘cPB respite’ or ‘temporary’ care item and record the fact this is joint funded in the ‘costs’ tab in the notes field.
The social care percentage/amount should be recorded here.
d) **Direct Payments**

<table>
<thead>
<tr>
<th>Existing DP and additional DP for respite</th>
<th>Add respite provision. cPB recalculated. Contribution may change depending on the upper limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing DP and managed service for respite</td>
<td>Add respite provision. cPB recalculated. Contribution may change depending on the upper limit</td>
</tr>
<tr>
<td>DP includes provision for respite</td>
<td>cPB is calculated at start of DP provision</td>
</tr>
</tbody>
</table>

Full cost service users should not be in receipt of a Direct Payment.

e) **Respite exceeding 8 weeks**

Residential respite should only be for up to 8 weeks. If the service user has a residential respite placement and, for whatever reason, stays in that placement over 8 weeks, the placement becomes a temporary stay and is charged under CRAG. The practitioner will need to close the respite provision and put a new temporary stay provision on Swift.
<table>
<thead>
<tr>
<th>What type of stay is it</th>
<th>Reablement</th>
<th>Respite with other chargeable services</th>
<th>Respite with no other chargeable services</th>
<th>Trial Placement</th>
<th>Temporary Stay</th>
<th>Permanent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Free Crisis Care – covers reablement and time to think beds</td>
<td>Short term residential respite care (up to 8 weeks at any one time) with a clear start and end date. This is defined as - giving a service user a break from the home circumstances and also to enable a carer to have a break from the caring role. The service user has a non residential package of care and has a non residential financial assessment.</td>
<td>Short term residential respite care (up to 8 weeks at any one time) with a clear start and end date. This is defined as - giving a service user a break from the home circumstances and also to enable a carer to have a break from the caring role. The service user receives no other chargeable services and does not have a non-residential financial assessment.</td>
<td>Trial period, there are two types; 1) trial period in a residential unit to see if permanent residential care is appropriate for service user and 2) trial period to see if they like particular home. Service user wishes to have a trial placement to decide if staying in residential care is right for them. If this placement is after a period of reablement then this should be recorded as a permanent long stay provision.</td>
<td>Stay in care is temporary with no planned end date. For example carer breakdown, awaiting for new non res arrangements to be put in place or safeguarding, protecting the service user.</td>
<td>Practitioner and service user agree permanent residential care is needed. Service user cannot or does not want to return home to the community.</td>
</tr>
<tr>
<td>Type of Provision selected</td>
<td>Free Crisis Care</td>
<td>cPB Respite (choose programmed respite if LD user with programmed respite)</td>
<td>Non-cPB respite (choose programmed respite if LD user with programmed respite)</td>
<td>Long Stay</td>
<td>Temporary Stay</td>
<td>Long Stay</td>
</tr>
<tr>
<td>Process and Charging Information</td>
<td>Provision is to be added as appropriate</td>
<td>The start and end date must be entered at the time the provision is put on AIS. Cost of service is included in the cPB and smoothed over 52 weeks. If service user stays over 8 weeks, this provision to be ended and a new Temporary stay provision to be set up from the 9th week.</td>
<td>The start and end date must be entered at the time the provision is input on AIS. Where no other chargeable services are received CRAG will be used to determine how much the service user contributes towards their care. Billed for each individual stay under CRAG. If service user stays over 8 weeks, this provision to be ended and a new Temporary stay provision to be set up from the 9th week.</td>
<td>Usually 28 days but actual length of trial agreed with Practitioner. Provision to be ended only when service user goes home. New provision should be recorded from date service user is permanent or date that non residential care package begins. Trial placement is billed under CRAG.</td>
<td>CRAG allows temporary stays up to 52 weeks or longer in exceptional circumstances. Billed for each individual stay under CRAG.</td>
<td>Billed monthly under CRAG.</td>
</tr>
<tr>
<td>Charging</td>
<td>Non-Chargeable</td>
<td>Non-Res financial assessment as a reasonable amount</td>
<td>Residential Charging Financial Assessment – CRAG</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Need for residential respite care (meeting the definition - 'What is Respite?') is identified and agreed with the service user:

What is Respite? – HCC Definition

1) Gives the service user a break from their home circumstances; And / or
2) Enables a carer to have a break from the caring role

Practitioner records the requirement for residential respite on the Support Plan.

Is the required service short term respite – i.e., up to 8 weeks (for one period)?

Yes

Is the service to be programmed residential respite care? (mainly LD service users)

Yes

Follow specialist process

Programmed Respite: Care provision and recording

Other types of residential placements, or longer term respite placements should be recorded as 'temporary' or 'permanent' residential care as appropriate – NOT respite

No

Residential respite must be recorded on the Support Plan Summary.

Does the service user have other non-residential chargeable services?

Yes

Residential respite must be recorded on the Support Plan Summary.

No

Record the provision: Select the 'cPB Respite' care item. For service users who have a carer, tick the 'carer box'.

Does the service user already have a Financial Assessment for non-residential care?

Yes

Follow Panel process for authorisation of the respite service provision

The 'cPB Respite' provision will be included in the panel form.

No

Refer to the FAB team for a Financial Assessment

Record the provision; Select the 'Temporary' care item. For service users who have a carer, tick the 'carer box'.

Does the service user already have a current Financial Assessment under CRAG?

Important Information:

For Respite alongside other non-residential, chargeable services, any cost for residential respite will be included in the cPB, which will be used to calculate the service user’s contribution as normal. Any cost for residential respite will be spread over the following 52 weeks as with all chargeable NRC services.

For Respite provisions where there are no other services in place (Respite only), the service user’s contribution is assessed under CRAG. The charge will be paid at the time of the respite, will NOT be spread over 52 weeks

Service User takes Respite period with Provider

The In-House provider sends a weekly return to the Financial Assessments Group of all admissions and discharges.

Financial Assessments Group review the weekly returns for non cPB provisions.

Is there a matching, authorised Swift Provision?

Adult Services Business Management Information Team: Is Swift recording up to date and correct when matched against the weekly returns?

Yes

The In-House provider raises an invoice for the service user's charge under CRAG.

Service User is invoiced as appropriate for their residential respite care.

No

Adult Services Revenue Team check - Has the 'cPB Respite' care item been used to record the provision?

‘Temporary’ residential care item: Revenue Team raise an invoice for the service user’s charge under CRAG.

No

Adult Services Revenue Team: Business Management Information Team: Contact the allocated Practitioner or Responsible team to request a provision is added/amended as required.

Yes

‘Temporary’ residential care item: Revenue Team DO NOT raise an invoice or charge the service user separately – they are covered within the cost of the cPB.

Adul Services Revenue Team check: Has the 'cPB Respite' care item been used to record the provision?

Yes

The provider send an invoice to Adult Services Revenue Team.

Is there a matching, authorised Swift Provision?

Adult Services Revenue Team check the client Swift record for provisions.

Book the placement dates with the provider. Inform the provider that this is a Respite placement. The provider does not need to collect a charge.

No

Book the placement dates with the In-House provider. Inform the provider whether this is a 'cPB Respite' placement or a 'Temporary' stay

Does the respite being provided by an external provider?

Yes

Record the provision; Select the 'Temporary' care item. For service users who have a carer, tick the 'carer box'.

No

Adult Services Revenue Team:

Revenue Team DO NOT raise an invoice or charge the service user separately – they are covered within the cost of the cPB.
**Programmed Respite: Care provision and recording – Business Process**

**Need for programmed residential respite care identified and agreed with the service user (mainly LTD):**
- The service meets the definition “What is Respite?”
- Care can be used flexibly by the service user through the year

**What is Respite? – HCC Definition**
1) Gives the service user a break from their home circumstances;
2) Enables a carer to have a break from the caring role

**Residential Respite:**
- NB: Programmed respite is usually agreed around the end of one financial year, for the following financial year

**Residential respite must be recorded on the Support Plan Summary.**

**Record the provision:**
- Select the ‘cPB Respite’ care item.
- Record one period of respite, for the total number of days respite agreed, with an end date 52 weeks after the respite service was agreed.
- For service users who have a carer, tick the ‘carer box’

**The ‘cPB Respite’ provision will be included in the cPB form.**

**Re-calculate the cPB – as at the start date the service was agreed for (often the first day of the financial year, eg. 9/4/12).**

**Important Information:**
- For Respite alongside other non-residential, chargeable services, any cost for residential respite will be included in the cPB, which will be used to calculate the service user’s contribution as normal. Any cost for residential respite will be spread over the following 52 weeks as with all chargeable NRC services.
- For Respite provisions where there are no other services in place (Respite only), the service user’s contribution is assessed under CRAG. The charge will be paid at the time of service at an agreed rate, any cost for residential respite will be spread over the following 52 weeks as with all chargeable NRC services.

**Residential respite must be recorded on the Support Plan Summary.**

**Financial Assessment for non-residential care:**
- Does the service user already have a Financial Assessment for non-residential care?
- Follow Panel process for authorisation of the non-residential care provision.

**Important Information:**
- If there is any instance where the Service User cannot take their planned respite care, an alternative equivalent should be offered.
- This can happen up to four times in a year
- If Service Users do not take the full amount of programmed respite care allocated, there will be no adjustment, and therefore they could be contributing towards services they did not receive

**Service user and Practitioner agree specific dates to be booked with the provider:**
- Inform the provider that this is a Respite placement
- The provider does not need to collect a charge

**Use online day counter and date calculator tool to determine when the end of 52 weeks is:**
- http://intranet.hants.gov.uk/ctdept/treasurers-doitonline.htm

**Record the provision:**
- Select the ‘Temporary’ care item.
- For service users who have a carer, tick the ‘carer box’

**Temporary’ residential care item**
- Does the service user already have a current Financial Assessment under CRAG?

**Important Information:**
- No invoice will be generated.
- Follow Panel process for authorisation of the respite service provision.

**Service User takes Respite period with provider.**

**Important Information:**
- Service user and Practitioner agree specific dates to be booked with the provider
- Inform the provider that this is a ’Respite placement’ or a ’Temporary’ stay
- The provider sends an invoice to the In-House provider
- The In-House provider send a weekly return to the Financial Assessments Group of all admissions and discharges.

**Financial Assessments Group review the weekly returns for non cPB provisions.**

**Business Management Information Team:**
- Contact the allocated Practitioner or Responsible team to request a provision is up to date and correct when matched against the weekly returns?

**Revenue Team do NOT raise an invoice or charge the service user separately – they are already being charged through the cPB.**

**Service User is invoiced as appropriate for their residential respite care.**

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**Procedure 01/12**

**Adult Services Contributions Policy**

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