Adult Social Care and Health Directorate

Residential and Nursing Care Home Placement Guidance

Status:	Final
Version No:	15 (see version control below)
Re Issued	02 January 2024
Review Date	January 2026
Review by:	Jean Wells: Policy and Quality Assurance Officer
Owner	Assistant Director– Strategic Safeguarding, Policy, Practice & Quality Assurance
Lead Officer/s:	Jean Wells
Master Location	Strategic Safeguarding, Policy, Practice and Quality Team
Publication	Tri-x - the home of Adult Social Care policies, procedures, and practice guidance. https://www.proceduresonline.com/kent/adults/local_resources.
Authorised to vary	Jean Wells, Sharon Buckingham, Chloe Williams, Sarah Denson.
Replaces	Residential and Nursing Care Home Placement Guidance (Interim) Older People.

Governance

Version	Date	Sign off
15	19/12/2024	Senior Management Team

Version control

No.	Date	Summary of key changes/updates	Review by
15	02/01/24	Arrange Support Redesign – Go live 11 September 2023. The Residential and Nursing Care Home Placement Guidance is now applicable for **all people we support** in Kent or placements outside Kent, **unless otherwise stated** (older people with long term conditions, people with a physical disability, people with mental health conditions; autistic person; people with a learning disability; people with sensory impairments). Following the **restructure of the Purchasing Team** on the 11 Sept 2023, the new "Placement Team" is responsible for residential placements. Previous reference to County Placement Team (CPT) replaced with "Placement Team." The new "Hospital Discharge Team" (part of the revised Purchasing Team) is responsible for direct referrals for residential placements from the Short Term Pathway, Early Discharge Planning, Homes not Hospitals and Kent Enablement at Home. Full details in the *Guidance for Arranging Support Team and Practitioners.* The KCC Authorisation and Placement" form has been replaced with *KCC Arranging Support – Residential and Nursing" form,* available for use in MOSAIC. The "KCC Arranging Support – Residential and Nursing" form will need to be completed for any person requiring residential and nursing placements. Following Purchasing Team restructure, processes update and available in Appendix 7 (A-E). **Searches**: 2.3.1, Appendix 2(5) and Appendix 3 (1.9) (1.10): amended : The individual will be provided with a minimum choice of 3 providers, all of which will be providers KCC has a contract with. Searches will be countywide unless "restricted searches" identified by the practitioner. When there is not an appropriate choice of providers KCC has a contract with, searches will include non-contracted providers. **Other changes:** **Section 1-"Practitioner responsibility"** now includes role when refusal of arrangements. Section 3: Disputes new paragraph 3.5 added. **Section 2.3.5:** amended. The Placement Team will not be required to undertake searches when a person has already decided on a specific home. The arrangements will be made when the provider has agreed the cost with KCC. If the specific home does not agree to KCC contract price or a higher individual provider contract price, as long as the specific care home is suitable to meet needs and available, the arrangements may be made by the Placement Team/ Hospital Discharge Team, subject to a Top Up agreement. **General guidance**: **4.1a Benefits** and Glossary 12 week property disregard have been amended to include the situation when, following the needs assessment, the person remains in the care home on an interim basis pending availability of the person's preferred chosen long term care home. From Friday 1 September 2023, the Accounts Receivable team (Cashiers and Sundry Debt) and Client Financial Services merged to become the "*Financial Assessment and Income Unit*". All references to Client Financial Services (CFS) replaced with "Financial Assessment and Income Unit" (FA&I). Reference to "*Accommodation Solutions* "replaced with *Adults Commissioning.* **Appendix** 1 **Level of Need** expanded to include summary of Service Category Guidance for a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments.	Jean Wells

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Scope

This guidance is for Adult Social Care practitioners and the Placement Team, when a residential or nursing care home placement (hereinafter referred to as "placement") has been identified through the care and support planning process as the way of meeting needs. This can arise from a hospital or the community when a person is unable to return home (either temporarily or permanently); a person has been self-funding and their money has depleted; or the person is a continuing healthcare improver.

The guidance is applicable for all people we support in Kent or placements outside Kent **unless otherwise stated** (older people with long term conditions, people with a physical disability, people with mental health conditions; autistic person; people with a learning disability; people with sensory impairments) that are either:

- Long term (i.e. care home)
- Long Term trial (i.e. in a care home for first 4 weeks)
- Short Term Bed
- Planned Respite
- Emergency Respite
- Assessment Bed
- Intermediate Care Treatment

Reference to person applies equally to the person's legal representative.

This guidance is to be read with the *Guidance for Arranging Support Team and Practitioners* and the Charging Policy and Procedures for a Residential and Nursing Care Home Placement on Tr-ix page.

The practitioner will retain responsibility throughout the placement process.

Section 1. Practitioner Responsibility

Fig 1

Action	Who	Note
Request a financial assessment	Practitioner	Request a financial assessment via Mosaic at the end of MADE Care Needs Eligibility[1]
Check /verify	Practitioner	Check/verify if a Lasting Power of Attorney or Deputyship is in existence and advise the Placement Team and update the System accordingly.
Determine which level of need	Practitioner	Referring to Appendix 1 and type of placement required to meet eligible unmet needs and personal outcomes, using information factored into the MADE Care Need Assessment, KCC Residential Care Needs Assessment (as appropriate) and the MADE Care and Support Plan.
Manage reasonable	Practitioner	For the person with complex needs, take the initiative in conversations with the person/relatives to manage

[1] There may be a need to request a financial assessment at other times. Therefore, practitioners can also request the financial assessment from the Emergency Request and/ or the Significant Information on an Open Case (SIOC) available from the start menu on Mosaic.

expectations- complex needs		reasonable expectations about 'search' areas (including placements outside Kent when applicable) - availability in the market, travel considerations and/or proximity to family members, top ups if applicable.
Decide if a "**restricted search**" location needed necessary to the person's health and wellbeing: a move nearer to family is vital for social contact and emotional support. This may include placements outside Kent	Placement Team for older people with long term conditions Practitioner for person with a physical disability, a mental health condition; autistic person, a learning disability or person with sensory impairments.	**When a restricted search not required**, the practitioner for older people with long term conditions will defer the detailed discussion about which placement preferences/location, to the Placement Team – with the assurance that the Placement Team, using the basis of the person's needs assessment, KCC Residential Care Needs Assessment and Care and Support Plan, have the expertise and knowledge regarding placement availability and accessibility. For a person with a physical disability, mental health condition, autistic person, a learning disability or a person with sensory impairments, the practitioner will liaise with the person and family/representative directly to identify suitable KCC contracted placements to meet needs.
Ensure a standard **DoLS authorisation** in place prior to the placement	Practitioner	The countywide Deprivation of Liberty Safeguards (DoLS) Service manages the statutory assessment process for a care home or a nursing home. Full details in Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Policy and Practice Guidance available on Tri-x.
Principles of the amount that KCC usually expects to pay	Practitioner	Explain the principles of the amount that KCC usually expects to pay to meet the relevant level of need within Kent and placing outside Kent- what this means.
Additional costs or **'top-up' payments** (as appropriate)	Practitioner	Explain the principles of additional costs or 'top-up' payments (as appropriate)-understanding the full implications of choice -a person has a right to choose between different providers of the same type of placement and locations (subject to Care Act conditions).
Seeking authorisation for the placement	Practitioner	As a minimum, along with the Practice Assurance Form, submit the MADE Care Needs Assessment (and Individual Needs Portrayal Assessment (INP) if used), the Care Needs Eligibility Criteria, the Care Needs Matrix (to identify support hours for a person with a physical disability, mental health conditions, autistic person, a learning disability or with sensory impairments), the MADE Care and Support Plan and the copied of the signed and dated Charging Letter - Residential (new people and placements only) and send all to Practice Assurance Panel (PAP) for residential placement authorisation (Practice Assurance form within

		the MADE Draft Care and Support on MOSAIC)
Authorisation for the placement **received**	Practitioner	Once authorisation received from PAP, complete the "*KCC Arranging Support – Residential and Nursing"* form "available for use in MOSAIC (replaces "Authorisation and Placement form), which must include the name, address, contact details of the financial agent, **together** with the relevant Made Care Needs Assessment (completed no m/ore than six months before request), the MADE Care and Support Plan, Care Needs Eligibility, Matrix (to identify support hours for a person with a learning disability, physical disability or mental health condition) and the PAP authorisation form, send to the Placement Team unless the request is for a placement out of hospital in which case the form should be sent to the Hospital Placement Team. A reminder of documents required for residential placements can be found in A*ppendix 7 (E)*
Providing information to the person/ representative/ agent	Practitioner	See section 1.1 (Fig 2) below for details
Placement process -. specific responsibilities for the practitioner .	Practitioner	See section 1.2 (Fig 3) below for details
Disputes	Practitioner	Refusal of arrangements. The practitioner to work with the Placement Team and Community Senior Practitioner (or Team Manager for Short Term Pathways) and to determine what the approach will be and who best to be involved. **Further details in Section 3 Disputes**

1.1 Providing Information.

The practitioner is responsible for providing and explaining the following information to the person.

Fig 2

Action	Who	Note
The "Charging Letter - Residential	Practitioner	Ensuring signature and dated. Note the charging letter **supplements** the practitioners' conversations about charging. The signed letter is a record of understanding the person has been told about care and support charges pertaining to their circumstance.
Charging for Residential Care Booklet" (Red book)	Practitioner	www.kent.gov.uk Click here
Deferred Payment	Practitioner	Provide -available on kent.gov.uk Click here

factsheet		
"Your guide to funding yourself in residential and nursing care	Practitioner	Updated every April. Issue when person paying the full cost of their care, www.kent.gov.uk Click here
Financial Assessment Estimator Tool	Practitioner	Depending on the circumstances, inform the person of the **ASC Financial Assessment Estimator Tool on Kent.gov** and how it can be accessed on the link. Estimate how much you may need to pay - Kent County Council
CQC	Practitioner	Provide information on and how services are regulated. http://www.cqc.org.uk

1.2 Placement Process.

The practitioner will have the following specific responsibilities.

Fig 3

Action	Who	Note
Suspend or end	Practitioner	Inform the Placements team to suspend or end any previous placement provision on the System.
Cancel	Practitioner	Cancel the care in the person's home on date of admission to the placement, giving notice as needed in line with contractual obligations.
Transport	Practitioner	Arrange transportation (if family/relatives cannot do it) for the person to the placement in line with the Transport Policy. Relatives expected to be responsible for the transport of any personal belongings.
Undertake the Protection of Property function if necessary	Practitioner	For an older person with long term or a person with mental health condition, liaise with Operational Support Services. Full details in the Protection of Property(including care of pets) Policy and Practice Guidance on Tri-x.
Arrange a light touch review within 8 weeks	Practitioner	Arrange a light touch review within 8 weeks of the commencement of the placement (4 weeks for Short Term Pathway beds) and annually thereafter (sooner as needed). Full details in the Care and Support Plan Review Practice Guidance on Tri-x. Update System with placement review date.
Finalised the MADE Care and Support Plan	Practitioner	Finalised the MADE Care and Support Plan with the actual personal budget amount.
Changes in circumstances	Practitioner	Inform the Placement Team, at the earliest opportunity, of any changes in circumstances that impact on the residential placement

		arrangements, so they can take any necessary actions. Update the System accordingly.
Termination Notice	Practitioner	If, during a review, a proportionate re-assessment of needs and revision of the care and support plan, it is determined that a person's needs can no longer be met in their current placement and it is necessary to move them to a new one, the practitioner must: - Follow the placement process. - Inform Placement Team when notice to be given to the placement. - Prepare an Individual Placement Termination Notice letter. This should be included within the paperwork prepared for the Practice Assurance Process for residential placement authorisation. Once authorisation received, upload the Termination of Notice letter to the Placement Team together with the relevant documentation
When the person dies	Practitioner	Enter the date of death on System and inform Placement Team using End Reason form on Mosaic.
Former Self funder	Practitioner	See Appendix 6 for procedure to follow when a former self funder resident asks KCC for financial assistance; the Placement Team process to contact the placement as soon as possible after the self-funder approaches KCC; to begin negotiations over interim pricing. See glossary if the person to remain in the placement (*detrimental to move*)
Ensure that all original documents and any correspondence received from the Placement Team/Hospital Discharge Team are uploaded to the System		

Section 2. Placement Team Responsibility

2.1 The Placement Team/Hospital Discharge Team is responsible for the following.

- For older people with long term conditions, the whole placement selection process including discussing with relatives to find a suitable placement
- For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the placement team with provide the practitioner with a short list of placements. The practitioner will work with the person and family to find a suitable placement.
- The central collation of information regarding the purchasing process. If the person has complex needs, the practitioner will be responsible for the discussions with the person/representative/relatives, For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner will **also** be

responsible to discuss with the providers
- For older people with long term conditions, the Placement Team will take the initiative in conversations with the person/representative/relatives to manage reasonable expectations about 'search' areas (including placements outside Kent when applicable) - availability in the market, travel considerations and/or proximity to family members, top ups if applicable. **Note, if the person has complex needs, the practitioner will be responsible for taking the initiative in the conversations**.
- Following the KCC residential and nursing contract. Adult Social care Commissioning Team contacts here
- Copying the practitioner in all email correspondence.

2.2 On receipt of the placement request, the Placement Team/ Hospital Discharge Team will:

Action	Note
Check	Check KCC Arranging Support – Residential and Nursing" form, and other documentation is fully completed (and no duplicate request received), liaising with the practitioner for more details as needed. For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, also check the "Care Needs Matrix"
Contact	For older people, contact the person/family/representative to introduce themselves. For older people with long term conditions, the Placement Team initiate conversations with the person/ relatives/ representative to manage reasonable expectations about 'search' areas. For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner will initiate conversations
Check	For older people with long term conditions, check that the person/family/representative is aware of financial implications and received charging letter/booklets from the practitioner. For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner is responsible.
Create	Create electronic case notes folder in mailbox and Placement Team Share Point drive.
Searches	For older people with long term conditions, Undertake the searches for all potential providers using the https://www.carechoices.co.uk/ or for placements outside Kent, google search to locate potential providers in the preferred other local authority area if applicable. For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner will undertake the searches on receipt of the "Short List" from the Placement Team
Transport	Once placement is agreed, the Placement Team to check with the family if they can transport the person to the placement (relatives will be expected to transport personal belongings). If transport or other help is needed on the day of the move, inform the practitioner who will make the necessary arrangements.

Inform	For older people with long term conditions, the Placement Team will inform the placement at 8 weeks if the person is going to be self-funding after the 12 weeks property disregard period, so the placement can discuss further funding with the person/family/ representative (also see Appendix 6- former self funder protocol). For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner will inform the placement.

2.3 The searches.

2.3.1 For older people with long term conditions, the Placement Team will provide individuals with a minimum choice of 3 providers, all of which will be providers KCC has a contract with.

For a person with a physical disability, mental health conditions, autistic person, a learning disability or with sensory impairments, the practitioner will provide individuals with a minimum choice of 3 providers, all of which will be providers KCC has a contract with. Searches will be countywide unless "restricted searches" identified by the practitioner as appropriate.

If no appropriate choice of contracted providers available, searches will include non-contracted providers.

2.3.2 For older people with long term conditions, for placements outside Kent, the starting point would be to agree the price at no more than the **host rate**, then negotiate with the placement/s determine the actual cost to meet needs**.** In exceptional circumstances, the contract with the placement could be agreed at a higher price.

For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner will do this, not the Placement Team.

2.3.3 For older with long term conditions, the Placement Team will advise the person/family/representative of **options** available and confirm **preferences** (considering personal outcomes, necessary Top Ups, travel considerations and/or proximity to family members). Inform the practitioner. A written record must be kept of any preferences that the person/family/ representative have or expressed and the decisions that were taken regarding the placement.
For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner will do this, not the Placement Team.

2.3.4 If all the identified providers are **deemed unsuitable** by the person/family /representative, the Placement Team/Hospital Discharge Team will discuss the individual circumstances with the Community Senior Practitioner (or Team manager for Short Term Pathways and keep the practitioner updated.

For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the Placement Team will also discuss with commissioning to assist with finding an appropriate placement. **See Disputes: section 3 below for further details.**

2.3.5 In some circumstances, the person may have already decided on a specific home that they wish to live in before searches are undertaken. The Placement Team/ Hospital Discharge Team will contact the provider to agree to KCC contract price unless the level of need requires a higher individual provider contract price. In this circumstance, the Placement Team will not be required to undertake further searches.

If the specific home does not agree to KCC contract price or a higher individual provider contract price, as long as the specific care home is suitable to meet needs and available, the arrangements for care and support will be made by the Placement Team/Hospital Discharge Team, subject to a Top Up agreement based upon the difference between the chosen home and the lowest cost, suitable alternative care home to meet needs.

2.3.6 The Placement Team/Hospital Discharge Team will liaise with the person/family/representative and provider to **confirm price and availability**, agree admission date (for older people with long term conditions) and then enter all relevant instructions and prices into System to trigger the Purchase Order via Mosaic. Inform the practitioner.

For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner will determine the admission date with the provider, the person and family, informing the Placement Team of the date.

2.3.7 The Placement Team/ Hospital Discharge Team will be responsible for coordinating the completion, return (signed) and dissemination of the Third-Party Top Up letter/agreement and the Third-Party Top Up (if relevant to the person we support.

2.3.8 Together with a copy of the Award Letter for older people contracts, signed and dated “Charging Letter -Residential”, Third Party Top Up form and waiver form (if appropriate), the Placement team will send all to the Finance Assessment and Income Unit (FA&I). At this stage, FA&I will be responsible to co-ordinate the 12- week property disregard and the Deferred Payment Agreement (if eligible).

2.4 Termination Notice

If the person is already in the placement, it is necessary to give notice of KCC intentions. For older people with long term conditions, the Placement Team will liaise with the current provider and send the Termination of Notice letter included within the placement request paperwork when undertaking searches for a new provider.

For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner will be

responsible to liaise with the current provider and send the Termination of Notice letter.

2.5 Former Self Funder

See Appendix 6 for procedure to follow when a former self funder resident asks KCC for financial assistance and process for Placement Team to contact the care home as soon as possible after self-funder approaches KCC, to begin negotiations over interim pricing.

2.6 Person remaining in the placement - detrimental to move.

Following the decision by the practitioner/authoriser it is detrimental to move a former self funder (or when a third-party top arrangement ends), the Placement Team will send an Award Letter (for older people with long term conditions) to the provider, confirming the person will be remaining and when KCC will start funding.

For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner will confirm with the provider the person will be remaining and when KCC will start funding.

3 Disputes for Older People Placements

3.1 If all the identified providers are deemed unsuitable by the person/family /representative, the Placement Team/Hospital Discharge Team will discuss the issues with the Community Senior Practitioner (or Team Manager for Short Term Pathways) and keep the practitioner updated. The senior practitioner (or Team Manager for Short Term Pathways) will advise the Placement Team/ Hospital Discharge Team on what the approach should be; who is best to be involved, and the scope.

3.2 The Placement Team/Hospital Discharge Team will go back to the person/ family/representative and if they are not willing to accept what is offered, the Placement Team/Hospital Discharge Team will escalate to the Community Team Manager (or Service Manager for Short Term Pathways) (cc senior practitioner or Team Manager for Short Term Pathways).

3.3 If the dispute relates to cost, the issues will be referred back to the Community Senior Practitioner (or Team Manager for Short Term Pathways) and that team will take lead responsibility for agreeing a way forward.

3.4 If the person/family/representative reluctance is based on quality, the community senior practitioner (or Team Manager for Short Term Pathways) will refer to Commissioning (or raise a Safeguard as appropriate) to check what the facts are.

3.5 Where a person unreasonably refuses the arrangements, KCC is entitled to consider that is has fulfilled its statutory duty to meet needs and may then inform the person in writing that as a result they need to make their own arrangements. This should be a step of last resort and the Community Team

Manager (or Service Manager for Short Term Pathways) must consider the risks posed by such an approach, for both KCC and the person concerned. Should the person contact KCC again at a later date, the practitioner should reassess the needs as necessary and re-open the care and support planning process.

3.6 The practitioner will be responsible to follow up on any charitable support which might be available to support a Third-Party Top Up e.g. SSAFA (Armed Forces charity) https://www.ssafa.org.uk/about-us

4. General guidance

4.1a **Benefits** Once a person becomes a permanent resident in a care home (when first moves to the care home even if a trial period, or following the needs assessment, the person remains in the care home on an interim basis pending availability of the person's preferred chosen long term care home,) their Housing Benefit or Mortgage Interest payments will stop unless the Department for Work and Pensions and District Council are told that they are in a "trial" period – i.e. they are trying out the particular home with a view to permanent admission. In these circumstances, the Housing Benefit or Mortgage Interest payments can continue for up to 13 weeks. The person/family/representative is responsible to notify the Department for Work and Pensions and District Council any changes in personal circumstances.

4.1b If this is not possible then, for Housing Benefit only, it should be possible for a permanent resident to continue getting Housing Benefit for up to 4 weeks after they have become permanent if they are still liable for the rent during the notice period and this could not reasonably have been avoided. Benefit Officers will be able to provide further advice if necessary.

4.2 **Capital over £23,250 (upper capital limit):** KCC is not required under the Care Act to meet eligible needs where needs are to be met in a care home.

If the person lacks mental capacity and there is no one authorised under the Mental Capacity Act 2005 or otherwise in a position to do so on their behalf to make the arrangements in a care home, as directed by the practitioner, the Operational Support Service will refer the person to a local solicitor who can apply to the Court of Protection to be their Deputy and manage their property and financial affairs. Until the appointment of a Deputy, KCC will temporarily fully fund care and support in a care home or a nursing home – this is called *Non-Discretionary Funding.*

Separate guidance: "Non-discretionary funding (temporary basis) self - under lacking capacity" available on Tri-x. The person will be charged the full cost of their care and support until a Deputy is appointed. There may be exceptional circumstances when a referral to a solicitor is not appropriate.

When a referral to a solicitor is not appropriate in this circumstance, KCC has a duty to meet eligible needs; provide a care and support plan; place the person;

contract directly with the care home; charge the person the full cost and undertake Care Act statutory reviews.

4.2 **Choice**: A person has a right to choose between different providers of the same type of care home and locations in accordance with The Care and Support and After-care (Choice of Accommodation) Regulations 2014 (subject to conditions listed in 4.2.1 below). More details in Section C in the Charging Policy for Residential and Nursing Care Home Placement, Appendix 2, and 3 about practitioner's professional judgement, practice around choice and the role of the Placement Team/Hospital Discharge Team in shortlisted placements.

4.2.1 **Care Act conditions, right to choose**: Where KCC is responsible for meeting a person's care and support needs and their needs have been assessed as requiring care home accommodation in order to ensure that they are met, the person must have the right to choose between different providers of that type of accommodation provided that:

- The accommodation is suitable in relation to the person's assessed needs.
- To do so would not cost KCC more than the amount specified in the person's personal budget for accommodation of that type.
- Accommodation is available.
- The provider of the accommodation is willing to enter into a contract with KCC to provide the care at the rate identified in the person's personal budget on KCC terms and conditions.

This choice **must not be limited** to those settings or individual providers with which KCC already contracts with or operates, or those that are within KCC geographical boundary. It must be a genuine choice across the appropriate provision to meet needs, including the move to another local authority area when the needs assessment and care and support planning process has determined that, to meet an eligible need, it is a necessary placement.

4.3 **Data Protection.** Documents and information need to be protected in a way that is proportionate to their sensitivity and to the impact on individuals and organisations in the event of inadvertent or malicious disclosure.

The sharing of information must be in line with the General Data Protection Regulation and the legal bases identified in the directorate's *General notice to cover adult social care and health* For further advice, the Adult Social Care Information governance lead is Lauren.Liddell-Young@kent.gov.uk or refer to KNet Information Governance SharePoint page

4.4 **Information:** A person must be provided with information about making a genuine informed choice of placement/top ups, funding themselves, charging for their residential placement, their financial contribution and how this is worked out, if they own a property and what this means (12 weeks property disregard, Deferred Payment Agreement), personal budget and direct payments.

5. Glossary - in alphabetical order

Assessment Bed. Non-chargeable for up to 6 weeks. Used to assess (or review) a person over a time-defined period to ensure the best outcome for that person can be met in the short and/or longer term.

If the bed is required for longer than the initial 6 weeks for non-health-related reasons, an alternative placement must be sourced, and person discharged to the alternative placement. The alternative non assessment bed placement will be a chargeable service under the normal residential charging process.

Appropriate management authorisation is required for any placement that exceeds 6 weeks.

"Charging Letter Residential" Issued by practitioner to person considering residential care, (reading and providing opportunity to seek clarification) regardless of whether it is believed they will be self-funders or not. Signed and dated by person/representative to confirm letter received and understood.

Charging policy and procedures for a residential and nursing care home placement. Contains essential information on the legislation, guidance and procedures related to Kent County Council's responsibilities for people entering residential care and nursing homes.

Continuing healthcare improvers. A person with complex ongoing healthcare needs (a primary health need), receiving free care package in a care home under NHS continuing healthcare (i.e. NHS paying the full fees for the accommodation, board, and care), but needs have changed: no longer eligible for NHS continuing healthcare. These needs may be eligible for social care support.

Deferred Payment Agreement. Designed to prevent people from being forced to sell their home in their lifetime to meet the cost of their care. It enables a person to defer or delay paying some or all the cost of their care until a later date. Local authorities must offer them to people who meet certain criteria and who are able to provide adequate security for the debt.

Direct payments. Cash payments (usually via the Kent Card), to a person who requests to receive one to meet some or all their eligible social care needs (conditions apply). The direct payment amount is less any contribution that the person is required to make, following a financial assessment. NOTE: When a person is receiving a management service from KCC in addition to a direct payment, the direct payment is gross.

Direct Payments cannot be used to pay for long-term residential care but can be used to purchase short-term residential stays if the stay does not exceed a period of four consecutive weeks in any 12-month period. More details in the Direct Payment Practice Guidance on Tri-x.

Detrimental to Move. This applies when the practitioner has undertaken a risk assessment, carefully considered individual circumstances; concluded the move is detrimental to a person's wellbeing and obtained authorisation from the Practice Assurance Panel.

Purchase Order. Used to inform providers of the start date and, if applicable, end date of the placement; when a payment will be made; where to send future invoices and the dates for those invoices to be submitted.

Finance Referral form. Commonly called "FAR," completed by the practitioner and sent to the Financial Assessment and Income Unit (via Mosaic) to undertake the financial assessment to determine what a person can afford to pay towards their care and support.

Financial Assessment Estimator Tool. Launched 29 March 2023 on Kent.gov and can be accessed on the link. Estimate how much you may need to pay - Kent County Council It will estimate for a person, their maximum ability to pay amount, based on accurate financial information inputted by the person (shares, savings, investments, pensions, any other income received, which benefits received, housing costs (including Council Tax, ground rent, mortgage or rent and service charges).

This tool does not replace a financial assessment undertake by the Financial Assessment and Income Unit.

Former self funder. A former self funder is someone who had arranged and paid for their care privately without involving a local authority and they become eligible for assistance from KCC (i.e. assessed eligible needs and now has capital assets below the upper capital limit).

"Full coster." A person who has over the upper capital limit (£23,250) or income higher than the cost of the home, but whose arrangements are still made by KCC, who then charges that person **the full cost** of the placement.

Funded Nursing Care (FNC). Weekly payment made by the NHS to cover nursing care provided by a Registered Nurse. FNC is only provided if a resident needs nursing care within a care home setting. The nursing care contribution is paid directly to the care home by the NHS (the resident does not receive any money directly).

Host. In this document, this refers to another local authority area when a placement is being arranged/considered outside Kent.

Long term placement. Chargeable. Any home that is registered with the Care Quality Commission to provide accommodation together with personal care and possibly nursing care.

Long term placement – trial period. Chargeable. 4 weeks to ensure placement is meeting personal outcomes following hospital discharge. The trial period is part of the 12-week property disregard (not in addition to). This trail period must be reviewed to ensure long-term placement arrangements are made. Any home is registered with the Care Quality Commission (CQC) to provide accommodation together with personal care and possibly nursing care.

Personal budget. This is a statement (recorded on the Care and Support Plan), that sets out the **actual** cost to KCC of meeting a person's care needs. It includes the amount that the person must pay towards that cost themselves (based on their financial

assessment), as well as any amount that KCC must pay. “Top Ups” payments do not form part of a personal budget.

“Case note.” Used for recording key events on the person’s Record System, this includes a summary of casework outcomes agreed in supervision. They should not contain information that can be found in other parts of the System**.**

Respite (Planned). Chargeable service provided to the cared for person to give a carer a break from caring (replacement care). Recorded on the person’s Care and Support/Support plan.

Respite (Emergency). Chargeable. Used for emergency placements e.g. because of carer breakdown or to offer a place of safety. The person should be told that an urgent placement is not an indicator of a longer-term residential provision.

Restricted Searches. Necessary to the person’s health and wellbeing to move nearer to family is vital for social contact and emotional support. This may include placements outside Kent.

Short Term Bed (Non-chargeable). A placement for a time limited period of assessment (up to 6 weeks) providing intensive personalised social care reablement intervention so a person is supported to attain a level of independence to enable a return home. Also see Appendix 7 (F) flowchart “*Discharge to Assess Transfer of Funding”.*

Short Term Bed (chargeable). When the bed is **not** used for assessment /enablement as described above.

Termination Notice Letter. A formal notification of KCC intention to terminate a current individual placement contract with a provider.

Top Up. A person has a right to choose affordable accommodation options between different providers and locations, including a more expensive setting than the amount specified in the personal budget for accommodation of that type.
When the person’s chosen option offers more than is required to meet needs, a third party or in certain circumstances the resident, must be willing and able to pay the additional cost (‘top-up’). **The top up payment does not form part of the personal budget**. A person must not be asked to pay a ‘top-up’ towards the cost of their accommodation because of market inadequacies. **Third Party Waiver will apply.**

Third Party Waiver form (TPTU waiver form). Used by the practitioner to request to **exceed the Usual Price.** Authorised by appropriate person in line with Authorisation of Funding Policy, when KCC could not identify a home at **usual price** to meet eligible needs or there are personal circumstances relating to the ability to pay a Top Up. KCC will arrange care in the more expensive accommodation and adjust the personal budget accordingly.

Third Party Top Up (TPTU) letter. Used when a third party on a person’s behalf is making an additional payment (or a ‘top-up’) to be able to secure the care and support of the person’s choice, where this costs more than Kent would pay for such a type of care. In these circumstances, the additional payment does not form part of the personal budget since the budget must reflect the costs to Kent of meeting the needs. Attached to this letter is a TPTU Agreement which must be completed and signed.

Third Party Top Up Financial Assessment Form. Used when the person agreeing the top up will be required to complete a light touch financial assessment to determine ability to pay the 'top-up' for the likely duration of the arrangement, recognising that this may be for some time into the future.

12-week property disregard. A local authority must disregard the value of a person's main or only home for 12 weeks in the following circumstances:

(a) when they first enter a care home as a permanent resident (or following the needs assessment, the person remains in the care home on an interim basis pending availability of the person's preferred chosen long term care home).

(b) when a property disregard other than the 12-week property disregard unexpectedly ends because the qualifying relative has died or moved into a care home

The first 12 weeks property disregard includes the 4-week trial period. This 12-week period aims to give the person time to decide how best to pay for their care and whether or not to sell their home.

Note: When a self-funder (with eligible care needs) already living in a care home permanently, whose wealth depletes, for example, nine weeks after they moved in permanently, they will have their former home disregarded for 3 weeks (i.e. 12 pd -9 weeks already in the home = 3-week property disregard).

Full details in section D3 in Charging Policy for Residential and Nursing Care Home placements and separate new 12-week Disregard Factsheet on Tri-x

Usual Price. The amount KCC usually expects to pay to meet the relevant level of need in Residential or Nursing Care within Kent. It is determined by assessing the costs of care and reviewed on a regular basis by KCC Adults Commissioners. Commissioners refer to this as "Guide Price."

For placements outside Kent, the price is based on the cost of care that is suitable and available in that area (**"Host"**), not "usual price" for placements in Kent.

Appendix 1

LEVELS OF NEED

For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments.

The Care Needs Matrix determines the level of need. The "*Service Category Guidance"* provided by KCC commissioning, are summarised below.

Mid

- Staffing ratio1:6.
- Ordinary house environment usually no specialist equipment needed.
- Assistive technology.
- Supports individuals who have either or a co-morbidity of a learning, physical disability and/or mental health needs and have been assessed as requiring some supervision/guidance/support such as verbal prompting & guidance to carry out/develop skills for independence/daily living tasks.
- The individual may have intermittent support from health professionals or co-funding.
- All staff can support a range of communication methods.
- Can accommodate required level of personalised Care/Support hours, per week, to meet the needs of the individual as required by their assessment of need.
- Provides night support with sleep in staff or with assistive technology.

High

- Staffing ratio1:6.
- May have some minor adaptions to support accessibility.
- Assistive technology.
- May have a Multi-Sensory Environment.
- Supports individuals who may have, co-morbidity of learning/physical/mental health care needs and require support such as verbal prompting & guidance to carry out/develop skills to for independence/daily living tasks. They may also present behaviours of concern and require a slightly higher level of supervision than offered in a mid level home to ensure their safety.
- The individual may have intermittent support from health professionals or co-funding.
- All staff can support a range of communication methods.
- Can accommodate required level of personalised Care and Support hours, per week, to meet the needs of the individual as required by their assessment of need.
- Provides night support with either waking or sleep-in staff, supported by assistive technology.

Specialist

- Staffing ratio1:2.
- Adapted accessible environment supported with specialist equipment (for example ceiling track hoists, wet rooms/height adjusting baths.
- Assistive technology.
- Multi-Sensory Environment

- Specialist Therapy areas.
- Supports individuals who may have, co-morbidity of learning/ physical/ mental health care needs. Individuals may require physical support or a level of nursing care and/or guidance to carry out/develop skills to for independence/daily living tasks. They will present high risks behaviours. They will require a high level of supervision to ensure their safety. This may include individuals who are subject to statutory orders or may require some level of nursing care.
- The individual may have intermittent support from health professionals or co-funding.
- Provider co-ordinates input of multiple agencies in respect of positive risk management. A Clinical Risk Management system will be used to monitor relapse indicators.
- Registered Nurse or Masters level registered manager. Supervision of staff incorporates a clinical approach. All staff can support a range of communication methods. There will be a lead member of staff who will support staff in developing communication tools for Individuals.
- Can facilitate high levels of personalised Care/Support hours to meet the needs of the individual as required by their assessment of need.
- Provides night support with waking staff, supported by assistive technology. Supervision of waking/sleep-in night staff may include a clinical approach with a focus on risk management.

Specialist Plus

- Staffing ratio1:2.
- Adapted accessible environment supported with specialist equipment (for example ceiling track hoists, wet rooms/height adjusting baths.
- Assistive technology.
- Multi-Sensory Environment.
- Specialist Therapy areas.
- Supports individuals who may have, co-morbidity of learning/physical/mental health care needs. Individuals will require physical support or a level of nursing care and/or guidance to carry out/develop skills to for independence/ daily living tasks. They will present high risks behaviours. They will require a high level of supervision to ensure their safety. This will include individuals who are subject to statutory orders or require some level of nursing care. Specialist High is generally time limited as this level of care is required during periods of acute intensive care due to periods of ill health or instability. It is expected that the service will provide appropriate support to ensure that individuals will move to more appropriate, less restrictive service provision levels of care & support once a period of stability has been maintained.
- The individual may have intermittent support from health professionals or co-funding.
- Provider co-ordinates input of multiple agencies in respect of positive risk management. A Clinical Risk Management system will be used to monitor relapse indicators.
- Registered Nurse or Masters level registered manager. Supervision of staff incorporates a clinical approach.
- All staff can support a range of communication methods. There will be a lead member of staff who will support staff in developing communication tools for Individuals.

- Can facilitate high levels of personalised Care and Support hours to meet the needs of the individual as required by their assessment of need.
- Provides night support with waking staff, supported by assistive technology. Supervision of waking/sleep-in night staff may include a clinical approach with a focus on risk management.

For older people with long term conditions.

People will be assessed by a practitioner using the Levels of Need table. The summaries below indicate the typical characteristics attributable to an individual with Residential needs, Residential High needs, Nursing needs or Nursing High needs. This does not attempt to be an exhaustive list but a guide to the typical needs of each category of dependency.

Residential:
- requires care and support over a 24-hour period, including observation/supervision to maintain safety.
- low to medium level of assessed care needs.
- requires assistance with some activities of daily living to maintain skills and independence.
- requires input by carers on a daily basis.
- nursing care provided by community services

Residential High:
- requires care and support over a 24-hour period, including observation/supervision to maintain safety.
- high level of assessed care needs.
- requires assistance with most activities of daily living to maintain skills and independence.
- requires a high level of input by carers on a daily basis.
- nursing care provided by community services.
- requires additional equipment, activities, or measures such as DoLS

Nursing:
- requires care and support over a 24-hour period, including observation/supervision to maintain safety.
- moderate level of assessed care needs.
- FNC funded.
- requires assistance with most activities of daily living with a focus on essentials of care.
- requires input by carers on a daily basis.
- requires nursing care on a daily basis

Nursing High:
- requires care and support over a 24-hour period, including observation/supervision to maintain safety.
- high level of assessed care needs.
- FNC funded.
- requires assistance with most activities of daily living with a focus on essentials of care.
- requires a high level of input by carers on a daily basis.

requires a high level of nursing care on a daily basis

***** - category titles and wording based on the NHS Continuing Healthcare Decision Support Tool:
https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Category of Need	No Needs	Low Needs	Medium Needs	High Needs
Behaviour *	No evidence of 'challenging' behaviour.	Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The person is compliant with all aspects of their care.	'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The person is nearly always compliant with care.	'Challenging' behaviour that poses a predictable risk to self, others, or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.
Cognition*	Some minor evidence of impairment, confusion, or disorientation.	Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident OR Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect, or health deterioration.	Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues, they are unable to consistently do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect, or health deterioration.

Psychological and Emotional Needs*	Psychological and emotional needs are not having a major impact on their health and well-being.	Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which are having an impact on their health and/or well-being but respond to prompts and reassurance **OR** requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.	Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or well-being OR Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in care planning, support and/or daily activities.	Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which have a severe impact on the individual's health and/or well-being OR Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities.
Communication*	Able to communicate verbally or non-verbally. May require translation if English is not their first language.	Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	Communication about needs are difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The person has to have most of their needs anticipated because of their inability to communicate them.

Mobility*	Independently mobile but with occasional need for support.	Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Not able to consistently weight bear OR Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning OR In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers OR At moderate risk of falls (as evidenced in a falls history or risk assessment).	Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning OR Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate OR at a high risk of falls (as evidenced in a falls history and risk assessment) OR Involuntary spasms or contractures placing the individual or others at risk.
Nutrition - food and drink*	Able to take adequate food and drink by mouth to meet most nutritional requirements.	Needs supervision, prompting with meals, or may need feeding and/or a special diet OR Able to take food and drink by mouth but requires additional/supplementary feeding.	Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed OR Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non- problematic PEG.	Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway OR Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers OR Nutritional status “at risk” and may be associated with unintended, significant weight loss OR Significant weight loss or gain due to identified eating disorder OR Problems relating to a feeding device (for example PEG.) that require skilled assessment and review.

Continence*	Mostly continent of urine and faeces.	Continence care is routine on a day-to-day basis. Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. AND is able to maintain full control over bowel movements or has a stable stoma or may have occasional faecal incontinence/constipation.	Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation.	Continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs, manual evacuations, frequent re-catheterisation).
Skin Integrity (including tissue viability)*	Minor risk of pressure damage or skin condition.	Risk of skin breakdown which requires preventative intervention once a day or less than daily without which skin integrity would break down OR Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound **OR** a skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down OR Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis,' which is responding to treatment **OR** a skin condition that requires a minimum of daily treatment, or daily monitoring/ reassessment to ensure that it is responding to treatment.	Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis,' which is not responding to treatment OR Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule,' which is/are responding to treatment **OR** Specialist dressing regime in place; responding to treatment.

Breathing*	Normal breathing, occasional issues with shortness of breath.	Shortness of breath which may require the use of inhalers or a nebuliser and has no impact on daily living activities OR Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities OR Episodes of breathlessness that do not respond to management and limit some daily living activities OR Requires any of the following: low level oxygen therapy (24%); room air ventilators via a facial or nasal mask; other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers OR Breathlessness due to a condition which is not responding to treatment and limits all daily living activities.
Drug Therapies & Medication*	Symptoms are managed effectively and without many problems, and medication is not resulting in any unmanageable side- effects.	Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime OR Mild pain that is predictable and/or is associated with certain activities of daily living. Pain and other symptoms do not have an impact on the provision of care.	Requires the administration of medication (by a registered nurse, carer, or care worker) due to non-concordance or non-compliance, or type of medication (for example insulin) or route of medication (for example PEG,) OR Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for the task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage OR Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.

Altered States of consciousness (ASC)*	No evidence of altered states of consciousness.	History of ASC but it is effectively managed and there is a low risk of harm.	Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm OR Occasional ASCs that require skilled intervention to reduce the risk of harm.
Hygiene (washing / grooming)	Independent with occasional assistance required.	Some assistance required.	Most assistance required.	Full assistance required.
Dressing	Independent with occasional assistance required.	Some assistance required.	Most assistance required.	Full assistance required.
Sleeping	Sleeps well, may require occasional supervision and/or assistance during the night	Sleeps well, may require occasional supervision and/or assistance during the night.	Requires reassurance during the night to settle, may require supervision and/or assistance during the night.	Unsettled nights, may be unaware of day and night, requires assistance to avoid disturbing other residents. May require repositioning and/or supervision and/or assistance, usually more than once, during the night.

Appendix 2 Supplementary placement guidance for a practitioner to facilitate choice.

Expectation on Practitioners

- This document must be observed in conjunction with this Residential and Nursing Care Home Placement Guidance above. It provides operational guidance to assist KCC staff in the facilitation of 'Choice' for people eligible for KCC funding when entering long term residential and nursing care home placements. It also applies to people who were previously 'self-funding' in care homes and are now eligible for financial assistance from the local authority (former self funder).

- It must be read by all operational staff and managers involved in assessment, practice assurance process, and discussing placement options with the person/their representatives (Placements Team).

- This guidance recognises there is a diverse market of residential and nursing provision across the county and seeks to ensure this is reflected in placement activity.

Professional judgements

- The practitioner, with support from their management, is responsible for making professional judgements based on the need's assessment: how the person's needs impact on their wellbeing and whether those needs are eligible for support.

- The practitioner has the delicate task of balancing expectation with the agreed spending guidelines and decisions on provision. 'Panels' do not make these judgements. The role of Panel is to ensure appropriate consideration has been given to reasonable options for meeting eligible needs.

- KCC must take into account the preferences of the individual/ their representative but may weigh up the total cost of different options and suitable alternatives for meeting needs, the Placement Team are responsible to take the initiative in these conversations, unless the person has complex needs. In practice this means being clear and transparent about 'preferences' and 'eligible needs' in the care and support planning process and separating these. The practitioner should be clear that the Personal Budget for any person will be agreed at the amount KCC would expect to pay for that type of care.

- If the placement is outside Kent, the personal budget allocated, must be based on the actual cost of the hosts local authority residential care placement, which is suitable and available to meet needs.

- Where the type of care (including care home) is more than KCC would expect to pay as specified in the personal budget, the additional payment is not a part of the Personal Budget and forms a 'top- up.'

The 9 must-dos in practice about 'Choice' are:

1) The practitioner must be clear as to when assessed needs can be met by community nursing support into a residential setting, and when the nursing needs can only be adequately met within a Nursing home setting.

2) Unless person has complex needs, for older people with long term conditions the practitioner will defer the detailed discussion about residential preferences/location factors to the Placement Team. For a person with a physical disability, mental health condition,

autistic person, a learning disability or with sensory impairments, the practitioner will be responsible for the detailed discussion.

3) For older people with long term conditions, the practitioner should avoid discussing the location of the placement, unless a restricted search required, but should focus on a description of the person, their needs and the nature of relationships and contact significant to their wellbeing.

4) Unless a person has complex needs, or has a physical disability, mental health condition, autistic; a learning disability or sensory impairment, the Placement Team will be responsible to take the initiative in conversations with the person/relatives/representative to manage reasonable expectations about 'search' areas (including placements outside Kent when applicable)- availability in the market, travel considerations and/or proximity to family members, top ups etc. Otherwise, the practitioner will be responsible to take the initiative in conversations with the person/relatives/representative.

5) For older people with long term conditions, Placement Team will provide individuals with a minimum choice of 3 providers, all of which will be providers KCC has a contract with. Searches will be countywide unless "restricted searches" identified by the practitioner. If there is not an appropriate choice of contracted providers, searches will include non-contracted providers. For a person with a physical disability, mental health conditions, autistic person, a learning disability or with sensory impairments, the practitioner will be responsible for this.

6) For older people with long term conditions, the Placements Team will try to match 'Preferences' expressed by the person/their representatives with what is available to meet the assessed and unmet eligible needs of the person. The Placements Team will try to offer at least x1 suitable place at or closest to KCC **usual price/host price** – i.e. one that meets the eligibility criteria Outcomes – even if this does not match the preferences For a person with a physical disability, mental health condition, autistic person, a learning disability or with sensory impairments, the practitioner will be responsible for this.

7) When it is not possible to identify a suitable vacancy at KCC **usual price/host price**, then it will be expected that 'interim' measures be considered – including temporary placement. For older people with a long term condition,, the Placements Team will often refer such situations to the relevant Community Senior Practitioner (or Team Manager for Short Term Pathways), or to the Practitioner for a person with a physical disability, a mental health condition; autistic person; a learning disability or with sensory impairments, The relevant manager (or practitioner for a person with a physical disability, mental health conditions, autistic person, a learning disability or with sensory impairments) will respond to the Placements Team within 24 hours.

8) For older people with long term conditions, where there is a lower cost and suitable place available, but a higher cost 'preferred' home is chosen by the person/family/representative, then an additional contribution (e.g. Third-Party Top Up) will be required based upon the difference between the chosen home and the lowest cost, suitable alternative care home to meet needs.

9) The practitioner, including Out of Hours services, must avoid scenarios where people are placed temporarily in placements that are above the KCC usual price/host price, given the risk that some of these will be assessed as needing long term care. 'Urgent' short term placements must be rapidly followed up within 72 hours to ensure that individuals do not become settled in unaffordable homes.

This is the same practice that should be demonstrated in 'Best Interests' (MCA) decision-making; remembering that there will often be a priority of needs that have to be met for any

particular individual, with some having little or no ‘significant’ impact on well-being and which are therefore not eligible.

Former Self funders do present some different challenges. Where appropriate, with guidance from line manager of the practitioner should carry out ‘risk assessment’ of moving the individual to a lower cost alternative home. The assessed ‘impact’ on the person’s wellbeing is clearly going to be critical, and the risk assessment approach should focus on what actions can be taken to mitigate and reduce impact to within a safe and manageable level.

if it is decided that a person is to be moved to an alternative home, it is important that the Placement Team give written Advance Notice of Termination of individual placement contract to the existing home provider, to prevent penalty costs being accrued. For a person with a physical disability, mental health conditions, autistic person, a learning disability or with sensory impairments, the practitioner will be responsible to give the Advance Notice of Termination to the existing home provider.

Appendix 3: Placement Team role and responsibility in producing shortlisted placements.

1.1 Under the Care Act (2014), The Care and Support and After-care (Choice of Accommodation) Regulations 2014, KCC must take into account the preferences of the individual/ their representative but may weigh up the total cost of different options and suitable alternatives for meeting needs. In practice this means being clear and transparent about 'preferences' and 'eligible needs' in the care and support planning process and separating these when looking at the location of the care home.

1.2 The Performance Information Management Team, on behalf of the Placement Team, will produce monthly reports. The reports will provide recent placement activity and costs by area for the lead practitioner and Commissioning/Procurement to better discuss availability, prices, and costs (including top ups). The relevant KCC usual price/host price for the category of home identified to meet assessed eligible need becomes the estimated Personal Budget.

1.3 Following initial conversations with the person/representative, for older people with long term conditions, the Placement Team will be responsible to seek appropriate placement options in another local authority area when the needs assessment and care and support planning process determined that, to meet an eligible need, a move to another local authority area is necessary and not to rely/expect/ask the person//family/ representative to provide a list of care homes. For a person with a physical disability, mental health conditions, autistic person, a learning disability or with sensory impairments, the practitioner will be responsible to seek appropriate placement options in another local authority area.

1.4 For older people with long term conditions, where the person/representative has expressed preferences outside assessed eligible need the Placement Team will always check whether person/representative have indicated they can pay a Top-Up, and in what approximate range, prior to commencing their search for available beds to avoid unnecessarily raising expectations.

1.5 The practitioner will usually be expected to request a residential placement where the assessed needs of the person can be met by community nursing services 'in-reaching' to the person.

1.6 Consultation with NHS professionals on the frequency and predictability of the individual's nursing care needs in the assessment will inform this decision. Individuals or their representatives may choose a higher level of care setting – e.g. Nursing home rather than Residential High – BUT the KCC Usual Price/Host price - and any Third-Party Top-Up - for the assessed level of care will be based on the type of care setting identified by the practitioner.

1.7 For older people with long term conditions, , the Placement Team will aim to produce a Shortlist , based on the Individual's estimated personal budget. This will inform the individual on the likely top up required for the placement. For a person with a physical disability, mental health conditions, autistic person, a learning disability or with sensory impairments, the Placement Team will provide the practitioner with the "Shortlist

1.8 For older people with long term conditions, where no suitable vacant bed at or close to the KCC usual price/host price can be included on the shortlist, then further discussion must take place between the Placement Team and the relevant Community Senior Practitioner (or Team Manager for Short Term Pathways) BEFORE the Shortlist is finalised – this is to enable consideration of temporary alternatives etc based on location, quality, and value for money.

1.9 Each Shortlist will include a minimum of three available choices. The Shortlist will be for KCC contracted homes where a home can meet eligible needs at or near the KCC usual

price/host price. Any issues arising from this will be escalated to the Accommodation Commissioning Group (ASG) or Contract Manager.

1.10 When there is not an appropriate choice of KCC contracted providers, each Shortlist will include non-contracted providers. Non-contracted homes that are willing to offer beds should be encouraged to join the KCC Contract – and such instances will be flagged to the Commissioning Manager and/or Contract Manager. Information regarding this will be included in the reports for ACG.

1.11 KCC Contracted homes that are unwilling to flex their price from their Indicative Price should be reported to the Contract Manager so that the provider can be informed of how the contract works.

Appendix 4: Authorisation Levels for Third Party Top Ups

Third Party/First Party Contributions agreements:

- All: Older People, Physical Disability Head of Purchasing
- All excluding above group: Community Team Manager

Appendix 5: Hospital Discharge to Short Term Placement for a person who lacks capacity.

Introduction

This appendix provides best practice guidance when decisions are made to discharge a person from any hospital setting to a short-term placement, when that person has been assessed as lacking capacity for this specific decision. This guidance applies to everyone, including self-funders.

This guidance note should be used in conjunction with the KCC Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Practice Guidance on Tri-x.

The Mental Capacity Act 2005 (MCA) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make specific decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act.

Once a person is deemed as medically fit for discharge, hospitals can insist the person is moved from the acute setting. Every effort must be made to identify suitable discharge arrangements but must also follow the legislative framework of the MCA to ensure the person is safeguarded.

A move can still be lawfully achieved in a person's best interests under s5 MCA provided:

- all the correct principles have been applied and processes followed,
- there is no dispute, and
- the person being moved is not objecting

It is reasonable for the practitioner to consider a short-term placement in these circumstances to ensure a more comprehensive assessment is undertaken.

Temporary placements on discharge should not be viewed as a permanent solution for the person. It should be seen as protected time to give all relevant interested parties space to make a decision about where the incapacitated person's needs can best be met in the future. This does not mean that placement in a short-term bed should automatically lead to the person staying in the home on a long-term basis.

<u>Independent Mental Capacity Advocate IMCA) involvement</u>

The MCA Code of Practice, Chapter 10 states than:

"An IMCA must be instructed, and then consulted, for people lacking capacity who have no-one else to support them (other than paid staff), whenever:

- an NHS body is proposing to provide serious medical treatment, or
- an NHS body or local authority is proposing to arrange accommodation or a change of accommodation) in hospital or a care home, and
- the person will stay in hospital longer than 28 days, or
- they will stay in the care home for more than eight weeks."

Therefore: If the accommodation is for less than 28 days in a hospital, or less than 8 weeks in a care home an IMCA need not be instructed.

KCC Good Practice requirements

- The starting point is always to follow the 5 statutory principles of the Mental Capacity Act. Ensure the principles of the MCA are rigorously applied.
- The practitioner should undertake a capacity assessment for complex decisions. If the person is deemed as lacking capacity, then the best interest decision making process must be followed.
- Consider and place considerable weight on the person’s wishes, feelings, and beliefs.
- Continue to involve the person as far as possible during the decision-making process.
- Consider if there is a Lasting Power of Attorney for Health and Welfare Decisions – if so, this person will be the Decision Maker for this specific decision. It is best practice to request a copy of the LPA to verify their position.
- Communicate clearly with family members so they understand that once their relative is medically fit for discharge, they are not afforded the right to occupy or remain in an inpatient bed.
- Consult with anyone identified by the person as someone to consult, family members/ friends and those involved in their care and treatment
- Instruct an IMCA only if the person is unfriended and the stay in the care home is anticipated to be longer than 8 weeks.
- For anyone (including self-funders) that you have assessed as lacking the capacity to make the decision about moving to a short-term placement, you must convene a best interests meeting/discussion using the Best Interests Decision Making document. Even if you call the Best Interests meeting, you may not be the appropriate person to be chair as you will be required to contribute a lot of information to the meeting. Negotiate the role of chair with Health colleagues.
- Records of capacity assessments and best interest decisions must be clearly and comprehensively completed, and all options should be identified (e.g. return home, enablement, short term placement and long-term placement) as well as the associated risks of remaining in hospital and the burdens and benefits of discharge options. Documentation must be kept in the Relevant Person’s file.
- Consider whether there may be issues of deprivation of liberty on discharge and encourage the Managing Authority (placement) to apply in anticipation for a DoLS authorisation to take effect after discharge.
- Consider the need for Court of Protection application where there is objection. Discuss in usual supervision arrangements and engage in discussion with Legal as appropriate.

Appendix 6: Revised protocols for former self funder – A person who currently self-funds a placement, but whose capital is reducing and will soon fall below the eligibility threshold of £23,250)

This process is to be followed the Adult Social Care Community Teams, Placement Team, Financial Assessment, and Income Unit (FA&I) for any former self funders for placements for older people in a nursing or residential home.

To minimise unnecessary delays and costs that can often be incurred when KCC begin to fund a "Former Self Funder" please be advised of the revised process that all teams should familiarise themselves with and follow with immediate effect (28 June 2019, updated July 2023 (v14).

The Adult Social Care (ASCH) Financial Assessment Estimator Tool launched in March 2023, will give a person an idea of how much they *may* need to pay towards the cost of their care. Full details about the Estimator tool and what it does on Kent.gov

1. A person or their representative should be advised to approach KCC (via ASCH Referral Service) three months before they expect their capital to fall below the £23,250 financial eligibility threshold. Informed the person of the **ASC Financial Assessment Estimator Tool on Kent.gov** and how it can be accessed on the link. Estimate how much you may need to pay - Kent County Council

2. If it appears the person may be eligible for funding, the ASCH Referral Service team will refer to the locality Community Team for allocation for a MADE Care Needs Assessment and the Placement Team and close their involvement.

3. Financial Assessment and Income Unit (FA&I) will aim to confirm financial eligibility within 15 working days of receipt of the referral to them.

4. The Placement Team will, upon receipt of the referral from ASCH Referral Service, make contact (**within three working days)** with the provider to confirm KCC's potential involvement in the funding of the placement and commence negotiation with the provider.

5. The Community Team Manager will allocate a worker straight away for a MADE Care Needs Assessment to be completed. The due date for assessment should also be recorded on the scheduling tracker so we know when these are due on the scheduling tracker. If allocation is unable to be completed **within 6 weeks**, then the case will sit with the Community Team Manager to ensure that during the FA&I step, the person's case is routinely monitored to ensure that there is management oversight whilst FA&I are progressing a financial assessment.

6. Through the MOSAIC workflow process FA&I will inform the Community Team and Placement Team the date that the person will be eligible for social care, Business Support Team (BST) will arrange for the Community Team Manager to reallocate the person so that the Community Team can proceed with the assessment or make contact to cancel the appointment, as appropriate.

7. The Community Team Manager is responsible for ensuring that the MADE Care Needs Assessment, MADE Care and Support plan, and progression to Practice Assurance Panel (PAP) is completed **within 6 weeks** of receipt of the referral and should be prior to the person becoming financially eligible for Social Care funding*. (*Assumes that the person contacts KCC three months prior to their wealth depleting (see point 1).

8. A person, representative and provider should expect the complete process to be within the three-month window stipulated in point 1. This process should reduce anxiety for care homes,

the people we support, and their families, whilst reducing the likelihood of KCC having to pay “private” fee levels resulting from delays.

Appendix 7

A	High Level process - Placements Team LDPDMH (ACC and TSKC) V1.0	Appendix C - High Level process - Place
B	High Level process - OP Placements and LDPDMH pilot (NK and WK) V1.0	Appendix D - High Level process - OP Pl
C	High Level process - Hospital Team (PW1) V1.0	Appendix E - High Level process - Hosp
D	High Level process - Hospital Team (PW3) V1.0	Appendix F - High Level process - Hosp
E	Arranging Support Approval Documents V1.2	Arranging Support Go Live Guidance_V
F	KCC Discharge to Assess transfer of funding processes.	See below

Appendix 7(F). KCC Discharge to Assess transfer of funding processes