

# Adult Social Care Policies and Procedures

## PERSON CENTRED CARE AND SUPPORT PLANNING

**WARNING!** Please note if the review date shown below has passed this procedure may no longer be current and you should check the PPG E Library for the most up to date version

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## PERSON CENTRED CARE AND SUPPORT PLANNING

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## POLICY VERSION CONTROL

<b>POLICY NAME</b>	<b>Person Centred Care and Support Planning</b>		
<b>Document Description</b>	This document sets out the county council's response to the Care Act 2014 and provides its policy and procedure for care and support planning following an appropriate social care assessment.		
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# 1. POLICY STATEMENT

## 1.1 Introduction

Following completion of a Care Act 2014 assessment of needs (or a carer's assessment), an eligibility determination and a calculation of an indicative personal budget, and if the individual meets the national threshold, the county council **must** undertake Care and Support Planning to detail how these eligible needs will be met. There is also a duty on the county council to do this under section 117 of the Mental Health Act 1983.

Before proceeding to Care and Support Planning it is necessary to establish whether the person is an 'ordinary resident' of Lancashire. It is also important to ensure the individual is aware that the duty on the county council is to meet needs that are not, or cannot be met, by universal services or others, and additionally that any support provided is chargeable as per the Care Act, i.e. they are not free (although s117 after care under the Mental Health Act *is* provided free).

The county council will look for evidence that the person's strengths, capabilities and sources of informal support within their network and the wider community have been used to the full before considering formal care and support services or interventions. If there is ever a change in the informal support being provided for a person then their care needs would be reviewed.

Throughout the Care and Support Planning process it is imperative that staff consider issues such as mental capacity, deprivation of liberty (DOL), protection of property, and safeguarding. For more details on these issues please consult the appropriate policy and procedure documents.

Reablement [LINK] and rehabilitation services may also be offered at this time, as may equipment or adaptations. Universal services such as clubs and services run by voluntary and community organisations would also be included as would the use of 'brokerage' services (usually for people who self-fund their care needs).

The individual will also be provided with options on using their personal budget and given real examples as to how they might work in their specific situation. These different options (or pathways) are: Direct Payments, Individual Service Funds (ISF) and "care managed" (see [Section 2](#) for more information).

The plan will state which option is to be used, what the outcomes are and how these will be measured. It will also contain details of what contingencies are in place to cover, for example, absences, unexpected cancellations of services or informal carer's unavailability.

The plan **must** clearly detail how eligible needs will be met and how the personal budget will be spent. Other options that have been offered should also be highlighted in the Plan *even if* they have been discounted. This is because recent legal rulings (e.g. [Davey v Oxford CC](#)) mean councils must be able to show in detail whether they "have regard to each person's particular individual circumstances" and have considered all elements of the individual's wellbeing.

As part of the care and support planning process people can be supported to access other services that they may be entitled to that will meet their eligible needs, such as housing or benefits. Until those eligible needs are actually met, the county council should continue to work with the individual to ensure that these services are accessed or needs met in an alternative way.

The county council is not under a duty to meet needs that an informal carer is providing unless the carer does not continue in their caring role. A carer's assessment should be offered [LINK].

## **1.2 Principles of Quality Care and Support Planning**

The purpose of the Care and Support Planning process is to agree how a person's needs should be met, and therefore how the county council will discharge its duty, and/or its power, to do so. Care and Support Planning should always be done with the person and not for them; it should always start by the identification of their wishes, feelings, values and aspirations, not just their needs, and should always consider their wellbeing in the wider context of their rights to security, liberty and family life.

Good care and support planning includes identifying the strengths, capabilities and resources already available to the person which they could draw upon to meet their needs. Formal interventions or care and support services should only be considered when these assets have been exhausted.

The "plan" can be in any format that works for the person and creativity and flexibility is encouraged. The individual should also be told of their indicative personal budget before planning starts (see [Section 2](#) for more information).

It is important that individuals are given every opportunity to prepare their own plan, if they wish. Genuine involvement will aid the development of the plan, increase the likelihood that the options selected will effectively support the person in achieving the outcomes that matter to them, and may limit disputes as people involved will be fully aware of, and have agreed to, any decisions made. The county council may instruct an Independent Advocate [LINK] should the individual have substantial difficulty to engage in the Care and Support Planning process.

The county council's role is to ensure the plan's production, that it represents the best balance between value for money and maximisation of outcomes and to 'signoff' the plan as appropriate to meet those needs and outcomes. However it is important that the individual appreciates that the plan 'belongs' to them and that the county council does not share it without their permission.

## **1.3 Sign off and Dealing with Disputes**

While there is no defined timescale for the completion of the Care and Support Planning process, the plan should be completed in a timely fashion, proportionate to the needs to be met.

Signoff should occur when the person, their representative (if involved) an advocate (if involved) and the relevant social care worker have agreed the details of the plan,

including the final personal budget amount (which may have been subject to change during the planning process) and how precisely the needs in question will be met. The county council will take all reasonable steps to reach agreement with the person for whom the plan is being prepared.

An appropriate governance mechanism to sign-off large or unique personal budget allocations and/or plans will be agreed via a team's specific delegation process.

In the event that the plan cannot be agreed with the person, or any other person involved, the county council will revisit the earlier planning process and take into account the views of all parties, including providers (if involved). However, if a dispute remains and the county council considers that all reasonable steps to address the situation have been taken, the county council will state the reasons for the dispute and the plan will be signed off. The individual should be directed to the county council's [complaints procedure](#) at this time. The individual must not be left without support while a dispute is resolved and the county council should provide the services it considers necessary and appropriate until the complaint has been addressed.

Upon completion of the plan, the county council must give a copy of the final plan in a format that is accessible to the person for whom the plan is intended, any other person they request to receive a copy, and their advocate (if they have one).

Where the county council is required to meet needs under section 117 of the Mental Health Act 1983 staff should consult chapter 34 of the "Mental Health Act 1983 Code of Practice (Department of Health, 2014)" (on the Care Programme Approach) and "Refocusing the Care Programme Approach" (Department of Health, 2008). Staff must liaise with the relevant health team/commissioning authority prior to commissioning any support or services or if any changes are made. If this is not done then there could be issues with shared funding arrangements.

Therefore to fulfil its duty under section 1 of the Care Act, the county council will, working with its statutory, voluntary and private sector partners, comply with the national guidance relating to care and support in a manner that is relevant, coherent, timely and sufficient.

The county council will make all reasonable adjustments to ensure that all disabled people have equal access to participate in the eligibility decision in line with the Equality Act 2010.

The geography and population of Lancashire is diverse and our Adult Social Care Policies and practice will aim to deliver services and supports that are representative of the communities in which we work.

The county council will follow the Care Act and other relevant legislation, policies and guidance to ensure our practice is of high quality and legally compliant. Where our customers or those we come into contact wish to challenge or raise concerns in regard to our decisions regarding eligibility, the county council's complaints procedures will be made available.

## 2. KEY DEFINITIONS AND PRINCIPLES

### 2.1 Meeting Needs

"Meeting needs" is an important concept under the Care Act and moves away from the previous terminology of "providing services". This definition provides a greater variety of approach in how needs can be met. The concept of "meeting needs" is intended to be broader than a duty to provide or arrange a particular service. Because a person's needs are specific to them, there are many ways in which their needs can be met. The intention behind the Act is to encourage this diversity, rather than point to a service or solution that may be neither what is best nor what the person wants.

In deciding how to meet needs, the county council may take decisions on a case-by-case basis which weigh up the total costs of different potential options, and include the cost as a relevant factor in deciding between suitable alternative options for meeting needs. This does not mean choosing the cheapest option; but the one which delivers the outcomes desired for the best value.

### 2.2 Brokerage [\[LINK\]](#)

In general, a support broker is someone who assists people with their personal budget to find out what services they need and help them to find the most suitable provider. A support broker is a nominated individual who plans the support packages for the person who needs it. It can be:

- A family member
- Friend
- Neighbour
- A representative from a local charity or organisation

Potentially, brokers may also be 'bought' or employed – in a similar way to the financial sector – meaning those who can afford to pay for professional brokers can do so, while others may pay family members or friends from their personal budget.

### 2.3 Resource Allocation System (RAS)

The county council uses a computerised system – called a Resource Allocation System or RAS – to calculate a person's personal budget using data about the individual's care needs, based on their assessment, and applying a formula based on statistical information about care costs. Statutory guidance makes clear that RAS can only ever produce an "indicative figure" which is then used as the basis for planning an individual's care and support. The estimated budget **must** be shared with the individual (or their representative) when the care and support plan is being drafted. As the care and support plan develops, the indicative figure must be checked against the actual costs of purchasing the care and support needed. This means that the final personal budget figure may be more or less than the original RAS indicative amount.

**2.4 Personal Budgets** The personal budget is the mechanism that, in conjunction with the care and support plan, enables the individual, and their advocate if they have one, to exercise greater choice and take control over how their care and support needs are met. It means:

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

It is vital that the process used to establish the personal budget is transparent so that people are clear how their budget was calculated. The allocation of a clear upfront indicative (or 'ball-park') allocation at the start of the planning process will help people to develop the plan and make appropriate choices over how their needs are met.

## **2.5 Direct Payments**

Direct Payments are intended to empower individuals by allowing them control and choice over the services they use to meet their needs. Individuals are given an amount of money to be managed by themselves, possibly with the aid of others such as family or an external advocacy organisation. This money can be used to purchase any care and support services that meet the person's assessed needs.

## **2.6 Individual Service Fund (ISF)**

An Individual Service Fund (ISF) is used when an individual wants to use their individual budget to purchase supports from a specific provider. ISFs mean that:

- The money is held by the provider on the individual's behalf.
- The individual decides how to spend the money.
- The provider is accountable to the individual.
- The provider commits to spend the money only on the individual's service and the management and support necessary to provide that service (and not into a general pooled budget).

## **2.7 Care Managed**

A "care managed" account is available to people who need support to manage the use of their direct payment. Under this arrangement, an individual's direct payment is paid into a bank account that is set up and managed by a third party who then use the account to pay for things in the individual's support plan. A care managed account



gives the individual the same level of choice and control as managing their own direct payment -- they remain in control of the decisions made about their support – but the individual does not manage the money directly.

### 3. PROCEDURES

#### 3.1 Preparing the plan

Empowering and enabling individuals to do as much of the planning as they are able to themselves is preferred wherever possible. This is sometimes referred to as "DIY planning". Staff should offer individuals a range of options and assistance in developing and completing their care and that such assistance is tailored to the capacity and needs of the person. A person may also receive assistance to prepare their plan from carers, friends, and relatives (and in the absence of these should be offered an advocate [LINK]). Social care workers must also ensure that people are aware of the options available to them such as care managed, direct payments or Individual Service Fund (ISF). [LINK].

If a direct payment is chosen then the worker will refer to the Direct Payment policy [LINK] to Direct Payments PPG will be available shortly] and refer the person to the direct payments advice service for support with all aspects of budgeting and employing staff.

The length and style of plans will vary depending on the individual's approach but each plan should also be in a format that works for the person.

#### 3.2 What to include in a Care and Support Plan

Care and Support plans should include as a minimum:

- Evidence of how the person's existing strengths, capabilities and resources available within their network of support are being drawn upon to meet their assessed needs. This should be the starting point and formal interventions or services should only be considered when these assets have been exhausted.
- The needs -- both eligible and ineligible -- as identified in the assessment [LINK]. What the estimated and actual budget is.
- Any associated risks and the management of these risks.
- The desired outcomes of service provision, the timescale for implementation, how they will be measured and how frequently progress towards these outcomes will be reviewed.
- Contingency plans and emergency contacts.
- Details of how identified outcomes will be achieved. Provide specific details of what care options have been considered, their associated estimated costs, and the rationale behind any decision to include or reject these options in the final care plan, in relation to the individual's stated wishes and identified outcomes.
- Details of other services that the person receives to meet their needs e.g. NHS funding, education, or as part of the benefit system.
- The associated costs, any charges the person is assessed to pay, and how they wish to receive their budget.
- If a direct payment is offered, a detailed breakdown of all intended spending and on-costs.
- If a carer: their wishes around providing care, work, education and recreation.

- Contributions, financial or otherwise, that carers and others have undertaken to make.
- How significant changes in the support plan will be notified.
- The mechanism for managing or delegating control of the support plan.
- At review – who would be best placed to undertake this and when?

The plan should maximise the individual's choice and control while at the same time keeping them healthy, safe and well.

The plan should provide value for money. The county council has a statutory duty to ensure that social care funds are used effectively and in accordance with the principle of best value. Lancashire County Council therefore also needs to ensure that the measures proposed in the support plan represent an effective use of the personal budget in relation to the individual's needs and desired support outcomes. The council will look for evidence that the person's strengths, capabilities and sources of informal support within their network and the wider community have been used to the full before considering formal care and support services or interventions.

Any activity, item or service that can be legally purchased with the budget can form part of the plan as long as it meets the established objectives. Illegal *items* are not acceptable components of a plan. Similarly, the county council cannot arrange *services* that are the responsibility of the NHS (e.g. care provided by registered nurses and services that the NHS has to provide because the individual is eligible for NHS Continuing Healthcare).

There are a number of considerations to take into account when drafting a plan:

- If a plan meets the person's assessed eligible needs within the available budget without endangering their health or wellbeing then the plan should be validated.
- Positive risk taking practice and a risk assessment should be considered if required.
- The actual budget required may be less than the estimated budget, in which case it is the lower budget that becomes the actual Personal Budget.
- If during assessment the carer has identified a need for respite and this relates to a need for short breaks, then this must also be included in the person's plan and estimated Personal Budget and validated budget.
- If a person is saving up/ banking towards meeting a specific variation/ need, this should be specified within the care and support plan, along with any contingency planning.
- If the needs that meet the national eligibility criteria are met but only with spending that is outside the estimated budget allocation, this would be considered via the agreed delegation policies on a case by case basis.
- Whether the plan addresses all of the county council's statutory obligations.
- The plan must also identify measurable and specific scope for progression and how this will change or reduce the need for support in future.

### 3.3 Managing risk

The plan should be designed flexibly, balancing the council's duty of care with its responsibility to manage risk appropriately while encouraging innovative ways to use personal budgets to achieve overall objectives. Specify within the plan how actual or perceived risk will be managed. Persons with capacity should be supported to make informed choices as to the element of acceptable risk that they wish to accept. The plan should also include a contingency to discuss what should happen if a predictable anticipated risk could take place (e.g. an informal carer being rushed to hospital). The three governing principles for effective risk management, set down by the Department of Health are:

- People have the right to live their lives to the full as long as that doesn't stop others from doing the same.
- Acknowledge that there will always be some risk, and that trying to remove it altogether can outweigh the quality of life benefits for the person.
- Continue existing arrangements for safeguarding people.

### 3.4 Considering involving an advocate

An independent advocate must be provided [LINK] if there is no one else in a person's informal network that can facilitate their involvement AND if the person would, without the representation and support of an independent advocate, experience substantial difficulty in any of the following:

- Understanding relevant information;
- Retaining that information;
- Using or weighing that information as part of the process of being involved;
- Communicating their views, wishes or feelings (whether by talking, using sign language, or any other means).

People should be assumed to have the capacity to consent and make their own decisions unless there is evidence to the contrary. If a social care worker thinks a person may lack capacity to make a decision or a plan, even after they have offered them all practicable support, an assessor needs to carry out a capacity assessment in relation to the specific decision to be made.

Where an individual has been assessed to lack capacity to make a particular decision, then the local authority must commence support planning under the 'best interest principle' within the meaning of the [Mental Capacity Act](#) .

### 3.5 Combining Plans

Plans should have regard to all of the person's needs and outcomes, rather than just their care and support needs. The social care worker should attempt to establish where other plans are present, or are being conducted, and seek to combine plans, if appropriate. One key area where plans can be combined are cases where the person is receiving both local authority care and support *and* NHS health care. It could also be combined with the plans of carers, or other family members or with Education, Health and Care plans (for children and young people).

Consideration should also be given to how plans could be combined where budgets are pooled, either with people in the same household, or between members of a community with similar care needs. Where it has been agreed to combine the plan with plans relating to other people, it is important that the individual aspects of each person's plan are not lost in the process of combining plans. The combined plan should reflect the individual needs and circumstance for each person involved.

### **3.6 Procedure for completing the Care and Support Plan**

#### **Completing the Assessment and Estimated Budget:**

- Ensure the assessment has been completed, including entering details of the eligibility determination on the [Liquid Logic Adults' Social Care System \(LAS\)](#). This may be necessary if the assessment was completed by another worker.
- Finalise the assessment.
- In the RAS (Resource Allocation System) section of the assessment, the estimated budget for the individual will be displayed. Inform the person that this is estimated and that some aspects of it may be met by universal services.
- The estimated budget is the funding required to meet the care needs based on the assessment.

#### **Involving people in the care and support planning process and meeting needs:**

- Identify who to discuss the support planning process with. The first choice is, of course, the service user but they may ask for a representative to help them. If mental capacity is an issue, complete a Mental Capacity Act (MCA) assessment [LINK] will be available shortly] on the specific question of if they are able to plan for their support needs, and identify a representative.
- Discuss with the individual or their representative what the support plan is and why it is needed. Discuss how they would like to complete the plan: either by themselves or with support from another person, advocate, organisation or the allocated worker.
- Document that a discussion with the individual or their representative around charging policy [LINK] has been had.
- Discuss with the service user or their representative how they want to manage their budget, i.e. Direct Payment, care managed, Individual Service Fund (ISF) or a combination of options.
- Issue any relevant factsheets i.e. Direct Payments, providing care at home, How to complete a DIY support plan, financial implications, etc.

Discuss the eligible needs identified in the assessment that will be part of the care and support plan.

**Formatting the Care and Support Plan:**

- The care and support plan can be in any format that works for the individual and most formats can be stored on Documentum (the file storage system within LAS).
- If received in another format the worker should record on LAS as to where the care and support plan is actually stored. The worker should be mindful that other professionals (e.g. Finance or the Emergency Duty Team) may want to find the information easily.
- Create care and support plan on LAS.
- All identified needs migrate over from the assessment to the care and support plan.
- Make sure that the needs, how they are met and what outcomes are expected are clearly detailed and agreed with the individual or their representative.
- Make sure that it clearly explains how the budget is spent and apportioned.
- In the case of a Direct Payment refer to the Direct Payment policy and guidance [LINK] to Direct Payments PPG will be available shortly].
- Make sure there is a robust contingency plan with contacts, telephone numbers and email addresses if available.
- Ensure all mandatory fields (in red) are completed. Finalise care and support plan and send for approval or self-authorize if self-delegation.
- See LAS guidance for following the care package line item (CPLI) process – the financial approval process for any element of an adult's care package.

**If the care and support plan is not completed by the county council** it must nevertheless be validated by the county council before it is implemented. Staff must ensure that such plans must adhere to all of the elements listed above on pages 9-10.

Where a care and support plan DOES NOT contain these elements the county council will work with the individual (and their carer or representative, if involved) to ensure the principles of a quality care and support plan, and related information, are contained in the revised plan.

When services are activated they will follow the care and support plan as outlined above and the care and support that has been commissioned will commence. This process is automated and ContrOCC – the financial system used to ensure payment is made – is informed.

**Activation:** Ensure that the services are activated on LAS once the delegated authoriser has approved the budget: there will be a note in your worktray to complete this task once this has been approved. You may need to confirm this process with your manager.

**Remember:** Services will not start until you have activated them on LAS. (NB If services are sent for brokerage, Care Navigation may activate the services for you but you must check this has been done.) Do not activate a Direct Payments CPLI

until the FIN107 has been signed and stored on Documentum – see Direct Payment procedure.

The CPLI for the services commissioned will now display **PROVISIONED** as opposed to **Proposed**. Refer to LAS guidance for more information.

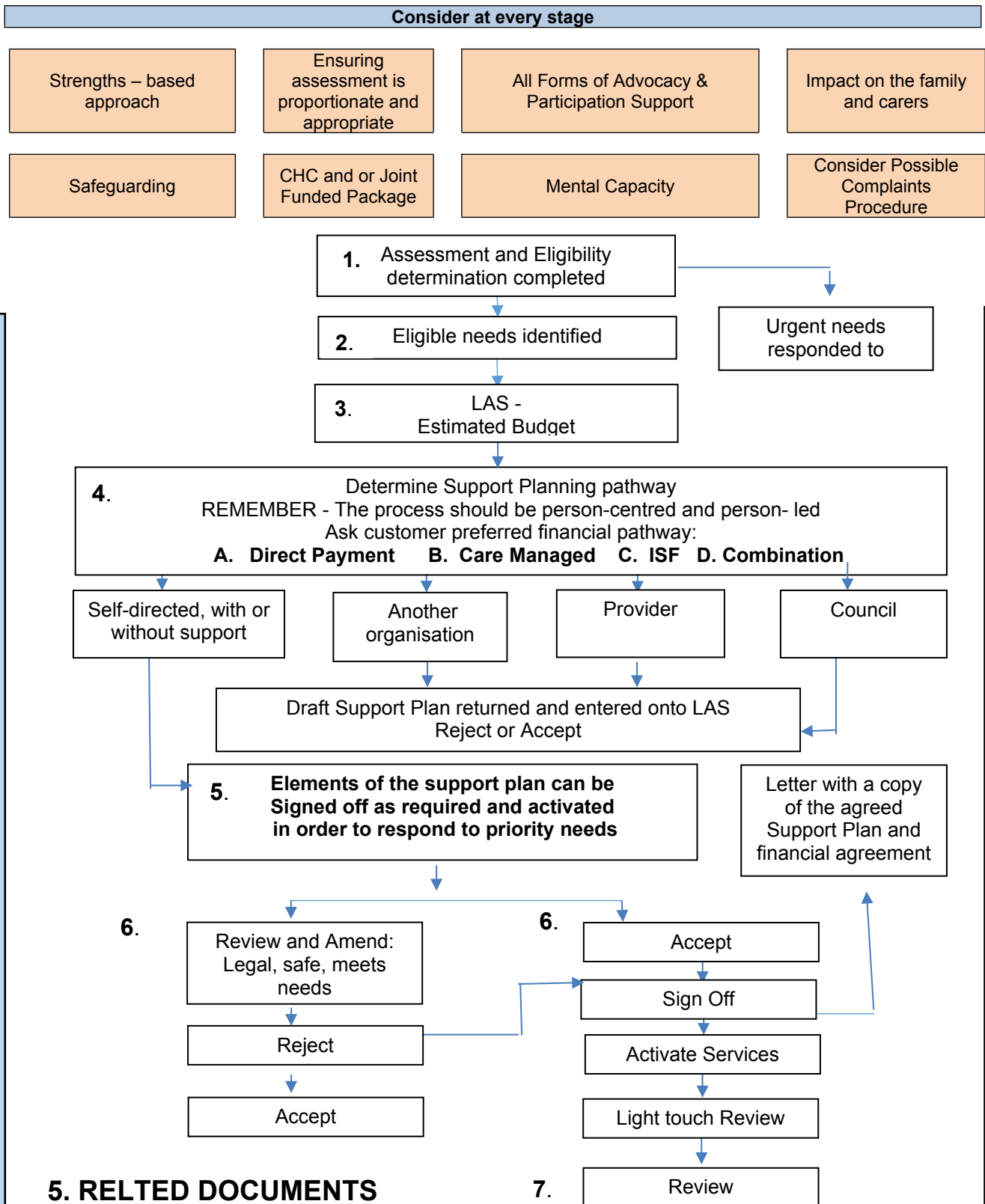
### 3.7 Sending a copy of the plan and reviewing the plan:

- Send out a copy of the care and support plan together with a covering note (see "Letters" on LAS).

The county council must also consider whether the person's needs have changed, which might indicate a need to change the type of support, or whether there are more effective ways of meeting the person's needs.

- Reviews of care and support plan can take different forms:
  - Light Touch Review (6 - 8 weeks) – this can be often over the telephone or home visit and is proportionate to the service user. "Light Touch Review" can be used when there is no change in the level of need, or a small change only which is within personal budget. Light Touch is in keeping with the need to respond in a proportionate and reasonable way.
  - Or consult the more formal reviews described in the Review of Care and Support Planning PPG [\[LINK\]](#)
- Send for annual review (case closed if required).

## 4. FLOW CHART



## 5. RELATED DOCUMENTS

The offer of Direct Payments should be made at points throughout the process

### RELATED DOCUMENTS



OTHER RELATED PPG DOCUMENTS	<a href="#">Policies, Procedures and Guidance Intranet site.</a>
LEGISLATION OR OTHER STATUTORY REGULATIONS	<ul style="list-style-type: none"> <li>• Care Act Section 1</li> <li>• Chapter 1 Promoting Wellbeing Statutory Guidance</li> <li>• Chapter 6 Assessment and eligibility Statutory Guidance</li> <li>• Chapter 7 Independent advocacy Statutory Guidance</li> <li>• Chapter 10 Care and support planning Statutory Guidance</li> <li>• Chapter 12 Direct payments Statutory Guidance</li> <li>• Chapter 19 Ordinary residence Statutory Guidance</li> <li>• Mental Capacity Act 2005</li> <li>• Mental Health Act 1983 s117</li> <li>• Mental Health Act 1983 Code of Practice Care Programme Approach &amp; Refocusing the Care Programme Approach</li> </ul>

## 6. EQUALITY IMPACT ASSESSMENT

The Equality Act 2010 requires the county council to have "due regard" to the needs of groups with protected characteristics when carrying out all its functions, as a service provider and an employer. The protected characteristics are: age, disability, gender identity/gender reassignment, gender, race/ethnicity/nationality, religion or belief, pregnancy or maternity, sexual orientation and marriage or civil partnership status.

The main aims of the Public Sector Equality Duty are:

- To eliminate discrimination, harassment or victimisation of a person because of protected characteristics;
- To advance equality of opportunity between groups who share protected characteristics and those who do not share them. This includes encouraging participation in public life of those with protected characteristics and taking steps to ensure that disabled people in particular can participate in activities/processes;
- Fostering good relations between groups who share protected characteristics and those who do not share them/community cohesion.

It is anticipated that the guidance on Care and Support Planning in this document will support the county council in meeting the above aims when applied in a person-centred, objective and fair way which includes, where appropriate, ensuring that relevant factors relating to a person's protected characteristics are included as part of the process.

More information can be found on the Equality and Cohesion intranet site on

<http://lccintranet2/corporate/web/?siteid=5580&pageid=30516>