HALTON BOROUGH COUNCIL

Communities Directorate

Assessment and Eligibility

Adult Social Care Services

Policy

April 2015 - 2017

DRAFT

CONTENTS

INFORMATION SHEET

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	POLICY	*Practice*
1.0	**Introduction**	
1.1	The Care Act 2014 (the Act) sets out in one place local authorities' duties relating to the assessment of people's needs and their eligibility for publicly funded care and support.	
1.2	Prior to the implementation of the Act, if people had different entitlements for different types of care and support, these were spread across a number of Acts of Parliament, some of which were over 60 years old. The law on entitlement was confusing, complex and it was sometimes difficult to understand what an adult was entitled to in particular cases. Anomalies and claims of a post-code lottery where entitlement varied (often significantly) from LA to LA resulted. What was required was a process that would establish not only an entitlement to public care and support for all adults with needs, but also and on a similar basis, an entitlement to support for their carers.	
1.3	The Act which became law in May 2014 attempts to develop such an equable approach – a national standard, capable of helping people to access care and support relevant to their needs.	Care Act 2014
1.4	The new approach sets out the steps that must be followed to work out a person's entitlement and to help them understand the process. It follows their journey through the 'care and support' system. This begins with an assessment of their needs and a decision about whether their needs are 'eligible.' LAs have the power to meet both eligible needs, and a duty to arrange care and support for those with eligible needs. After the support plan has been agreed a financial assessment is carried out which looks at the value of the person's assets (not their house). This will determine whether people will need to pay for their care and how much they are expected to contribute. After the process of financial assessment is completed, a decision can then be made about whether the person is entitled to care and support arranged by Halton as their local authority. The overarching principle is that if people have to make a contribution to their social care, they will be required to pay only what they can afford.	
1.5	The result is a new legal duty for the council to meet an	

adult's 'eligible needs.' These eligible needs are those that are determined after assessment. Meeting such needs could vary from supplying information, arranging a care provider on the person's behalf, or making a direct payment to the person so they can arrange their care themselves. It does not mean that the local authority will always fund the care and support.

1.6 An adult (aged 18+) will be entitled to have their needs met when:

- Their needs are 'eligible';
- They are ordinarily resident in the Halton area (i.e. their established home is there);
- Any one of the following five situations apply:
  - There is no charge for the type and care they need;
  - The person cannot afford to pay the full cost of their care and support;
  - The person asks the local authority to meet their needs;
  - The person lacks mental capacity and has no one else to arrange care for them;
  - Once the cap on care costs comes into force and the individual's care and support costs have exceeded the cap.

1.7 Depending upon a person's financial resources, the local authority may ask an individual to contribute towards the cost of their care (up to and including the full amount). However, in cases where the costs of care would reduce an individual's income below a set level, the LA will pay some of the costs to make sure the individual retains a manageable minimum level of income. This ensures they will receive the care they need in cases where they have only modest resources.

1.8 Any adult living in the borough can ask Halton Borough Council, regardless of their finances, to arrange their care and support for them. This ensures that people who are uncertain about the system or lack confidence to arrange their care do not go without. However, they will still need to pay for their care and support if they have adequate financial resources to do so.

2.0 Definitions

2.1 *Assessment*: This is how the local authority decides whether a person needs care and support to help them live their day-to-day lives. The assessment is carried out by a trained assessor (often a social worker) and the aim is to get a full picture of the person and what needs they may have. Assessment must be appropriate and proportionate. It must consider the needs of the family. Assessors must have the appropriate training.

2.2 *Eligible Need*: Local authorities have a duty to carry out a needs assessment to determine whether a person requires care and support. Determining eligible needs is important to work out whether the person is entitled to care and support provided by the authority. The local authority will also give people advice and information about what support is available in the community to help them. This is an important means of assistance for those who have care needs that are not considered eligible.

2.3 *Funding Cap*: Currently there is no cap on costs for those with modest wealth. These individuals can lose their home in order to pay for their care and support. The government is committed to protecting individuals from catastrophic care costs if they have the most serious needs. When the Care Bill is introduced in April 2016, the cap will be £72,000. New financial help will also be provided to ensure that those with the least money will get the most support. Currently only those with less than £23,250 in assets (such as savings or property) and low incomes receive help from the state with residential care costs. Post 2016 changes will mean that people with around £118,000 (equivalent to £123,000 by April 2017) worth of assets or less will receive financial support. The amount they receive toward care home costs will depend upon what assets they have.

2.4 *Care and Support Planning*: This is a process which seeks to establish a consensus about the best way to meet a person's needs. It considers a number of different things such as: what needs the person has and what they want to achieve; what they can do by themselves or with the support they already have; what types of care and support might be available to them. The local authority must do everything it reasonably can to reach agreement with the person on how best their needs should be met. It must produce a plan that sets out in detail what was agreed. As part of this planning process they will tell the person about their personal budget.

2.5 *Personal Budget*: This is the amount of money that the local authority has worked out it will cost to arrange the necessary care and support for a particular individual. It includes any amount that the LA will contribute toward such costs (this could range from all to none). Having a personal budget helps the person decide how much control they want to have over arranging their own care and support. Using the information from their personal budget, the person can ask the LA for a direct payment.

2.6 *Direct payment*: This is payment of money from the local authority to either the person needing care and support or to someone else acting legally on their behalf.

This money is to pay for the cost of arranging all or part of their own support. The LA could make a direct payment instead of arranging or providing any service itself, if the person asks them to do so. This flexibility gives the person autonomy over their own care.

2.7 *Deferred Payment Agreements*: This existing scheme will be made more widely available from April 2015. People who own their own home will be able to make an arrangement so they do not have to sell their home, during their lifetime, to pay for care home costs. Instead the LA will pay the costs and recover the money the person owes plus interest at a later date.

2.8 *Continuity of Care*: Continuity means ensuring that when a person receiving care and support in one area of England moves home to another, they will continue to receive care on the day of their arrival in the new area. This means that there will be no gap in care and support when people choose to move home. Also, when a local authority is requested to assess a child (including a young carer) who is receiving support under legislation relating to children's services, the care Bill requires them to continue with this support through the assessment process. This will continue through transition until adult care and support is in place to take over, or until an assessment suggests adult care and support does not need to be provided.

2.9 *Market Shaping*: This enables local authorities to develop the kinds of services that are best for their local community. When buying and arranging services LAs must consider how they might affect an individual's wellbeing. They need to think about whether their approaches to buying and arranging services can undermine the wellbeing of the people receiving those services. For example arranging home visits which are inappropriately short.

2.10 *Advocacy*: In the context of the social care assessment advocacy means supporting the person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need. The requirement to provide independent advocacy applies equally to individuals requiring care or support and to carers with support needs.

3.0 National Context

3.1 This wider context of personalisation beyond those with highest need, places a strong emphasis on prevention, early intervention and support for carers. In practice, this enabled councils to make adjustments to ensure a seamless approach between their personalisation programmes and how they determine eligibility for social care.

3.2 The concepts of prevention and early intervention can be extended beyond adult social services to include: adapted housing smart technology and equipment, improved health care and joint working, greater benefits take-up and community support that can help delay or avoid the need for care completely. The 2008 document *'Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own'*, views carers as fundamental to strong families and stable communities. The aim of support is two-fold: enabling carers to balance their caring responsibilities with their life outside caring; while at the same time enabling the person they are supporting to have full and equal citizenship. Carers 2008 also says that children and young people should be protected from inappropriate caring and have the support they require to learn, develop and thrive , while achieving all five outcomes of 'Every Child matters', 2003. This requires the support of adult and children's services.

3.3 These themes from 'Putting People First' and the 'Carers Strategy' also run through the 'Care and Support' Green Paper (Shaping the future of care together, 2009). This sets out long-term proposals to tackle the challenges of rising demand and expectation facing the present system. Its aim is to ensure that: care is high quality and cost effective, people have choice and control over the care and support they receive, the funding system is sustainable and affordable for individuals and the state.

3.4 To achieve these goals effectively councils need to have a strong focus on the overall wellbeing of their communities and recognise that people should be helped in a way that can prevent, reduce or delay their need for social care support. There is a growing body of evidence that interventions can prevent or delay people entering the social care system and therefore produce better outcomes for individuals at a lower overall cost.

3.5 The review document, 'Cutting the Cake Fairly…' (2008) made several recommendations for making eligibility criteria more equitable and effective. Based on these the DH issued separate guidance on eligibility – Prioritising need in the context of 'Putting People First': A whole system approach to eligibility for social care (2010). This guidance was aimed to support fairer, more transparent and consistent implementation of the eligibility criteria. Outcome priorities included greater choice and control, better access to public services and information, empowerment of people and their carers using services at local level and the definition of 'User Satisfaction' as the measure of success.

3.6 This Care Act 2014 guidance underpins the current responsibilities local authorities have for identifying priorities and allocating their resources accordingly. In doing so, they need to ensure that those individuals who do not meet the eligibility threshold are adequately signposted to alternative sources of support such as: luncheon clubs, befriending, volunteering, SureStart to Later Life…(*Prioritising need in the context of putting people first, Place-Shaping and promotion of well-being through universal services, p 13-14, 2010*). Such universal services improve outcomes for the wider population and can help some individuals avoid or delay having to rely on health or social care services for support. The overall theme is to promote wellbeing.

3.7 A LA such as Halton can promote a person's wellbeing in different ways. Exactly how this happens will depend on the circumstances, including the person's needs, goals and wishes and how these impact on their wellbeing. There is no set approach and each case will be considered on its own merits, consider what the person wants to achieve and how the action which the LA is taking will affect the wellbeing of the person.

3.8 The Act signifies a shift in focus from existing duties to provide particular services, to the concept of 'meeting needs.' This is the core legal entitlement for adults to care and support and establishes one clear and consistent set of duties and power for all adults who need care and support.

This is set out in sections 8, 18, 19 and 20 of the Act.

3.9 The concept of '*meeting needs'* recognises that everyone's needs are different and personal to them. This means that LAs must meet these specific needs rather than merely considering which service they will fit into.

4.0 Local Policy

4.1 This policy sets out how decisions will be made around individual need and how through discussion with the person or their representative, appropriate outcomes can be selected to match need and help to promote wellbeing.

4.2 *Principles and Standards*: Halton's approach will:

- Be non-discriminatory;
- Be applied equally across **all** adult service user groups including adult carers;
- Lead to equitable, transparent and consistent decision making within available resources;
- Be based on the needs of and risks to, individuals with particular reference to the seriousness of any consequences to independence;
- Be clear about the importance of prevention that will trigger a service and the level that will trigger redirection and / or information and advice;
- Enable the authority to balance demand for services with available budget;
- Be written in a way that is easily understood by staff, service users and carers and available in different formats.

4.2. Adults (including carers) with needs for care and support, have the right to an assessment of their needs and a discussion around the outcomes they wish to achieve. If the LA charges for a certain type of support, an adult will have a financial assessment to determine what financial support they may receive.

4.4 Those individuals with eligible needs who choose to arrange their own care and support, will receive an Independent Personal Budget, as well as information and guidance for meeting their needs.

4.5 **Prevention -**This is often split into three different approaches: **Prevent need occurring** (Primary prevention or promoting wellbeing); **Reduce current need** (secondary prevention or early intervention); **Delay deterioration** among those with complex health conditions (tertiary prevention, minimising the effect of disability or progressive decline). It is important that prevention is seen as an ongoing process and not a single activity or intervention. Even at the end of life prevention services could include pre-

bereavement support.

4.5.1 *1. **Prevent**: Primary prevention & promoting wellbeing*

4.5.1.1 These services, facilities or resources are for adults who have no immediate health and care needs and are generally universal (available to all). The aim is to help a person to avoid the need for care and support or a Carer to avoid developing support needs. Some example services would include:

- Providing universal access to good quality information;
- Safer neighbourhoods;
- Promote healthy active lifestyles (exercise classes);
- Reduce social isolation through befriending schemes and community activities
- Encourage discussions in families or groups around future planning should a family member become ill or disabled

4.5.1.2 Additional support on offer at this level generally involves providing or directing them (signposting) to some form of support available either locally or nationally. Local examples are:

- Support from the local community through organisations and neighbourhood schemes;
- Benefits advice to make people more aware of what benefits are available and how to access them;
- Hot meals deliver to a person's home
- Telecare monitors and alarms to help people feel safe and supported all the time;
- Provide support and advice for carers;
- Sheltered accommodation with a support worker providing help to manage the property, budget and maximise the person's independence;
- Lifestyle related including social activities, improving diet, levels of exercise and wellbeing.

4.5.2 *2. **Reduce**: Secondary prevention or early intervention*

4.5.2.1 The aim of the provision of targeted services is to slow down or reduce any further deterioration and prevent other needs from developing. Such individuals may need only a little extra help to get on with their everyday life and avoid a crisis. This can involve helping them at home to recover from a bought of illness to prevent their conditioning from worsening. This form of help is preventative and aimed at reducing the need for a hospital admission. Prevention can also involve Reablement to help people recover at home

after a period of hospitalisation.

4.5.2.2 Support is provided when there is some risk to a person's independence, either currently or in the near future. This may be:

- Planned support to equip or adapt a person's home;
- Housing related to enable a person to manage their property, budget and their entitlement to benefits;
- A small grant to fix a short-term problem that would keep a person healthy, safe and well at home;
- Care management will work closely with housing and other partners to expand the support available for people to adapt their home or make positive choices over their housing options.
- Support for carers
- Support to help people to volunteer or access paid employment or training;
- Intermediate Care and Reablement
- Extra care housing with appropriate levels of care and support available on site

4.5.2.3 Support is given when there are significant risks to a person's independence and safety. This support is to reduce the likelihood of a hospital admission or increase in severity of the condition.

- Provide a community care package after a period of Reablement has been completed;
- Personal budgets;
- Support for carers;
- Focus on community support including maximum use of telecare equipment;
- Intermediate care crisis response services (RARS);
- Short breaks for the person with support needs and their carer.

4.5.3 3. ***Delay****: Tertiary prevention, minimising decline*

4.5.3.1 Support is given when there are immediate risks to a person's safety and independence. This support could include:

- End of Life care to enable the person to die with dignity in the place of their choice;
- Enhanced residential or nursing care;
- Short stay crisis housing services such as refuge from domestic violence.

4.5.3.2 This form of prevention supports people to regain skills and manage or reduce need where possible. It could include the rehabilitation of people who are severely sight impaired. Halton will provide or arrange services, resources or

facilities that maximise independence for those already with such needs (community equipment services, rehabilitation/ Reablement, adaptations and joint case management for those with complex needs.

4.5.3.3 Another important aspect of tertiary prevention is improving the life of Carers by enabling them to have a life of their own alongside their caring role. This could involve respite care, peer support groups like dementia cafes, emotional support and stress management classes. The latter provide opportunities for shared learning and coping tips from other Carers. The aim being to help the Carer to cope with the stress associated with the role and help them develop an awareness of their own physical and mental health needs.

4.5.3.4 Examples of services, facilities and resources that could contribute to preventing, reducing or delaying the needs of Carers could include the following which help Carers to:

- Care effectively and safely
- Look after their own physical and mental health, wellbeing and coping mechanisms
- Making use of adaptations, equipment, IT and assistive technology
- Making choices for themselves – managing care and paid employment
- Locating local support and services
- Accessing the information and support they need. This could include welfare benefits, financial information and making use of their entitlement to a Carers assessment.

PROCEDURE | ***Practice***

5.0 **Principles of Assessment**

Appendix 1 outlines the assessment and eligibility process. this stresses the importance of ensuring that at each stage of the process the following need to be borne in mind:

- mental capacity
- advocacy and participation support
- impact on person's family and their carer(s)
- safeguarding
- approach based on the individual's strengths
- ensuring the assessment is appropriate/ proportional

5.0.1 Individual procedural steps are described below

Always assume a person has capacity unless it is shown they lack capacity. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken.
Link to Care Act Guidance: Sections 6.11; 6.32
Link to the Care Act: Section 9(5); Section 13

5.1. *Mental capacity*

The council has a duty under the mental capacity act 2005 to ensure that individuals who may lack capacity either to ask for or contribute to a needs assessment are fully supported and that the process is person-centred and compliant with the act. From the start of the process the LA must give the person as much information as possible about the steps involved in the assessment and about the different ways in which they can engage that might be relevant to the person. If at any point during the assessment process there is reason to think the individual involved may lack capacity.

5.2 *Advocacy and participation support*

5.2.1 This step covers what the authority must consider to ensure the individual is fully involved in the needs and carer's assessment and facilitate the person's involvement (when appropriate). The LA must ensure that:

- The person is able to be involved as far as possible/ support the person to be involved where appropriate;
- Consider reasonable adjustments under the equality act;
- Consider whether the person would have 'substantial difficulty' being involved in the assessment;
- Provide access to independent advocacy (see definition on p.7) for those who have substantial difficulty and have no appropriate individual who can support their involvement;

- Seek to establish the total extent of needs through the assessment, before considering the person's eligibility for care and support.

5.2.2 The local authority must be confident at all times that the person involved in the assessment is fully supported to be at the centre of the process. From the point of first contact the la will need to consider whether the person requiring care or support or their carer have 'substantial difficulty' in being involved in the assessment. This is based on the capacity test:

- Ability to understand relevant information;
- Retaining information;
- Using or weighing the information as part of engagement
- Ability to communicate wishes or feelings.

5.2.3 An individual who has difficulty with any of these will require assistance. If the la determines there is no one available or capable of representing the individual (a carer family member or friend) it must appoint an independent advocate to provide support and representation. It must also consider any needs for such advocacy the person's carer may have and ensure such needs are met.

5.2.4 An appropriate individual must be able to support the person's active involvement with the local authority processes. Individuals unlikely to fulfil this role would include:

- A family member living at a distance and who has only occasional contact with the person;
- A partner (husband, wife) who also finds it difficult to understand the la processes;
- A friend or family member who expresses strong opinions of their own before finding out those of the person concerned;
- A housebound individual.

5.2.5 A person would be excluded from the role if they have been implicated in any enquiry of abuse or neglect or have been judged by a safeguarding adults review (SAR) to have failed to prevent abuse or neglect.

5.3 *Impact on the family and Carers* (whole family approach).

- The LA must have regard for the needs of the family of the adult receiving the assessment.
- Consider the impact of the person's need for care and support on family members or other appropriate people. To achieve this, individuals who are part of the person's wider network of care and support will

need to be identified.

- Consider in terms of the impact of the person's needs on those around them, whether or not the provision of any information and advice would benefit those individuals identified. This could be signposting to any local support services.

5.3.1 Throughout the assessment process the assessor must take into account the impact of the adult's needs on the whole family network and identify those adults and children who are providing care. This may require the identification of other adults in need of care and support, who are part of the support network. For example, the assessor may find that an adult has a carer who in turn has parenting and caring responsibilities in addition to the adult with care needs. Such a situation would constitute an 'appearance of need' and the assessor should then offer both a carer's assessment and an assessment for the elderly relative in addition to the assessment of the adult with care and support needs.

5.3.2 In considering the impact on the wellbeing of carers and others in the adults support network and how the assessor can help the following are important:

- Where Carers or others are identified as being affected by their caring role, the assessor must consider whether the provision of information or signposting to relevant services or a Carer's assessment, would be of benefit;
- Where a child is identified as being involved in the provision of care, the needs of the child must be considered, the impact of their role as carer on their wellbeing and whether it is inappropriate for them to be in this role. Inappropriate tasks could include: lifting and handling; personal care (bathing and toilet needs), handling cash transactions, looking after the family budget and providing emotional support. For example it may be necessary to refer the child or young person for a young carer's assessment under the Children Act 1989.
- Any decisions made should include the young people's views.

5.4. *Safeguarding*

5.4.1 Where necessary the safeguarding process should run in parallel to the assessment process and is not subject to any eligibility considerations. This ensures the LA can address safeguarding concerns effectively without disrupting the assessment process and meet its duty to meet eligible needs. The safeguarding duties apply to an adult who: has

needs for care and support (whether or not the LA is meeting those needs); is experiencing or is at risk of abuse or neglect and as a result of their needs cannot protect themselves from such abuse or neglect.

5.4.2 The objectives of an enquiry into abuse and neglect are to:

- Establish facts
- Ascertain the adult's views and wishes
- Assess the needs of the adult for protection, support and redress and how they can be met;
- Protect the adult from abuse and neglect according to their wishes;
- Decide on what follow-up action needs to be taken to achieve resolution and recovery;
- LAs must cooperate with their relevant partners and those must cooperate with the authority in all functions relevant to the Care Act including those to protect adults;

Section 6 (7) of the Care Act.

5.4.3 Conducting a safeguarding enquiry and any action which needs to be taken as a result, is entirely independent of the person's eligibility.

5.5 *Strengths-based approach*

5.5.1 This considers the individual's strengths and capability as well as any support which may be available as a result of their wider network and in their community. It is important to consider whether such networks have the capacity to continue to meet the adult's needs on a regular basis. What is important here is this helps to ensure the assessment is person-centred and focuses on individual and wider network strengths, rather than on their condition. The central feature is how the support network and wider community can contribute towards meeting the outcomes the person wants to achieve.

5.5.2 The strengths-based approach values the capacity, skills and knowledge of an individual and their immediate family/ carer network, as well as the existing connections to the person's community. This is not about imposing more on Carers! In some cases a person's eligible needs may be met through support from their own networks or the wider community and the local authority retains responsibility for ensuring that eligible needs are met and will review the situation if the person's circumstance changes.

5.5.3 The strengths-based approach creates a full picture of the person's current and past situation. This focuses on the problems the person is experiencing (deficit-based) and their

history (likes, dislikes, hobbies, occupation, social network…) to produce a picture of their skills and abilities (strength based). Through subsequent discussion, the assessor and the person may identify potential sources of support not previously mentioned. This form of confidence building helps upskilling and independence and contributes overall to their wellbeing.

5.6 *Ensuring assessment is both proportionate and appropriate*.

5.6.1 The assessment has to be appropriate to support the person's involvement. Hence it must be as extensive as required to support the person's needs, will be person-centred and will be based on their individual circumstances.

5.6.2 Proportionate and appropriate are concepts that must be applied to all assessments and are not in themselves a form of care assessment.

5.6.3 The local authority must:

- seek to establish the total extent of needs through the assessment before considering the person's eligibility for care and support;
- consider whether the individual's needs impact upon their wellbeing in any way, including those areas of wellbeing that the person hasn't identified, and must establish the impact of this on the adult's desired outcomes;
- carry out an assessment in a manner which is appropriate and proportionate to the needs and circumstances of the individual to whom it relates and ensure it has regard to the:
    - Wishes and preferences of the individual to whom it relates;
    - Outcome the individual seeks from the assessment;
    - Severity and overall extent of the individual's needs.

5.6.4 The assessment process must have the needs of the person at its centre. That means the process must be suitable to the individual's capacity and capabilities, and any difficulties they may face in communication. The process must be proportionate to the extent and severity of the person's needs, which will have been identified at the stage of initial information gathering and subsequent contact.

5.6.5 Needs and carer's assessments must be carried out appropriately and proportionately – this may be applied in a

range of ways. To ensure the method of assessment is **appropriate** local authorities must take into account the ability and situation of the individual being assessed; establish how much they want to be involved in the assessment and meet that wish as far as is possible. Formats of assessment include but are not limited to:

- face-to-face assessment between the person and an assessor;
- supported self-assessment, where the person leads on the completion of the assessment material and the local authority assures itself that it is an accurate reflection of the person's needs;
- online or phone assessment;
- Joint assessment, where relevant agencies work together to avoid the person undergoing multiple assessments;
- Combined assessment, where an adult's assessment is combined with a carer's assessment and/or an assessment relating to a child. It is, of course, important to recognise that where there is a young carer, their assessment will be conducted by children's services by an appropriately qualified assessor;
    - If both the adult with support needs and the carer have substantial difficulty in being involved in the assessment process, and do not have an appropriate individual to support them, an independent advocate must be arranged;
    - The local authority may be carrying out assessments of two people in the same household. If both people agree to have the same advocate, and if the local authority consider there is no conflict of interest between the individuals or either of the individuals and the advocate, then the same advocate may support and represent the two people.

5.6.6 For the assessment to be **proportionate** this will involve:

- Both hearing and understanding the initial presenting problem;
- Not taking this at 'face value'; and
- Ensuring any underlying needs are also explored and understood.

5.6.7 To address proportionality the assessor will be required to take into account that needs may differ in their breadth and depth, meaning it may be necessary to:

- explore underlying needs
- consider that an individual or carer may have needs

only in relation to some aspects of their lives
- consider that individuals with a clear understanding of their own needs may require less intensive assessment than someone who is approaching the local authority for the first time and does not know what care or support they require.

5.6.8 These considerations will ensure the extent of the assessment is proportionate, is not overly burdensome and recognises both the individual's and their carer's own knowledge and capacity.

5.7 *Duties Around Initial Information-Gathering*

5.7.1 This step provides an overview of the responsibilities of the local authority from first contact with a person who appears to have a need for care and support. The first contact sees the local authority providing as much information as possible on the assessment process and where possible taking action to prevent or delay the need for care and support.

5.7.2 First contact is important, particularly as it may be the only contact some people will have with their local authority.

5.7.3 **Core duties -** The local authority must:
- Seek to establish the total extent of needs through the assessment before considering the person's eligibility for care and support;
- Ensure that staff are appropriately trained to carry out an assessment, be able to identify a person who may lack capacity and be able to steer people seeking support to appropriate information and advice;
- Undertake proportionate and appropriate assessments of any adult or carer with an appearance of need, irrespective of any presumptions of the eligibility of the person's needs or financial situation;
- Give the person, from their first contact with the local authority, as much information as possible about the assessment process, in a format that is accessible to the person.

5.7.4 Information gathered at first contact at this stage might usefully establish the basic facts about:
- Whether the person has the capacity to understand and articulate their own needs;
- Whether the person has difficulty communicating their needs (e.g. due to autism or profound and multiple learning disabilities, mental health needs or

Appendix 2 shows Halton's Referral and Signposting process from the point of the initial contact. Contact is made by a call to the Contact Centre and a triage form completed (Initial Assessment and Screening – **Appendix 3**). Once completed this can be referred in two directions:
1. The person can be signposted and the details of when and where recorded on the form. After a period of 4 weeks a reminder is triggered to Halton Direct Link (HDL). An HDL advisor will then telephone the person and complete a Signposting Follow-up Review (**Appendix 4**). As a result of this, further signposting may be required or no further action taken if the person has met their outcome.

2. They can be directed to the Initial Assessment Team (IAT). Here they will have an assessment and/ or be signposted to an appropriate service. As above a signposting review will be carried out by an HDL Advisor after 4 weeks.

First contact acts as a form of triage which can direct people to information about available services of interest to them, or to IAT where they can arrange to have a comprehensive assessment of their needs. The Mental Health Wellbeing Form (Appendix 5) gives an initial

dementia) (see Appendix 5, Mental Health Wellbeing Form);
- Whether the person faces any safeguarding issues;
- The person, their needs, expected outcomes in day-to-day life and the overall impact of the current circumstances on their wellbeing.

picture of how relaxed, optimistic and useful the person feels. It also allows the person to self-assess their ability to deal with problems, think clearly, consider their feelings of closeness to others and whether they can make a decision about things.

5.7.5 The local authority could also consider whether the person has an immediate network of support and how this network contributes to the individual achieving their desired outcomes.

5.7.6 It is important for the local authority to consider that many of the people who qualify for independent advocacy under the Care Act may also qualify for a mental capacity advocate (MCA). The same advocate can therefore provide support as an advocate under the Care Act and the Mental Capacity Act. This ensures that the person receives seamless advocacy support and also avoids them having to repeat their stories for support under different legislation to different advocates.

5.8 *Identifying An Urgent need*

5.8.1 This step enables an urgent need to be identified quickly for those who require immediate care and support. The local authority can then act on such a need without the necessity for assessment or eligibility checks.

See Appendix 1. Clearly such an urgent need would have a significant effect on wellbeing.

5.8.2 The Care Act 2014 provides the local authority with the power to meet urgent need without undertaking an assessment or making a determination of eligibility, regardless of the person's ordinary residence.

5.8.3 There will be instances where it is obvious that immediate action is required, and in such cases it is likely that the assessment will be paused to be resumed later so a fuller assessment can be conducted.

5.8.4 Circumstances under which needs could be classified as urgent include, for example:
- people who are terminally ill
- rapid deterioration in an adult's condition
- the occurrence of an accident
- a specific issue such as a stroke
- evidence of a safeguarding issue
- unsafe living quarters.

5.8.5 This applies equally to adults with care and support needs and to carers with support needs.

5.9 *Meet urgent care need*

5.9.1 The local authority can act on such a need without the need for assessment or eligibility determination. Having established that the individual faces an urgent need, the local authority can and should choose to provide support without first conducting an assessment or eligibility determination.

5.9.2 Under these circumstances the local authority should meet the identified urgent care needs immediately. It should also inform the individual that a more detailed needs assessment, an eligibility determination, establishment of ordinary residence and a financial assessment will follow the intervention.

5.9.3 This applies equally to adults with care and support needs and to carers with support needs.

5.10 *Duties Around Signposting and Prevention*

5.10.1 Following the provision of initial information to the individual on the assessment process, this step provides an overview of the requirements for the local authority to conduct initial information-gathering and assessing the appearance of needs. This builds on the provision of initial information provided at first contact (initial information-gathering and signposting) and may run concurrently, particularly in cases where there is no urgent need identified.

5.10.2 This also provides a narrative on the importance of the provision of advice and guidance to all who seek support from the local authority, irrespective of any existing care or determination of eligibility. This step also provides the first opportunity for the local authority to prevent or delay the development of needs for care and support which remains an important consideration throughout the process.

5.10.3 *Core duties* -The local authority must:

- seek to establish the total extent of needs through the assessment before considering the individual's eligibility for care and support;
- consider whether the individual's needs impact upon their wellbeing in any way, including those areas of wellbeing that the person hasn't identified, and establish the impact of this on the adult's desired outcomes;
- consider how the adult, their support network and the

wider community can contribute towards meeting the outcomes the individual wants to achieve;

- ensure that the individual is able to be involved as far as possible, for example by providing an interpreter where they have a particular condition affecting communication – such as autism or deafblindness;
- offer an assessment where an individual previously refused an assessment and the local authority establishes that the adult's or carer's needs or circumstances have changed, unless the person continues to refuse;
- ensure the assessor is appropriately trained and has the right skills, knowledge and competence to carry out the assessment in question, whichever method is used;
- ensure that support is available to the assessor where the assessment relates to a specific condition or circumstances requiring expert insight (e.g. autism, learning disabilities, mental health needs or dementia).

5.10.4 This is a two stage process involving:

a. offer information and advice/refer to preventative services;

b. proceed to the next step or pause the assessment process.

5.10.5 The objective is to ensure the individual receives a personalised approach to assessment. Staff must be appropriately trained to be able to carry out an assessment, and should have access to professional support to assist in the identification of more complex needs or underlying conditions.

5.10.6 If the initial information gathered suggests that the person would benefit from targeted interventions or preventative services, the local authority can pause the assessment, while the person receives such services. When resumed, the assessment can focus on the remaining needs that have not been met by the intervention. If the local authority pauses the assessment, it should inform the person that they are doing so.

5.10.7 When the local authority provides information, it must be in an accessible format to support the individual's involvement in the process. A further and important part of this and every subsequent stage of the assessment process is the prevention, delay or reduction in the escalation of care and support needs. This will involve the local authority providing or arranging services that either:

- help keep people well and independent;
- aim to reduce needs and help people regain skills.

5.10.8 It is important to note that prevention may be considered at different levels and may be utilised at any appropriate point in the assessment process:

- Primary prevention/promoting wellbeing (e.g. by supporting access to universal services);
- Secondary prevention/early intervention (e.g. targeted support to provide a few hours of support to a Carer, or adaptations at home to reduce the likelihood of falls);
- Tertiary prevention /intermediate care and reablement (e.g. support to regain specific skills or provide support to improve a carer's life).

5.10.9 This is an important step in ensuring the assessment is centred on the needs of the person and is appropriate and proportionate to the individual's circumstances. Establishing the correct initial information as well as enabling people to access preventative services will also save time and costs later.

5.10.10 Following the completion of the initial information-gathering and provision, the local authority will be in a position to decide which format of assessment may be appropriate to the person's needs, circumstances and preferences or, if the process should stop or be paused, to test the effect of preventative services or other interventions as appropriate.

5.10.11 Relevant protection is built into the process to ensure adults do not exit the assessment process too early, and suitable preventative interventions are put in place.

5.10.12 The actions for the local authority in terms of the decision about appropriateness and proportionality are:

- If yes, the local authority should progress the assessment, including establishing if any carer might benefit from assessment as well.

- If no, If the local authority decides not to proceed with assessment it should consider:
  - Pause: the local authority should consider if there is a need to pause the assessment process to establish the benefit of identified preventative interventions and the extent to which these prevent the adult's needs from progressing. Making use of the opportunity to pause the assessment enables the appropriate point to be reached at which the assessment can be

continued appropriately;

- Prevention: if a full needs or carer's assessment is not taken forward the local authority must ensure appropriate steps are taken to prevent, delay or reduce the escalation of care and support needs. Whatever level of prevention is implemented it is important that this is reviewed and the person returns to the assessment process if and when appropriate;

- Signposting: the local authority must not let the person exit the assessment process without offering information and advice on coping with their condition or referring them to preventative services or to organisations in the community who can provide relevant support. The local authority must provide the person with information and advice on how to reduce or meet their needs and how to prevent, reduce or delay the development of needs.

5.11 Adult Or Carer with care and support needs

5.11.1 Often the immediate focus might be on the adult who requires care and support, however, the needs of any carer the individual has may require a separate assessment.

5.11.2 This step describes the process of identifying the person's needs and in particular whether it is just the individual who has care needs or if there are additional support needs for their carer caused by their responsibilities.

5.11.3 This requires the local assessor to consider how these impact on the individual's wellbeing and to explore who else might be affected by the person's situation.

5.11.4 Core duties - The local authority must:

- seek to establish the total extent of needs through the assessment before considering the person's eligibility for care and support;
- consider whether the individual's needs impact upon their wellbeing in any way, including those areas of wellbeing that the person hasn't identified and establish the impact of this on the adult's desired outcomes.

5.11.5 The assessment must seek to establish a complete picture of the individual's needs, what outcomes they want to achieve in their day-to-day life and what impact this has on

their wellbeing. In the case of a needs assessment of an adult with care and support needs, the assessment must discount the care currently provided by any carer to ensure that a full picture of the overall needs is established. It is important to understand what impact the provision of care may have on any carer's wellbeing.

5.11.6 If the information provided indicates that the carer might have needs for support due to their caring responsibilities, then the local authority must offer to undertake a carer's assessment for that individual.

5.12 *Refusal of assessment*

5.12.1 There is no absolute requirement for an individual – either a person with care needs or a Carer with support needs – to have a needs or carers assessment. If an individual refuses an assessment, the local authority is not required to undertake one. People may choose not to have an assessment if they do not feel they need care or do not want local authority support.

5.12.2 However, if the local authority believes that the person either lacks capacity or is at risk of abuse and neglect, then it is required to carry out an assessment regardless of the person's refusal.

N.B.
Local authorities must assess a person who previously refused an assessment, but has changed their mind.

5.13 *Duty To Assess Carers*

5.13.1 The authority must provide an assessment for any carer who appears to have any level of need for support.

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5.13.2 *Core duties* - The local authority must:

- offer an assessment to any carer with an appearance of need for support;
- ensure the carer is involved in their assessment along with anyone else they might want involved;
- seek to establish the total extent of needs through the assessment before considering the person's eligibility for support;
- establish whether the carer is willing and able to continue to provide care;
- establish whether the carer has substantial difficulty in being involved in the assessment process and, if there is no appropriate person to support them, appoint an independent advocate.

5.13.2 The local authority must ensure that any carer who may have support needs is offered a carer's assessment. This must happen irrespective of any future determination of eligibility and is important in establishing the fullest picture of the carer's needs and, importantly, the sustainability of the current arrangements.

5.13.3 The carer's assessment must seek to establish:

- the carer's needs for support
- the practical and emotional sustainability of the caring role
- the willingness and ability of the carer to continue to provide this support.

5.13.4 It must also consider:

- the impact of their support needs on their wellbeing;
- the outcomes the carer desires from daily life;
- the impact of their caring responsibilities on their ability to work, access education, training or recreation;
- whether support could help achieve these outcomes;
- whether the adult, their support network and the wider community can contribute towards meeting the outcomes the person wants to achieve;
- whether the carer would benefit from preventative support or information and advice.

5.13.5 The outcome of the carer's assessment will provide an understanding of the sustainability of the carer's input in the short, medium and long term. The general principles of assessment still govern a carer's assessment. For instance, the format of assessment must be appropriate to the carer's circumstances.

5.14 *Needs and carers assessment*

5.14.1 This step outlines the various approaches to conducting a needs or carer's assessment. It also considers the requirement for the local authority to ensure that any assessment is appropriate and proportionate to the needs and circumstances of the individual and remains so for the duration of the assessment process.

5.14.2 Core duties - The local authority must:

- seek to establish the total extent of needs through the assessment before considering the person's eligibility for care and support
- consider whether the individual's needs impact upon their wellbeing in any way, including those areas of wellbeing that the person hasn't identified, and must establish the impact of this on the adult's desired outcomes
- consider how the adult, their support network and the wider community can contribute towards meeting the outcomes the person wants to achieve
- ensure that the person is able to be involved as far as possible, for example by providing an interpreter where a person has a particular condition affecting communication – such as autism or deafblind, or an independent advocate in cases of substantial difficulty
- ensure that where the assessor does not have the necessary knowledge of a particular condition or circumstance, they must consult someone who has relevant expertise
- carry out an assessment in a manner which is appropriate and proportionate to the needs and the circumstances of the individual to whom it relates, and ensure that the individual is able to participate in the process as effectively as possible.

5.14.3 Having determined the type of assessment, the local authority must identify the person's needs and how these impact on their wellbeing, and the outcomes that the person wishes to achieve in their day-to-day life.

5.14.4 The principle of proportionality means that an assessment goes as far as is necessary to establish a complete picture of the person's needs. The principle of appropriateness means that an assessment must be carried out in a manner that has regard to the person's wishes, preferences and outcomes, the complexity of the person's needs and any potential fluctuations of those needs.

5.14.5 Additional support may need to be provided (e.g. understanding may be aided through the provision of accessible information or independent advocacy).

5.14.6 Assessments can be undertaken via telephone or online, provided that the local authority has made sure it has fulfilled its duties in relation to the assessment and the need for safeguarding, independent advocacy and assessing mental capacity.

5.14.7 The local authority must ensure the assessment is person-centred, which may include provision of support in circumstances where there are capacity issues or specific difficulties in communication.

5.14.8 What constitutes an appropriate and proportionate assessment needs to be kept under constant review throughout the assessment and eligibility process to ensure the process fits the person's overall needs.

5.14.9 The SCIE Care Act hub provides practice examples of good practice in ensuring assessment is proportionate and appropriate. This is at:http://www.scie.org.uk/care-act-2014/.

5.14.10 In considering the specific assessment to be applied, the following checklist is a guide to choose which format to use:

- Where can the assessment take place?
- Who will conduct the assessment?
- Are there any specific communication needs to be addressed?
- When will the assessment take place?
- What is the mental capacity of the adult with care needs?
- Who has been consulted?
- Who will be involved?

5.14.11 During assessment it is important to ensure the process remains person-centred, the impact of preventative services is considered in maintaining or improving the individual's wellbeing and the outcomes that the person sets for themselves are considered at all times.

5.14.12 It is also important to establish the needs of any carers in the process as an ongoing part of the assessment of an individual's needs and the impact these have on those around them.

5.14.13 Depending on the answers to these questions, any of the following forms of assessment may be deemed appropriate. They do not constitute an exhaustive list.

5.15 *Types of Assessment*

5.15.1 *Face-to-face assessment* - A face-to-face assessment is conducted between the person requiring care and support and an assessor, whose qualification and job title may vary depending on the circumstances, and who must always be appropriately trained, with the right skills and knowledge to conduct the relevant assessment. There may be other circumstances in which the local authority should ensure that the assessor has access to relevant expert knowledge.

5.15.2 *Supported self-assessment* - A supported self-assessment is where the same assessment materials are used as in a face-to-face assessment, but the person requiring care and support completes the assessment on their own and leads the assessment process, with appropriate help from a carer or advocate. The local authority must assure itself that the assessment is an accurate reflection of the person's needs (e.g. by consulting with other relevant professionals and people who know the person).

5.15.3 *Online or phone assessment* - An online or telephone assessment may be an appropriate way of carrying out an assessment if, for example, the person who needs care and support has less complex needs, or is already known to the local authority and it is carrying out an assessment following a change in the person's needs or circumstances.

5.15.4 *Joint assessment* - A joint assessment, where relevant agencies work together to avoid the person undergoing multiple assessments (including assessments in a prison, where local authorities may need to put particular emphasis on cross-agency cooperation and sharing of expertise) is a good way to fit around the needs of an individual. Doing joint assessments with more than one agency or local authority requires good practice in sharing information and working together to ensure needs are accounted for and provided for in a coordinated way.

5.15.4.1 This should include transition assessments to reflect the changes in circumstances and desired outcomes on a young person's transition to adult care and support – which applies equally for people in need of care and young carers, which should be conducted as joint assessments.

5.15.5 *Combined assessment* - A combined assessment is when an adult's assessment is combined with a carer's assessment and/or an assessment relating to a child so that interrelated needs are properly captured and the process is as efficient as possible. If either of the individuals to be

assessed disagrees with the proposal to combine assessments, the assessments must be carried out separately.

5.16 *Needs, outcomes and impact on wellbeing*

5.16.1 The step provides a summary of the individual's care needs, their desired personal outcomes and the impact of their condition and circumstances on their wellbeing.

5.16.2 Core duties - The local authority must:

- Seek to establish the total extent of needs through the assessment before considering the person's eligibility for care and support
- Consider whether the individual's needs impact upon their wellbeing in any way, including those areas of wellbeing that the person hasn't identified, and establish the impact of this on the adult's desired outcomes
- Consider how the adult, their support network and the wider community can contribute towards meeting the outcomes the person wants to achieve.

5.16.3 The assessment must provide sufficient information for the assessor to be able to establish what the person's needs are and how they impact on the person's wellbeing, what outcomes they are seeking to achieve in their day-to-day life, and how care and support, or in the case of a Carer, support, can contribute to the achievement of those outcomes. In order to make an eligibility determination, the assessor ought also to establish how the person's desired outcomes fit with the specified outcomes in the eligibility criteria.

5.16.4 Following the assessment the individual must be given a written record of their needs or carer's assessment. If the person asks the local authority to share the record with anyone, the local authority must do so. If an independent advocate has been involved in the process, the local authority should also inform them of the outcome of the assessment in order for the advocate to help the person understand the implications of the assessment.

5.16.5 As a minimum this must record:

- the adult's care needs – including any supporting information from any combined or joint assessment;
- the carer's support needs – including any support information from any combined or joint assessment;
- the individual's outcomes – which in this context refer to the outcomes set by the person for themselves and

not those associated with the eligibility determination;
- the impact on the individual's wellbeing of their care needs;
- any care being provided by a carer (this should still be recorded for the care planning process, if the person has eligible needs.

5.17 *Consider if needs are likely to fluctuate*

5.17.1 This step considers the action required by the local authority to identify those needs of an adult with care and support needs which may not be apparent at the time of the assessment but which have been an issue in the past and which are likely to arise again in the future.

5.17.2 Core duties - The local authority must:
- Seek to establish the total extent of needs through the assessment before considering the person's eligibility for care and support;
- Consider whether the individual's needs impact upon their wellbeing in any way, including those areas of wellbeing that the person hasn't identified, and establish the impact of this on the adult's desired outcomes;
- Consider whether the individual's current level of need is likely to fluctuate and what their ongoing needs for care and support are likely to be.

5.17.3 The local authority must consider the needs of an individual over an appropriate period of time to understand the full implications of their condition.

5.17.4 The point at which the local authority assesses the individual's needs may not be a true reflection of their condition over time. Where a condition is likely to present fluctuating need – which may mean that the individual is coping with a condition in which they have good and bad days, or parts of a day, or are well for weeks or months at a time – the local authority must assess the impact of this in order to reach the right eligibility decision and build a care and support plan that is suitable to the person's real needs.

5.17.4 The local authority should also consider that needs may not fluctuate because of a condition but may fluctuate because of changing circumstances such as changes in employment or education, or the transition to adult services, which may be the case for young carers entering adulthood. Carers' needs might fluctuate, for example because of school holidays or changes in employment.

5.17.5 This requires the local authority to consider the person's care and support history over a period of time which captures the fluctuating need the person or their representative reports, in terms of frequency and degree of fluctuation. It is vital to ensure that the impact of these varying needs on any carer is also considered as part of a carer's assessment.

5.17.6 If the individual's needs are likely to fluctuate, the local authority must make an accurate record of fluctuating needs to ensure they are effectively factored into the person's care plan, assuming their needs are eligible for support.

5.17.7 This could be done – for example – by the provision of flexible services resulting in a more responsive care plan that can save time if/when the person with care and support needs comes back into the system.

5.17.8 The local authority must also consider the impact the fluctuation in the adult's needs may have on their Carers.

5.17.9 The SCIE Care Act hub provides practice examples of good practice associated with fluctuating need and can be found at: http://www.scie.org.uk/care-act-2014/

5.18 *Meeting The National Eligibility Threshold*

5.18.1 This section considers the local authority's duty to establish eligibility in relation to the minimum threshold set out in regulations for adults and carers. The use of the word 'eligible' here refers only to the needs of adults with care needs and carers with support needs, not to their financial resources or other circumstances.

5.18.2 Core duties - The local authority must:

- Determine whether the individual has eligible needs as described in the national eligibility criteria;
- Establish whether there are needs which the local authority must ensure are met – everyone will receive a written record of that decision, whether their needs are eligible or not;
- In cases where the adult with care needs or their carer does have eligible needs – establish the adult's ordinary residence and carry out a financial assessment, as well as considering what support, in whatever form, could be provided to meet those needs;
- Meet the minimum level of needs as prescribed in the regulations, however, local authorities can also decide to arrange services to meet needs at a lower

level.

5.18.3 The minimum threshold for eligibility has been set to ensure that all local authorities meet the same minimum level of needs. This does not mean that local authorities cannot choose to meet needs that fall below this threshold, but that they must provide for needs that meet the following three conditions:

- The needs arise from or are related to a physical or mental impairment or illness
- As a result of those needs the adult is unable to achieve two or more of the specified outcomes:
  a. managing and maintaining nutrition
  b. maintaining personal hygiene
  c. managing toilet needs
  d. being appropriately clothed
  e. being able to make use of the home safely
  f. maintaining a habitable home environment
  g. developing and maintaining family or other personal relationships
  h. accessing and engaging in work, training, education or volunteering
  i. making use of necessary facilities or services in the local community, including public transport and recreational facilities or services
  j. carrying out any caring responsibilities the adult has for a child

As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing.

5.18.4 For an adult's needs to be considered eligible for support by the local authority they must meet all three criteria.

5.18.5 An adult is to be regarded as being unable to achieve an outcome if they:

a. Are unable to achieve it without assistance
b. Are able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety
c. Are able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others
d. Are able to achieve it without assistance but take significantly longer than would normally be expected.

5.18.6 Similarly, a carer's needs are eligible where they meet three conditions:

1. The needs arise as a consequence of providing necessary care for an adult
2. The effect of the needs is that any of the

For further information on Carer's assessment and eligibility see: Carers Assessment and Eligibility, Adult Social Care Services, HBC, April 2015-16

circumstances specified in the Care and Support (Eligibility) Regulations 2014 apply to the carer, namely:

3.

a. The carer's physical or mental health is, or is at risk of, deteriorating

b. the carer is unable to achieve any of the following outcomes:

i. Carrying out any caring responsibilities the carer has for a child

ii. Providing care to other persons for whom the carer provides care

iii. Maintaining a habitable home environment in the carer's home, whether or not this is also the home of the adult needing care

iv. Managing and maintaining nutrition

v. Developing and maintaining family or other personal relationships

vi. Engaging in work, training, education or volunteering

vii. Making use of necessary facilities or services in the local community, including recreational facilities or services

viii. Engaging in recreational activities.

4. As a consequence of that fact there is, or there is likely to be, a significant impact on the carer's wellbeing.

5.18.7 For a carer's needs to be considered eligible for support by the local authority they must meet all three criteria.

5.18.8 The Care Act guidance provides examples of how these outcomes could be interpreted or be relevant in a given situation of these eligibility criteria.

5.18.9 Following the outcome of the eligibility determination the local authority must provide the person to whom the determination refers with a copy of the decision. If the needs have been deemed not eligible, the local authority has to explain how they have reached this decision.

5.19 <u>If Needs Are Not Eligible</u>

5.19.1 This step details the requirements on the local authority to provide information to adults who are determined as ineligible for support and care as well as providing preventative services.

5.19.2 *Core duties* - The local authority must:

- Establish and maintain a service for providing people in its area with information and advice relating to care

and support for adults and support for carers
- Ensure appropriate steps are taken to prevent, delay or reduce the escalation of care and support needs.

5.19.3 If, following completion of the assessment, the local authority deems that a person's needs are not eligible, it must provide information and advice on:

- Meeting or reducing the needs e.g.:
- The choice of types of care and support, and the choice of providers available in the community for the adult or their carer
- How to access the care and support that is available
- Planning for future care and support needs
- How to access independent financial advice on matters relevant to the meeting of needs for care and support.
- Any package of information provided to the adult or carer should be tailored to reflect the needs of the individual, to prevent future needs and delay deterioration. This will ensure people are helped to access local services, which may be provided by the local authority or by another organisation.

5.19.4 The local authority must also take action to prevent or delay the development of needs, considered at different levels:

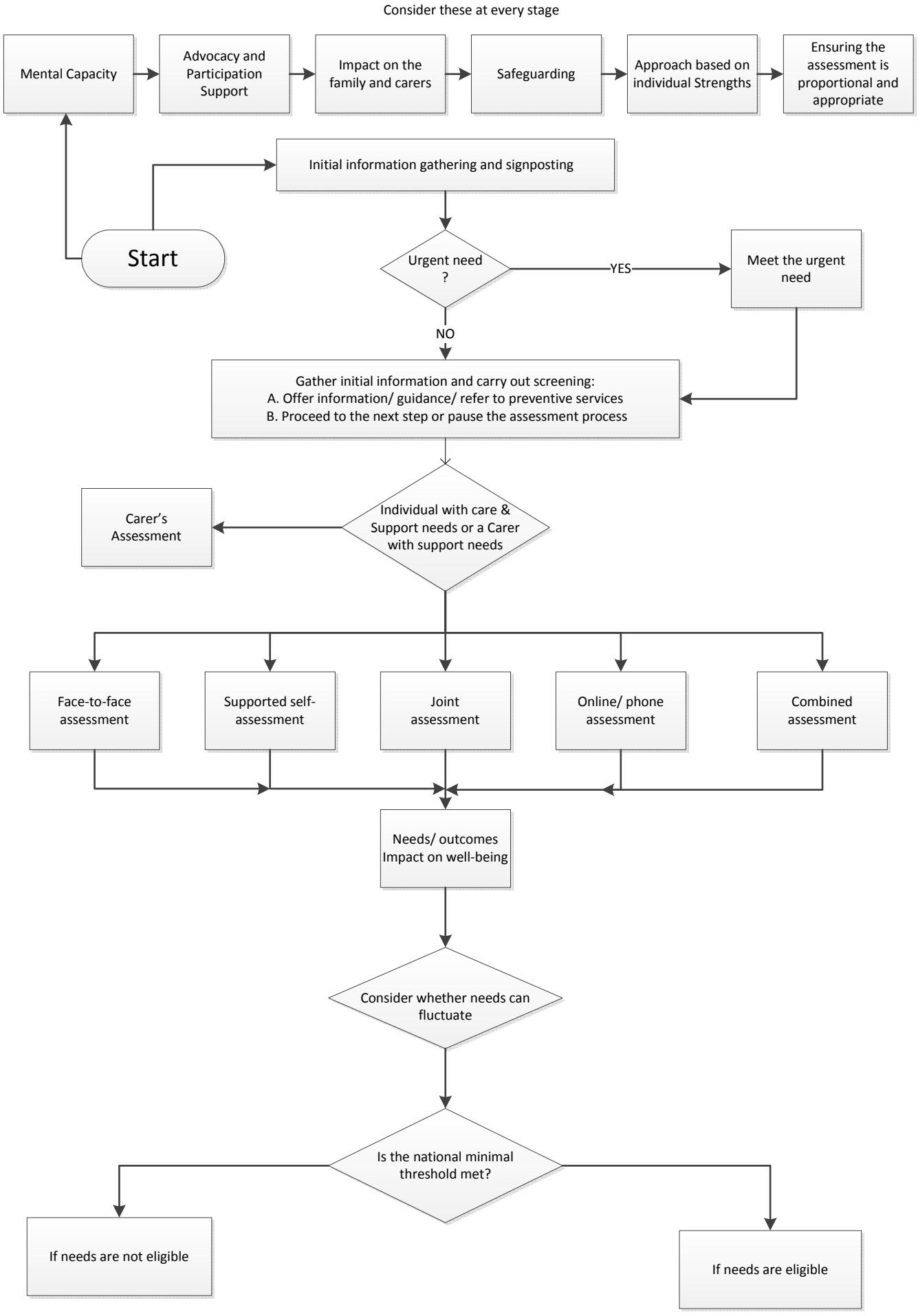
- primary prevention/promoting wellbeing (e.g. by supporting access to universal services);
- secondary prevention/early intervention (e.g. targeted support to provide a few hours of support to a Carer, or adaptations at home to reduce the likelihood of falls);
- tertiary prevention/intermediate care and reablement (e.g. support to regain specific skills or provide support to improve a carer's life).

5.19.5 The process of assessment ends for people with needs that have been deemed ineligible.

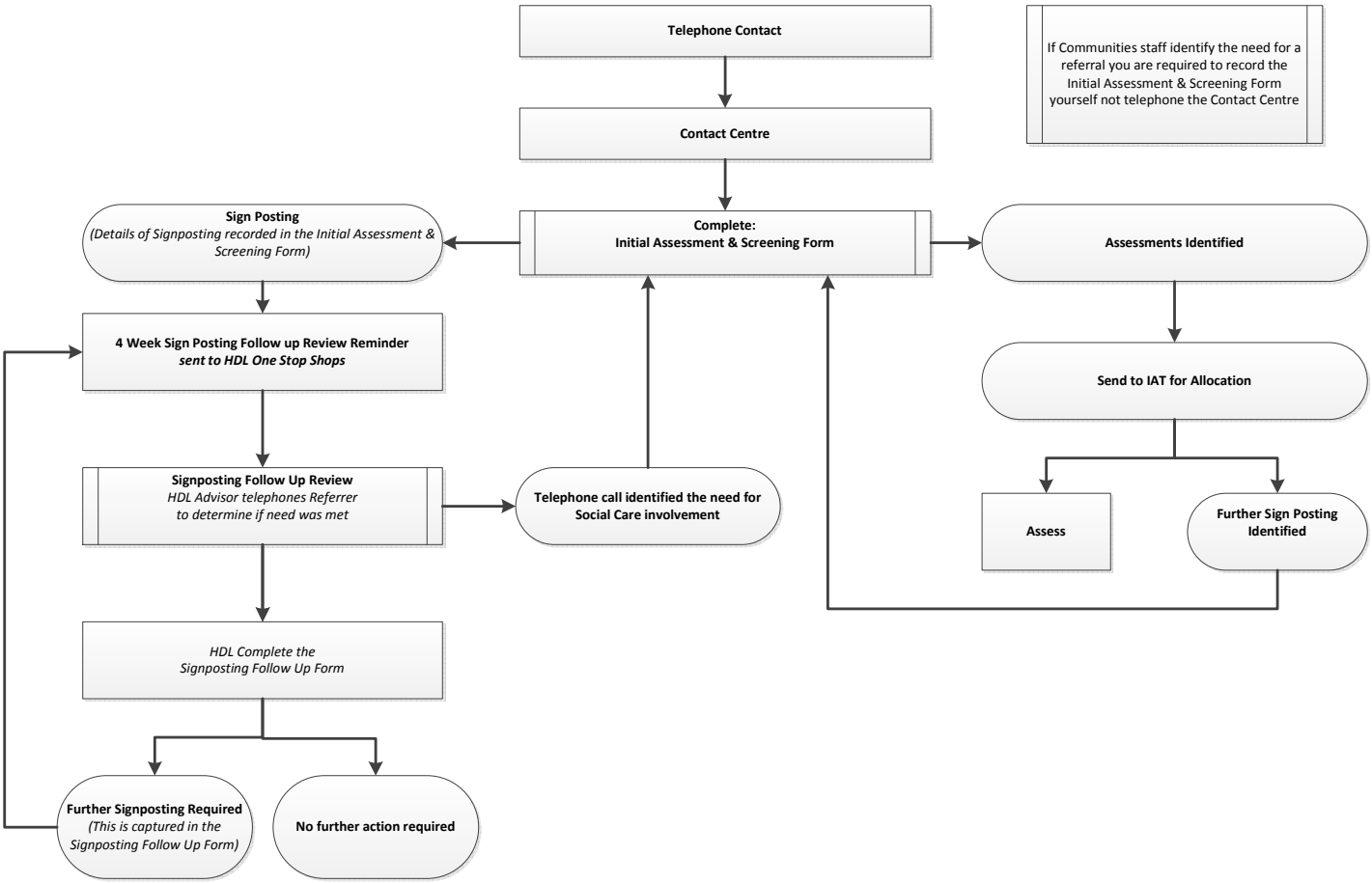
5.19.6 The local authority should maintain a record of the person's need to be able to provide support in the future if their circumstances change.

Appendix 1

Assessment and Eligibility Process



Appendix 2


Telephone Contact
Contact Centre
If Communities staff identify the need for a referral you are required to record the Initial Assessment & Screening Form yourself not telephone the Contact Centre
Sign Posting
(Details of Signposting recorded in the Initial Assessment & Screening Form)
Complete:
Initial Assessment & Screening Form
Assessments Identified
4 Week Sign Posting Follow up Review Reminder
sent to HDL One Stop Shops
Send to IAT for Allocation
Signposting Follow Up Review
HDL Advisor telephones Referrer
to determine if need was met
Telephone call identified the need for Social Care involvement
Assess
Further Sign Posting Identified
HDL Complete the
Signposting Follow Up Form
Further Signposting Required
(This is captured in the Signposting Follow Up Form)
No further action required

Initial Assessment Screening Form

Worker Name		Assessment Date	

Person Details			
Name		CareFirst ID	
DOB		Gender	
Address		Tel No	

NHS Number			
Ethnicity			
Religion			
Name and Address of Doctor			
Marital Status			
Civil Partnership		Separated	
Married		Single	
Divorced		Widow/Widower	
Partnered			
Accommodation Type			
Tenure Type			
Household Composition			
Do you have any communication needs?			
Not applicable		Needs Interpreter	
B.S.L. Signer		Other Sign Language	
Makaton Signer		Specialised Equipment Required (specify)	
How would you like to be contacted (add actual number / email)			
Day time phone number		Emergency Phone Number	
Email		Minicom	
Fax		Mobile Phone Number	
Home Phone Number		Work Phone number	
Letter		Other (please specify)	
Next of Kin *(Name and Address)*			
Is Next of Kin a Keyholder?			

Emergency Contacts *(Name and Address)*
Main Carer (Name and Address)
Is Main Carer a Keyholder?
Other Professional Relationships e.g Health contacts (district nurse / community psychiatric nurse, consultant)
Current Services the individual is receiving

Referral Details

Please enter date of request for support				
Time of Request				
Is the Client Aware of this Referral	Yes		No	
Have you had a discussion with the client	Yes		No	
What does the client want from the referral?				
Route of Access (Tick)				
Planned Entry (Transition) – Clients moving from children's social care to adults services				
Discharge from Hospital -- Clients being referred following a planned or emergency hospital admission				
Diversion from Hospital --Clients referred in order to prevent hospital admissions. For example, falls prevention and falls response services				
Community / Other route -- Requests from clients or on their behalf based in the community, residential/nursing care or any other route of access				

Contact Method			
Event		Home Visit	
Internal Correspondence		Letter / External Correspondence	
Personal Caller		Secure Email	
Telephone		Web Entry	
Contacted By – Caller information (Name / Organisation & telephone number)			
Referral Topic			
Referral Presenting Issue			
Referral Notes			

Assessments Required				
What is the impact on the whole family?				
THE FOLLOWING QUESTIONS ARE MANDATORY				
Are there any Safeguarding Concerns?	Yes		No	
Does this person require an assessment of their self-care? (**SAQ)**	Yes		No	
If yes, which team would you send to for allocation				
Is an Outcome Focused Review required?	Yes		No	
If yes, which team would you send to for allocation				
Is a Carers Assessment Required?	Yes		No	
If yes, which team would you send to for allocation				
Is an online Carers Self-Assessment Required?	Yes		No	
Is a Visual Impairment Assessment Required?	Yes		No	
If yes, which team would you send to for allocation				
Is a Mental Capacity Assessment required?	Yes		No	
If yes, which team would you send to for allocation				
Is a Deprivation of Liberty Safeguards (DoLS) required?	Yes		No	
If yes, which team would you send to for allocation				
Is an Accessible Homes Service Assessment Required?	Yes		No	
Is an Equipment Assessment required? (**SAMME)**	Yes		No	
If yes, which team would you send to for allocation				
Is a Deafness Resource Assessment required?	Yes		No	
Is a Learning Disability Nurse Assessment required?	Yes		No	
Does this person require a Meals on Wheels Assessment?	Yes		No	
If yes, which team would you send to for allocation				
Is a referral to Universal Services Required?				
Carers Centre		Community Bridge Building		
Independent Advocacy		Sure Start to Later Life		
Welfare Rights		Young Carers Referral		
Is a referral required to the GP?				
Wheelchair Assessment		Physio		
Walking Aids				
Is a referral required to the Health Improvement Team Required?				
Weight Management		Smoking		
Substance Support		Alcohol Support		
Breastfeeding Support Group		Exercise Programme		
Falls		Weight Management		
Record details of signposting				
Is a Signposting Review Follow Up required by HDL?	Yes		No	

Follow-Up Review Form (in CF6)

Worker Name		Assessment Date	

Personal Information			
Name		CareFirst ID	
DOB		Gender	
Address		Tel No	

NHS Number			
Ethnicity			
Religion			
Name and Address of Doctor			
Marital Status			
Civil Partnership		Separated	
Married		Single	
Divorced		Widow/Widower	
Partnered			
Accommodation Type			
Tenure Type			
Household Composition			
Do you have any communication needs?			
Not applicable		Needs Interpreter	
B.S.L. Signer		Other Sign Language	
Makaton Signer		Specialised Equipment Required (specify)	
How would you like to be contacted (add actual number / email)			
Day time phone number		Emergency Phone Number	
Email		Minicom	
Fax		Mobile Phone Number	
Home Phone Number		Work Phone number	
Letter		Other (please specify)	
Next of Kin *(Name and Address)*			
Is Next of Kin a Keyholder?			

Emergency Contacts *(Name and Address)*
Main Carer (Name and Address)
Is Main Carer a Keyholder?
Other Professional Relationships e.g Health contacts (district nurse / community psychiatric nurse, consultant)
Current Services the individual is receiving

Follow up for Signposting
Date followed up signposting
Record details in relation to the follow up for signposting

Further Signposting			
Is a referral to Universal Services Required?			
Carers Centre		Community Bridge Building	
Independent Advocacy		Sure Start to Later Life	
Welfare Rights		Young Carers Referral	
Is a referral required to the GP?			
Wheelchair Assessment		Physio	
Walking Aids			
Is a referral required to the Health Improvement Team Required?			
Weight Management		Smoking	
Substance Support		Alcohol Support	
Breastfeeding Support Group		Exercise Programme	
Falls		Weight Management	
Record details of signposting			
Is a Signposting Review Follow Up required by HDL?	Yes		No
Has another Referral been identified?	Yes		No

Mental Well-Being Form

Worker Name		Assessment Date	

Personal Information			
Name		CareFirst ID	
DOB		Gender	
Address		Tel No	

NHS Number			
Ethnicity			
Religion			
Name and Address of Doctor			
Marital Status			
Civil Partnership		Separated	
Married		Single	
Divorced		Widow/Widower	
Partnered			
Accommodation Type			
Tenure Type			
Household Composition			
Do you have any communication needs?			
Not applicable		Needs Interpreter	
B.S.L. Signer		Other Sign Language	
Makaton Signer		Specialised Equipment Required (specify)	
How would you like to be contacted (add actual number / email)			
Day time phone number		Emergency Phone Number	
Email		Minicom	
Fax		Mobile Phone Number	
Home Phone Number		Work Phone number	
Letter		Other (please specify)	
Next of Kin *(Name and Address)*			
Is Next of Kin a Keyholder?			

Emergency Contacts *(Name and Address)*
Main Carer (Name and Address)
Is Main Carer a Keyholder?
Other Professional Relationships e.g Health contacts (district nurse / community psychiatric nurse, consultant)
Current Services the individual is receiving

Worker &Team Allocation
Allocated Worker
Allocated Team

Mental Well Being Scale					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my own mind about things					