Appendix B

Adult Care & Support Assessment, Review and Eligibility Policy

November 2013

1. Policy Statement

Telford & Wrekin Council aims to deliver a personalised and flexible approach to support alongside delivering Community Care responsibility in a fair, equitable and transparent way to all residing in Telford & Wrekin, with the focus on putting the person at the centre of the service. The Council has a duty to facilitate the provision of Adult Care & Support Services to those residents who qualify under its eligibility criteria.

This policy applies to those individuals eligible for support from the Council following a co-produced assessment. Individuals with assessed eligible unmet needs will be allocated a personal budget which will enable them to meet those needs in accordance with a validated Support Plan. Adult Care & Support Services aim is for all assessments to be co-produced with the service user.

The Resource Allocation System (RAS) is the system by which resources will be allocated to service users with assessed eligible unmet needs and is integrated into the Community Care Assessment (My Assessment & My Review). The RAS will provide an indicative resource allocation; this will give the service user an early indication of how much money it is likely to cost them to get the support they need for their unmet eligible needs. The final allocation amount or 'Personal Budget' is agreed as part of the Support Planning process. It should be noted that in certain circumstances the person's indicative Personal Budget could be substantially different to the sum of money finally allocated.

2. Purpose of the Policy

The purpose of the Policy is to outline the assessment, review and eligibility processes which includes:

- The assessment process which is outcome focussed as opposed to needs led
- The different assessment tools which may be used such as the RAS and more specialist assessments such as Prevention, Enablement and Nursing assessments.
- The principles that will be adhered to when undertaking an assessment.

- The process for determining eligible need against Fair Access to Care Services criteria (FACS)
- Links with person centred Support Planning

The Policy will follow the guiding principles of:

- Putting the person at the centre of the assessment process ensuring that this is outcome focused and co-produced
- Ensuring that the Council is meeting the unmet eligible needs of service users by ensuring the RAS accords with FACS criteria.
- Allowing available resources to be fairly allocated in a transparent way to individuals on the basis of assessed unmet eligible needs, regardless of gender, age, ethnicity or impairment though the RAS.
- Enabling a personalised response to need by providing individuals with an Indicative Personal Budget within which they can plan to meet their assessed eligible unmet needs.
- Facilitating the Council to monitor and manage the resources available in accordance with its financial and budgetary responsibilities.
- Ensure the appropriate services and support is provided to people.
- Recognised that an individual's situation and circumstances may change over time and as such their care needs and the support they receive will need to be reviewed regularly.

3. Policy Information

This policy sets out:

- The levels of Assessment and Review
- Details the tools which will be used to assess and support an individual's social care needs
- How eligibility is determined
- Provides the framework for the way in which the RAS will allocate resources for service users to meet their eligible unmet needs.
- This policy should be read in conjunction with all Adult Care & Support Policies & Procedures for Community Care.

3.1 Service Specification Information

This policy describes an approach to Assessment and Review which is applicable across all care and support services. Although the same criteria and principles are applied across all services, the tools through which assessment information is collated differs from each service in order to collate the most relevant information for that service.

4. Assessment

Assessment is a service in its own right, even if no services are being provided to an individual. Therefore, the threshold for receiving an assessment is kept low. If in doubt, an assessment should always be offered/undertaken as enquiries/referrals cannot be taken at face value e.g. the needs that lie behind an initial request need to be explored to inform any decision being made about whether further assessment is required before any decisions are made. Undertaking an assessment is not a commitment by social services to providing or arranging Adult Care & Support Services but a means of collecting relevant information to inform a decision as to whether the individual does require any further services/assessments.

- An assessment should commence within 48 hours of receiving the referral or initial contact i.e. the date at which the person being referred/making the enquiry has been contacted directly by the Department either on the telephone or in person (in line with national standards).

- The assessor (regardless of which team) will work with the individual to establish clear expectations at the assessment/Review stage regarding the purpose of the assessment. The purpose is to establish an individual's key needs, outcomes as well as distinguishing between the 'presenting' needs and those needs which may be 'eligible' for funded community care services and/or intervention once the initial Reablement service has been provided

5. Assessment Principles

The following principles and approach should be followed by assessors regardless of what type of assessment/Review is being undertaken.

The assessor will need to explore with the person and their carer, if appropriate, the outcomes they want and any service to achieve this. Active partnership and co-production with the individual in the assessment process evidences good assessment practice.

Similarly, wherever an informal carer is identified, who provides or intends to provide a substantial amount of care on a regular and unpaid basis, should be involved in the assessment/Review process as much as possible As such, through the assessment process individuals should:

- Maximise their network and informal support
- Gain a better understanding of their situation.
- Be able to identify the options that are available for managing their own lives.

- Be able to identify the outcomes required from any help that is provided.
- Gain an understanding of the basis on which decisions are reached.
- Co-produce their assessment

The assessment process should culminate in a description of unmet need – not a prescription for service. The level of risk to the person's independence associated with each need should be explored in detail with the person to determine what the consequences would be if these needs were not met. This will determine eligibility for funded services/support. The assessment should be clearly recorded on the appropriate forms and held on the individual's social care record.

The aim of assessment is to determine the best way to enable and empower individuals and their carers. Assessment is a co-produced evaluation of a person's needs that identifies problems and objectives and incorporates all relevant viewpoints to determine how best those needs can be met.

6. Eligibility Criteria

Telford & Wrekin Care and Support services are required by law to make sure that people requesting social care help are measured against the Department of Health's Fair Access to Care Services criteria (FACS). This is intended to ensure that we reach decisions in a fair, consistent and open way.

There are four possible levels of need.

- Critical
- Substantial
- Moderate
- low

The following four risk factors are considered as essential to maintaining independence:-

- Autonomy & freedom to make choices
- Health and safety including freedom from harm, abuse and neglect
- The ability to manage personal and other daily routines
- Involvement in family and wider community life, including leisure, hobbies, unpaid and paid work learning volunteering

With the exception of life threatening circumstances, there should be no hierarchy between these factors. In other words, ability to access employment should be viewed as being just as important as personal care needs with the person themselves determining where their own priorities lie.

Authorities may set their eligibility threshold in accordance within their resources. The threshold is reviewed annually. Telford & Wrekin currently provide

support/services for unmet Critical and Substantial Needs. Citizens with Low and Moderate needs are provided with advice and information or directed to other services. Where possible these low/moderate needs will be dealt with at point of Access with such services including low level preventative support or community meals, community alarms, assistive technology and equipment etc. Information and Advice is available on the MyLife website. Eligibility for adult social care must be established as a result of an assessment.

The decision on eligibility should be separate from the process to decide the indicative resource allocation (using the RAS). This is undertaken before agreeing the support plan, which will check to ensure that all eligible unmet needs are going to be met. The support /reablement plan is co-produced between T&W and the client, this will inform the creation of a Self Directed Support package which will identify how outcomes are to be met using personal budgets.

Once all relevant assessments have been undertaken, the assessor will need to determine whether the individual is eligible for funded Adult Care & Support Services from the Council against the eligibility framework.

An individual's eligibility will be determined and prioritised according to the seriousness of risks to the person's independence both in short and long term if their assessed needs are not addressed. The council has locally overlaid the RAS sections to FACS risks factor (see Appendix 1)

6.1 Determining Eligibility

Determining eligibility may be undertaken at various stages of the process depending on the individuals' needs and therefore their journey through the community care process. The application of the FACS criteria may be undertaken by Reablement and Prevention staff where an individual requires on-going support. This will usually be following their period of reablement. In order to ensure that community care services are delivered in a fair, equitable and transparent way, the Council will apply the FACS criteria to each individual case to determine whether they are eligible for social services.

In determining an individual's eligible needs the following will be completed:-

- Evaluation of all available assessment information
- Identify eligible needs as opposed to presenting needs (presenting needs are all those needs/problems being experienced by the individual. Eligible needs are those which are unmet and may require social care support that are above the Councils eligibility threshold).
- Determination of an "eligible need" as defined by the threshold set by the Council. The Council has a legal responsibility to provide a service to address the identified risks arising from eligible, unmet needs (including consideration of

continuing health care criteria and NHS responsibility for service provision). Options to meet these needs may not always require a Community Care funded service.

- An assessment of risk will be made in relation to each of the identified needs i.e. the extent to which the problem/issue poses a risk to the individual's independence. Each need will be allocated a risk banding – the highest of which will become the individuals overall band. In doing this, the practitioner should consider:
    - The instability and/or unpredictability of the needs;
    - The intensity of the needs and the level of distress they cause the person;
    - The complexity of the person's needs, in particular the number of different needs,
    - How they interact, and how the individual reacts to the difficulties facing them;
    - The impact of external and environmental factors;
    - The sustainability of support from family, wider community and other agencies.

6.2 When the Assessed Need is Below the Threshold

In some cases service provision may be made to individuals that have assessed needs that are below the threshold and will consider the provision of low intensity, preventative services in these cases. This is dependent upon available resources - the Council has no obligation to meet these needs.

If a person has social care needs which fall below the eligibility threshold which are not met they will be given information and advice about how they might access other forms of support. The Council needs to be satisfied that needs will not worsen or increase in the foreseeable future and bring that person back into eligibility because their independence has become undermined. This could include for example, involvement in employment, training & education and parenting responsibilities. If individuals need other services, they should be helped to find the right person to talk to in the relevant agency or organisation, and contact made on their behalf if necessary.

The decision about eligibility will be put in writing to the person and they should be told that if their circumstances change, they can be re-assessed. A contact number in the Council should be given. If the person is unhappy with the decision they should be invited to let the Council know with the intention of resolving the situation at the lowest level. They should also be made aware that they may use the complaints procedures to challenge decisions to withhold or withdraw services. They should be given the appropriate Council leaflet (Have Your Say) which includes information on available advocacy services.

6.3 When the Assessed need is above the Threshold

When it is clear that the individual's needs are above the Council's threshold (ie substantial or critical) then the individual will be offered help to find options to meet those needs and where they cannot be met in other ways, funded services by the relevant team. Although an individual is assessed as having needs above the threshold, the level of funding they may receive can only be determined by undertaking a financial assessment. The Financial assessment will be undertaken by the Financial Case Management Team – see Fairer Charging Policy and Financial Case Management Policy & Procedure.

In undertaking an assessment of eligibility, the following will be completed:-

- Evaluation of all available assessment information
- Determination of an "eligible need" as defined by the threshold set by the Council linked to RAS stages. The Council has a legal responsibility to provide a service to address the identified risks arising from eligible, unmet needs (including consideration of Continuing Health Care criteria and NHS responsibility for service provision). The Council will explore all Community based services before Community Care Funding is provided.
- For those needs falling below the threshold, the Council **may** provide a service subject to the availability of resources and will consider the provision of low intensity, preventative services via the Reablement and Prevention service.

7. Assessment Details: Assessment & Review

The Resource Allocation System (RAS) is the system by which resources will be allocated to service users with eligible unmet needs. It is a component of the Community Care Assessment. The RAS supports the overarching policy objectives of Personalisation which are to promote the independence, health and wellbeing of individuals while improving their choice and control over the support they receive. The community care process may be undertaken at various stages of the Adult Care & Support process depending on the individuals needs and therefore their journey through the community care process.

7.1 Resource Allocation System: Introduction

The Resource Allocation System enables available Council Adult Social Care resources to be allocated fairly, and services delivered, in a consistent and transparent way. The purpose of the RAS component of the assessment/Review is to identify and evaluate an individual's unmet needs in order to deliver an indicative personal budget with enough resources to enable a service user to meet their identified eligible unmet needs.

The RAS is integrated into the Community Care Assessment or 'My Assessment and My Review'.

The RAS is the system by which an indicative personal budget is calculated for eligible service users who are exercising their right to a Community Care Assessment and Self Directed Support. It does so by translating support needs into a resource budget. The purpose of the system is to provide an equitable and transparent way of allocating resources, and is based on a co-produced assessment/Review of an individual's support needs, the eligibility of those needs and the availability of resources to meet those needs.

For resource allocation to work well and efficiently it is important that it forms an integrated part of a self directed support process – that includes good contact arrangements, investment in information and advice, and early intervention and prevention, and within a market that is prepared to respond to individual's needs and requirements.

7.2 Resource Allocation System: How does it operate?

The RAS consists of three main components:

- A supported co-produced assessment questionnaire that seeks to identify a service users' support needs and is used in a supported way as part of the community care assessment;
- A points allocation system which translates these needs into points to reflect the relative scale of these needs; and
- A 'pounds per point' calculation that converts the points into a sum of money, known as the *indicative* personal budget.

It is the *indicative* personal budget which allows service users to plan the support that will deliver the outcomes to best meet their identified needs. The RAS does not generate an absolute amount. Rather, it provides an *indication* of the resources an individual may need to meet the cost of addressing their assessed eligible unmet needs. It is the Support Planning and validation process which determines the final allocation or personal budget.

7.3 Resource Allocation System: Co-produced Assessment and Review

Appropriate assessment is at the heart of effective service delivery for adult social care provision and the Council recognises that it is imperative for service users' to be active partners in the assessment of their needs. The RAS therefore forms part of the community care assessment and is co-produced with the service user and assessor.

Therefore the RAS captures three different views:

- **My View**
  This is the perspective of the Service user
- **Representative View**
  If the Service User lacks capacity in a decision specific area the Representative view will be recorded in this section.
- **Assessor View**
  This is the perspective of the assessor and is the 'view' that the RAS uses to generate points. The 'My View' and 'Representative View' do not contribute to the RAS score.

In order to ensure equity of resource allocation, there is one RAS component of the assessment/Review for all service users, regardless of age, disability or type of need.

7.4 Resource Allocation System: Points Allocation System

The points allocation system translates the needs identified in the Co-produced RAS assessment into numerical points.

The points for each answer remain the same regardless of who is completing the RAS component of the assessment/Review thus ensuring that service users who have the same answer for a particular question will receive the same points in relation to that question. This maintains the equality of the points allocation system.

7.5 Resource Allocation System: Pounds per Point Calculation

Once the points have been allocated, they are then converted into the indicative personal budget via a 'pounds-per-point' calculation. The 'pounds-per-point' rate sets a certain monetary figure for each point scored on the questionnaire. This figure is multiplied by the number of points scored on the questionnaire in order to determine the total indicative personal budget.

The pounds-per-point rate is based on the cost of meeting eligible support needs, having regard to the available Council resources.

7.6 Resource Allocation System: Validation

All needs and outcomes identified from the assessment, will be documented in the Support Plan, and in order for the Council to meet its duty, these needs must be met in the Support Plan in order for the plan, and therefore the budget, to be validated. The Support Plan will aim to maximise where possible needs through Community or other resources.

The indicative personal budget identified through the RAS must be validated before it can be physically allocated. This validation is undertaken on agreement of the

Support plan and confirmation of the Personal Budget after the support plan has been brokered.

An individual's budget is generally expected to be able to be the maximum needed. However in exceptional circumstances additional resources may be necessary to meet eligible unmet needs through the Support Planning. Any additional funds will require approval through the Adult Care and Support Panel. In addition a service user can supplement their budget from their own funds to meet ineligible needs and outcomes.

7.7 Resource Allocation System: Calibration

In addition, the Council will monitor the overall implementation of the RAS to ensure that it remains equitable and transparent and allows service users to meet their assessed needs. This will include a review of the RAS formula to ascertain whether the point's allocation and pounds-per-points rate remain adequate to meet service users' eligible needs; and to ensure that the RAS remains sustainable in light of available Council resources. RAS calibration will be reviewed annually but 'add hock' reviews can be undertaken if issues with calibration are identified.

7.8 Resource Allocation System: Change in Personal Circumstances

If a person's needs change fundamentally a Review of their support needs can be undertaken, and a new revised indicative personal budget allocated as required. This will be undertaken as part of the Review process.

7.9 Resource Allocation System: Exceptional Cases

Where exceptionally high support needs are identified during the assessment/Review and planning process the Council will work with the service user to find the best solution for their individual eligible unmet needs.

It is recognised with the current market place that it may not be possible to purchase residential/nursing placements within the agreed allocated personal budget. In individual circumstances the Care Fund and cost Calculator will be used to agree placements. Where it has been agreed that the only service that can meet the unmet eligible needs of the individual are outside the RAS calculation, we would use the Care Fund or cost Calculator where positive risk taking assessment has been considered, and there is significant funding difference between RAS and purchased price. If the placement is community based then additional funds can be requested through the Panel process. Each case will be discussed on a 'case by case' basis.

The Care Fund Calculator supports the negotiation of fees for residential care only for ALD placements costing over £1000. For Adult and Older People residential and nursing home placements, the brokerage team will negotiate directly with the market.

7.10 Resource Allocation System: Disputes

Any dispute will follow the Council compliments, comments and complaints process: http://www.telford.gov.uk/site/scripts/documents_info.aspx?categoryID=200025&documentID=79

7.11 Resource Allocation System: Carers

As the help and support of family members and/or other carers is essential for many people, assessment/Review of the level of support provided by carers is included in the RAS component of the assessment/Review. Carers' own needs are not yet assessed within a RAS component of the assessment/Review. However if it is determined that they may benefit from services, or they request one, a separate Carers Assessment should be completed to deal specifically with their needs. Carers are entitled to an assessment even if the service user does not agree to undertake an assessment.

7.12 Resource Allocation System: Stages/Domains

There are ten stages to the RAS component within the My Assessment and My Review. These stages are:

- Communication
- Making Decisions and Organising My Life
- Managing Actions
- Keeping Myself Safe
- Meeting Personal Care Needs
- Eating and Drinking
- Running and Maintaining My Home
- Being Part of My Communication
- My Role as a Parent or Carer
- Having Work and Learning Opportunities

Each of these ten stages or domains are broken down into seven sections. These sections are:

- **Evidencing Needs**
  This section is 'free text' and is used to Evidence the level of need recorded and FACS. It is also the section where the narrative of the individual's life is recorded. This section is not used to generate points**.**

- **Determining Level of Need**
  The section is a range of statements, which classify a series of increasing levels of need. For example for the Stage Meeting Personal Care Needs the statements are:
  A) I do not need any support with my personal care
  B) I need occasional support/encouragement with my personal care (e.g. once or twice a week)

C) I need some support/encouragement with my personal care (e.g. at least once a day)
D) I often need support/encouragement with my personal care (e.g. at least twice a day)
E) I need frequent support/encouragement with my personal care (e.g. several times a day)
The 'total' level of need of the individual is matched to the most relevant statement. Each statement is associated with a Point.

- **Number of Carers (day/night)**
  The section is a range of statements linked to the number and frequency of carers required. For example *'I need one person to support me with my personal care'* will receive less points than *'I need two or more people to support me with my personal care'.* The points will also incrementally increase if you select day and night rather than just day or night. The number and frequency of carers is match to the most relevant statement. Numbers of carers is only asked for the RAS Stages of 'Managing Actions', 'Keeping Myself Safe' and 'Meeting Personal Care Needs'.

- **Identifying Provision of Informal Support**
  This section looks at whether the service user has any informal support and whether that support is sustainable. Sustainability is a key word in this question and will require professional judgment to determine sustainability. Unlike the previous two questions where you select a level of need this question identifies if the service user is receiving informal support.

Yes indicates that some level of informal support is being provided.
No indicates that the service user has no informal support or the informal support being provided is not sustainable.

- **Identifying the Level of Informal Support Provided Considering Sustainability**
  Answering YES to 'Identifying Provision of Informal Support' requires the need to identify how much informal support is provided.
  Sustainability is a key word in this question and will require professional judgment to determine the level sustainability. How this question is answered will incrementally reduce the number of points gained from the previous three sections. Therefore

(A) 'My family and friends can provide all of the support I need' will reduce the number of points received from previous sections more than (D) 'My family and friends are unable to support me.

- **Outcomes**

This section is 'free text' and records the Outcomes the Service User wants to achieve in relation to the specific RAS stage being completed.
This section is not used to generate points.

- **Discrepancy Sections**

During the assessment it may become apparent that the view of the service user or their representative may not correspond with that of the assessor. If this discrepancy

cannot be resolved during the assessment then details of the conversation and the rationale for the decision is recorded here. This section is not used to generate points.

Each of the RAS stages has been associated with FACS Domains (see Appendix 1)

7.13 Resource Allocation System and Fair Access to Care Services Criteria

The RAS component of the assessment/Review is not a FACS criteria as RAS and FACS assess different areas:

- Eligibility criteria assess the risks and consequences of not meeting identified unmet needs to independence, health and well-being. The decision on eligibility establishes which of the person's needs are eligible and must be met.

- Domains in the self-directed assessment questionnaire identify level and frequency of support required to meet a person's needs and achieve defined outcomes. The RAS determines how much money is likely to be required to meet these needs. The purpose of the RAS is only to decide the indicative allocation. This allows the RAS to be kept as simple as possible.

In order to ensure the Council is meeting the eligible needs of service users a separate FACS Criteria template should also be completed.

8. Review and Monitoring

The Council has a statutory duty to re-assess each service users' and carer's support needs at least annually, and may do so more frequently should this be necessary. The review will be used to ensure that needs are being met and support is appropriate. Frequency of reviews will be agreed and included in the support plan. Service users and carers are also entitled to request a Review of their overall situation in the interim should they wish to do so.

9. Financial Contribution

The Council will maximise the resources available to meet need, by charging for services (people have a right to a community care assessment at no cost to themselves) in accordance with national regulations for residential care and national guidance for non-residential services (See Fairer Contributions and Charging Policies).

10. Assessing Capacity

Where an individual appears to lack the capacity to assess their own support needs, an assessment under the Mental Capacity Act (MCA) should be carried out. The decision maker, if the person is deemed to lack capacity, will also make the decisions relating to the assessment under the best interests guidance, taking into account the views of all relevant people including family, friends and representatives having regard to s4 MCA and the Code of Practice; These views will be recorded in Representatives Views of RAS component of the assessment/Review

11. What are the Assessor's Responsibilities.

The person completing the assessment is responsible for:

- Collating information about the individual from different agencies/sources.
- Co-ordination of the appropriate professional input, e.g. from Social Services staff, Health colleagues, etc. If a referral is being made to another agency or service e.g. to a Physiotherapist, District Nurse etc the information captured within each stage of the assessment should form part of that referral. Forwarding of this information ensures that the person requesting services does not have to produce the same information twice. It also ensures that the receiving agency/service has some information on which to determine the best way for them to proceed and to potentially prioritise/allocate their ongoing involvement.
- Involving the individual and their family or carers in the assessment process. This will include identification of their perspective about needs and preferences, expressed outcomes and options already identified by the individual and/or their carer(s). It is clearer if people who use services' and carers' views are expressed in direct quotations.
- Advising/assisting the person about completion of the relevant parts of the assessment/Review and support plan themselves if they wish to do so.
- Obtaining consent from the person being assessed for the information taken to be shared with health and social care professionals involved in their care.
- Ensuring the person who has been assessed is given a copy of the assessment
- Informing the service user of their indicative and personal budget.
- Providing relevant information and giving whatever explanation is required so as to ensure that the individual is able to use and to benefit from the information provided.
- Informing people who use services, carers, advocates/representatives and close family members as appropriate, of the action to be taken if they are dissatisfied with the assessment or subsequent services.
- Obtaining, recording and sharing accurate information in a safe and appropriate manner in line with relevant legislation and good practice requirements.
- Informing people who use services, and/or carers if appropriate, that their information will be held electronically, and that legislation such as the Data Protection Act 1998 entitles them to apply for access to information held about them.
- Recording all activities on CareFirst in a timely and accurate way
- Ensuring any safeguarding issues are managed appropriately

12. Four Levels of Assessments

There are four levels of assessment which may be undertaken depending on the individual's presenting needs – in all cases, a contact assessment will be undertaken when an individual initially contacts our services via the Access Team and any one or more of the other types of assessment may be undertaken depending on the suspected need.

12.1 Contact Assessment

Contact Assessments are undertaken when an individual initially contacts our services. The purpose of this assessment is to quickly and effectively collate information and screen contacts in order to signpost the individual to the most appropriate service. This assessment collates basic information on all initial enquiries in order to quickly establish the key presenting needs of that individual and therefore determine which services they may or may not require to address these needs.

The Contact Assessment could be completed at this stage with Information and Advice or indicate that further assessment is required. If further assessment is required a referral is made to the most appropriate service as well as passing on the contact assessment to ensure the receiving team are aware of the key issues therefore avoiding the need for the individual to repeat this information to another service.

In situations where two or more contact assessments are undertaken within a short interval, consideration should always be given to the need for a Social Care Assessment.

12.2 Community Care Assessment: My Assessment

My Assessment is undertaken by one of our Assessment Teams where it is suspected that an individual has social care needs. This is a more in-depth assessment to set the context of the individual's strengths, needs and wishes and provides a full picture of the individual's circumstances whilst enabling service users and carers to detail their perceptions of their needs. The My Assessment is co-produced with the service user.

The My Assessment also contains a RAS component which will provide an indicative personal budget on the completion of the assessment to enable Support Planning for eligible unmet needs.

This level of assessment is carried out by competent, trained practitioners across agencies if they judge a more wide-ranging assessment is required. The depth and range of exploration will be determined by the presenting situation and person's

views and as a result involvement of more specialist staff may be required e.g. occupational therapy, physiotherapy in order to form a complete picture. The involvement of specialist staff should be proportionate to the individual's needs. Wherever possible and practical, the assessment will be completed by a single professional.

Similarly, where particular domains of the assessment are not relevant to the person's circumstances there is no need to explore them in any detail but a note of this must be made within the documentation.

Before undertaking an assessment, the allocated worker should determine whether a Social Care assessment has already been completed by another person or agency, and if this is so, a copy should be requested if not already on record. This should avoid unnecessary repetition of questions for the person being assessed. This Assessment should then be updated with any new information and any changes to existing information noted.

12.3 Community Care Review – My Review

The authority has to ensure that it regularly reviews the needs of people receiving Adult Care & Support Services arranged or provided by the Council. This is to ensure that people are still eligible to receive services and that the services being provided are achieving the agreed outcomes as set out in their support plan. This involves regularly re-assessing an individual's needs.

Review will be undertaken the following circumstances:-

- Initial Review within 3 months of the first service being provided or major changes in service provision being effected, and thereafter at least annual Reviews of the individual's needs.
- Where there is any significant change in an individual's situation, Review to determine "current" eligibility will be undertaken.
- Reviews can also be requested by the individual or their carer where it is felt there has been a change in circumstances or it is felt that the services are no longer meeting their needs.

Where an individual is classed as an inactive case, a Review will be scheduled every year as a minimum to ensure that the services they receive are still meeting their needs or that their needs have not escalated since services were introduced. As the individual will not be allocated a worker on an on-going basis, the Team Leader will allocate Reviews to the most appropriate worker when the Review is due/requested.

Whenever an individual is provided with services to address their on-going eligible social care needs, the case will be allocated to the Assessment and Case Management Team who will determine whether the individual is an active or inactive case.

Where an individual's situation is unstable, they require regular contact with social services or their service needs to be monitored closely, their case will be considered to be an active case. Where an individual receives on-going services which result in their condition remaining stable, the case will be considered inactive until such time as their circumstances change or their care is reviewed (whichever is the sooner).

All active cases will be allocated a worker from assessment and case management who will act as the individual's first point of contact within Adult Care & Support Services and will provide on-going monitoring of the individual and the services they receive in partnership with any service providers. This worker will continue to manage the individual's case to ensure that services are being provided in line with their support plan.

Reviews should:-

- Involve the people who user services, their carer and providers as fully as possible
- Establish whether care services have achieved the agreed outcomes as set out in the support plan
- Reassess the needs and risks faced by individual users of services
- Determine the continued eligibility for care services
- Confirm or amend the current Support plan or lead to closure of a case
- Comment on how the individual is managing their finances where appropriate
- Agree actions for the future
- Update the indicative personal budget

12.4 Community Care Assessment – My Support Plan

Support Planning is a principle that starts prior to the Council being contacted. MyLife is a website that has been developed by Adult Care & Support to enable the people of Telford & Wrekin to find services independently and to maximise 'free' support before contacting the Council. There are seven steps that are followed at every stage of a persons journey through Adult Care & Support Services, these are:

1. Enhanced Resource Information: Providing access to relevant information that is accessible when needed
2. Maximise Informal and Community Support: Maximise service available in the Community and provided by family and friends; ensuring that support is sustainable and carers are supported (see carers policy)
3. Maximise the use of Equipment, Assistive Technology, Telecare and Enablement.
4. Funding: Maximise alternative funding routes and provide an indicative budget up front at the start of the process.
5. Direct payments: Direct Payments to be preferred deployment option to support creative Support Planning.

6. Discuss and share alternatives to traditional deployment options
7. Talk to Commissioning to inform of potential gaps in the market or market development options.

12.5 Other Assessments

The Social Care Assessment may in itself indicate that the individual requires a more specialist assessment by specialist workers e.g. Occupational Therapist/ Physiotherapist. Where this is the case, a further assessment is arranged by the allocated worker.

Nursing Assessments are co-ordinated by the Reablement service where it is suspected that an individual may have Health/nursing care needs. Where this is the case, the reablement worker will arrange for a nursing assessment to be undertaken by a qualified nurse. A nursing assessment will be recorded on a separate nursing assessment form as this is a more specialist assessment of nursing and health care needs. Wherever this is the case, any previous assessments undertaken by social care staff will be shared with Health staff so that the nurse has some background to the individuals needs and avoids the individual having to repeat information to another assessor.

Reablement & Prevention - Referral to the Reablement and Prevention Team will be made by Access or Assessment & Case Management in order to maximise and increase the individual's independence before identifying and putting in place arrangements to maintain independent living. Reablement covers a range of short-term interventions which help people recover their skills and confidence after an episode of poor health, admission to hospital, or bereavement. Reablement can help people to continue to live independently in their own homes without the need for an ongoing social care support package.

12.6 Carers Assessment

Carers Assessments – The initial contact assessment may identify a carer for the individual – this should be recorded on the contact assessment and on CareFirst (with permission of the carer). Where an informal carer is making the initial enquiry on behalf of the person they care for, they will be offered a carers assessment in their own right. Where the carer accepts the offer of an assessment and is a known case, their details will be passed to the appropriate team in order that a full carers assessment can be undertaken to identify any needs the carer may have (as oppose to the needs of the person they care for). If the carer is not known to the council their carers assessment will be undertaken by the Carers Centre.

This assessment focusses solely on the carer and their needs as an informal carer with the aim or providing services which may support them in their caring role (please refer to the Carers policy for further information). Where a carer refuses an assessment, this should be recorded on the contact assessment and on CareFirst.

13. Recording

All community care processes per individual client is recorded on the Council's electronic client record database called CareFirst.

14. Policy Implications

14.1 Legal Implications

This policy outlines the Authority's obligations for provision of social services in line with the NHS & Community Care Act 1990 and other relevant legislation. It is recognised that the Government's draft Care & Support Bill may place further/amended obligations on Local Authorities in due course. Once this is finalised, this policy will be amended accordingly.

14.2 Finance and Value for Money Implications

The aim of the Community Care Policy and associated policies is to reduce individuals' need for high level intensive care and support (which can be high in cost) by providing preventative services which aim to rehabilitate and reable the individual to live independently wherever possible and avoid their care needs escalating to high dependency care. Although this may result in a reduction in the use of high intensity, expensive care packages, the anticipated savings are being re-diverted into investing in the Authority's Reablement and Preventative services as well as into community developments and encouraging/enabling development of support mechanisms within the community.

14.3 Economic Implications

It is anticipated that the personalised approach being implemented via the Community Care process will ensure that each individual is able to continue to play an active part in their own community as well as achieving their own personal goals and outcomes which for those of working age, may include gaining employment or training which in turn will support and develop their own local community and economy.

In order to provide a wide range of services which allow a flexible approach to meeting individuals' needs, the Council is committed as part of its Co-operative Council approach to investing in, encouraging and shaping a varied market of providers including smaller social enterprises in order to meet the needs of the community as a whole.

14.4 Environment Impact

Not Applicable – there are no environmental impacts associated with this policy.

14.5 Other Impacts

There are no other impacts associated with this policy.

15. Cross Referencing Information

15.1 Standards

- General Social Care Council (GSCC) Codes of Practice see the following link:

http://www.gscc.org.uk/codes/Get+copies+of+our+codes

15.2 Legislation

- Disabled persons (Employment) Act 1944
- National Assistance Act 1948
- Health Service and Public Health Act 1968
- Chronically Sick and Disabled Persons Act 1970
- National Health Service Act 1977
- Health and Social Services and Social Security Adjudications Act 1983
- NHS and Community Care Act 1990 S47 (5) and S47(6) – *temporary provision in urgent situations, prior to full assessment*
- Community Care (Direct Payments) Act 1996
- Health and Social Care Act 2001
- Carers and Disabled Children Act 2000
- Nationality, Immigration and Asylum Act 2002
- Community Care (Delayed Discharges etc) Act 2003
- LAC (93) 7- DOH –Ordinary Residence
- LAC (2002) 13 - Fair Access to Care Services – guidance on eligibility criteria for adult social care
- LAC (2001) 32 Fairer Charging Policies for Home Care and other non-residential Social Services – guidance for councils with social services responsibilities
- Charging for Residential Accommodation Guide (CRAG) (updated annually by DOH and issued with covering LAC)
- National Service Framework for Older People (2001)
- National Service Framework for Mental Health 1999
- Valuing people – a New Strategy for Learning Disability for the 21st Century 2001

15.3 System Implications

This policy is supported by the use of the council's Abacus, Agresso and Care first systems and relates to ICT guidance notes on use of these systems.

15.4 Other Relevant Documents

- Adult Care & Support Directory
  http://www.telford.gov.uk/info/100010/health_and_social_care/1160/adult_care_and_support_directory
- Making It real
  http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/MakingItReal.pdf
- Think Local Act Personal
  http://www.thinklocalactpersonal.org.uk/_library/PPF/NCAS/Partnership_agreement_easy_read_1_November_2010.pdf
- Caring for our Future White Paper
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_130455.pdf
- The Commission on Funding of Care and Support
  http://www.dilnotcommission.dh.gov.uk/our-report/
- A Vision for Adult Social Care: Capable Communities and Active Citizens
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121971.pdf
- Care and Support Bill – HM Government, 11 July 2012
  http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/

Appendix 1

DOMAIN Applicable to	RAS Stages		CRITICAL Definition	SUBSTANTIAL Definition	MODERATE Definition	LOW Definition
	Overriding Priority		Life is or will be threatened **C1**			
			Significant health problems have developed or will develop **C2**			
Autonomy	Communication	Making Decisions and Organising My Life	There is or will be little or no choice and control over vital aspects of the immediate environment **C3**	There is or will be only partial choice and control over the immediate environment **S1**		

			There is, or will be, an inability to act on informed choices **C4**	There is, or will be, a limited ability to act on informed choices **S2**		
Health & Safety	Managing Actions	Keeping Myself Safe	Serious abuse or neglect has occurred or will occur **C5**	Abuse or neglect has occurred or will occur **S3**		
				There is, or will be, some risk of harm or danger to self or other **S4**		
Managing personal and daily routines	Meeting Personal Care Needs Eating & Drinking Running and Maintaining My Home		There is or will be an inability to carry out vital personal care or domestic routines **C6**	There is or will be an inability to carry out the majority or personal care or domestic routines **S5**	There is or will be an inability to carry out several personal care or domestic routines **M1**	There is or will be an inability to carry out one or two personal care or domestic routines **L1**

Family and Social Involvement	Being Part of My Community My Role as a Parent or Carer Having Work and Learning Opportunities			Vital involvement in work, education or learning cannot or will not be sustained **C7**	Involvement in many aspects of work, education or learning cannot or will not be sustained **S6**	Involvement in several aspects of work, education or learning cannot or will not be sustained **M2**	Involvement in one or two aspects of work, education or learning cannot or will not be sustained **L2**
				Vital social support systems and relationships cannot or will not be sustained **C8**	The majority of social support systems and relationships cannot or will not be sustained **S7**	Several social support systems & relationships cannot or will not be sustained **M3**	One or two social support systems and relationships cannot or will not be sustained **L3**
				Vital family and other social roles and responsibilities cannot or will not be undertaken **C9**	The majority of family or other social roles and responsibilities cannot or will not be undertaken **S8**	Several family and other social roles and responsibilities cannot or will not be undertaken **M4**	One or two family and other social roles and responsibilities cannot or will not be undertaken **L4**