Appendix 12b Care & Support Policy & Procedure Document

Policy & Procedure Title	**:**	**Adult Care & Support Community Care Policy & Procedure**
Policy & Procedure Ref:	**:**	**30: Community Care**
Date IIA Approved by Line Manager:	**:**	
Date CIA Approved by HoS	**:**	
Intranet Location:	**:**	**Adult Care and Support pages (pending new Community Care Process page) and CC Handbook**
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Owner:	**:**	**Assistant Director: Social Care Specialist**
Approver:	**:**	**Assistant Director: Care and Support**

1. POLICY STATEMENT

- This policy explains the Council's approach to the delivery of Community Care services as laid down by the NHS & Community Care Act 1990 and other relevant legislation. It also sets out our approach to meeting the recommendations and principles set out in the Think Local, Act Personal guidance for Transforming Adult Social Care and the recently published Government White Paper.

- This Policy is an overarching statement relevant to all of Adult Social Services. It explains in general terms the approach taken by the Council to meet the objectives laid down for Social Services by the Department of Health (DoH) in respect of services for adults within Caring for Our Future, Think Local, Act Personal and the wider Personalisation agenda.

- The Council has other social services responsibilities to adults that can run separately or in parallel to its community care responsibilities, including the protection of vulnerable adults (see Adult Protection, Mental Capacity and Deprivation of Liberty Safeguards policies), services for carers (see Carers policy), the delivery of mental health services (see Joint Policies produced by the Partnership Policy Committee), delivery of Drug and Alcohol Recovery Services (DARS), Continuing Health Care (CHC) arrangements, financial assessment & charging, the delivery of Supporting People Services and delivery of transition services for young people from the age of 14 prior to moving into adult services at the age of 18.

- A range of other policies & procedures flow out of this policy and are either part of the Community Care process or are stand alone policies and procedures. Although these

sit outside of the community care process, they do, and will continue to contribute to the community care process where an individual's needs are assessed as requiring input from these services e.g. Drug & Alcohol Recovery Services (see ***Appendix 3***: Adult Care & Support Process).

- The Government White paper 'Caring For Our Future: Reforming Care and Support' published in July 2012 supports the approach set out within this policy with the key principles of :-

  - ***Health, wellbeing, independence and rights*** so that individuals are at the heart of care and support including timely and effective interventions
  - People are treated with ***dignity and respect*** and are safe from abuse and neglect
  - ***Personalisation*** is achieved where individuals have real choice and control over the care and support they need to achieve their goals
  - ***Skills, resources and networks*** in every community are harnessed and strengthened to support people to live well and contribute to their communities where they can
  - ***Carers*** are recognised for their contribution to society and are supported to reach their full potential
  - A ***caring, skilled and valued workforce*** delivering high quality care and support in partnership with individuals, families and communities

- It should be noted that the approach set out within the Government White Paper is a long term vision with some initiatives not due until 2015 or beyond. It is recognised that the detail of some of these initiatives e.g. introduction of a national minimum eligibility threshold, Government start up funding for online care and support information, Social Impact Bonds, Care & Support Housing Fund, legislation giving entitlement to a personal budget are not yet known, but will have a potential significant impact on this and other operational policies. Similarly, a comprehensive modernisation of care and support law is proposed by the draft Care & Support Bill. Therefore, an unscheduled review of this policy will be undertaken to take account of any significant changes emerging from these developments over the coming months/years.

2. PURPOSE OF THE POLICY

2.1 This policy sets out a high level overview of the community care process which has recently been significantly reviewed and updated to reflect key changes in legislation and best practice issued by the Department of Health with a focus on delivering preventative services to ensure individual's needs do not escalate unnecessarily to on-going, high level support needs. This demonstrates the Councils shift in focus to enabling as many people as possible to live independently, stay active and healthy with an active involvement in their communities for longer, and delaying or avoiding the need for targeted services whilst ensuring that those individuals who do need targeted support are given the appropriate information, means and confidence to direct their own support. For most people, enablement will be a key process to determine what on going support needs are required. **Where people choose not to engage with the enablement process, on going services will not normally be provided by the council.**

2.2 Telford and Wrekin endorse the 7 key principles set out in the Government Vision For Social Care document required for a modern social care system (see section 7.1) and the following key themes highlighted in the 'Making It Real' and the Government White Paper 'Caring for Our Future' - it is these principles which underpin our overall approach:-

1. **Information & Advice –** access to easy to understand, consistent, accurate and up to date information in order that individuals feel able to make well informed decisions and enabling individuals to help themselves
2. **Active and Supportive Communities –** access to a range of support networks including carers, family, friends and the wider community to help them live the life they want and continue to be a contributing member of society (this is covered in more detail within our My Community Policy & Procedure (ref 31))
3. **Flexible and Integrated Care & Support –** ability to exercise maximum choice over how they are supported
4. **Workforce –** support is delivered by a competent workforce
5. **Risk Enablement –** supported to manage risks and plan for crisis before it occurs whilst maintaining choice and independence
6. **Personal Budgets and Self Funding –** Individuals know the amount of money available to them and can determine how this is used, with support where necessary, regardless of the source of funding or whether the individual pays for their own services in full.

2.3 The procedure set out below is based on the above principles which are endorsed by Telford & Wrekin Council. In following these principles, the Council aims to:-

- Secure greater co-operation and better use of ***resources*** across public services to improve individuals and their families' experiences. This includes housing, leisure, culture, transport, health, welfare benefits, employment support, social care and community safety throughout the community care process and in particular as part of the 'My Community' aspect of the community care process (see process map at ***Appendix 2***) and the 'My Community' Policy & Procedure (ref 31).

- As a Co-operative Council, we will encourage and help local communities, groups and external providers to work in ***partnership*** with us to provide networks of support, to help people improve their health and well-being, and to reduce their need for more acute care and health services

- Actively ***involve*** people, carers, families and communities in the design, development, delivery and review of innovative care and support arrangements to maximise choice and independence and utilise the widest range of resources

- Ensure that the general public, service users, carers and their families have the ***information and advice*** they need to make informed care and support decisions which work for them, regardless of who is paying for the care. This includes helping them to make the best use of their own resources to support their independence and reduce their need for long-term care

- Provide everyone who may need to access social services the opportunity to receive ***Reablement & Prevention services*** according to their need. This may be from a few days up to a maximum of 28 days free of charge, in order that they can receive short term support with the aim of maintaining their own independence in the long term and preventing their needs escalating to the point of requiring acute or on-going services

- Ensure that access to ***low level and preventative services*** is easily accessible without the need for assessment wherever possible

- Facilitate a broad range of ***choice*** in the local care and support market, including housing options, and personalise the way in which care and support services are delivered wherever people live

- Wherever possible, individuals are given ***choice and control*** on how their finances are managed as well as receiving transparent information in relation to their financial contributions and the cost of services, allowing real choice and control over their services and finances.

- Ensure those people eligible for ongoing council social care funding receive this via a ***personal budget*** (either as a direct payment or a managed account or a mixture of both) allowing them to exercise the same amount of choice and control as those who pay for their own care.

- It should however be noted that the Council aims to secure the most cost effective package of services that meets the users needs whilst taking account of service user preferences wherever possible. This must be within available resources which may sometimes involve difficult decisions where a balance has to be struck between meeting identified needs within available resources and meeting the care preferences of the individual service user. Although each individual's circumstances will be considered on a case by case basis, the following principle will be applied:-

    - The maximum cost to Telford & Wrekin Council for community based care packages should in all but exceptional cases, be no more than the cost of a care home placement per week to Telford & Wrekin Council (excluding Funded Nursing Care or other NHS contribution)

Where an individual who is subject to the above principle wishes to remain in the community but they or their family does not want to top up the care package to the level of that recommended as result of the assessment, a risk assessment must be carried out to ensure we do not fund or part fund a care package that puts the service user or care staff an unacceptable risk (please refer to our risk assessment policy and procedure).

It is recognised that there may be exceptional circumstances where alternatives will be considered but this must be agreed by the budget holder. Social Services reserve the right to review all care packages and provide a cheaper alternative so long as this will continue to meet the needs of the service user.

- Enable individuals who pay for their own care to have access to the services described in this policy though there may be a charge made for these services depending on individual circumstances (see guiding principles above).

These key principles underpin our Personalisation model (see **Appendix 1**) which was developed in conjunction with service users as part of our Putting People First (PPF) Project and forms the basis of this policy and associated procedure.

2.4 How will we meet these objectives?

Our approach has an emphasis on effective prevention and intervention with a greater focus on enabling self-help and self service for those individuals who are able to do so. Where long-term support is required, the Council will aim to deliver it in a way that is cost effective and will enable the people who use services to remain in their home, wherever possible.

In order to meet the principles set out above, a significant restructure has been undertaken following extensive consultation to ensure that resources are appropriately organised to enable a focus on Reablement & Prevention rather than resources being organised by

client group. This allows more flexibility and cross working in order to deliver a personalised service. The process that community care services will be delivered through is known as, the "Community Care Process". There are a number of stages in this process that are illustrated in the high level process map (**Appendix 2**) and medium level process maps (**Appendix 4**) and described in more detail at section 5 of this policy. Operational policies and procedures apply to each of these stages (see section 7.1).

The list below highlights the key stages of the community care process as well as which team/s are responsible for each stage. However, it should be noted that not everyone will pass through every stage and neither will the stages necessarily occur in this order as this will very much depend on the individual's needs and circumstances:-

1) ***Information and advice*** (delivered by the wider community, Access Team and wider Council Services e.g. Contact Point, Customer Services etc)
2) ***Referral and access*** (delivered by the Access Team and the Home From Hospital Team)
3) ***Reablement and prevention*** (delivered by the Reablement & Prevention Teams)
4) ***Personal Budget support*** (delivered by the Personal Budget Support Team (PBS) (and Assessment & Case Management Teams)
5) ***Assessment and eligibility*** (undertaken by the Assessment & Case Management and Financial Case Management Teams)
6) ***On-going care and review*** (undertaken by the Assessment & Case Management teams)

Ultimately, our ambition is that everyone is able to:-

- Live independently
- Stay healthy and recover quickly from illness
- Exercise maximum control over their own life and where appropriate the lives of their family members
- Participate as active and equal citizens both economically and socially
- Have the best possible quality of life irrespective of illness or disability and;
- Retain maximum dignity and respect

3. POLICY INFORMATION

3.1 Who does the policy apply to?

- Telford and Wrekin Council is the Authority responsible for the delivery of community care services for adults (people aged 18 years and over) normally resident in the Borough.

- The following people may require community care support as a result of illness, frailty or substantial disability:

  - Older People (65 years +)
  - People with a Physical Disability
  - People with a Sensory Disability
  - People with a Learning Disability
  - People who have mental health problems
  - People who have problems resulting from excessive misuse of drugs and/or alcohol
  - Young people in transition who will bring community care needs into adulthood
  - Carers
  - Children who are carers of adults

This policy applies to all adult care and support service delivery units as follows:

- Access & Enablement
- Assessment & Case Management
- Personalisation Support & Service Provision
- Adult Safeguarding
- Commissioning Services

3.1 Service-Specific Information

This policy applies to all Care and Support Services.

4. PROCEDURE STATEMENT

This procedure provides a consistent, transparent and equitable approach to the delivery of social services as part of the community care process and is supported by operational policies and procedures in relation to each aspect of the overarching process e.g. information and advice, referral and access, reablement & prevention, personal budget support, assessment and eligibility & on-going care and review.

It should be noted that where an individual has primarily health care needs, these will be assessed by the local health services and not via the Council's Community Care Process. These health care needs may be eligible for full Continuing Health Care (CHC) funding by the NHS or where the individual is placed in nursing home care, Free Nursing Care (FNC) funding from the NHS can pay a proportion of the cost. Some health related needs should also be met by the NHS as part of a joint package of care – further details of the CHC & FNC process are available within the CHC & FNC Process Guides.

5. PROCEDURE DETAILS

5.1 The overarching Community Care process consists of five key stages through which most individuals will pass (see **Appendix 2**). It is recognised that not every individual who contacts our services will pass through every stage – the advice, information and support provided will be tailored to individuals' needs dependent upon the nature and level of need. It is the Council's aspiration to ensure that wherever possible, individuals' needs are addressed at first point of contact with recognition that where this is not appropriate, referral to the Rehabilitation and Prevention Team will prevent the individuals' needs from escalating and encourage independent living wherever possible.

Despite not all stages of the process being appropriate for every individual, each stage is delivered in such a way as to ensure that every individual is dealt with in a transparent, efficient way. Every individual receives a personalised service which meets their own needs whilst aiming to give every individual as much choice and control over their own care and support as possible throughout the process. It is the Council's aspiration that individuals will maintain real choice and control over their own lives and decisions around their care and support throughout the Community Care process.

5.2 The key stages below will be delivered by corresponding teams with timely intervention and support from the Financial Case Management and Personal Budget Support teams. It is recognised that any team playing a part in the community care process may contribute to an individual's care and support particularly those teams who do not directly form part of the community care process but whose services are inextricably linked e.g. Drug and Alcohol Rehabilitation Services (DARS) (See diagram at ***Appendix 3***).

The following sections give a brief breakdown of the services provided at each stage of the community care process by team. However, it should be noted that for each stage of this process, there is a more detailed operational policy and procedure (see section 7.1). In addition, for each stage, there is a medium level process map at ***Appendix 4***:-

5.3 Referral and Access

5.3.1 ***Information and Advice*** – ensure that accurate, easy to understand information about community resources and social services care & support is easily available to citizens to give them real autonomy and choice whilst enabling them to make informed choices about their care and support. This information will be made available on the Council's website through the My Life portal which will be accessible by members of the public and professionals alike. This will enable individuals to decide whether or not they need to contact Social Services for further help, advice and guidance. This links closely to the Council's Co-operative Council approach, encouraging local communities to play a significant role in contributing to and planning services for the Borough (this aspect of the process is referred to as 'My Community' on the process map at ***Appendix 2*** and is covered by an operational 'My Community' Policy & Procedure).

5.3.2 ***Access*** -Where information is not available or further support is required, contact can be made with our Access team which provides a single point of contact for all adult care and support services – this provides the public with a single point of contact for all queries. The Access team aims to resolve as many enquiries as possible at the first point of contact by providing high quality information and advice and signposting citizens to sources of community support such as community/ voluntary organisations and community groups. The role of the access team is to:-

- Receive all initial enquiries made to social services whether from carers, service users or members of the public
- Receive vulnerable adult referrals
- Screen information and establish if a referral is appropriate
- Where appropriate, offer information and advice, signpost queries to other agencies, community resources
- Ensure that individuals are signposted to appropriate services when discharged from hospital (this is undertaken by the Home from Hospital Team)
- Where queries cannot be resolved at first point of contact, undertake a contact assessment to determine whether the query can be resolved through appropriate advice & information and/or signposting to a low level service
- Where appropriate, make a referral to the Reablement & Prevention Service (See para 5.4.1 below) and the Financial Case Management Team for further intervention/assessment
- In emergency situations or where the individual clearly has high level needs, also make a referral into the Assessment & Case Management service (see 5.5.1 below)

For more detailed information on the Referral and Access process, please refer to the 'Referral and Access' Policy & Procedure (see Section 7.1) and the process map shown at ***Appendix 4***.

5.4 Reablement & Prevention

5.4.1 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. During this time, the Financial Case Management Team will also help to maximise income and establish an individual's assessed contribution to the cost of any on going care required. Where an individual (following reablement) still requires longer-term care, the individual will be referred into the Assessment & Case Management Team (See 5.5 below). The role of the enablement team is to:-

- Receive referrals from the Access Team where basic low level services will not meet their needs
- Receive referrals from the Assessment & Case Management team where an individual is assessed as requiring reablement or prevention services
- Undertake and co-ordinate full assessment of the individual which could include Occupational Therapy assessment, Nursing Assessment, Social Work Assessment and/or Physiotherapy assessment to inform the individuals reablement plan
- Identification of carers and offer carers assessments
- Deliver free short term (up to 28 days) reablement, rehabilitation and preventative services in order to help individuals return to live independently in their own home
- Where on-going need is identified and longer term services are required undertake a Fair Access to Care Services (FACS) assessment to determine eligibility
- Co-ordinate and produce a support plan with the individual taking account of provisional funding arrangements
- With the assistance of the Personal Budget Support Team identify, agree and arrange services with the individual to meet their individual support plan requirements
- Once a support plan is in place and services arranged, handover case to Assessment & Case Management for on-going monitoring/assessment (see Section 5.5 below).

For more detailed information on the Reablement and Prevention process, please refer to the 'Reablement and Prevention' Operational Policy & Procedure (see Section 7.1) and process map shown at ***Appendix 4***.

5.5 Assessment & Case Management

5.5.1 Assessment and Case Management will deal with those individuals whose needs cannot be met through Reablement, Rehabilitation or Prevention services and who require longer term care. This team consists of social workers and other professional staff who will focus on assessment of need, determination of eligibility, case management and review of services. The role of Assessment and Case Management includes:-

- Receiving referrals where individuals require on-going services past the initial reablement service provision

- Arranging specialist assessments when required e.g. Mental Health Act assessments, capacity assessments, best interest assessments and DoLS assessments
- Where individuals have primarily Health needs, refer them to health for an assessment in accordance with the Continuing Health Care process
- Case management role, providing support and advice to individuals based on their individual needs (which may change over a period of time)
- Working with individuals to understand and manage any known risks
- Acting as Investigating Worker in cases referred into the adult protection process
- Identification of carers and offer carers assessments
- Evaluate assessment information to determine eligibility against FACS (See Assessment & Eligibility Operational Policy & Procedure at section 7.1)
- Work closely with the Personal Budget Support (PBS) Team to ensure the individual continues to manage their own budgets effectively and that when their needs change, options are explored with the individual in terms of services available to them and the cost of those services.
- Consider the need for further assessment by the Reablement and Prevention team to maximise independence
- Support planning by working with the individual, their carers and other relevant professionals to discuss and arrange an appropriate support plan that the individual feels will best meet their needs
- Working with the PBS team to arrange services where required to meet agreed needs set out in the support plan
- Identify changes in needs and any resulting change in services (with referral to the Personal Budget Support Team where service changes are required - see 'Personal Budget Support' Policy at section 5.7 below).
- Undertake the first initial review following the set up of care arrangements in line with the On-going Care & Review Policy as well as undertaking regular (at least annual) reviews of individuals care and support in liaison with other relevant professionals, the individual, carers and family members to re-assess on-going care needs and eligibility for services and ensure that services remain essential and appropriate.

5.6 Personal Budget Support Team and Financial Case Management

5.6.1 An individual will require involvement from the Financial Case Management Team as soon as it seems likely they will need on going services to establish how much they will need to contribute to their personal budget to pay towards on-going services to meet FACS eligible needs. The Personal Budget Support Team will use the support plan developed between the individual and the enablement / assessment teams to help them set up these services. The Personal Budget Support Team will also provide the same support for individuals who fund their own care services using a personal budget, however, there may be a charge for this service depending on the individual's circumstances and nature of the support required (see para 2.3 above).

5.6.2 The Financial Case Management Team

A referral will be made to the Financial Case Management Team by Access Services at the same time that the individual is referred to Reablement & Prevention Services. The Financial Case Management Team will then continue to work with the individual past their reablement phase if they have on-going support needs.

The Financial Case Management team will undertake:-

- Financial assessments
- Highlight any opportunities for individuals to follow up to maximise their income
- Determine the individual's personal financial contribution to the cost of services (this in undertaken during the reablement phase as a provisional contribution and re-assessed/confirmed during assessment and case management phase if the individual does require on-going care and support see Charging policy and procedure at section 7.1)
- Arranging income collection from service users
- Where there is no one else able or appropriate to take on the role, to take on appointeeship or Court of Protection roles
- Undertake annual reviews of the individual's financial assessment to ensure it remains accurate
- Share information with the Personal Budget Support Team to support the setting up of services

5.6.3 The Personal Budget Support Team

Referral to this service may be made by Reablement & Prevention Services or the Assessment & Case Management Team.

The Personal Budget Support Team will assist service users to find the personalised services they need to meet their assessed needs and make sure they are delivered effectively and efficiently. They will:-

- Provide a Direct Payment service to include assisting people to set up care arrangements, payroll support, audit of use of budget
- Provide a brokerage service and help service users to set up services (service agreements) following the establishment of a personal budget to meet detailed support plans produced by Reablement or Assessment teams and brokerage support to the Enablement Team in setting up interim services
- Where the outcome of the support plan is nursing home care, ensure that a referral has been made to the NHS for an assessment for eligibility for Free Nursing Care in line with the FNC process Guide
- Where appropriate/possible, work with Commissioning and Contracts Services to negotiate contract costs, contracts with service providers and set up contracts with the chosen provider on behalf of the Council whilst seeking the best possible rates for the service user
- Monitor service delivery against individual care contracts and payment of bills from service providers
- Support the service user to make changes to their care arrangements within the agreed support plans and budget commitment (this will include reduction of care costs but not increases)
- Refer individuals back to the Assessment and Case Management Team for unscheduled review where changes require reassessment or increased budget commitment
- Arranging timely payment to providers for services provided to meet contract obligations
- Monitor service provision and trends in order to assist Commissioning Services in planning for future demand

For further information and detail in relation to each of the areas outlined above, please refer to the Financial Case Management and Personal Budget Support Team Policies and Procedures as listed at section 7.1 of this policy and reflected within the process maps at ***Appendix 4***.

5.7 Commissioning Services

It is also recognised that although not part of the Community Care Process, Commissioning Services have a significant role to play in developing and encouraging services which are flexible, responsive and person centred in order to meet the needs of individuals as part of our new ways of working. It is crucial that there are services available within the community which can be tailored to meet the needs of individual service users to meet the expectations of our new approach. In order to achieve this, Commissioning will link particularly closely with the Personal Budget Support Team who will act as brokers for individuals and will therefore be aware of services required by service users, gaps in the current provider market and preferences expressed by service users. This information will be used by commissioners in order to develop, shape and encourage service provision to meet any gaps in the market as well as developing micro markets of smaller providers who may be able to provide more specialist services not currently available. Commissioning Services are described in more detail within the Commissioning and Contracting Policy & Procedure.

6 POLICY IMPLICATIONS

6.1 Legal Implications

This policy outlines the Authorities 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.

6.2 Finance and Value for Money Implications

The aim of this procedure 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.

6.3 Economic Impact

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.

6.4 Environmental Impact

There are no environmental impacts associated with this policy.

6.5 Other Impacts

There are no other impacts associated with this policy.

7. CROSS REFERENCE INFORMATION

7.1 Standards

- General Social Care Council (GSCC) Codes of Practice see the following link: http://www.gscc.org.uk/codes/Get+copies+of+our+codes

7.2 Legislation

Assessment

- National Health Service & Community Care Act 1990 http://www.legislation.gov.uk/ukpga/1990/19/contents
- Disabled Persons (Services Consultation and Representation) Act 1986 http://www.legislation.gov.uk/ukpga/1986/33
- Mental Health Act 1983 http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_4002034
- Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/contents

Carers

- Carers (Recognition and Services) Act 1995 http://www.legislation.gov.uk/ukpga/1995/12/contents
- Carers (Equal Opportunities) Act 2004 http://www.legislation.gov.uk/ukpga/2004/15/contents

Service provision

- Disabled persons (Employment) Act 1944 http://www.legislation.gov.uk/ukpga/Geo6/7-8/10
- National Assistance Act 1948 http://www.legislation.gov.uk/ukpga/Geo6/11-12/29
- Health Service and Public Health Act 1968 http://www.legislation.gov.uk/ukpga/1968/46
- Chronically Sick and Disabled Persons Act 1970 http://www.legislation.gov.uk/ukpga/1970/44
- National Health Service Act 2006 http://www.legislation.gov.uk/ukpga/1977/49 -
- Health and Social Services and Social Security Adjudications Act 1983 http://www.legislation.gov.uk/ukpga/1983/41
- Community Care (Direct Payments) Act 1996 http://www.legislation.gov.uk/ukpga/1996/30/contents
- Health and Social Care Act 2012 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
- LAC (2002) 13 - Fair Access to Care Services – guidance on eligibility criteria for adult social care http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Localauthoritysocialservicesletters/DH_4004734

7.3 Systems Implications

Please refer to the CareFirst user guide for guidance on recording the Community Care process onto the CareFirst system. Also refer to the CareAssess guidance when recording on CareAssess. All information and guidance relating to Adult Social Services Systems can be found on the following intranet page:-

http://ecouncil/AdultSocialCareDelivery/AdultSocialCareSystems/Pages/default.aspx

7.4 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

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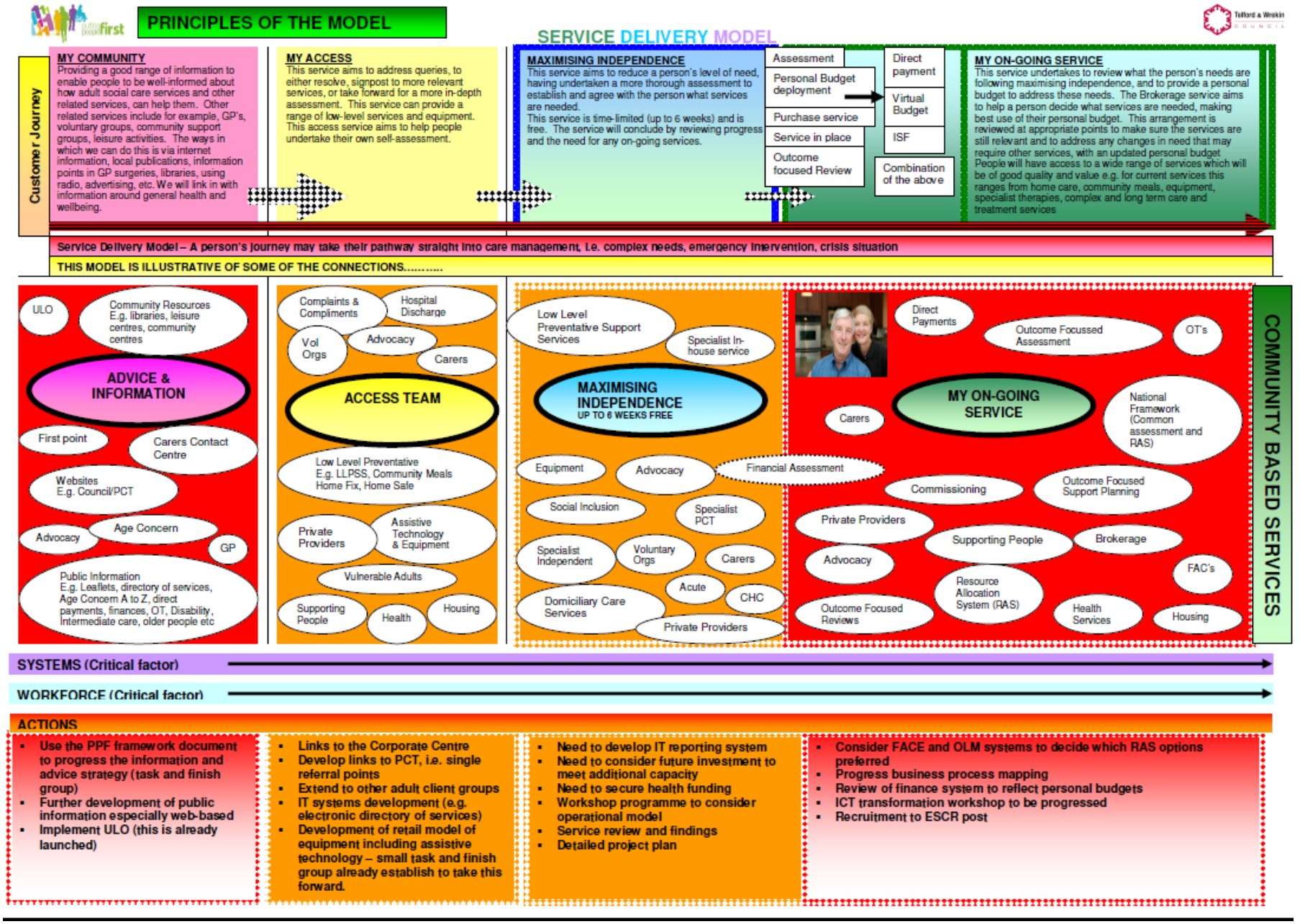
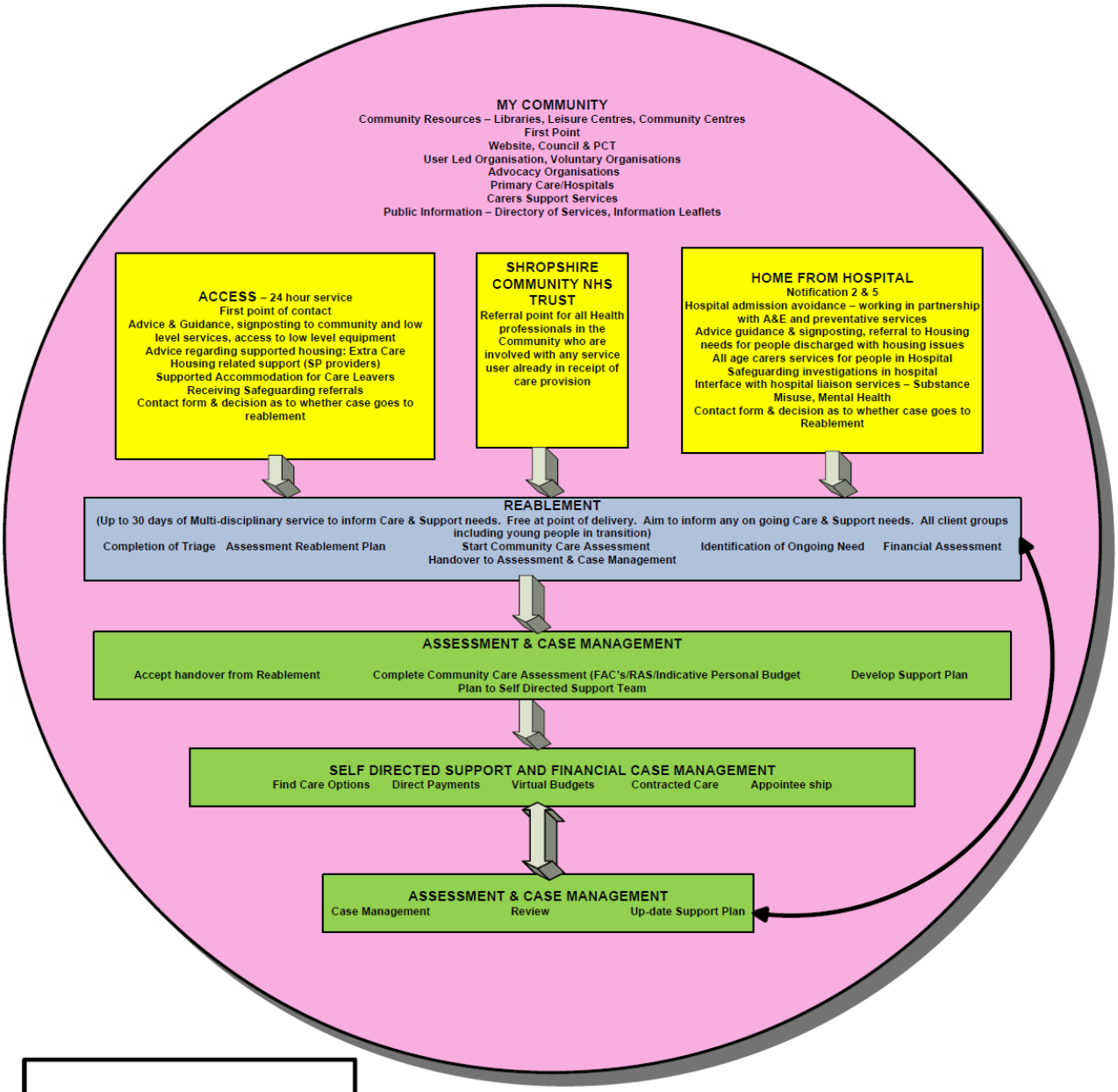
7.5 Linked Policies

- Adult Protection Policy & Procedure
  http://ecouncil/SafeguardingAndCorporateParenting/SafeguardingAdvisory/Pages/SafeguardingandAdultProtection.aspx
- Joint Mental Health Policies & Procedures
  http://ecouncil/AdultSocialCareDelivery/Pages/default.aspx
- In-house Provider Policies & Procedures (TBC)
- Supporting People Policies & Procedures
- Fairer Charging Policy
  http://extranet/CommunityCareHandbook/CommunityCareHandbook/Chapter%207%20Charging.doc
- My Community Policy & Procedure (TBC)
- Referral and Access Operational Policy & Procedure (TBC)
- Reablement & Prevention Operational Policy & Procedure (TBC)
- Assessment & Eligibility Operational Policy & Procedure (TBC)
- Personal Budget Support Team Operational Policy & Procedure (TBC)
- Financial Case Management Operational Policy & Procedure (TBC)
- On-going Care and Review Operational Policy & Procedure (TBC)
- Risk Assessment & Management Policy & Procedure (TBC)
- Commissioning & Contracting Policy & Procedure (TBC)

APPENDIX 1: PUTTING PEOPLE FIRST SERVICE DELIVERY MODEL



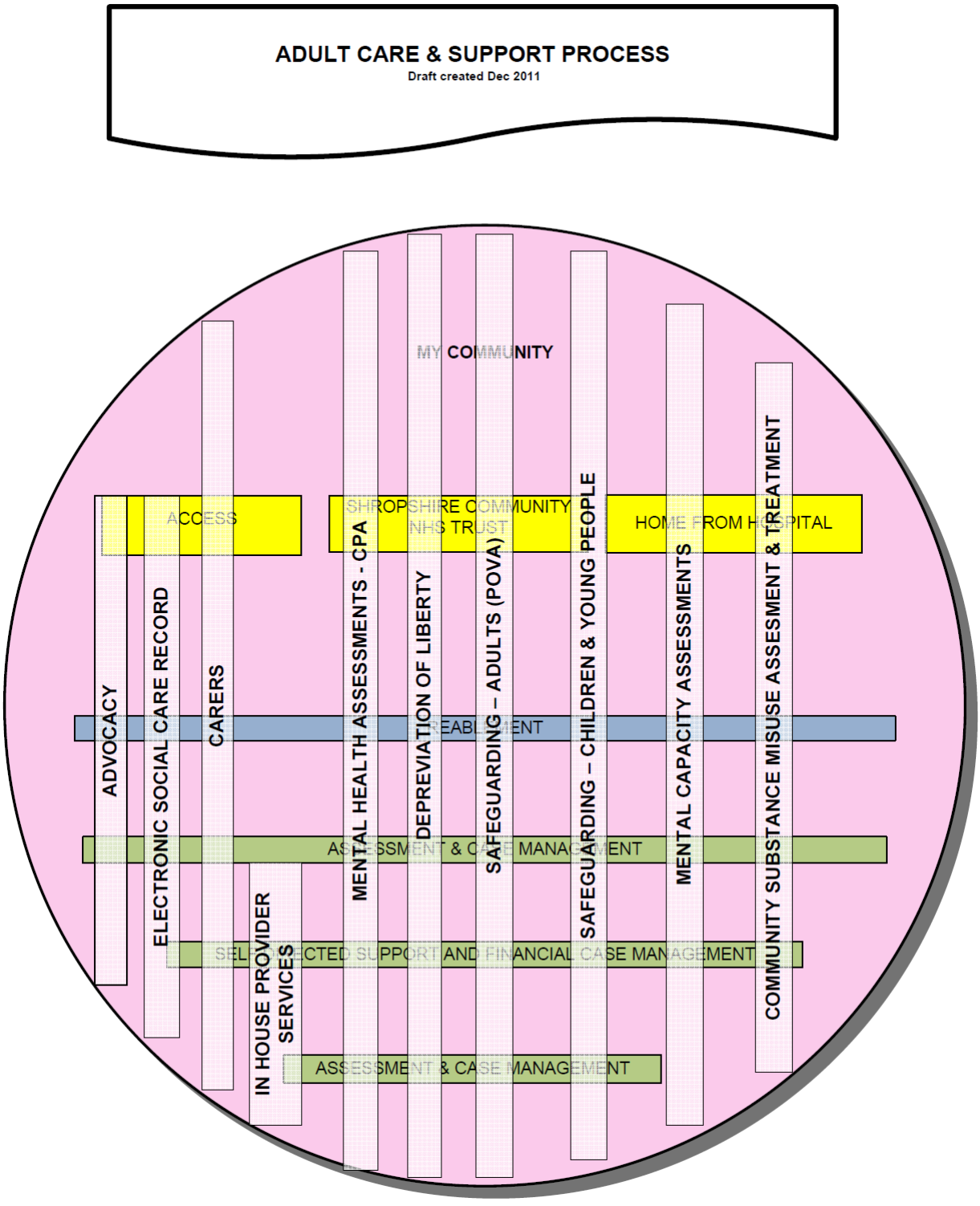
Appendix 2: Adult Care & Support High Level Flow Chart Business Process



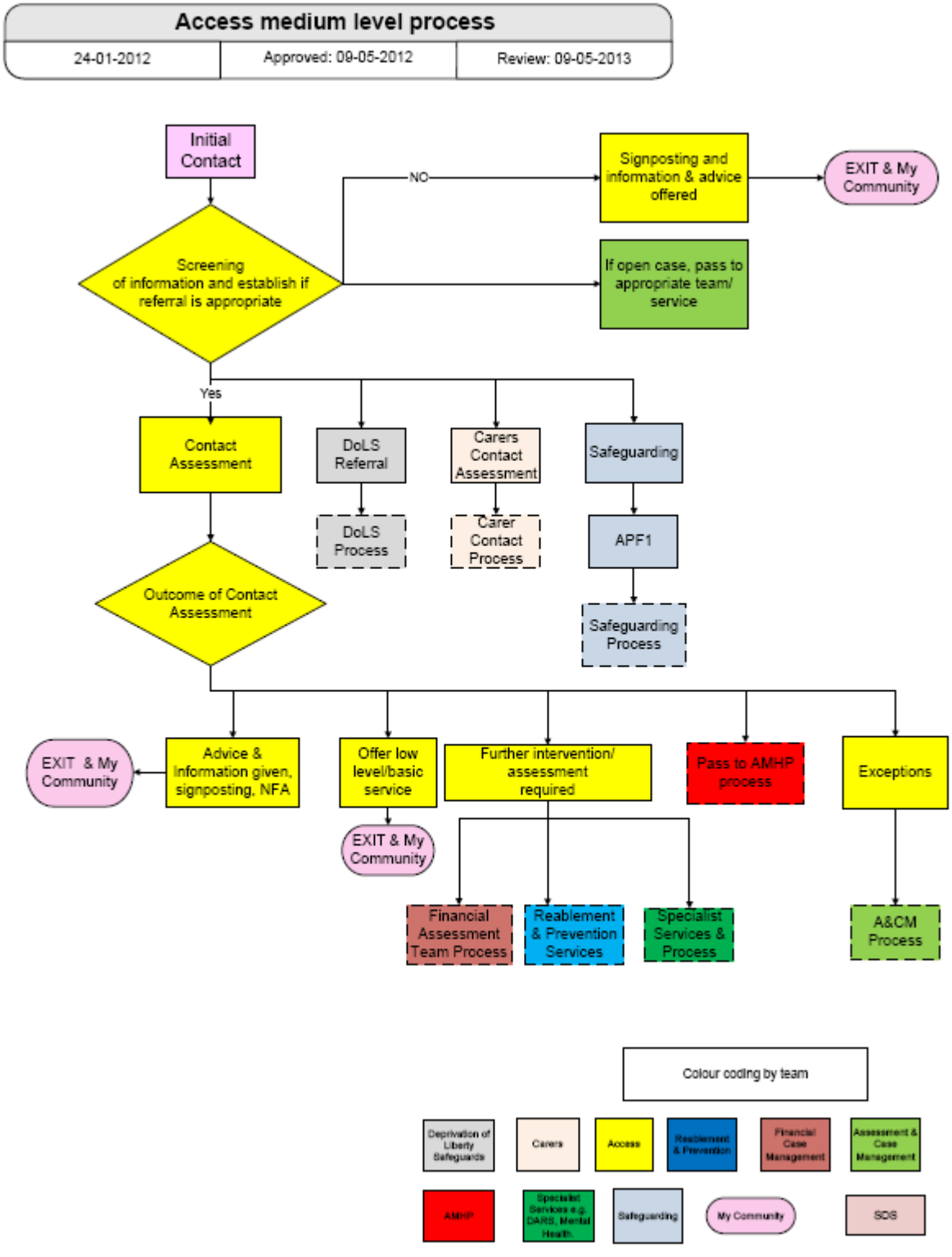
The Circle represents My Community, therefore, EXIT back into My Community can happen at any stage of the process. The whole process is undertaken in My Community

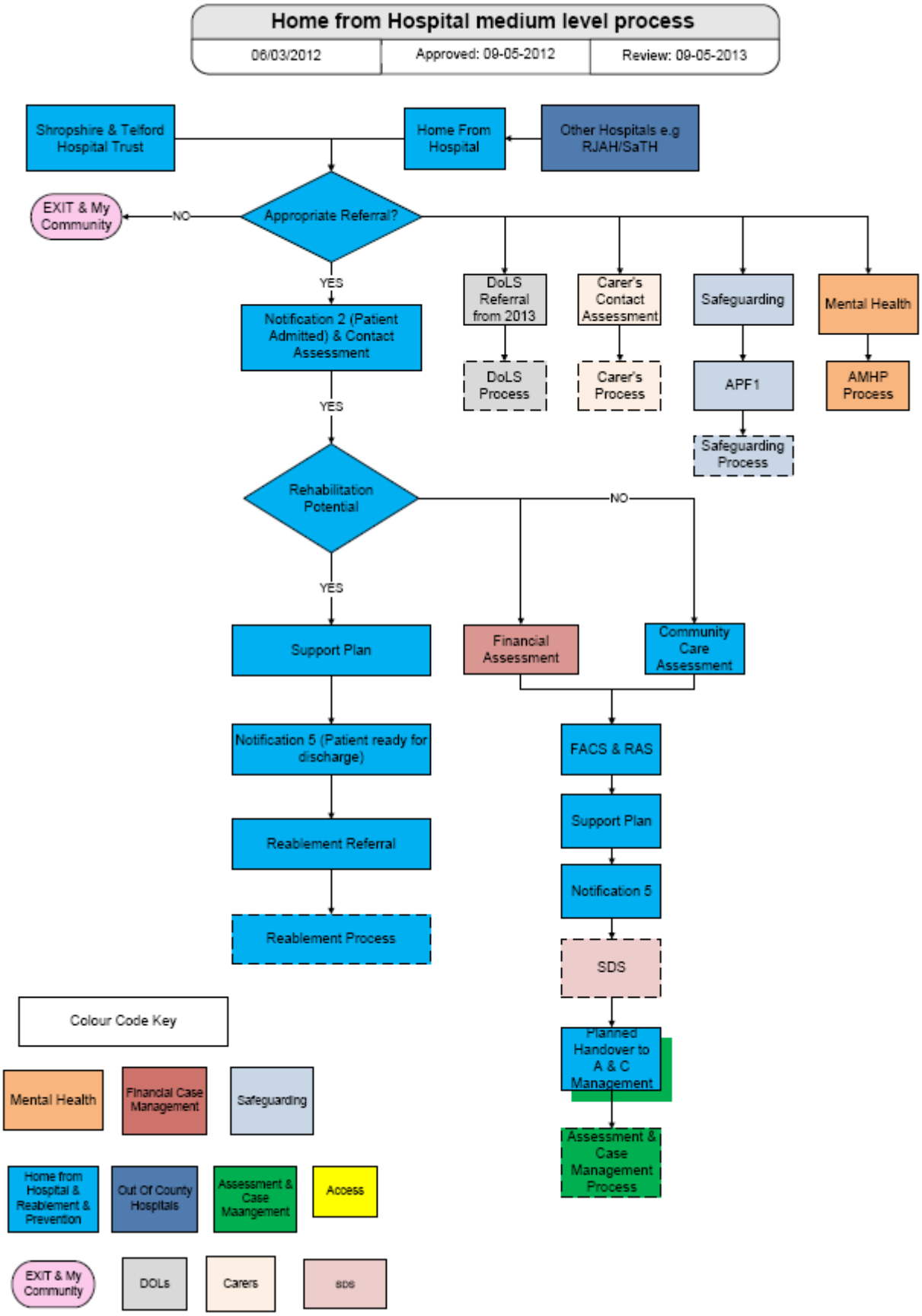
Appendix 3: Adult Care & Support Processes: Linkages

The diagram below illustrates the core processes associated with the Community Care process as well as those processes which sit outside of the community care process but will contribute to an individuals journey through the community care process:-



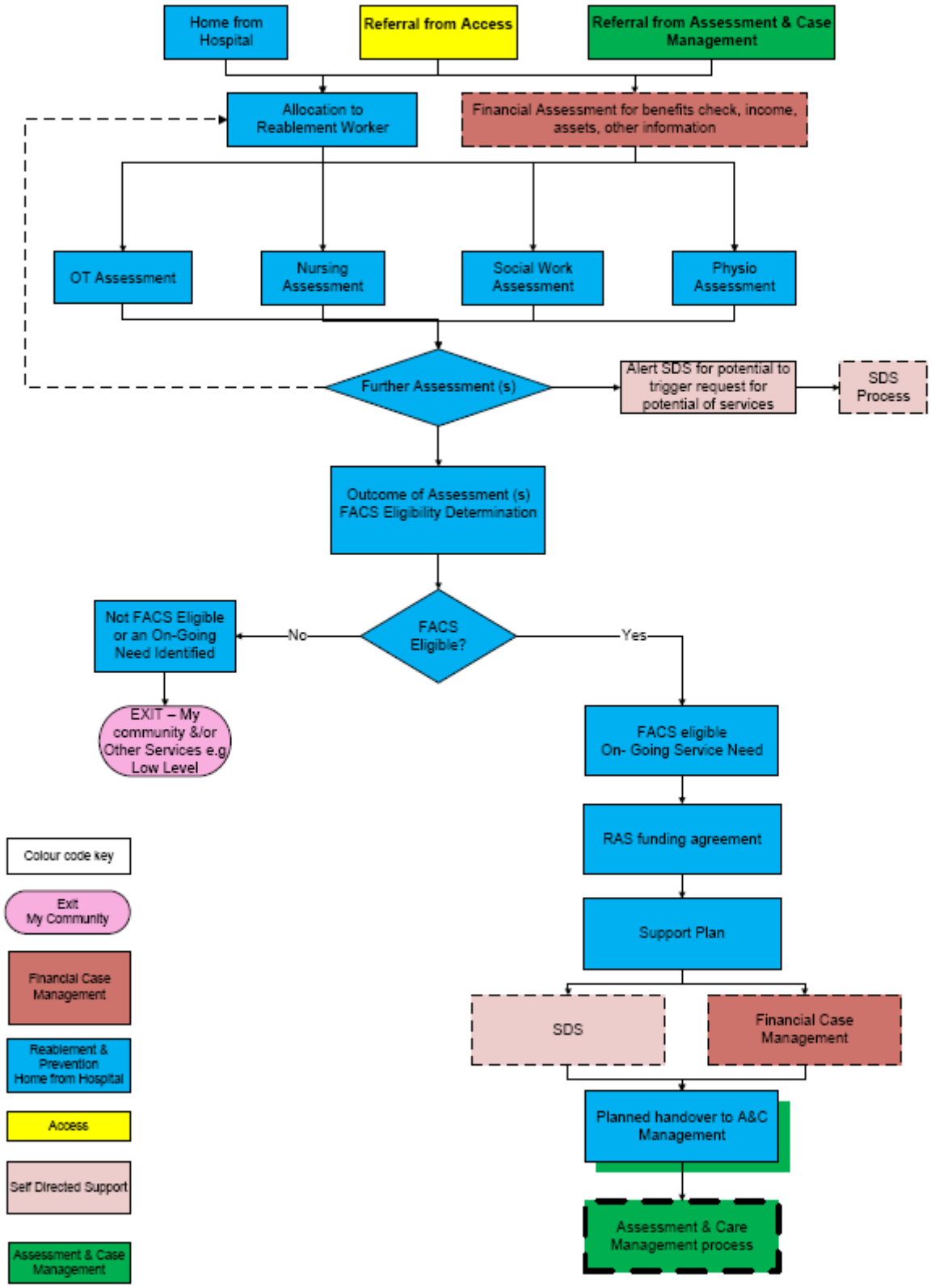
Appendix 4: COMMUNITY CARE MEDIUM LEVEL PROCESS MAPS




Home from Hospital medium level process
06/03/2012
Approved: 09-05-2012
Review: 09-05-2013
Shropshire & Telford Hospital Trust
Home From Hospital
Other Hospitals e.g RJAH/SaTH
EXIT & My Community
NO
Appropriate Referral?
YES
DoLS Referral from 2013
Carer's Contact Assessment
Safeguarding
Mental Health
Notification 2 (Patient Admitted) & Contact Assessment
DoLS Process
Carer's Process
APF1
AMHP Process
Safeguarding Process
YES
Rehabilitation Potential
NO
YES
Support Plan
Financial Assessment
Community Care Assessment
Notification 5 (Patient ready for discharge)
FACS & RAS
Reablement Referral
Support Plan
Notification 5
Reablement Process
SDS
Planned Handover to A & C Management
Assessment & Case Management Process
Colour Code Key
Mental Health
Financial Case Management
Safeguarding
Home from Hospital & Reablement & Prevention
Out Of County Hospitals
Assessment & Case Maangement
Access
EXIT & My Community
DOLs
Carers
SDS

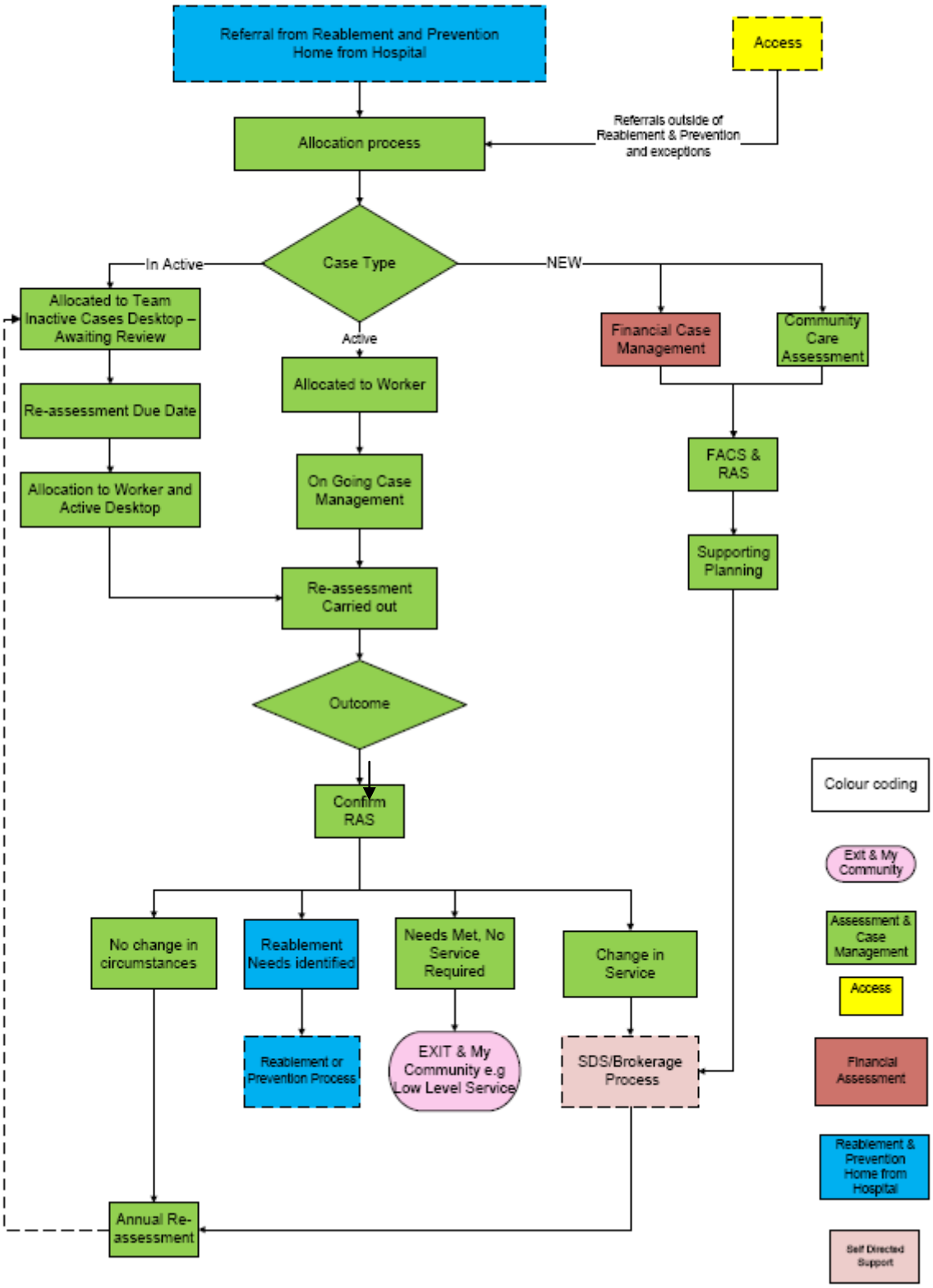
Reablement Rehabilitation & Prevention medium level process

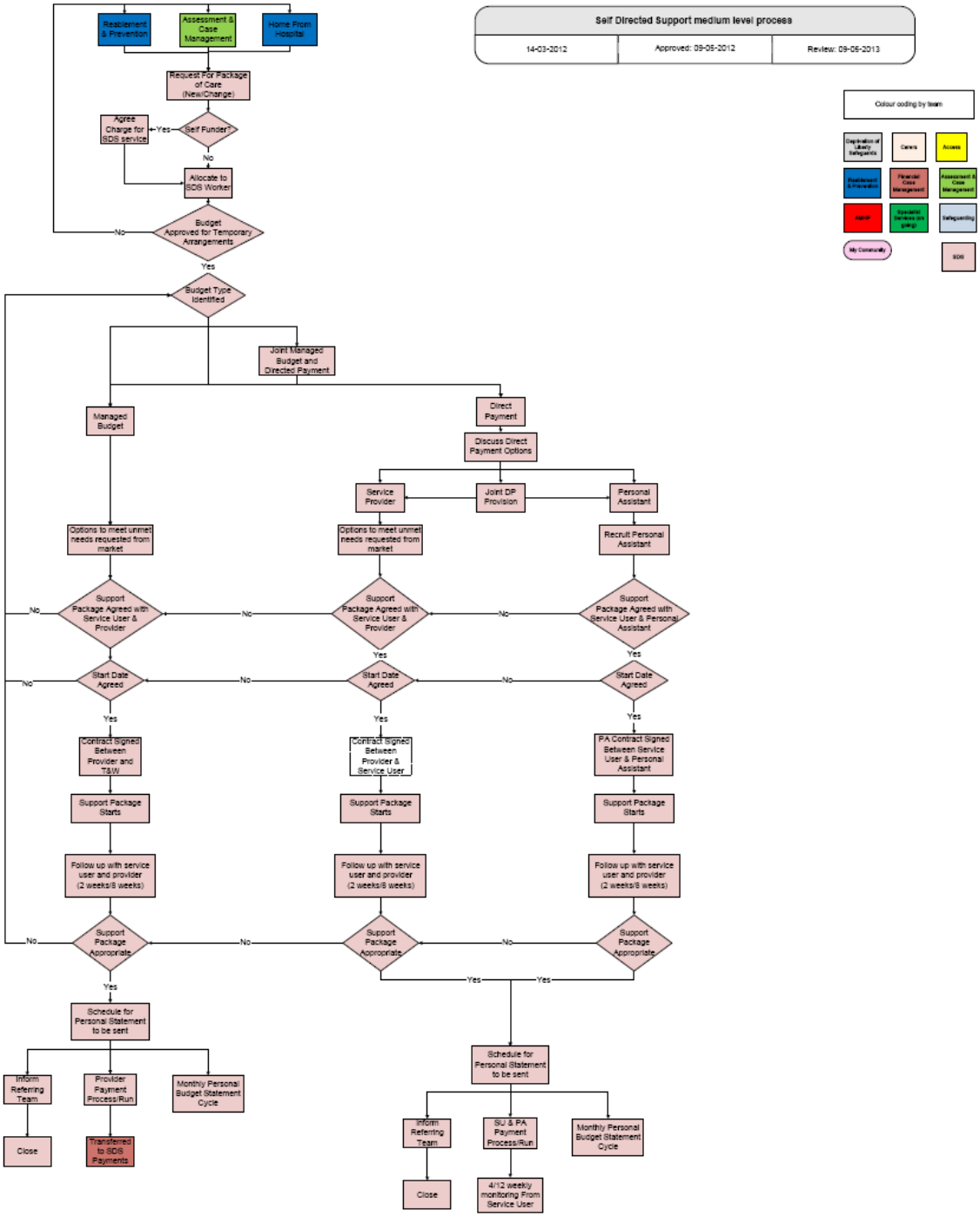
24-01-2012	Approved: 09-05-2012	Review: 09-05-2013

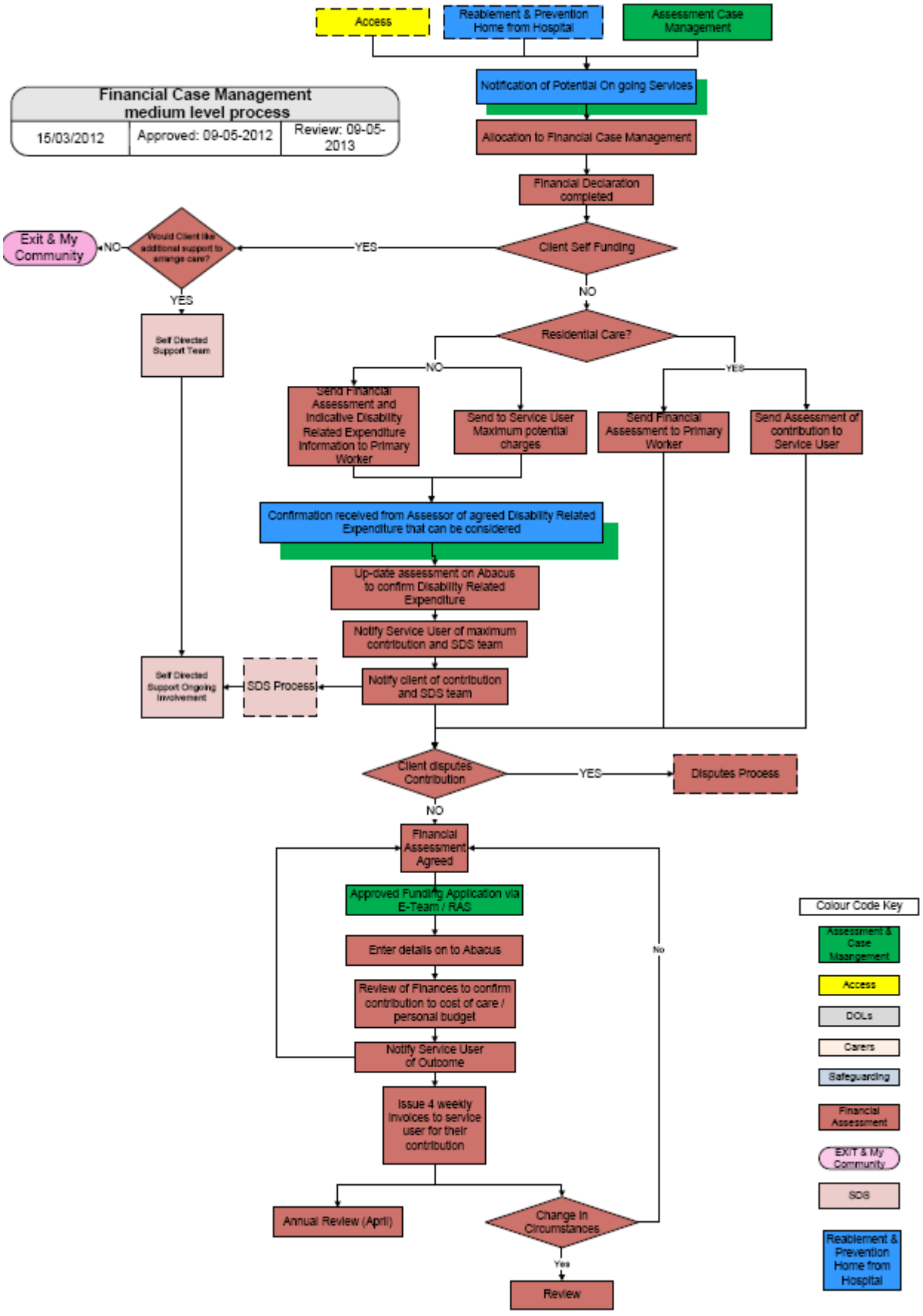


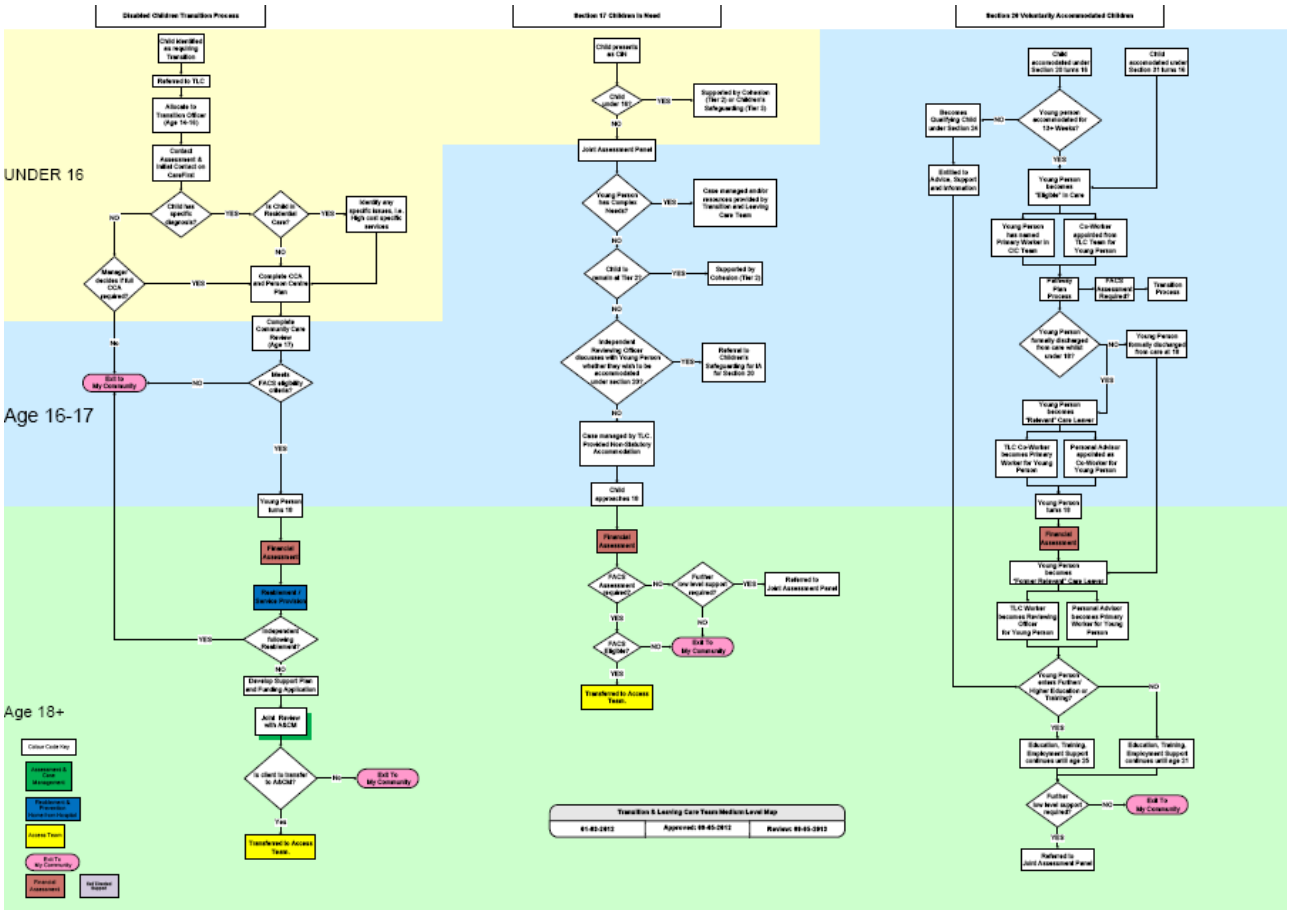
Assessment & Case Management medium level process

24-01-2012	Approved: 09-05-2013	Review: 09-05-2013




Self Directed Support medium level process
14-03-2012
Approved: 09-05-2012
Review: 09-05-2013
Colour coding by team
Reablement & Prevention
Assessment & Case Management
Home From Hospital
Request For Package of Care (New/Change)
Agree Charge for SDS service
Yes
Self Funder?
No
Allocate to SDS Worker
No
Budget Approved for Temporary Arrangements
Yes
Budget Type Identified
Joint Managed Budget and Directed Payment
Managed Budget
Direct Payment
Discuss Direct Payment Options
Service Provider
Joint DP Provision
Personal Assistant
Options to meet unmet needs requested from market
Options to meet unmet needs requested from market
Recruit Personal Assistant
Support Package Agreed with Service User & Provider
No
Support Package Agreed with Service User & Provider
No
Support Package Agreed with Service User & Personal Assistant
No
Yes
Start Date Agreed
No
Start Date Agreed
No
Start Date Agreed
No
Yes
Yes
Yes
Contract Signed Between Provider and T&W
Contract Signed Between Provider & Service User
PA Contract Signed Between Service User & Personal Assistant
Support Package Starts
Support Package Starts
Support Package Starts
Follow up with service user and provider (2 weeks/8 weeks)
Follow up with service user and provider (2 weeks/8 weeks)
Follow up with service user and provider (2 weeks/8 weeks)
Support Package Appropriate
No
Support Package Appropriate
No
Support Package Appropriate
No
Yes
Yes
Yes
Schedule for Personal Statement to be sent
Schedule for Personal Statement to be sent
Inform Referring Team
Provider Payment Process/Run
Monthly Personal Budget Statement Cycle
Inform Referring Team
SU & PA Payment Process/Run
Monthly Personal Budget Statement Cycle
Close
Transferred to SDS Payments
Close
4/12 weekly monitoring From Service User


Access
Reablement & Prevention Home from Hospital
Assessment Case Management
Financial Case Management medium level process
15/03/2012
Approved: 09-05-2012
Review: 09-05-2013
Notification of Potential On going Services
Allocation to Financial Case Management
Financial Declaration completed
Client Self Funding
YES
Would Client like additional support to arrange care?
NO
Exit & My Community
YES
Self Directed Support Team
NO
Residential Care?
NO
YES
Send Financial Assessment and Indicative Disability Related Expenditure Information to Primary Worker
Send to Service User Maximum potential charges
Send Financial Assessment to Primary Worker
Send Assessment of contribution to Service User
Confirmation received from Assessor of agreed Disability Related Expenditure that can be considered
Up-date assessment on Abacus to confirm Disability Related Expenditure
Notify Service User of maximum contribution and SDS team
Notify client of contribution and SDS team
SDS Process
Self Directed Support Ongoing Involvement
Client disputes Contribution
YES
Disputes Process
NO
Financial Assessment Agreed
Approved Funding Application via E-Team / RAS
Enter details on to Abacus
Review of Finances to confirm contribution to cost of care / personal budget
Notify Service User of Outcome
Issue 4 weekly invoices to service user for their contribution
No
Annual Review (April)
Change in Circumstances
Yes
Review
Colour Code Key
Assessment & Case Management
Access
DOLs
Carers
Safeguarding
Financial Assessment
EXIT & My Community
SDS
Reablement & Prevention Home from Hospital


Disabled Children Transition Process
Section 17 Children In Need
Section 20 Voluntarily Accommodated Children
UNDER 16
Age 16-17
Age 18+
Child Identified as requiring Transition
Referred to TLC
Allocate to Transition Officer (Age 14-16)
Contact Assessment & Initial Contact on CareFirst
Child has specific diagnosis?
Is Child in Residential Care?
Identify any specific issues, i.e. High cost specific services
Manager decides if full CCA required?
Complete CCA and Person Centred Plan
Complete Community Care Review (Age 17)
Exit to My Community
Meets FACS eligibility criteria?
Young Person turns 18
Financial Assessment
Reablement / Service Provision
Independent following Reablement?
Develop Support Plan and Funding Application
Acid Review with ASCM
Is client is transfer to ASCM?
Exit To My Community
Transferred to Access Team.
Colour Code Key
Access Team
Exit To My Community
Financial Assessment
Child presents as CIN
Child under 16?
Supported by Cohesion (Tier 2) or Children's Safeguarding (Tier 3)
Joint Assessment Panel
Young Person has Complex Needs?
Case managed and/or resources provided by Transition and Leaving Care Team
Child is remain at Tier 2?
Supported by Cohesion (Tier 2)
Independent Reviewing Officer discusses with Young Person whether they wish to be accommodated under section 20?
Referral to Children's Safeguarding for IA for Section 20
Case managed by TLC Provided Non-Statutory Accommodation
Child approaches 18
Financial Assessment
FACS Assessment required?
Further low level support required?
Referred to Joint Assessment Panel
FACS Eligible?
Exit To My Community
Transferred to Access Team.
Transition & Leaving Care Team Medium Level Map
01-03-2013
Approved: 09-05-2013
Review: 09-05-2013
Child accommodated under Section 20 turns 16
Child accommodated under Section 31 turns 16
Becomes Qualifying Child under Section 20
Young person accommodated for 13+ Weeks?
Entitled to Advice, Support and Information
Young Person becomes 'Eligible' in Care
Young Person has named Primary Worker in CIC Team
Co-Worker appointed from TLC Team for Young Person
Pathway Plan Process
FACS Assessment Required?
Transition Process
Young Person formally discharged from care whilst under 18?
Young Person formally discharged from care at 18
Young Person becomes 'Relevant' Care Leaver
TLC Co-Worker becomes Primary Worker for Young Person
Personal Advisor appointed as Co-Worker for Young Person
Young Person turns 18
Financial Assessment
Young Person becomes 'Former Relevant' Care Leaver
TLC Worker becomes Reviewing Officer for Young Person
Personal Advisor becomes Primary Worker for Young Person
Young Person enters Further/ Higher Education or Training?
Education, Training, Employment Support continues until age 19
Education, Training, Employment Support continues until age 21
Further low level support required?
Exit To My Community
Referred to Joint Assessment Panel