

Health and Social Care for Adults  
Gofal Iechyd a Chymdeithasol i Oedolion

**Creating a Unified and Fair System  
for Assessing and Managing Care**

**Creu System Deg ac Unedig  
i Asesu a Rheoli Gofal**

BWRW YMLAEN Â GWELLA IECHYD YNG NGHYMURU AC ADEILADU AR GYFER Y DYFODOL

TAKING FORWARD IMPROVING HEALTH IN WALES AND BUILDING FOR THE FUTURE

# **HEALTH AND SOCIAL CARE FOR ADULTS: CREATING A UNIFIED AND FAIR SYSTEM FOR ASSESSING AND MANAGING CARE**

**GUIDANCE FOR LOCAL AUTHORITIES AND HEALTH  
SERVICES**

**Taking Forward *IMPROVING HEALTH IN WALES* and  
*BUILDING FOR THE FUTURE***



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## FOREWORD



### Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care

It has been nearly 10 years since the Care in the Community reforms were first implemented. We have moved along at quite a pace since that time and have seen major changes in the way services are delivered to meet need. We have some excellent examples across Wales of joint working between health, social services and other partners in care. However, we are all aware that we have yet to reach on a wide scale the fully integrated seamless approach we have aspired to since the early 1990s.

I believe this Guidance will take us closer to the vision set out in *Improving Health in Wales and Building for the Future*. It consolidates earlier work and is the obvious next stage. The longer term strategy and incremental approach to implementation is set out in this Guidance.

The key feature is a Person Centred approach to managing care. The service user is at the centre of the whole process. Additionally, whichever agency an individual first approaches for help will need to ensure that the individual is responded to in a joined up manner and not passed inappropriately from one agency to another. Assessments will be proportionate to a person's needs and individuals will not have to repeat the same information on numerous occasions to care professionals. This will be of huge benefit to users of services and their carers and will encourage care agencies to make more effective and efficient use of resources.

Using the same Domains/Areas of Assessment will lead to greater consistency and improved quality of assessments across Wales. The Guidance also addresses issues of Fair Access to Care and sets out an All Wales framework for developing eligibility criteria focusing on the risks to an individual's independence. This should lead to greater equity in the way eligibility decisions are made. The need for harmonisation between health and social services criteria is also emphasised.

The approach to assessment and planning care is one which focuses on outcomes for service users and their carers. Services will need to become increasingly flexible to meet the unique needs of individuals. Ensuring that people are helped to remain as independent as possible and building on an individual's strengths is key to this. I also place strong emphasis on the continuing support for service users and their carers and the important role of the care co-ordinator.

The Guidance also addresses the need for regular reviews to reassess service user's and carer's needs and to check that agreed outcomes are being achieved.

I am aware that it will take time to achieve every aspect that is set out here but I believe that the unified approach to assessing and managing care is a key development that will underpin all other initiatives focusing on integrated care and joint working.

A handwritten signature in black ink that reads "Jane Hutt". The signature is written in a cursive, flowing style.

Jane Hutt  
Minister for Health and Social Services

## PREFACE

This Guidance was developed from:

- The findings of a multi-agency All Wales Reference group, chaired by Jon Skone, Director of Social Care and Housing, Pembrokeshire. This work focused on how the Unified Assessment and Care Management System should operate in Wales.
- Participation of the Welsh Assembly in the Department of Health's National Assessment Working Group which was set up to advise on the Single Assessment Process.
- The work of Age Alliance which contributed its own findings and sought the views of older people and their carers in Wales on the Unified Assessment Process on behalf of the Welsh Assembly Government.
- Written responses to the draft consultation paper and contributions at an All Wales workshop for health and social care agencies and other partners in care.



# CHAPTER 1

## INTRODUCTION TO THE GUIDANCE

**1.1** This Guidance is issued under section 7(1) of the **Local Authority Social Services Act 1970**. It updates and consolidates the former Welsh Office Guidance *Managing Care* April 1991. It also provides the required Guidance for health bodies to ensure compliance with the targets set in *Improving Health in Wales – a Plan for the NHS with its Partners*.

**1.2** Responsibility is therefore placed on both NHS bodies and local authorities to ensure effective multi-agency working takes place in order to secure compliance with this Guidance.

**1.3** As a result of the consultation exercise the wording **Unified** has been substituted for **Single** to emphasise the co-ordinated and streamlined approach to assessment and care management that is required in this Guidance.

**1.4** The core principles of the Unified Assessment and Care Management System are summarised in Chapter 2 and are relevant to all adult service user groups. Additionally, Chapter 5 on eligibility criteria (Fair Access to Care Services) which will take effect from October 2002 for local authorities must be applied to all adult groups. Further planned guidance on Continuing Care will build upon the approach outlined in Chapter 5 and will assist in the development of a unified set of criteria for health and social care agencies. Chapter 8 also provides guidance on the management and performance information requirements for all adult groups.

**1.5** The remaining chapters of the Guidance provide more detail of the Unified Assessment and Care Management System as it should be developed for Older People from April 2002. Agencies will need to draw on these chapters in creating a unified assessment and care management system for other groups of adult service users, to begin by April 2004 (see Annex 7). Future strategies for these other groups will assist in this process and will augment this Guidance.

### Policy context

**1.6** This Guidance forms part of the Welsh Assembly Government's response to the National Service Framework for Older People.<sup>1</sup>

The White Paper Building for the Future also identifies the following aims and priorities for social services in Wales:

#### **Key Aims for Social Services in Wales**

**Social Inclusion** *To contribute towards securing an inclusive society in which people can lead productive and meaningful lives*

**Independence** *To support individuals and families towards greater independence*

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<sup>1</sup> Other aspects of the NSF for Older People will be taken forward through other initiatives.

**Responsiveness** *To provide services which are responsive to individual needs and choice*

**Carers** *To recognise and support carers of all ages in their role in caring for vulnerable people*

### **Priorities for Social Services in Wales**

**Staffing** *To ensure that staff involved in social care are appropriately skilled, trained and qualified and that their conduct and practice are properly regulated*

**Effectiveness** *To secure effective and efficient services in keeping with the principles of Best Value*

**Management** *To provide a management framework that monitors performance and secures accountability, and is built on local authorities' corporate responsibilities, particularly towards children*

**Safeguards** *To ensure that safeguards (including advocacy, complaints procedures, inspection and regulation) are in place and are publicised, to protect and promote the welfare of vulnerable children and adults*

**Planning** *To ensure that all partners, including users and carers, can contribute to the planning and development of services*

**Partnership** *To work closely with agencies and services, including those in the statutory, voluntary and private sectors, to support people to achieve these objectives*

**1.7** These aims and priorities will inform the requirements in the new planning frameworks provided through the Health and Well Being Strategies and the requirements outlined in the *Guidance on Planning for Social Services* issued in December 2000. They also provide the basis for use of new joint working flexibilities incorporated in the **Health Act 1999**.

**1.8** *Improving Health in Wales A Plan for the NHS with its Partners* set out a programme for tackling inequalities, improving health and service performance and working in partnership. Specifically it gave a commitment to the development of a co-ordinated system of care management in partnership with relevant interests. This is to provide co-ordination between health and social care and primary and secondary care particularly for people with complex problems.

**1.9** Social and health care services provided for vulnerable adults therefore must aim to promote maximum independence and to support community integration. These are features of the developments to tackle social exclusion, and to promote and maintain health and normal patterns of living whenever possible. These responsibilities social services' departments share with the wider range of public services that support adults and older people.

**1.10** A common understanding of needs and risk assessment, and the ability to identify and assess the impact of those factors, which promote independence for

individuals, is essential. This information should inform any decisions about the advice, help or services that are to be provided. These emphases are central to the content of this guidance, and should be central to local implementation.

**1.11** It is essential that a balance is maintained between the promotion of independence on the one hand and the safeguarding of vulnerable adults and the public as a whole on the other. The development of a risk assessment framework as outlined in this Guidance will be key to achieving this balance.

## **Monitoring the implementation and impact of the Unified Assessment and Care Management System**

**1.12** The performance of local authorities in their management of social services' functions will be assessed through the development of a national framework for performance management. Similar arrangements are being developed for health services to support the implementation of *Improving Health in Wales*.

**1.13** Both social services' and health service performance management strategies focus on measuring the outcomes for service users and the links back to policies, service requirements, management performance and the standards of local service provision.

**1.14** Robust and effective plans that set clear targets to address local needs and priorities for service development are the essential starting point for performance management and evaluation exercises. Such plans will play an important role in inspection and evaluation programmes managed through the Assembly and other bodies. Clearly the development of the new Unified Assessment and Care Management requirements need to be highlighted in the relevant health and local authority plans, which will in turn need to identify local targets for implementation and ongoing performance and how they will be met.

**1.15** Performance against these and any relevant national targets will be monitored and evaluated in the context of this guidance (see Chapter 8). Whilst the immediate key concerns for service agencies will be in designing and developing the service models to implement the content of this guidance, it will clearly also be important to develop the performance monitoring and management framework alongside this. This will enable:

- learning from experience to inform local service improvement and development
- the development of future national policy in these areas.

**1.16** The national performance indicator sets for health and social care services will be designed to provide a common core alongside which agencies can develop local performance management indicators and activity. These sets will need to incorporate the developments outlined in this guidance to measure the impact of this Guidance nationally and inform its future development.



## CHAPTER 2

### CORE PRINCIPLES OF THE UNIFIED ASSESSMENT & CARE MANAGEMENT SYSTEM - *for all adult groups*

#### Background

2.1 This chapter outlines the core principles of the Unified Assessment and Care Management System and is applicable to all adult groups. These core principles are developed in greater depth for older people in subsequent chapters.

#### Unified Assessment and Care Management

2.2 The purpose of assessment is to describe and evaluate an individual's presented needs and how they constrain or support his/her capacity to live a full and independent life. The impact of a person's needs on his or her independence, daily functioning and quality of life is evaluated, so that appropriate action can be planned. Assessment involves both the person with needs and professionals thinking through different explanations for how needs have arisen, and how different needs interact with each other.

2.3 Individuals who require help typically have been assessed by a variety of health and social care staff. Unified assessment procedures however take a holistic approach to assessment with benefits for people who use services, for agencies and for professionals. The aim in developing unified assessment procedures is to ensure more effective joint working and to prevent people being serially assessed and asked for the same information by different agencies. Subject to certain constraints, which are described in this Guidance, basic personal and assessment information can be stored in a unified assessment summary record.

2.4 Assessment should be carried out in such a way, and be sufficiently transparent, for individuals to:

- Gain a better understanding of their situation.
- Identify the options that are available for managing their own lives.
- Identify the outcomes required from any help that is provided.
- Understand the basis on which decisions are reached.

2.5 Agencies should ensure that individuals are active partners, with strengths and abilities, in the assessment of their needs. Appropriate service provision can then be planned both in the immediate and the longer-term to promote or preserve independence.

2.6 The Guidance addresses the requirement for a fairer approach to the setting of eligibility criteria for social care which, where appropriate, can form the basis for the development of unified eligibility criteria for health and social care.

2.7 Ongoing management of care is also described and involves:

- The drafting and implementation of Personal Plans of Care.
- Monitoring, review and reassessment of needs.

This activity needs to be co-ordinated across agencies to promote a more seamless response to service users and their carers.

## A person-centred approach to assessment

2.8 One of the key principles underpinning this Guidance is that assessment should always be person-centred. This means ensuring that the person's views and wishes shape the assessment process. Using methods which help individuals prepare for their contribution to the assessment and having the right information, support and advocacy arrangements available, will facilitate this.

2.9 Where appropriate and possible, assessment commences with using the person's own words to build a rounded picture of their problems and circumstances. The depth and breadth of the assessment should be **proportionate to the individual's needs**. Assessments should be responsive to people's changing circumstances and levels of independence overtime.

2.10 The appropriate involvement of family members, carers and significant others is crucial to an effective assessment of individuals. However each person is unique in their relationship to others and practitioners must seek to agree with individuals how other people will contribute and be involved in the assessment. Assumptions should not be made about partners being carers and that other family members will share the same view of the situation as the user.

## Developing unified assessment across agencies for all adult groups

2.11 A unified assessment process should enable all kinds of needs to be evaluated to inform a co-ordinated approach to supporting the individual. Therefore, it must be the goal that assessment processes for all adult groups are aligned and integrated across local agencies. Alignment of assessment across agencies should over time result in a unified assessment process, such as that described in detail later for older people.

2.12 Agencies should work together to improve and consolidate a shared culture, common understanding and reliable information sharing. The content of the unified assessment process, and the protocols and systems for how agencies interact with each other, should be agreed. This must include ensuring that professional skills are used appropriately and that clarity of role and function is maintained. However, the result should be an assessment process that individuals experience as seamless and timely.<sup>2</sup> Chapter 3 outlines the implementation process for the Unified Assessment and Care Management System for older

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2 With regard to their statutory duties, as a general rule local authorities are reminded that they are not allowed to delegate their statutory functions, including those for assessment and review. However, when arrangements have been put in place under section 31 of the Health Act 1999 or section 113(1A) of the Local Government Act 1972, professionals from certain NHS bodies may, for example, carry out such assessments. In addition, local authorities should continue to ask NHS staff and others to contribute to local authority-led assessments, as and when necessary.

people. It describes further how lead responsibilities within agencies should be identified.

**2.13** The assessment process for older people identifies a model of the different types of assessment and the areas or domains of need that should be referred to by agencies in completing an assessment. (see Chapter 4) Agencies may wish to consider how far this can be used as a template for other service user groups.

**2.14** The Learning Disability Advisory Group's report *Fulfilling the Promises* has recommended to the Welsh Assembly Government that it adopts a Person Centred Planning (PCP) approach for all people with a learning disability. PCP is aimed at discovering and acting upon what is important to a person with a learning disability, for the present, and in the future. It encompasses the whole range of activities that make up a person's life, and may include such issues as housing, education, training, employment and leisure. The Welsh Assembly Government is presently considering the proposals in *Fulfilling the Promises* and the related consultation responses and will announce in due course whether the PCP approach will be adopted for people with learning disabilities.

**2.15** The Welsh Assembly Government's *Adult Mental Health Strategy* supports the adoption of the Care Programme Approach (CPA) and this is reinforced in the *Welsh National Service Framework for Mental Health*. The personal plan of care will ensure that users of mental health services should have a comprehensive assessment of their medical, psychological and social care needs. Guidance on CPA will be issued in due course. There will be a need to ensure that CPA and the Unified Assessment and Care Management System are fully integrated.

## **Key elements of a unified assessment process**

### **Provision of information and support**

**2.16 Access** - Traditionally, people have accessed social care through contacting their local social services office, either by telephone or calling in person and accessed health care through their GP. Increasingly initial contact may be made at other sites such as 'one stop shops' or unified access points for all local authority services, telephone contact centres, NHS Direct and so on. **All agencies should ensure that equal and consistent access is available through these various routes.**

**2.17 Information** - Agencies should work together to publish and disseminate a co-ordinated set of information about services and eligibility in a range of languages and accessible formats. The information should also say what usually happens during assessment and care management processes, related time-scales, and how individuals might access direct payments (see Annex 10). The National Carers Strategy (2000) highlighted the importance of information for carers, and outlines ways in which information can be provided and the sorts of information that carers need.

**2.18 Dissemination** - *The Health and Social Care Guide for Wales* will make a commitment to the users of health and social care that they will be given information in an appropriate format or language to suit their needs. This should have particular regard to the needs of those people with sensory impairments and /or learning disabilities as well as to English, Welsh and any other community

languages. Local agencies may also wish to use community networks to highlight the help that may be available by taking road shows or presentations to appropriate places such as places of worship or community centres and groups.

**2.19** Agencies will need to be mindful of the requirements of the ***Disability Discrimination Act 1995*** (refer to Annex 1).

**2.20** With reference to the ***Welsh Language Act 1993***, agencies when planning and delivering their services, including those commissioned from others, should ensure they are in accordance with their Welsh Language Scheme.

**2.21 Advocacy**- Access to independent advocacy for users and carers should be available if required to ensure that their interests are represented and that fair access is facilitated. This may be relevant for users from the point at which they are simply seeking information. Advocacy is particularly important for those users, who because of their disability may have difficulty in expressing their views and/or wish or need to have independent representatives to act on their behalf. This will include people with dementia or severe learning difficulties.

**2.22 Interpretation & translation** - Agencies should also consider those situations in which it will make interpretation and translation available. Agencies should ensure that appropriate interpretation and translation of relevant documents are available to assist users through the assessment and later stages of the process.

**2.23** With reference to section 47 of the ***NHS and Community Care Act 1990***, local authorities should set a low threshold (so that people are not excluded at the first point of contact) when deciding whether or not it appears to them that any person for whom they may provide or arrange community care services, may be in need of such services. Health Bodies will be mindful of this approach in relation to assessing for Continuing Care.

### **Involving Service Users**

**2.24** Agencies should recognise that individuals are the experts on their own situation and encourage a partnership approach to assessment. They should help them find the best ways to state their views in order to prepare for and contribute to the assessment process.

**2.25** The involvement of the service user in this way is not about the user determining their eligibility for help but rather it is about them gathering, organising and evaluating information about their own needs and circumstances. This opportunity helps users to think through, decide their priorities and prepare for the assessment that will take place with the practitioner.

**2.26** The assessment process should begin by requesting that service users provide basic personal information in line with the Guidance on the unified assessment process referred to for older people [see Annex 4].<sup>3</sup> This can also provide a common basis for the eventual development of shared electronic recording systems across the agencies.

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<sup>3</sup> This basic personal information should include preferred language, as this will guide the service contact with the person from then on.

**2.27** In addition to collecting basic information, this initial stage may also take the form of a questionnaire covering a limited number of questions that cover the users perspective and include the relevant areas to inform the process of the assessment. The unified assessment process for older people has identified seven key issues, and these may be considered for use with all service user groups. (See Chapter 4)

### **Involving inter-agency and other partnerships**

**2.28** The assessment should be a 'layered' process which develops to accommodate the aspects of the individual's situation that may emerge. It may proceed through a combination of prompts, triggers and professional judgement, from the contact assessment stage, to providing an overview of needs or a more comprehensive assessment. Assessment should collect and evaluate information so that need, eligibility, and likely service responses are identified.

**2.29** Appropriate multi-disciplinary involvement in the assessment should be decided. This will range on a continuum from exchanges of information through to joint visits.

**2.30** Staff who are competent in assessment, multi-disciplinary working and the circumstances of specific service user groups should carry out assessment.

**2.31** Agencies should ensure that their assessment process identifies the presence of carers, and their requirements for assessment.

**2.32** In the course of assessing an adult's needs, a check should be made on whether the person has parenting responsibility for a child less than 18 years. If so, the contact assessment should consider the use of the *The Framework for the Assessment of Children in Need and their Families* to explore whether there are any issues relating to children in need and their parenting (refer to Annex 1 – for further details).

**2.33** Assessment should not discriminate against individuals on the grounds of their age, gender, ethnic group, language, religion, disabilities, personal relationships, or living and caring arrangements. An individual's financial circumstances should not determine the level or detail of the assessment process.

**2.34** Agencies should respond and aim to complete the assessment process without undue delay. They should monitor the speed of their responses.

### **Content of assessment and risk factors**

**2.35** A person-centred assessment starts from the individual's perspective of their situation. The assessment should be based on an appreciation of their particular needs and the impact on their independence. Together, the individual and professional should look at the strengths and abilities that the individual can bring to bear on meeting needs.

**2.36** An evaluation of assessed needs should take full account of the likely progress of people's conditions and health status, their potential to become more independent, given the right help, or the likely outcomes if help were not to be provided or was provided in different ways. In thinking through how needs and

risks might change over time, professionals should focus on the impact of needs on people's independence both in the immediate and longer term. They should think of the risks involved to the person, their family and others close to them, and which risks cause serious concern and which may be acceptable. Central to an individual's independence is his/her:

- Autonomy and freedom to make choices;
- Health and safety including freedom from harm, abuse and neglect, and taking wider issues of housing and community safety into account;
- The ability to manage personal and other daily routines; and
- Involvement in family and wider community life, including leisure, hobbies, unpaid and paid work, learning, and volunteering.

**2.37** Well-developed risk assessment is essential to assess the likelihood of changing needs and the impact on independence. Assessors should explore:

- The past (including family history where appropriate), the immediate present and the longer-term.
- The intensity of particular needs including the physical pain, distress or disruption they cause.
- The instability/predictability of needs, both on a day-to-day basis and over longer periods of time.
- The complexity of needs, including the number of different needs, how needs interact, and how individuals react to the difficulties facing them.

**2.38** Refer to Annex 1 and Box 2 Domains of Assessment for further details on risk assessment.

## **Role of the Care Co-ordinator**

**2.39** Throughout their contact with agencies, people should be kept informed of the process, and involved in the discussions about their assessment and the options available for providing help or support. It is the responsibility of agencies to make the process as simple and clear as possible and the service user should not have to manage their way through and round the process unless they wish to take on this role themselves. This is best achieved by designating one member of staff to have a co-ordinating role. This role would encompass checking and reporting on progress and co-ordinating input from various professionals who may be involved in and contributing to the assessment, and most important, being the main point of contact for the service user. It is often the case that this individual may also take on the ongoing monitoring function.

(Chapter 6 on Care Coordination and Personal Plans of Care, gives further guidance on the role of care co-ordinator.)

## Recording needs and Personal Plans of Care

**2.40** The purpose of assessment is to identify, describe and evaluate people's needs, circumstances, risks to independence and other aspects of daily life.

**2.41** Eligibility for an individual should then be determined by comparing the risks to autonomy, health, safety, ability to manage daily routines and involvement in family and wider community life with the eligibility criteria for care and support. Account should be taken of both the current situation and the foreseeable future (See Chapter 5). It is essential that eligibility and care planning decisions are based on a thorough analysis of the assessment information.

**2.42** **Once it is determined that an individual is eligible for support, then and only then should decisions be made about the type and level of service to be provided.**

**2.43** If agencies together with service users are to be concerned with promoting independence, they should consider the outcomes and objectives to be achieved by the provision of services. This will demand an individualised approach to care planning and support. A standard service response to individual need and care provision is unlikely to be flexible enough to enable optimum gain from services, and is therefore neither cost effective for agencies nor of benefit to the service user. (Refer to Chapter 6 for further details on an outcome approach to care planning)

**2.44** Agencies should record and develop Personal Plans of Care, to include as a minimum:

- A summary of the assessed needs and associated risks including how they will be managed.
- Outline the contribution of family and others and address the needs that carers have in carrying out their caring role.
- The eligibility decision and basis for that decision.
- A clear statement of the objectives of providing help and care and the preferred outcomes for users.
- Details of the services to be provided together with contact details of providers.
- Record of unmet need and reason.
- Arrangements for co-ordinating and monitoring the personal plan together with contact details.
- A review date.

**2.45** Unmet need (needs which cannot be met or which can only be partially or unsatisfactorily met) should both be recorded in individual Personal Plans of Care and used properly to inform the agency's information and planning processes. (ref *Community Care Practice and the Law* – second edition – Michael Mandelstam)<sup>4</sup>

**2.46** Appropriate services should be identified with reference to the 'Statements of Purpose' provided by service providers. These will detail the aims and objectives, philosophy of care, services and other facilities, and the types of person for whom the service is designed.

**2.47** Decisions should also be made about whether direct payments may be applicable.

**2.48** Staff also need to be aware of the range of services that is available, and agencies may wish to develop an A to Z or *service directory* of all the services available.

**2.49** Wherever possible, Personal Plans of Care should be developed with, and agreed by, service users. Agencies should provide service users with a copy of the plan and ensure that it is fully explained to the user and other relevant people, including carers. Service users should be made aware of the arrangements for review from the outset and, where appropriate, advised that services may be withdrawn or changed as a result.

## Monitoring

**2.50** Once services are provided, agencies should ensure that appropriate arrangements are put in place to monitor both the person's needs and the effectiveness of those services. Providers will play an important role here, and they will need to be commissioned not only to provide services but also to keep a watching brief for marked changes in an individual's conditions or situations which may indicate the need for a revised personal plan of care or service plan.

## Reviews

**2.51** The purpose of a review is to:

- Establish how far the services provided have achieved the outcomes, set out in the personal plan of care.

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<sup>4</sup> Recording unmet need -When local authorities have completed assessments, they have a duty to decide whether people's identified needs for services 'call for' provision, or whether services are 'necessary'. They do not necessarily have a duty to provide all the services for which they have identified needs. For example, an authority might be able to state, quite lawfully, that ideally a person 'needs' a service, but say also that it is not necessary for the authority to provide it, because the person does not fall into the priority categories. This would then be recorded as unmet need – in other words, need which has been identified but which it is not going to meet.

**However having decided that it is necessary to meet a person's need, a local authority must do so even if it is short of resources.** Although if an authority has identified more than one way of meeting need it can take into account resources when choosing a particular service option, so long as the need is still genuinely met. Authorities should also record where needs have been met but an alternative more appropriate/desirable service would ideally be available.

For fuller details see "Responsibilities of local authority social services departments: implications of recent legal judgements". Welsh Office circular 59/97

- Re-assess the needs of individual service users and their carers.
- Help determine a user's continued eligibility for support.
- Confirm or amend the current personal plan of care, or lead to closure; and
- Comment on how individuals are managing direct payments, where appropriate.
- Monitor the quality of the service provided.

**2.52** The depth and detail of the re-assessment within a review should be tailored to the particular circumstances of the individual. It should add to the rounded picture of an individual's needs, wishes and circumstances that emerged during the assessment. The review should focus on the needs of users and the effectiveness of the personal plan in addressing those needs. It is particularly important to consider whether the individual's potential for improving their level of independence is being supported.

**2.53** All the services that are being received by the user should be considered at the one review.

**2.54** At a minimum, there should be an initial review within three months of services first being provided. Thereafter, reviews should be scheduled at least annually, or more often if individuals' circumstances appear to warrant it, or upon request from service users, providers of services and other appropriate individuals or agencies.

**2.55** Equipment provided to meet assessed needs for personal care, or to help service users manage their environment, after the initial confirmation of suitability should be reviewed as to its appropriateness and safety on at least an annual basis (there may also be servicing requirements). The suitability and effectiveness of periodic services such as short-term breaks should be reviewed shortly after the first period and annually thereafter.

**2.56** In addition to the service user, reviews should involve carers, representatives of the user such as advocates, agencies that have commissioned services and key providers. Reviews should consist of a meeting between the individual service user and a professional, and may also include other personnel. In exceptional circumstances reviews may be undertaken without direct face-to-face contact with the service user, but agencies need to be assured that this is feasible, particularly with respect to the re-assessment part of the review.

**2.57** Agencies should record the results of reviews. For those service users who remain eligible the personal plan should be updated. For those people who are no longer eligible, the reasons for closure should be recorded and, where possible, shared with the individual.

(Further details on the format and content of reviews are available in the more detailed Chapter 7.)

**2.58** In line with the principles of Fair Access to Care Services detailed in Chapter 5, from October 2002 there is a requirement to review the circumstances

of all individuals in receipt of social care services, provided or commissioned by the local authority or purchased with direct payments. All service users should have received a review by October 2003.

## **Complaints**

**2.59** Agencies should make individuals aware, at the outset, that they may challenge assessment and eligibility decisions and/or the way the process was managed, and that if necessary they can use the complaints procedures of the relevant agency for this.

**2.60** Refer to Annex 1 for links with related policy guidance and legislation.

## CHAPTER 3

### THE UNIFIED ASSESSMENT & CARE MANAGEMENT SYSTEM - *for older people*

#### Background

**3.1** This chapter sets out how the Unified Assessment and Care Management System should be developed from April 2002 for older people. It also provides a useful reference when developing this system for other adult groups (to start 2004). It requires a locally agreed joint approach to assessing, and planning to meet, the health and social care needs of older people.

**3.2** Local implementation of the unified assessment process by health and social care agencies will promote better care services and better outcomes for older people, and more effective use of professional resources. In particular, the unified assessment process should ensure that the breadth and depth of assessment is kept in proportion to older people's needs, agencies do not duplicate each other's assessments, and professionals contribute to assessments in the most effective way.

**3.3** The unified assessment process is also key to the provision of NHS funded nursing care in care homes which began in December 2001.

**3.4** This Guidance does not recommend the use of a particular unified assessment tool. Rather it provides a rigorous framework that will lead to convergence of assessment methods and results over time irrespective of the tools chosen for local use. The Welsh Assembly Government Wales Office of Research and Development has commissioned work on the evaluation of a number of assessment tools, the results of this research, when available, will be considered within the context of this Guidance.

#### Who should use this Guidance?

**3.5** The Guidance is directed at staff working in health and social care and includes the following settings:

- GP surgeries.
- Community health services.
- Accident and emergency and out-patients departments of hospitals.
- In –patient facilities.
- Other NHS facilities including day hospitals, community rehabilitation teams and community mental health teams.
- Social services offices and access points, including those based in hospitals.

- NHS Direct.

**3.6** Annex 2 sets out general implications of this Guidance for professionals, and specific aspects of implementation for social workers, registered nurses, therapists, GPs and consultants in old age medicine and psychiatry.

## **Key Attributes of the Unified Assessment and Care Management System**

**3.7** It is essential that the unified assessment and care management system adopts the following key attributes:

### **A person-centred approach whereby:**

- The older person seeking help from health and social care services experiences a unified assessment process in which:
  - a) Information about needs is **given once**, no matter that the assessment and subsequent care planning and service delivery involves a number of professionals and agencies. Basic information may however need to be checked/validated with the user to confirm that it remains up to date and accurate.
  - b) Professionals work together in the best interests of the older person (as defined by the older person or those close to them).
- The older person's views and wishes are central to the assessment process, and the assessment takes account of the strengths the older person can bring to bear on their needs, and external or environmental factors that are causing or exacerbating needs.
- Assessment builds a rounded picture of the older person's needs and circumstances, including not only health and social care issues but also relevant housing, benefits, transport and other issues.
- The depth and detail of the assessment is proportionate to an individual's needs.
- Each older person is informed of, and consents to, information about their needs and circumstances being collected and shared; and
- Key decisions and issues are copied in writing, or other appropriate formats, to the older person.

### **A standardised approach that:**

- Is supported by an agreed evidence base.
- Builds on, and supports, existing good practice.
- Is useful to those practitioners responsible for its day-to-day operation.
- Enables professionals to see each others contributions to assessment, which are subsequently trusted and accepted.

- Produces a unified assessment summary record for each individual.
- Within the law, facilitates the sharing of this information from the unified assessment summary between professionals and agencies; and
- Generates information for strategic planning and performance monitoring.

**An outcome-centred approach that:**

- Evaluates assessment information and translates it into appropriate and effective Personal Plans of Care and services; and
- Promotes the health, independence and quality of life of older people seeking help and their potential for rehabilitation.
- Is timely and is aware of evidencing a capacity to improve from a particular crisis.

## Implementation - approach and timetable

**3.8** The Welsh Assembly Government is committed to a unified national assessment framework, which will result in a convergence of local assessment procedures, outputs and outcomes over time. Agencies and localities will therefore be required to demonstrate that their agreed approach to assessment complies with this Guidance. A checklist is included in Annex 8 which sets out the criteria that will have to be met before agencies and localities can be certain that their agreed approach to assessment is compliant.

**3.9** The criteria emphasise that while different localities may opt for different tools or approaches to assessment, their assessment systems should be capable of generating a unified assessment summary record comprising sets of standardised unified assessment and care management information.

**3.10** The criteria and timetable for implementation for older people recognise that implementation in many localities may need to be incremental. Bearing this in mind the timetable is as follows:

By April 2002 agencies in all localities should begin reviewing how their assessment systems compare with the criteria, and should put in place action plans to address the most serious difficulties. Further reviews are required by April 2003 and April 2004 to address remaining difficulties, accompanied by revised action plans if necessary. These must be recorded in Health and Social Care Plans.

Where localities cannot fully meet the criteria they will have to implement action agreed with the Welsh Assembly Government to ensure compliance by April 2005. (Timetable summary is provided in Annex 7).

## Implementation - responsibilities

**3.11** *Improving Health in Wales* recognised that the relationship between health organisations and local authorities at the strategic and planning level was crucial

in achieving a real change in the culture around joint working. Local authorities, with their new and enhanced responsibilities for community strategies (**Local Government Act 2000**) have a major role to play in promoting health improvement and working to reduce inequalities in health. The **1999 Health Act** also placed a new duty on health and local authorities to co-operate in promoting health and well being.

**3.12** The chief officers in each health and social care organisation must therefore take responsibility for ensuring implementation of the Unified Assessment and Care Management System. Local Health Groups and their successor bodies will also be key to progressing this.

## Implementation Process

**3.13** Agencies should involve local stakeholders, including service users, carers, providers and local voluntary and community organisations, in implementation. Project plans for implementation should be based on the following 12 steps.

### STEP 1 **Agree purpose and outcomes**

With reference to the "Key attributes" detailed above local agencies should agree what they want to achieve through local implementation of the unified assessment process. In helping them to do this, they should:

- Identify current good practice in their locality, and build on it.
- Ask service users, carers and professionals what they see as the benefits, and potential problems, of the unified assessment process.

The early parts of the assessment process described in this Guidance may replace or build on the content of a normal consultation with a GP or an initial approach to other professionals. However, **the full process is not intended to apply to older people who have straightforward needs eg for information or advice.**

### STEP 2 **Agree shared values**

Agencies in localities should agree the shared values that will underpin their joint approach to assessment and care planning. In discussing shared values, agencies and professionals should attempt to appreciate each other's roles, and statutory responsibilities, the resources at their disposal and the constraints under which they operate (see Annex 3).

### STEP 3 **Agree terminology**

Agencies should review the terminology that is locally used to describe assessment and other care processes, and agree a common language. The glossary in Annex 9 will be useful for this.

### STEP 4 **Map care processes**

Agencies should identify how service users currently move through the system, from point of access to delivery of a service. As part of this, they should map current systems of assessment and care planning. They should

identify duplication and omission, and the potential for a more integrated approach with a view to reducing work for professionals. They should use their maps to describe the involvement of independent providers.

In addition, when mapping care processes, agencies should clearly identify which professionals need to see information about individuals seeking or receiving treatment or services, how they will use the information, and related safeguards for individuals.

#### **STEP 5 Estimate the types and numbers of older people needing assessment**

Within a locality, the different agencies should estimate the types and numbers of people who will approach them for help and the type of assessment they receive. This will help agencies to design their assessment systems in the first place, and monitor and review them over time. As a guide, it may be anticipated that across all agencies in a locality a relatively small proportion of older people, in the region of 20% of all referrals, would receive a comprehensive older person's assessment. In individual agencies, the proportions will differ markedly. Primary care teams may expect to lead on very few comprehensive older person's assessments. Social services departments may expect between 20 and 30% of cases, where they have the lead, to require a comprehensive older person's assessment. For Consultants in old age medicine and psychiatry and their teams the proportion will approach 100%.

#### **STEP 6. Agree the stages of assessment and other aspects of care management**

Agencies should agree the stages of assessment, care planning, review and other aspects of care management. These should cover:

- Publishing information about services.
- Types of assessment.
  - a) Contact Assessment, including the collection of basic personal information.
  - b) Overview Assessment.
  - c) Specialist/in-depth Assessments.
  - d) Comprehensive Assessment for Older People.
- Evaluating assessment information.
- Deciding what help should be offered, including eligibility decisions.
- Care planning.
- Monitoring.
- Review.

In addition, agencies may wish to take a pro-active approach to identifying individual need among older people, who are not in touch with health and social services. "Case-finding" of this kind can play an important part in preventive strategies and health promotion.

#### **STEP 7 Agree the link between clinical diagnosis and assessment**

Agencies should reach an understanding of how clinical diagnosis fits within the unified assessment process. Diagnosis describes the process whereby the whole problem is understood. Clinical diagnosis is the identification of a specific health condition, how it arose and its likely course. However, the impact of the diagnosis will vary from one person to another and according to their circumstances. As such clinical diagnosis can be seen as distinct from the assessment of wider health and social care needs. However, the inter-related nature of specific health conditions (such as stroke or a fractured neck of femur) with social, physical and mental health issues and problems means that provision of support should ideally be managed in a co-ordinated fashion.

#### **STEP 8 Agree the domains and sub-domains of assessment**

Agencies should agree the domains and sub-domains of the overview assessment. Local agencies may add to, or break down, the domains and sub-domains already provided. (See Chapter 4). However, they should not delete any.

#### **STEP 9 Agree assessment approaches, tools and scales**

In each locality, agencies should work to, or adopt, a common approach to assessment. Their approach should emphasise that assessment involves the collection **and** evaluation of information. In particular, agencies should agree the assessment tool or approach they will use for overview assessment. As well as agreeing assessment tools, agencies should agree the assessment scales that will be used in the locality in support of professional judgement. It is important that scales are valid, reliable, and culturally sensitive.

Agencies may find it useful to access the following website [www.doh.gov.uk/scg/sap](http://www.doh.gov.uk/scg/sap) **Select SAP-Tools and Scales**. Examples of assessment tools that have been developed are available together with assessment scales and questions.

While none of the tools yet fully comply with the requirements of this Guidance, they provide a useful starting point for localities that wish to start from scratch or replace their current system.

#### **STEP 10 Agree joint working arrangements**

Agencies should agree joint working arrangements for assessment and care planning, and protocols for the involvement of professionals in these processes. Agencies will need to draw up local protocols which:

- Confirm that unqualified members of staff may collect basic personal information, and that single members of staff (professionally qualified or

not) from either health or social care, provided they are competent to do so and have received appropriate training and support should be able to carry out both contact and overview assessments.

- Map out the continuum of professional involvement that is anticipated in different cases and how this will be monitored.
- Describe which professionals may act as care co-ordinators, and the tasks that they may undertake.
- Describe how professionals' input to assessment and care planning may be secured, and related time-scales.
- Identify those situations in which one agency can commit the resources and services of another agency to an individual's care.
- Address confidentiality and data protection.

Agencies will need to be clear about joint working arrangements when admissions to care homes for older people are likely. This will be essential where an individual may require nursing care in a care home as the registered nurse employed by the NHS will need to undertake or contribute to the assessment in order for the individual to qualify for NHS funded nursing care.

In reaching these local agreements, agencies should look to their statutory functions. Where local NHS bodies and local authorities are operating either under section 31 of **the Health Act 1999** or section 113(1A) of the **Local Government Act 1972**, staff from either the NHS or the local authority can legitimately carry out a full overview assessment. Where these arrangements are not in place, a local authority will need to focus on those aspects of the overview assessment that are likely to call for a response on its services, and draw the attention of the local NHS to problems where a health response is likely to be needed and vice versa. In addition, and again with due regard to relevant legislation, local protocols should also identify those situations in which one agency can commit the resources and services of another agency to an individual's care, for example, where use is made of the increased partnership flexibility arrangements under the **Health Act 1999**.

The unified assessment process applies to health and social care. These agencies as acknowledged in the domains of the overview assessment, must be prepared to address the full range of needs older people may experience. For many older people services such as housing, benefits and transport can make important contributions to promoting independence and well being.

This Guidance does not formally extend to housing authorities or other statutory agencies. Where possible, local NHS bodies and local authorities are encouraged to engage these wider interests as they implement the unified assessment process. They should take account of their duties under section 47(3)(b) of the **NHS and Community Care Act 1990** to invite

housing authorities to assist in the assessment where a housing need is identified.

Where more than one agency is involved in assessing needs or planning care, those agencies should explain to services users which agency is responsible for what aspect of care. This will be useful if individuals need to complain about or comment on services.

#### STEP 11 **Agree a unified assessment summary record**

It is essential that local agencies work to an agreed common format for the collection of information on older people who are assessed, whether or not they go on to receive services. This is the most valuable step towards a unified assessment process. The components of the unified assessment summary are set out in Annex 4. The Welsh Assembly Government requires local agencies, as the basis for a unified summary record, to provide sets of standardised assessment information on basic personal information, assessed needs and current diagnosis, important medical conditions, and a summary of the personal plan of care. When agreeing their unified assessment summaries, localities may add to these information items, but should not delete any.

With respect to the collection and sharing of information about individuals' needs and circumstances for assessment or other care purpose, agencies should ensure that they comply with the requirements of the Common Law duty of confidentiality, the **Data Protection Act 1998**, and the **Human Rights Act 1998**, and with due regard to the *Caldicott report* (see Annex 5).

Agencies should agree how the Unified Assessment and Care Management Information set may be used to inform strategic planning and commissioning decisions.

#### STEP 12 **Implement a joint staff development strategy**

Agencies should agree and implement a joint staff development strategy. This will be part of a co-ordinated approach to staff development that follows from the implementation of *Improving Health in Wales* and other related health and social care current policy initiatives. It will determine the arrangements for ensuring that organisations and staff are competent to introduce and operate the unified assessment process over time. Effective arrangements will include ongoing programmes for multi-disciplinary groups of staff that will support professional practice, and cover issues of organisational change; knowledge of older age and related health and social care conditions; multi-disciplinary working; and assessment skills and techniques (see Annex 6 for details).

## CHAPTER 4

### DEPTH AND BREADTH OF ASSESSMENTS - *for older people*

#### Background

4.1 This chapter describes the unified assessment process in detail as it should be developed for older people from April 2002. It also provides a useful reference point when adapting this process for other adult groups (to start 2004).

#### Types of assessment

4.2 Assessment is a process whereby the actual or potential needs of an individual are identified and their impact on independence, daily functioning and quality of life is evaluated, so that appropriate action can be planned.

4.3 Assessment systems should be based on the four broad types:

- Contact Assessment.
- Overview Assessment.
- Specialist /in-depth Assessment.
- Comprehensive Assessment.

4.4 Agencies should guard against implementing these types as if people progress in an ordered sequence from contact to comprehensive assessment, practice is usually more complex than that. Professional judgement should be capable of identifying the correct level of assessment to be offered at the right time to the individual service user. For example, in emergencies, professionals may collect a few basic details, undertake specific in-depth assessments to understand and treat the immediate problem, and then return to complete the contact assessment and possibly an overview assessment.

4.5 Similarly the context of when the assessment is done can be decisive. Someone may have experienced a sudden crisis or change. They may be in hospital, fearful, unsure of the future, or they may be over optimistic about their capacities. One part of the assessor's role is to judge how comprehensive an assessment can be in these circumstances and whether the process will need to be reviewed further, particularly in terms of major changes over a period of time.

4.6 In most, if not all localities, agencies will already be operating assessment systems that match, to a greater or lesser extent, the types of assessment described in this Guidance. They should not dismantle current practice, but review and adjust it so that it reflects the Guidance.

## Enquiry

**4.7** It is essential that whenever an individual service user approaches an agency there should be clear and consistent care pathways to other services. The system has to be joined up and to take individuals to where they need to be.

**4.8** Initial contact with an agency may be with a receptionist, a customer services officer, a helpdesk advisor, one-stop shop, duty social worker or occupational therapist, the out-of-hours service and possibly through NHS Direct, computer terminals or on-line facilities. Staff involved in the referral or enquiry stage should have the requisite skills and knowledge not to make inappropriate assumptions that might lead to people being wrongly excluded from assessment.

**4.9** Agencies will develop protocols (if they have not done so already) to distinguish three kinds of enquiries:

- Simple enquiries for information.
- Straightforward service requests.
- Enquiries leading to a contact assessment.

**4.10** Staff will thus need to be prepared to:

- To take basic personal details from callers.
- Disseminate information about goods and services that may be provided by the statutory, voluntary or private sectors.
- Ask the right questions to establish the complexity and range of the caller's problems.
- Subject to agency agreement, arrange for the provision of certain services for service users who can be fast-tracked for straightforward requests, resulting in an efficient access to low levels of service. Where people have indicated there are no other needs or issues, it would usually be inappropriate for the enquiry stage to be prolonged. Such instances include specific minor ailments, requests for pieces of assistance equipment, meals at home and services under the **Road Traffic Act 2000**.
- Make referrals to professionals and other people to assess more complex situations.
- Help service users by making appointments on their behalf and progress chase.

**4.11** Thus it is from the point of initial enquiry that the assessment may begin. It is important that requests for information or services are not taken on face value. Nevertheless, where presented needs or requests are straightforward and there are no other needs, an initial enquiry does not inevitably lead to a contact assessment, as described below or a full personal plan of care.

**4.12** It will be appropriate for staff to explore for wider health and social care needs which will lead to a contact assessment where:

- Presented needs are not clear cut; or
- Other potential needs are identified; or
- Requests for more intensive forms of support or treatment have been made.

**4.13** Enquiry Staff should be trained to understand the eligibility criteria of health and social care agencies.

**4.14** Local authorities should bear in mind their duties under section 47 of the **NHS and Community Care Act 1990**. In short, before embarking on a community care assessment, local authorities should first ascertain whether a person appears to be in need of community care services. In exercising their judgement, local authorities are advised to set a low threshold and avoid screening people out of the assessment process before sufficient information is known about them. Otherwise, a range of older people may be denied a proper assessment prematurely and an opportunity for a cost-effective preventative response to eligible needs may be missed. Local authorities should not operate eligibility criteria to determine the complexity of the assessment offered; rather the depth and breadth of the assessment should be proportionate to individuals' presented needs and circumstances. Health bodies should consider eligibility issues in line with the current continuing care guidance and the Coughlan Judgement. Further revised guidance on continuing health and social care is planned.

## Contact assessment

### Purpose

**4.15** This level of assessment refers to a contact, following referral, between an older person and health and social services **where significant needs are first described or suspected**. It does not refer to every straightforward contact between, for example, a GP and an older person coming to their surgery. At contact assessment basic personal information is collected and the nature of the presented problem is established and the potential presence of wider health and social care needs is explored.

### Basic personal information

**4.16** The collection of some basic personal information will in fact have started at the enquiry stage. Between enquiry/referral stage and contact assessment, a service user may be invited to complete a checklist as he or she prepares for the assessment. Basic personal information may be collected by trained non-professional members of staff.

**4.17** The exploration of the presented and other needs should be undertaken by a trained and competent single assessor, qualified or not, in any of the care settings to which this Guidance applies.

**4.18** Agencies should agree what basic personal information should be collected at this stage, or verified if collected on a previous occasion, and implement a common format. It may not be possible to collect information on all the items at contact assessment or in one sitting. Where this occurs, agencies should ensure that the information is collected as soon as possible thereafter. In collecting and sharing this and other information for the purposes of assessment and care planning, agencies should work to the principle of informed consent and related legislation and guidance (see Annex 5).

**4.19** This information may also be collected by GP surgeries when older people register or when over 75 health checks are carried out. Time can then be saved if and when the need for an assessment under the unified assessment process arises.

**4.20** As a minimum the basic personal information should include the items listed in Annex 4. This information should be made available to other professionals and agencies when appropriate, preferably through electronic means. Depending on the specific circumstances, it may be useful for information on family history to be collected, either at contact, overview or specialist assessment.

### **Establishing and looking at the presented problem**

**4.21** At contact assessment where significant needs are described or suspected, assessors should establish the nature of the problems faced by the older person. To do this, they should be satisfied that seven key issues have been addressed. These issues should be explored in a developmental fashion, as information on them is given as the assessment discussion proceeds, however prompts may be required to ensure all the areas are properly covered.

#### **Box 1. SEVEN KEY ISSUES**

1. The nature of the presented need.
2. The significance of the need for the older person and /or their carer.
3. The length of time the need has been experienced.
4. Potential solutions identified by the older person.
5. Other needs experienced by the older person.
6. Recent life events or changes relevant to the problem(s).
7. The perceptions of family members and carers.

**4.22** In making decisions about the breadth and depth of assessment, assessors will rely on their judgement. In doing this, they will look to cues that may be given in the ways in which older people describe their needs or how they present at the consultation. If, for example, there is evidence of forgetfulness, disorientation, tearfulness, balance or mobility needs, sensory needs, relationship difficulties, and the like, the assessor may check on these specific matters. The question about recent unsettling life events, included in the seven key issues, may be useful in highlighting events or changes that can lead to, or exacerbate, health and social care needs. Such events and changes cover significant personal loss including bereavement, the breakdown of caring relationships, and being a victim of burglary or other crime.

**4.23** At contact assessment one or two of the domains shown in Box 2, in addition to the user and carer perspectives' domains, may be explored if particular needs have been highlighted. The need to explore more domains at this stage probably signals the need for an overview assessment.

## **The domains/areas of assessment**

**4.24** Although user and carer perspectives appear in discrete domains, it is expected that the perspectives of user and carer should inform information collected in each domain. Assessments should cover the following three systems: the person/service user system; the informal care network system; and the formal care network system. Assessment starts from the first of these and moves outward.

### **Box 2. Domains/areas of assessment**

#### **User's perspective**

- Problems and issues in the user's own words
- User's expectations, needs, strengths, abilities and motivation including cultural and social expectations
- Recent life events – including strengths and coping mechanisms
- Personal and spiritual fulfilment and life-style choices
- Advocacy needs

#### **Carer's perspective and need for carer assessment**

- Physical difficulties in caring
- Psychological difficulties and pressures arising from caring role, including shock, grief, felt inadequacy
- Life constraints arising from caring role e.g. clashes with employment, child care responsibilities, leisure activity
- Carer's strengths, expectations, motivation and perception of her/ his needs and user's needs

#### **Clinical background**

- History of medical conditions and diagnoses
- History of falls
- Medication use and ability to self-medicate
- Recent hospitalisation
- Breathing difficulties

#### **Disease prevention**

- History of blood pressure monitoring
- Nutrition/current diet/swallowing ability/fluids
- Vaccination history
- Drinking and smoking history
- Exercise pattern
- History of screening

#### **Personal care and physical well-being**

- Pain
- Oral health
- Foot-care
- Skin care including prevention of pressure areas
- Mobility in and out of the home
- Climbing stairs
- Continence and other aspects of elimination
- Sleeping patterns

### **Activities of Daily living**

- Washing
- Bathing
- Grooming, including hair care and shaving
- Dressing
- Accessing and using toilet
- Transfer in/out of chair
- Transfer from bed
- Eating and drinking
- Ability to make choices and have control over environment
- Suitable equipment

### **Senses**

- Sight
- Hearing
- Smell
- Taste
- Speech and communication, first/preferred language and understanding

### **Mental health**

- Cognition and dementia, including orientation and memory
- Mental health including confusional states, paranoid states, depression and reactions to loss, and other emotional difficulties
- Substance misuse (including tranquillisers or alcohol)

### **Relationships**

- Social support and network, personal relationships, and involvement in leisure, hobbies, religious groups,
- Carer support and strength of caring arrangements
- Ability to care for others where necessary e.g. partner

### **Safety**

- Abuse and neglect (risk assessment)
- Other aspects of personal safety (risk assessment)
- Public safety/hazards (risk assessment)
- Manual handling assessment (risk assessment)

### **Instrumental Activities of Daily Living**

- Meal and snack preparation
- Make hot drink
- Heavy housework (cleaning)
- Keeping warm
- Shopping
- Care of the home
- Managing affairs (finances, paperwork)

### **Immediate environment and resources**

- Accommodation (including noise), heating or physical hazards (risk assessment), location and access
- Level and management of finances and need for benefit advice (risk assessment)
- Access to local facilities and services
- Work, education, learning and participating in community activities
- Transport needs

## Overview assessment

### Purpose

**4.25** Professionals carry out an overview assessment if, in their judgement, the individual's needs are such that a more rounded assessment should be undertaken.

**4.26** Agencies may conduct an overview assessment where third parties, or older people themselves, request more intensive help. Therefore, an overview assessment may build on contact assessment. Alternatively the need for an overview assessment may be immediately<sup>5</sup> apparent, and should be started once basic personal information has been collected. In some situations, an in-depth assessment of a specific need may have been undertaken first, with the overview assessment providing subsequent contextual assessment information.

**4.27** In considering whether to explore all the domains or just some of them at the overview assessment, professionals will be guided by their judgement, taking into account service users' wishes and any indications of wider needs that may have been triggered at the contact assessment. They should satisfy themselves and the service user that there is no need to address the particular area, (this should be recorded) rather than simply omit to explore it. Assessment tools that are strongly rooted in evidence, and include built-in "signposts", can help professionals make decisions about the domains they should explore. For example, if it is established that an older person is incontinent of urine, further assessment of mobility, medication and access to the toilet should usually be carried out.

**4.28** Once a domain is triggered through the Overview Assessment all aspects of that Domain (ie sub domains) should be considered.

**4.29** In reaching decisions on individual cases, professionals may wish to err on the side of caution, and apply all the domains. This is because there is considerable evidence that **many treatable health conditions and other needs go undetected or mis-diagnosed**. Where an overview assessment is being carried out, professionals should explain to the older person the benefits of taking a preventative approach.

**4.30** As a result of an overview assessment, professionals will have a rounded view of an older person's situation; some needs may be confirmed, and further specialist/in-depth assessment may be indicated.

### Who undertakes overview assessment?

**4.31** It is both possible and practical for all of the overview assessment to be completed by a single professional from either the NHS or social services. The domains of "clinical background" and "disease prevention" do not require specific health tests to be undertaken; rather, in the first instance, they ask the assessing professional to check on past assessments. While it is not essential for overview assessments to be carried out by qualified professionals, local agencies should

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<sup>5</sup> Some referrals may be made by NHS Direct, and in these situations sufficient assessment information may have been collected for agencies to make judgements about proceeding to overview assessment. Some items of information that are needed for an overview assessment may also be collected during a NHS Direct contact.

nevertheless have clear agreements as to who is competent to carry out the overview assessment. Staff training and development should be offered to ensure appropriate levels of professional competence.

## **Specialist/in-depth assessments**

### **Purpose**

**4.32** Where the contact or overview assessment has indicated actual or potential needs in a domain or sub-domain, a more in depth or specialist assessment may be required. (Some parts of overview assessment may be sufficient that further assessment is not needed.) As a result of a specialist assessment, professionals should be able to confirm the presence, extent, cause and likely development of a problem or health condition, and establish links to other conditions and needs.

### **Professional judgement**

**4.33** At all times, specialist assessments will rely for their quality on the involvement and judgement of appropriately qualified and experienced professionals, such as occupational therapists, physiotherapists, qualified social workers, registered nurses, consultants, housing and benefits professionals, and so on. At times specialist assessment will rely on the use of assessment scales in support of professional judgement.

**4.34** Specialist assessments, and associated scales, should be administered and interpreted by the most appropriate professional. Agencies should ensure that professionals, particularly those carrying out overview assessments, can accurately identify the most appropriate professionals to carry out specific specialist assessments.

**4.35** Those carrying out specialist assessments should draw on information collected at contact assessment and during the overview assessment. Some of the information collected at these levels may be relatively detailed.

## **Comprehensive assessments**

### **Purpose**

**4.36** A comprehensive assessment may arise in several ways. For example, from the outset, it may be obvious to a doctor or other qualified professional that, based on their professional judgement, the needs and circumstances of an older person are such that a comprehensive assessment involving specialist assessments of all or most of the domains of the unified assessment process should be commenced. In this situation, conducting an overview assessment would be unnecessary and could delay getting the right help to the older person.

**4.37** Alternatively at the initial stage there could be less certainty, and an overview assessment may be carried out to explore areas of concern. When all the domains of an overview assessment have been surveyed, and specialist assessments carried out in most or all of them, the result is also a comprehensive assessment.

**4.38** In addition, comprehensive assessments should be completed for people where the level of support and treatment likely to be offered is intensive or prolonged, including permanent admission to a care home, intermediate care services, or substantial packages of care at home. However, no decisions on where people are best supported should be made before all information from a comprehensive assessment has been evaluated, including information from medical assessments and a thorough exploration of rehabilitation potential.

**4.39** Comprehensive assessment will involve a range of different professionals or specialist teams, with the relevant skills and knowledge. Consultants in old age medicine and psychiatry, and their teams, should usually play a leading role in comprehensive assessment. This involvement is crucial for accurate and timely diagnoses of treatable and other health conditions, without which wider assessment and subsequent care planning is likely to be flawed. It will be important for the various specialist assessments to be co-ordinated and drawn together and interpreted. For further details on care co-ordination see Chapter 6.

### **Admission to care homes providing nursing care**

**4.40** A comprehensive older person's assessment for people entering care homes will require the input of a range of professionals, with experienced registered nurses employed by the statutory NHS body and social workers playing a prominent role.

**4.41** Where a care home offering nursing care is required the assessment of the individual's needs and the drafting of the personal plan of care will have involved a registered nurse employed by the NHS. This assessment will have determined that this is the most appropriate setting in which the care can be provided. The assessment decision will be submitted to the NHS manager who is responsible for the implementation of 'NHS Funded Nursing Care' and is the budget manager for this expenditure. This manager will be responsible for agreeing funding for registered nurse services in a suitable home and arranging reimbursement.

**4.42** Agencies should note that where local authorities contribute to funding of placements in care homes offering nursing care, the placement will actually be made by the social worker, in consultation with the nurse.

### **The older person's contribution to assessments**

**4.43** During assessment, care planning and other processes, the older person's account of their problems, views and wishes must be kept at the centre of all decisions that are made. The strengths and abilities that individuals can bring to bear on their needs should also be taken into account together with any external or environmental factors that may have precipitated their needs.

**4.44** It is important for a user-centred focus to feature strongly in all types of assessment. Agencies can encourage older people to make the maximum contribution to contact, overview and specialist assessment in a number of ways. Central to this is a positive attitude and inclusive style of individual professionals. For example, at the beginning of, or prior to, a contact assessment, professionals might advise older people of the seven key issues that should be covered. Before a fuller consultation or assessment discussion, older people can be advised to

think about the needs and issues they may wish to raise, and how this might be structured. Where appropriate, older people can be asked to complete customised forms or make written statements that can feed into the assessment process.

**4.45** At overview, specialist assessment and comprehensive assessment, where appropriate and possible, professionals should encourage the older person to provide a biography. This should include not only the needs they have faced in the past, but also key life events, relationships, motivations and beliefs that may have a bearing on how the assessment is carried out and services are provided. Such information will be crucial where contact with agencies and service providers is likely to be either intense or prolonged or both.

**4.46** Older people should not be asked to repeat or duplicate information already provided. Where users have been referred by other agencies, users should be invited to confirm the accuracy of information provided, as well as being offered the opportunity to add to it.

**4.47** Agencies should consider at the earliest opportunity whether older people might need, or benefit from, the assistance of advocates in the language they prefer, interpreters and translators during the assessment process. The contribution of trained bi-or multi-lingual co-workers in the older person's preferred language can be key.

**4.48** As a matter of good practice and in line with legal requirements, individuals should be told beforehand of the uses to which information collected during assessment may be put, and who else will see the information. Users should be provided with a copy of the assessment information in an appropriate format (see Annex 5).

**4.49** Helping the service user prepare for and contribute to assessment initiates the process of them being placed at the heart of the assessment. However, it does not replace or reduce the need for prompt and professional involvement. Agencies should be mindful that introducing these procedures might have an impact in terms of making the assessment process longer. Management information and monitoring procedures will alert agencies to any undesirable lengthening of time scales between the assessment starting and the receipt of services. An appropriate balance will need to be struck between achieving user involvement and the delivery of timely services.

## **Carers**

**4.50** Any type of assessment of an older person's needs should explore the support and treatment they are already receiving. Where support from carers is identified, professionals should ascertain the nature of that support, the strength of the caring relationship, and whether the carer requires support and services, either to help them to continue to care for the older person or in their own right. Even where carers and others are providing support to an individual, the nature of the individual's needs, and the level of care, could be such as to make the individual eligible for community care services.

**4.51** A separate carer's assessment should be offered. Agencies should bear in mind that services which help carers may be provided under **community care legislation**, the **Children Act 1989** or the **Carers and Disabled Children Act 2000**. Which legislative basis is used will depend on individual circumstances and what is in the best interests of the service user and carer. For further information on assessment refer to Policy Guidance and Practitioners Guide on the Carers and Disabled Children Act 2000.

### **Case finding**

**4.52** When implementing the unified assessment process, agencies may wish to develop "case finding" systems to identify and invite for assessment, older people who are not referred to them for help. Case finding can make an important contribution to preventative strategies and health promotion and some agencies have developed a number of methods including postal questionnaires to help with this. Examples are given on [www.doh.gov.uk/scg/sap](http://www.doh.gov.uk/scg/sap) **Select SAP-Tools and Scales**.

**4.53** The over 75s health check can also identify people for whom a fuller assessment may be beneficial. As well as GPs, other professionals who have regular contact with the public, including older people, can be alert to wider health and social care needs and refer older people to other agencies when necessary. Dentists and podiatrists, for example, come into this category.

### **Joint working arrangements - A continuum of involvement**

**4.54** Multi-agency involvement will range along a continuum. Where one professional needs input from another, the extent of the involvement could be restricted to a phone call to check whether the older person is in receipt of services, or whether certain information is known. At the other extreme, involvement can extend to two or more professionals needing to undertake a joint assessment visit, and a case conference meeting.

**4.55** Where joint teams have been established, the integration of assessment, care planning and service delivery across agencies and disciplines is often reported as less difficult to achieve. Agencies may also wish to consider the value of setting up co-ordination arrangements between relevant staff who may be members of separate teams e.g. developing virtual teams.

**4.56** Once local agencies have agreed which professionals should be involved in what types of situations, they should ensure that access to these professionals is readily secured. To help with this, agencies should include contact arrangements in their protocols for care co-ordination, with commitments on how soon professionals could become involved.



## CHAPTER 5

### FAIR ACCESS TO CARE SERVICES: SETTING ELIGIBILITY CRITERIA – *for all adult groups*

#### Background

**5.1 This Fair Access to Care Services (FACS) Guidance applies to local authorities when carrying out their Community Care duties in respect of all adult groups<sup>6</sup>.** It will help authorities to review and develop the way in which they set eligibility criteria and how decisions on individual eligibility are made and reviewed. It proposes that there will be only one eligibility framework to be used by all local authorities and for all potential adult service user groups, whatever the nature of the problem or issue that brings them to the notice of the local authority's social services department.

**5.2** The Guidance emphasises that eligibility decisions should be made with reference to assessed needs and their impact on independence.

**5.3 The Guidance is also relevant to health bodies as**

- a) Local Authorities at a minimum will need to consult with health partners and ensure the development of the social care eligibility criteria is compatible with the current continuing NHS care criteria.
- b) It ensures that health bodies are fully aware of eligibility for social care services.
- c) The Guidance may also be used as a starting point for developing unified eligibility criteria for packages of continuing health and social care. Further revised guidance on continuing care is planned to assist this process.

**5.4** The chapter provides a **framework** for determining eligibility for **all adult social care services**. Health and social care agencies should ensure that they can provide or commission services to meet assessed needs, subject to their resources, and that within a local area people in similar circumstances receive services capable of achieving broadly similar outcomes.

**5.5** This framework to determine eligibility should lead to greater equity and fairer access to care services across Wales. This Guidance does not require different local authorities to make identical decisions about eligibility, nor does it prescribe to the way in which the needs of service users who are in similar circumstances should be met, nor prescribes what services should be available to service users who have similar needs. However, it is the case that all authorities work within a legal framework that sets down key duties and responsibilities for how care supports should be assessed for and provided across Wales. This

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<sup>6</sup> The provision of services, such as travel concessions and disabled persons' parking badges for motor vehicles is covered by regulations and guidance under the Road Traffic Act 2000, which give prescribed eligible categories and descriptions of disabled people who may receive such services. As such, these are outside the scope of this Fair Access Guidance.

Guidance provides part of the interpretative framework for the case law in this area.

**5.6** Local authorities should prioritise and meet individuals' assessed needs according to the risks to their independence in both the short and longer-term, where help not to be provided. Local authorities should also make the necessary changes in their practice to take a longer term, preventative view of individuals' needs, issues and circumstances.

**5.7** Local authorities should use this Guidance to review and revise their eligibility criteria and related arrangements in consultation with health partners. From October 2002 they should use revised eligibility criteria for adult social care, and case reviews should be commenced, according to this Guidance. By October 2003 reviews of the needs of service users in receipt of services at the start of October 2002 should have been completed.

## Eligibility framework

**5.8** The eligibility framework presented in this Guidance is constructed by identifying the impact of needs and issues on four factors that are judged to be key to maintaining an individual's independence.

**5.9 The Assessment Domains (Chapter 4) provide the information which must be evaluated to determine the overall impact of needs on these 4 key factors of independence below. This will in turn determine the individual's position within the eligibility band.**

### Four Key Factors of Independence

**5.10** The key factors are –

- **Autonomy:** This refers to the control a person has over their immediate situation and the extent to which they are able to make and act on informed choices.
- **Health and safety:** This will consider issues of risk to the health of the individual, it will include mental and physical health, it will include maintaining the current health status and preventing deterioration. Safety has two aspects. The safety of a person from harm, which could be caused by themselves or others; and the safety of others, including family members, from harm caused by the person. Harm can be caused intentionally or unintentionally.
- **Managing daily routines:** This has two aspects. The ability of a person to look after their own personal care, domestic needs and other daily routines; and their ability to look after dependent family members or others close to them.
- **Involvement:** This refers to a person's involvement in work, education and learning, family life and social networks and community activities. It includes recognition of an individual's social roles and responsibilities, including parenting and caring.

**5.11** These four key factors of independence are intended to present a holistic view of person's circumstances and their possible impact on independence. It is not suggested that there is any hierarchy of importance between these key factors, although service users often give autonomy a higher priority than the others.

**5.12** For some individuals some factors may be more crucial than others and it will be through assessment that the importance of these factors for the individual is identified.

**5.13** Assessing an individual's problems, circumstances and related risk, are the basis for determining an individual's eligibility. Whilst many people have difficult problems and circumstances, it is only when these have an impact on independence which falls within the banding that the local authority has deemed eligible will it result in the person receiving help.

**5.14** Once a person is deemed to have some eligible needs it does not follow that all their problems will become eligible for help. However, in practice, sometimes less serious problems may be addressed as a consequence of, or to facilitate, eligible needs being met.

**5.15** Combining the extent of risk to the key factors of independence provides the framework of eligibility criteria. The framework has four bands each **describing the extent** of risk to independence if needs and issues are not addressed. The four bands range from critical and substantial, to moderate and low. **It will be for individual local authorities to draw the line of eligibility within the framework according to their local circumstances** (see paragraph 5.21).

## Setting the eligibility criteria

**5.16** Local authorities should use the following framework for determining their eligibility criteria. These should be developed in conjunction with statutory health bodies and the framework should assist in the development of unified eligibility criteria overtime.

**Critical** – when:

- Life is, or could be, threatened; and/or
- Major physical or mental health problems have developed or are likely to develop; and/or
- There is, or could be, an extensive loss of choice and control over vital aspects of the immediate environment; and/or
- Abuse or neglect (self or other) have occurred or are likely to occur; and/or
- There is, or could be, an inability (physical or mental) to carry out vital personal care, domestic or other routines; and/or
- Vital involvement in work, education or learning is, or could be, at great risk of not being sustained; and/or

- Vital social support systems and relationships cannot or will not be sustained; and/or
- Vital family and social roles and responsibilities cannot or will not be undertaken.

**Substantial** – when:

- Significant physical or mental health problems have developed or are likely to develop; and/or
- There is, or could be, some significant loss of choice and control over the immediate environment; and/or
- There is, or could be, an inability (physical or mental) to carry out the majority of personal care, domestic or other routines; and/or
- Involvement in many aspects of work, education or learning is, or could be, at risk of not being sustained; and/or
- The majority of social support systems and relationships are, or could be, at risk; and/or
- Individuals cannot undertake, or will be unlikely to be able to undertake, some significant family and social roles and responsibilities that are important to them and others.

**Moderate** – when:

- There is, or could be, some inability (physical or mental) to carry out several domestic or other routines; and/or
- Several aspects of work, education or learning are, or could be, at risk of not being sustained; and/or
- Several social support systems and relationships are, or could be, at risk; and/or
- Individuals cannot undertake, or will be unlikely to be able to undertake, several family and social roles and responsibilities.

**Low** – when:

- There is, or could be, some inability (physical or mental) to carry out one or two domestic or other routines; and/or
- Involvement in one or two aspects of work, education or learning cannot or will not be sustained and/or
- One or two social support systems and relationships are, or could be, at risk of not being sustained; and/or
- Individuals cannot undertake, or will be unlikely to be able to undertake, one or two family and social roles and responsibilities.

## Strategic concerns

**5.17** The framework makes no reference to age, gender, ethnic group, religion, disabilities, personal relationships, or living and caring arrangements as in themselves they do not threaten independence, however they may need to be taken into account as needs are assessed and services considered.

**5.18** In determining eligibility criteria at a strategic level, local authorities should ensure that those individuals whose needs have immediate and longer-term critical consequences for their independence, are prioritised as eligible ahead of those with needs that have substantial consequences. Similarly, those individuals with needs that have substantial consequences should be placed before those with needs that have moderate consequences; and so on. Because local authorities are now considering both the short **and longer-term** implications for independence as the deciding factors in eligibility, there may be different types of circumstances that are eligible for help.

**5.19** In setting their eligibility criteria local authorities will want to take account of their resources, local expectations, and local costs. Local authorities will take account of agreements with other agencies, including the NHS over hospital discharge, as well as other local and national factors. It is recognised that in order to manage these resources, local authorities will continue to have to decide those they are able to help and those they are not.

**5.20** Prioritisation of needs is a significant factor in determining who gets what. In the past the imperative to target those in immediate need has, to some extent, resulted in people with low level needs not receiving appropriate or timely responses. It is a challenge to get the right balance between responding to immediate and high level needs on the one hand, and low level needs, which *nonetheless* may require a speedy response to prevent deterioration or to enhance individual quality of life, on the other.

**5.21** Some local authorities will be able to draw the line of eligibility **between** these four bands and will say for example that all needs that fall within the substantial and critical bands are eligible. Some local authorities will draw the line of eligibility **within** these four bands but it is important to note that the descriptors are not written to imply that one is any more significant than another. In order to draw the line within the bands, therefore local authorities may need to expand on the descriptors to give more detail as to which circumstances within a particular band are eligible and which are not. Any set of criteria must also allow for exceptional cases to be assessed for supports outside this framework where an individual situation clearly fits the overall judgement and where the circumstances are unique or unusual. An authority's eligibility criteria must remain in line with the implications of case law.

**5.22** Local authorities should review their eligibility criteria at least annually in consultation with health partners. If there are major changes in a local authority's financial position or other factors, then they may wish to review their criteria more frequently. Account should always be taken of the effects of such changes on other agencies. Social services departments should arrange for criteria to be scrutinised by local authority legal departments before they are put to elected members for approval.

**5.23** Agencies should have regard to the *Human Rights Act 1998* when drawing up eligibility criteria. Account should also be taken of the implications of the *Race Relations (Amendment) Act 2000*, when commissioning and providing services. Services should be planned and delivered in accordance with the agency's Welsh Language Scheme (see Annex 1).

**5.24** In preparation for determining their eligibility criteria for the first year, local authorities will need to look at their existing eligibility criteria and ascertain how far they match the framework proposed by the Fair Access Guidance. Given the many variables in how local authorities currently determine their eligibility criteria, each authority will determine its own process for changing from their current model to the framework required by FACS.

**5.25** Although final decisions remain with the statutory agency, they should consult service users, carers and appropriate partner agencies and local organisations about their eligibility criteria and how information about the criteria is presented and made available. Eligibility criteria should be published and made readily available and accessible to service users, the public more generally, and other relevant local bodies.

**5.26** Agencies should make individuals and their families aware that they may use the complaints procedures to challenge decisions made at assessment or about eligibility.

### **Preventative approaches**

**5.27** Local Authorities through their housing, education and leisure services have a corporate role in enabling people to have fulfilling lifestyles and to participate and contribute to the wider community. They may become involved with other agencies in wider community development or health promotion approaches where there is widespread social disadvantage, or evidence that particular groups of people are socially excluded. They should be prepared to act where it is difficult to estimate the likely benefit to a particular individual, but there is evidence of the likely preventative benefits from non-intensive help to certain populations or groups.

### **Commissioning services**

**5.28** In determining their eligibility criteria for any given period, local authorities together with partner agencies should ensure that they have services in place to meet eligible needs. If local authorities identify that there is a different range of needs that are becoming eligible under the FACS process than were eligible under their existing criteria then it will be necessary to develop a strategic view of the changes in commissioning of services that needs to take place. This analysis will need to be included in health and social care plans. It will not be feasible to ignore the historical pattern of provision in the first year, and local authorities may have to increase the proportion of spot purchased provision in the interim until they can develop a more informed commissioning system based on the new criteria.

**5.29** Services cannot be shaped without a clear understanding of what outcomes must be achieved. This will not be a one off exercise. Needs and expectations change and service responses need to be flexible and adaptable.

**5.30** The introduction of Best Value into the planning and delivery of local authority services has required a critical examination of how needs are identified, services are planned and delivered and outcomes measured. As a guiding principle, local authorities should be prepared to provide the most appropriate and cost-effective support to meet assessed needs. In this context, local authorities that have decided not to provide or commission certain services – such as shopping only, cleaning only, the provision of bathing equipment only, or other low-level services – should review their positions. Such services, if targeted purposively, can have an appreciable cost-effective impact on promoting independence and preventing deterioration in an adult's personal circumstances. Local authorities that choose not to provide such services, are taking a service based and not a needs based, approach, which may not be in the best interests of the service users.

**5.31** Agencies should pay particular attention to ensuring that services are available to meet the needs of minority ethnic groups and that these services are sensitive to their culture and faith. Services also need to be accessible to those who live in remote and isolated rural areas.

## **Considering support requirements**

**5.32 There should be only one eligibility decision; namely, whether people are eligible for help or not. Once a person has been deemed eligible for support, the services they will receive should be considered at the care planning stage. Local authorities should not operate eligibility criteria for different services.**

**5.33** For each service local authorities directly provide or commission from others, there should be a statement of purpose. For registered services, statements of purpose will have been provided to the Care Standards Inspectorate for Wales. For non-registered services, agencies should secure similar statements of purpose, when agreeing contracts, that should set out the objectives and philosophy of care, nature of services, facilities, physical access, and likely charges. They should also describe the types of circumstances and types of people for whom the service is designed. The statements of purpose should be used at the care planning stage to match services to needs and desired outcomes.

**5.34** For eligible situations, outcome-focused plans should be developed with people which record assessed needs, and associated risks to independence and agreed wherever possible by them or their representatives.

**5.35** Agencies should provide services promptly once they have agreed to do so, but where waiting is unavoidable they should ensure alternative services are in place to meet assessed needs.

**5.36** Local authorities should provide an immediate response to those individuals who approach, or are referred to, local authorities for social care support in emergencies and crises. After this initial response, they should inform

the individual that a fuller assessment will follow, and services may be withdrawn or changed as a result of this assessment.

**5.37** Local authorities are reminded that they should consider potential outcomes and the costs of providing particular care on the merits of each case. They should only use upper-cost parameters for care packages as a guide. It is not appropriate for local authorities to stick rigidly to pre-determined cost ceilings.

**5.38** Where local authorities decide not to provide help, the decision with reasons must be put in writing and made available to the individual. Local authorities should tell people who are not eligible for help that if their circumstances change, they may be re-assessed. They may also provide useful information and advice.

### **Ensuring fairness**

**5.39** All adults – irrespective of health conditions, disability, and age – should be subject to the same eligibility processes, and eligibility decisions should be based on assessed need.

**5.40** Each local authority should ensure that all service users in its area with similar assessed needs, receive packages of care that are capable of achieving broadly similar outcomes, even though the particular form of help offered will be tailored to the individual service user.

**5.41** Practitioners should accurately record information on individual referrals, assessments, Personal Plans of Care and reviews and must record clearly how a person is eligible for help and if applicable, what eligibility or priority band they fall into. This is essential in demonstrating that eligibility criteria are applied consistently and fairly and is a key factor in authorities having accurate, accessible and timely information.

**5.42** Regular reviews of existing service users will determine whether people are still eligible for help against current criteria. Thus all existing and potential service users will be assessed against the same criteria in an equitable way.

**5.43** When a service user permanently moves from one local authority area to another, the "receiving" authority should, pending an assessment, take account of the services that were previously received and the effect of any substantial changes on the service user when taking an interim decision about what services to provide. The "receiving" authority should have regard to these factors, as well as the outcomes that were previously pursued, when carrying out the assessment and taking longer-term decisions about what services will be provided. Where "receiving" local authorities intend to pursue significantly different outcomes, or provide significantly different services, they should produce clear and written explanations for service users.

### **Developing joint eligibility criteria**

**5.44** Some individuals have a range of needs, and their circumstances require input from more than one agency. Ensuring that social care criteria are compatible and coherent with the criteria of other relevant agencies should mean that such

individuals are not excluded, or fall through the gaps between the respective criteria of these agencies.

**5.45** Local authorities and Health agencies will need to agree their respective responsibilities for the services that are needed and ensure that there is no gap in the services provided.

**5.46** Ideally, local agencies may wish to develop one unified set of criteria that will cover the health needs and the social care needs for which help will be provided. Planned revised guidance on continuing care will assist in the development of this joint approach.

**5.47** Any arrangements within the **1999 Health Act Flexibilities** to pool budgets will necessitate local authorities developing joint eligibility criteria. Local authorities should use their eligibility criteria as determined by the Fair Access framework as a basis to develop the joint eligibility criteria. Other flexibilities such as lead commissioning and integrated working will not require joint eligibility criteria, but will require that the local authority's eligibility criteria are clearly spelt out and understood by health agencies.

**5.48** Policies and protocols for hospital discharge arrangements, developed jointly by health bodies and social services will need to be reviewed and to be consistent with eligibility criteria. Agreements about managing the care of people who are discharged from hospital should not result in a different decision about eligibility than if they presented to social services via a different route.

### **Staff learning and understanding**

**5.49** Agencies should put in place training and development activities to enable an organisational culture that promotes independence and prevention. In particular, training on the assessment process should focus on improving risk assessments to identify the longer-term consequences of individuals' circumstances. Training should build on agencies achievements in this area and include knowledge of the circumstances of user groups, anti-discriminatory practice and effective multi-disciplinary working.

**5.50** The effectiveness of eligibility criteria will depend on how well they are known, understood and applied by all staff in social services departments, health services and other relevant agencies. Staff also need to be competent and confident in their assessment skills for the service user groups they are likely to be working with.



## CHAPTER 6

### CARE CO-ORDINATION AND PERSONAL PLANS OF CARE – *for older people*

#### Personal Plan of Care Essentials

**6.1** Care planning involves users, carers and professionals discussing how the assessed needs can best be met and agreed goals achieved. Care planning should be responsive to – but not prejudiced against – the age, living circumstances, geographic location, disabilities, gender, culture, faith, personal relationships and lifestyle choices of service users. Care planning should build on the strengths and abilities of individuals and the part they can play in addressing their needs. It should address external or environmental factors that have caused the needs to arise, or will hamper the resolution of needs if not addressed.

**6.2** Care planning is concerned with identifying and recording outcomes from the support that is to be provided and the time-scales within which it is hoped that the outcomes will be achieved. Outcomes can be described as the changes and effects that the service user requires resulting from service provision and the support network available to them. Outcomes should reflect what people can do and their capacity for self-care.

**6.3** Plans should aim for the minimum intervention possible to achieve these required outcomes and objectives. They should also take account of activities other than those provided by the statutory services and the positive contribution that they have in helping service users maintain independence and improve their quality of life. All agencies providing or commissioning services that are part of an individual's package of care should have been involved in planning the care.

**6.4** Staff need to be aware of the full range of services available, and agencies may wish to develop an A to Z or *service directory*. This should facilitate users, carers and their care planners to develop more innovative care packages, by providing information on the whole range of services available that may meet the individual's specific needs. Local health and social care agencies, housing, voluntary and other bodies would provide a statement of purpose for the services they organise and/or commission to make up this service directory.

**6.5** The Guidance on Fair Access to Care Services requires that there should not be eligibility criteria for different services. At the care planning stage, services are matched to eligible needs through the use of **statements of purpose**, which all service providers should prepare. These statements should set out the objectives and philosophy of care underpinning the service, the nature of services, facilities, physical and geographical access, and likely charges. They should also describe the types and circumstances and the people for whom the service is designed.

**6.6** Wherever possible, care co-ordinators should be able to set up Personal Plans of Care that are flexible in meeting the needs of service users. For example, some users may benefit from having an allocation of 10 hours of home care per week to call upon when they most need it rather than a set time for the service to be delivered.

**6.7** All older people who receive services should receive a personal plan of care. The detail of the plan should be in proportion to the assessed needs and service provision. For people who receive one-off support or treatment of a very basic nature, a simple statement of service delivery and purpose is all that is needed.<sup>7</sup>

**6.8** Personal Plans of Care and other information that is provided to service users should be in accessible and appropriate formats. Where possible plans should be agreed with service users. Where other agencies' services are a part of the Personal Plan of Care, these agencies should have been party to the plan.

**6.9** Clear decisions taken in conjunction with the service user also need to be made as to who else needs a copy of the personal plan of care and why. A list of the agreed recipients should be included.

**6.10** The care planning process also involves giving users clear information about any charges for services that will be made to them. As such, a financial assessment should be completed before the personal plan of care is put in place and include checks that the service user is receiving their full entitlement to state benefits, or other sources of income. The user will need to know what the charge is, how to pay it, how the financial assessment is calculated and how to appeal if they disagree with it.

## **An outcome approach to care planning**

**6.11** Care planning is concerned with identifying and recording outcomes from any care provided and the time scales within which it is hoped that the outcomes will be achieved. It is within this context that the user with the care co-ordinator can explore the various options that may be appropriate to meeting their eligible needs.

**6.12** Outcomes should be identified and agreed on the basis of users and carers own views about what they themselves would like to achieve. The preparation for assessment described in Chapter 4 should enable users to begin thinking about what is most important for them.

**6.13** Outcomes should include preventative and rehabilitation or re-ablement outcomes that reflect the need to optimise the four key factors of independence (Chapter 5). Broad outcomes are summarised below, but these will need to be expressed in specific terms in individual circumstances.

- Promote control, choice, dignity and the ability to take decisions about life-style and activities.
- Ensure care and support to secure or promote personal health, and the safety of the individual and of others.

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<sup>7</sup> Local authorities are reminded (see chapter 2) that they may take their resources into account in assessing a person's need for the services listed in section 2 of the Chronically Sick and Disabled Persons Act 1970, and in deciding whether it is necessary to make arrangements for those services. However, this does not mean that local authorities can take decisions on the basis of resources alone. Once a local authority has decided it is necessary to provide services to meet the assessed needs of a disabled person through services listed in Section 2, then it is under a duty to arrange those services. For fuller details see "Responsibilities of local authority social services departments: implications of recent legal judgements"(Welsh Office circular 59/97)

- Retain or improve current levels of ability to manage daily routines, both personal care, domestic care, and the ability to care for dependent family members close to them.
- Maintain and develop the ability to be involved on the wider family, community, social and employment activities that are important.

**6.14** For some individuals the context for these outcomes will be that they have never had an acceptable level of independence and this is the first opportunity they have had to maximise their potential. For others they will be aiming to regain optimum levels of independence, following illness, accident or trauma, or the gradual onset of sensory or other impairment. Others will be aiming to maintain or improve the quality of life and personal dignity as independence and circumstances inevitably change, this would include people with palliative care needs.

**6.15** Outcomes should reflect what people can do and their capacity for self-care. They should be responsive to – but not prejudiced against – the age, living circumstances, geographic location, disabilities, gender, culture, faith, and personal relationships of service users.

## Objectives

**6.16** The objectives are the stages and steps that need to be undertaken to achieve the overall outcome. In care planning terms, this means stating the specific objective of each service or support and the way in which it would contribute to the achievement of, for example, improving an individual's level of managing their daily routines. Provision of domiciliary support may have the stated objective of improving an individual's capacity to undertake self care tasks with respect to personal hygiene. This objective would contribute to the overall outcome, along with other inputs, of improving their level of independence and therefore assisting them to remain in their own home.

**6.17** Once a personal plan of care is implemented, it is essential that its effectiveness is evaluated against the specified objectives and outcomes.

## Involvement of providers

**6.18** Where Personal Plans of Care are being drafted, either for existing or new service users, agencies should ensure they are realistic and that providers can provide whatever services are recommended. This will require dialogue between professionals who have responsibilities for assessment and care planning and those who provide services.

**6.19** To help providers meet their own obligations for assessment and care planning, the outcomes of assessments and Personal Plans of Care should be shared with providers, in line with the service user's wishes and the requirements of the **Data Protection Act** (see Annex 5). The National Minimum Standards for care homes for older people gives details of the obligations of providers in this respect.

## Risk and contingency management

**6.20** Care planning should include understanding and anticipating activities which will invoke risk either to the individual and/or others and developing an action plan that can manage the situation appropriately (see Annex 1).

**6.21** Contingency planning prevents crises by detailing the arrangements to be used when an essential feature of the personal plan of care is removed at short notice, or key personnel are absent. It should include how to obtain alternative care or replacement personnel. This may be based on previous experience with the service users and should also include clear arrangements that can be accessed out of normal office hours.

## Content of Personal Plans of Care

**6.22** For those service users who receive plans, local agencies should ensure they include:

- A summary of assessed needs indicating the intensity, instability, predictability and complexity of needs, the associated risks to independence, and the potential for rehabilitation.
- The eligibility decision and supporting reasons for the decision.
- A note indicating if the service user has agreed its content. In instances where this is not possible, a reason must be recorded.
- A note on whether or not the user has consented for Personal plan of Care information to be shared among relevant agencies and a reason where this was not possible.
- A clear statement of the objectives of providing help and anticipated outcomes for users. These objectives and outcomes should tally with, or be matched against, those already indicated by users.
- Significant dates and time-scales by which the outcomes are expected to be reached and the possibility of services being changed and withdrawn.
- A summary of how the services will impact on the person's autonomy, health and safety, functionality, and involvement in family and wider community life. In doing so, it should explicitly describe how services are to promote health, independence, prevention and rehabilitation.
- The part the user will play in addressing needs, including the strengths and abilities s/he will bring to this.
- Details on managing risk as appropriate. Where it has been agreed that users will accept a certain degree of risk, this must be written in the plan.
- Any details of manual handling assessment.
- Outline what family and other carers are able and willing to do, and the needs that carers have in carrying out their caring role, including the support they need for their own health and well-being.

- A description of the level and frequency of the help that is to be provided, stating which person or agency is providing what service. Where appropriate, agencies should indicate their agreement to the use of their services.
- Details of any unmet need and reason.
- Details of any contributions to care costs that users are asked to make.
- A statement noting the arrangements for Direct Payments if they are to be used.
- A nursing plan where appropriate and which is integrated into the overall personal plan of care where possible, including a detailed assessment of nursing need for people admitted to nursing homes.
- Include the name of the person responsible for co-ordinating the personal plan of care and the GP and their contact number and the contact details of providers.
- Include a name or an office for users and carers to contact in case of emergencies.
- Include a contingency plan if things go wrong.
- Including details of monitoring arrangements.
- Include an appropriate date for review.
- A list of people who have a copy of the personal plan of care.

## Care co-ordination and ongoing monitoring

**6.23** Where more than one professional is involved in the assessment of needs and subsequent care planning, they will need to liaise as appropriate.

**6.24** In some situations, typically where the needs are complex and require the input of several professionals and/or agencies, local agencies should consider nominating one professional as a care co-ordinator for both the assessment and subsequent care planning. The care co-ordinator will act as the focus for communication for the different professionals and, most importantly, with the individual older person. Evidence suggests that as the needs of many vulnerable older people are multiple and long-term, specialist professionals who may only be involved in a case for a limited time may not be well placed to co-ordinate care. Often the role is best handled by community-based nurses or social workers, who tend to have a long-term role.

**6.25** Agencies should agree local protocols for care co-ordination, including who should operate as such a co-ordinator, and what tasks are involved. Criteria for identifying who should be a co-ordinator can include the following:

- Service user choice.
- The person who has responsibility for the majority of the assessment process.
- A person who is best known to the service user.

**6.26** Generally, the Welsh Assembly Government would expect that where older people's needs are predominantly associated with their health, a nurse or other health worker should co-ordinate the assessment and care provision. Where social care needs are to the fore, a social worker might be expected to co-ordinate activity. Where mobility and access needs predominate, occupational therapists or physiotherapists could assume care co-ordination. However, these are not cast-iron rules and agencies should be prepared to act flexibly in the best interests of service users, who may value continuity and familiarity above everything else.

**6.27** Once services have been provided, agencies should ensure that appropriate arrangements are put in place to monitor both the older person's needs and the effectiveness of services. Many service users and carers are capable of and would wish to play the central role in monitoring the help and its effects. However many require this continued support from a care co-ordinator provided from a professional agency.

**6.28** The support to both users and providers of service may take different forms,

- Counselling on personal and family issues related to their eligible needs.
- Ensuring that responses meet eligible needs.
- Offering a consistent point of contact for users and carers.
- Progress chasing.
- Helping manage conflicts or difficulties.
- Fine-tuning the personal plan of care.
- Co-ordinating/chairing case conferences.
- Identifying when further reviews should take place, including emergency reviews when circumstances change suddenly.
- Advising in relation to information sharing (see Annex 5).

**6.29** Providers will also play a crucial role in ongoing monitoring. They will need to be sensitised to not only providing services but also keeping a watching brief for marked changes.

## CHAPTER 7

### REVIEWS OF PERSONAL PLANS OF CARE – *for older people*

7.1 Agencies should review the circumstances of all individuals in receipt of health and social care. In summary reviews should:

- Establish how far the services provided have achieved the outcomes, set out in the personal plan of care.
- Re-assess the needs and issues of individual service users and their carers.
- Help determine users continued eligibility for support.
- Confirm or amend the current personal plan of care or lead to closure.
- Comment on how individuals are managing direct payments, where appropriate.

#### Reviews as a re-assessment<sup>8</sup>

7.2 Most reviews should follow the format of an assessment as, in effect, the user's needs are being reassessed and will need to be considered against eligibility criteria to determine if they are still eligible or if their needs have escalated or changed and hence require a different response. In preparation for the review, users should be offered the opportunity to re-assess their own needs and be offered appropriate support to do so. It will also be necessary to consider whether a further Carer's Assessment should be undertaken at this time.

7.3 The depth and detail of the reassessment within a review should be tailored to the particular circumstances of the individual. No assumptions should be made about an individual's needs, and either an overview assessment should be carried out or the same domains that were covered at the previous assessment should be explored again.

7.4 The review should focus on the needs of users and their carers and the effectiveness of the personal plan of care in addressing those needs. It should consider whether the individual's potential for improving their level of independence is being facilitated. Wherever possible, one review should consider all the services that are being received by the user. Where individual service providers conduct their own monitoring of service effectiveness with users, information from these should be fed into and contribute to the overall review of the whole personal plan of care.

#### Location and method

7.5 As with the assessment process, care co-ordinators or reviewing officers should always seek to involve the user in the review, and they should undertake

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<sup>8</sup> Local authorities will need to consider the extent of their power to arrange for any aspect of their statutory functions to be carried out by a third party.

reviews and reassessments directly with users, usually face to face in their normal living situations.

**7.6** Triggers to indicate the need for "face to face" reviews could include:

- Where the user requests it.
- Where there is a conflict between key individuals.
- Where needs are critical or substantial.
- Where the situation is volatile.
- At the start of a new placement or new care arrangements.
- Where carers are providing most of the care with relatively little support.
- Where there is a young carer.
- Where the 'predicted progress' of the person's needs suggests a deterioration or significant change eg dementia, motor neurone disease etc.
- Where the package is complex and involves different providers.

**7.7** In addition to the service user other people should also be involved as appropriate, including their carer, other relevant agencies, service providers and advocates. Where a review meeting is arranged, those people who need to be there should be invited. It is important to strike a balance between involving all necessary parties and overwhelming the service user, particularly in their own home. (Some contributions may be gathered through telephone contact outside of the meeting or through written reports or comments).

**7.8** In particular, for users in care homes, it should be ensured that health professionals contribute to the review to ensure that nursing and other health care needs are identified and met. It is particularly important to consider whether the individual's potential for improving their level of independence is being facilitated within the care setting. For those people in a care home receiving nursing care the Registered nurse employed by the statutory NHS body will need to confirm the person's nursing care needs and whether they continue to qualify for NHS funded nursing care.

**7.9** Agencies should bear in mind that professionals involved in providing services may not be best placed to carry out the review functions as many users would prefer reviews to be independent of those actually providing their care. Such providers can however, provide useful information for use in the review.

**7.10** Other methods of reviewing are possible. In some instances, care co-ordinators may contact the user and where appropriate, other key players, by telephone. In other situations, it may be appropriate to contact users by letter or to send them a questionnaire. This would usually only be appropriate where the user had low needs, the personal plan of care was stable and appeared to be successfully meeting the users needs.

## Timing

**7.11** *The Health and Social Care Guide* will remind service users that they can expect to have their personal plan of care reviewed on a regular basis and adjusted to take account of any changes in their circumstances.

**7.12** In deciding when to have a review, practitioners will need to use their professional judgement, drawing on their knowledge, evidence from research and their experience to ensure the review is timely and relevant for the user. For example, for a person who has been admitted to residential care, evidence suggests that the personal plan of care is best reviewed after 6-8 weeks of the person moving in. In other situations, account should be taken of the 'predicted progress' of needs related to conditions such as dementia or the impact of loss on an individual to determine the most appropriate timing for the review.

**7.13** The intensity, instability/predictability and the complexity of a person's care needs, and the resultant risks to the four key factors of independence (see Chapter 5) will be the determinant in the timing and frequency of reviews. Some users and carers will require reviews on a more frequent basis than others. It is essential that the purpose, type and frequency of review be established and understood by the service user and carer at the first review and at each subsequent review.

**7.14** At a **minimum** there should be an initial review within three months of services first being provided, thereafter, reviews should be scheduled at least annually, or more often if individuals' circumstances appear to warrant it.

**7.15** Some cases will, by their nature, be subject to almost constant changes. It will be necessary to address these changes as they arise. In these situations it might appear to staff that they are involved in continuous re-assessment. It is important, however, in these cases to take the opportunity from time to time to step back from the immediate and ongoing changes in the person's situation and consider the needs following the review format outlined below.

## Format

**7.16** Most reviews should commence in the same way that an assessment starts, and then proceed in the same way that personal plans proceed. As such, reviews should cover:

- A reassessment of current needs indicating the intensity, instability, predictability, and complexity of needs, and the potential for rehabilitation. This should include consideration of risk assessments.
- A reappraisal of eligibility for assistance recording any reasons for changes.
- An evaluation of the achievement of objectives and outcomes with reasons for success or failure.
- A revision of personal plan objectives and outcomes.
- Identification of carer's needs.

- The review should consider whether service users wish to switch to Direct Payments, if they are not already in receipt of them. Where a service user is receiving Direct Payments, the review should consider whether the person's needs are being met and whether Direct Payments continue to be appropriate.
- A consideration of service quality issues including frequency, locality, reliability, timeliness, whether service is culturally sensitive and so on.
- Any required changes in service provision.
- Revised costing of personal plan of care.
- Check that the service user is receiving their full entitlement to state benefit or other sources of income.
- Ensure that the user understands the charging policy and are enabled to pay any charges.
- Any points of difference between parties to the review.
- Date of next planned review or decision to close the case.

## **Review report and new personal plan of care**

**7.17** Review activity should result in a review report that in addition to covering the issues listed above, describes who was present or otherwise involved, key individuals not involved and the reasons why, the location or method of review, and particular issues that service users or carers raised.

**7.18** On the basis of the review report, the current personal plan can be confirmed and rolled forward, or a new plan can be drafted and agreed. In doing this, staff should observe the foundations for good care planning set out in the previous section. A copy of the review report, and new plan, should be given to the service user and, subject to the constraints of confidentiality, it should also be shared with all other contributors to the review.

**7.19** Agencies also need to develop a process for capturing the intelligence gained from reviews on the effectiveness of service options, and being able to feed this back into the commissioning process. This will help agencies identify service deficits and potential for innovative service development.

**7.20** Where services continue to be provided, cases should remain active and reviewed as appropriate, according to the guidelines suggested in this Guidance. Although a case may not be active to a care co-ordinator, staff should make clear to users and carers that whilst they are in receipt of services commissioned or provided by the local authority, then their case remains "open". In some situations, it may be appropriate for the care co-ordinator who was involved in the initial review to continue to take responsibility for reviewing the needs of the user. In other situations, it may be that reviews will be undertaken by reviewing officers or others. Whatever arrangements are put in place, the agencies should be very clear with the user as to the status of their case and provide clear information as to whom will be responsible for reviewing their needs.

**7.21** Where it is agreed that services will no longer be provided, the review report should include a closure statement covering:

- Reasons for closure (eg outcomes achieved; user moved away; services no longer wanted/required; user died) and where possible share these with the user.
- An evaluation and record of the extent to which the objectives and outcomes were achieved. This should happen even where the user has died or moved away.
- Where appropriate the name of a professional that the user can contact, if needs and circumstances change.

### **Implementation**

**7.22** In line with Fair Access to Care services (Chapter 5) from October 2002, local authorities should review the circumstances of all individuals in receipt of social care services, provided or commissioned by the local authority or purchased with direct payments. All service users should have received a review by October 2003.



## CHAPTER 8

### INTEGRATING PERFORMANCE MANAGEMENT AND EVALUATION – *for all adult groups*

**8.1** The Welsh Assembly Government has placed increased emphasis on the need for public services to evaluate and learn from performance. Improvements in management information systems mean there are new and more robust sources of data that can be used to enhance performance management.

**8.2** The Assembly's strategy for performance management in social services sets out to:

- Ensure the development of performance information in social services.
- Develop modern approaches to performance management in the management and delivery of social services.
- Make the most effective use of new information and communications technology in measurement, monitoring, provision and management of social services.

**8.3** *Improving Health in Wales* proposes that a new performance management framework for the NHS will be developed which will assess management performance in the round and be based on a robust set of performance indicators. This work is being taken forward in the NHS in collaboration with local government.

**8.4** The Unified Assessment and Care Management System provides an important foundation for the various performance management needs of the Assembly, the health service and local government with regard to the delivery of services for older people and adults. They will thus be integrated into the Welsh Assembly Government's development of performance management and evaluation processes for health and social services.

**8.5** The implementation of this Guidance should be undertaken using good performance management data and processes from the start to inform local implementation strategies and inform ongoing developments across Wales.

#### **Performance and Management Information**

**8.6** If not already part of their information gathering activities, agencies should consider how best to collect and use information from assessments, Personal Plans of Care and reviews. The Welsh Assembly Government is developing, in close collaboration with local service agencies, the requirements for national data returns to inform performance indicators. This process will provide core definitions for data items, however local performance management processes may also draw on other key information. Agencies should ensure that their record and information systems are sufficiently robust and comprehensive to enable them to audit and monitor their performance with respect to the implementation of the Unified Assessment and Care Management System.

**8.7** Once information has been collected and analysed, results should be shared with interested stakeholders such as service users, elected members and other local agencies and used to inform local and integrated planning.

**8.8** Specific requirements for national data returns will be developed from the list below to inform performance indicators. This will be in line with developments in management information collection being undertaken in Wales, in particular the implementation of the 'Referrals, Assessments and Packages of Care' framework:

- People referred, and subsequently assessed and reviewed – including numbers and types of cases at different stages of care management, needs identified at assessment and then met, and outcomes being set and achieved.
- What services/support are provided for which types of need ie the content, frequency and cost of care packages - including what services singly and in combination, are currently being received, and how often, by which users with what needs, in what circumstances, at what cost.
- Outcomes for users in terms of the four key factors of independence – it will be essential to consider the balance that is achieved in relation to preventive outcomes for lower level need and outcomes for those with more intensive, higher level needs, rehabilitation and so on.
- Monitor which presented needs are evaluated as eligible needs and which remain unmet.
- Audit service effectiveness with reference to Personal Plans of Care and reviews.
- Needs which were eligible for help, but for which users and carers would have preferred other or additional services.
- The time between needs having been assessed as eligible for help and the receipt of services.
- Complaints from users and /or carers in relation to the various aspects of access covered by this guidance.
- A population needs assessment and analysis of referrals for those with needs who do not approach care agencies, but who may be eligible for help. These needs may be identified through carers' views, eg family carers of people with dementia who only refer at a late stage of the disease.
- The extent to which estimated numbers in the population from different service user or, ethnic groups are over- or under-represented in those receiving assessments and services.
- Comparisons between different service user groups and between different ethnic groups with respect to proportions who get an assessment after first contact and those who go on to receive different services after assessment.

- Comparisons between different areas eg between rural and urban areas as to the numbers of people are over or under represented in those receiving assessments and services (eg by age group).
- How far the requirements for first and subsequent reviews, as set out in the policy guidance are met.

**8.9** For older people in the short term and other adult groups in the longer term these performance measures will be supplemented to include the unified assessment process and other aspects of co-ordination between health and social services.

**8.10** Annex 4 lists the areas needed for the operation of the unified assessment record. This record will be integrated into an agreed basic data set currently being developed that will deliver key nationally and locally required performance information.



## KEY ASSESSMENT ISSUES AND RELATED POLICY INITIATIVES – *for all adult groups*

### Transitions

1. The transition to adulthood for young people with disabilities can be a crucial time in ensuring that their health and social care needs continue to be met appropriately. Arrangements should be in place to ensure that an assessment of the needs of these users is undertaken in a timely way and that full consideration is given to understanding the needs and associated risks to their independence that are likely to present when they enter adulthood. Given the potential vulnerability of these service users, it is important that a significant degree of continuity is achieved in meeting their needs. Services provided should aim to continue to achieve similar outcomes in relation to promoting their independence and quality of life. Arrangements should be put in place to make this transition as seamless as possible and to ensure consistency and fairness in dealing with the needs of these individuals.
2. There are some parallels with adults who are approaching older age, when services designed for older people may become more appropriate to their changing needs. In these situations, agencies may wish to re-assess needs, but in responding note that marked changes in the type, level and location of support are usually not in users' best interests.
3. The system of regular reviewing and re-assessing service users referred to earlier should help agencies recognise and plan for a potential change in needs in this respect.
4. The needs of carers must also be taken into account at the time of transition and the effect of any changes on the sustainability of the caring role.

### Disabled Adults who have parenting responsibilities

5. This Guidance does not apply to children under the age of 18 years, but it applies to disabled adults who may have parenting responsibilities. The **Children Act** (s17) places on the Local Authority Social Services Department a duty to safeguard and promote the welfare of children in need in their area, through the provision of services appropriate to the needs of such children, and as far as is consistent with this, to promote the upbringing of children within their families. *The Framework for the Assessment of Children in Need and their Families*, [*The Assessment Framework*] is the Guidance used by local authorities and other agencies to determine if a child is a child in need<sup>9</sup>.
6. Although the legislative framework for assessment and service provision is different for children and adults, disabled parents and their families should experience assessment and decisions about the provision of services as seamless and co-ordinated. Local authorities should ensure that they offer a holistic and

<sup>9</sup> See s17(10) Children Act 1989 for definitions of children in need

equitable approach to disabled parents and their children, and they should be similarly provided with help irrespective of whether they approached the services through a child care or adult care route.

7. The process should begin with the referral, when it should be ascertained whether the person has parenting responsibilities for a child under 18. If so then any initial assessment of the adult should consider whether the children may be in need. If after the initial referral and/or contact with the family it does appear that there may be children in need, then an assessment of each child should be undertaken in accordance with the Assessment Framework. Children who live with parents who have disabilities, learning difficulties and mental or chronic physical illness will be young carers.<sup>10</sup> For some children this will mean excessive burdens of responsibility, inappropriate caring roles and significant impact on their personal, social and educational development. The **Children Act** and the *Assessment Framework* provide the appropriate statutory and practice basis on which to identify and meet the needs of young carers.

8. The *Assessment Framework* aims to provide an understanding of what is happening currently, and what is expected to happen in the longer term to children concerning their

- Developmental needs.
- The parent's capacity to respond to those needs, and
- Wider family and environmental factors which may impact on the parenting capacity and the child's development.

9. Practitioners must in their assessment of children and families consider the potential effects on children of not providing appropriate support to disabled parents to enable them to effectively carry out their parenting role.

10. It does not follow that all the children of disabled parents are children in need. Where it appears that the adult has needs in their own right, the assessment and eligibility decision for services will be made in line with the *Adult Assessment* and *Fair Access Guidance* (see Chapters 2 & 5).

11. On occasions however it will be the case that both the adult assessment process, and the *Assessment Framework* for children is being used concurrently within one family. If this is the case then the relevant staff must work together, and with the family to explore the least invasive and most effective way of carrying out these assessments. Local authorities need to consider therefore how they can plan and organise their resources and staff expertise to ensure that the needs of children, and the needs of disabled adults arising from their parenting role, and the assessed needs of other adults in the family are met effectively. Best practice will result from a teamwork approach which uses the expertise of staff from both children and adult services.

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<sup>10</sup> Caring about Carers: A Strategy for Carers in Wales – Implementation Plan (Welsh Assembly Government 2000)

## Approach to risk assessment

12. An evaluation of risk is essential to identifying appropriate help, which will prevent people becoming too dependent on services and undermine their potential for rehabilitation and independence. This is the case for any assessment whether that risk is occasioned by:

- The environment, eg gas fires for older people with dementia.
- The personal characteristics, eg unstable diabetes, mental state, capacity to make informed decisions.
- Other people's actions, eg financially exploitative relationship with a family member.

13. A useful framework for professionals to use when exploring potential threats to independence is to consider the time-scale, predictability and complexity of the issues that are presented.

14. **Timescales:** This will include a consideration of the past, the immediate present and the longer-term. Referring back to family history and the course of similar or related need experienced by a person, may help professionals to think about the likely course of the current need. Those needs also need to be identified which may seem minor and confinable in the present, but could for the lack of help worsen over time and have a detrimental impact on independence.

15. **Intensity:** The intensity of particular needs including physical pain, distress or the disruption caused.

16. **Predictability:** This will include identifying the instability/predictability of needs, both on a day-to-day basis and over longer periods of time. The model developed by Isaacs and Neville distinguishes between critical interval needs, short-interval needs and low/long interval needs. Typically:

- Critical-interval needs are those which arise daily, often, and at unpredictable times.
- Short-interval needs arise daily but with predictable gaps between each episode.
- Low/long interval needs arise less than daily, perhaps weekly, and can often be predicted.

Agencies may wish to use this typology in assessments.

17. **Complexity:** the complexity of needs, including the number of different needs, and how individuals react to the difficulties facing them is also a significant factor in evaluating risk. It is possible for individuals to have several low risk conditions which in themselves would not pose threat to independence, but this combination and how the needs interact will result in a more serious threat to independence.

18. Generally, the more unpredictable a risk and the higher the negative impact of a need when it arises, the greater the likelihood that a user will need

considerable help. On the other hand, a frequently occurring and predictable risk with low impact will call for a different response.

### Acceptable risks

19. The risk assessment should address whether the individual is competent to judge the risks for themselves and is willing and able to accept and bear those risks. Positive risk taking is an essential part of everyday life which enhances independence and choice.

20. Professionals must also take into account the agency's responsibility in terms of the law and the wider community. A balance has to be achieved between ensuring that the health and safety of vulnerable adults and other people, is not put at risk, against curtailing the choice, autonomy and independence of particular individuals.

21. To manage this balance, in making decisions under uncertainty, the assessment has to be undertaken jointly with the user and will be led by their preferences and wishes in relation to achieving and enhancing their independence and quality of life. The assessor should use their training, skills and experience in making judgements that take account of both the likelihood, frequency and the severity/gravity of the impact of risks on users and others. They should also use knowledge and evidence available to predict the probable progress and development of needs, and their associated risks and impact over time on the individual in particular circumstances. For example, it is possible to understand the "predicted progress" for some individuals in the early stages of dementia or for an individual who has experienced a significant loss.

22. Care planning should include understanding and anticipating activities which will invoke risk either to the individual and/or others and developing an action plan that can manage the situation appropriately. The recorded and agreed risk assessment remains an integral part of the personal plan of care (see Chapter 6).

23. A key element will be to develop crisis and contingency plans. Contingency planning prevents crises by detailing the arrangements to be used when the individual's condition (eg mental state or physical condition) suddenly changes or when an essential feature of the personal plan of care is removed at short notice, for example carer illness or key personnel are absent. It should include the necessary information to help obtain alternative care or replacement personnel. This may be based on previous experience with the service users and should also have clear arrangements that can be accessed out of normal office hours.

### Health and safety at work

24. The approach to risk assessment outlined above is distinct from that which is undertaken in relation to ensuring that services are delivered appropriately to an individual. Once it has been identified that particular services will most appropriately meet the needs identified, a risk assessment in relation to the delivery of the service must be completed. Duties include (under section 3 of the **Health and Safety at Work etc. Act 1974**) ensuring so far as is reasonably practicable the health and safety of those being cared for, and (under the

**Management of Health and Safety at Work Regulations 1992**) assessing risks to people who may be affected by their work activities.

### Working with housing agencies

25. When adults require social care services, local authorities need to take account of their duties to invite housing authorities to assist in the assessment of need under section 47(3)(b) of the **NHS and Community Care Act 1990**. Housing authorities need to be engaged in assessment and eligibility decisions:

- To offer support and advice in individual assessment where a housing need has been identified (formal triggers for the involvement of housing authorities need to be established).
- To advise on what exists in terms of housing solutions to identified problems.
- To contribute to individual service reviews.

### Underpinning Legislation

26. **Human Rights Act 1998**: Agencies are reminded that the **Human Rights Act 1998** came into force in October 2000, and they are now under a duty to comply with their obligations under that Act. As indicated in this Guidance local agencies will need to bear in mind service users' convention rights when drawing up eligibility criteria for social and health care. If agencies are in any doubt as to their compliance they should seek legal advice.

(See also Annex 5 **Data Protection Act**).

27. **Race Relations (Amendment) Act 2000** The implications of the **Race Relations (Amendment) Act 2000** must also be taken into account. The legislation requires that public authorities, including local and health authorities should have due regard to the need to eliminate unlawful discrimination and to promote equality of opportunity and good relations between persons of different racial groups when performing their functions. In other words, public authorities have to comply with the positive duty to promote race equality. The proposed specific duties mean that public authorities need to:

- Prepare and publish a Race Equality Scheme setting out how it intends to meet its obligations under the general duty and any other proposed specific duties to promote race equality which are relevant to it;
- Assess which of its functions and policies are relevant to the general duty, with regular subsequent reviews, eg three yearly;
- Set out its arrangements for assessing and consulting on the impact on the promotion of race equality, of policies it is proposing for adoption;
- Set out its arrangements for monitoring for any adverse impact on the promotion of race equality, of policies it has adopted or is proposing for adoption;
- Set out its arrangements for publishing the results of: assessments; consultations; and monitoring for any adverse impact on the promotion of race equality of policies required.

- Set out its arrangements for ensuring ethnic minorities have access to information and to services it provides;
- Set out its arrangements for training staff on issues relevant to the duty to promote race equality.

28. The **Disability Discrimination Act 1995**. The **Disability Discrimination Act** makes it unlawful for a service provider to discriminate against a disabled person by:

- Refusing to provide (or deliberately not providing any service which it offers or provides to members of the public) or
- Providing service of a lower standard or in a worse manner; or
- Providing a service on worse terms; or
- Failing to comply with a duty to make reasonable adjustments if that failure has the effect of making it impossible or unreasonably difficult for the disabled person to make use of any such service. **This has been a duty since 1st October 1999.**

29. In making reasonable adjustments the service provider may have to:-

- Change a practice, policy, or procedure which makes it impossible or unreasonably difficult for disabled people to make use of services.
- Provide a reasonable alternative method of making services available to disabled people where a physical feature makes it impossible or unreasonably difficult for disabled people to make use of them.
- Provide an auxiliary aid or service if it would enable or make it easier for disabled people to make use of services.

30. It is also intended that from 2004, service providers have to make reasonable adjustments to the physical features of their premises to overcome physical barriers to access. The Code of Practice, published in 1999 points out that it makes sense now for service providers to plan ahead by taking any opportunities which arise in bringing forward plans, to make alterations to their premises to benefit disabled people before 2004. The Code also states that:-

*Service providers should not wait until a disabled person wants to use a service which they provide before they give consideration to their duty to make reasonable adjustments. They should be thinking now about the accessibility of their services to disabled people.*

### **Welsh Language Act 1993**

31. Agencies are reminded that they should plan and deliver their services in accordance with the **Welsh Language Act 1993**. If they are delivering services themselves, they will need to comply with their Welsh Language Scheme, or if they are commissioning services from others they will need to ensure that those services are also delivered in accordance with their Scheme.

### KEY IMPLICATIONS FOR OLDER PEOPLE AND PROFESSIONALS

#### Older people

1. Agencies may wish to use 'Key Implications for Older People' as the basis for public information (see Annex 10) on the unified assessment process, that they give to potential or actual service users of health and care services.
2. The unified assessment process applies to health and social services, and should be developed from April 2002. It recognises that many older people have health and social care needs, and that agencies need to work together so that assessment and subsequent care planning are person-centred, effective and co-ordinated. In particular, implementation will ensure that:
  - The scale and depth of assessment is kept in proportion to older people's needs.
  - Agencies do not duplicate each other's assessments, and
  - Professionals contribute to assessments in the most effective way.
3. Older people are the most important participants in the unified assessment process. There are two reasons for this. First, the assessment is about and for them. Second, of all the experts in the care of older people, the greatest experts are older people themselves. They will know when they are having difficulties, the nature of those difficulties, and what might be done to resolve them. In the past, assessments may have been done *to*, not *with*, older people; and services planned without considering their views and wishes.
4. So that they can play a full part in the unified assessment process and make informed choices, older people should expect to receive, and be given, information about access, assessment, services, charges, and complaints procedures in appropriate and accessible formats.
5. At all times, older people should expect respect and courtesy from health and social care professionals who are helping them. They should expect assessments of their needs to begin with their perspective, and for their views to be kept to the fore throughout the assessment and subsequent stages of care planning and service delivery. They should expect assessment to focus not only on their needs, but also on the strengths and abilities they can bring to bear in addressing these needs, and for assessment to help them achieve maximum possible independence. Assessment should take account of support older people receive from family members, relatives, friends and neighbours, and whether these carers have needs in their own right.
6. Older people should feel confident in taking the lead in their own assessment, even helping to fill out some of the assessment forms if that is appropriate and what they want. To help them do this, where possible agencies

should prepare individuals for the assessment, letting them know what issues are to be covered and in what way. Older people should feel able to request translation, interpretation and advocacy services, or specific communication equipment, to help with their assessment.

7. Older people should be able to share information about their needs and circumstances in private and in confidence. They should be aware that information about them may be shared with other professionals and agencies, and their consent to this sharing should normally be obtained (see Annex 5).
8. Older people should expect to be involved in all decisions about their needs and subsequent care, and to be notified of key decisions in writing or other suitable formats. All older people who subsequently receive services should have a personal plan of care. Where needs are low and a single service is provided, the plan will amount to a simple statement of services. Where, needs are more complex and a range of services is provided, the plan will be fuller. All Personal Plans of Care should include the reasons for providing help, the objectives, and a review date.
9. Older people should expect their needs, and the services they receive, to be reviewed at regular intervals. As a minimum, first reviews should be carried out within three months of services starting, and further reviews should be carried out annually. As with assessment, older people should play a full and active part in such reviews, and indeed may request reviews in advance of a scheduled review, if the need arises.
10. If older people feel they have been unfairly treated, if they wish to challenge decisions, or if things go wrong or crises develop, older people should know who to turn to or what and action they might take. No older person should feel reluctant to complain for fear of reprisals by professionals or withdrawal of services by agencies. No older person should be unfairly discriminated against on account of their age, sex, race, lifestyle or other factors.

### **Implementation issues for particular professional groups**

11. Implementation of the unified assessment process has implications for the work of social workers, registered nurses employed by statutory NHS bodies, therapists, GPs, hospital consultants and other doctors, and other professionals working in a range of community-based, hospital and other settings. These professionals are asked to become engaged in local implementation by:
  - Considering the types of assessment most relevant to their practice. The involvement of some professionals may be mainly confined to one assessment type; other professionals will often contribute to all types.
  - Exploring and considering the assessment scales and tools that can best help their practice in particular and local practice in general.
  - Discussing and clarifying their role in assessment and the contribution they can make to effective joint working.
  - Identifying which of the 12 steps of implementation are most relevant to them and become involved in, and informed about, them (see Chapter 3).

- Identifying the contribution they can make to the development of the unified assessment summary.
- Considering what part they can play in staff development, either as a recipient or provider of learning and developmental opportunities.

12. Different professional groups may wish to focus on particular aspects of implementation that draw on their skills and experience or reflect their current roles.

### **Social Workers**

13. Social workers have expertise and experience in working with older people who are experiencing health and social care difficulties. They often have to understand these difficulties in the wider context of the older person's family, social, financial, housing and other circumstances. Social workers also play an important role in contributing to, or co-ordinating, assessment and care planning where a number of agencies are involved.

14. The unified assessment process builds on these strengths. Social workers will contribute to all four types of assessment. They will undertake many overview assessments. They are likely to co-ordinate assessment and care planning activity for older people who receive support and treatment in their own homes.

15. Social workers should be prepared to update their skills and knowledge so that they are able to work effectively with older people, other disciplines and the assessment procedures. As they will carry out many overview assessments, social workers will need to accurately identify those colleagues best placed to carry out specialist assessments. Social workers, particularly those with specialist roles or working in specialist teams, will have to undertake specialist assessments when appropriate.

16. Many older people will need long-term support from social services, and social workers should consider how best to manage their input so that their time and expertise is most effectively used.

17. It is likely that social workers will need to take account of all aspects of the unified assessment and care management Guidance.

### **Nurses**

18. Registered Nurses working across primary, community and secondary care settings will contribute to all four types of assessment. In the main, registered nurses will undertake many overview assessments, specialist assessments and provide the registered nurse input to the comprehensive assessment of older people. For many older people their contact with practice nurses, district nurses and other community-based nurses will be long term and important to them. Similarly, for many older people their contact with hospital-based nurses will be equally as important to them. Nurses in all these settings, and health visitors, have expertise in working with older people who are experiencing health and social care difficulties. They often have to understand these difficulties in the wider context of the older person's family, social, financial, housing and other

circumstances. Experienced registered nurses will also play an important role in care co-ordination, namely, around the planning and implementation of complex packages of care.

**19.** Registered Nurses have the additional responsibility of contributing to the comprehensive older person's assessments in order to consider the need for nursing care in care homes. The nursing assessment will determine the need for nursing care and will be completed by experienced registered nurses employed by the statutory NHS body working in the community and hospital setting.

**20.** Under the supervision of a registered nurse, unqualified nurses play an important role in the assessment process. In the main, they will contribute to the contact assessment and the overview assessment.

**21.** Both qualified and unqualified nurses will need to ensure that their skills and knowledge are up to date, and they will need to accurately identify those colleagues best placed to carry out specialist assessments.

**22.** All registered nurses will need to take account of all aspects of this Guidance. Under the supervision of a registered nurse, unqualified nurses will need to take account of certain aspects of this Guidance.

### **Therapists**

**23.** Physiotherapists, occupational therapists, speech and language therapists and other therapists play a critical role in assessing the needs of older people. Too often this contribution is under-recognised. However, like social workers and nurses, therapists will contribute to all types of assessment. While they may do their share of overview assessments, they will contribute greatly to specialist / in-depth assessments and comprehensive older person's assessments. They can offer a specialist contribution to the assessment of mobility, transfers, speech, language, eating, drinking, and functional capacity, and the impact of the home and wider environment on assessed needs. In particular therapists are skilled in the assessment of the potential for rehabilitation and independence.

**24.** They will act as care co-ordinators in some cases. They should ensure that assessment scales to identify physical and personal care needs have a prominent role in assessment procedures, but that these scales do not predominate and are used to support professional judgement.

**25.** It is likely that therapists will need to take account of all aspects of this Guidance.

### **General Practitioners**

**26.** The Guidance should not compromise the professional and statutory responsibilities of a General Practitioner in relation to the provision of general medical services.

**27.** GPs and their practice teams are constantly assessing patients in order to decide on the appropriate care for them. They do this by drawing together the information currently held about them, adding new information about the current situation and then assessing all this to produce an action plan to deal with the needs.

**28.** When GPs or their practice nurses are the only professionals involved and they are using their own GP computing system, the process can run smoothly. But when they go beyond that to out-of-hours deputising services, secondary care or social services, problems may occur with sharing of information and duplication of information gathering. The different language used by each professional group further complicates matters.

**29.** Implementation of the unified assessment process is intended to address these problems, and lead to a more effective and efficient response to older people's needs.

**30.** The key implementation issues for GPs are:

- Understanding the values underpinning the unified assessment process. These can be summarised as person-centred care with involvement of patients and carers in decision making, and a focus on achieving agreed treatment objectives.
- Knowing about the stages of assessment. Although GPs may contribute to all types of assessment, GPs will be mostly concerned with contact assessment.
- Not treating all contacts with older people who come to their surgeries as occasions for contact assessment as defined in the unified assessment process Guidance. The full unified assessment process is not intended to apply to all older people who have specific needs that can be readily addressed with no wider repercussions.
- Understanding the uses of tools and scales. In case finding and other proactive health screening purposes, assessment tools and scales are useful in identifying those with a particular problem. In other stages of assessment, they can support professional judgement and can also help ensure that no areas of assessment, are missed.
- Structuring the information on GP medical systems so that it is easy to share with other care professionals when necessary and appropriate in line with legislative and professional practice requirements. GPs are in an excellent position to contribute valuable information to the assessment process. Basic personal information can be collected at the time of registration and then shared in an agreed format. Medical information about key diagnoses and medication, summarised in an agreed way, is also of great help to other decision makers.

### **Consultants in old age medicine and psychiatry**

**31.** Many comprehensive assessments will need the involvement of either or both of the above consultants and their teams on behalf of, or working with, primary care and social services. A key role of these professionals will be ensure treatable and reversible conditions are not overlooked, and that assessments are timely, appropriate and in proportion to older people's needs. In most localities, these consultants will often have considerable understanding of the best use of assessment tools in complex older person's assessments. They will be central in

providing the medical assessment, diagnosis and subsequent prognosis for future action.

**32.** Bearing this in mind, consultants in old age medicine and psychiatry can play a critical role in the local implementation of the unified assessment process by:

- Assisting in the selection of assessment tools.
- Identifying an individual to take a special interest in the assessment process and to act as a focal point for medical involvement in implementation.
- Working with other managers to help ensure that secondary health services are able to support implementation.
- Ensuring that assessments undertaken by other secondary health departments, not primarily associated with care of older people, are aligned to the unified assessment process, and there is consistency of assessment across the hospital setting eg involving other NHS consultants such as those in orthopaedics, cardiology etc.
- Ensuring training about assessment procedures is available for hospital doctors, especially specialist registrars, senior house officers and those on vocational training schemes, and making related links with primary care teams.
- Stimulating and undertaking research into assessment procedures.
- Linking assessment procedures to clinical governance for consultants in old age medicine and psychiatry and their departments

### SHARED VALUES

Agencies are asked to review and share the values that underpin their strategies and professional practice for older people. Successful implementation of the unified assessment process will depend on the extent to which this takes place and the degree of agreement agencies can reach on the values that are most important to their common purpose. They may wish to take account of the fact that these values apply beyond older people to all adults seeking health or social care support, and should be shared with other local agencies such as housing.

The Welsh Assembly Government believes that all health and social care systems must work to the following common set of shared values if older people are to receive appropriate and effective services. Agencies will need to be aware that some principles underpinning the values, such as the need to gain consent before sharing confidential information between agencies, are required by law whereas others permit greater flexibility (see Annex 5).

#### Valuing person-centred care and independence

- Older people should be appropriately informed, in clear language and suitable methods, about assessment and services and how to access them. Their comments on assessment arrangements and services should be actively sought.
- Their views and wishes should be kept to the fore throughout assessment, care planning and service delivery.
- Assessment should help older people to identify both not only their needs but also their strengths and abilities and any external or environmental factors that cause or exacerbate needs.
- The assessment process and services that are provided should enable people to maximise their potential for independence.
- Older people should be involved in decisions about their care, and empowered to determine the level of risk they are prepared to take.
- Older people should have realistic options for how their needs may be met.
- Older people should consent to information that is collected on them and shared.
- Where individual older people lack capacity to make decisions or give their agreement, agencies should have procedures in place to secure the maximum possible participation and safeguard the older person's interests.
- Professionals should be aware of the impact of age, gender, race, living arrangement, personal relationships, lifestyle choices and disability on older people and their needs, and be prepared to respond appropriately.

## **Valuing carers and family members**

- Agencies should acknowledge the role that many carers and family members play in the care of older people, and be prepared to offer necessary support.

## **Valuing integrated and responsive services**

- Age, of itself, should not determine how services are accessed or provided.
- Access to services should be via assessment that is co-ordinated and straightforward, with duplication kept to a minimum.
- Effective information sharing between professionals, where confidentiality is respected, can be crucial for effective person-centred care.
- Where an older person needs the help of more than one agency, services should co-ordinate service delivery in the best interests of the older person.
- Promoting health and well-being is as important as helping when needs arise. The potential for rehabilitation should be explored at assessment and subsequently kept under review.

## **Valuing staff**

- Professionals who work with older people need to be properly, trained and offered ongoing staff development.
- Front-line professionals should be supported to take responsibility for planning the care of individual older people.

## UNIFIED ASSESSMENT SUMMARY:

### Unified Assessment Summary: Collecting and Recording Common Information Sets

1. Local agencies should agree which case information will be collected and stored as a unified assessment summary record for older people and made available to identified professionals in health and social services. They should agree how the information is shared and kept up-to date, and the most effective means of doing this so as to avoid duplication and reduce paperwork. The implementation of 'Caldicott' principles in NHS and local authority settings across Wales and the adoption of information-sharing protocols which implement these principles, will provide the basis for the transfer of data between agencies. This will assist in co-ordinating individual assessments and care arrangements and in sharing aggregated information to assist in service evaluation and planning.

Annex 5 provides further guidance on how information sharing can be facilitated.

### Unified Assessment and Care Management (UACM) Information Sets/Unified Summary Record

2. The following sets of UACM information should be collected in every locality, and used as the basis for the local unified summary record. UACM sets will provide commonality across all local systems. In conjunction with the adoption of a national social care data set for Wales they will, in turn, provide software developers with an outline of how they may support the unified assessment process; and will allow the unified assessment process to support the development of electronic health and social care records.

3. The three sets of information cover:

- A. Basic personal information;
- B. Needs and health; and
- C. Summary of the personal plan of care.

#### A. Basic personal information

<ul style="list-style-type: none"> <li>▪ Family name and forenames</li> <li>▪ Present address and postcode</li> <li>▪ Permanent home address if different</li> <li>▪ Phone number</li> <li>▪ Type of accommodation</li> <li>▪ Tenure of accommodation</li> <li>▪ NHS Number</li> <li>▪ Date of birth</li> <li>▪ Gender</li> <li>▪ Preferred first language</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ethnicity</li> <li>▪ Religion</li> <li>▪ Current or previous occupation</li> <li>▪ Household composition</li> <li>▪ Name, address and phone number of person most close to the older person</li> <li>▪ Name, address and phone number of carer (if different)</li> <li>▪ Name of GP</li> <li>▪ Name of dentist</li> </ul>
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**B. Needs and health:** this set should comprise all the domains and sub-domains of the unified assessment process (see Chapter 4), important medical conditions and list of medication taken.

**Domains and sub-domains of the unified assessment process:** for the domains of "Clinical background" and "Disease prevention" brief text may be used, including important medical conditions, current medications and linked diagnoses. However, standard clinical codes and classification should also be included if any electronic approach is adopted. Details of hospital in-patient admissions may also be recorded.

For the needs of the remaining domains and sub-domains the following codes may be used as appropriate:

- a) Needs identified and assessed as eligible.
- b) Needs not identified in this area.
- c) Unmet needs

Brief text descriptions should be used where a code is inappropriate to explain how conclusions were reached and where the main risks to independence lie. If appropriate an ADL (activities of daily living) score and a cognitive function score should be given, with a note giving the scale that was used.

Where an overview or comprehensive assessment has not been completed, whatever information that has been collected from contact or specialist/in-depth assessment should be entered. With regards to the contact assessment, professionals may wish to record textual descriptions around the seven key issues.

Where a statement of service delivery has been provided rather than a full personal plan of care the agencies should fill out as much of the unified assessment summary as possible.

**C. Summary of personal plan of care:** this set should comprise a list of services with simple coding to show whether the service is currently provided or not, the overall care aims and type of interventions delivered including intensity. Include also the name of the care co-ordinator and other staff who provide a significant input. Services should include:

<ul style="list-style-type: none"><li>▪ Support from family or other carers</li><li>▪ Home care</li><li>▪ Respite care in own home</li><li>▪ Visiting nurses</li><li>▪ Delivered meals</li><li>▪ Equipment to assist daily living</li><li>▪ Adaptations/improvements to accommodation</li><li>▪ Physiotherapy</li><li>▪ Speech and language therapy</li><li>▪ Occupational therapy</li><li>▪ Dieticians</li><li>▪ Chiroprody/podiatry</li><li>▪ Clinical Psychologist</li></ul>	<ul style="list-style-type: none"><li>▪ Dental care</li><li>▪ Other professional (specify)</li><li>▪ Attendance at day centre</li><li>▪ Attendance at day hospital</li><li>▪ Transport</li><li>▪ Attendance at out-patients clinic</li><li>▪ Intermediate care in hospital or care home</li><li>▪ Respite care in a care home or other setting away from home</li><li>▪ Other temporary stay in a care home</li><li>▪ Permanent admission to care home and type of care received</li></ul>
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Agencies should note that while all the full information of the personal plan of care is not required for the unified assessment summary, it should nevertheless be readily accessible and in such a format that copies can be given to service users.

4. The requirements for a unified assessment summary do not obviate the need for professionals to keep their own detailed electronic and other records on older people they have assessed and are helping. In fact, the information for the unified assessment summary will be drawn from these records in general practice, community health, hospitals, social services, and elsewhere.

## Implementation

5. In implementing their local unified assessment summary, and the sets of standardised (UACM) information, local agencies may add to or sub-divide the categories given above. However, they should not delete any to ensure that there is a consistent set collected across Wales. This will assist in ensuring that when information is aggregated there is a consistency across Wales for both future national data returns and local benchmarking exercises. Having decided on the information that will comprise their unified assessment summary, local agencies should:

- Identify a single local source of data for each information item of the unified assessment summary. The fewer the sources in any locality, the better. A "source" may be an individual professional, an agency team or multi-disciplinary team.
- Agree how the information can be kept up-to-date. This is crucial if professionals are to use the unified assessment summary with confidence.
- Agree the format of local documentation for collecting, storing, retrieving and transferring unified assessment summary information.
- Agree **local protocols** for the transfer of this information when appropriate, including agreement on which professionals can access the information and which can update it, and how this will happen (see Annex 5 for further details on developing local protocols).
- Agree a **mechanism** that enables unified assessment summary information to be brought together and made available, or transferred, to the person requesting it, in all agreed locations and around the clock.
- Agree how the UACM information identified for inclusion in the unified assessment summary is to be collected, stored and shared with due regard to Caldicott and to the **Data Protection Act 1998**, particularly the need to process information fairly and lawfully. In most cases that will involve seeking informed consent for the use of personal information for agreed purposes. However, agencies should note that the **Data Protection Act 1998** expressly recognises that in some cases personal information may be shared, lawfully and fairly, without consent. In this regard agencies should seek their own independent legal advice as to the circumstances when personal information may be lawfully shared without consent.

- Introduce training and awareness programmes for professionals and administrative staff involved in the collection, storage, retrieval, sharing and updating of the unified assessment summary.
6. It is likely in most localities that a fully operational electronic system that generates and facilitates the sharing of the unified assessment summary, will not be in place for some time. It is likely that while IT may support some aspects of the guidance in the medium term, manual approaches may also be required in the short term.

# UNIFIED ASSESSMENT AND THE DATA PROTECTION ACT 1998: INFORMATION SHARING

## INTRODUCTION

### Definitions

#### **DPA - Data Protection Act 1998**

**Data Controller** - means a person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal information (see below for definition of personal information) are, or are to be, processed.

#### **HRA - Human Rights Act 1998.**

**LASSD** - Local Authority Social Services Department.

**Health Bodies** - NHS Trusts, Health Authorities and Local Health Groups and primary care.

**Service User** - In this guidance means, the person who is the subject of the unified assessment process.

**Other Data Subjects** - In this guidance means, where appropriate, any person other than a Service User, in respect of whom it is necessary to hold personal information for the purposes of the unified assessment process (eg the Service User's carer, a family member or friend, an individual providing services to the Service User etc.).

**Personal Information** - In this guidance the term "personal information" should be taken to include, where appropriate, "sensitive personal information" (eg health information). Those terms have the same meaning as "personal data" and "sensitive personal data" in the DPA.

### Purpose

This guidance is not prescriptive. It is issued in respect of LASSDs under Section 7 (1) of the **Local Authority Social Services Act 1970** and as guidance to Health Bodies.

The purpose of this guidance is to help LASSDs and Health Bodies develop local information-sharing arrangements in order to facilitate the unified assessment process by establishing protocols, which:

- Clarify the purposes for which LASSDs and Health Bodies need to share personal information about Service Users and Other Data Subjects.
- Clarify the agencies/bodies with which LASSDs and Health Bodies will normally wish to share personal information about Service Users and Other Data Subjects.

- Ensure that LASSDs and Health bodies take full account of their responsibilities under the DPA.
- Ensure that the legal and ethical boundaries to information sharing and the rights of individuals are fully respected.

### **Why develop formal information-sharing protocols?**

The unified assessment process entails sharing personal information about a range of individuals (eg Service Users and Other Data Subjects) at local level with the aim of developing a 'seamless' service for Service Users. To make the service as effective as possible, LASSDs and Health Bodies will need to be able to share relevant personal information about those individuals between themselves and with other agencies/bodies (eg local housing authorities or independent care providers).

LASSDs and Health Bodies already have a great deal of experience in dealing with personal information, and in sharing that information with other organisations as part of their work whilst at the same time fulfilling the legal and ethical obligations that are placed upon them. The development of formal information-sharing protocols will build on that existing work. This guidance recognises that LASSDs and Health Bodies will require flexibility in order to develop information-sharing protocols that meet local need. It is, therefore, possible that the protocols developed in different localities will meet the need to share information in different ways. The Welsh Assembly Government will be keen to take on board best practice highlighted through the development of information-sharing protocols.

## **SECTION ONE**

### **Relevant Legislation**

1. It is not the purpose of this guidance to set out the legal powers upon which LASSDs and Health Bodies may rely to share personal information between themselves and with other agencies/bodies. LASSDs and Health Bodies will need to form their own view, taking legal advice as necessary, on the extent of their existing legal powers.
2. However, information sharing must comply with human rights and data protection legislation.

#### ***Human Rights Act 1998***

3. The HRA, which came into force in October 2000, incorporates provisions from the European Convention on Human Rights into UK law. The HRA makes it unlawful for a public authority to act incompatibly with the Convention rights, and requires all legislation to be interpreted and given effect as far as possible compatibly with the Convention rights. LASSDs and Health Bodies will be "public authorities" for the purposes of the HRA. Article 8 of the Convention provides for the right to respect for private and family life. This could cover, among other things, collection and use (including disclosure) of information about an individual, and protection of a person's reputation. All of these have direct relevance to information sharing in the context of the unified assessment process, although it is the Welsh Assembly Government's view that compliance with the

principles of the DPA will, in most cases, ensure compliance with the principles of Article 8 HRA.

### **Data Protection Act 1998**

4. The DPA came into force on 1 March 2000. It provides the legal framework within which individuals' personal information must be handled. The 8 Data Protection Principles set out in the DPA require personal information to be:

- Fairly and lawfully processed.
- Processed for limited purposes.
- Adequate, relevant and not excessive.
- Accurate.
- Not kept longer than necessary.
- Processed in accordance with the data subjects' rights.
- Secure.
- Not transferred to countries outside the European Economic Area without adequate protection.

5. LASSDs and Health Bodies should already be complying with the provisions of the DPA relating to notification. Notification involves registering with the Information Commissioner details relating to the way that personal information held by a Data Controller is processed. LASSDs and Health Bodies must ensure that those agencies/bodies with whom they propose to share personal information also comply with the notification provisions set out in the DPA.

### **Sharing personal information between LASSDs and Health Bodies and with other agencies/bodies**

6. LASSDs and Health Bodies will need to develop and agree locally, the arrangements for the sharing of personal information. These arrangements will need to support the provision of a seamless and comprehensive service for the Service User and close working relationships between the agencies involved in delivery. **The exchange of personal information must be carried out in accordance with the 8 Data Protection Principles and have proper regard to the rights of the Service User and Other Data Subjects under the DPA and HRA.**

In providing services (including assessments) to Service Users, it is expected that LASSDs and Health Bodies will need to hold and share personal information at a number of levels, including:

- Aggregate and management information to plan and monitor progress of services and to manage local services to provide most effective support to Service Users;
- Detailed personal information necessary to perform assessments of need and to provide services to those assessed to be in need of such services.

7. In some cases the exercise of their respective functions will necessitate LASSDs and Health Bodies sharing personal information between themselves; in other cases personal information may need to be shared with other agencies/bodies. LASSDs and Health Bodies may need to share personal information with and between organisations that they contract as service providers. Agencies involved in the service may include public bodies and institutions and voluntary and community-based bodies and commercial companies.
8. LASSDs and Health Bodies will wish to ensure that such agencies/bodies are identified at an early stage and are involved in the development of the information-sharing protocols. An unwillingness on the part of an agency/body to comply with the information-sharing protocols might raise doubts about the agency's/body's suitability for information-sharing and involvement in the unified assessment process.
9. Once LASSDs and Health Bodies have identified those agencies/bodies with which they will routinely share personal information, they will wish to consider working with those agencies/bodies to identify all the usual purposes for which personal information is likely to be shared in order to facilitate the unified assessment process.
10. In reaching those conclusions, LASSDs, Health Bodies and those other agencies/bodies must ensure that the purposes for which the personal information is shared and the extent of the personal information that is shared fully respects the rights of individuals under the DPA and HRA. In particular, it will be necessary to ensure that personal information which is shared for particular purposes (eg to contract with independent service-providers for the provision of community care services) is adequate, accurate and not excessive for that purpose.
11. Identifying the sources and recipients of the personal information and the purposes for sharing that information will facilitate provision to Service Users and Other Data Subjects of the 'fair processing' information, required by the first data protection principle.
12. Once these details have been identified, LASSDs and Health Bodies will want to consider in conjunction with the other agencies/bodies, the possibility for inclusion in the information sharing protocols of a mechanism for bringing the 'fair processing' information to the attention of the Service User and Other Data Subjects at the time that the personal information is first processed or as soon as practicable thereafter. For further guidance see **Safeguarding the rights of service-users and gaining their consent** section below.
13. Information-sharing protocols will also need to take into account the possibility that Service Users may move from one area to another or may attend a residential establishment away from the home area. Information-sharing will be facilitated if local information-sharing protocols contain provision for sharing personal information with other LASSDs and Health Bodies in such circumstances.
14. LASSDs and Health Bodies will wish to consider whether information-sharing protocols should contain the same elements and principles, even if expressed in different forms.

15. Whenever information is shared – for instance, when there is input from different quarters in contributing to an assessment– there is a danger of misunderstanding. Terms such as "at risk" may be used in different ways, and it is advisable that an agreement is reached on common definitions of terms to be used in information-sharing protocols.

## Responsibilities

### Responsibilities of LASSDs and Health Bodies as Data Controllers

16. Under the DPA, the "**Data Controller**" has the responsibility for:
- Deciding the purposes for which personal information will be processed (including disclosed).
  - Respecting the rights of data subjects.
  - Ensuring that the processing of personal information complies with the 8 Data Protection Principles set out in the DPA; and
  - Ensuring compliance with the notification provisions set out in the DPA.
17. LASSDs and Health Bodies will be joint data controllers in relation to personal information used in the unified assessment process. Depending on how information-sharing protocols are developed and how information is shared with and between other agencies/bodies there may be other data controllers that will be joint data controllers. LASSDs and Health Bodies should ensure that no personal information is shared with any other agency/body unless that agency/body has complied with the requirements of notification set out in the DPA and has agreed to comply with the information-sharing protocols.
18. In requesting personal information, LASSDs and Health Bodies should make clear the purposes for and basis upon which they require and intend to use personal information so that the disclosing agencies are able to determine whether and on what basis they can disclose that information. **All agencies involved in information-sharing on an on-going basis should be covered by the information-sharing protocols.**

### Role of Care Co-ordinators in information-sharing

19. Care co-ordinators may also be involved with collecting personal information directly from the Service User and Other Data Subjects and may be responsible for pulling together assessment information, developing the personal plan of care and offering ongoing monitoring. Therefore care co-ordinators are ideally placed to take on the role of explaining to the Service User and Other Data Subjects at the beginning of the unified assessment process and throughout that process, how the service will operate, why and what personal information will be recorded and how that information will be used. The care co-ordinator should also ensure that the Service User and Other Data Subjects are made aware of their rights under the DPA.
20. The care co-ordinator should, where possible, seek and encourage service-users to give informed consent to information sharing. They should also explain to service-users that they have the right to withdraw their consent and the implications of doing this.

21. The role of the care co-ordinator (as set out above) should be reflected in the information-sharing protocols.

22. In developing their arrangements for collecting and sharing personal information in relation to Service Users and Other Data Subjects, LASSDs and Health Bodies should bear in mind that there are circumstances where consent may not be needed in order to process personal information. The conditions for processing personal information are set out in Schedules 2 and 3 of the DPA. LASSDs and Health Bodies should ensure that such processing fully meets the requirements of the Data first and second Data Protection Principles.

23. There are also occasions where LASSDs and Health Bodies may have an obligation to disclose personal information without consent, eg, for crime prevention or detention or when required by law.

### **Safeguarding the rights of service-users and other data subjects and gaining their consent**

24. In developing local information-sharing protocols, LSSDs and Health Bodies will need to consider putting in place mechanisms by which the 'fair processing' information is provided to data subjects. That requirement derives from the first Data Protection Principle. The 'fair processing' information should normally be provided at the time that the personal information is first collected. As stated above, the care co-ordinator may take on this role but that may not always be the case particularly where they are not involved in the initial stage. The 'fair processing' information should include:

- The identity of the data controller(s);
- All the purposes for which the personal information may normally be used and by whom (including the identity of other agencies/bodies to whom the personal information may be disclosed);
- Any other information necessary to render the obtaining fair in the circumstances of the case, for example:
  - the right of the data subject to have access to the personal information;
  - the right to request that personal data is not processed if it will cause the data subject or another substantial harm or distress;
  - the right of the data subject to ask the Information Commissioner to carry out an assessment of whether the personal information has been processed in accordance with the DPA;
  - the right of the data subject to seek compensation in certain circumstances;
  - the right of the data subject to seek rectification etc. of inaccurate data.

25. Local information-sharing protocols must take into account that in order for information-sharing to be lawful, the consent of the service-user may be required. This consent needs to be freely given and informed and in the case of processing sensitive personal data must be explicit. Provision of the 'fair processing' information should provide the basis for providing to Service Users and Other

Data Subjects the information necessary to enable them to reach an informed decision upon consent.

26. Service Users and Other Data Subjects may withdraw consent at any time. Withdrawal of consent should also be adequately recorded. If consent is withdrawn, the implications of doing so should be drawn to the attention of the Service User or Other Data Subject as appropriate.

### Other guidance on Information Sharing

27. The NHS has introduced "Caldicott Guardianship" to ensure clear standards for sharing and security of personal information, with clear mechanisms for identifying responsibility, audit trails and so on. Health Bodies will, therefore, need to take that guidance into account also.

### Security

28. Local information-sharing protocols will need to ensure that the overarching principles of security are upheld:

- **Confidentiality.** Protecting all personal information from unauthorised disclosure or intelligible interception.
- **Integrity.** Safeguarding the accuracy and completeness of personal information and computer software.
- **Availability.** Ensuring that personal information and vital services are available to users when required.

29. Hard copy files should be held within secure filing cabinets to which only authorised personnel have access. Reasonable care should be taken to ensure that they cannot be accessed by unauthorised persons or stolen while they are being used, stored or transported. Computerised files should be accessible only by password to authorised personnel and should not be visible to unauthorised users. Neither method of storage should prevent easy retrieval in the event of a request for access by a Service User or Other Data Subjects.

## SECTION TWO

### Information-sharing good practice checklists

- LASSDs and Health Bodies and all other agencies/bodies with whom personal information is likely to be routinely shared have signed up to the information-sharing protocols.
- Organisations that need to share personal information have agreed definitions of terms that they may ordinarily use differently, to minimise misunderstanding.
- All partner organisations are familiar with the principles of the DPA and its implications for sharing personal information.
- Measures are in place to safeguard the security of systems in which personal information is held, both electronically and otherwise (eg hard copies).

- All partner organisations understand how the sharing of verbal as well as recorded information is to be conducted.
- The protocol is understood by staff at all levels in partner organisations, and it is part of staff induction and training.
- Arrangements are agreed for ongoing monitoring and periodic review of the information-sharing protocols.
- All partner organisations have an identified a person responsible for data protection.
- All partner organisations understand how to deal with complaints in accordance with complaints procedures that are swift, simple and effective.
- The aim should be to achieve transparency in information sharing.

### **Recommended elements of the information-sharing protocols**

- Statement of purpose.
- Statement of equal opportunities.
- Statement of intention to adhere to relevant legal obligations.
- Definition of target group in respect of which personal information is to be shared.
- Statement of information flows (including what personal information is to be shared and for which purposes, sources and recipients of that personal information).
- Definition of terms commonly used differently by partner organisations.
- Principles by which personal information may be shared including:
  - Service User's and Other Data Subjects' consent
  - Access limitations
  - Restrictions on use
  - Transparency of operation
- Swift, simple and effective complaints procedure.
- Arrangements to ensure security of personal information held, whether electronically or otherwise (eg hard copies).
- Copies of any forms to be used.
- Retention schedules.
- Arrangements for considering requests for disclosure of personal information beyond the limits of the protocol, and for documenting the outcome.
- Agreement on monitoring and review of information-sharing.

# A STRATEGY FOR JOINT STAFF DEVELOPMENT

## Introduction

1. Effective implementation of the unified assessment process will depend on organisations being fit for purpose and operating with integrity to support staff in how they interact with service users and each other. Staff learning will play an important part, and local partnership arrangements with higher education and local agencies can ensure that core curricula include input on the unified assessment process. In addition, human resource departments in local agencies should identify specific assessment skills in staff job descriptions.

## Developing and delivering the strategy

2. As a start, agencies should develop and implement a joint strategy for organisational and staff development. The strategy should aim to help:
- Managers and practitioners understand the organisational and cultural changes required for successful implementation of the unified assessment process, and to agree shared values and a common language across agencies.
  - Practitioners working with older people to become competent in multi-agency work and assessment, and to understand health and social care needs in older age.
3. The strategy should involve all stakeholders including services users. It should extend to agencies other than the NHS and social services and, in particular, should involve housing authorities. It should outline staff development programmes that build on, and support, good professional practice with regards to older people, and address discriminatory practice. Estimates should be made of the numbers of staff who will need to receive what level and type of training and development.
4. The joint strategy should take account of local arrangements for clinical governance and best value reviews. It should link to existing programmes for staff development both pre- and post-qualification, such as induction standards and foundation in social care, NVQ levels 2/3 "Promoting Independence". It should include evaluation mechanisms to test its effectiveness.

## The content of development programmes

5. Agreed organisational and staff development programmes should cover:

### Multi-agency work

- Managing change, and the effect on professional roles and responsibilities.

- Helping to developing a shared value system across health, social services, housing and other agencies, and an appreciation of the outcomes that older people and their carers value.
- Agreeing common terminology for care processes that may be understood by service users.
- Understanding colleagues' roles and responsibilities, the services they provide and the constraints they work under. This should apply not only to health and social services, but also to key services such as housing.
- Identifying common core skills.
- Understanding the local system of care and how people move through it.
- Understanding the varying needs of local communities.

### **Assessment and care management skills**

- Empowering service users and carers, and facilitating their contribution to assessment including preparation for assessment.
- Using advocacy and supported communication.
- Working with older people to recognise the strengths and abilities they have that can play a part in addressing needs.
- Understanding the types of assessment in the unified assessment process.
- Competence in collecting assessment information for all the domains of the unified assessment process, and appreciating issues of informed consent and confidentiality.
- Clarifying and negotiating the different perspectives on an individual's needs that may be held by the older person, their carer and other professionals.
- Using professional judgement in assessment, and how scales and tools can support this.
- Evaluating assessment information including risk assessment/management.
- Understanding related care management tasks such as care planning, review, and case budget-management.
- For registered nurses employed by the statutory NHS body using assessment information to confirm nursing need when admission to a care home providing nursing care is indicated.
- Understanding when health and social services professionals should seek the contribution of housing and other professionals in the assessment process.

- Promoting an outcome approach to care planning.
- Managing reviews.

### **The older person**

- Understanding the ageing process and its relationship to particular health and social care conditions.
- Understanding how poor or inappropriate housing, poverty, isolation, poor transport systems and other factors effect the health and well-being of older people.
- Understanding specific issues for particular community groups of people, including people from minority ethnic communities.
- Promoting health, independence and safety.
- Working with carers.
- Understanding end-of-life issues and how to handle these.

### **Delivery methods**

6. In planning the delivery of development programmes, agencies should ensure that delivery methods are multi-disciplinary, and apply across agency boundaries, and include housing and other agencies. There should be opportunities for mixed staff groups from all levels in all organisations to develop and learn together, and for tailored input for specific management/staff levels, such as strategic and operational staff. Delivery may include the use of distance learning packs, mentors, locally-based practice forums, road shows, videos, and work books.



### **IMPLEMENTATION MILESTONES: UNIFIED ASSESSMENT AND CARE MANAGEMENT SYSTEM including FAIR ACCESS**

#### **APRIL 2002**

- **From April 02**

- Agencies to consider 12 steps of implementation to ensure start of the Unified Assessment and Care Management System for older people. Assessing training needs of staff and developing an action plan with partners as a first priority.
- Commence development of eligibility framework- to include consultation process.

- **30th September 02**

- Provide update to Welsh Assembly Government on progress with Unified Assessment and Care Management System.

- **1st October 02**

- Revised social care eligibility criteria to be operational for all new adult service user groups.
- Begin reviews of all current service users.

#### **APRIL 2003**

- Revised action plan for further implementation of the Unified Assessment and Care Management System for older people.
- Begin to plan the unified system to cover the remaining adult service user groups - ensuring integration with other policy developments for these groups (eg Care Programme Approach).

#### **1st October 2003**

- Reviews now complete for all service users in line with the revised social care eligibility criteria.
- Update on progress to Welsh Assembly Government in relevant plan updates.

## **APRIL 2004**

- Revised action plan for older people.
- Begin to implement unified assessment and care management system for remaining groups.
- Update on progress to Welsh Assembly Government in relevant plan updates.

## **APRIL 2005**

- Unified assessment and care management system fully implemented for older people.
- Revised action plan for other adult groups.
- Update on progress to Welsh Assembly Government in relevant plan updates.

## **APRIL 2006**

- Unified assessment and care management system in place for remaining adult service user groups.
- Update on progress to Welsh Assembly Government in relevant plan updates.

## CHECKLIST FOR IMPLEMENTING LOCAL APPROACHES TO THE UNIFIED ASSESSMENT PROCESS – *older people*

1. In implementing the unified assessment process, local agencies should have at the forefront of their thinking that the purpose of the unified assessment process is to guarantee better care services and better outcomes for older people. Better assessment tools, more effective information systems, better information sharing between professionals, and the like, are only means to this end.
2. Local agencies should review the approach they propose to take against the checklist below. Agencies should ask different stakeholders, including service users, to evaluate the proposed approach, and then to compare results. This checklist aims to assist agencies in ensuring compliance with this Guidance in respect of older people at the latest by April 2005. It can also be adapted for use by other adult groups.

### CRITERIA FOR LOCAL IMPLEMENTATION OF THE UNIFIED ASSESSMENT PROCESS

#### General

1. Have the 12 steps of "Preparing for implementation" been completed?
2. Will assessment processes lead to better services and outcomes for older people?
3. Is the approach acceptable to all stakeholders, including older people?
4. Is the unified assessment process implemented in the settings listed in the Guidance?
5. Are links between the unified assessment process and the over 75s health check clear?

#### Structure and content of assessment

6. Does the approach to assessment incorporate the four types of assessment?
7. Are all the sub-domains of the unified assessment process covered?
8. Are the ways in which older people may contribute to assessment made explicit?
9. Are older people's views, wishes, strengths and abilities kept to the fore during assessment and care planning?
10. Does the approach guide professionals to further specialist assessment?

11. Do assessment scales and tools support, rather than replace, professional judgement?
12. Are assessment scales/tools valid, reliable and culturally sensitive?
13. Are professionals helped to evaluate assessed needs according to this Guidance?
14. Are needs assessed, and services provided, promptly?
15. Does the approach lead to minimal duplication of assessment across agencies?
16. Are Personal Plans of Care produced according to this Guidance?
17. Are older people who receive services, following an assessment, given a copy of their personal plan?

### **Information**

18. Has a unified assessment summary been agreed by partner agencies according to this Guidance?
19. Has a single local source for each item of the unified assessment summary been identified?
20. Have arrangements for the collection and upkeep of the information sets of the unified assessment summary been agreed?
21. Is the consent of older people actively and individually sought with regard to the information that is collected and shared about their needs and circumstances?
22. Have agencies taken full account of the legal requirements for information sharing within and between agencies in setting up and using the unified assessment summary?
23. Are there local protocols and mechanisms that allow for the timely transfer of this information when required for the purposes of the unified assessment process?
24. Do these protocols include agreements about which professionals can access and /or update which information items?

### **Professional Involvement and development**

25. Are professionals and other staff competent and confident with their part in assessment, including the use of assessment scales?
26. Are local protocols for joint working in place, as described in this Guidance?

## GLOSSARY OF TERMS

**Assessment** – the process whereby the needs of an individual are identified and their impact on independence, daily functioning and quality of life is evaluated, so that appropriate action can be planned. Assessment involves both professionals and those with the needs thinking through different explanations for how needs have arisen, and how different needs interact with each other. Assessments should cover the following three systems: the service user system; the informal care network system; and the formal care network system. Assessment starts from the first of these and moves outward. (See also outcomes approach to assessment).

**Care management** – a process whereby an individual's needs are identified and evaluated, eligibility for services is determined, Personal Plans of Care are drafted and implemented, and needs are monitored and re-assessed. ("Case management" is an alternative term.)

**Care co-ordination** – this is undertaken by a named professional when a person has needs that require the input of a number of professionals. It ensures that assessment and subsequent action is joined-up.

**Care planning** - a process based on an assessment of an individual's needs that involves determining the level and type of support to meet assessed needs, and the objectives and potential outcomes that can be achieved.

**Carer** –For the purposes of the *Carers and Disabled Children Act 2000* the term "carer" includes people (age 16 and over) who may or may not be a relative and who may or may not be living with the person for whom they are caring. The 2000 Act excludes from the definition of a carer, paid care workers and volunteers from a voluntary organisation. Children and young people affected by caring situations should be considered and assessed as children in need under the *Children Act 1989*.

**Case finding** - a process by which people with needs, who are not referred for health and social care help by either themselves or third parties, might be identified by agencies and invited for assessment.

**Comprehensive older person assessment** - this refers to assessments in which most or all of the domains of the unified assessment process have been triggered and explored through the use of specialist/in-depth assessments. All people entering care homes or in receipt of intermediate care services should have received a comprehensive older person assessment. It will include medical assessment.

**Contact assessment** - this refers to a first assessment involving the older person and professional, and establishing the nature of the presented problem and whether or not there are potential wider health and social care needs. Basic personal information will also be collected, or verified if previously collected, at contact assessment.

**Diagnosis** – this is another term for assessment most usually associated with health care. It often implies a cause and /or prognosis.

**Domain/sub-domains** - these refer to the content of the unified assessment process, and they are described in Chapter 4.

**Eligibility Criteria** – describe the full range of eligible needs that will be met by local authorities having taken their resources into account.

**Eligible needs** – those presented needs for which a local authority will provide help because they fall within the local authority's eligibility criteria.

**Outcomes approach to assessment** – an approach that emphasises the relevance of establishing intended outcomes in the assessment process in order to provide clearer links between both assessment and the resulting personal plan of care, and, as a basis for clear information to providers. Outcomes can be described as the changes and effects that the service user requires resulting from service provision and the support network available to them.

**Overview assessment** - this refers to situations where all or most of the domains of the unified assessment process are explored. Overview assessment may be able to fully identify and describe needs; if not, it should indicate or trigger where specialist assessment is required.

**Personal Plan of Care** - a record that sets out, for people who are to be provided with help, the objectives of that help, preferred outcomes, services to be provided, a review date, and other details. All older people who receive services should receive an appropriate Personal Plan.

**Presented needs** – the needs or issues that are identified when individuals contact or are referred to agencies seeking support are defined as presented needs. Those presented needs for which a local authority will provide help because they fall within the local authority's eligibility criteria become eligible needs.

**Reliable** - generally speaking, this refers to the trust that can be placed on an assessment tool when used to score the needs of an individual by different assessors, or over time. For an assessment tool to be reliable there should be evidence of a measurement of reliability of a scale's use in at least one similar population and that this was of an acceptable degree. Reliability refers to the degree of agreement that is achieved between different raters (or assessors) using the same scale at around the same time on the same person, or between different times.

**Review** - this refers to re-assessment of people's needs and issues, and consideration of the extent to which services are meeting the stated objectives and helping to achieve the desirable outcomes.

**Scale** - this is a means of identifying the presence and/or severity of a particular problem, such as depression or difficulties with personal care.

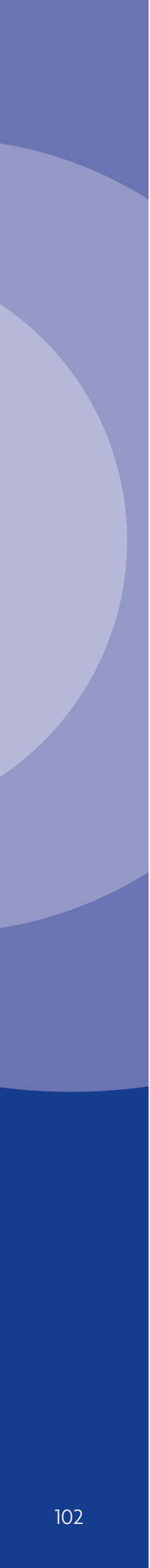
**Service user** - this refers to an older person who is in receipt of either health or social care services. It includes patients of the NHS.

**Specialist/in depth assessment** - this refers to further exploration of assessment domains that have been triggered by contact or overview assessment. Specialist assessment will usually be carried out by qualified professionals and may require the use of scales. It will result in detailed knowledge and insights about particular needs.

**Tool** - this is a collection of scales, questions and checklists that have been brought together for assessment purposes. An alternative term for "tool" is "instrument".

**Unmet needs** – presented needs that are not evaluated as eligible needs or where eligible needs are met but an alternative more appropriate/desirable service should ideally be available.

**Valid** – generally speaking this refers to a scale actually measuring what it is supposed to measure.



### **PUBLIC INFORMATION STRATEGY CHECKLIST - FOR HEALTH AND SOCIAL CARE AGENCIES**

#### **Does the agency have a public information strategy?**

- Does the public information strategy identify an appropriate range of information and how it is to be effectively delivered to intended participants?
- How has the agency assessed the need for information?
- How has the agency consulted service users and carers about their information needs?
- Has the agency developed a service information directory?
- Does the public information strategy comply with the agency's Welsh Language Scheme?
- Has the agency defined what information should be provided to individuals as a matter of routine? For example, all people assessed should receive leaflets on care management, complaints, information for carers etc.
- Does the strategy include arrangements for the updating, distribution, monitoring and reviewing of information.
- Does the agency undertake periodic audits to ensure the information it provides is relevant, up to date and in the right place?
- Is there a multi-agency strategic planning group for information?
- Is there a strategy for joint assessment of information requirements and sharing of data bases? i.e each can make available information about the others services to the public
- Has the agency defined what information it requires other agencies to pass onto service users on its behalf?
- Has the agency undertaken an audit of information service providers and their resources within its catchment area. eg small voluntary organisations employ information officers. Some local voluntary organisations may have access to national data bases such as CABs, National Carers Association, etc.
- Does the strategy meet the needs of minority groups?
- Does it address the needs of people with disabilities?
- Does it operate to defined quality standards?

- Is there a dedicated budget for the provision of information?
- Has the agency considered working towards some form of accreditation as an information service provider?
- Does the agency regularly communicate information through the local media (including talking newspaper)?

### **Information is the responsibility of all staff and managers**

- Is the provision of information to the public built into the job descriptions of key staff?
- How are staff kept up to date?
- Is the provision of information built into the procedures of the agency?
- Is training provided to staff concerning their role in providing information?
- Does the provision of information feature in staff induction?
- How has the agency engaged staff in helping to identify information needs?
- Are specialist staff employed for the provision of information? Do they have clearly defined tasks?
- What are the responsibilities of managers for providing information about their services?

### **Corporate Working**

- Does the Local Authority have a public information strategy/communications strategy?
- How does the Social Services strategy complement the corporate strategy?
- Is there a corporate information strategy group?

### **Provider Services**

- What responsibilities do the providers have for producing information over and above registration requirements?
- How many local service providers have achieved some form of accreditation as information service providers?

### **Advocacy**

- Is there published information on access to independent representation and advocacy as well as complaints procedures?

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