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THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster

London Borough of Hammersmith and Fulham | The Royal Borough of Kensington and Chelsea | Westminster City Council

Adult Social Care

Policies and

Standard Operating Procedures

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PART A – OVERVIEW

1 INTRODUCTION AND CONTENTS

1.1 About the Policies and Procedures

Welcome to the Adult Social Care Policies and Standard Operating Procedures.

These are the policies and procedures for Adult Social Care practitioners across the three boroughs of Westminster City Council, the Royal Borough of Kensington and Chelsea and the London Borough of Hammersmith and Fulham. They replace all other Adult Social Care Practitioner policies and procedures for the three boroughs.

How they are organised

The policies and standard operating procedures are organised into 6 parts:

Part A – Overview (you are currently in this part)

Part B – Assessments

Part C – Support Planning and Provision of Services

Part D – Management of Cases

Part E – Safeguarding, MCA, DoLS

Part F – General and Reference

Each part has a number of sections within it.

How to use the policies and procedures – some general principles

These policies and procedures are applicable to all practitioners within Adult Social Care. Some of them are also applicable to staff in mental health teams who also work with Care Programme Approach procedures. The main process is the same for all teams: variations have been included for specialist teams where they make the process work better for particular groups of people.

- You can read each part for a complete overview, or open specific sections.
- We suggest that you don't keep printed-out copies of the procedures or sections of them as your reference unless you require them for immediate use. Over time they will be replaced by more up-to-date versions.
- For clarity we have indicated distinct IT actions with an icon:

= computer system (usually Frameworki)

Frameworki (Fwi) is the electronic customer information system used in Adult Social Care.

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- Practice issues, context, and background information are shown in different font and colour; for example:

Legitimate interest: It is important to make sure that the caller is who they say they are, so if you are in any doubt, if it is a phone call, take the caller's number and ring them back. A caller has a legitimate interest if they are a professional involved in the care of the named person, or if they care for the named person, or if they are a friend or relative with concerns about the named person.

- There is a **glossary** (Section 46) explaining key terms and concepts – please refer to this as people sometimes mean different things by the same term, even simple ones! The glossary clarifies what they actually do mean.

Tips for navigating the document

- **You can use the links in the table of contents and in the text (for example section X.X) to quickly find specific areas. Hold the 'Control' button down on your keyboard and left click on your mouse to jump to the section indicated. You can get back to your original place by holding down the 'Alt' button and pressing the left arrow on your keyboard. (For example, section 1.2.)**
- **Use the 'Search' tool to find specific instances of a particular term or phrase**

Do they make sense?

- The editor and Reference Group want your feedback – is there anything that seems confusing or contradictory? The process is complex and evolving – as are these procedures. But we want to know about anything cryptic and obscure that could be explained better.
- Bear in mind that practice may vary locally, within acceptable agreed limits, but anything you think is simply wrong, or out-of-date, let us know.
- Please email any comments or suggestions about these policies and procedures to SOPS@rbkc.gov.uk.

1.2 Legislative framework and good practice

- These procedures explain the process and how you should be undertaking your day-to-day working. They reflect best practice.
- The procedures reflect current legislation and will change over time as both national and local policy changes. In particular, some procedures have been reviewed and revised to meet the requirements of the Care Act 2014, but there will be further changes necessary during 2015. The relevant Legislative Framework is laid out in Section 45.
- Local authorities are bound by duties and powers. A **duty** is used to describe responsibilities that legislation makes obligatory, as in 'shall', 'will', 'must'. A **power** is used to describe actions that legislation provides permission to carry

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out, as in 'may' and 'can'. The 'you musts' described in this policy relate to legal duties in the Act itself or the Regulations. Where 'you should' or an instruction is used, it is intended to set a clear expectation, but not to create a legal requirement.

- If you are undertaking courses of action outside these procedures **you must tell your manager and have their agreement**. The consequences of not doing so could be serious.
- Some sections are being written and will be added in due course. There are notes in the text indicating this.

1.3 Where to go for help

- For practice issues ask **your manager** for guidance. Colleagues are also a good source of help, particularly for information about local knowledge and resources. Don't be shy about asking!
- Use the **People First website** for up-to-date information about Adult Social Care services and resources in the borough.
- For help with **Frameworki** issues, call [redacted] or email aschelpdesk@rbkc.gov.uk.

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2 STATEMENT OF INTENT

2.1 Introduction

This section sets out how we as Adult Social Care in the three boroughs of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and Westminster City Council intend to meet our responsibilities under the Care Act 2014. It sets out our commitment to promoting wellbeing and independence for those adults requiring care and support and for carers whose needs we have a duty to meet, whilst also seeking to ensure that adults at risk are safeguarded from harm. Adult Social Care is committed to working in partnership to provide high quality information and advice, and care and support that respects people's dignity, rights and choices.

The three boroughs are committed to being guided by the general principles of promoting wellbeing and personalisation as set out in **Section 3**.

Our overall purpose is to:

- Support people to live their life as fully and independently as possible
- Offer clear and helpful advice when people need it and linked up to health advice and information
- Inform people about where to come in Adult Social Care and Health if they are in need of support
- Support people through unplanned life events and back into their independent life. We address mental wellbeing as well as physical health
- Support carers in their caring role and recognise the importance of people's relationships and families
- Ensure that if people need care and support it is personalised and promotes health and wellbeing
- Provide care and support which feels good even if someone's life is difficult at that time.

The top four principles that apply to all service areas of our department:

Prevention – Promoting health and wellbeing and managing avoidable demand. Providing good advice and information: Public Health and wider public services have an important role here.

Personalisation – Giving adults in need of care and support flexibility, choice and control. Recognising carers and family relationships.

Integration – Joining up with health and with housing where it provides a better service for our customers.

Localised services – Using the local community and its resources and networks to support people.

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2.2 Our approach

Working with support networks

Adult Social Care recognises that the solutions for many people to meet their care and support needs can be found within their own families, their communities and within themselves. We work with each person and their network to find these solutions. Where people have lost their support networks we work in partnership to rebuild them. We encourage our customers, using a strengths-based approach, to help find creative solutions to achieve their identified desired outcomes. We always look for solutions that offer value for money.

Whole family approach

Adult Social Care takes a holistic approach to the person's needs and is committed to identifying how each person's needs for care and support impact on family members, and to providing information and advice that would be beneficial to them. Where a young carer is identified, Adult Social Care is committed to supporting them by referring them to the appropriate Children's service to carry out an assessment of the young carer's needs which will consider the impact on the young carer's wellbeing, welfare, education and development, and whether any of the caring responsibilities are inappropriate.

Partnerships across organisations

Adult Social Care is committed to continuing to develop an integrated and outcome-focused approach to our work with our health partners and other organisations, including Housing.

Assessment

Adult Social Care is committed to providing appropriate and proportionate assessments to its residents who appear to have need for care and support, to consider fluctuating needs and to explore the potential solutions.

Eligibility

Adult Social Care is committed to ensuring that its practitioners determine eligibility for support in a fair and accurate way, through considering the inability to achieve the specified eligibility outcomes and the consequential impact on the person's wellbeing.

Positive Risk Taking

Adult Social Care is committed to enabling people to exercise choice and control over their lives, and therefore the management of risk is central to achieving better outcomes for people. Key to a positive risk management approach is the need to balance the potential for harm with the likely benefits of a particular choice.

Support Planning

Adult Social Care is committed to providing creative support planning to its customers and carers, through determining, in conjunction with the person, how their needs and desired outcomes can be best met through a variety of care and support.

including information and guidance, family networks and community resources and preventative services.

Transition

Adult Social Care is committed to providing ongoing support to young people and their parents/carers to ensure a smooth a transition as possible with continuity of service. This responsibility extends to all staff and across other organisations/ agencies and is not confined to the Transition teams.

Carers

Carers make a vital contribution to society, giving their time and energy to caring for a family member, friend or neighbour. Many people with care and support needs rely on the person caring for them to help keep them independent in their own homes for as long as possible. Adult Social Care recognise and value the role of carers and see them as key partners in the planning and delivery of support to the person they care for.

Caring can often have an impact on the health, wellbeing and independence of carers themselves.

When people become carers, they need to be able to access timely support when they need it. Adult Social Care is committed to working with carers to ensure that they:

- have access to good information and advice
- are informed of their right to have a carer's assessment, either jointly with the cared for person or separately
- through the duty to provide advocacy where there is substantial difficulty in communicating wishes, retaining and assessing information during the assessment, make it easier for carers to access support and plan for their future needs
- receive appropriate support where they have identified assessed eligible needs
- are involved in planning and decision-making from the outset so that they and the person they care for have choice and control over their care and support
- can maintain a balance between their caring responsibilities and a life outside caring – this includes young carers
- can access a range of prevention and support services when they need it (for example, respite care/ carers breaks, access to carers groups, support systems and emergency care) to help prevent a crisis and to sustain them in their caring role
- are supported to maintain their own health and wellbeing.

Complex cases

Where a person has complex high level needs and there is a multi-agency approach, Adult Social Care is committed to clearly identifying each risk and the responsibility for managing that risk. Adult Social Care will work collaboratively to ensure the most

favourable solution to promote the person's wellbeing, to ensure safety and to achieve the best outcomes.

Self Neglect and Hoarding Behaviour

In cases of self neglect and/or hoarding behaviour, Adult Social Care is committed to ensuring that the wellbeing of the adult at risk is paramount. Adult Social Care will seek to engage with the individual, and to balance the person's wishes and choice of lifestyle with the duty to protect. Adult Social Care will undertake multi-agency partnership working to assess the risks and to determine the most favourable approach for achieving engagement with the adult, in conjunction with a care and support plan for delivering the agreed goals and achieving the best outcomes.

Safeguarding

Adult Social Care is committed to working together with other organisations and individuals to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted. Adult Social Care follows the principles and practice of Making Safeguarding Personal, which means safeguarding should be person-led and outcome-focused, having regard to the views, wishes, feelings and beliefs of the adult concerned in deciding on any action.

Recording

Adult Social Care is committed to ensuring that its staff adhere to data protection, information sharing and recording requirements and standards. Staff are committed to completing their training on information security and data protection within one month of starting work within the three boroughs.

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3 PROMOTING WELLBEING, PERSONALISATION AND OTHER KEY CONSIDERATIONS, AND ORDINARY RESIDENCE[1]

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

3.1 The wellbeing principle

The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. Underpinning all of these individual "care and support functions" (that is, any process, activity or broader responsibility that we as the local authority perform) is the need to ensure that doing so focuses on the needs and goals of the person concerned.

Under the Care Act 2014, the local authority **must** promote wellbeing when carrying out any of its care and support functions in respect of a person. This is referred to as "the wellbeing principle" because it is a guiding principle that puts wellbeing at the heart of care and support.

The wellbeing principle applies in all cases where you are carrying out a care and support function, or making a decision, in relation to a person. For this reason it is referred to throughout these procedures. It applies equally to adults with care and support needs and their carers with support needs.

In some specific circumstances, it also applies to children, their carers and to young carers when they are subject to transition assessments.

3.1.1 Definition of wellbeing

"Wellbeing" is a broad concept, and it is described in the Care Act as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal

[1] This section is based on Chapter 1 of the Care and Support Statutory Guidance 2014

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- suitability of living accommodation
- the individual's contribution to society.

There is no hierarchy, and these areas are of equal importance when considering "wellbeing" in the round. However, in individual cases, it is likely that some aspects of wellbeing will be more relevant to the person than others.

Supporting people to live as independently as possible, for as long as possible[2], is a core part of the wellbeing principle. This includes an individual's control of their day-to-day life, the suitability of their living accommodation and their contribution to society. Crucially, the Act requires the local authority to consider each person's views, wishes, feelings and beliefs.

3.1.2 Promoting wellbeing

Promoting wellbeing involves actively seeking improvements in the aspects of wellbeing set out above when carrying out a care and support function in relation to an individual at any stage of the process from the provision of information and advice to reviewing a care and support plan. Wellbeing covers an intentionally broad range of the aspects of a person's life and encompasses a wide variety of specific considerations depending on the individual.

It is possible to promote a person's wellbeing in many ways. How this happens will depend on the circumstances, including the person's needs, goals and wishes, and how these impact on their wellbeing. There is no set approach – consider each case on its own merits; consider what the person wants to achieve, and how the action which you are taking may affect the wellbeing of the individual.

The Act requires the local authority to consider how to meet each person's specific needs rather than providing services. The concept of meeting needs recognises that modern care and support can be provided in any number of ways, rather than the previous legislation which focuses primarily on traditional models of residential and domiciliary care.

Promoting wellbeing does not mean looking at a need that corresponds to a particular service. At the heart of the assessment and planning process is a genuine conversation about people's needs for care and support and how meeting these can help them achieve the outcomes most important to them. Where someone is unable to participate fully in these conversations and has no one to help them, arrange for an independent advocate (see **section 3.3.1**).

The principle of promoting wellbeing is embedded throughout the care and support system. During the assessment process, for instance, explicitly consider the most relevant aspects of wellbeing to the individual concerned, and assess how their needs impact on them, and what outcomes they wish to achieve.

During care and support planning, identify how care and support or resources in the local community, could meet the identified needs and help the person to achieve

[2] as expressed in the UN Convention on the Rights of People with Disabilities2 (in particular, Article 19 of the Convention)

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their outcomes. Promoting the person's wellbeing may mean making decisions about particular types or locations of care (for instance, to be closer to family).

Wellbeing cannot be achieved simply through crisis management. It must include a focus on delaying and preventing care and support needs, and supporting people to live as independently as possible for as long as possible.

Promoting wellbeing is not always about meeting needs directly. It is just as important for people to have the information they need to take control of their care and support and choose the options that are right for them. People can request their local authority support in the form of a direct payment that they can then use to buy their own care and support using this information.

Under the Care Act, wellbeing is also a key principle in safeguarding – see **Section 34**.

The Care Act is designed to work in partnership with the Children and Families Act 2014, which applies to 0-25 year old children and young people with special educational needs (SEN) and/or disabilities. In combination, the two Acts enable areas to prepare children and young people for adulthood from the earliest possible stage, including their transition to adult services. This is considered in more detail in **Section 31**.

3.2 Personalisation

In addition to the general principle of promoting wellbeing, there are a number of other key principles and standards which you must have regard to when carrying out activities or functions relating to adult care and support; the approach must be **personalised:**

- the importance of beginning with the assumption that **the individual is best-placed to judge the individual's wellbeing**. Building on the principles of the Mental Capacity Act, assume that the person themselves knows best their own outcomes and wellbeing. Do not make assumptions as to what matters most to the person
- the need to take into account **the individual's views, wishes, feelings and beliefs**. Considering the person's views and wishes is critical to a person-centred approach. Do not ignore or downplay the importance of a person's own opinions in relation to their life and their care
- the need to ensure that assessments are both **proportionate and appropriate**. A proportionate assessment is as extensive as is required to establish the extent of a person's needs, is always person-centred and based on their individual circumstances. Ensure the assessment process is adapted to the person's circumstances and needs (communication needs, level of complexity) and is only as intrusive as it needs to be to establish an accurate picture of the needs of the individual or their carer
- the need to ensure that **decisions are made having regard to all the individual's circumstances** (and are not based only on their age or appearance, any condition they have, or any aspect of their behaviour which

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might lead others to make unjustified assumptions about their wellbeing). Do not make judgments based on preconceptions about the person's circumstances, but in every case work to understand their individual needs and goals

- the importance of the **individual participating as fully as possible in decisions about them** and being provided with the information and support necessary to enable the individual to participate. Care and support should be personal: do not make decisions from which the person is excluded
- the importance of **achieving a balance between the individual's wellbeing and that of any friends or relatives who are involved in caring for the individual**. Consider people in the context of their families and support networks, not just as isolated individuals with needs. Take into account the impact of an individual's need on those who support them, and take steps to help others access information or support
- the need to ensure that **any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary** for achieving the purpose for which the function is being exercised. Where you have to take actions which restrict rights or freedoms, ensure that the course followed is the least restrictive necessary.

Consider all of the matters listed above in relation to every individual when carrying out a function as described in these procedures. Look at a person's life holistically, considering their needs in the context of their skills, ambitions, and priorities – as well as the other people in their life and how they can support the person in meeting the outcomes they want to achieve. Focus on supporting people to live as independently as possible for as long as possible.

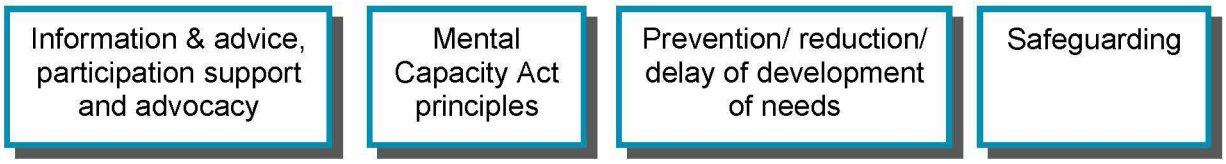
As with promoting wellbeing, the factors above will vary in their relevance and application to individuals. For some people, spiritual or religious beliefs will be of great significance, and should be taken into particular account. For others, this will not be the case. Consider how to apply these further principles on a case-by-case basis.

Personalisation is equally important in safeguarding. Follow the principles and practice of Making Safeguarding Personal, which means safeguarding should be person-led and outcome-focused, having regard to the views, wishes, feelings and beliefs of the adult concerned in deciding on any action.

The steps to take will depend entirely on the circumstances. The principles are not intended to specify the activities which should take place. Instead, their purpose is to set common expectations for how to approach and engage with people.

3.3 Key considerations at every stage of the process

As well as the wellbeing and personalisation principles, there are a number of particular things to consider at every stage of the process:



3.3.1 Information and advice, participation support and advocacy

Information and Advice

Practitioner: Throughout the process, you must give the person as much information as they require about the steps involved in the assessment and care and support planning process, and support them to participate in the process. Involve friends, family or an advocate as appropriate.

Information and advice should help people to understand how care and support services work locally, the care and funding options available, and how people can access care and support services. The Act states that information and advice **must** be provided on these five areas in particular:

- How the system works – an outline of what the 'process' may entail and the judgments that may need to be made, including specific information on what the assessment, eligibility and review process is, how to complain or make a formal appeal to the authority, and when independent advocacy should be provided.
- How people can access care and support – where/who and how to make contact, including information on how and where to request an assessment of needs, a review or to complain or appeal against a decision.
- The types and range of care and support services available to local people, for example, specialised dementia care, befriending services, residential care, which local providers offer what types of services, including prevention and reablement services and wider services that support wellbeing. Where possible this should include the likely costs to the person of the care and support services. This should also include information on different types of service or support that allow people personal control over their care and support, for example, direct payments.
- Care and support-related financial information and advice about the extent of their personal responsibilities to pay for care and support, their rights to statutory financial and other support, locally and nationally, so that they understand what they are entitled to. Local authorities **must** also identify those who may benefit from independent financial advice or information as early as possible, and help them to access it.
- How people can raise concerns about the safety or wellbeing of someone who has care and support needs and what will happen when such concerns are raised (and how to do the same for a carer with support needs).

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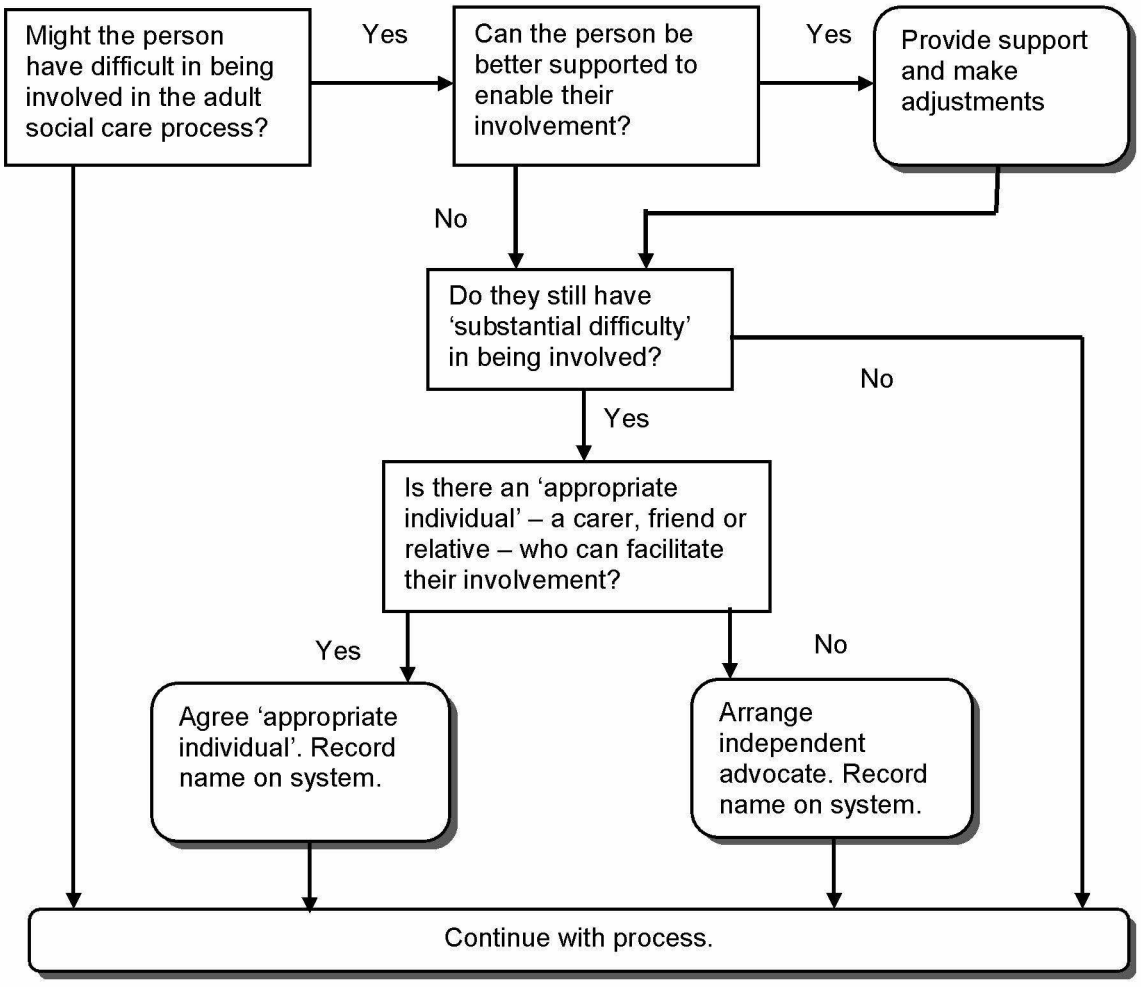
Use the **People First website** as a useful source of information and advice about services in the three boroughs and how to access them.

Supporting a person's involvement, and advocacy



Practitioner: If there is a concern that the person might have difficulty in being involved, first check whether the person can be better supported or you can make reasonable adjustments to enable their participation[3].

However, under Sections 67 and 68 of the Care Act, where a person still has *substantial difficulty* in any of these four areas:

- understanding the information provided
- retaining the information long enough to be able to use it as in next bullet point
- using or weighing up the information as part of the process of being involved, and
- communicating their views, wishes and feelings,

then arrange for an advocate to facilitate their involvement in the local authority processes as follows:

[3] As required under the Equalities Act 2010

In the first instance, seek to identify with the person concerned an 'appropriate individual' – a carer, relative or friend –

- who can represent the person's wishes and support them in their active involvement in the local authority processes
- who is not paid or professionally engaged in providing care or treatment to the person or their carer
- whom the person being supported agrees to.

Create a record for this advocate on Frameworki and link to the person concerned via the most appropriate relationship type.

If the person has substantial difficulty in being involved *and* there is no appropriate individual available, then the local authority has a duty to provide independent advocacy as follows:

Practitioner: In such a case, arrange for an appropriate, independent advocate. Contact the local commissioned advocacy organisation for that client group in the relevant borough. (See People First website for contact details.) If the person is in an out-of-borough placement, contact the relevant local authority to identify the local commissioned advocacy organisation. Record the name of the advocate on a case note on Frameworki.

The role of the advocate is to represent the individual, always with regard to their wellbeing and interests, including assisting the person to:

- understand the process
- communicate their wishes, views and feelings
- understand how their needs can be met
- make decisions about their care and support arrangements
- where necessary challenge decisions made by the authority
- understand their rights.

Please Note: There is a separate duty to arrange an independent advocate where necessary for adults who are subject to a safeguarding enquiry or Safeguarding Adult Review (SAR). See also **Section 34 SAFEGUARDING**.

The Guidance lists a number of individuals/situations where a person would not be considered an appropriate advocate, or where a conflict of interest would arise. These include:

- a family member living at a distance, who has occasional contact with the person
- a spouse who finds it difficult to understand the local authority processes
- a friend who expresses strong opinions of her own prior to finding out those of the individual concerned
- a housebound elderly relative
- parents of a young person with a learning disability who are worried that they will not cope living in their own home and are against them doing so

- the child of an older man with advanced dementia who will inherit the house and who say the father can cope at home and does not need to go into residential care
- any person who has been implicated in any enquiry of abuse or neglect or has been judged by a SAR to have failed to prevent an abuse or neglect.

There are two situations in which the local authority can provide an independent advocate even though the person has a family member/other who can facilitate the person's involvement in the local authority processes:

- Where the assessment or planning process might result in placement in NHS-funded provision in either a hospital for a period exceeding four weeks or in a care home for a period of eight weeks or more and the local authority believes that it would be in the best interests of the individual to arrange an advocate
- Where there is disagreement relating to the individual, between the local authority and the appropriate person whose role it would be to facilitate the individual's involvement, and the local authority and the appropriate person agree that the involvement of an independent advocate would be beneficial to the person.

Please Note: This policy about advocacy also applies to:

- Those people whose needs are being jointly assessed by the NHS and the local authority or where a package of support is planned, commissioned or funded by both a local authority and a Clinical Commissioning Group (CCG) under a joint package of care
- Those people who do not retain a right to an Independent Mental Health Advocate (IMHA), whose care and support needs are being assessed, planned or reviewed. [Under the Mental Health Act 1983, some people known as 'qualifying patients' are entitled to help and support from an IMHA, generally those are detained as in-patients. Section 117 places a duty on the NHS and local authorities to provide aftercare and must involve a joint assessment, including an assessment of the person's care and support needs, a care and support plan and subsequent review.]

Independent advocates and IMCAs

Independent advocacy under the duty flowing from the Care Act is similar in many ways to independent advocacy under the Mental Capacity Act (MCA) (see **section 3.3.2**). Regulations have been designed to enable independent advocates to be able to carry out both roles. People for whom there is a power to instruct an IMCA in relation to care review will (in nearly all cases) also qualify for independent advocacy under the Care Act. The Care Act creates a duty rather than a power in relation to advocacy and care reviews.

However, the duty to provide independent advocacy under the Care Act is broader and provides support to:

- people who have substantial difficulty in being involved in the care and support 'processes'

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- people in relation to their assessment and/or care and support planning regardless of whether a change of accommodation is being considered for the person
- people in relation to the review of a care and/or support plan
- people in relation to safeguarding processes (though IMCAs may be involved if the authority has exercised its discretionary power under the MCA and appointed an IMCA if protective measures are being proposed for a person who may lack capacity to consent to one or more measure)
- carers who have substantial difficulty in engaging
- people for whom there is someone who is appropriate to consult for the purpose of best interests decisions under the Mental Capacity Act, but who is not able and/or willing to facilitate the person's involvement in the local authority process
- adults who are subject to a safeguarding enquiry or Safeguarding Adults Review.

Frequently a person will be entitled to an advocate under the Care Act and then as the process continues, it will be identified that there is a duty to provide an advocate (IMCA) under the Mental Capacity Act. This will occur for example when during the process of assessment or care and support planning it is identified that a decision needs to be taken about the person's long-term accommodation. It would be unhelpful to the individual and to the local authority for a new advocate to be appointed at that stage.

3.3.2 Mental Capacity Act principles

The five principles of the Mental Capacity Act are as follows:

Principle 1: A presumption of capacity. **Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.**

Principle 2: Individuals being supported to make their own decisions. **A person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.**

Principle 3: Unwise decisions. **People have the right to make what others might regard as an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat them as lacking capacity for that reason.**

Principle 4: Best interests**. If a person has been assessed as lacking capacity then an action taken, or decision made for, or on behalf of that person, must be made in his or her best interests.**

Principle 5: Less restrictive option. **Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way**

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that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. In essence, any intervention should be proportional to the particular circumstances of the case.

Practitioner: Assume that a person has capacity to make the decision in question, and support the person to make an informed choice if possible. Where you have concerns about a person's capacity to make a specific decision involved in the assessment, support planning and review process, or if a person appears to have care and support needs but refuses an assessment, then support them to make an informed choice if they can and arrange to carry out an assessment under the Mental Capacity Act. See **Section 35 CONSENT AND CAPACITY**. If you assess that the person does not have capacity to make the decision, then follow the best interests process in order to reach a decision as to what is in their best interests. See **Section 36 BEST INTERESTS**.

Make sure that you record the result of the capacity assessment by completing a mental capacity assessment form, *whether or not* you conclude that the person does have capacity. This evidence may need to be referred to at a later date.

You must refer anyone who may lack capacity to consent to certain major decisions, and who does not have someone to support or represent them, to an Independent Mental Capacity Advocate (IMCA). If they already have a Care Act advocate this advocate should be able to accept the IMCA referral (**section 3.3.1**).

3.3.3 Prevention, reduction, delay of development of needs

Practitioner: At every interaction with a person, you must consider whether or how the development of the person's needs could be prevented or reduced or delayed. You must consider a range of preventative solutions/options during the assessment and support planning process to help them to retain or regain their skills and confidence.

Prevention is about supporting people to find their own solutions by providing good information and advice, rather than by our actions, which can create dependency on Adult Social Care and services.

Local authorities' responsibilities for prevention apply to *all* adults, not just those who may have eligible care and support needs, and apply *equally* to carers.

There are three different types of prevention:

1. **Prevent: primary prevention/promoting wellbeing** – This category is aimed at people who have no current particular health or care and support needs. Universal services, which are generally available to all people, give access to good quality information, support safer neighbourhoods, promote healthy and active lifestyles (for example, exercise classes) reduce isolation through community activities and encouraging conversations in families about future needs, for example, moving to more suitable accommodation.

These interventions can help individuals by avoiding or reducing the need from them developing needs for care and support and can help carers through maintaining their independence and good health and by promoting wellbeing.

2. **Reduce: secondary prevention/early intervention** – This category is a more targeted intervention aimed at individuals who have an increased risk to developing needs where the provision of services may slow down or reduce any further deterioration or prevent other needs from developing. Early intervention can prevent a crisis from occurring.

3. **Delay: tertiary prevention** – These are interventions aimed at minimising the effect of disability or deterioration in those people with established or complex health conditions. This includes reablement, and equipment services and adaptations. Reablement needs to be considered in *all* instances where a person has the potential to benefit, *prior* to an assessment of any remaining unmet needs for care and support. (See **Section 7 COMMUNITY INDEPENDENCE SERVICE** and **Section 8 REABLEMENT**.)

Prevention is an *ongoing* activity and local authorities must respond to changes in an individual's situation which might require a different level of response. Effective interventions at the right time can stop needs from escalating, and help people maintain their independence for longer.

3.3.4 Safeguarding

Practitioner: In any activity which you undertake, consider how to ensure that the person is and remains protected from abuse or neglect, particularly if the person is not able to protect themselves. This must be balanced against the need to ensure the person has as much control as possible over decisions involving risk and their ow safety in line with Making Safeguarding Personal. This is not confined only to safeguarding issues, but is a general principle to be applied in every case throughout the assessment and support planning process. In particular, if you have concerns about possible abuse, neglect or harm, it is essential that you record your concerns and discuss these concerns with your manager on return to the office, and follow the safeguarding procedure. Be mindful of the six key principles underpinning all adult safeguarding work. See **Section 34 SAFEGUARDING.**

3.3.5 Think Whole Family

Practitioner: Take a holistic approach to the person's needs and identify how each person's needs for care and support impact on family members. Provide information and advice that would be beneficial to them. In particular, if a young carer is identified, ensure an assessment of the young carer's needs is carried out which considers the impact on the young carer's wellbeing, welfare, education and development, and whether any of their caring responsibilities are inappropriate.

3.4 Confidentiality and Information Sharing

Obtaining and recording consent is vital for the safe and legal sharing of personal information.

Practitioner: Seek the permission of the adult and/or carer to share information as required to enable safe and comprehensive assessment and arranging of care and/or support.

If you have concerns about the capacity of the person to give consent, then see **section 3.3.2**.

Exceptional circumstances in which a person's consent may be overridden would be where information is required by statute or court order, where there is serious risk to public health, risk of harm to themselves and/or other individuals or for the prevention, detection or prosecution of crime. In these circumstances the public interest in maintaining confidentiality is outweighed by the public interest in disclosing the information.

The disclosure of personal information without consent must be justifiable on statutory grounds and meet one of the conditions of Schedule 2 of the Data Protection Act 1998. The disclosure of 'sensitive' information without consent must meet one of the conditions of Schedule 3 of the Data Protection Act 1998. See **Section 45 LEGISLATIVE FRAMEWORK**.

Practitioner: Check with your manager in such circumstances before overriding the consent of the person concerned to share information.

You must record on Frameworki when you seek consent to share information and when the person gives their consent, and also when consent to share information is not requested or given. If you disclose information without consent, then record full details about the information disclosed, the reasons why you took the decision to disclose, the person who authorised the disclosure and the person(s) to whom it was disclosed.

Key principles of information sharing[4]

- **Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.**
- **Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.**
- **Seek advice if you are in any doubt, without disclosing the identity of the person where possible.**
- **Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.**

[4] "Information Sharing: Guidance for Practitioners and Managers", HM Government, March 2009

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- **Consider safety and wellbeing: base your information-sharing decisions on considerations of the safety and wellbeing of the person and others who may be affected by their actions.**
- **Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.**
- **Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.**

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3.5 Ordinary Residence

Adult social care services are available to adults with eligible needs who are ordinarily resident in the borough. When considering whether the Authority is responsible for meeting the eligible needs for care and support of an adult it is therefore crucial to establish whether the adult's 'ordinary residence' is in the borough.

'Ordinary residence' is not defined in legislation, but the Care Act Guidance states that it is *"the place the person has voluntarily adopted for a settled purpose, whether for a short or long duration. Ordinary residence can be acquired as soon as the person moves to an area, if their move is voluntary and for settled purposes, irrespective of whether they own, or have an interest in a property in another local authority area. There is no minimum period in which a person has to be living in a particular place for them to be considered ordinarily resident there, because it depends on the nature and quality of the connection with the new place."*

The Local Authority within whose area a person is ordinarily resident is responsible for the assessment of need and the provision of service for that person.

Please Note:

- Seek advice from your manager/ senior and/or legal services for any cases that are not clear-cut or where there is a dispute as to the ordinary residence of a person requesting assessment.
- Do not delay a referral or an assessment whilst ordinary residence is being determined. Continue to carry out the assessment whilst the dispute is resolved.

Responsibility for placements in residential or nursing care – Under the previous legislation (National Assistance Act 1948) an adult placed in residential care by Local Authority A ('Authority A') in Local Authority B ('Authority B') was treated as still being ordinarily resident in Authority A as the result of the deeming provision in the National Assistance Act 1948. A 'deeming provision' is a legal provision that alters the usual 'where the person is' rule regarding social care responsibility.

Under the Care Act an adult placed by Authority A in residential care in Authority B *before* 1st April 2015, and who remains in that placement as at 1st April 2015, remains ordinarily resident in Authority A.

The Care Act includes a new and wider 'deeming provision' in place of the previous National Assistance Act provision set out above. Instead of applying only to placements in care homes it now extends to supported living placements and shared lives placements.

The Care Act section 39 deeming provision applies when Authority A places an adult in specified accommodation in Authority B after 1st April 2015. 'Specified accommodation' is defined under Regulations as covering the following:

(a) care home accommodation

(b) shared lives scheme accommodation

(c) supported living accommodation.

These three different types of specified accommodation are defined more fully in the Regulations.

As a result an adult placed (or funded) in 'specified accommodation' by Authority A after 1st April 2015 remains ordinarily resident in Authority A for Care Act purposes, whilst physically present in Authority B.

No settled residence – If the person has no current or recent address and is of no settled residence then the Local Authority where the person presents themselves is responsible for assessing and then meeting any eligible needs. However the Guidance makes clear that only in rare circumstances should an authority conclude that someone is of no settled residence. Notify a senior manager where someone appears to be of no settled residence.

Where a person owns property in two separate Local Authority areas – It is not possible under the Care Act to have more than one ordinary residence, and so even if they divide their time evenly between both homes, it is necessary to establish to which of the two homes the person has the stronger link. If this is Authority A then if Care Act needs arise when present in Authority B then the Care Act duty falls on Authority A. Factors to take into account include where the person's family lives, where they are registered with a GP, and whether they are members of local organisations.

Where a person owns a property in Local Authority A but is on holiday or visiting family in Local Authority B when urgent needs arise – If a person is ordinarily resident in Authority A but visiting Authority B (intended to be for a temporary visit) when urgent needs arise then the duty falls on Authority A. However logistically it may be easier for Authority B to assess the needs and provide the services on behalf of Authority A, with Authorities A and B reaching an agreement as to funding.

Where a person owns a property in Local Authority A but moves permanently or indefinitely to Local Authority B – If Care Act needs arise when the person is physically present in Authority B having moved there indefinitely, then the Care Act duties fall on Authority B, not Authority A, because the person will have changed their ordinary residence to Authority B.

Where Local Authority A places a person in accommodation in Local Authority B under Housing legislation – Where Authority A places a person in non-specified accommodation in Authority B (for example, bed & breakfast accommodation) then if the person requires a Care Act assessment whilst in Authority B then the duty falls on Authority B since their ordinary residence will have passed to Authority B, the person having accepted that accommodation on a voluntary basis. The fact that the accommodation is not necessarily permanent does not alter the passing of ordinary residence to Authority B.

Assessment of and Care Act responsibility for a patient in hospital – An adult in hospital or other NHS accommodation is treated as ordinarily resident in the Local Authority where they were ordinarily resident before the NHS accommodation was provided. This applies regardless of length of stay in the hospital.

So if an adult is ordinarily resident in Authority A and then enters hospital in Authority B then responsibility for that adult's care and support remains with Authority A. This applies regardless of the length of that admission to hospital. Responsibility only passes to Authority B where the adult had no settled residence immediately prior to admission to the hospital. This will be a rare event.

Responsibility for section 117 Mental Health Act 1983 after care upon discharge from hospital – The Care Act changes section 117 of the Mental Health Act: section 117 responsibility is now determined by the Authority where the patient was ordinarily resident prior to detention under section 3 of the Mental Health Act.

If the person was living in and ordinarily resident in Authority A (for example, in their own home or in bed and breakfast) when detained under section 3, then Authority A will be responsible for the section 117 after care package and for any eligible care needs which fall outside the section 117 after care package.

Please Note: There is one scenario where the law is currently unclear. This is where Authority A place the person in specified accommodation (see above) in Authority B and the person is then detained under section 3 whilst living in Authority B. There are three disputes involving six London Boroughs which are likely to go to the Secretary of State for resolution. This Operating Procedure will be updated once the law is clarified. In the meantime, refer any new cases where the issue arises to a senior manager and to Legal Services.

Assessment of and Care Act responsibility for a prisoner – Local Authorities are responsible for the assessment of all adults who are in custody in their area who appear to be in need of care and support, regardless of where they came from or where they will be released to. The assessing Local Authority is then responsible for any eligible needs whilst the person is detained in prison.

Responsibility for people leaving prison – Where a person requires 'specified accommodation' upon release the presumption is that responsibility lies with the Local Authority where they were ordinarily resident before starting their sentence ('Authority A').

Where the offender had no settled residence prior to detention or where they do not intend to return to their previous Local Authority (Authority A) but to settle in a new Local Authority area (Authority B), then responsibility for assessing and then meeting eligible needs falls on Authority B to which they intend to move on release.

Responsibility for someone in care home in Authority B who has entered into a Deferred Payment Agreement with Authority A – Where a person is ordinarily resident in Authority A and is eligible for a Deferred Payment Agreement with Authority A and moves into a care home in Authority B then Authority A remains responsible for funding their care for so long as the Deferred Payment Agreement remains in force. Where the money runs out before the person dies, then seek advice from Legal Services regarding legal and financial responsibility.

Where a person arranges and pays for their own residential accommodation in Authority B, having previously lived in Authority A – In most circumstances where a person arranges and pays for their own residential accommodation in

Authority B, having previously lived in Authority A, ordinary residence passes to Authority B. However where Authority A assisted in making the arrangements then ordinary residence remains in Authority A. Check such circumstances with a senior manager.

Young People in transition from CHS to ASC at 18 – The Care Act Statutory Guidance provides considerable guidance and examples covering a number of scenarios for young people in transition. When dealing with a young person in transition from CHS to ASC refer to Chapter 16 and Annex H8 of the Guidance. Where there is any uncertainty as to which Authority is responsible, refer the matter to a senior manager and to Legal Services.

Responsibility for Carers – Under the Care Act different arrangements apply to carers who are caring for someone with care and support needs. The Authority responsible for the provision of care and support for carers is the Authority where the adult for whom they care is ordinarily resident, and not where the carer is ordinarily resident.

Dispute Resolution – Ultimately where two Local Authorities are in dispute about where an adult with eligible need for care and support is ordinarily resident then the Care Act provides a process for determination by the Secretary of State. The Authority where the person is living or physically present must accept responsibility until the dispute is resolved. **The 2014 Care and Support Dispute Regulations set out the process that must be followed in such a case.**

4 OVERVIEW OF THE PROCESS

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

4.1 The overall process

In this section, we give an overview of the process for assessment and arranging care and support.

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

Any member of the public or professional can contact the department. Staff must give **information and advice** about how to get help from a wide range of organisations, using the People First website. This includes community and voluntary organisations who can also give information and advice or provide services directly.

If it is clear that the person requires more than signposting to further help, that he or she is a resident of the borough and is an adult with an appearance of need for care and support), we take a **referral**, and if it is clear that an assessment of needs is required, we undertake an **initial assessment**. At this point there are two options:

If there is potential for the person to become more independent they are referred to the **Community Independence Service** to provide time-limited services including reablement to support them regaining all or some of their independence through making changes to their environment or helping them to regain skills of daily living or retraining them or providing equipment where appropriate.

If the person is unlikely to benefit from Community Independence Services or he/she is receiving such services, and will have remaining social care and support needs, we carry out an **assessment.** We take into account the individual's wishes and preferences, and the results of any Community Independence Services they have received. We identify their needs, what outcomes they are unable to achieve as a result of those needs, and the consequent impact on their wellbeing in order to determine whether they meet the **national eligibility criteria** for adult care and support services. If the person concerned is a young person in **transition**, we work

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with Children and Families to ensure as smooth a transition to adult services as possible.

If the person's needs are eligible, we set a **personal budget**, which is the amount of money that the Council determines is necessary to meet their eligible needs in order to remain living safely at home. We determine an up-front indicative allocation through our **Resource Allocation System** (RAS) before support planning takes place. This amount may be adjusted following the development of the support plan.

The Council's personal budget allocation can be either a full or a partial contribution to the person's social care costs. The person may also choose to pay for support in addition to their personal budget. We also consider what universal services might help the person improve their wellbeing.

The Council undertakes a financial assessment which determines whether the individual will need to make a contribution to any personal budget allocation and the amount of that contribution.

A person may take a personal budget:

- Either in the form of a **direct payment**, held directly by the individual, by a third party where the person has capacity, or, where they lack the capacity to consent to receive it and where it is in their best interests, by a 'suitable person', enabling the direct payment holder to benefit from the flexibilities that direct payments offer, or
- by way of Council–commissioned services, that is, to pay for community care services which are commissioned by the Council, or
- as a combination of the above.

Individuals can use their personal budgets to access a wide range of support and services, including traditional social care, as long as the service is legal and meets agreed needs and helps the person to achieve their desired outcomes. Ultimately, the Council must decide what is or is not an acceptable use of public funds.

The next step is to design a **care and support plan**. There are three options:

- Where the person chooses to manage their own personal budget, they develop a care and support plan, which lays out in detail how they intend to use their personal budget to stay safe and independent at home, what support and services will be used, how much these will cost and how much the person might need to contribute, depending on their financial situation. The care and support plan must be approved by the Council.
- Where the person chooses not to manage their own personal budget, but rather wishes the Council to arrange appropriate care to meet their needs, the assessor works with them to develop a care and support plan, which identifies which Council-funded services the assessor will arrange to meet the individual's identified needs.
- Some combination of the above two options.

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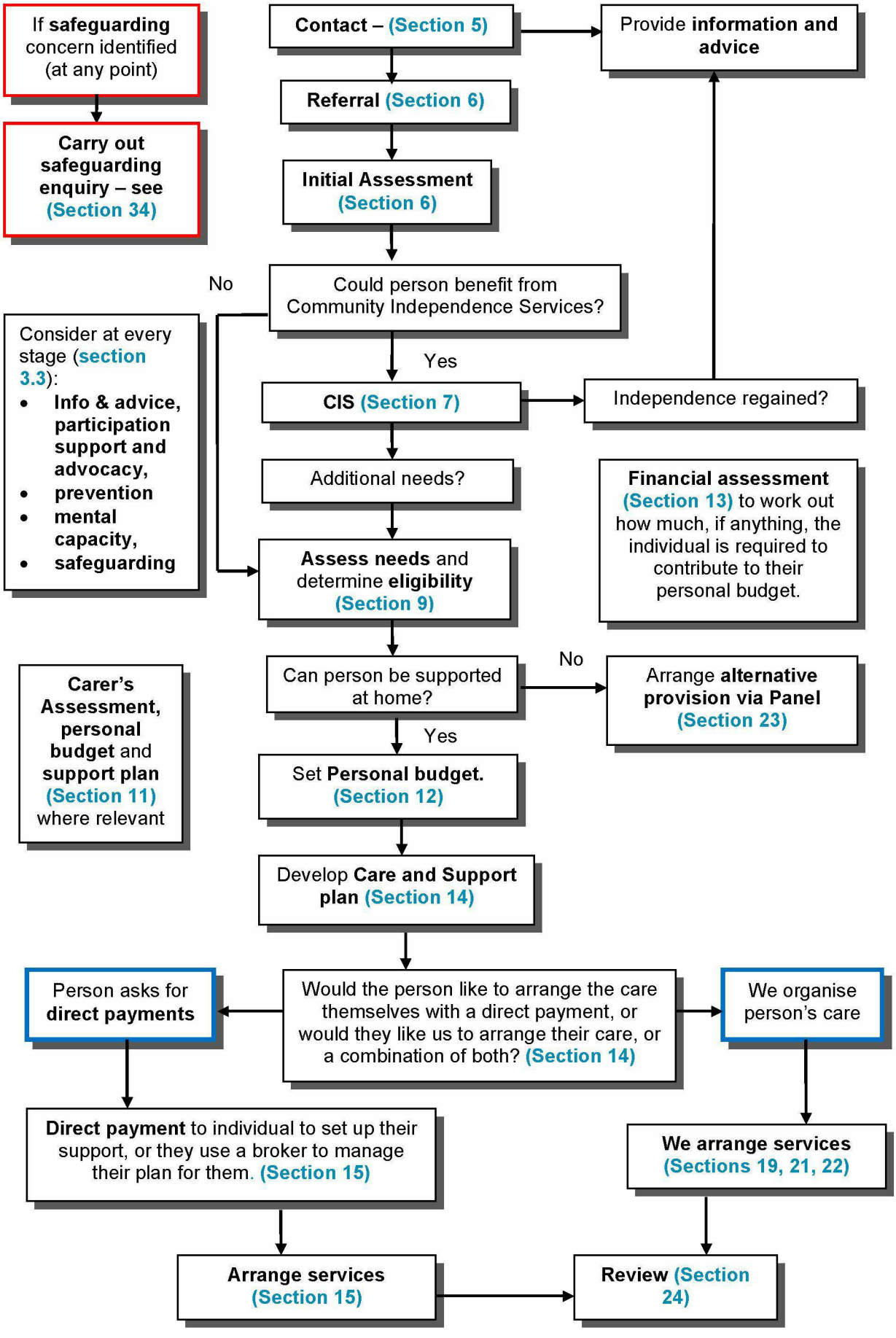
The next step is to **arrange the person's care and support**. We either put in place the care and support services, or make available through direct payments the money needed to pay for the services in the care and support plan.

If needs can potentially be met through adaptations or major pieces of equipment, we carry out an occupational therapy (OT) assessment. If appropriate needs are identified, the person can choose either to have the adaptation or equipment arranged by the OT service or to take a direct payment to purchase equipment themselves, or to organise an adaptation in privately owned or rented properties. If they qualify for a Disabled Facilities Grant (DFG), the person can choose to manage the grant themselves.

A 'carer' is a person who provides unpaid support to a relative or friend to help them to meet their needs. If it appears that the carer has a need for support to enable them to continue in their caring role, then we offer a **carer's assessment**, whether the person they care for is receiving services from the Council or not. The carer can choose whether to be assessed jointly with the cared for person, or in their own right. If the carer has eligible support needs, they can be allocated a **carer's personal budget**, and enabled to develop a **carer's support plan**. If there is a young carer, we work with Children and Families to assess their needs and the impact of their caring responsibilities on their wellbeing, welfare, education and development, and and whether any of their caring responsibilities are inappropriate.

We **review** the care and support plan and carer's support plan at key points in the first months and then at regular intervals (at least annually) to check whether the outcomes agreed are being achieved, and whether the needs of the person or their carer have changed. The first review of a direct payment is at six months. We work with the individual and carer to adjust the care and support plan and carer's support plan accordingly, or if needs have changed significantly, to re-assess and develop a revised plan.



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PART B – ASSESSMENTS

5 INITIAL CONTACT – INFORMATION AND ADVICE

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

5.1 Introduction

This section is guidance for all staff receiving requests for information and advice or contacts from people wishing to make a referral: it is particularly relevant for staff in the following teams:

LBHF: H&F Advice

RBKC: Social Servicesline (SSL)

WCC: Customer Services Centre, and Citywide Access Service for OP/PD

Such requests or contacts may be in the form of a phone call, email, fax or letter. Always begin by saying who you are.

In most cases a member of the public or another professional wishing to find out about Adult Social Care services first of all contacts one of the Contact Centres. However, staff at other access points may also receive calls, and follow the same process described below.

Decide the nature of the contact and whether the person concerned is known to Adult Social Care/ the Council see **section 5.3** and **section 5.4**.

If the call is about a No Reply or Failed Visit, go to **section 5.5**.

If the call is about a safeguarding concern, go to **section 5.6**

If the call is a request for information, go to **section 5.7**.

If the call is about Accessible Transport, go to **section 5.8**.

If the person is known and the case is open, and the call needs to be transferred to a community team or hospital team, go to **section 5.9**.

If the person is not known and the call is about specialist services, that is, learning disability, mental health, sensory impairment, homelessness or substance misuse, go to **section 5.10**.

If the person is not known (or is known and the case is closed) and you decide a referral is required, go to **section 5.11**.

If the request is for a referral or assessment, go to **section 5.11**.

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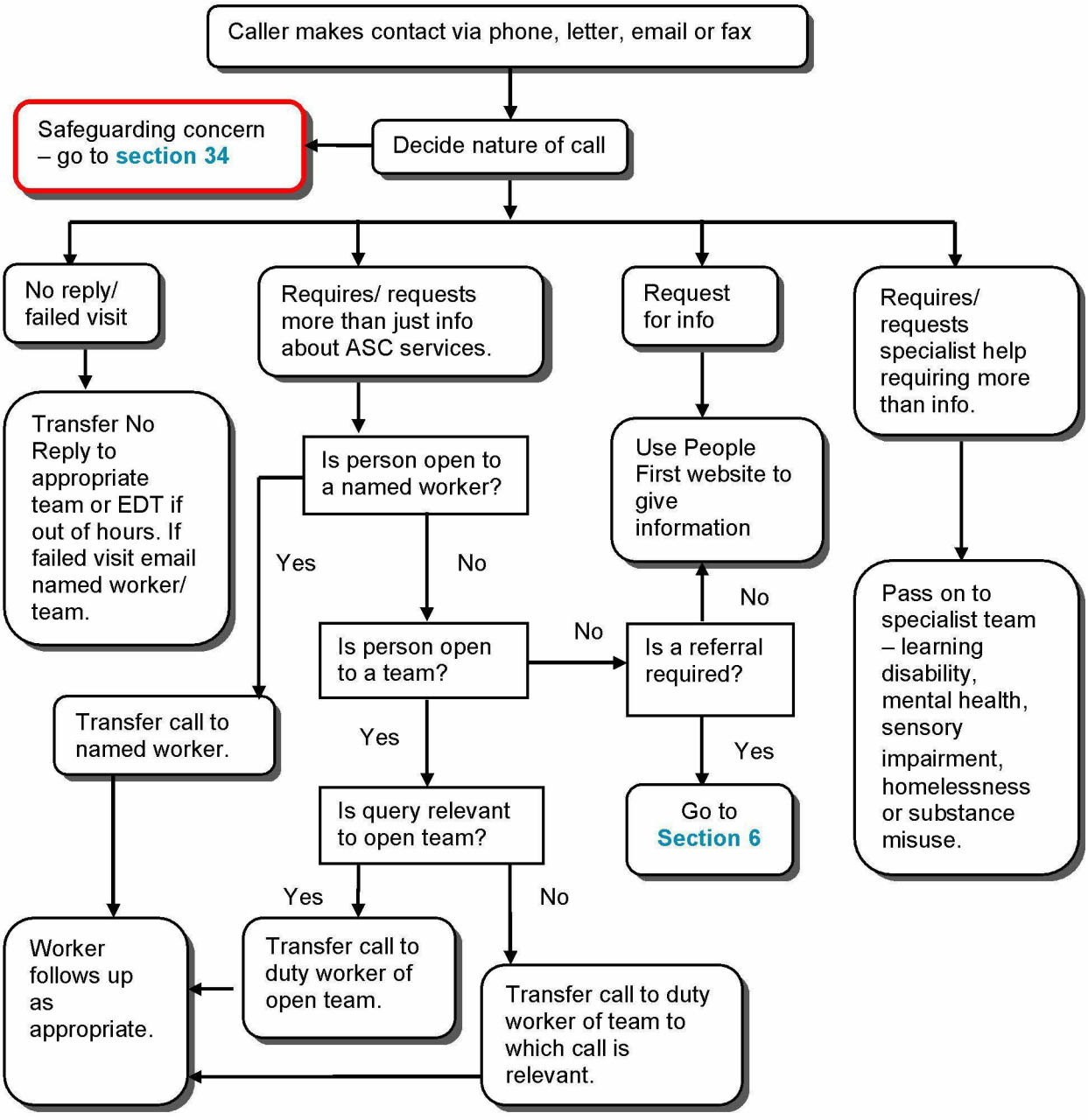
If this is an initial contact about social work for a person in hospital, go to **section 5.12.** ***Please Note:*** Requests for OT assistance with equipment or minor adaptations follow the standard route.

The essence of the approach is for you to respond to as many calls as possible at the first point of contact, by providing helpful relevant information. If it is clear that the caller needs further assistance, either take a referral or transfer the caller to another team as appropriate, taking care to record enough information for the receiving team to decide what steps to take next.

5.2 Overview flowchart



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5.3 RBKC only: The Person Index

RBKC only: RBKC's Person Index (PI) is the central index holding basic details of individuals known to adults' and children's social care. It holds their core demographic data, that is, name, address, date of birth, and so on. It also holds a complete allocation history for a person across adults' and children's services, but it does not hold any confidential case information. It sits on top of other systems. When someone first becomes known to either service in the Royal Borough they are added to PI which creates a unique identifier (a person number) and the person can then be downloaded to either Frameworki or the Integrated Children's System (ICS), or both, so that records for that for that person are bound together, no matter what services are delivered to them, and from whom. When you change the demographic details of a person in Frameworki or there is a change in allocations on Frameworki, it will tell PI.

The benefits of the PI are:

- to provide a common central record for people known to different services
- to show the complete picture of services received by the person
- to avoid duplication of effort or resources
- to highlight risk and help to safeguard people by having the complete picture.

You access PI through the "Search PI" button in Frameworki. Business Support also have access to a system called PI Plus which allows warnings and notifications about individuals to be recorded so that these details are available to both adults' and children's systems. See also **section 40.6 Warnings**.

5.4 Frameworki

Frameworki is the system holding details of individuals known to Adult Social Care. It holds their core demographic data including name, address, and date of birth. You can check on Frameworki to see whether a person is known to Adult Social Care. Frameworki also holds a complete episode history for a person. Warnings about individuals can be recorded on Frameworki where appropriate. See also **Section 40 RECORDING** .

5.5 No Replies and Failed Visits

No Replies arise when a worker has tried to make contact with a person but has not found them there at a pre-arranged time. Failed visits are when a person refuses their service/does not open their door.

No Replies are the highest priority work for contract centre and reception staff and must take precedence over all other tasks. Failure to deal with them correctly can have fatal consequences.

The **golden rule** for dealing with No Replies is always to pass it on to the relevant team and confirm that the person responsible has received it. **It is NEVER acceptable to deal with a No Reply purely by email or fax.**

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LBHF – H&F Advice

RBKC – Home Care Management Team

WCC – Access team OP/PD

For additional details see **Section 20 FAILED VISITS/ NO REPLIES.**

5.6 Safeguarding concern

If you receive a call concerning safeguarding, complete the safeguarding concern form in the corresponding episode on Frameworki and then discuss with the manager/senior who will decide the appropriate response.

Manager/Senior: If the concern is about an adult with mental health or substance misuse issues, then send it on to the appropriate Mental Health or Substance Misuse service to respond. If it relates to an older person or an adult with physical disabilities, then decide the appropriate action, based on your risk assessment. Record your decision-making process on the safeguarding concern form. If you decide the concern needs to be acted on, then forward the safeguarding concern to the appropriate team; if urgent, also phone them. If you are unsure whether this is a safeguarding issue, then speak to a manager with whom you can discuss the concern, and, if you need to, consult the Safeguarding Adults Leads. See also Safeguarding procedures (see **section 3.3.4**).

5.7 Request for information

Under the Care Act 2014, local authorities must provide comprehensive information and advice about care and support services in their local area. This will help people to understand how care and support services work locally, the care and funding options available, and how people can access care and support services.

So providing relevant and accurate information and signposting the caller to appropriate organisations who may be able to help is an important part of the role of the Adviser.

Adviser: If the caller is requesting information about care and support services for adults or support services for carers, deal with the query using the **People First website** as necessary/appropriate and give the caller relevant information and advice. Where possible, transfer the call to the appropriate department or organisation. If appropriate, give the caller contact details of external organisations (including voluntary and community organisations) who may be able to help. Explain to the caller that the public and other professionals outside the Council can consult the People First website should they wish to find more information themselves. See also **section 3.3.1**.

RBKC Adviser only: Enter wrap up code on 59R.

If the call goes beyond providing information, go to **section 5.11**.

5.8 Calls about Accessible Transport

If the caller wishes to enquire about accessible transport (blue, white and purple badges, personalised parking bays for disabled people, taxicards, freedom passes), transfer them to the appropriate department or, if they prefer, give them the relevant department details – see below. Also refer them to the People First website.

LBHF and RBKC: Accessible Transport Service (in RBKC, ATS is in SSL)

WCC: Transport department

RBKC Adviser only: Enter wrap up code on 59R.

5.9 If the person is known and the case is open, and the call needs to be transferred to community or hospital team

Adviser:

If the call is about a person who is known to Adult Social Care and whose case is open, find the record of the person on Frameworki. Note any warnings about the person (see **section 40.6**). If there are no warnings and no restrictions (which will be displayed on the main screen 'personal details'), and the caller has a legitimate interest, then proceed with the rest of this section.

Legitimate interest: It is important to make sure that the caller is who they say they are, so if you are in any doubt, if it is a phone call, take the caller's number and ring them back. A caller has a legitimate interest if they are a professional involved in the care of the named person, or if they care for the named person, or if they are a friend or relative with concerns about the named person.

Whilst you may decide to pass the call to another team, do not give out any personal information about the named person to the caller unless the named person has given consent.

If the case is open to an allocated worker, transfer the call to the allocated worker or to the team duty number if the worker is not available. If the call goes to answer phone, then email the team with details of the call. The allocated worker will then either action the query if relevant to them, or complete a case note and send an alert to the relevant team.

If the call is about a person who is open to a team without an allocated worker, then hold an initial conversation about the reason for the call. There are basically two options:

- If the call is relevant to the team to which the case is open, then transfer the call to the duty worker of the team to which it is open (or deal with it appropriately if it is your team to which the case is open).
- If the call is not relevant to the team to which the case is open, take some more details and redirect the call to the team to which the call *is* relevant.

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If the case is open or the person is known someone must be dealing with it – the contact centre will not be able to do anything more than specialist or locality teams can. Make the decision about where the call should go: this keeps a level of consistency for the person/caller and avoids them speaking to more people than necessary.

5.10 If person is not known and call is about specialist services

Adviser:

If the caller wishes to discuss learning disability, mental health, sensory impairment, homelessness or substance misuse issues, first seek to provide information using the People First website, following the guidelines in **section 5.7**. If further assistance is required, transfer the caller to the relevant specialist team (who go to **Section 6**).

In particular, if you receive a referral about mental health, then redirect the referrer to the individual's GP to make a referral direct to mental health services. If the referral is urgent, then transfer the referrer to the AMHP duty service of the mental health team.

RBKC Adviser only: Enter wrap up code on 59R.

5.11 If person is not known (or is known and the case is closed) and you decide a referral is required

Adviser:

If a call goes beyond providing simple information and the call is not about specialist issues, then check whether the caller is willing to give details of the person they are phoning about. If yes, then go to **Section 6 REFERRALS**.

Encourage the caller to give relevant information, but if the caller is not willing, then provide any additional non-personal information they request. However, if the call has alerted you to concerns, then discuss with your manager.

RBKC Adviser only: Enter wrap up code on 59R.

5.12 Hospitals

Adviser:

Redirect all referrals from NHS hospitals about social work to the relevant Hospital Team:

LBHF: Charing Cross Hospital: [redacted] for reception; duty is [redacted]

RBKC: Chelsea and Westminster Hospital on [redacted]. Redirect referrals from private hospitals to AIA team. Fax all Schedule 3 assessment/discharge notices to fax number [redacted]

WCC: Hospital team [redacted]

These guidelines cover the majority of cases. But use common sense and check with your manager/senior social worker if you are not sure.

Do your utmost to ensure that the call does not get lost in the system. If the call is urgent, then make sure you talk to someone either in person or on the phone, and that the individual you talk to has taken responsibility for taking action.

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6 REFERRALS

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

6.1 Introduction

This Section is guidance for staff taking referrals. You may be a member of staff in an assessment team or an adviser in one of the following teams:

LBHF: H&F Advice

RBKC: Social Servicesline (SSL)/ AIA

WCC: Citywide Access Service for OP/PD: Access Team

You will have reached this point in the process after dealing with an initial contact – see **section 5.11.**

Please Note: Learning Disabilities and Mental Health services have their own access points.

A **referral** is a request for action by Adult Social Care on behalf of a specific person who appears to have social care and support needs who is either not known to the department or whose case has been closed, which is accepted by a member of staff as requiring further action. A referral can be made by anyone, either for themselves or on behalf of another person. A referral can be made by phone, by letter, by fax, in person, or by email. Giving general advice is not a referral, but is an enquiry.

When does an enquiry become a referral? An enquiry is essentially a single discussion with the caller in which you are able to provide them with the information they require, and for which it is not essential to know the name of the caller or the person they are calling about. A referral is when you carry out action(s) which require you to know the name of the caller and the person they are calling about. We take information about individuals only when it is necessary for us to carry out our responsibilities or to determine whether or not they are already receiving services from the Council.

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6.2 Standards

The following standards apply:

A no reply must be responded to immediately.

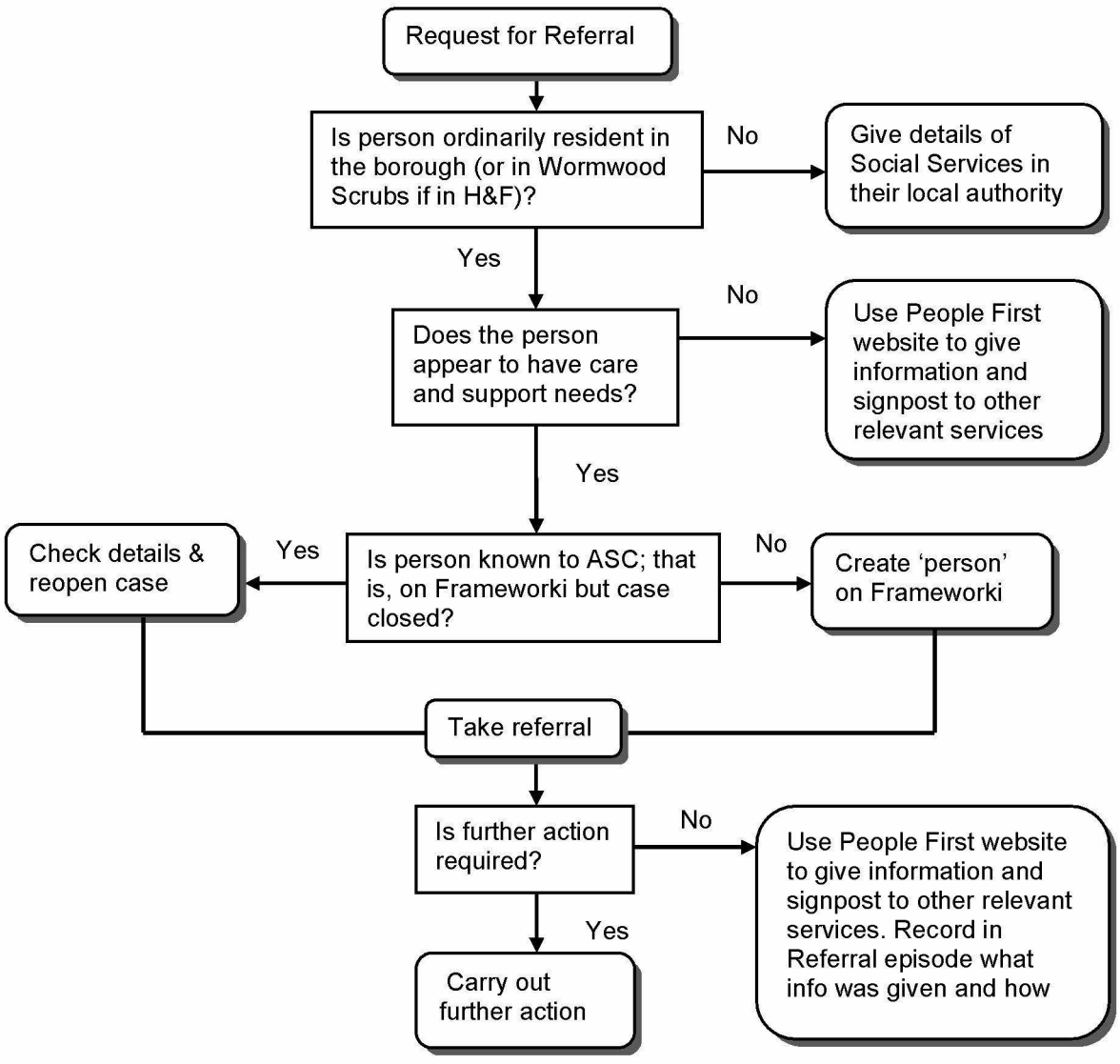
A safeguarding concern must be responded to within 2 hours.

A referral with an element of risk identified must be acknowledged and processed if possible within 24 clock hours of initial contact.

A referral with no element of risk identified must be acknowledged and processed if possible within 48 clock hours of initial contact.

These are key quality performance indicators which reflect the need for a quick and helpful response.

6.3 Flowchart



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6.4 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

Safeguarding concern – see also **section 5.6**.

6.5 Dealing with a request for a referral or an assessment

If the caller requests a referral or assessment for themselves or a third party, or if you decide a referral is required, then establish whether the named person is or may be an adult with social care needs or a carer of one, and that they are ordinarily resident in the borough (see **section 3.5**). Check with the referrer and record whether the person being referred knows that a referral is being made, and that the referrer has the permission of the person being referred.

6.6 Checking whether person is known

Provided the named person is being referred to Adult Social Care as the appropriate service, that is, they appear to have social care and support needs, search Frameworki to find out whether the person is already known to the Council.

If the person is known, but is not an open case, then check personal details; do not add to Frameworki again. Go to **section 6.9**.

If the person is not known, then set up as a new person on Frameworki, and continue as described below.

RBKC only: Search the Person Index (see **section 5.3**) to find out whether the person is already known to the Royal Borough but not on Frameworki. If the person is not known then add the person details and create a 'person' on the Person Index.

Please Note: It is important to prevent creating duplicate records for the same person.

6.7 Ordinary Residence

Please Note: Social care and support services are available to adults with eligible care and support needs who are residents in the relevant borough, or to carers with eligible support needs who are caring for someone with social care needs who is resident in the borough; Health services are available to adults registered with a GP in the relevant borough.

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For more information on 'ordinary residence', see **section 3.5.**

Please Note: Do not delay a referral or an assessment whilst ordinary residence is being determined.

6.8 Carers

If you are dealing with a request for a carer's assessment:

- Create a separate record for the carer with any attachment. If the cared for person is also being referred or is already on the system, make sure you complete the personal relationship section in order to connect the two records together.

RBKC only: Create a 'person' on the Person Index for the carer. Note: this is important because later in the process any payments for a carer's budget are run through the Person Index.

6.9 Start a New Referral

If you decide that a new referral is required, complete the referral form on the Referral episode on Frameworki using information provided by the referrer. (Requests that do not require a new referral will have already been dealt with – see **Section 5**.) Complete all the fields.

Give the caller a contact telephone number in case of further difficulties.

Staff from Hospital Team, go to **section 6.12.**

RBKC and WCC: for Older Adults Community Mental Health Team, go to **section 6.14.**

RBKC and WCC: for Substance Use, go to **section 6.15.**

For Learning Disabilities team, go to **section 6.16**.

For sensory impairment, go to **section 6.17**

For young people in transition, go to **section 6.18**.

Recommend the referral decision:

- No assessment required; information and advice – in this case, use the People First website to give the referrer information and advice and signpost to appropriate services. Email or send them hard copy of the information, using large font if the person requires it. Record in the Referral episode on Frameworki what information and advice you have given and in what form. Forward the referral to your manager to sign off.

No Further Action – sometimes it is important to record that a piece of work has been carried out for a person even though no further action is required at the present time. For example, there may be a possibility that they will contact the

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department again later and it will be important to know what happened previously.

- Further assessment required – forward the referral to your manager to sign off.

If the referrer stops the process before sufficient information is added, then discuss the referral with your manager/ senior and follow their instructions.

Manager: Check and sign off referral form on Frameworki.

6.10 Dealing with Referrals

6.10.1 LBHF:

H&F Advice Worker:

- Send cases that at first sight appear to be in the "less complex" range – that is, issues likely to be resolved within six weeks – to the Community and Hospital Assessment Service.
- Send cases where there are indications of complexity to the Adult Community Social Work Service. There may be instances where further investigation indicates that a simple situation is actually complex – there will then be a manager to manager negotiation as to which team should have the case.

Duty Manager: Decide what happens next – whether any immediate action needs to take place on the respective duty desk or whether the case goes straight to the awaiting allocation list.

6.10.2 RBKC: AIA Team Process

This section provides guidance to staff in the RBKC Advice, Information and Assessment (AIA) team receiving referrals from SSL or directly from a member of the public or other professionals.

AIA duty worker: receives in their duty inbox:

- filled-in referrals from the SSL team or from community teams – screen the referral to make sure it does require assessment of an individual or a carer or both

  AIA Duty Manager: if accepted, sign and put on waiting list for allocation to an AIA team member ("the assessor")

- filled-in referrals where the case is complex (for example, involving self neglect or hoarding, or the person has more complex cognitive impairment, or there are difficult family dynamics) or there are safeguarding issues; then pass the referral or in-progress assessment on to a community team following a verbal discussion with the receiving team manager

- filled-in referrals where more than one assessor needs to be involved in the first assessment; for example, social worker and occupational therapist (OT) due to complexity and variety of the need.

  AIA duty manager: Agree with the OT about the need for OT involvement. Allocation to the OT is completed by the OT or an OT manager

- emails indicating No Further Action (NFA) from the SSL team – the manager either approves the NFA, in which case they sign it off on Frameworki; or if they have concerns, they do not approve it and allocate it to an AIA team member ("the assessor").

Assessor: Decide what action is required for each case:

- Arrange to carry out an assessment; always consider Community Independence Services as the first option. (See **Sections 7 COMMUNITY INDEPENDENCE SERVICE and 8 REABLEMENT**.)
- If the referral will obviously require complex equipment or adaptations, AIA OT passes the referral or in-progress assessment on to the relevant Occupational Therapy service, changing the name of the assessor. See **section 9.19.6**.
- If there is insufficient information provided, contact the referrer or the individual being referred to find out further information (after which the process is repeated).
- If no further action is required, pass the case back to the duty manager for approval.

Duty Manager in locality team: Approve the referral.

6.10.3 WCC: Adults Access team

I&AO (Information & Access Officer):

- Receive information about possible referral either by fax, team email/secure email from health/or phone, or calls transferred by WCC Contact Centre or message emailed directly to the access team
- If there is insufficient information provided, contact the referrer or the individual being referred to find out further information.
- Sign post to other services or organisations if the person does not appear to have care and support needs using People First, Community Hubs.

- If referred adult does appear to have care and support needs, or the referral is for a carer providing support to an adult, then on Frameworki open and complete Referral episode. Send to Access Manager.
- If referral is for link alarm or key holding, carry out assessment for these services, process them until they are in place and then set up annual review for access team.

Access Manager: Agree outcome to send to either:

  - reablement to screen
  - locality care management team to assess if the person is unlikely to benefit from reablement

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- Able 2 (OT contract) for complex equipment

If the case is already 'open' then use case notes and alerts.

If urgent (same day) care is required then set up this care before passing on.

6.11 Police Referrals: Vulnerable Adults Coming to Notice (VACN) (Merlin) reports

Check the Merlin reports:

- If the report relates to a person with mental health or substance misuse issues, then send to the appropriate Mental Health or Substance Misuse team.
- If the report relates to a person known to Adult Social Care send to the team to which the person is allocated (mainly locality/ community teams).

Access Manager:

- If the notice is about an older person or a person with physical disabilities not currently allocated, then assess the risk and decide appropriate action.

6.12 Hospital teams

The Hospital teams receive assessment notices and discharge notices under Schedule 3 of the Care Act. They may also receive emails in their in-box from the relevant contact centre or from community/locality teams about known individuals who have been admitted to hospital.

Business Support:

- Check each notification to make sure the person is ordinarily resident in the borough, and follow the process for taking a referral described above in **sections 6.6 – 6.9**.
- For a new referral, enter relevant information into Hospital Admission/ Discharge episode.

RBKC and WCC:

- ***Business Support:*** Send the relevant information to the allocated worker for that ward/section, and a copy to the duty manager.
- ***Social worker/ Care manager:*** Complete the referral and follow up accordingly, either arranging reablement (see **Section 8 REABLEMENT**), or assessing for longer-term care if the person is not suitable for reablement.

LBHF:

Duty Manager:

- If the person is likely to be suitable for reablement, arrange assessment to determine a) the level of functional ability (carried out by OT) and b) the adult social care needs, to determine the initial level of care needed. Refer to the Reablement Service (see **Section 8 REABLEMENT**) to arrange reablement for

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up to six weeks. If the Reablement Service does not have the capacity to provide a service on discharge, then where necessary to avoid delay of discharge, commission agency care until Reablement can take over.

- Where there are complex needs and the person is not suitable for reablement, transfer to a social work manager to check the referral and where appropriate allocate to a social worker for assessment.

6.13 Hospital OT equipment orders

See **Section 17 OCCUPATIONAL THERAPY.**

6.14 Mental Health

RBKC and WCC: Older Adults Mental Health team:

The majority of referrals to the Older Adults Mental Health teams (CMHT) come from GPs. These teams assess the person's mental state if there appears to be a need in this area. Access teams and mental health teams need to establish which team is responsible for adult social care needs in the short term if needed for example with emergencies. If the mental health services determine that the adult has care and support needs, then they will be responsible for meeting these needs and a case manager from the team will be allocated to carry out an assessment. In such a case, also record under Care Programme Approach (CPA) procedures.

LBHF: Consider whether reablement would be appropriate for a person with mild dementia. If the dementia is more severe, then a core assessment is carried out by a social worker from a community team. People with functional mental health are dealt with by mental health teams.

6.15 Substance use

If a person is in the community and has alcohol issues and care and support needs but not requiring detox, then pass them to the appropriate community social work team for assessment.

Individuals who require an assessment for treatment, detox and/or rehabilitation are dealt with by the appropriate Substance Use team or Drug and Alcohol Team (DAAT) (see **section 9.19.4**).

6.16 Learning Disability Partnerships

On receipt of the referral and information, staff from the LD partnerships put into action a detailed process to determine whether a person can access their services. Staff have their own assessment procedures which involve testing of the cognitive abilities of the person. They also use standard assessment forms to assess the person's adult social care needs. The response must be verbal and in writing, using the language of choice and accessible to the person being referred.

Whilst this determination is being carried out, assess and address any immediate needs.

6.17 Sensory impairment

People with sensory impairment are dealt with by the Community Independence Service.

To be expanded

6.18 Transition

For young people in transition from Children's Services to adult services, see **Section 31 TRANSITION**.

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7 COMMUNITY INDEPENDENCE SERVICE

7.1 Introduction

This section describes the Community Independence Service.

The aim of CIS services is to maximise people's independence to remain at home safely: they work with clients for a short period of time usually up to six weeks. The service receives referrals from the relevant borough contact centre, review team or community team. CIS also manage discharge from hospital.

7.2 CIS services

CIS provide a range of services.

- reablement (see **Section 8**)
- community or bedded rehabilitation accessed via the Community Rehabilitation Team (CRT) which is managed by Health and includes input from occupational therapists and physiotherapists
- telecare and assistive technology
- moving and handling
- social work
- occupational therapy
- sensory impairment specialist assessment and care and support
- Intermediate Care
- In-Reach.

7.2.1 Longer-term support

If it is identified that the service user may require longer-term support, then arrange a core assessment. CIS workers carry out core assessments or re-assessments for longer-term stable support. Assessments of more complex needs (for example, involving self neglect or hoarding, or the person has more complex cognitive impairment, or there are difficult family dynamics) or safeguarding enquiries are carried out by Community teams. See **Section 9 ASSESSMENTS**.

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8 REABLEMENT

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

8.1 What is reablement?

Reablement is the process of improving a person's ability to carry out activities of daily living for themselves, and restoring or improving their level of independence, through regaining lost skills, acquiring new ones and restoring confidence, following a crisis in their lives (for example, being in hospital). Reablement is a time-limited intervention of usually up to six weeks, but can be longer in certain circumstances; for example, following a stroke. Reablement is a free service.

Most people who have care and support needs are given reablement in order to increase their level of independence: it will be the exception for a person not to undergo reablement.

Where a person has the capacity to refuse reablement, a short-term care and support package could still be offered and reviewed at the six week stage. If ongoing care and support is required, a financial assessment would take place at this point.

8.2 When to use reablement

Reablement services can be accessed either from the community or from hospital.

Reablement and other community independence services should always be considered first before developing a longer-term care and support plan. Offer reablement services to the person if there is potential for the person to become more independent. Reablement is a new concept for many people and needs to be explained carefully. Some people may believe that care should always be provided. Be sensitive about their concerns but explain the benefits in terms of increased independence and less need for care and support longer-term. Explain that it is important for the person to engage positively in the process (if their cognition or mental health allows them to do so) if they are to regain independence.

The period of reablement is normally up to six weeks; it can be for a shorter period where appropriate. Reablement is not 'six weeks of free care'.

People unlikely to benefit from reablement include those who require palliative care or continuing health care, but in these cases other CIS services can help the person to be as independent as possible – for example, with the provision of appropriate

equipment. In addition some people with advanced dementia may not benefit and each case should be considered in relation to the person's level of cognitive impairment and the ability to engage and benefit from the intervention.

Where the person has a large care and support plan, reablement intervention relating to specific goals may still be appropriate: discuss this with your team manager and the Community Independence Service (CIS).

It is possible for an individual to have more than one episode of reablement relating to their changed needs; for example, hospital admissions for differing medical needs.

If you are unsure about whether there is potential for a person to become more independent through reablement, discuss the case with your team manager and the Community Independence Service (CIS).

8.3 Other reablement routes

- Individuals with learning disabilities follow their own reablement programme within the Learning Disabilities service.
- Individuals with mental health and drug and alcohol problems follow recovery models within their own service.

8.4 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

8.5 Setting up reablement

Reablement providers are:

LBHF and RBKC: in-house reablement teams

WCC: Allied Healthcare provider

8.5.1 Hospital:

Social Worker: If the assessment has identified that reablement if appropriate, then contact the provider to arrange services to enable a safe discharge.

The reablement service will then contact the person as soon as possible after discharge (this will be within 24 hours in the specification for the new contract) to review the arrangements and adjust accordingly within the home setting.

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8.5.2 Community

Contact Centre worker (AIA or Access Service or H&F Advice):

- If urgent, contact provider to set up immediate emergency services.
- Otherwise, open case to Reablement Team.

Reablement Team worker:

- Contact person within 24 hours to inform them that they will be assessed soon for reablement services. Arrange to visit to assess and to set goals for reablement period.

- Carry out assessment, set goals, and arrange services to start as soon as possible. Complete Reablement forms on Frameworki.
- Review services every two weeks. If it is clear that the person will require longer term support after the period of reablement, then arrange to carry out core assessment (see **section 9 ASSESSMENTS**).

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9 ASSESSMENTS

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

9.1 Introduction

Under Sections 9 and 10 of the Care Act 2014, a local authority has a duty to assess an individual who appears to have need for care and support regardless of their eligibility for local authority services: the assessment must be fit for purpose and proportionate to the presenting needs. Chapter 6 of the Care Act Guidance applies.

See **Section 11 CARERS** for duty relating to assessment of carers.

This section provides guidance for **assessors** (customer services adviser, occupational therapist, social worker, social care assistant, rehab assistant, care manager) in carrying out an assessment of needs for care and support. It is also intended for managers signing off assessments.

An individual's financial situation must not pre-empt or influence the assessment of their social care needs.

9.2 Standards

Completing core assessments for long-term care and support within **28 days** is a key quality indicator for users.

For adults in hospital it is essential to record the date and time of receipt of assessment notices under Schedule 3 of the Care Act[5]. The local authority must carry out a needs assessment, determine whether any of these needs meet the eligibility criteria, and put in place any arrangements for meeting such needs in relation to a patient and, where applicable, carer, **before "the relevant day"**. The relevant day is either the date upon which the NHS proposes to discharge the patient (as contained in the discharge notice – see below) or the minimum period, whichever is the later.

The minimum period is **2 days** after the local authority has received an assessment notice or is treated as having received an assessment notice.

Any assessment notice which is given after 2 pm on any day is treated as being given on the following day.

If a Schedule 3 assessment notice is issued it must be accompanied by a completed continuing health care check list.

[5] given under paragraph 2(1)(b) of Schedule 3 to the 2014 Care Act

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The minimum discharge notice under Section 3 is at least **one day** before the proposed discharge date. Again, where the discharge notice is issued after 2 pm, it will not be treated as being served until the next day.

Safeguarding actions and case notes must be recorded on the same day as the action was taken or within **24 hours** at the latest.

The record of assessment must be updated on Frameworki as soon as possible but at the latest within **3 working days**. (See **Section 40 RECORDING**.)

9.3 Purpose of assessment

The purpose of any assessment is:

- to identify the needs to be addressed, and the impact of the person's needs on their wellbeing and day to day life, both during a period of reablement and as required in the longer term
- to identify the person's own strengths and capabilities
- to identify which of these needs are already being met or could be met by other forms of support
- to identify any risks and decide how to respond (see **Section 10 RISK**); in particular, to determine whether there are safeguarding concerns, or a need for urgent care
- to determine which of the person's needs are eligible for Council services under the national eligibility criteria
- to identify the person's wishes and preferences
- to agree the desired outcomes the person wishes to achieve
- to support the person to make an informed choice about each type of support that is being offered to them, and, if in doubt, assess their capacity to make each decision in question
- to determine whether there is a carer or carers, and whether they have eligible support needs.

9.4 Methods of Assessment

Assessments can be carried out in a number of different ways:

- face to face
- a supported self assessment where the person completes the core assessment themselves and this is then validated by the local authority (see **section 9.9**)
- telephone/online assessment – this may be suitable for less complex cases or for re-assessments
- a combined assessment to avoid unnecessary duplication (see **section 9.18**)

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- joint assessments where an adult's assessment is combined with a carer's assessment, or an assessment relating to a child carer or an assessment of a child in transition to adult services, to ensure as efficient a process as possible.

9.5 Arranging the assessment

Assessor:

- Check for any Warning Indicators on Frameworki. (See **section 40.6**.)
- Contact the person (or the carer where appropriate) to arrange the assessment.
- Check any communication needs, including translation, and arrange for any necessary support.
- Give the person as much information as possible about the assessment process, including the likely timescale, in a format they find accessible.
- Consider the impact of the assessment on the person's condition: consider the timing and location and method of assessment.
- Encourage the person to invite members of their circle of support whom they would like also to be present at the interview.
- Where appropriate, send an **appointment letter** to the person, with the assessment information leaflet, which contains a list of the questions to be covered.

9.6 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

9.7 Consent to sharing information

Obtaining and recording consent is vital for the safe and legal sharing of personal information.

Assessor: Explain to the adult and their carer that in order to understand their situation fully, it may be helpful to discuss with other staff and organisations what they know and to share information that we have about individuals. Only information about an individual's health and care needs will be shared. Explain that if they do not give their consent to sharing such information, it may not be possible to give them a full service. Record the results of the discussion, whether the person gives consent (and what specific information they consent to be shared) or not.

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For further details, including guidance on when information may be shared without consent, see **section 3.4 Confidentiality and Information Sharing**.

9.8 Whole family approach

Assessor: During the assessment you must consider the impact of the person's needs for care and support on family members or other people you feel appropriate. Consider whether or not the provision of any information and advice would be beneficial to those people you have identified. For example, this may include signposting to any support services in the local community. In particular, if there is a carer involved, see **section 9.15**.

You also must identify any children who are involved in providing care. Where appropriate, consider whether to refer to Children's Services to undertake a young carer's assessment or a needs assessment under the Children Act 1989, or whether to undertake a young carer's assessment under section 64 of the Care Act. When carrying out an adult's or carer's assessment, if it appears that a child is involved in providing care, consider:

- the impact of the person's needs on the young carer's wellbeing, welfare, education and development
- whether any of the caring responsibilities the young carer is undertaking are inappropriate.

If you have concerns about possible domestic abuse, see also **section 34.17**.

9.9 Supported self-assessment

The (Supported) Self Assessment (SSA) is a document designed to help the assessor and person talk through the needs of the individual. Offer a supported self assessment if the adult or carer is able, willing and has capacity to undertake it. If they wish to complete it, send the SSA to the person in advance of the needs assessment interview with an **accompanying letter** so that they have an opportunity to read through the areas that will be discussed and to think through what they feel their needs are.

Please Note: **In some cases, the person may be unable to complete the SSA even with help; for example, if they are significantly cognitively impaired or have a functioning mental health problem. In this case, work with the service user's carer(s) or informal advocates, such as family members or friends, to complete the SSA.**

It is important to explain to the person that the SSA will be used alongside the needs assessment, and any existing care and support plan or previous review to help allocate an indicative personal budget that will be used to address their care and support needs.

While discussing the needs and helping complete the SSA with the individual, explain the potential choices available to them; to choose a direct payment instead of

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Council-commissioned services, to choose council or third party managed services or to have a combination of both.

Please Note: you must offer the option of using direct payments at several points throughout the assessment and care and support planning process.

9.10 Conducting the assessment

Assessor: Have regard not only to the Care Act, but also to the Sex Discrimination Act 1975, the Disability Discrimination Act 1995, the Human Rights Act 1998, the Race Relations (Amendment) Act 2000, Age Legislation 2006 and Equalities Act 2010. (See **Section 45 LEGISLATIVE FRAMEWORK.**)

For instance, this means that under the Equalities Act, you need to make reasonable adjustments to ensure that disabled people have equal access to information and advice on care and support and keeping safe from abuse or neglect. Many people with some form of cognitive impairment, mental health problem, substance use, or other difficulties, might need extra support to be involved in the assessment, support-planning or reviewing process.

Checklist

Make sure that during the assessment process, you inform the adult and their carer (where relevant) about:

- **the purpose of the assessment**
- **the need for their consent if they wish us to share information with other professionals in order to provide more complete services**
- **ordinary residence conditions (see section 3.5)**
- **eligibility criteria, making it clear that not everyone will have eligible support needs**
- **the charging policy, making clear that those that have eligible needs will have to contribute up to 100 per cent towards their support (except in LBHF)**
- **reablement and community independence**
- **personal budgets, support planning and direct payments**
- **where relevant, details of specialist services**
- **carers' assessments and support services**
- **the appeals and complaints procedure**
- **the right to have access to records.**

Make sure you take the relevant information on the visit with you.

Check whether the person is distressed by the assessment process. If so you may need to consider ending the assessment and seeking advice from a manager.

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If you identify that there are needs requiring urgent care, address these immediately and arrange the necessary services. Local authorities can meet urgent care and support needs *regardless* of the person's ordinary residence (see **section 3.5**).

If you do not have the necessary knowledge of a particular condition or circumstance, you must consult someone who has relevant expertise. Contact a social worker or occupational therapist as required.

During an assessment if there is the appearance of sensory impairments, even if when taken separately each sensory impairment appears relatively mild, you must consider whether the person is deafblind and if they are, this must trigger a specialist assessment. See **section 9.19.2.**

9.11 Principles of assessment

There are lots of things to think about when carrying out an assessment. The most important are outlined below.

- **The success of the assessment is dependent on the relationship and communication between you and the person and advocate where involved. Communicate with the person in a way that they understand and which enables them to participate fully in the assessment.**
- **Actively seek consent to the assessment process and support the person's participation in it. See also section 9.6.**
- **Base your approach to the assessment on the promotion of wellbeing and other principles described in Section 3. Consider whether the individual's needs impact upon their wellbeing beyond the ways identified by the individual. An example is where an adult expresses a need re their physical condition and mobility: establish the impact of this on the adult's desired outcomes and whether their need(s) have further consequences on their wider wellbeing, for example, their personal health or the suitability of their living accommodation.**
- **Assessing is about developing an understanding of the individual's needs, concerns, wishes and preferences, and desired outcomes, that is, what they would like to achieve with a suitable support plan. The adult may also want to identify personal outcomes – for example, to learn a foreign language. These should be recorded (separately from social care outcomes) but, when planning support, make clear which needs and outcomes are eligible for council funding and which need to be met from other sources.**
- **The assessment begins with a discussion rather than filling in a form. The form is the tool on which to record the assessment.**
- **Keep the scale and depth of assessment in proportion to the needs of the individual. Make the assessment flexible to meet the individual case. Identify needs and risk factors but ensure that the information gathered is pertinent to the assessment to avoid unnecessary intrusion and invasion of privacy. At the same time, continue to look for the appearance of further needs which may be the result of an underlying**

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condition. Where you believe that the person's presenting needs may be as a result of or a part of wider needs then undertake a more detailed assessment.

- Assessment is a continuing process and in some cases it can take some considerable time to gain the trust and confidence of the person before a complete assessment of needs is possible. This may be particularly true of people with complex needs, people who are homeless, people with mental health problems, or when abuse might be indicated. There are particular problems in assessing the needs of people with dementia. The assessor needs to use information gained through observation, through sensitive and active listening, and by talking to carers and relatives where appropriate.
- Identify needs that are likely to be best met by other agencies or services such as Housing or the NHS, and make appropriate referrals for specialist assessments, including preventative services.
- Focus positively on what the individual can do and their strengths as well as what they cannot do, taking account of their personal and social relationships. Look for opportunities to optimise independence. Good assessment is needs-led and person-centred and should not focus on the person's suitability for a particular existing service.
- Consider the person's home/physical environment, what difficulties they have with access and mobility, and chair, bed, toilet and bath transfers, and in what way these difficulties could be minimised; any presenting physical impairments; and daily living skills including personal care including dressing and feeding, communication, and domestic tasks.
- Assess risks. You must record this as it is an important part of the core assessment. (See Section 10.)
- Assess the carer's willingness and ability to provide care and support, and in doing so, offer choices. (See section 9.15.)
- Take into account fluctuations over time.
- Ensure that you record evidence for the rationale for risks identified and conclusions reached (see section 9.16).
- Be transparent at all stages of the process.

9.12 Questioning techniques

Consistent with a person-centred approach is the need to use appropriate questioning techniques. Use open questions such as those listed below and including What? When? How?, and in addition 'Describe' and 'Tell me about' are particularly effective and reinforce the strengths and capabilities model.

Examples of good open questions to ask adults are:

1. What is working for you?

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2. What is not working for you?

3. What is important to you? (quality of life issues)

4. What is important for you? (health and wellbeing and safety issues)

5. What things are difficult for you?

6. Describe how they affect you living your life

7. What would make things better for you?

8. What is stopping you from doing what you want to do?

9. What risks, if any, exist?

10. How could things be done in a different way, which might reduce the risks?

11. How does your current housing situation impact on the risks you have identified?

12. What do you need to do?

13. What could family/carers do?

14. Who is important to you?

15. What do people important to you think?

16. Are there any differences of opinion between you and the people you said are important to you?

17. What would help to resolve this?

18. Who might be able to help?

19. What are you able to do to make the changes you want to make?

20. What could we (practitioner and others involved) do to support you?[6]

Assessment draws on a number of techniques. Alongside questioning, direct observation by the assessor is key, as is utilising resources, including reablement and the provision of equipment to provide the assessor with an accurate picture of the person's abilities and difficulties.

9.13 Outcomes

The Guidance states that the purpose of a needs assessment is to identify the adult's needs and the outcomes that they wish to achieve in their day to day life, and how the provision of care and support may assist the individual in achieving their desired outcomes.

There are two ways in which outcomes are discussed within the Care Act and guidance.

[6] Ref: Adapted from Independence, choice and risk: a guide to best practice in supported decision making Department of Health 2009

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Desired outcomes (of the individual): these are the outcomes a person wishes to achieve in order to lead their day-to-day life in a way that maintains or improves their wellbeing. They will vary from one person to another because each individual will have different interests, relationships, demands and circumstances within their own life. These are the outcomes that need to be identified at the assessment and then refined at the support planning stage. Desired outcomes are the end result, not the means to the end. They are the *difference* the support makes to the carer's quality of life.

Desired outcomes need to be defined broadly at the assessment stage and then refined and further specified in support planning (see **section 14.5 Outcomes**).

Assessor: Discuss with the individual the desired outcomes that the person wishes to achieve in their day to day life, and record them on the assessment form on Frameworki.

It is important that a person includes all desired outcomes that are important to them and not just those that may be relevant to adult social care. Explain to the adult that only those desired outcomes which are adult social care related may be eligible for Adult Social Care funding. With other desired outcomes, an assessor may be able to offer advice, guidance or suggestions, or through the discussion, the person may come up with their own suggestions/solutions to achieving their desired outcome.

Where a person is unable to express their desired outcomes, it is important to see whether they have previously been able to write down or express their views in any way to family, friends or others.

The second set of outcomes, described below, are the specified **eligibility outcomes**, which form the second of three conditions, all of which must be met for an adult to be eligible for support.

9.14 Refusal of assessment

A person who appears to have needs for care and support can refuse to participate in the process.

Assessor:

- If you are concerned that the person may lack capacity to make this decision, then carry out a mental capacity assessment, and record it. If the person lacks capacity to give consent, then take a decision as to whether an assessment is in the best interests of the individual. (See **section 3.3.1 Information and advice, participation support and advocacy**.)
- In situations where a person declines support, and has capacity, this could be seen to constitute self neglect and may include or be associated with hoarding. See **Section 27 SELF-NEGLECT, HOARDING, UNSAFE ENVIRONMENT** and **Section 28 PEOPLE REFUSING CARE AND SUPPORT**.

Where a person has refused an assessment but later requests one, the local authority must carry out the assessment. Where a person refused an assessment and the local authority establishes the needs or circumstances have changed, the

local authority must consider whether it is required to offer an assessment, unless the person continues to refuse.

9.15 Carers

Assessor: During the assessment, consider all of the adult's care and support needs, regardless of any support being provided by a carer. Where the adult has a carer, capture information on the care that they are providing during assessment, but it must not influence the eligibility determination. After the eligibility determination has been reached, if the needs are eligible or the local authority otherwise intends to meet them, take into account the care which a carer is providing during the care and support planning stage. The local authority is not required to meet any needs which are being met by a carer who is willing and able to do so, but record where that is the case. This ensures that the entirety of the adult's needs are identified and the local authority can respond appropriately if the carer feels unable or unwilling to carry out some or all of the caring they were previously providing.

Where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of need for support, arrange to carry out a carer's assessment. (See **Section 11 CARERS**)

In particular, if there is a young carer involved, then consider the impact of caring on the young carer, and whether there are any caring responsibilities that are inappropriate. (See **Section 11 CARERS**.)

9.16 Recording the assessment

Assessor: Record the assessment (including both needs and broad desired outcomes) using:

- either a Core Assessment (adults including mental health), or
- a Sensory Impairment Assessment, or
- an Occupational Therapy Assessment (OT), or
- a hospital discharge proportionate assessment, or
- a reablement assessment and goal planning form.

Substance Use and Dual Diagnosis services have their own assessment tool.

The assessment report and subsequent clinical reasoning form the basis of all decision-making by staff. Make sure that the assessment report can be understood by anyone that the person chooses to allow to read it. Proof read the assessments to ensure a good standard of English.

The needs identified from the assessment must be clear and specific. Separate out the individual needs to ensure that subsequent intervention can be referenced back to the needs that are to be met.

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Needs must be non-prescriptive in terms of provision. The need should reflect the nature of the problem and not the recommendation that will be made to meet that need. For example,

> **"would benefit from opportunities to meet and talk with other people" or "needs to engage in significant activity during the day"; rather than "go to day centre"; or**
>
> **"manage toileting during the night" rather than "use a commode every night".**

Clearly record any differences of opinion between you and the adult or carer. Where you have obtained information from another professional, note and attribute this information. (See **Section 40 RECORDING**.)

Ensure that any mental capacity assessment has been recorded.

Record risks on the appropriate Risk Assessment – see **Section 10**.

Make sure that you leave your full name and telephone extension and the name of your team and an alternative contact number for emergencies with the person.

9.16.1 Processing the assessment

Assessor: Once the assessment has been completed:

- Discuss with your manager any concerns that have arisen whilst completing the assessment.
- Complete all appropriate requests for specialist assessments (see **section 9.19**).

Manager: Check and approve assessment.

9.17 Eligibility Criteria

The next step is to determine whether the adult has eligible needs for care and support from the local authority. The Care and Support (Eligibility Criteria) Regulations 2014 set out the criteria for eligibility for both adults with care and support needs and for carers. The core entitlement for adults to care and support is about *meeting need*, rather than *providing services*. The Act introduces a minimum threshold which applies nationally. The threshold is based on identifying how a person's needs affect their ability to achieve relevant eligibility outcomes, and how this impacts on their wellbeing.[7]

Assessor: Make the eligibility determination without consideration of whether the adult has a carer, or what needs may be being met by a carer at that time. The determination must be based solely on the adult's needs and, if an adult does have a carer, take the care they are providing into account when considering whether the needs must be met at the support planning stage.

[7] The eligibility threshold for adults with care and support needs is set out in the Care and Support (Eligibility Criteria) Regulations 2014 (the 'Eligibility Regulations').

An adult's needs are eligible only where they meet ***all three*** of the following conditions:

- **The adult's needs arise from or are related to a physical or mental impairment or illness.**

  Consider whether the adult has a condition as a result of either physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. Base your judgment on the assessment of the adult – a formal diagnosis of the condition should not be required.

- **As a result of the adult's needs the adult is unable to achieve two or more of the specified outcomes**:
  - managing and maintaining nutrition: consider whether the adult has access to, and is able to prepare and consume, food and drink
  - maintaining personal hygiene: consider the adult's ability to wash themselves and launder their clothes
  - managing toilet needs: consider the adult's ability to access and use a toilet and manage their toilet needs
  - being appropriately clothed: consider the adult's ability to dress themselves and to be appropriately dressed, for example, in relation to the weather, to maintain their health
  - being able to make use of the adult's home safely: consider the person's ability to move around the home safely, for example, getting up steps, using kitchen facilities or accessing the bathroom. This includes the immediate environment around the home such as access to the property, for example, steps up to the house
  - maintaining a habitable home environment: consider whether the condition of the adult's home is sufficiently clean and maintained to be safe. A habitable home is safe and has essential amenities. An adult may require support to sustain their occupancy of the home and to maintain amenities, such as water, electricity and gas
  - developing and maintaining family or other personal relationships: consider whether the adult is lonely or isolated, either because their needs prevent them from maintaining the personal relationships they have or because their needs prevent them from developing new relationships
  - accessing and engaging in work, training, education or volunteering: consider whether the adult has the opportunity to apply themselves and contribute to society through work, training, education or volunteering, subject to their own views. This includes physical access to any facility and support with participation in the relevant activity
  - making use of necessary facilities or services in the local community including public transport, and recreational facilities or services: consider the adult's ability to get around in their community safely and their ability to use facilities such as public transport, shops or recreational facilities
  - carrying out any caring responsibilities the adult has for a child.

  An adult is seen as being unable to achieve an outcome if they are:

- unable to achieve the outcome without assistance
- able to achieve the outcome without assistance but doing so causes them significant pain, distress or anxiety
- able to achieve the outcome without assistance, but doing so endangers or is likely to endanger their health or safety, or that of others
- able to achieve the outcome without assistance but it takes significantly longer than would normally be expected.

- **As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing,** including:
  a) personal dignity (including treatment of the individual with respect)
  b) physical and mental health and emotional wellbeing
  c) protection from abuse and neglect
  d) control by the individual over day-to-day life (including over care and support provided and the way it is provided)
  e) participation in work, education, training or recreation
  f) social and economic wellbeing
  g) domestic, family and personal relationships
  h) suitability of living accommodation
  i) the individual's contribution to society.

  Consider whether the adult's inability to achieve the outcomes above impacts on at least one of the areas of wellbeing in a significant way; or, the effect of the impact on a number of the areas of wellbeing mean that there is a significant impact on the adult's overall wellbeing.

  Please Note:
  - The term "significant" is not defined by the regulations, and is therefore understood to have its everyday meaning.
  - Needs may have a different impact on different individuals.

Consider an individual's need over a period of time in order to identify the frequency and degree of any fluctuation in needs when determining eligibility.

9.17.1 Recording and evidence

Assessor: Record the determination on the Assessment form against the three conditions:

- the nature of any physical or mental impairment or illness
- which eligibility outcomes the person is unable to achieve, and to what extent, and which of the four circumstances apply
- whether the consequential impact on the person's wellbeing is significant.

Record evidence in the assessment: it provides managers and Panel members with the reasons and justification for the eligibility decision. Evidence must be accurate, specific and honest. Given the requirement to provide the eligibility decision in writing to the person being assessed, it will be important when recording information, to

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consider the status of the information – what the person reports, your direct observation, verifiable factual information, or written professional report. (See **section 40.11 Evidence**.)

Manager: Approve the eligibility determination.

9.17.2 Where it is determined that a person has eligible needs

Assessor: If you determine that the adult has eligible care and support needs, and there are:

- eligible needs that not *already* met by informal carer/s, and will *continue* to be unmet, and/or
- eligible needs which the carers is currently meeting but will be unable to continue to meet, and/or
- needs which are *not* eligible but which the local authority has *decided* to use its powers to meet, then:

- Where it becomes apparent during the assessment process that it is unclear whether the person meets the ordinary residence requirement, that is, the person must be ordinarily resident in the authority's area (see **section 3.5**), then do not delay meeting eligible needs whilst determining ordinary residence (OR). (There are different OR requirements for carers.)
- Inform the adult which needs are eligible and agree with them which of their **eligible needs** they would like the local authority to meet. The person may not wish to have support in relation to all their needs. They may, for example, intend to arrange alternative services themselves to meet some needs. Others may not wish for the local authority to meet any of their needs, but approach the authority only for the purposes of determining eligible needs.
- Send the assessment and eligibility determination to the person with a **covering letter**.
- Consider with the person **how the local authority may meet those needs**. This does not replace or pre-empt the care and support planning process (see sections below), but is an early consideration of the potential support options, in order to give the person the opportunity to think about and discuss with others the possible/available options.
- It also helps to determine whether some of those care and support options may be services for which the local authority makes a **charge**. (***Please Note:*** reablement and services provided under Sn 117 of the Mental Health Act are free of charge.) Where that is the case, ensure that the person understands that they may have to pay a contribution towards their services, and that a **financial assessment** has to be completed. Record the person's decision either to request or decline a financial assessment on the Core assessment on Frameworki.

  RBKC only: Ask the person to sign a Financial Assessment Agreement form, unless they have already done so, or it is inappropriate at that point (for example, if the person is ill or distressed).

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All boroughs: The Financial Assessment Team will then contact the adult or their carer if appropriate to arrange to carry out a financial assessment. (See **Section 13 PAYING FOR CARE AND SUPPORT**.)

- You must consider what support might be available from the person's **wider support network** or within the community which might assist the person in meeting the desired outcomes they want to achieve. Explore with the person how their cultural and spiritual networks can support them in meeting needs and building strengths.

- Explain the process of **personal budget allocation, budget management options and support planning** to the person, and how long that process might take. Explain that the options can include direct payments which can be used to employ a Personal Assistant (PA), or agency care, options within their own community, networks, own income and benefits and natural resources.

- Explain to the adult and carer/advocate the options for how to manage a **direct payment** for them to consider:
  - *Self-management* – money is paid into the individual's bank account or onto a pre-loaded card in their name.
  - *Third party management* –a relative or friend is willing and able to manage the money on adult's behalf and the person has capacity (there are also various agencies which offer such a service).
  - *Authorised person management* – for people assessed as lacking mental capacity to agree to a direct payment in its entirety but for whom a direct payment is the best way to meet their needs (agreed through a best interests decision). An authorised person will be appointed to receive and manage the money on the individual's behalf.

- Discuss with the person their options for safely meeting their needs in the **intervening period**.

Use the relevant information leaflets to aid discussions.

9.17.3 Where it is determined that a person has no eligible needs

Assessor: Where it is determined that an individual does not have eligible needs, record this decision on the assessment form. Send the assessment and eligibility determination to the person with a **covering letter**, and you must provide the person with useful information and advice about other sources of support to address outstanding issues and needs, and to prevent or delay the development of needs in the future. If the person needs other services, help them to find the right officer to talk to in the relevant agency or organisation, and make contact on their behalf. Use the People First website.

Make the person aware that they may use the appeals process to challenge decisions to withhold or withdraw services.

Tell individuals who do not have eligible needs that if their circumstances change, they should renew contact at which time their needs may be re-assessed. Give them the necessary contact details.

9.18 Combining assessments

The Care Act Guidance states that all of the agencies involved should work closely together to prevent the individual having to undergo a number of assessments at different times, which can be distressing and confusing.

Where a person has both health and care and support needs, local authorities and the NHS should work together effectively to deliver a high quality, coordinated assessment.

Assessor: You may combine an assessment of an adult needing care and support or of a carer with any other assessment you are carrying out either of that person or another where both the individual and carer agree, and the consent condition is met in relation to a child. If either of the individuals being assessed does not agree to a combined assessment, then these must be carried out separately.

9.19 Specialist assessments

Assessor: When conducting the assessment, it is important that you identify other needs such as health or housing for which other agencies hold responsibility. Request an assessment from the relevant agency using the appropriate referral form.

Make any urgent onward referrals where risk/s have been identified, for example, falls risk and a need for physiotherapy immediately.

Make any standard onward referrals for non-urgent work – for example, referral to the Housing department or referral for a wheelchair – no later than one week after the need being identified.

Similarly, if the person has eligible needs, consider whether specialist assessments are required, such as:

Continuing healthcare (see **Section 29**).

Carer's assessment (see **Section 11**).

Make requests for additional assessments within two weeks.

There are some variations in the assessment process for specialist services:

For people with learning disabilities, go to **section 9.19.1** below.

For people with sensory impairments, go to **section 9.19.2** below.

For people with mental health problems**,** go to **section 9.19.3** below**.**

For people with substance use problems or with a dual diagnosis, go to **section 9.19.4** below.

For people with housing issues, go to **sections 9.19.5 b**elow

For occupational therapy, go to **section 9.19.6** below

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9.19.1 Learning disabilities

The Learning Disabilities partnerships have their own assessment processes. See **section 6.16**.

9.19.2 Sensory impairment

Assessor: If it becomes apparent during the assessment process that the person being assessed has significant sensory impairment, for example, loss of hearing or eyesight, then contact the Sensory Disability team.

Sensory disability worker: Assess needs and develop a plan using the Sensory Impairment Assessment. If the person has difficulty managing at home, request Occupational Therapy to assist with assessing needs in activities of daily living.

9.19.3 Mental Health

As well as following this guidance, practitioners in mental health must also follow the Care Programme Approach.

For details of Mental Health recording on Frameworki, see **Mental Health – Referral and Initial Assessment** and **Mental Health Assessments and Reviews Fwi Guidance.**

9.19.4 Substance Use and Dual Diagnosis

Substance Use Assessor: Most appointments are office-based but where more appropriate, offer other venues including other social services offices, hospitals, mental health offices, supported accommodation and occasionally at an individual's home. Complete the assessment within two weeks as standard although this timeframe may vary dependent on complexity of need, and ability of client to co-operate and attend appointments. In complex cases, carry out joint assessments with other teams, most often these being Family and Children's Services, Mental Health Teams, Community Teams, Homeless Recovery and Safeguarding Team and services in the independent sector.

Complete a TOPS form if modality start is with SUT or if review TOPS is due if referred from within DAAT treatment system.

Team Support Officer: Input NDTMS information gathered from the assessment on Frameworki.

9.19.5 Housing

The Care Act places an emphasis on closer cooperation and working relationships within the local authority, for example, housing and leisure services, and with voluntary sector providers. Housing and the provision of suitable accommodation should be a factor when considering the provision of care and support and carers' support.

The Guidance states that local authorities have broad powers to provide different types of accommodation in order to meet people's needs for care and support. The Act is clear that suitable accommodation can be one way of meeting care and support needs and clear on the responsibilities and relationship between care and

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support and housing legislation, to ensure there is no overlap or confusion. Section 23 of the Act clarifies the existing boundary in law between care and support relevant housing legislation, such as the Housing Act 1996.

Where a local authority is required to meet accommodation related needs under housing legislation as set out in the Housing Act 1996 or under any other legislation specified in regulations then the local authority must meet those needs under that housing legislation. Any care or support needed to supplement housing is covered by the Care Act.[8]

Assessor:

- Where re-housing is indicated, advise the individual to contact a Housing Options Adviser. An adviser can tell the person whether they are eligible to register for re-housing and assist them through the process, as well as provide information on other housing options.
- Where housing forms part of the solution to meeting a person's needs for care and support, or preventing needs for care and support, then include this in the care or support plan. Work together with Housing to resolve the housing issues.

9.19.6 Occupational Therapy

Occupational therapy is provided by:

LBHF – CIS and long-term OT team

RBKC – OTs in the community teams (and also in CIS)

WCC – Able 2, external provider.

Occupational Therapist: Make an assessment of need and make recommendations which could include adaptations to the property where you have assessed this as being necessary and appropriate. Discuss the available options with the person in the case of major adaptations in privately owned or privately rented properties (and in the case of housing associations properties where the user wants to make a tenant application and the housing association agrees to this). Then the user can either:

- choose to manage applying for the grant themselves, or
- appoint an agent to manage this process for them.

[8] Care Act guidance, para 15.50 and 15.51

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10 RISK ASSESSMENT AND RISK MANAGEMENT, AND POSITIVE RISK TAKING

10.1 Introduction

Risk assessment and risk management are underpinned by the following principles:

- Risk is an essential part of everyone's everyday life
- People should understand, as far as is possible, the implications of their decisions
- Individual approaches should be taken to support or manage identified risks.

Risk relates to the uncertainty of an outcome in a given situation. It is a view taken on the ***likelihood*** of an event occurring which will result in either a beneficial or harmful ***outcome*** for a particular person or others, and takes into account the potential seriousness of that harm. The type of event depends on the individual, their relationships with others and the circumstances in which they find themselves.

Risk is often thought of in terms of danger, loss, threat, damage or injury. But as well as potentially negative characteristics, risk-taking can have positive benefits for individuals and their communities. Assessment and management of risk is a dynamic and on-going process. The aim is to increase benefits and minimise the risk of serious harm.

People's human rights must underpin all decisions and actions, irrespective of setting.

One of the key principles of the Care Act is to begin with the assumption that the individual is best placed to judge their own wellbeing. Enabling people to exercise choice and control over their lives, and to manage risk, is central to achieving better outcomes for people, including increased independence.

Therefore, a balance has to be achieved between the desire of the individual to exercise their own choices, the duty of care owed by services and employers to their workers, the duty of care owed to individuals, and the legal duties of statutory and community services and independent providers. The potential benefits of risk-taking need to be identified alongside any risks in a process that involves everyone affected – the individual, their family and advocate, and practitioners.

This section sets out some key considerations and then describes the process for assessing and managing risk.

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10.2 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

For further details of these considerations as they relate to risk, see **section 10.5**.

10.3 The Process

Risk assessment and risk management ensure that practical steps are taken to protect people from real harm, where the local authority has the right to intervene. There are six steps to assessing risk:

1. Identifying the risks
2. Assessing the risks - deciding who might be harmed and how
3. Evaluating the risks and deciding on precautions
4. Recording findings and acting upon them
5. Resolving disagreements and managing serious risks
6. Reviewing the assessment and updating if necessary

These six steps provide a framework to achieve a balance between enabling risk and the needs and rights of the person requiring support.

10.3.1 Stage 1 – Risk Identification

Practitioner: As part of the assessment and support planning process, work with all involved to identify the risks, and record in the Risk Assessment section of the assessment form. People involved include the adult, their carer, provider staff, health colleagues, and people who may be directly affected by the delivery of the care and support plan (for example people living in the same property). The risk areas include:

- physical risk
- a new activity/pursuit
- the adult doing an activity/task on their own
- new relationships
- financial loss
- mental health/substance use

Examine both:

- immediate risks – for example, the risk of falls, the obvious physical risks associated with a given activity; and
- wider risks – for example, the risk of fire associated with smoking or cooking, the risks associated with engaging with the general public, the risk of a family member unknowingly negating mitigating actions or precautions.

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10.3.2 Stage 2 – Risk Assessment and Impact

Practitioner: Determine the potential consequences of those risks. Consider both the ***likelihood*** of the risk occurring and the subsequent ***impact*** for each identified risk to determine the level of the risk. Consider these alongside the value/benefit for the person of undertaking the activity, taking account of their wellbeing and desired outcomes.

10.3.3 Stage 3 – Risk Management/Risk Enablement

Practitioner: Identify the needs which arise out of the assessment of risk. Draw up a realistic, achievable risk management action plan describing how risks can be reduced/mitigated, including relevant timescales, using the findings from the Risk Assessment. Agree the support arrangements to meet the identified, assessed eligible needs, and check that the potential benefits outweigh the potential harm. See **Risk Case Examples** on TribNet for examples.

A broad range of solutions may be required, often linked closely to the wider process of support planning. The measures may include preventative solutions, for example, telecare, or responsive and supportive measures to reduce the potential negative consequences of risk and to promote the potential benefits of taking appropriate risks. Negotiate and agree decisions between all parties and make sure rights and responsibilities are clearly understood about what is included in the care and support plan.

Limit the duration of the decision to enhance risk-taking, that is, work to shorter timescales and with smaller goals. Support this by putting mechanisms in place to check on progress and to change previous decisions quickly when needed, including intervening in a more restrictive way where necessary and possible.

In terms of the elements of the care and support plan being paid for by the local authority, where people are behaving recklessly, risk management may include the setting of explicit boundaries to contain situations that are developing into potentially dangerous circumstances for all involved. For example, you may stipulate, as part of agreeing the care and support plan, that a person who is at risk of prolonged outbursts when at a class in a leisure centre, is accompanied on these visits.

If a person or their carer makes a decision to continue behaviour that causes risk to others, make a record of their decision and when it was taken. If Council or provider staff are affected by this decision, review any support service being delivered to ensure that how it is delivered guarantees the safety of any worker involved.

Where a person has complex high level risks which might include a combination of a number of the following:

- multiplicity of illnesses/disabilities
- pressure areas
- challenging behaviour
- weight and/or gait which make manual handling more difficult
- substance misuse
- capacity issues
- compliance issues

and there is a multi-agency approach which might include district nurses and/or other health staff, mental health services and others, ensure that the risk management plan clearly identifies each risk and the responsibility for managing that risk, so that, in the event of something going wrong, it is absolutely clear who should/needs to take responsibility.

Managers/Supervisors:

- Use supervision sessions to discuss concerns and refine ideas, as well as to review the progress of the implementation of risk assessments.
- If you identify there is serious risk, go to **section 10.4**.
- Recognise that there is shared accountability/ownership for risk decisions. Practitioners need to know that support is available if things begin to go wrong.

10.3.4 Stage 4 – Recording

Practitioner:

Clearly evidence decision making about risk on the relevant documentation. Complete the separate Complex Risk Assessment document on Frameworki for more complex cases. Incorporate an action plan for each outcome where risks are identified in the care and support plan on Frameworki. See **Section 40 RECORDING.**

10.3.5 Stage 5 – Resolving disagreements

Practitioner: It is possible that agreement may not be reached for the following reasons:

- The care and support arrangements/activities chosen by the adult/carer present a level of unmanaged risk that you, or one of the other key people involved in the risk assessment, determines is unacceptable.
- You agree with the adult concerned that there are benefits to the proposed care and support arrangements, yet there is a level of unmanaged risk that requires a shared decision making process.
- You identified prior to the support planning process that due to the risk history of the adult concerned a professional discussion of the future support arrangements would be a necessary part of the support planning process.
- There are risks identified with or to the carers involved in the individual's life that may impact upon the care and support plan.
- The adult concerned lacks capacity to make specific decisions in relation to the care and support plan.

If an agreement cannot be reached, then discuss this with your team manager.

Manager:

- Review the cause of the disagreement to identify any amendments to the plan which would be acceptable to all parties.

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- Call all the people involved, including the adult and their advocate/carer(s), if any, to a 'Risk Management Planning Meeting' (chaired by the Team Manager). The meeting provides all parties with an opportunity to discuss and negotiate the options available in a mediated context.
- Record the conclusions of the meeting.

Practitioner:

- Amend the care and support plan in the light of the conclusions of the meeting.

10.3.6 Stage 6 – Reviewing and signing off the support plan

Practitioner: Keep the risk assessment and risk management plan under review, and amend as necessary in the light of experience of it being implemented.

10.4 The management of serious risks

In a small minority of cases, the risks to the adult, their support staff or others may be too great to balance safely against the Council's duty of care. Illustrative cases in this category include:

- There is strong evidence that an adult may put direct payments to illegal uses.
- An adult (perhaps who has dementia or moderate learning disabilities) has an informal carer who wants to manage their direct payment, and this has been agreed by the adult as far as possible. However, there is a history of financial abuse or neglect by that carer, which has led to the person being left without care they need and this has resulted in harm or risk of harm.
- An adult has a history of disengagement from services, non-concordance with medication, and presents high levels of risk to self or others.

The list above is not comprehensive.

Practitioner/Manager: Where you believe that serious unmanaged risk may be present, submit the case to the Risk Enablement Panel.

10.4.1 Risk Enablement Panel

The aim is for risk issues to be resolved at the lowest level. Where a practitioner's line manager is unable to resolve the situation, the case may be escalated to the Risk Enablement Panel for resolution. The Panel meets when required and deals with risk within the LA's control as part of the support planning process and risks outside the LA's control where advice or guidance is being sought.

Escalation will occur in the following situations:

(i) Where one or more identified risks cannot be resolved satisfactorily, that is, a risk/s remain/s which, in the assessor's judgment, is deemed to be too high to accept and outweighs any potential benefits

(ii) Where an acceptable solution/s is/are not available or sustainable long term

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(iii) Where there is a dispute/disagreement between interested parties as to the acceptable level of risk

(iv) Where there is a dispute/disagreement between interested parties as to proposed solutions to one or more aspects

(v) Where the level of risk is particularly complex and the Assessor/Manager would value endorsement from the Panel.

See **Risk Enablement Panel procedures** for more details of the working of the REP.

Practitioner:

- Complete the **REP Form 1** Panel submission and pass it to your line manager, to request a Panel hearing.
- Advise the Panel Chair if the adult/family are attending and any particular requirements – access/language/time

REP Chair: After the Panel has met record the decision on **REP Form 2** and upload into documents in Frameworki.

Practitioner: Inform the adult and family/carers of the outcome/s of the Risk Enablement Panel decision and of the complaints procedure should the person disagree with the decision made. Update the care and support plan as a result of the Panel decision and sign off completed plan, before presenting the plan if required to Best Outcomes Panel for the actual personal budget to be authorised.

10.5 Further considerations

10.5.1 Duty of Care

Practitioner: Remember you have a duty of care towards the person concerned (see **section 45.2 Duty of care**). An individual with capacity may choose to take risks. In some circumstances, a court may decide that the individual consented to the risk, and therefore find that the duty of care will not have been breached. There is an important distinction between *putting* people at risk and enabling them to *choose* to take reasonable risks.

10.5.2 Mental Capacity Act principles and Mental Health Act

The promotion of choice, independence and autonomy are important when considering risks involving a person who may lack capacity to make certain choices.

Practitioner:

Where the risks in a situation may involve a potential for harm to self or the need to protect others, consider the person's capacity to make decisions in the respective matter.

If the risk is to the person's welfare or wellbeing and they lack the relevant capacity, then take the necessary and proportionate action, in respect of the likelihood and seriousness of the harm, under s5 and s6 of the Mental Capacity Act 2005, in the

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person's best interests, using the least restrictive intervention possible. See **Section 36 BEST INTERESTS**.

Do not conflate the capacity assessment with beliefs about a person's best interests, driven by the desire to protect the person. Do not treat a person as being unable to make a decision because you perceive it to be an unwise one. An unwise decision which may lead to adverse consequences is not proof of incapacity.

Equally when considering a person's best interests, consider the consequences for the person's wellbeing. As with the situation when a person has capacity, the person without capacity also has the right to express their wishes, which professionals may consider to be unwise, but which should be considered as part of the factual mix when arriving at a best interests judgment.

Balance and proportionality are vital considerations in encouraging responsible decision making. Reasonable risk is about striking a balance in empowering people to make choices.

Be clear about your role. All of the above depends on offering advice to the individual on the decisions they have reached and supporting them to achieve their outcomes, or seeking to reach agreement on an acceptable level of risk, for the care and support plan to be signed off.

Equally where there is a need to protect others from an incapacitated person, seek legal advice or consider using the MCA, as appropriate.

Where there are concerns about the person's welfare, wellbeing or the need to protect others and you believe that the person may be suffering from a mental disorder, whether they have capacity or not, seek assistance from mental health services. In the more severe cases, this may include the consideration to detain the person under the Mental Health Act 1983. See **section 28.6.2** for more details.

10.5.3 Situations where the LA cannot intervene

There are areas in a person's life in which risk taking is completely under the control of the individual. This is where a person has made a choice, even though the risk has been fully explained to them, they have capacity, and the risk is not part of the care and support plan activity. In these instances, the aim would be to engage the person to explain the risk, give them the necessary information and encourage them to seek an alternative course of action. An example is a person who is losing a lot of money through gambling activities and, as a result, is running up large debts. The risks and consequences can be explained to them and advice/support offered but, if they have the capacity to make the decision to gamble, the local authority cannot intervene.

10.5.4 Situations where the LA can refuse to endorse an aspect of a person's care and support plan

Where the identified risks are part of the person's care and support plan and would be funded by the authority - for example, an activity the person wishes to undertake or their choice of support arrangements, and where the risks outweigh the benefits –

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the local authority has the authority, in discharging its duty of care, to exclude that particular element from the care and support plan.

Practitioner: In such a case, work with the person to seek ways of reducing the identified risks to a level acceptable to the authority and in the meantime, explore acceptable alternatives which still meet the person's identified outcomes.

10.5.5 Safeguarding

Positive risk-taking is also a key part of the safeguarding process under the Care Act, with the aim of Making Safeguarding Personal. See **Section 34 SAFEGUARDING**. It is important to get the balance right between empowerment and safeguarding, choice and risk.

10.5.6 Self funders

The principles of balancing choice and risk apply to self-funders. The local authority will not arrange services for a self-funder if the risks the self-funder wishes to take exceed the level that the local authority accepts.

10.6 Mental Health and Substance Use

Whilst this policy replaces Risk Assessment policies outside of the Mental Health (MH) service, it is acknowledged that in the MH service, a Clinical Risk Assessment is used, and therefore this section is to be used for reference only by mental health practitoners. In the Substance Use teams, giving individuals more choice through personalisation at the earlier stages of engagement may be detrimental and impact on the decision not to accept treatment.

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11 CARERS

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

11.1 Introduction

A **carer** is a person who provides unpaid support to a relative friend or neighbour to help them to meet their needs. Under the Care Act 2014, the local authority has a responsibility:

- to give carers information about the assessment and support planning process, and about relevant local services for carers
- to assess a carer's needs for support, where the carer *appears* to have such needs. [***Please Note:*** this replaces previous legislation, which said that the carer must be providing a "substantial amount of care on a regular basis"]
- where it is determined that the carer meets the national eligibility criteria, to set a personal budget and to develop a support plan to enable the carer to meet their needs in order to continue to fulfil their caring role.

This section is guidance for assessors responsible for carrying out carers' assessments and supporting them to meet their needs.

Please Note: The term 'carer' does not include people who work as volunteers or paid carers; these people should be referred to as 'care workers' or 'support workers'.

Carers make a vital contribution to society, giving their time and energy to caring for a family member, friend or neighbour. Many people with care and support needs rely on the person caring for them to help keep them independent in their own homes for as long as possible. Adult Social Care recognise and value the role of carers and see them as key partners in the planning and delivery of support to the person they care for.

Caring can often have an impact on the health, wellbeing and independence of carers themselves. By working with service providers and health partners, including GPs, Adult Social Care can continue to raise awareness and encourage the earlier identification of carers.

The emphasis on prevention means that carers should receive support early on before reaching crisis point.

When people become carers, they need to be able to access timely support when they need it. Adult Social Care work with carers to ensure that they:

- have access to good information and advice

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- are informed of their right to have a carer's assessment, either jointly with the cared for person or separately
- are involved in planning and decision-making from the outset so that they and the person they care for have choice and control over their care and support
- can maintain a balance between their caring responsibilities and a life outside caring – this includes young carers
- can access a range of prevention and support services when they need it (for example, respite care/ carers breaks, access to carers groups, support systems and emergency care) to help sustain them in their caring role
- are supported to maintain their own health and wellbeing.

A **young carer** is any person under 18 years of age who is a carer. Young carers must be given an assessment of their own needs. They should not have to take on inappropriate tasks and levels of responsibility which adversely affect their physical, emotional, educational or social development. Either Children's or Adults' services can be the first to become aware that a young person is a young carer.

A **parent carer** is a person with parental responsibility for an ill or disabled child or young person under 18.

11.2 Carers' Assessments

Under the Care Act 2014, where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of needs for support, local authorities must offer to carry out a carer's assessment, although the carer does have the right to refuse an assessment (see **section 11.5**.)

A carer does not need to be resident in the relevant borough, to have a carer's assessment or to receive carers' services. It is the responsibility of the Borough in which the cared for person lives to provide the carer's assessment and necessary support.

Carers do not necessarily have to live with the person they are looking after or be caring full time to have a carer's assessment. They may be juggling work and care and this is having a big impact on their life. It is up to the carer to decide at what point in their caring role they choose to have a carer's assessment. They can ask for an assessment before they take up caring or decide to have one at any point when they are already caring for someone.

They can have a carer's assessment to look at the help they need even if the person they care for does not want to have an assessment to look at the care and support needed for their own circumstances, or does not have eligible care and support needs.

Carers are ***not*** excluded from applying if the cared for person has respite or day services, but this will be taken into account during support planning with carers.

The carer's assessment can be paused, for example, when the cared for person is receiving reablement, the outcome of which may have a direct impact on the carer.

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Please Note: The assessment and any resulting carer's personal budget will not affect the Carer's Allowance (which is provided by the Department of Work and Pensions) or any other benefit the carer may receive.

Assessor:

- If the carer requests an assessment of their needs in relation to their caring role, or if you identify that the person has a carer or carers, then offer each carer an assessment. Inform them about the assessment and support planning process.

The use of the word 'carer' in itself may be problematic for people unfamiliar with the term. The questions 'Do you look after someone?' or 'Is there anything that would help you to support the person you care for better?' may be more meaningful to a carer.

- If the cared for person is a ***child,*** then help for the child and the carer should be provided under the Children Act. Where you have particular concerns about the child or young person, then consult with Family and Children's Services to determine whether the carer is a 'child in need' under the Children Act and to consider whether cross-divisional work is appropriate. If the needs of the young carer have not been properly addressed under this assessment then the carer can ask for a carer's assessment for their own needs and help can then be provided through the carer's assessment.

11.2.1 Purpose of assessment

The carer's assessment is a key intervention in itself. The purpose of an assessment of a carer is:

- to identify the needs to be addressed, and the impact of their needs on the outcomes they can achieve, and on their wellbeing and day to day life
- to evaluate the sustainability of the caring role itself, which includes the practical and emotional support the carer provides to the adult: consider the carer's potential future needs for support and whether the carer is and will continue to be able and willing to provide care
- to agree the desired outcomes of any package of support
- to determine the carer's eligibility for support services.

11.2.2 Timescale

An assessment "should be carried out over an appropriate and reasonable timescale" taking into account the urgency of needs and consideration of any fluctuation in those needs.

Assessor: Inform the individual of the likely time the assessment will take and keep the person informed throughout the assessment process.

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11.3 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

11.3.1 Safeguarding

Circumstances in which a carer could be involved in a situation that may require a safeguarding response include the following:

- a carer may witness or speak up about abuse
- a carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with, or
- a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others.

Assessor: With the latter two, consider whether, as part of the assessment and support planning process for the carer and/or the adult they care for, support can be provided that removes or mitigates the risk of abuse. An example is the provision of training or information or other support that minimises the stress experienced by the carer. In some circumstances the carer may need to have independent representation or advocacy; in others, a carer may benefit from having such support if they are under great stress or similar. Consider whether other agencies should be involved; in some circumstances where a criminal offence is suspected, this will include alerting the police, or in others the primary healthcare services may need to be involved in monitoring.

Also consider:

- involving carers in safeguarding enquiries relating to the adult they care for, as appropriate
- whether or not a joint assessment is appropriate in each individual circumstance
- the risk factors that may increase the likelihood of abuse or neglect occurring, and
- whether a change in circumstance changes the risk of abuse or neglect occurring.

See also **Section 34 SAFEGUARDING**.

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11.4 Consent to sharing information

Obtaining and recording consent is vital for the safe and legal sharing of personal information.

Assessor: Explain to the carer that in order to understand their situation fully, it may be helpful to discuss with other staff and organisations what they know, and to share information about an individual's health and care needs. Explain that if they do not give their consent to sharing such information, it may not be possible to carry out an assessment or to give them a full service.

For further details, including guidance on when information may be shared without consent, see **section 3.4 Confidentiality and Information Sharing**.

11.5 Arranging the carer's assessment

Assessor:

- Discuss with the carer whether they choose:
  - to be jointly assessed with the person they assist, in order to avoid unnecessary duplication
  - to be assessed in their own right as a carer
  - to refuse any involvement with the carer assessment process.
- If the carer chooses to be assessed with the person they assist, then carry out the carer's assessment alongside the assessment for the cared for person (see **section 9.15**).
- If the cared for person has not had an assessment and would like one, arrange for one to be carried out.
- If the carer chooses to be assessed in their own right, there are two options:
  - For carers for whom caring has a very significant impact on their wellbeing (and/or for whom the cared for person has high care needs and is known to Adult Social Care/ Mental Health services) you as the assessor for ASC/Mental Health services carry out the assessment
  - For carers for whom it *appears* that caring has less of an impact, the assessment can be carried out either by you or by the local contracted carers organisation:

    LBHF and WCC – the Carers Network
    RBKC – Carers Kensington and Chelsea.

When carrying out the carer's assessment:

- Establish any communication needs and adapt the assessment accordingly.
- Explain the assessment options:
  - a supported self assessment which is then validated by the local authority or the contracted local carers organisation. If the carer chooses this option, email or post a copy of the borough-specific carer's self assessment:

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and ask them to return the completed form to the address on the form.

- a face-to-face meeting to carry out a full carer's assessment.

- Send/give the carer a **letter advising of the initial assessment** and a copy of the relevant local Carers Information booklet.

11.6 Conducting the assessment

Assessor: Carry out the carer's assessment in a convenient and private place. For example, this could be at an Adult Social Care office or at the carer's home. Explain that the carer's assessment can be carried out with or without the person they are looking after being present. Where it is an assessment on their own, it is desirable to refer to the cared for person's assessment to ensure that any support offered is appropriate, as intervention/support provided to the cared for person is likely to have an impact on the carer. Make sure you have the consent of the cared for person to share this information. Offer the carer time to talk away from the cared for person, if they wish. If necessary, arrange for the carer to be assessed by a different person. Discuss the carer having someone with them, for example, a family member, a friend or a professional person.

Have regard not only to the Care Act, but also to the Sex Discrimination Act 1975, the Disability Discrimination Act 1995, the Human Rights Act 1998, the Race Relations (Amendment) Act 2000, Age Legislation 2006 and Equalities Act 2010. (See **Section 45 LEGISLATIVE FRAMEWORK.**)

Under the Equalities Act, make reasonable adjustments to ensure that disabled people have equal access to information and advice on support and keeping safe from abuse or neglect. For carers, this might include interpreters, or choice of venue or time of day.

Checklist

Make sure that during the assessment process, you inform the carer (where relevant) about:

- **the purpose of the assessment**
- **the need for their consent if they wish us to share information with other professionals in order to provide more complete services**
- **ordinary residence conditions (see section 3.5)**
- **eligibility criteria, making it clear that not everyone will have eligible support needs**
- **personal budgets, support planning and direct payments**
- **support services available**
- **the appeals and complaints procedure**
- **the right to have access to records.**

Make sure you take the relevant information on the visit with you.

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Check whether the person is distressed by the assessment process. If so you may need to consider ending the assessment and seeking advice from a manager.

11.7 Principles of assessment

There are lots of things to think about when carrying out a carer's assessment. The most important are outlined below.

- **The success of the assessment is dependent on the relationship and communication between you and the carer. Communicate with the carer in a way that they understand and which enables them to participate fully in the assessment.**
- **Actively seek consent to the assessment process and support the carer's participation in it. See also section 11.4.**
- **Base your approach to the assessment on the promotion of wellbeing and other principles described in Section 3.**
- **Assessing is about developing an understanding of the individual's needs, concerns, wishes and preferences, and desired outcomes, that is, what they would like to achieve.**
- **The assessment begins with a discussion rather than filling in a form. The form is the tool on which to record the assessment.**
- **Keep the scale and depth of assessment in *proportion* to the needs of the carer. Make the assessment flexible to meet the individual case. Identify needs and risk factors but ensure that the information gathered is pertinent to the assessment to avoid unnecessary intrusion and invasion of privacy.**
- **Focus positively on what the individual can do and their strengths as well as what they cannot do, taking account of their personal and social relationships.**
- **Assess risks. You must record this as it is an important part of the assessment. (See Section 10.)**
- **Assess the carer's willingness and ability to provide care and support now and in the future, and in doing so, offer choices.**
- **Ensure that you record evidence for the rationale for risks identified and conclusions reached (see section 11.10).**
- **Explain what is happening at each stage of the process.**

11.8 Areas to cover during the carer's assessment

Assessor:

When carrying out a carer's assessment, cover the following areas:

- the caring role
- feelings and choices about caring

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- the carer's own strengths and capabilities
- the carer's own wishes and preferences and desired outcomes
- health
- work and education
- leisure
- housing

Key questions may include:

- **How long has the carer been caring?**
- **How much help does the carer get?**
- **How often does the carer get a full night's sleep?**
- **How much physical impact does the caring role have?**
- **How much emotional impact does the caring role have?**
- **Does the carer understand the nature of the cared for person's condition?**
- **How much time does the carer have when they feel 'off duty'?**
- **How appropriate is the role for someone of the carer's age or in that particular relationship to the cared for person?**
- **How appropriate is the role for someone of the carer's culture, religion, gender?**
- **How many other roles (parent, spouse, partner, employee, carer for someone else) impact on the carer?**
- **How does the caring role impact on the carer's other relationships and community networks?**
- **How sustainable does the carer's role appear?**
- **What plans does the carer have in place in the event of them being unable/unwilling to continue to care in an emergency or on a longer term basis?**
- **Does the cared for person want the carer to continue in this role?**
- **How far does the carer gain any sense of satisfaction/reward from caring?**
- **How much control does the carer have over their life as a result of caring?**

Check whether there are any difficulties that the carer has with their caring role. Clarify what are the care and support needs of the cared for person that the carer ***can*** meet and those that they ***cannot*** meet.

Never make assumptions about the level or quality of care and support available from carers.

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It is important to acknowledge those carers who provide care intermittently – for example, carers of people with mental health needs, substance misuse issues, neurological problems or fluctuating conditions. These intermittent caring roles can be as just as stressful as 'continuous' caring because the carer may be waiting for, or trying to prevent, the next crisis.

If the carer has completed a self assessment, use it as a way to focus on the areas of most importance to the carer in continuing to carry out their caring role, and validate their answers.

11.9 Outcomes

The Care Act Guidance states that the purpose of a needs assessment is to identify the carer's needs and the outcomes that they wish to achieve in their day-to-day life, and how the provision of support may assist the individual in achieving their desired outcomes.

There are two ways in which outcomes are discussed within the Care Act Guidance:

Desired outcomes (of the individual): these are the outcomes a person wishes to achieve in order to lead their day-to-day life in a way that maintains or improves their wellbeing. They vary from one person to another because each individual has different interests, relationships, demands and circumstances within their own life. These are the outcomes that need to be identified at the assessment and then refined at the support planning stage. Desired outcomes are the end result, not the means to the end. They are the *difference* the support makes to the carer's quality of life.

Assessor: Discuss with the carer the desired outcomes that the carer wishes to achieve in their day to day life, and record them.

The second set of outcomes, described in **section 11.11** below, are the specified **eligibility outcomes**, which form the second of three conditions, all of which must be met for a carer to be eligible for support.

11.10 Recording the assessment

Assessor:

- If the carer has completed a self assessment, after speaking with the carer to verify the information and ensure the assessment captures all they wish to say, scan and upload their self assessment into the Carer Assessment episode on the carer's record in Frameworki. Then complete only the mandatory fields and eligibility sections of the Carers Assessment and Support Plan (along with any new information gained from discussion with the carer).
- If the carer has not completed a self assessment, then complete the full Carers Assessment and Support Plan on Frameworki.

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For guidance on completing the eligibility part of the Carers Assessment and Support Plan, see the next section.

11.11 Eligibility

The next step is to determine whether the carer has eligible needs for support from the local authority. The Care and Support (Eligibility Criteria) Regulations 2014 set out the criteria for eligibility for both adults with care and support needs and for carers.

A carer's needs are eligible only where they meet **all three** of the following conditions:

- **The needs arise as a consequence of providing necessary care for an adult.**

  Carers can be eligible for support whether or not the adult for whom they care has eligible needs. Make the eligibility determination based on the carer's needs and how these impact on their wellbeing.

  The carer must also be providing "necessary" care. If the carer is providing care and support for needs which the adult is capable of meeting themselves, the carer may not be providing necessary support. In such cases, provide information and advice to the adult and carer about how the adult can use their own strengths or services available in the community to meet their needs.

- **The effect of the carer's needs is such that the carer's physical or mental health is either deteriorating or is at risk of doing so, or the carer is unable to achieve any of the following eligibility outcomes:**
  - carrying out any caring responsibilities the carer has for a child
  - providing care to other people for whom the carer provides care
  - maintaining a habitable home environment: consider whether the condition of the carer's home is safe and an appropriate environment to live in and whether it presents a significant risk to the carer's wellbeing. A habitable home should be safe and have essential amenities such as water, electricity and gas
  - managing and maintaining nutrition: consider whether the carer has the time to do essential shopping and to prepare meals for themselves and their family
  - developing and maintaining family or other significant personal relationships
  - engaging in work, training, education or volunteering
  - making use of necessary facilities or services in the local community
  - engaging in recreational activities.

  A carer is seen as being unable to achieve an eligibility outcome if they are:
  - unable to achieve the outcome without assistance
  - able to achieve the outcome without assistance, but doing so causes or is likely to cause significant pain, distress or anxiety

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- able to achieve the outcome without assistance but doing so is likely to endanger the health or safety of the carer or any adults or children for whom the carer provides care.

- **As a consequence of that fact there is, or there is likely to be, a significant impact on the carer's wellbeing,** including:
  a) personal dignity (including treatment of the individual with respect)
  b) physical and mental health and emotional wellbeing
  c) protection from abuse and neglect
  d) control by the individual over day-to-day life
  e) participation in work, education, training or recreation
  f) social and economic wellbeing
  g) domestic, family and personal relationships
  h) suitability of living accommodation
  i) the individual's contribution to society.

  Consider whether the carer's needs and inability to achieve the outcomes above impact on at least one of the areas of wellbeing in a significant way; or, the effect of the impact on a number of the areas of wellbeing mean that there is a significant impact on the carer's overall wellbeing.

  Please Note:

  - The term "significant" is not defined by the regulations, and is therefore understood to have its everyday meaning. It depends on a person's particular circumstances; the type of care they deliver; and the effect it has on their life. It is not just a question of how many hours a week a person spends caring for someone but the overall impact on their life. Use your professional judgment. If in doubt, discuss with your line manager.
  - Needs may have a different impact on different individuals.

Assessor:

- Determine the carer's eligibility for support using these national eligibility criteria.

11.11.1 Recording eligibility and evidence

Assessor: In all cases (whether the carer has completed a self assessment form or not), record the eligibility determination in the relevant section of the Carers Assessment and Support Plan against the three conditions:

- whether the carer is providing necessary care, and the nature of the needs arising
- the effect of the carer's needs on their physical or mental health, or which eligibility outcomes the carer is unable to achieve
- whether the consequential impact on the carer's wellbeing is significant.

Record evidence in the Carers Core Assessment form: it provides the reasons and justification for the eligibility decision. Evidence must be accurate, specific and honest. Given the requirement to provide the eligibility decision in writing to the carer

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as part of the assessment form, it is important, when recording information, to consider the status of the information – what the person reports, your direct observation, verifiable factual information, or written professional report. (See **section 40.11 Evidence**.)

11.12 Action following eligibility assessment

11.12.1 Where it is determined that a carer has eligible needs

Assessor: If it is determined that the carer has eligible needs, then:

- Send the carer their completed core assessment form, and inform the carer which needs are eligible, using **accompanying letter**. Agree with the carer which of their **eligible needs** they would like the local authority to meet. The carer may not wish to have support in relation to all their needs – for example, they may intend to arrange alternative support themselves to meet some needs.

- Consider what support might be available from the carer's **wider support network** or within the community which might assist the carer in meeting the desired outcomes they want to achieve. Explore with the carer how their cultural and spiritual networks can support them in meeting needs and building strengths.

- Explain the process of **personal budget allocation** and **support planning** to the person, and how long that process might take. Explain that the personal budget can be used to provide support directly to the carer to assist them in achieving their outcomes – for example:
    - to support them to take a break
    - to assist them to maintain good health and wellbeing
    - to reduce some of the difficulties that can arise when caring for someone
    - to sustain their caring role.

  See **section 11.16** for examples of what the carer's personal budget can be used for.

- If appropriate, discuss with the carer their options for safely meeting their needs in the **intervening period**.

11.12.2 Where it is determined that a carer does not have eligible needs

Assessor: Where a carer is found to have no eligible needs, record this on the Carers Assessment and Support Plan. Send the assessment with the eligibility determination to the carer with **accompanying letter**, and provide the carer with useful information and advice about other sources of support to address outstanding issues and problems, and to prevent or delay the development of needs in the future (**provision of information and advice only**). If the carer needs other services, help them to find the right person to talk to in the relevant agency or organisation, and make contact on their behalf. Use the People First website.

Make the carer aware that they may use the appeals process to challenge decisions to withhold or withdraw services.

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11.13 Types of support for carers

There are four levels of support available to carers:

LEVEL ONE: The universal offer

This is available to all carers as part of services which are universally available to all citizens. Carers will be directed to these agencies if it is appropriate. Examples of this type of support include, benefits advice lines, websites, libraries, citizen's advice bureaux, leisure centres and work opportunities.

The Local Offer. In line with the Children and Families Act, there is a requirement to set out the Local Offer for young people and families who are going through Transition (14-25 years). This Local Offer is shared under the Universal Offer as described above.

LEVEL TWO: Targeted services low-level support

These are services which are available to carers only which are specifically funded by the health service and the local authority to provide support to carers. They include health checks, training, GP support, yearly consultation and surveys, the Carers Partnership Board, the voluntary sector support provided by specialist carers' voluntary providers in the boroughs, carers support groups, advocacy services, local hubs, and Adults safeguarding.

Level one and two DO NOT require assessment in order to access them.

LEVEL THREE: Carer's assessment and support

This level involves a carer's assessment carried out by the Council or a commissioned carers organisation on behalf of the Council. It is designed to provide support to carers who have eligible needs.

If the carer has eligible support needs as defined by the Care Act a carer's personal budget may be agreed.

LEVEL FOUR: Complex assessment and support

This level involves a full complex assessment of the carer and the cared for person. If the cared for person has eligible care and support needs they will be provided with a personal budget. The personal budget will be provided to meet eligible needs of the cared for person and the carer. For example, if a short break is needed the cost of this will be part of the cared for person's personal budget. This assessment can also result in an agreed carer's personal budget (see below).

11.14 Support planning

As the carer's assessment can also affect the core assessment of the person they look after, some of the carer's assessed needs and support may be reflected in the care and support plan of the cared for person.

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Assessor:

- If the carer has eligible needs, work with the carer to develop a support plan to meet their assessed eligible needs. Record on the Carers Assessment and Support Plan on Frameworki.
- The support plan may also include a carer's personal budget determined by the Carers RAS (see **section 11.15**).
- Since each carer's situation is unique, consider how much support is being provided to the cared for person by Adult Social Care, to assist in understanding the impact of caring on the carer. This includes respite and day services. The carer's personal budget forms part of the total budget for the carer and cared for person. Clearly identify where the carer's needs will be met as part of the cared for person's care and support plan. Record on the cared for person's Care and Support Plan on Frameworki.

11.15 Carer's Resource Allocation System (RAS) and Personal Budget

To be considered for a carer's personal budget (CPB), a carer must:

- be aged over 18
- be caring for someone who is aged 18 or over
- have had a carer's assessment and been assessed as having eligible needs which cannot be met by any other provision/service
- be caring for a person who is living at home and who is a resident of Hammersmith and Fulham, Kensington and Chelsea or Westminster (or placed out of borough by the specific council – excluding people in residential/nursing care). The carer does not have to be living with the person they are caring for, nor be a resident of the specific borough the person lives in
- be an unpaid carer: carers are still considered to be 'unpaid' if they receive Carers Allowance or manage the cared for person's personal budget
- be providing unpaid care to someone who is entitled to an assessment of their needs. The cared for person may not be entitled to or in receipt of services to meet these needs or may even have refused an assessment.

A person cannot be considered for a CPB if they are a volunteer who provides care as part of their work for a voluntary organisation, or providing care in exchange for rent and board. However, where an adult is providing care under a contract or voluntary work, and is also providing care for the adult outside of those arrangements, consider whether to carry out a carer's assessment for the person for that part of the care they are providing outside of the contractual/voluntary basis.

The Care Act Guidance states that a carer's personal budget (CPB) must be an amount sufficient to meet their needs to continue to fulfil their caring role, and which takes into account the desired outcomes that the carer wishes to achieve in their day-to-day life. This includes their wishes and/or aspirations concerning paid

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employment, education, training or recreation if the provision of support can contribute to the achievement of those outcomes.

Please Note: One application may be made for each carer within a twelve-month period. Where a person is being cared for by more than one person, both carers are entitled to an assessment and support planning (where eligible needs are identified). In this instance they need to be seen by the same assessor who should consider the whole caring unit when making an application for CPB.

Assessor:

- If the carer is deemed to have eligible needs as a result of assessment, complete the borough-specific Summary and Eligibility section on the Carers Assessment and Support Plan in Frameworki (external carers organisations use a Word version of this tool). RAS determines whether the assessment leads to any allocation, and if so, the indicative amount. The amount is the carer's indicative **Personal Budget.** In Frameworki the Carers Assessment and Support Plan automatically calculates the indicative budget (which is borough-specific). External organisations need to undertake the calculation themselves.
- The final agreed personal budget may be more or less than the indicative budget. Discuss with your manager any cases in which a carer's needs cannot be met within the amount calculated by the Carers RAS.

There could be exceptional circumstances in which a carer requires ongoing support via care management in their own right. Discuss any appeals or exceptional cases with your manager.

Please Note: None of the three boroughs charges for carers services, so that it is not necessary to carry out a financial assessment of the carer.

11.16 What the carer's personal budget can be spent on

If the carer is allocated a personal budget as a one-off direct payment, the direct payment can be spent on any item(s) which will benefit the carer and help them with their caring or provide them with a break from their caring role. The amount does not have to be spent at one time. No two carers' needs are the same but the following are examples:

- beauty treatments/health and wellbeing therapies
- driving lessons
- a washing machine, cooker or microwave oven or other domestic appliance which assists them or helps them to maintain a clean and comfortable environment
- holidays, with or without the cared for person
- carpet
- computer – laptop or tablet for internet shopping, studies, information, recreation
- gym membership
- gardening

- socialising – for example, going to the theatre
- access to education
- five-day residential support programme (Substance Use team only).

The Council is entitled to meet identified eligible needs in the most cost-efficient way possible. So the following indicative amounts for commonly requested items are recommended to ensure equity of provision for carers. These must be considered a guide only. The way in which the carer has chosen to meet their needs is a vital consideration and must be taken into account.

- Alternative therapies – up to £200 annually
- Laptop/tablet – up to £350
- Gym membership – up to £200 annually
- Short break/holiday – up to £300 annually
- Driving lessons – up to £250 annually
- Washing machine – £200
- Microwave – £50

What is excluded?

- anything that could bring WCC, RBKC or LBHF into disrepute
- living expenses such as food, heating, lighting, council tax, rent/mortgage payments, clothing, general transport costs and repayment of debt
- retrospective funding of goods or services, for example a holiday that has already been taken
- gambling of any form including bingo and the lottery
- direct care for the cared for person
- drugs or alcohol
- any illegal activity.

The carer's personal budget may not be used by or for anyone other than the carer.

11.17 Setting up the Carers Personal Budget

- Ensure that the carer is aware of the process and how the personal budget has been calculated. Explain that the carer's personal budget is provided as a one-off direct payment each year (though it does not have to be spent at one time), and has to be used to pay for the support that has been agreed, and that they will be asked to account for how the money was spent at their annual review.
- Give the carer an information leaflet advising them how they can and cannot spend their CPB (see **section 11.16**).
- Ask the carer to complete the Carer's Bank Details form.

  Record the carer's bank details on the form. If they do not have a bank account, their CPB may be paid into the bank account of a friend or relative so that they can give the money to the carer. CPBs cannot be paid into post office accounts. Explain that payment is usually made within four weeks after the application has been approved and processed.

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- Send the Carer's Bank Details form to the appropriate Finance Team so they can process for payment. Do not upload this document into Frameworki.
- Complete the Support Plan section of the Carers Assessment and Support Plan on Frameworki, setting the review for one year hence.
- If the carer has been allocated a carer's personal budget, complete the relevant borough specific purchasing episode to facilitate payment to the carer.

Manager: Check and authorise the payment in the purchasing episode.

Please Note: A sample range of applications will be moderated by a panel of managers to ensure equity of service for carers.

11.18 Notifying carers about the result of their carer's assessment

Assessor: Following the assessment, notify the carer **in writing** together with a copy of the Carers Assessment and Support Plan confirming the result of the eligibility determination, the eligible needs that have been identified, how the needs will be addressed and the personal budget allocated if any. In addition, include information and advice on how to meet ineligible needs.

11.19 Carers choosing to accept or reject the help they are offered

Assessor: Carers can accept some or all of the help that you offer them. If they do not feel the help they are offered is necessary or appropriate, they can refuse it. Before they refuse help, you should encourage carers to talk about their concerns – it may be that more suitable arrangements can be made.

11.20 Situations where the cared for adult does not agree to an assessment or does not have eligible needs

This section covers the situation where a carer is assessed as having eligible needs, but the cared for person either does not have eligible needs or chooses not to be assessed. In such cases the cared for person will not have a personal budget or care and support plan.

Assessor: Work with the carer to develop a support plan which covers their needs and which specifies how their needs are going to be met – for example, via replacement care to the adult, and the personal budget would be for the cost of meeting the carer's needs. Although the cared for person will not have their own personal budget or care and support plan, they do need to be involved in the decision making process. The carer could decide to commission their own replacement care from an agency. The cared for person would pay the costs as they are the direct recipient of the service. Agree the decisions taken by the carer and the cared for person and the cost implications and record them in the support plan. If the cared for person refused to pay the cost, you would need to consider alternative ways of supporting the carer.

11.21 The Carers' Emergency Scheme

This scheme gives carers peace of mind that, should something happen to them or they have an emergency, the person they care for will be supported.

When carers join the scheme, they are sent a card with a unique ID number and the number to call to access emergency support.

When a call is made, the Council arranges support in their home with one of the people they nominated when they registered or, if they are not available, support via Adult Social Care. This care, which is provided in the home, is free for up to 48 hours (72 hours over the weekend). After 72 hours, if help is still required, Adult Social Care will reassess and provide ongoing support.

11.22 Short breaks/ respite care

Short breaks/ respite care recognises the vital role that carers play and the local authority's duty to support them. A short break away from home for the person they are caring for, perhaps in a bed and breakfast or a care home, can help them to have a necessary break from caring and help them to continue to provide their support and enable the cared for person to stay at home in the community for a longer period.

The amount of respite a person may be offered will depend on their individual assessed needs and circumstances.

The cared for person will need to be financially assessed for their contribution towards respite care.

11.23 Reassessments and reviews

Assessor: When you are carrying out a carer's assessment, agree with the carer the likely point at which their assessment should next be reviewed.

As a minimum, arrange to review or re-assess the carer every 12 months, both as part of the cared for person's review and separately where appropriate. At the review, check and record what money was given and what it was spent on, and record the review on the Carers Assessment and Support Plan.

Carers can ask for a re-assessment of their carer's assessment and support plan at any time if their circumstances change or the circumstances of the person they are looking after change.

Follow same steps as for Carer Assessment and Support Plan – see above. See also **Section 24 REVIEWING CARE AND SUPPORT**.

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11.24 Additional Carer specific resources

Correct as at December 2014:

- Advice and support from carer specific organisations across all three boroughs. Carers Network provide this service in Hammersmith and Fulham, (LBHF), and Westminster (WCC) and Carers UK provide this service in Kensington and Chelsea (RBKC).
- Support groups for carers:
    - Carers Network provide these in WCC and LBHF
    - RBKC fund voluntary organisations to run support groups – these include Hestia and the Kensington and Chelsea Mental Health Carers Association (carers of people with mental health issues), Equal People and Full of Life (carers of people with a learning disability), Age Concern (carers of older people).
- Activities for carers – Carers Network in LBHF and WCC; funded voluntary organisations above in RBKC. In addition, Open Age offer activities in RBKC and WCC for carers, New Horizons offer activities in RBKC, and Westminster Carers operates a 'Timebank' and range of carer activities.
- Access to psychological support via IAPT (Increasing Access to Psychological Therapies).
- Spurgeons support young carers across the three boroughs of Kensington and Chelsea, Hammersmith and Fulham and Westminster.

LBHF:

- Carers' small grant scheme
- Reflexology sessions
- Mental Health First Team – Friends and Family Support group

WCC:

- Carers' break scheme
- Subsidised access to gyms (discount card)
- Gordon Hospital Carers Support Group
- Early Intervention in Psychosis Team (EIPT) – Quarterly carers evening
- Turning Point Drug and Alcohol Service Carers Support

RBKC:

- Subsidised access to a local gym in the north of the borough
- Specific counselling for carers in RBKC

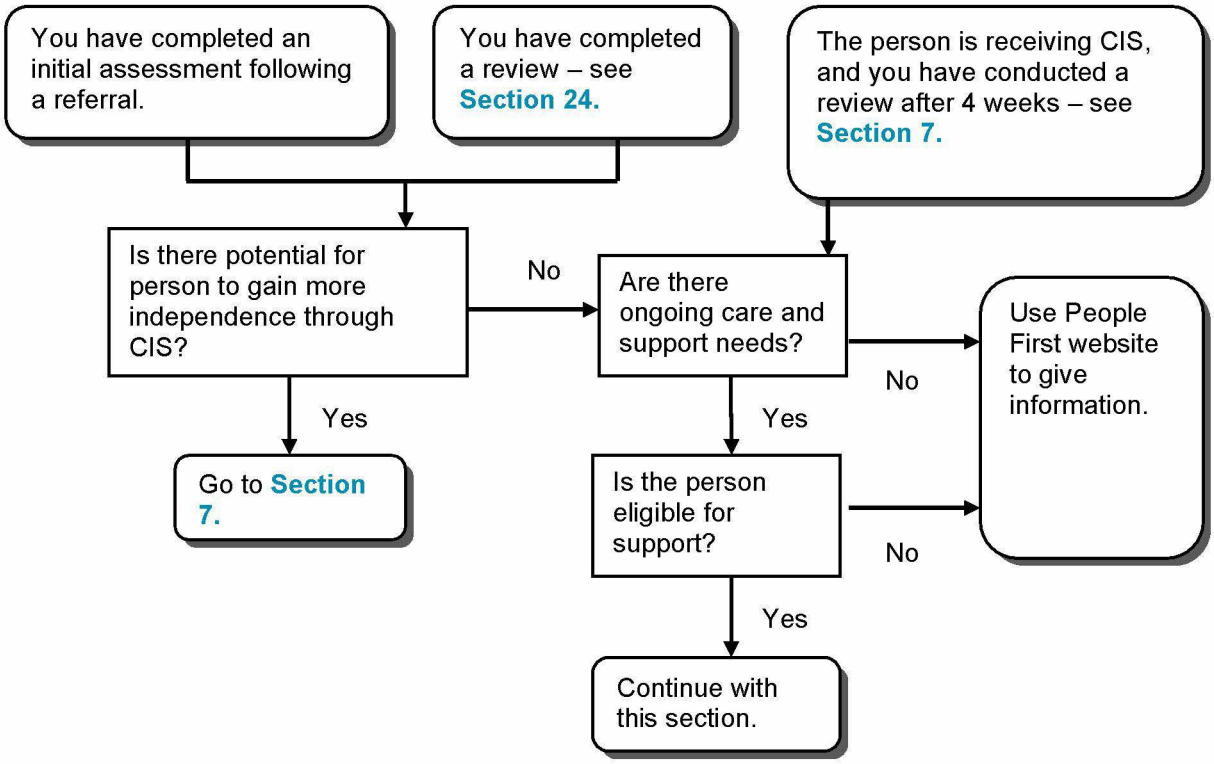
Carer services/provisions are detailed on the **People First website**.

PART C – SUPPORT PLANNING AND PROVISION OF SERVICES

12 RESOURCE ALLOCATION AND PERSONAL BUDGETS

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

12.1 Introduction



12.2 Financial Assessment

Assessor: If some of the care and support options may be services for which the local authority makes a charge, ensure that the person understands that they may have to pay a contribution towards their services, and that a financial assessment has to be completed if it has not already been done. Record the person's decision either to request or decline a financial assessment on the core assessment on Frameworki.

RBKC only: Ask the person to sign a Financial Assessment Agreement form, unless they have already done so, or it is inappropriate at that point (for example, if the person is ill or distressed).

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All boroughs: The Financial Assessment Service will then contact the adult or their carer if appropriate to arrange to carry out a financial assessment. (See **Section 13 PAYING FOR CARE AND SUPPORT**.)

If the person is eligible for financial support, the financial officer explains to the direct payment recipient the payment processes and the options for receiving the direct payments.

12.3 Personal Budget

A **personal budget** is the amount of money (if any) that the Council determines is necessary to help the person remain living safely at home. The personal budget must always be an amount sufficient to meet the person's care and support needs, and must include the cost to the local authority of meeting the person's needs which the local authority is under a duty to meet, or has exercised its power to do so.

The local authority must take into account any needs being met by a carer. The person may have eligible needs which are being met by a carer at the time of the plan: in these cases the carer must be involved in the planning process. If the carer is willing and able to continue to provide the support, the local authority is not required to meet those needs. The final/agreed personal budget does not therefore include funding to cover those needs being met by the carer.

12.4 Calculating Indicative and Final/Agreed Personal Budgets

Under the Care Act, the local authority needs to:

- determine a person's ***indicative Personal Budget*** based on all of their eligible needs, whether met (for example, by an informal carer) or not
- determine a person's ***final/agreed Personal Budget*** based on what is required to address unmet needs.

A person's *indicative Personal Budget per week* is calculated using the LA specific RAS/Budget Calculator Tool [*Please Note:* In RBKC this has been renamed as the RAS Indicative Budget Calculator (RBKC)]. This figure is 'carer neutral' – that is, you disregard the fact that a carer may be meeting this need for the purposes of the *indicative* personal budget. To support this approach the following changes have been made:

- **RBKC – questions on carer support removed**
- **LBHF – questions on residential placement / carer support removed**
- **WCC – answer all questions without taking account of carer input – no change to form required**

Some fields on the RAS/Budget Calculator tools have been renamed to make it clearer which ones relate to the Indicative Personal Budget and the Final/Agreed Personal Budget

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The Care and Support Plan needs to include ***both*** the indicative and final/agreed amounts, and the final/agreed amount needs manager sign off.

Assessor: Follow this sequence:

- **Determine indicative PB via RAS/Calculator tool** (this can be done in either the assessment/review episode, or in the care and support planning episode).
- **Enter indicative PB on Care and Support Plan** (this will auto-populate from RAS/Calculator tool if it was in a previous, completed episode).
- **Identify costed needs which *are not met* by carer/other resources**.
- **Total cost = Final/Agreed PB**.
- **Update RAS/Calculator tool to enter Final/Agreed PB** (if you completed it in preceding episode, choose "copy forward").
- **This figure populates PB purchasing for WCC and RBKC**.

Please Note: **RBKC and WCC**, Personal Budget purchasing is based on the Final/Agreed personal budget per week – as recorded on the RAS/Budget Calculator tool.

Please Note: The allocation is only finalised when your manager is satisfied with the quality of the support plan and signs it off.

For details of the steps on Frameworki, see **3B Purchasing in Frameworki** (guidance updated July 2015).

12.5 Sending written documents

Provide the person with a copy of:

- their assessment
- the eligibility determination
- a covering letter to include:
  - the amount of the indicative personal budget
  - the amount of the assessed contribution if it has been determined by this point
  - an explanation of the Appeals process
  - the next steps in the process
  - your contact details
- and where appropriate, an outline care and support plan once your manager has approved it.

Either email these documents to the person if they have an email address, or send them by post, or if appropriate hand a copy to the person face to face, to give an opportunity for you to read through it with them and explain anything they do not understand.

Also send a copy of the documents to any individual that the person specifies. Where an independent advocate, an IMCA or an IMHA is involved in supporting the individual, keep the advocate informed so that they can support the person to understand the outcome of the assessment and its implications

Make a note in the case notes of the date you have given the person a copy of these documents.

Explain to the person that they will be deemed to have agreed with the assessment eligibility determination and indicative personal budget unless they let you know otherwise.

12.5.1 Where the person disagrees with the agreed provisional personal budget

Assessor: If the person (or their carer) raises concerns about the amount of the agreed provisional personal budget, then discuss it with them. Explain the process that has been followed to arrive at the budget, and that the allocation reflects the needs identified during the assessment. In most cases, the allocation will be appropriate, but if it is clear that any needs have been overlooked or the severity of a particular need has not been adequately recognised, then raise these concerns with your manager.

13 PAYING FOR CARE AND SUPPORT

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

13.1 Introduction

Please Note: **This whole section is applicable to WCC and RBKC only: LBHF no longer charges for community-based services for those with assessed needs which are eligible for local authority care and support.**

Everyone should have access to the information and advice needed to make care and support decisions which work for them, regardless of who is paying for that care and support. This includes help to make best use of the person's own resources to support their independence and reduce their need for long-term care.

The Council can only provide financial support to a person if the person:

- has assessed eligible care and support needs, *and*
- is unable to pay the full cost of their care, *and*
- has not deliberately given away their assets to avoid paying their care costs.

If the person receives a personal budget, whether this is in the form of a direct payment or not, they will be asked to contribute towards it if they are financially able to afford it. For some this might mean paying for the full cost of their care. If they (or their suitable person) choose to receive their personal budget as a direct payment, their assessed contribution will be deducted and the Council will pay the remaining balance of the direct payment to them. (See **Section 15 DIRECT PAYMENTS**.)

13.2 Financial Assessment

Assessor: If some of the care and support options may be services for which the local authority makes a charge, ensure that the person understands that they may have to pay a contribution towards their services, and that a financial assessment has to be completed if it has not already been done. Record the person's decision either to request or decline a financial assessment on the Core assessment on Frameworki.

RBKC only: Ask the person to complete and sign a Financial Assessment Agreement form, unless they have already done so, or it is inappropriate at that point (for example, if the person is ill or distressed).

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All boroughs: The Financial Assessment Service will then contact the adult or their carer if appropriate to arrange to carry out a financial assessment.

If the person is eligible for financial support, the financial officer explains to the direct payment recipient the payment processes and the options for receiving the direct payments.

To find out how much the person might have to contribute, the Financial Assessment Service carries out a financial assessment. Part of the financial assessment might include referring the user to an income maximisation service to check that they are receiving all the benefits they are entitled to, using the income maximisation service for over 50s referral form.

[WCC: financial assessment form; joint team welfare benefit form]

Direct payments do not affect any benefits the person might be receiving.

Assessor: If there is concern that the person does not have capacity to make a financial decision and has no family or friends to assist with their financial affairs, carry out a mental capacity assessment. If you determine that the person does not have the capacity to make this decision, then arrange a Best Interests meeting to determine which course of action is necessary. Discuss with your manager how to do this. (See **Section 35 CONSENT AND CAPACITY** and **36 BEST INTERESTS**.)

Please Note: **It is important to complete a Financial Assessment form and return it to the Financial Assessment Service as soon as possible to avoid delays in arranging support, especially for Direct Payments.**

13.3 People who organise their own care

More and more people are choosing to organise their own care. These can be either:

- People who have chosen not to approach Adult Social Care for help and have decided to pay for all services themselves (these are self-funders)
- People who have been assessed but are not currently eligible for social care services (these are also self-funders)
- People who have approached adult social care and have been assessed as having eligible needs but their savings are above £23,250 (these are full cost payers)
- People who have chosen to have their care services delivered via a direct payment where they organise, arrange and plan their own care services (these are direct payment recipients).

These services usually relate to residential and nursing care but may include other services such as home care or equipment and adaptations.

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People who organise their own care are sometimes known as 'self funders'. Some people choose to organise their own care because they prefer not to be financially assessed.

Please Note: **Self-funders are people who choose to organise and pay for their own care. Full cost payers are persons who have had an assessment and have been deemed to be eligible for services, but at full cost to them. Direct payment recipients are people who are eligible for services who have chosen to take their personal budget directly so they can manage, arrange and organise their own care services.**

Assessor: If the person you have assessed chooses to organise their own care, advise them that Adult Social Care may be able to help them in one or all of the following ways:

- free assessment of care and support needs
- assessment and advice from OT service to determine required works for any home adaptations, and support in the process
- access to reablement services
- information about residential and nursing care
- information to help arrange care and support
- free income maximisation check
- information about NHS Funding
- help if they have concerns about their care
- support for direct payment recipients.

13.4 Charging and contributions

Under the Care Act local authorities have a duty to arrange care and support for those with eligible needs. Local authorities have the power to charge for services following a person's needs assessment.

An individual will not be required to pay a contribution for their care if they:

- receive intermediate care including reablement (community independence) services. These are short-term services usually provided for a maximum of six weeks, for example, to help them recover when they are being discharged from hospital (see also **section 13.4.1**)
- receive mental health 'after care' services (under Section 117 of the Mental Health Act 1983 these services must be provided free of charge regardless of the person's ability to pay for them)
- they suffer from Creuzfeldt Jacob Disease (CJD)
- their services are provided as 'continuing healthcare' by the NHS

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- they receive equipment or minor adaptations to increase their independence at home.

People have always had to pay something towards the cost of chargeable care and support depending on their ability to pay.There are services that the Council provides, for which individuals may have to make a financial contribution.

The Council asks for contributions towards the following categories of care:

- respite care (see **section 13.4.2 Carers' services**)
- home care
- day care
- transport to day care
- residential/nursing care (see **section 13.5**)
- services in "supported" or "sheltered" housing.

To decide what a person can afford to pay, the local authority carries out a financial assessment by taking in to account their income and assets. The local authority then calculates how much the person can afford to pay towards their care and support costs. (See **section 13.2**.) Sometimes the person may be required to pay the full cost and sometimes the cost will be shared between the person and their local authority. The size of the contribution depends on both the relevant Council's charging policy and the outcome of the financial assessment.

For all the services listed above, if a person has savings and/or investments over £23,250 they have to pay the full cost of their support in these categories. If they have savings and/or investments below £23,250 the financial assessment works out how much they can afford to contribute towards their personal budget. The Council ignores the value of the home in which the person normally lives.

13.4.1 Reablement

Adults do not have to pay for care provided by the Reablement Service for *up to* six weeks.

If an adult with an existing package of care and support is referred to the Reablement Service because of new needs, charging will continue for the existing care and support package. The person will not be charged for the new 'reabling' part of the care and support package.

Where there is a delay in setting up a person's reablement package, the six week non-chargeable period will apply from the date the reablement service starts.

13.4.2 Carers' services

There is no charge for services provided directly to carers. **See Section 11 CARERS**. However:

WCC and RBKC only: Services provided to the cared for person are subject to charging. These include sitting services and carers' respite in residential units.

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13.5 Charging for Care Homes

See **section 22.7 Financial Assessment** for procedures for financial assessment and treatment of property for people entering residential and nursing accommodation.

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14 SUPPORT PLANNING

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

14.1 Introduction

This section is intended for all practitioners who, following an assessment of an adult's/ carer's needs and the agreement of an indicative/ provisional personal budget, undertake care and support planning, where the local authority will be meeting some or all of the person's identified eligible needs. It is also intended for managers signing off assessments and for Panel members.

Sections 24, 25 and 26 of the Care Act 2014 set out the duties and powers in relation to care and support planning for adults and carers. Chapters 10, 11 and 12 of the Guidance apply. A plan must be provided where a person has eligible needs under Section 18 or 20(1), or where the LA chooses to use its powers to meet needs under Section 19(1) or (2) and 20(6) of the Act. For support planning for carers, see **Section 11 CARERS**.

Meeting needs is an important concept under the Act and moves away from the notion of providing services. The purpose of the care and support planning process is to agree how a person's needs should be met.

14.2 Purpose of care and support planning

The purpose of the care and support plan is to identify appropriate care and support to meet the person's identified needs and to enable them to achieve their desired outcomes, within the agreed indicative personal budget.

Support planning may involve a process of liaising with various agencies. Seek the person's consent before sharing information (or, if they lack capacity to provide this consent, where it is in their best interests).

Keep the person at the centre of the process. Where appropriate, and with the person's consent, consult informal carers and family members.

Please Note: This policy applies to all individuals regardless of the setting in which their needs are met. People in residential care homes must also receive a personal budget and care and support plan.

RBKC: Where home care is part of the support plan, it is the Home Care Management Team who liaises with providers.

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14.3 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

14.4 Designing the support plan

The assessor will already have explained the process of personal budget allocation, budget management options and support planning to the person, and how long that process might take. They will have explained that the options can include direct payments which can be used to employ a Personal Assistant (PA), or agency care, options within their own community, networks, own income and benefits and natural resources.

The next step is to design a care and support plan for an individual assessed as having eligible needs.

Practitioner: When the indicative personal budget has been determined, explain to the person that they have a choice. They can take a personal budget in one of the following three ways:

- in the form of a **direct payment**, or
- by way of Council–managed services, i.e. to pay for community care services which are commissioned by the Council, or
- as a combination of the above.

Our aim is to maximise the number of people receiving direct payments or having third party-managed care rather than using directly commissioned services. However, a person must not be forced to take a direct payment against their will.

Direct Payments can be:

- paid directly into the person's bank account
- managed by Adult Social Care on behalf of the person
- managed by a third party where the person has the mental capacity to make this decision
- managed by an authorised person where the direct payment recipient lacks the mental capacity to make this decision.

Please Note: the actual budget and care and support plan are agreed only when the plan is authorised.

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14.5 Outcomes

The next step is to identify specific desired outcomes for the person. Outcomes are central to assessment and support planning. Broad outcome areas will have been determined at the assessment stage (see **section 9.13 Outcomes**), but they are refined and made more specific at this point to inform support planning

Practitioner: Discuss with the individual to refine and further specify the desired outcomes identified at the assessment stage, and record them

It is important that a person includes all outcomes that are important to them and not just those that may be relevant to adult social care, in order to provide an holistic approach. However, explain that only those outcomes related to the needs which have been assessed as eligible can be met using Adult Social Care funding. With other outcomes, you may be able to offer advice, guidance or suggestions, or through discussion, the person may come up with their own suggestions/solutions to achieving their desired outcomes.

Encourage people to consider what would make a difference in how their care is provided, who is important in their lives, and how the way that care needs are met will help them achieve their desired outcomes and keep them safe.

Where a person is unable to express their desired outcomes, see whether they have previously been able to write down or express their views in any way to family, friends or others.

Outcomes need to be:

- the end result, not the means to the end
- written using the person's own words where possible, and be clearly recorded as such
- recorded in the person's name.

Using the SMART acronym can be helpful when supporting an individual to identify their outcomes:

S = Specific
M = Measurable
A = Achievable
R = Realistic and relevant
T = Timely

It needs to be possible to measure at the review stage whether the outcome has been achieved partially or fully, or not at all, and, if not, the reasons for this.

Outcomes personal to the individual help to ensure that the care and support provided is tailored to individual need, circumstances and, where possible, preferences. It is important therefore to consider how someone's own quality of life will be improved by meeting their needs and how this may affect the support that should be provided.

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It would not be appropriate in a complex care and support plan to attach an individual outcome to every single identified need. It should be possible to identify those outcomes that are of particular significance to the person.

Example 1

Broad outcome: – Jonah wants to be clean and tidy every day.

Specific outcomes: these are determined by inserting the word 'by'; for example:

By having a shower every morning
By washing his hair twice a week
By choosing what he wears every day

The next step is to address the options as to how each aspect could be achieved. The solutions, that is, how it will happen, might include the following:

Employing a PA who will attend to his personal care needs on a daily basis.
His PA will support him to wash his hair on a weekly basis.
His sister is going to support him to de-clutter his wardrobe, to sort out his clothes and help him to arrange them in his wardrobe so they are readily accessible.

Example 2

Broad outcome: – Sam wants to feel more positive in his caring role

Specific outcomes, for example:

By having an afternoon off once a week to go for a cycle ride
By going swimming on a Saturday morning
By going out with his son once a week
By reading books again
By eating healthier meals

Example 3

Broad outcome: – Asha wants to get involved in her community and feel less isolated.

Specific outcomes, for example:

By joining a swimming class
By meeting her sister twice a week for coffee
By joining a local walking group
By going to her library twice a week

The solutions might include:

She will need a support worker for two hours to accompany her to go swimming.

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She will ask her sister to collect her twice a week and take her to the local café.

She can join the group independently but will need her support worker to accompany her on the walks each time so will need to cost this into her care and support plan.

Her mum has agreed to take her to the library twice a week.

We should give as much choice and control on how services are delivered to the person as possible within the boundaries of the Council's policies.

14.6 Care and support plan

A good care and support plan must include:

- a statement of the person's needs identified in the assessment, and whether and to what extent the needs meet the eligibility criteria
- the personal budget
- how and on what the personal budget will be spent to address eligible needs
- what outcomes the individual wants to achieve, how the plan will enable this to happen, and how those outcomes will be measured
- information and advice on what can be done to reduce the needs in question, and to prevent or delay the development of needs in the future
- where some or all of the needs are being met via a direct payment, the needs to be met via the direct payment and the amount and frequency of the payments
- what safeguards are in place
- what suitable contingencies have been put in place.

14.7 Keeping safe

Practitioner: Encourage people to consider both practical and financial risks relevant to their support plan. Include an overview of any risks identified, for example:

- in the home environment
- where support is refused
- in intended activities
- in relation to the choice of a Personal Assistant/s
- standards of service
- management of finances and of the Personal Budget
- meeting employment law responsibilities
- absence of a named person to contact in an emergency

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and how they are to be minimised and managed.

Please Note: The plan will not be agreed if it is too general and where there are no clear actions detailed to ensure the person's safety and to ensure they have as much control as possible. Refer to **Section 10 RISK** for more details.

14.8 Needs met by carer

Practitioner: In developing a care and support plan for the cared for person, consider any needs which are being met by a carer. The cared for person may have assessed eligible needs which are being met by a carer at the time of the plan. In these cases, involve the carer in the planning process. Provided the carer remains willing and able to continue caring, the local authority is not required to meet those needs. However, where the carer has eligible needs, consider combining the plans of the adult requiring care and support and the carer, if all parties agree. Establish whether the carer requires an independent advocate. See **Section 11 CARERS**.

Consider which needs are being met by a particular type of support, to whom the support will be provided directly, and therefore who is liable to pay any charges due. Where the service is provided directly to the adult needing care, even though it is meeting the carer's needs, then the adult is liable for any charges and charges must not be imposed on the carer in these instances.

Decide, as part of the care and support planning process, which individual's personal budget includes the cost of meeting which needs. Where appropriate, consider joint plans and therefore joint personal budgets.

Where an adult has their own care and support plan to meet eligible needs, and the carer's needs will be met in part or full by the specified support, document this provision in both plans.

14.9 Process

Practitioner:

- When the elements of the care and support plan are known, enter them on the Care and Support Plan on Frameworki in the Care and Support Plan episode. Include both the services covered by direct payment and any traditional services (purchased by the Council) that are applicable.
- For details of the steps on Frameworki, see **3B Purchasing in Frameworki** (guidance updated July 2015).
- Choose the outcome to purchase any services required by the care and support plan for both services covered by direct payment and any traditional service. The budget amount will transfer to any personal budget purchasing episode.

If the person is taking some or all of their personal budget as Direct Payments, see **Section 15 DIRECT PAYMENTS**.

If the person will be receiving Council-commissioned services, see **Section 19**.

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Apply to Best Outcomes/ Complex Needs Panel if extra care sheltered, residential or nursing care is indicated – see **Section 23 PANEL.** The Panel will check whether this course of action will lead to best outcomes for the person.

14.9.1 Approval

Manager:

- Check:
  - that the person has agreed the care and support plan and the personal budget
  - the amount of the personal budget, particularly if it differs from the indicative personal budget, and
  - the start date for the direct payments, where applicable.

- Check and approve the care and support plan and complete the episode on Frameworki.
- Ensure that a personal budget purchasing episode outcome has been created either from the Review Support episode or the Care and Support Plan episode.
- Ensure that Review episode has been created following on from the Care and Support Plan episode.

14.10 Giving the support plan to person

Practitioner: Send a letter to the person confirming that the care and support plan has been agreed and enclose a copy of the plan.

It is essential to give the person a copy of their care and support plan as this is a quality measure of informing adults and carers about their care. When printing out on Frameworki, consider the option of using a larger font. The only exception is if the person is unable to receive a plan because of the effects of a learning disability, mental health or cognitive problem, in which case give the carer or representative a copy, if appropriate. Also send copies to anyone else the person requests should have one, including an advocate.

Record on the care and support plan the planned date of issue (to person or carer) or the reason why it wasn't issued to the user. If a person is unable to read it, then verbally explain or translate the plan for the user or a representative.

Record in the case notes the date that a care and support plan has been sent.

14.11 Personal budget agreement for people taking a direct payment

Practitioner: When the care and support plan is agreed, make a final visit to the person to ensure they are satisfied with the process and the agreed plan and use of their personal budget.

If they have not already done so, the person signs a Personal Budget (PB) Agreement. The PB agreement is a formal contract which sets out the rules on the

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use and management of a personal budget and explains to the individual their responsibility and the Council's responsibility.

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15 DIRECT PAYMENTS

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

15.1 Introduction

This section explains the process of using a direct payment, so that the practitioner (assessor, broker, direct payments staff) can guide the person appropriately. You will have reached this section whilst the person is writing a care and support plan (see **Section 14 SUPPORT PLANNING**) and the person wishes to take their personal budget in the form of a direct payment.

Direct payments are payments made to individuals who prefer this method to meet some or all of their eligible care and support needs. The legislative context for direct payments is set out in the Care Act, Section 117(2C) of the Mental Health Act 1983 (the 1983 Act) and the Care and Support (Direct Payments) Regulations 2014. See also **Section 45 LEGISLATIVE FRAMEWORK**.

For direct payments to carers, see **Section 11 CARERS**.

Please Note: Further details of practical steps can be found in the **Direct Payments and Support Planning Handbook for Practitioners**.

15.2 Using direct payments

Practitioner: You must offer the person the choice to take some or all of their personal budget as a direct payment at several points throughout the process.

Adult Social Care is committed to enabling people with eligible needs to have as much choice, control and independence as possible within the boundaries of Council policy on how public money may be spent, and will offer direct payments to all individuals who are eligible. Rather than receiving a fixed range of services and little choice, individuals should be better able to design the support which best meets their agreed needs and achieve their desired outcomes.

If a person decides to take some or all of their personal budget in the form of a direct payment, to be managed either by themselves or by a suitable third party, the person may require assistance from the practitioner to set up the support arrangements. A person must not be forced to take a direct payment against their will. Direct payments can only be used to pay for the support that meets the person's assessed

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eligible needs and are detailed in the support plan. An example of the way direct payments are used is to employ someone of the person's choice to assist them.

Please Note: The local authority still has a duty to ensure needs are being met, and that the resources made available are sufficient to meet their eligible needs, even if the person makes their own arrangements via direct payments. The arrangements need to be written in the care and support plan.

Direct payments must not be provided to[9]:

- people in receipt of specific treatment under the Mental Health Act
- people receiving services through a compulsory court order
- people receiving compulsory treatment for substance misuse
- people going through the criminal justice system or who are serving a community sentence for a criminal offence.

15.3 Giving information about direct payments

Practitioner:

Give the person and their advocate, as appropriate, the following information verbally and with the appropriate leaflets:

- Explanation that the direct payment is designed to be used flexibly and innovatively with no unreasonable restrictions placed on its use, as long as it is to meet eligible care and support needs
- What needs could be met by direct payments – these needs must be assessed eligible needs, and the direct payments must be used to help meet the identified outcomes
- The option to have a mixed package of direct payments and other forms of using personal budgets
- Explanation of the amount of the direct payment, and that the person will be financially assessed and may need to make financial contributions, and whether the direct payment is the whole or part of the personal budget
- The difference between purchasing regulated and unregulated services (for example, regarding personal assistants)
- Explanation of responsibilities that come with being an employer, managing the payment, and monitoring arrangements
- Signposting to direct payment support and support organisations available in the area (for example, employment, payroll, administrative support, personal assistants, peer support)
- Local examples and links to people successfully using direct payments in similar circumstances to the person

[9] The 2009 Direct Payment regulations and the Care and Support (Direct Payments) Regulations 2014.

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- The circumstances in which direct payments may be terminated or suspended as written in the direct payment agreement.

15.4 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

15.5 Request for direct payments

Practitioner:

- If a person requests to receive direct payments, consider their request carefully.
- If there is concern about the person's capacity to decide to take some or all of their personal budget as a direct payment, assess their capacity to make that decision (see **Section 35 CONSENT AND CAPACITY**). Consider whether capacity is constant or likely to fluctuate. Where it is clear that fluctuating capacity is a known issue, or likely to be, record details of this in the care and support plan. The Care and Support (Direct Payments) Regulations 2014 allow for direct payments to continue to be made in cases of fluctuating capacity. If you assess that the person does not have capacity to make this decision, then make a decision in their best interests (see **Section 36 BEST INTERESTS**).
- Where you have assessed that the person in need of care and support lacks capacity to request the direct payment, an authorised person can request the direct payment on the person's behalf. Consider any circumstance where it would not be appropriate for a third party to be involved, and make a best interests decision.
- Consider the suitability of the person requesting the direct payment and determine whether direct payments are an appropriate way of meeting the assessed needs in question. Record the determination in the care and support plan. Advise whether direct payments are suitable, and explain what is involved.
- If you consider that direct payments are not suitable in this case, check with your manager. If they agree, inform the person and provide reasons for the decision, and advise the person how to appeal the decision through the complaints process should they so wish.
- Make this determination in as timely a manner as possible.

15.6 Methods of managing the direct payments

Direct payments can be:

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- managed by the direct payments recipient themselves, in which case they are paid directly into the person's separate current bank account (not a savings account) set up specifically for the direct payments, or
- managed by a third party nominated person in which case the nominated person must set up a separate current bank account (not a savings account) in their own name specifically for the direct payments. This can be done in one of two cases:
  - where the person either is assessed not to have capacity to manage the payments themselves and a suitable person is identified to act in their best interests. This 'nominated person' must sign the 'suitable person agreement', and becomes the legal employer of any staff
  - where the person does have the capacity to manage the direct payments, but chooses to have someone else do so on their behalf. The person receiving care and the third party 'nominated person' both need to sign the direct payments agreement. Make it clear that if the person does choose to have a third party manage the direct payments for them and if the third party misuses the payment, the ultimate responsibility lies with the person themselves, not the third party.

  If the nominated person feels unable to manage the direct payment funds, there is the option of a managed account. This can be discussed with the Direct Payment Project team. See **section 15.6.1** below,

  If there is concern about the person's capacity to choose a third party to manage the direct payment for them, then undertake a mental capacity assessment. (Remember that capacity is assessed relative to each specific decision.) If you assess that the person does not have capacity to make this decision, then make a decision in their best interests.

  Where a nominated person has been requested to receive the direct payment, involve that nominated person in the development of the care and support plan, as long as the person receiving care agrees. Where the person does not specifically request this involvement, consider whether to encourage the person to make that request. During this process, give the nominated person information regarding the direct payments processes, as well as information and advice on using and managing the direct payment, so that the nominated person understands their legal obligations as the direct payment recipient to act in the best interests of the person receiving care (see also **section 15.8 Direct payments and employing someone** below).

If the person receiving care has been assessed to make a financial contribution towards their care, they must also pay this into wherever their funds are being held to ensure that there is sufficient money to pay for the care agreed within their support plan.

Please Note: Arrangements are being made to offer a pre-paid debit card to direct payment recipients: the Council would transfer direct payments onto this card. This option is not currently available (August 2015).

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15.6.1 Managed account

In certain circumstances a managed account can be set up.

The criteria to be met are:

- The person receiving care has the capacity to manage their care and support, but is assessed to be unable to manage the money element of the direct payments, or
- The person receiving care lacks capacity to manage the direct payments, but has a nominated person who can manage the care aspect of the direct payments but is unable or unwilling to manage the money, or
- The person responsible for the direct payments is not managing their direct payments appropriately, or
- The person responsible for the direct payments requires support to get back on track with their direct payments

In a managed account, the Council manages the direct payment funds on behalf of the person responsible for the direct payments. The Council holds the money and pays the PA/agency and liaises with relevant organisations. If employing a Personal Assistant, the person receiving care/nominated person needs to send in the timesheets each month in order for the PA to be paid. The direct payment costing breakdown needs to be included in the care and support plan and a copy sent to the Managed Account team.

15.6.2 Full Cost Payers

If the individual has been financially assessed as needing to pay the full cost of their care, and wishes to employ a Personal Assistant, the Direct Payment Project team can provide support to the practitioner and direct payment recipient with setting up the care, and ensuring all the correct employment responsibilities have been covered, such as employer's liability insurance, payroll, annual leave and contingency.

15.6.3 Recording in the Care and Support Plan

Practitioner: Whichever method is chosen, record it in the care and support plan, showing how the direct payment will be used to meet the direct payment recipient's needs. The direct payment recipient can draw up the plan individually, with family and friends, or with help from Adult Social Care. They need to sign the care and support plan and direct payment agreement (an agreement with the Council outlining the direct payment recipient's responsibilities as the employer).

Manager: Authorise the care and support plan.

Consider other community and voluntary options to meet the person's needs when writing the care and support plan, looking at better value for money services.

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15.7 What direct payments can be spent on

Individuals can use their direct payments to access a wide range of support, **as long as the support is legal and meets agreed eligible needs and helps the person to achieve their desired outcomes**. Direct payments must be spent on things included in the care and support plan and must meet all the assessed eligible needs which the direct payment is provided to meet; that is, the person should not spend such a large proportion of the money on one need that one or more of the other assessed eligible needs for which the direct payment is provided is/are neglected.

The Direct Payment money can be used to	Examples of how the Direct Payment might be spent
Help with personal care, such as bathing and getting dressed	- Employing a care worker - Choosing an agency of the person's choice
Help with day-to-day tasks at home	- Employing a care worker - Choosing an agency of the person's choice - Paying a laundry service to collect laundry, clean it and deliver it back
Arrange for delivery of food if the person is unable to get it themselves	- Meals on wheels (contribution may be required from the person) - Delivery costs of meals - Arranging for someone to support the person to cook a meal on occasions or pay for support to go out for a meal
Help the person access their local amenities/ attend activities	- Employing a care worker to help the person attend activities
Help the person to find and pay for day activities, such as a course or a club	- Pooling budgets with other direct payment recipients to pay to maximise options for activities and combined support
Get help to find work	- Paying for support to attend interviews - Paying for help to access employment advice services
Pay for one-off pieces of equipment that are not available through other support services (for example, through occupational therapy)	- Paying for a computer to help develop skills or stay in contact with friends and relatives

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What the Direct Payment cannot be spent on
Anything illegal
Gambling
Grocery bills, alcohol or cigarettes
Paying a partner or family member who lives with the person to care for them except where the local authority determines it to be necessary (but can pay them to provide admin support – see below)
Paying for anything that other departments or statutory organisations provide, for example the NHS
Paying any rent or household bills, for example, gas and electricity bills
Permanent residential placements
Paying for services from the local authority

15.7.1 Paying family members

Direct payments cannot be used to pay a close relative living in the same household to provide care, except where the local authority determines this to be necessary. However, the Care and Support (Direct Payments) Regulations 2014 allows people to pay a close relative living in the same household to provide management and/or administrative support to the direct payments holder in cases where the local authority determines this to be necessary. This reflects the fact that in some complex situations the direct payment amount may be substantial. Family members can be paid a proportion of the direct payment, similar to what direct payment holders may pay to third party support organisations, as long as the local authority allows this.

Practitioner:

- Discuss any such arrangements in advance with the Direct Payment Project team.
- Include these arrangements in the care and support plan.
- Ensure all parties are aware of what steps to take in case of a dispute about the management of the payment by a household family member. In such circumstances, the individual needs to inform the practitioner of their concerns.
- Contact the Finance team/Direct Payment Project team for an audit to be carried out to check the direct payments are being managed/spent correctly.

15.8 Direct payments and employing someone

The direct payments recipient may choose to use some or all of their direct payments to pay for a personal assistant (PA). They can do this either by employing someone directly, or by using an agency (see **section 15.9 Alternatives to employing a PA** below).

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Practitioner: If a person decides to use their direct payments to employ someone directly, discuss with them how to deal with the following:

- **Job description and person specification** – Think about the type of assistant they want and the things they want the assistant to do for them. A lot of direct payment recipients already have a family member or friend in mind. Please ensure they do not live with them. Only in exceptional circumstances can this be agreed by your manager. See **section 15.7.1 Paying family members** above.

- **Advertising for a Personal Assistant** – Think about the best way to do this – for example, by speaking to someone at the job centre, PA pool, local shop or local newspaper. The Direct Payment Project team can support care managers and direct payment recipients with recruitment.

- **Interviewing a Personal Assistant** – Decide where they want to interview (at home, council building), prepare questions, plan the length of each interview.

- **Employee's right to work in the UK –** It is the direct payment recipient's responsibility as an employer to check all staff have the legal right to work in the UK. Advice can be found **here**. As the employer, the direct payment recipient needs to keep a copy of proof of identity – for example passport, visa – and National Insurance number.

- **Contract of Employment –** The contract details what the direct payment recipient expects from their PA and what their PA can expect from them. Two copies must be signed by both them and the PA; one for the direct payment recipient's records and one for the PA's records.

- **Employer's responsibilities for pay, tax and national insurance. Payroll services**

  A direct payment recipient may opt to undertake all employer responsibilities themselves (as set out in **section 15.8.1 Payment rates and costings** below). Make them aware that if they choose this option, they need to register with the HMRC, be set up on HMRC's Real-Time PAYE scheme, and manage all employment aspects, including taxation and national insurance and issuing payslips. HMRC produce software that allows the direct payment recipient to calculate any necessary deductions from pay but this can be a complicated process which has strict deadlines and potential fines.

  Alternatively, the direct payment recipient may purchase a payroll service (using money from the direct payment) from a provider who can take care of calculating tax and national insurance and other aspects relating to pay, including producing payslips and dealing with any queries raised by the PA regarding their pay. As a practitioner, you cannot recommend a particular payroll company but you can provide the direct payment recipient with options (see DP Useful Documents/ Resources for details of payroll companies).

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15.8.1 Payment rates and costings

Practitioner: The direct payment recipient will have an agreed weekly personal budget to be paid in the form of a direct payment, from which you will need to work out how many hours of support the person can have per week based on the PA's hourly wage, taking into account the cost elements described below. Use the costing spreadsheet (see DP Useful Documents/ Resources) to work out all the costs to be paid out of the direct payments. For more information on any of these factors or for support with working out the costings of the direct payment, contact the Direct Payment Project team.

- **Paying staff –** The Personal Assistant **cannot** be paid in cash so the direct payment recipient pays the PA's wages either by cheque or by transfer directly into the PA's bank account. All employed staff need to have a National Insurance number. The direct payment recipient has to provide staff with a payslip every time they are paid (payroll companies do this on their behalf). Work out with them the hourly rate to pay their staff. They must pay at least the national minimum wage (national living wage from April 2016).

- **Money to set aside** – As well as wages the direct payment recipient needs to set money aside to pay for annual leave cover, sickness cover, redundancy (where applicable), employer's NI (where applicable), liability insurance, payroll and contingency, as described below.

- **Annual Leave** – All staff, regardless of the hours they work, are entitled to paid annual leave. Currently this is 5.6 weeks pro-rata annually. For example, the PA works 2 days per week – 2x5.6 = 11.2 days paid holiday per year, *or* the PA works 30 hours per week – 30x5.6 = 168 hours paid holiday per year. See the annual leave entitlement **here** and the record in Useful Documents/Resources.

- **Statutory Sick Pay**

  To qualify for Statutory Sick Pay (SSP correct as of *April 2015*) the employee must:

  - earn at least £112 per week before tax (current threshold of Lower Earnings Limit)
  - be classed as an employee and have done some work for the employer
  - have been ill for at least 4 days in a row (including non-working days)
  - inform the employer they are sick before the agreed deadline – or within 7 days if there is no agreed deadline.

  Employees won't qualify if they:

  - have received the maximum amount of SSP (28 weeks)
  - are getting Statutory Maternity Pay

  If the employee is not eligible or their SSP ends, they may be able to apply for Employment and Support Allowance (ESA) if they are not eligible for SSP or their SSP has ended or is coming to an end.

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- **Redundancy**

  Redundancy is when the direct payment recipient asks staff to leave either because they do not need to employ them anymore or because they need to reduce the number of staff they have. If the direct payment recipient has to make their PA redundant they must comply with the law concerning redundancy. The PA will have certain rights, which may include redundancy pay, a notice period, consultation, or time off to find a new job.

  The employer must pay statutory redundancy pay if their PA has been working for them for two years or more, when the employee is entitled to:

  - half a week's pay for each year they worked for the employer whilst under the age of 22
  - one full week's pay for each year they worked for the employer when they were aged between 22 and 41
  - one and a half week's pay for each year they worked for the employer when they were aged 41 or older.

  Some insurance companies will help with redundancy payment cover as part of independent living insurance, depending on the reason and circumstances for the redundancy. It is good practice for the direct payment recipient to consult with the PA on the redundancy situation.

- **Tax and National Insurance**

  It is the direct payment recipient's responsibility to ensure that they are paying people correctly. HMRC provide factsheets and help on their **website**.

  There are rates and thresholds for employers[10], which are based on the employee's total pay including earnings from other jobs they may have, which determine when income tax and national insurance deductions need to be made, and also when employer's national insurance needs to be paid.

- **Pensions** – see **section 15.8.2 Pensions** below.

- **Employers Liability Insurance** – It is a legal requirement for the direct payment recipient to have this insurance cover if they employ staff. This is purchased as an annual policy (see list Page 11).

- **Contingency** – see **section 15.11 Contingency planning** below.

15.8.2 Pensions

Every employer has a legal duty to help their workers in the UK to save for retirement. As an employer, they have duties in relation to everyone working for them:

- who is aged between 16 and 74
- who works in the UK

[10] These rates and thresholds change each financial year. Current thresholds may be found **here**.

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- for whom they deduct income tax and National Insurance contributions for their wage

Automatic Enrolment – From a certain date known as their 'staging date' employers must automatically enrol certain workers into a workplace pension scheme and make contributions towards it. The date depends on whether the employer pays their staff through PAYE or not. For automatic enrolment there are minimum contributions calculated as a percentage of earnings which employers must pay in order to comply with their duties.

Direct payment recipients who employ a Person Assistant will be receiving letters from the Pensions Regulator informing them of their staging date and also requesting them to nominate a contact. This could be themselves or if they feel unable to or lack mental capacity to do so, a family member or friend can be nominated. This person will receive the relevant information from the Pensions Regulator.

Direct payment recipients need to begin setting up their pension schemes 9 months before their staging date.

The three boroughs are working on a case by case basis as to whether a person's direct payments will be increased to cover the pension contribution and employer contribution cost. Some direct payments have extremely large contingencies already in place which will cover this. For new direct payments, practitioners and their managers need to allow additional funds to cover the pension costs from the direct payments.

Any direct payment recipient who is an employer and runs PAYE themselves or through a payroll company will need to automatically enrol for a pension, even if their Personal Assistants wish to opt out and not be part of a pension scheme. There are fines for any employer who does not have a pension in place by their staging date.

For more information, please see the **Pensions Regulator** website or contact the Direct Payment Project team.

15.8.3 Self-employed Personal Assistants

There is a big difference between the tax and employment status of a Personal Assistant (PA) who is employed and one who is self-employed and charges for their time by invoice.

The three boroughs have taken advice from HMRC that PAs working with direct payment recipients through direct payments cannot usually do this work on a self-employed basis under HMRC guidelines due to the nature of the work. If a PA is genuinely self-employed they will normally be registered as such with the HMRC and they will be responsible for arranging their own Tax and National Insurance contributions.

A person can only be self-employed if they have control over their work: HMRC have a set of questions to test whether someone has such control. It is very unlikely that in practice a PA will pass these tests. There is risk for both the direct payment recipient and the PA that the PA's self-employed status could be challenged in both an HMRC

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Tribunal and an Employment Tribunal, and the direct payment recipient might have to pay tax and National Insurance on everything they have paid for every day the PA has worked for them. It is therefore important for the direct payment recipient to get advice if considering this course of action.

Practitioner:

- If you discover a direct payment recipient is claiming to be using a self-employed PA, explain the policy of the three boroughs on the use of direct payments for recruiting the services of a PA and why in almost all circumstances HMRC will consider PAs to be an employee of the direct payment recipient. Explain the potential liability to the direct payment recipient for all tax and National Insurance owed for all payments made to the PA.
- Offer to assist the direct payment recipient to directly employ the PA, including advising on appropriate rates of pay, issuing a contract of employment, registering with a payroll company and obtaining appropriate employer's liability insurance.
- If the PA does not wish to become an employee, advise the direct payment recipient that they will either need to find an alternative PA or to use an agency.
- Always ensure that you follow up your advice in writing to the direct payment recipient, including their potential personal liability for any tax and National Insurance. You may also need to consider suspending the direct payment if the direct payment recipient refuses to comply.

15.8.4 Other issues to consider when employing a Personal Assistant

- **Employers Liability Insurance**

  Under the Employer's Liability (Compulsory Insurance) Act 1969 ALL employers are required to take out Employer's Liability Insurance cover. Without employer's liability insurance in place, the employer could potentially be fined £2500 per day. Employment liability insurance companies provide advice around PA misconduct, redundancy and other legal issues.

  There are a number of organisations that offer this insurance specifically for people employing staff through direct payments (see DP Useful Documents/ Resources).

  The Liability Insurance is payable as a one-off annual fee and cover needs to be arranged to start on the first day of employment.

  The three boroughs recommend taking the comprehensive, enhanced insurance policy from the chosen insurance provider. With the enhanced cover the individual has access to telephone helplines which can help with employment questions, personal injury cover, legal expenses and a number of other facilities that justify the small price difference.

- **Health and Safety**

  The direct payment recipient has a legal responsibility to make sure that their PA remains safe and healthy whilst doing their job.

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They must:

- carry out risk assessments on their home, including pets or any animals they keep
- think about any training the PA needs
- tell their PA about health and safety, including fire safety: the fire service offer a free assessment
- record (and possibly report) any accidents that take place in their home
- take out employers' liability insurance as a legal requirement (see above)

See DP Useful Documents/ Resources for an example of a health and safety risk assessment the direct payment recipient can complete with their PA.

For safer handling issues, contact the Direct Payment Project team

If the direct payment recipient employs more than five people they will need a health and safety policy. The health and safety executive website has lots of support and free leaflets, including a model policy.

- **Disclosure and Barring Service (DBS, formally CRB) checks** – are recommended but not required. If required, it needs to be clearly stated on any advert. The Council can help facilitate this and the costs are recouped from the direct payments. For more information, please see **DBS** and DP Useful Documents/ Resources.

- **Support for staffing issues** – The individual can contact ACAS or the Citizens Advice Bureau for guidance. The person's insurance company or payroll provider may also offer support and be contactable for support. Also there is an excellent toolkit **here**.

15.8.5 Record Keeping

It is the direct payment recipient's responsibility to maintain accurate financial records and all relevant documentation so that the Council can understand where and how they are spending their direct payments, and check that the service they use is lawful and meets their assessed needs.

The direct payment recipient must keep records of all income and spending for account used for direct payments for a period of 7 years. This includes:

- monthly bank statements
- payslips in respect of all PAs employed
- signed receipts for cash payments made for support (where the cash payment has been agreed by the council)
- records of any other costs, spending and receipts.

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15.9 Alternatives to employing a PA

There are a number of things to consider when becoming an employer. It might be that an individual has chosen the ideal person to become their Personal Assistant but they do not want or cannot manage all of the responsibilities. There are a few alternatives that could work for them:

Third Party Employer – A nominated person can manage the direct payment on an individual's behalf and not only look after the finances but also become the legal employer and take all of the employment responsibilities as described above in **section 15.6 Methods of managing the direct payments**.

Secondment to an agency –The PA signs up with a domiciliary care agency. The agency is then the employer and the person receiving care does not have any employment responsibilities. The agency can also provide replacement carers if necessary. The PA needs to meet the standards for the agency and the direct payment recipient is not in control of how much money the PA receives as this is set by the agency. However, for their fees the agency provides training and supervision for the PA.

'In Between' providers – There are two organisations who offer a middle-way between employment and agency. Homecare Direct and Independent Living Alternatives can become the legal employer of the PA but the direct payment recipient retains the management and supervision of the PA. The direct payment recipient sets the hourly rate and the organisation charges an administration fee on top to cover employment administration including PAYE. The direct payment recipient retains responsibility for replacing their PA if they are away from work.

15.9.1 Agency CQC registration

Any provider of regulated services must be registered with the Care Quality Commission (CQC).

Practitioner: If the direct payment recipient chooses to use an agency to provide a personal assistant, advise them to use an agency registered with the CQC. If the agency loses their CQC registration, then advise them that it would be wise to change. If the person has capacity to make the decision, they can choose to continue with the agency as long as they understand the risks. If the person is assessed as not having capacity to make the decision, then make the decision whether to change the provider in the best interests of the person.

15.10 Writing the Care and Support Plan

The following example illustrates the Information which needs to be included when writing a care and support plan

Information to be included	Example

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Personal budget amount and how the personal budget will be managed – for example, direct payment managed by the person receiving care, direct payment managed by nominated person, direct payment managed by the Council, or commissioned services managed by the council.	Personal Budget – £80 Direct payments managed by Mr Example's daughter (nominated person).
Assessed needs and agreed outcomes	Mr Example needs support with personal care on a daily basis – support to include showering, assistance with going to the toilet, getting dressed and breakfast preparation.
Managing the direct payment Details of how the assessed needs will be met – Personal Assistant's (PA) name, what support the PA will provide, name of agency/PA to be used to cover Annual Leave/sickness. Any informal support provided by family member(s).	Mr Example needs assistance with personal care. This will be met through direct payments. Mr Example wishes to use his direct payments to employ a Personal Assistant who will provide him with personal care for one hour daily at £9ph. The PA will provide assistance with showering, creaming, dressing and prompting medication.
Responsibilities of the employer (direct payment recipient)	Details of what the employer (direct payment recipient) will do – for example, Mr Example will complete timesheets, payslips, contract, and ensure the PA is aware they are entitled to annual leave
Provide costings for care, liability insurance, payroll company, PA's annual leave, employer's national insurance (if applicable), contingency money.	Costings per week: Personal Assistant: To provide 1hr per day x 7 days pw personal care @ £9ph= £63 Annual leave for PA pw =£6.78 Contingency pw = £3.62 Liability insurance (include the policy no.) = £2.60 Payroll – As PA has a second job, payroll will need to be run = £4 **Total £80 per week** *(Worked out using the costings Excel spreadsheet – see DP Useful Documents/ Resources)*

Risks and how the risk will be minimised	If the PA is no longer able to continue their role, Mr Smith's family will provide support until they can find a suitable PA.

15.11 Contingency planning

Practitioner: Where some or all of a personal budget is taken as a direct payment, describe in the care and support plan what will happen to address emergencies and planned absences. This is referred to as a contingency plan and forms part of the care and support plan. Also include in the direct payment breakdown/costings section how much money needs to be kept aside for contingency.

Examples are:

- a family carer is unwell
- the direct payment recipient needs to go into hospital
- a personal assistant, employed via a direct payment, is unavailable due to illness/annual leave/maternity

so that the person needs support from another source to ensure needs are still met.

Where the contingency arises from a planned event, for example, annual leave, include the cost of employing replacement support. Where the contingency is to cover an unexpected event – for example, sickness – include an indicative sum. The contingency plan may not always incur additional costs – for example, where a relative agrees to provide emergency cover on an unpaid basis when the person's PA is absent through illness. Where additional costs are identified, these should be proportional to the contingency need.

The amount of money set aside to cover contingencies cannot exceed 5% of each weekly direct payment up to a maximum total equivalent to 8 weeks direct payments. Funds in excess of this amount will need to be paid back to the Council.

Good contingency planning means the person will not need to check with their assessor first about additional costs.

Contingency arrangements need to include the **what, who, how** and **actual** and/or **indicative costs.**

15.12 Short-term care in a care home

Direct payments cannot currently be used to pay for people to live in long-term care home placements[11]. However, people who are living in care homes may receive direct payments in relation to non-residential care services.

However, direct payments can be used to pay for short-term respite care in a care home.

[11] However, the government intends to extend rights to direct payments in such circumstances from April 2020, to coincide with the introduction of the cap on care costs.

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15.13 Direct payment activation

For details of how to purchase a direct payment on Frameworki, see **3B Purchasing in Frameworki** (guidance updated July 2015).

Before a direct payment can be activated the person needs to complete the bank details form.

Practitioner:

- When the person is employing a care worker or other staff, check the support plan with the Finance team before being signed by the team manager and person.
- Send the completed borough-specific direct payment agreement and **Bank details form** to the Finance team. (These forms are not on Frameworki: they can be found on TriBNet – see links)

- Choose "Financial Assessment Notification" as the outcome at the end of the purchasing episode. A direct payment can only be activated once practitioners complete the purchasing episode and the budget has been authorised by the manager. Ensure the purchasing episode is finished once the manager has authorised the episode.
- It is good practice to set the direct payment start date with two weeks' notice.

If the person is using their personal budget for a service they get on a regular basis such as home care, Finance send out a 'Payment Schedule' when the direct payments are first set up, which:

- sets out the arrangements they have put in place to pay for their care
- specifies any agreements the person has made for times when they do not need care - for instance, if they go away on holiday or go into hospital, or if they do not need the care for any other reason. For example, they might agree to pay for the care if they are absent and have not given enough notice, but they do not pay if they have given notice within a pre-agreed timescale.

Finance send out an updated version of the 'Payment Schedule' each January.

15.14 Direct payments and changes in circumstances

Practitioner: Inform the person receiving care that if their circumstances change – for instance, they go on holiday or need to go into hospital – or they become unable to handle their affairs, they should contact the Council at the earliest opportunity. This enables Adult Social Care to take appropriate action to ensure their care continues to run smoothly.

If they wish to stop temporarily or to end their direct payment, they should contact the Council, giving us as much notice as possible. Payments cannot necessarily be stopped immediately: for example, if the direct payment recipient is using their direct payments to employ someone directly, then notice needs to be given to the employee.

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Alternative arrangements can be made for the person receiving care, and any unspent direct payment money should be paid back to the Council.

See also **section 15.11 Contingency planning**

Practitioner:

- When Adult Social Care is notified of a change, check the support plan to assess the appropriate action that will be required on Frameworki. The action on Frameworki triggers the workflow to Finance to start, suspend or end payment. If this requires urgent action, please also telephone the Finance team to alert them.
- If the authorised person managing the direct payments requires a stay in hospital, and where this has not been addressed in the contingency part of the support plan, then conduct an urgent review to ensure the person for whom the direct payments are being provided continues to receive the care and support they require.

For details about how to suspend a care package on Frameworki, see **3B Purchasing in Frameworki** (guidance updated July 2015).

15.14.1 Direct payment recipient going into hospital

Direct payments do not necessarily need to be suspended while the person is in hospital: they can be used, for example, to maintain employment arrangements for a PA. This needs to be written in the care and support plan and agreed by management. So the options for direct payments when the recipient goes into hospital are:

Practitioner:

a. Continue with the direct payments if the recipient requires ongoing support whilst in hospital: obtain your manager's agreement to this course of action.

b. If the recipient does not require ongoing support whilst in hospital and their usual direct payment pays for agency support, then ask the recipient to inform the agency immediately, and suspend the direct payments for the period of the hospital stay (as described above).

c. If the recipient does not require ongoing support whilst in hospital and their usual direct payment pays for a directly employed personal assistant, then ask the recipient to give the PA four weeks' notice of suspension of employment at the end four weeks if it is clear that the hospital stay will be for longer than eight weeks in total, and suspend the direct payments for the period of the hospital stay after eight weeks (as described above).

15.15 Reviewing direct payments

Practitioner:

- Conduct a 'light-touch' review after six weeks to check with the person that the direct payment arrangements are working properly, and make any necessary adjustments.

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- Review direct payments after 6 months in first year and every 12 months thereafter, to make sure the direct payments are being used to meet the care and support needs set out in the support plan.

Things to check during the review:

- Look at the last quarterly return to get an overview of the compliance with the employer responsibilities.
- Check with the Financial Assessment Service whether the person is making any contributions towards their personal budget if they have been assessed to do so.
- Check whether the person has a copy of the employee contract – does it include terms and conditions on pay, holidays, notice and disciplinary procedures?
- Check whether the person has given due consideration to their employee's health and safety while at work.
- Check payroll and Employer's Liability Insurance is set up.

Record the person's responses to the above questions as it is important that they maintain a full understanding of their responsibilities as an employer. Record if there are particular reasons why these questions are not appropriate. This will mean that everyone is comfortable about the person's role as an employer.

If these checks raise any concerns for you, then discuss with your manager.

The Direct Payments Finance team will write to the person quarterly requesting their financial monitoring returns, which need to be annotated highlighting the income and expenditure on the direct payments account. Failure to return the financial monitoring documents could lead to the direct payments being suspended.

If money is building up in the direct payment recipient's account, check with your manager and the Finance team about whether it is appropriate to request that the person pays back some or all of the balance to the Council. Arrange for a re-assessment of the person's needs and to check the amount of the personal budget. Then re-set the amount of the direct payments. Ensure there are no outstanding tax bills or PA wages before clawback.

The Care Act Guidance requires the local authority to keep the direct payments process minimal and not to place an undue burden on the person to provide information or disproportionate reporting. So consider lowering the monitoring requirements once you are confident that the direct payments are being used properly. ***Please Note:*** However, it is still the Council's responsibility to ensure that the direct payments are being used to meet the care and support needs of the recipient, and helping them to achieve their identified outcomes.

See also **Section 23 PANEL**.

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16 REVIEWING CARE AND SUPPORT

16.1 Discontinuing direct payments

Direct payments should only be terminated as a last resort, or where there is clear and serious contradiction of the Regulations or where the conditions in Sections 31 or 32 of the Act are no longer met (except in cases of fluctuating capacity – see below). Effective but proportionate monitoring processes will help to spot any potential issues before a termination is necessary.

Direct payments may be terminated in the following circumstances:

- The person to whom direct payments are made no longer needs the support or no longer wishes to receive the direct payments, or no longer appears to be capable of managing the direct payments
- The person has died or moved out of borough
- The person's capacity to consent changes
- The person does not comply with the direct payments agreement, for example, the direct payments are not being used to meet the person's care and support needs.

Practitioner:

- If you are considering discontinuing direct payments for any reason, in all cases, as soon as possible, discuss with individuals, their carers and any person managing the direct payments, in order to explore all available options before making the final decision to terminate the direct payments. For example, if ability to manage is an issue, give the individual an opportunity to demonstrate that they can continue to manage direct payments, albeit with greater support if appropriate. Do not automatically assume when problems arise that the only solution is to discontinue or end direct payments.
- If you decide to withdraw direct payments, conduct a review of the plan and agree alternative care and support provision with the person, their carer and independent advocate if they have one, unless the withdrawal was following a review after which you concluded that the services were no longer needed.
- Give a minimum period of 4 weeks' notice, except in serious cases (for example, the authorised person is not acting in the best interests of the person).
- Take reasonable steps to make people aware of the potential consequences if direct payments end, and any obligations they may have, for example, ongoing contractual responsibilities or having to terminate contracts for services (including possibly making employees redundant). There may be circumstances where the person has lost the capacity to manage the direct payment and there is no-one else to manage the payment on their behalf, or where a person needs additional support to terminate arrangements. In these cases consider whether to provide

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support to ensure that any contractual arrangements are appropriately terminated to ensure that additional costs are not incurred.

16.2 Direct payments and Personal Health Budgets

See **section 29.8 Personal Health Budgets (PHBs)**.

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17 OCCUPATIONAL THERAPY

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

To be added.

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18 DIRECT PAYMENTS FOR OT EQUIPMENT AND ADAPTATIONS

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

To be added.

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19 ORGANISING COMMUNITY BASED COUNCIL-COMMISSIONED CARE AND SUPPORT

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

19.1 Introduction

This section is for assessors working with people who have chosen (or, if they lack capacity to make this choice, where it is in their best interests – see **Section 36 BEST INTERESTS**) to have the Council arrange traditional Council-commissioned services on their behalf (see **Section 19**). In this case, it is the assessor's responsibility to work with the person and carer where appropriate to create a care and support plan which specifies what services are required.

Home care – **RBKC and WCC**: ordering of home care from providers is done by the Home Care Management Team (WCC – in the community only, not in hospitals), who decides who the provider is going to be and the exact timing of visits according to priorities. They also record variations on the care. (To be fully implemented in WCC in July 2015.) See **section 19.4** on this page below.

LBHF: Social workers order home care from providers.

19.2 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

19.3 Organising Care and Support

Assessor: Organise all other care and support, including the services below:

- nutrition and home meals – refer to a dietician to develop a dietary plan; then explore ordering on-line, making arrangements with a local provider, or arranging for frozen meals to be supplied

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- day opportunities – consider day centres, local voluntary groups, using personal budgets to create new day opportunities. Personal budgets can be pooled to provide day opportunities.
- telecare – consider using for assessment purposes as well as to increase independence and reduce risk at home. Stand alone equipment may be appropriate where ongoing monitoring is not required.
- community equipment and minor adaptations – consider whether simple equipment or minor adaptations may increase independence and safety. If more complex equipment may be required, discuss with OT to consider whether a request for OT assessment should be made

Please Note: Use the People First website to explore possible ways to meet identified needs.

To support carers in their role, consider:

- respite care in own home
- respite care outside own home.

Consider completing continuing health care (CHC) checklist.

Apply to Best Outcomes/Complex Needs Panel if extra care sheltered, residential or nursing care is indicated – see **Section 23 PANEL**.

For details of the steps for purchasing services on Frameworki, see **3B Purchasing in Frameworki (**guidance updated July 2015).

19.4 Ordering Home Care

RBKC only: For details of the steps on Frameworki, see "**Requesting home care from EMT" in Fwi Guidance.**

19.4.1 RBKC and WCC

Assessor: Specify what Home Care is required on the care and support plan:

- the task/s to be carried out
- the amount of time to be spent at each visit
- the day/s the visit should occur – maximum flexibility should be indicated
- the time of day the visit should occur – maximum flexibility should be indicated
- the frequency the visit should occur – only specify if it is not every week (the options are every 2, 3 or 4 weeks)
- any special requirements such as:-
  – any gender or cultural requirements
  – if it is a request for double-up visits
  – if a specialist BME or LD provider is needed
  – any non-ordinary budget type (for example, Reablement, Continuing Care, S117) that the care needs to charged against

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- whether the person lacks capacity to consent to any intervention and, if so, what is in their best interests (see **Section 36 BEST INTERESTS**).

Clearly it is important to be as flexible as possible in deciding the timing of visits in order to use the time of the home carers efficiently. However, in some situations, it is important to time visits accurately, for example, if the person needs to be helped to get up and dressed in time to be ready for transport to another service.

The options for priorities for the time frame of visits are:

Standard – visit can be set up for anytime 9 – 5 pm, generally Monday to Friday (for example, practical care visits)

Priority – visit must occur in a particular part of the day (for example, early morning/late morning/lunchtime – for medication visits, meal visits, getting person up/to bed)

Critical – visit must occur at the precise time specified (for example, because of its impact on other events that day such as day care, getting to work).

Please Note: All visits will be Standard unless the Home Care Management Team are told otherwise.

These visit priority categories are primarily to help our main home care providers (currently Care UK and Plan Personnel) know what degree of flexibility they have when first rostering these visits. The person will still get a regular time slot even with Standard visits. Note: other providers are not party to using these categories of Visit Priority, but will still need to be advised of critical time-frames.

Send a task in the Purchasing episode to Home Care Management Team so they can begin work on the package.

For emergency care requests and hospital discharges please make sure by phone that the HCMT is aware of the urgency to provide care.

If there are changes to the Care and support plan after you have sent it please contact the HCMT by phone to alert them of the changes – they will not know otherwise.

The HCMT creates a Home Care Order on Frameworki and liaises with Home Care Providers and the person or carer. In some cases it may be necessary to liaise with the care manager.

HCMT team only:

Confirm arrangements for homecare with providers, person and care manager.

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- Enter a case note on Frameworki and send an alert to the relevant team duty worker.

Please Note: Providers have been instructed not to accept requests for or changes to care packages directly from care managers. They will only deal with the HCMT.

Manager:

- Check and give final approval to the completed care and support plan from HCMT.
- Send a copy of the care and support plan to the person.

19.4.2 LBHF

Assessor: Specify and order home care provision on Frameworki. Select the type of care, and the day(s) and time(s) the care is required. Send to manager for authorisation.

Manager: Check and authorise the package of home care.

19.5 Dealing with 'No Replies'

The HCMT begin the process of resolving any No Replies or Failed Visits, but if they are unsuccessful in finding the person, they will inform the responsible Team Duty Worker who will then need to take appropriate action with the Duty Manager.

19.6 Arranging changes to the home care and support plan

Assessor: Pass any temporary or permanent changes or variations to the home care schedule to the HCMT.

HCMT: Create the variation on the Home Care Order.

For details of the steps on Frameworki, see **3B Purchasing in Frameworki** (guidance updated July 2015).

Manager: ***Please Note:*** If it is a new care and support plan, check and give final approval to the completed care and support plan.

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20 FAILED VISITS/ NO REPLIES

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

20.1 Introduction

No Replies are the most urgent work that we receive in Adult Social Care. Resolving a No Reply will always take precedence over other work (with the exception of carrying out a Mental Health Act assessment) unless failure to do the other work could result in a risk of serious harm to a person. No Replies are a higher priority than dealing with a new referral or a delayed hospital discharge. All staff must work as quickly as possible to resolve No Replies/Failed Visits.

The time taken to resolve a No Reply/Failed Visit could have an adverse or even fatal consequence for a person.

All members of staff have some responsibility to take action if a person does not answer their door. The amount of responsibility depends on the role of the worker and employing agency. No worker should be left in the position where they are expected to deal with a No Reply without being able to seek support and advice from a manager.

Deciding what action to take can be difficult. Sometimes persons go out or go away without informing you, or are admitted to hospital without your knowledge. Sometimes they are at home but have decided not to let anyone in. It is therefore extremely important that we explain to persons that they should let us know if they are not going to be at home and of the possible consequences if they do not do so. It is equally important that we are aware that persons are more likely to advise us of their movements if they are receiving a reliable service.

It is essential that we have adequate and up-to-date records on persons, so that we know:

- the names, addresses and telephone numbers (landline and mobile) of the next-of-kin and other important contacts
- whether the person is a subscriber to CAS/Link Alarm system
- who is the nearest key holder
- who their GP is
- which hospitals or day centres the user attends
- whether the person has any serious conditions such as epilepsy or a heart condition, or whether the person has known alcohol or substance misuse issues, as these influence the urgency of the response.

A good needs assessment which indicates how dependent the user is, whether he or she is housebound, at risk, vulnerable, or socially isolated or is likely to get lost outside their home or is forgetful or confused, is as important as personal details.

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There will always be times when difficult decisions have to be made. There is a requirement in the policy to obtain adequate information and to follow procedure and seek advice appropriately. We are caring for some of the most vulnerable people in the community and the welfare of our persons is our primary concern. The Policy is in place to protect adults requiring care and support, and workers.

The contact centres in the three boroughs have been set up to act as the first point of contact for both public and professionals and can be used to report any No Replies, failed visits and cancelled visits between 9.00 am and 5.00 pm Monday to Friday They are:

LBHF: H&F Advice

RBKC: Social Servicesline

CC: Agilysis Contact Centre.

Outside of these hours and bank holidays, all calls are picked up by the Emergency Duty Team (EDT).

Manager: All managers in Adult Social Care, the Emergency Duty Team, Social Servicesline (SSL), call centre, reception staff and mental health services must ensure **all** staff who may receive information on a No Reply or Failed Visit are thoroughly familiar with the Policy, have ready access to the Policy and are aware of their role in the reporting, recording, communication and follow up required. **The Policy must be made available to all staff that may encounter a No Reply/Failed Visit.**

There are different roles and responsibilities for SSL, reception staff, the Home Care Management Team, the homecare agencies and care coordination staff.

Managers may make decisions at any point in the process regarding action or no further action required. Not all sections of the document are applicable in all cases.

20.2 Definitions

No Reply: Where there is no access or contact with the person at a planned or agreed visit. This includes planned or agreed visits by the care manager or other essential service providers and should be dealt with under this policy. If you speak to a family member or carer who gives an explanation as to the person's whereabouts or why they do not want a visit, but you do not **see** the person, then you should report this. This is not considered a No Reply, but comes under the definition of a Failed Visit.

Failed Visit: Where the purpose of the visit is not achieved because although you know the person is there, they refuse access and/or the service or family member or carer gives an explanation as to person's whereabouts. This includes planned or agreed visits by the care manager or other essential service providers and should be dealt with under this policy.

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Cancelled Visit: When the person has cancelled a visit that is shown as a critical or priority visit and has alerted the Home Care Management Team, the care worker, the assessment team or the agency that they will not be at home for the planned visit. In such instances, it is important to check that the person has capacity to make such a decision. If they do not, then the visit must still take place which will potentially result in a failed visit or no reply.

20.3 Time standards

The time taken to resolve a No Reply/Failed Visit could have an adverse or even fatal consequence for a person. Therefore, there are time standards for communicating and taking action on No Replies. There will always be occasions when work cannot get done in the timescale required but these exceptional reasons must be discussed with a manager and recorded.

20.4 Process

20.4.1 H&F

No replies/failed visits for home care and MOW are sent to H&F Advice.

H&F Advice worker:

- If the case is known to the mental health or learning disabilities service, upload the referral documents to Frameworki and add a case note. Contact the team by email/fax and a phone call. The responsibility to investigate is at this point passed to the appropriate team to investigate.
- For older adults or adults with physical disabilities, upload the referral documents and then proceed with the Frameworki 'No Reply' episode.
- Undertake an initial check on the casefile to see if there is a note about the absence. If not, phone the person receiving care and support. If there is no response, investigate through phoning next of kin/emergency contact, and ring local hospitals to check for admissions. If the person receiving care and support is found, case note the circumstances. If the person is not found, pass the case to the allocated team. Pass on information regarding a hospital admission or a break/holiday to the agency so that the no reply is not repeated the following day.
- Send a referral coming in after 3pm directly to the allocated team to investigate in the same way.
- Alert your senior/manager.

Senior/Manager

- If the person receiving care and support is not found, make a professional judgement as to whether the police are called to undertake a welfare visit or the break the door down to gain entry.

Cases are expected to be resolved by the day time service and not passed to EDT.

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20.4.2 RBKC

SSL worker/Reception staff:

- Pass all No Replies to the Home Care Management Team (HCMT) immediately upon receipt. Forward No Replies received after 5pm (16.45 on Fridays) to the Emergency Duty Team (EDT) service for action: they will be picked up by the EDT at 5.30pm. Copy emails to EMT for information.

Home Care Management Team

- Complete all the checks on the No Reply and hand over to the relevant assessment team if the situation remains unresolved within an hour of a No Reply occurring. Notify Assessment teams before 4.30pm. Forward No Replies received after 4.30 but before 5pm (4.45pm on Fridays), immediately to the appropriate assessment team. Forward No Replies received after 5pm (4.45pm on Fridays) to the EDT service for action: they will be picked up by the EDT at 5.30pm. Copy emails to SSL for information.

20.4.3 WCC

Admin/Call Centre staff:

- Pass all No Replies to the Adults Access Team immediately upon receipt. Forward No Replies received after 4.45pm to the Emergency Duty Team (EDT) service for action.

Care workers:

- Telephone the office and report the No Reply to a manager within five minutes of having completed all required checks in the local area (see below).

Agency manager

- Hand over to the HCMT within 30 minutes of a No Reply occurring (all agency checks done).

Access team

- Complete all checks on non-allocated cases. Pass No replies to locality teams if allocated. Forward No Replies received after 4.45pm to the EDT service for action, if they cannot be resolved within the day time teams.

Duty worker and the duty manager in the relevant team

- Make an informed decision as to actions to be taken within two and a half hours of the No Reply occurring.

20.5 Responsibilities of the care worker

This applies to all care workers whether they are working for an agency or the Council.

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All care workers must pass on information they receive to their office about a person's planned absence for however brief a period, for example, outpatient appointments, holidays, day trips, visits to family/friends, going shopping, a planned hospital admission or a trip to the hairdresser.

This information is vital to prevent a waste of resources.

Care worker: If you receive a No Reply or failed visit (a failed visit can be the person refusing entry or telling you to go away) from a person's home when calling to carry out scheduled care, you must carry out or have completed the following checks:

20.5.1 Initial response

1. Give the person enough time to get to the door.
2. Knock or ring again in case they didn't hear.
3. Check for post, milk/paper deliveries, drawn curtains.
4. Look and call through the letter box, window etc.
5. Listen for sounds, for example the television, running water, the radio.
6. Check for unusual smells.
7. Check if there are any neighbours or friends around who could help you (confidentiality policy applies – if in doubt check with a manager). Ask when they last saw/heard the person.
8. Find out if there are any porters, housekeepers, caretakers or wardens on site who could help in discovering the whereabouts of person or help getting into the person's home.
9. If the person lives in a block of flats then you should try to gain access into the block; if you cannot, then you need to report this as a No Reply.
10. If you see the person on the floor call the Emergency Services immediately on 999.

Follow the No Reply procedure fully. Do not leave a note unless instructed to do so by your manager.

Ring your office to report the No Reply immediately if you still do not know the person's whereabouts.

If the person does not accept the care or they do not allow access then report in the same way as a No Reply.

20.6 Responsibilities of the agency (and Council Enablement Service managers in RBKC)

Manager:

1. Check that the No Reply Policy checks have been fully carried out up to that point: if not, ask the care worker to do the checks and telephone back.

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2. Telephone the person immediately (landline and mobile if appropriate) to see if they have returned home.
3. Check whether keys are held by your agency or by the Community Alarm Service (CAS).
4. Check your information systems and with the last care worker who saw the person to determine if there has been any new information which might tell you the person's whereabouts; for example, the person might have told their morning care worker they were going out shopping and the information has not reached you yet.
5. Check with a named contact person/next of kin/key-holder listed on the person's information to see if they know where the person is. Check when they last saw or heard from the person. Are they in a position to visit or help? Do they have keys or other contact details?
6. If the location of the person is established, record the action taken and outcome on person's file and notify the appropriate Care Management Team immediately of action taken and outcome by telephone then confirm by fax.
7. If all relevant checks have been completed and the whereabouts of the person are still unknown, contact the RBKC Home Care Management Team by telephone without delay on [redacted] between 9am and 5pm Monday to Friday. They contact the Emergency Duty Team outside of normal office hours on [redacted].
8. Contact the WCC access or care management team manager without delay, if all relevant checks have been completed and the whereabouts of the person are still unknown. This can be done via [redacted] or [redacted] out of hours
9. Record the name of the person in the Home Care Management Team that you reported the No Reply to and the time you did so.
10. Complete the No Reply form and fax it to the Home Care Management Team on [redacted], following your phone call. Record all the times, dates and checks done on the form. You may use emails provided it is secure to protect person confidentiality.

WCC: Fax: [redacted], email adultsocialcare@westminster.gov.uk or contact for .gscx account details

20.7 Responsibilities of the appropriate care management team

All Failed Visits require some form of follow up action, as the person will not have received their planned care. Investigate Failed Visits on the day they occur and inform a manager if there are concerns about the person's welfare.

The appropriate/relevant care management team take responsibility for further action on a No Reply to ensure that follow up work is done and a decision is made.

Team member:

1. When advised by the service provider (enablement or agency) of an unresolved No Reply, check the Policy has been followed and relevant checks have been carried out.

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2. Inform the care management team manager of the outstanding No Reply.
3. Continue the No Reply policy checks indicated on the faxed form sent by the service provider. Ask the service provider to fax/email the No Reply form if they have not already done so.

4. Use discretion as to whom to contact first, depending on the known history of the person. Record all contacts, including times, on Frameworki.
5. Check whether there is a contact person (for example: next of kin, a key-holder, relative, warden, porter, friend or neighbour) prepared to assist and visit the person's home. Ask them to telephone you as soon as they have done so. Explain the need to confirm the wellbeing of the person as soon as possible and before the end of the working day.
6. If the contact is prepared to visit the person's home, but is unable to do so before 5.30pm, ask them to telephone the Emergency Duty Team to report back what they have found.
7. If the contact is not prepared, or unable, to visit the person's home, explain the No Reply policy. Explain that we need to confirm the wellbeing of the person and if they cannot be located, may have to involve the police and force an entry.

8. Check the person's file on Frameworki case notes for previous No Replies in the past few days and follow up where it was established the person was on previous occasions.
9. Check whether the person has the Community Alarm System (if this has not already been done).
10. Telephone the appropriate local hospitals (Chelsea and Westminster, St Mary's, Charing Cross, Hammersmith or any hospital the person is linked to). Check A&E, Outpatients and Admissions.
11. Telephone the person's GP – establish if they have any particular concerns regarding the health of the person.
12. Telephone any day centres attended by the person.
13. Telephone any other providers of services to the person, for example, district nurses or Age Concern.
14. If possible contact any other known places the person may go.
15. Discuss with your manager if the situation remains unresolved at 4.30pm

    RBKC: Call and email the duty service of the relevant assessment team who makes a decision on the next course of action. Duty workers in the relevant assessment teams must see this as a priority and discuss the situation directly with the HCMT. If you are unable to contact the duty service call the manager of the relevant assessment team directly for advice on how to proceed.

16. If the location of the person is established, record the action taken and outcome on the person's case notes in Frameworki.
17. Inform all service providers experiencing a No Reply of the resolution as soon as possible by telephone.

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20.8 Emergency Duty Team (EDT) and out of hours response

20.8.1 The Emergency Duty Team's expectation of providers

If the agency cannot identify the whereabouts of the person after the relevant checks have been done they contact EDT if the No Reply is received out of hours.

Agency managers receiving No Replies ensure care workers have carried out the necessary checks by telephone and on the doorstep and ask them to do so if they have not.

20.8.2 Emergency Duty Team (social worker/manager) responsibilities *(This should be double checked now they are all one team WCC used to operate slightly differently – they used to get the call centre to do basic checks and feed back to EDSW)*

EDT social worker:

1. As soon as practicable in the light of other EDT referrals, telephone the person's number. If there is no reply, telephone the contact numbers available and check when the person was last seen, whether the No Reply was at the time the person expected a visit, at what time the next visit to the home is due.
2. Check local hospitals.
3. If you have still not identified the whereabouts of the person, wait until after 7pm to telephone again unless there is good reason to be very concerned.
4. If there is no good reason to suspect that the person is out then try again to contact the person. If the family members have been unavailable earlier in the day, try to contact them again this time.
5. If the whereabouts and safety of the person still cannot be ascertained, then call the Community Alarm Service (CAS) or the caretaker with access to the person's block of flats, determining whether they have keys for the personIf so, ask them to accompany you to visit the person.
6. If there are no keys available, ask the police to accompany you to visit the person and if necessary to break down the door to gain access. It can be frightening for a person to wake up to find strangers in their flat (even more so if the door is broken down). Many persons have heart problems or other illnesses affected by stress or sudden shocks. So do not instigate breaking doors down after 11.30 pm unless there is **very** good reason to suspect a person is in need of immediate help.
7. If during their investigations, you establish the location of the person, record the action taken and the outcome on the person's case notes in Frameworki.

20.9 Responsibilities of the assessment and care management team for allocated cases and cases on review

This section applies to all allocated cases and cases on 'review'. Allocated cases are the responsibility of the allocated worker and ultimately the relevant assessment team. This also includes community psychiatric nurses or occupational therapists when they are the only allocated worker to the particular person.

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All Failed Visits require some form of follow up action, as the person will not have received their planned care. Investigate Failed Visits on the day they occur and inform a manager if there are concerns about the person's welfare.

RBKC: The Home Care Management Team will have completed all of the necessary checks to ascertain where the person is or how they are. However, if they are unable to resolve the situation, they contact the relevant team for final action. All Teams must see this as priority work and discuss the situation with the HCMT directly to ensure all information is forwarded appropriately.

The allocated worker takes responsibility for further action on a No Reply if available: if not, a duty worker or manager takes responsibility to ensure the follow up work and decision making is made.

Allocated worker:

- Discuss with your manager if a visit to the person's home is required.

Team or Duty Manager:

- At 4.30 pm make a decision about whether to enter the property or to give the person further time to return to the property, if this has not already been actioned.
- If it is decided to enter the property, contact the Police and a local locksmith (see People First for contact details). The police will not always agree to visiting or entering the property. There is a need to have evidence before phoning the police that there is sufficient risk to justify a visit to enter the property and that all avenues have been exhausted before this action is to be taken. Have the person's information available in case police need specific information about health and risk. When visiting with the Police ensure that a decision is made as to which agency will secure the property as this is a joint responsibility between Social Services and the Police. This decision needs to be made before the property is left unattended.

Allocated worker:

- Inform any service providers experiencing a No Reply of the resolution immediately by telephone if possible.

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21 EXTRA CARE HOUSING

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

21.1 Introduction

Extra Care Housing schemes are for older people who are resident in one of the three boroughs and who need a package of care and support to live independently in the community in their own flat.

Extra Care Housing schemes offer individuals the opportunity to maintain or increase their independence. When writing and organising care and support plans, ensure that individuals are enabled to be as independent as possible: for example, encourage the person to make their own cups of tea, prepare their meals, and dust their flats where at all possible in order to maintain their independence.

Extra Care Housing is not an alternative to residential care; people needing residential care have higher needs. It also differs from ordinary sheltered care schemes by being staffed 24 hours a day. Ordinary sheltered accommodation will have limited access to a scheme manager who may visit only for a few hours a day.

Details of all of the Extra Care Housing Schemes in the three boroughs can be found on the People First website.

Extra Care Housing has nothing to do with the Councils' Housing departments.

21.2 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

21.2.1 Signing or ending tenancies

Individuals must have capacity to sign or end tenancies. A person can act on their behalf if they have a lasting power of attorney that covers the management of finances and property.

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If the person is assessed as not having the capacity to make a decision about their tenancy, and there is no-one else authorised to give consent on their behalf, then make a best interests decision. See **guidance from the Public Guardian Office on tenancy agreements**.http://www.mentalhealthlaw.co.uk/File:COP_guidance_on_tenancy_agreements_February_2012.pdf

21.3 LBHF

People can be considered for Extra Care Sheltered Housing in LBHF if they are aged 60+; have Adult Social Care needs between 1- 17 hours per week; and/or would have met the previous eligibility criteria for residential care.

There are currently 4 Extra Care Resources within LBHF:

Mary Seacole House – 24 Invermead Close W6 0QH
Elgin Close – 1-3 Elgin Close, Elgin Avenue W12 9NH
Elm Grove – 20 Bute Gardens W6 7DS
Olive House – 185 Townmead Road SW6 2JY

The waiting lists for the resources vary over time. It is imperative, as far as possible, for the individual to state a preference.

In addition to the process described in **section 21.2** , the process is as follows:

Allocated worker:

- Give full consideration as to why the person cannot be maintained in their current home with increased care provision and assistive technology.
- Complete a Core Assessment on Frameworki.
- When you have gathered all the information/ evidence, book a slot at the Best Outcomes Panel. See **Section 23 PANEL** for more details.

Panel:

- Once a decision is made, enter a case note on the case file and send an alert to the worker and their manager.
- Send a copy of the documentation to the relevant Extra Care Sheltered resource, and give them the name and contact number of the allocated worker.

The Resource will then contact the relevant worker to arrange a time when they can take the adult receiving care and support to visit and a time when the Resource will carry out their own assessment.

In some cases there may be an immediate vacancy; more often the person will be placed on the waiting list.

Allocated worker:

- You will be informed when a vacancy has arisen and if the person is still interested in moving you will need to arrange the move.

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- Keep the Service Manager updated about any move-in date or change in circumstances as she manages the waiting list. Failure to do so could result in an individual missing out and having to wait longer for a vacancy.
- Care staff within Extra Care Sheltered Housing do not deal with the practical aspects of moving in such as putting up curtains etc. If there are no family members/ friends who can assist with this, you may need to commission paid carer workers to do so.
- You are responsible for seeing that:
    - the previous tenancy is ended
    - financial systems are in place
    - there is a care plan which details what care and support the person needs in their new home
    - where appropriate, an application for Housing Benefit is completed.
- Complete a RAS and an EPAC order for a standard amount of care of 17.5 hours per week.

- Change the address on the front screen of Frameworki.
- Subsequent to moving in, review the person in line with usual arrangements.

21.4 RBKC

Currently there are four schemes all located in the north of the borough. Three are owned by Octavia housing; Highlever Road, James Hill House and Miranda House. Burgess Fields is owned by the Tenant Management Organisation.

All the schemes are staffed 24 hours a day. The schemes are registered with CQC to care for older people (55 years and above); however, CQC can be approached to consider someone who is slightly younger. Currently all schemes have individuals who have mental health problems (including moderate dementia), physical disabilities and learning disabilities. All schemes except Highlever have ordinary front doors (no key pad security doors), so consider carefully whether a scheme is suitable for a person with dementia who may need assistance to leave the premises, as they may not be observed. The exception is Highlever which has flats for people with high levels of dementia and has a key pad door entry system to cater for the level of needs of the tenants who live there.

Individuals to be considered for extra care should usually need care three times a day and their needs will not be able to be met in ordinary sheltered care accommodation. Extra care housing schemes will accept people needing double-up visits and requiring hoists for transfers. However it may be necessary to use an individual's personal budget to buy in additional care, either through the scheme's resources or through external care agencies.

21.4.1 Accessing extra care housing

Allocated worker: If you are considering extra care housing for residents of the Royal Borough, complete a Core Assessment and a Best Outcomes Panel Checklist form. Include clear evidence as to why extra care is being considered: national

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eligibility criteria need to be met. Consider carefully whether the needs of the potential new tenant at night can be met, for example, those who require two workers to turn or transfer – see details below of night workers.

See **Section 23 PANEL** for more detail of Panel process.

The Best Outcomes Panel considers all applications and sends out their decisions on the day. A list is maintained of all people currently waiting for extra care accommodation and there is a designated Team Leader who is notified of all vacancies as they come up. The Panel discusses vacancies and prioritises the most urgent adult in need waiting for extra care.

Allocated worker: Due to the unpredictability of vacancies there are no guarantees as to how long a person will wait for a flat to be available. In the meantime, if a person's needs change or become more urgent, please contact the designated team leader to amend the priority of the case.

Designated team leader: When the person most in need is identified, contact both the scheme manager and social worker/social care coordinator by email to inform them and to explain that the flat needs to be seen and accepted or refused within the week.

Allocated worker: Send copies of relevant assessments to the Scheme Manager to help inform their own assessment.

Scheme manager: Assess the person's suitability for the scheme. If the scheme manager refuses the person on the basis that the scheme is not able to meet their needs, then the scheme manager sends a report to the allocated worker and the designated team leader.

Allocated worker and designated team leader: Consider the reasons for refusal and ascertain whether there is anything else that could be done to ensure the success of the tenancy.

Strict time constraints are in place to avoid the housing association not receiving rent and then billing social services for loss of income. Therefore decisions need to be made carefully and promptly and to avoid delay to other potential tenants being offered the vacancy.

Allocated worker: Keep the designated team leader informed by email of potential and actual moving-in dates. This will enable the tracking of vacancies and voids.

At times a vacant flat will need to be redecorated and this may take a few weeks (see **section 21.4.4**). In this case, reach a clear agreement with the scheme manager on the date for moving in. Raise any concerns relating to the service provided by the schemes with the designated team leader who meets with the schemes on a quarterly basis to discuss issues/concerns arising but who will act as the prime point of contact at other times.

Viewing properties – Individuals and families can visit schemes by appointment at any time. However since a visit can raise expectations, you should encourage a person and family to make a visit once a decision has been made and a vacancy

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exists within a particular scheme. Please contact the manager of scheme to arrange the viewing.

Tenancy agreements – need to be signed prior to moving in and are short-hold tenancy agreements.

Utilities and connections – Individuals need to take responsibility for connecting to telephone, water, electricity and gas. Allocated workers must ensure this is done.

Health – Individuals need to be registered with a local GP if moving into a scheme in a different location and to bring 2/3 weeks of medication with them so that there is no disruption to their medication regime. District Nurses provide support to the schemes as necessary.

Furniture – The flats are not furnished.

21.4.2 Care and support plan

Allocated worker: Before they move in, make sure that the individual has been assessed and agree a care and support plan with both the individual and the scheme manager and give them each a copy.

All schemes are staffed 24 hours per day. All schemes try to meet the care needs of the individual through their existing staff team. However, at times due to limited resources or individuals having additional needs, you will need to purchase additional care.

The Home Care Management team use the care and support plan to order home care via a home care order.

Arrange regular reviews of the person's needs, and invite the scheme manager to attend.

21.4.3 Managing finances

Rent and service charges

Tenants pay rent for the property and a service charge which also includes the alarm system, in addition to any charges towards their care and support. Tenants can apply for housing benefit for the rent, council tax and service charge costs, if eligible. It is possible for individuals to continue to receive housing benefit on their existing property if they are already claiming and to apply for Housing Benefit for a period of up to 13 weeks for their new tenancy in the extra care scheme: this gives them the opportunity to organise the move.

Allocated worker: Let the housing officer know about your client's financial situation before the person moves in. Arrange for the housing officer to see a bank statement and benefit letters, and advise them of:

- information on any arrears, and if there are arrears, the repayment plan and whether the person can also afford their rent
- who is paying the rent and from which bank account, checking that a direct debit can be set up.

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Care packages

Inform all individuals that they will be financially assessed as to how much they will contribute towards their care package and all care hours received are liable to be charged. Offer a financial assessment before admission. If you assess a person as not having capacity to manage their money and having no one else to assist, refer them to Client Affairs using **referral form** to take on formal management of their money through appointeeship or Court of Protection. (See **section 36.8 Property and Financial Affairs decisions**.)

21.4.4 Voiding a flat

- There is a four-week notice period from the first Monday after notification to end a tenancy.
- After the four-week period, the lettings and maintenance team are notified. Then a list of home improvements / decorating that are required is made. These works could take from one to four weeks to complete.
- The lettings and maintenance team then pass the flat back to be ready to let.

21.5 WCC

WCC has two schemes:

Penfold St (Notting Hill Housing)
Leonora House (Octavia Housing).

The nominations come through Adult Social Care Best Outcomes Panel or managers.

The Panel will decide if the recommendation for Extra Care housing is an appropriate way to meet the identified needs. See **Section 23 PANEL** for more details of the Panel process.

These then go to the two providers who carry out an assessment and confirm if they can meet the person's needs. The providers therefore have the say about who they admit.

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22 RESIDENTIAL AND NURSING PLACEMENTS

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

22.1 Introduction

This section provides guidance for allocated social workers/ care managers arranging residential and nursing home placements, including respite care.

22.2 Exploring options

Social worker/ Care manager: You will have already carried out an assessment of needs of the person requiring care and support, and those of their carer(s) where appropriate, and determined whether they are eligible for care and support from the local authority (see **Section 9 ASSESSMENTS**). If the person's needs meet the national eligibility criteria, before considering any form of residential or nursing care you must have fully explored community-based options, and found them not to be feasible, including:

- a package of care and support
- community independence services, including reablement, telecare/ telehealth
- respite for carer
- multi-disciplinary involvement where appropriate
- Extra Care Sheltered Housing.

If none of these options is suitable for meeting the person's need due to the level of care and support required, you must record that a care and support package is not feasible with supporting evidence.

Only then consider the option of the person moving to residential or nursing care. Note that a residential or nursing placement is not necessarily a permanent placement, and that in any case the placement will not be confirmed until the first review at about six weeks.

22.3 Emergency residential and nursing placements

"Emergency Placement" is defined as a placement being needed within 24 hours.

An emergency situation relates to a crisis of care for the individual, and the following situations are considered to be emergencies:

- Environmental: A person's home is made uninhabitable due to fire, flood or infestation

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- Safeguarding: There is a suspicion based on professional judgment that a vulnerable adult is at risk in their accommodation or in their own home
- Breakdown of care and support provided by a carer: If a carer has been providing significant levels of care and is no longer able to do so and the emergency care plan does not meet need.

Hospital discharge is not considered to be an emergency situation.

"Urgent Placement" is defined as being needed within seven days.

Manager: If needed, discuss emergency residential or nursing care with your Service Manager. If agreed, sign Request for Placement Brokerage Form 17a found in Adult Care Home Placement Request episode, so that Placement Brokerage can arrange a placement.

Mental Health team/ Out-of-Hours Team Manager: Sign an out-of-hours referral form and send to Placement Brokerage.

22.3.1 Discharge from hospital

Social worker/ Care manager: If a person is being discharged from hospital and you have fully explored all community-based options and found them not to be feasible, then arrange an interim placement in intermediate care in order to give time to carry out all the steps in the placement process.

22.4 The need for residential or nursing care

For consideration of a placement in **residential care**, the person

- has a level of need and/or psychological factors which require care through a 24-hour period; and/or
- has a level of risk which cannot be managed in the community.

For consideration of a placement in **nursing care** one of the following criteria should normally be met. The person:

- has multiple healthcare needs, which require a complex regime of medication, which can only be carried out by qualified nursing staff and cannot be provided in their current environment, and/or
- requires nursing intervention on a long-term basis at regular intervals throughout the day and night, which cannot be provided in their current environment, and/or
- has been medically assessed as being likely to be permanently and regularly incontinent of both urine and faeces which will cause risk to their health and wellbeing and cannot be managed in the person's home or in a residential care home (acute reasons for incontinence must be ruled out), and
- requires a Health Needs Assessment which may lead to continuing healthcare or free nursing care.

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Older People with dementia and other mental health/ behavioural problems

You may need to consider accommodation registered for dementia care when the person:

- demonstrates significantly impaired judgment, impaired decision making, or inability to anticipate risk and where more individual support is needed, and/or
- displays persistent and severe behaviour that causes major disturbances to other residents and staff, including regular violent episodes – a specialist facility would be required, and
- requires a Health Needs Assessment which may lead to continuing healthcare or free nursing care.

22.5 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

Social worker/ Care manager: For guidance to follow when planning and reviewing a residential or nursing placement for an individual who may lack capacity to consent to the placement, see **section 38.5 Capacity assessment**. If it is likely that any type of restraint may be used, then see **Section 38 DEPRIVATION OF LIBERTY SAFEGUARDS**.

If you assess that the person does not have capacity to make a particular financial decision and has no family or friends to assist with their financial affairs, please discuss with your manager about making a best interests decision about which course of action is necessary.

If you have doubt that the person has capacity to decide about their property arrangements, see **section 22.14.4** .

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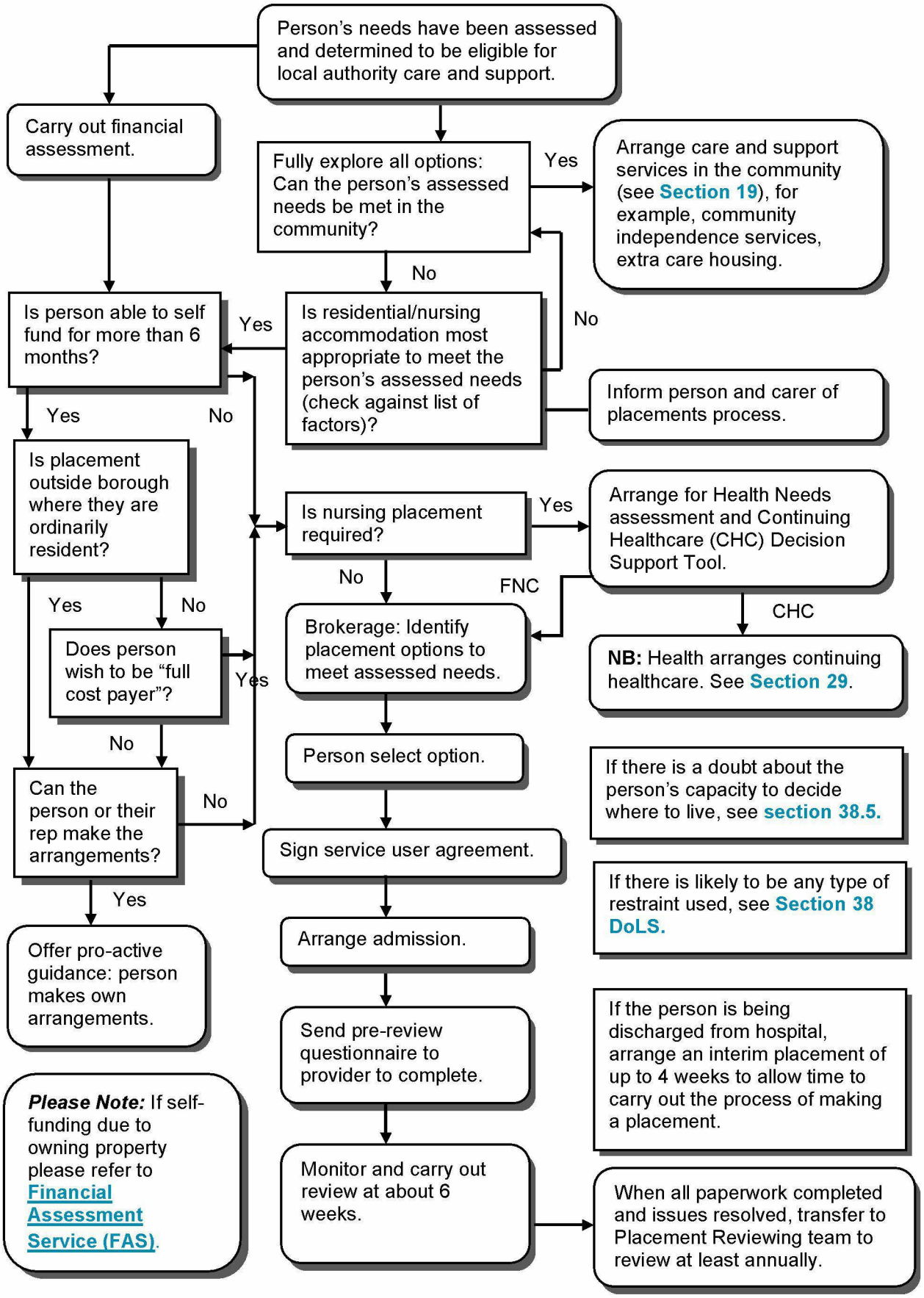
22.6 Flow chart of pathway



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22.7 Financial Assessment

Social worker/ Care manager: If you have assessed that the person requires residential or nursing care, then:

- Complete the financial assessment form as early as possible in the process and send it to the Financial Assessment Service.
- Explain to the person (and their carer) that the financial assessment will determine whether or not they will be charged for residential or nursing accommodation, and how much they will need to pay.
- Explain to them that if the fees for the accommodation they choose are above the funding level determined by the borough to be adequate to meet their assessed needs, the person may choose that accommodation, if the person themselves or a third party willing and able (or in certain circumstances the resident) to top up the cost for the duration of the placement. (See **section 22.11** for more details.)

The financial assessment can run parallel to the needs assessment but it must never influence the assessment of needs. Not completing a financial assessment in a timely manner can delay making or confirming a placement. Moreover, if a person is self-funding, this gives them more choice of placements to consider.

Within one week of receipt the Financial Assessment Service produces a provisional assessment. The person and family can also consult directly with the Financial Assessment Service if they wish.

If financial issues are complex, particularly if the person owns property, notify the Financial Assessment Service when considering a residential or nursing placement. They then arrange to visit the person to record details of the finances, to get proof of income and capital. They provide information and advice to the person at an early stage about the financial aspects of entering a care home. For more details, see **section 22.14** below.

All individuals will be charged for part or all of their care and support, except if the person:

- receives mental health 'after care' services (under Section 117 of the Mental Health Act 1983, these services must be provided free of charge regardless of their ability to pay for them)
- suffers from Creuzfeldt-Jacob Disease (CJD)
- receives services provided as 'continuing healthcare' by the NHS
- receives respite care in LBHF.

For residential/nursing care, if a person has savings and/or investments over £23,250 they have to pay the full cost of their care. If they have savings and/or investments below £23,250 they are financially assessed to calculate their contribution.

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Please Note: Where possible, identify a nominated finance contact prior to the admission of an individual, so that the home and finance team know who is dealing with finances with regard to collecting contributions/invoicing/chasing finance form. This may not always be possible in the case of emergency placements, but the importance of the financial assessment needs to be explained at the initial stages, to avoid the misconception that services are provided free (and this includes respite care in WCC/RBKC). Ensure that the financial assessment form is given to the person/nominated finance contact as early as possible for completion.

22.8 Support for those who are self funding

Local authorities must undertake an assessment for any adult with an appearance of need for care and support, regardless of whether or not the local authority thinks the individual has eligible needs or of their financial situation. However, where a person has been assessed as needing residential or nursing accommodation, if the person has the means to pay for it and if the person or someone close to them, is capable of making the arrangements themselves, then the person is considered to be a self-funder. The resident is considered self-funding if they have sufficient capital to fund their care for more than 6 months.

If the person is self-funding and has the capacity to make the decision to move to residential or nursing accommodation, or has a Lasting Power of Attorney for health and welfare and/or finance or a Lasting Power of Attorney for finance or an Enduring Power of Attorney (see **Section 37 LASTING POWERS OF ATTORNEY AND CERTIFICATE-PROVIDERS**) or a Court-appointed deputy, to assist, the Council is not required to arrange services.

Social worker/ Care manager: In this case, provide information about possible placements. Treat such self-funders in a way consistent with the Choice of Accommodation policy described below (see **section 22.10**), and encourage self-funders to look at places where there is availability.

In such a case, Adult Social Care do not negotiate with the chosen provider, and the person makes their own individual agreement with the provider regarding funding. If the accommodation is outside the borough where the person is ordinarily resident, send a letter to the relevant local authority to inform them that only advice was provided and that the resident will need to approach them for financial assistance once their capital drops below £23,250.

If Adult Social Care have fully assisted with making the placement, even if the person is self-funding, or if the person chooses to be a full-cost payer, then a Service User Agreement needs to be signed and a contract made with the provider as described below.

Social worker/ Care manager: If the person is a self-funder because they own a property, contact the Financial Assessment Service who can attend joint visits where necessary to explain the options with regard to treatment of property. (See **section 22.14 Treatment of Property**.)

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22.8.1 People who place themselves in private nursing or residential care within the borough

People who place themselves in private nursing or residential care within one of the three boroughs may approach Adult Social Care for financial assistance once their capital is likely to drop below £23,250. An assessment of need will be required at that point to establish whether the needs meet the national eligibility criteria and if so whether the person requires residential or nursing care to meet their needs.

Social worker/ Care manager: Make the resident aware that if there is a considerable delay in their advising Social Services that their capital has dropped below £23,250, then financial assistance would be provided from the date of the referral rather than the date capital dropped below £23,250.

22.9 Process for consideration and approval for individuals needing care and support throughout a 24-hour period and the role of the Best Outcomes/Complex Needs Panel

Social worker/ Care manager: You need to present any case in which an individual requires care and support throughout a 24-hour period to the Best Outcomes/Complex Needs Panel (BOP/CNP).

The Panel accepts cases for consideration for care and support throughout a 24-hour period from all adult teams, including some younger adults from CMHTs.

Social worker/ Care manager: If you are making a request for a person needing nursing care, arrange for a Health Needs Assessment and a Continuing Healthcare Decision Support Tool to be completed. Send these and all other relevant information regarding that person's needs to the Continuing Care Panel for their consideration as to whether that person meets Continuing Care eligibility for funding or Full Nursing Care funding (see **Section 29 CONTINUING HEALTHCARE** for more details).

Social worker/ Care manager: Complete the following documents in advance for a decision to be made at the Best Outcomes/Complex Needs Panel:

- Core assessment in Frameworki or Mental Health assessment and Panel checklist containing sufficient evidence to enable a decision to be made about the type of placement needed and the reasons why a care and support package in the community is not feasible
- Risk assessment
- Mental capacity assessment and Best interests decision (if required)
- Information from multi-disciplinary professionals included and attached to Assessment
- Decision support tool/Health needs assessment if considering nursing care or if continuing care funding eligibility indicated.
- Finance assessment

The Panel meets weekly to discuss the cases presented.

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Please Note: Urgent decisions can be made outside of Panel via the Head of Service. If it is not possible to take the case to the Panel, under no circumstances should social workers/ care managers be discussing possible placements with individuals until authorisation has been agreed by the Head of Service.

Please see **Section 23 PANEL** for more details of the Panel process.

The Panel makes the decision whether to approve a person's need for residential or nursing care.

Panel sends out decisions made, using Frameworki, to all concerned including the Placement Brokerage team, along with any suggestions of placements that would meet the person's needs.

Manager/Team leader: Sign off assessment after the decision has been made from HNP.

22.9.1 Finding a suitable placement

Please Note: **Only the Placement Brokerage team arrange placements, not social workers/care managers.**

Social worker/ Care manager:

Complete Request for Placement Brokerage Form 17a found in Adult Care Home Placement Request episode on Frameworki.

When contacting the Placement Brokerage team, be clear about:

- the individual's needs
- preferred date/priority of placement
- any cultural, language and/or religious needs of the person
- location preferred
- where the family or friends (if any) are located.

Placement Brokerage:

- Complete Placement Brokerage Response Form 17b found in Adult Care Home Placement – Brokerage Response episode, within agreed timescales.
- Identify placement options. The priority is voids in block contracts. If there are no voids in block contract accommodation or block contract accommodation does not meet the person's needs, search for vacancies in accommodation that does meet the person's needs and check value for money.
- Check whether the accommodation is on the Providers at Risk list and check Care Quality Commission (CQC) reports on the CQC website to see whether there are any concerns.
- Send selection of three suitable placements back for practitioner to consider. Advise the social worker/care manager of how many people Adult Social Care currently have placed there, the fee rate and contact details to arrange an assessment by the provider.

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Please Note: It is not Adult Social Care policy to place in shared rooms, unless the person/s request/s this as a positive choice. There must be a clear understanding between all parties (the individuals receiving care and support, Adult Social Care and the provider) when placing couples with written arrangements in place regarding what will happen when one party predeceases the other – for example, that the spouse will move to a single room.

All new placements and changes in placements are tracked by the Placement Brokerage team to ensure all stages in the process are completed and an appropriate placement is made.

Refer to the Choice of Accommodation Policy (see **section 22.10**) which outlines the rights available to persons when choosing residential or nursing accommodation and explicitly sets out the costs and legal responsibilities.

- The fee must be within the amount determined by the relevant borough to be sufficient to meet the person's assessed needs or a 'top-up' may be required. If the rate is above the set fee limits a third party who is able and willing (or in certain circumstances the resident) may make up the difference ('top-up'). See **section 22.11**.
- For accommodation for people with learning disabilities, the fee is determined by the Care Funding Calculator.
- If the accommodation is new to Adult Social Care and rates are not known the Placement Brokerage team assists with this and contacts the Local Authority in which the accommodation is placed to enquire about the fees being paid.

22.10 Choice of Accommodation Policy[12]

The aim of this policy is to outline clearly the rights available to individuals when choosing accommodation in a specific accommodation setting, and to set out explicitly the costs and liabilities therein. This could for example be extra care housing or a care home.

When the term "residential care" is used in this policy, it covers placements made on both a long-term and a temporary (which includes short-term care) basis to care homes, whether they provide nursing care or not.

The decision to live in a nursing home or residential care home is a major one. It is necessary for the person to weigh up factors such as the proximity of relatives, the quality and cost of accommodation and the quality of life which the person will experience. Once a home has been chosen, a person may have to consider the process they should follow until a vacancy becomes available in the home of their choice. This may involve putting in place temporary arrangements.

The underlying principles for this policy are the same as those set out in **Section 3 PROMOTING WELLBEING, PERSONALISATION AND OTHER KEY CONSIDERATIONS, AND ORDINARY RESIDENCE**.

[12] The policy is designed to meet the requirements of Annex A: Choice of accommodation and additional payments of Care Act Guidance 2014, DH

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The regulations and guidance on choice of accommodation and additional costs apply equally to those entering care for the first time, those who have already been placed by a local authority, and those who have been self-funders, but who because of diminishing resources are on the verge of needing local authority support.

Under the Care Act 2014, where the care and support planning process has determined that a person's needs are best met in a care home, the local authority must provide for the person's preferred choice of accommodation, subject to certain conditions.

Where Adult Social Care is responsible for meeting a person's care and support needs and their needs have been assessed as requiring a particular type of accommodation in order to ensure that they are met, the person must have the right to choose between different providers of that type of accommodation, provided that:

- the accommodation is suitable in relation to the individual's assessed needs
- to do so would not cost the authority more than it would usually expect to pay for someone with the individual's assessed needs
- the accommodation is available
- the provider of the accommodation is willing to enter into a contract with the local authority to provide the care at the rate identified in the person's personal budget on the local authority's terms and conditions.

The choice is between different settings, not different types. For example, a person cannot exercise the right to a choice of accommodation to choose extra care housing when the care and support planning process, which involves the person, has assessed their needs as needing to be met in a care home.

This choice must not be limited to those settings or individual providers with which the Council already contracts with or operates, or those that are within that borough's geographical boundary. It must be a genuine choice across the appropriate provision.

Social worker/ Care manager: Inform the individual receiving care and support that they have a choice of accommodation irrespective of whether they express a preference for particular accommodation. Inform the individual as fully as possible about the placements they are considering; in particular, be explicit about any CQC concerns about the nursing or residential accommodation.

If a person chooses to be placed in a setting that is outside the borough you must still arrange for their preferred care. In doing so, have regard to the cost of care in that area when setting a person's personal budget.

The person can only exercise their rights if the preferred accommodation is actually available. If a person indicates a preference for a chosen placement where there is a place available they can use their rights; if there is no place they cannot. If this is the case, set out in writing why it has not been possible to meet their choice, and offer suitable alternatives.

If you assess that the person receiving care and support lacks capacity to decide on the care home placement, follow the Best Interests procedure in order to decide

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which placement is in their best interests (see **Section 36 BEST INTERESTS**). Support the person to be involved in the decision-making process and take their views into account, which may involve supporting them to visit prospective care homes. It also includes consulting the person's carers to ascertain whether moving to one of the prospective placements is in the person's best interests. It is good practice to consider more than one placement. If their carer requests a specific placement, it must be considered whether moving there is in the person's best interests.

22.11 Care home prices and top-ups

There is recognition of the fact that some care homes/nursing homes charge prices greater than Adult Social Care's funding levels, and some individuals explicitly choose to enter accommodation which is more expensive than the relevant Council would usually expect to pay. One of the conditions associated with the provision of preferred accommodation is that such accommodation should not require the Council to pay more than it would normally expect to pay, having regard to assessed needs (the 'usual cost'). If the home is located outside the borough the 'usual cost' is the threshold set by the host borough.

In some circumstances, the Council can make placements in more expensive accommodation than it would usually expect to pay for, **provided a third party, or in certain circumstances the person in need of care and support, is able and willing to make up the difference (to 'top-up').** A third party might be a relative, a friend or any other source.

The person whose needs are to be met by the placement may themselves choose to make a 'top-up' payment only in the following circumstances:

- where they are subject to a 12-week property disregard (see **section 22.14.1**)
- where they have a deferred payment agreement in place with the local authority. Where this is the case, the terms of the agreement should reflect this arrangement. For further guidance on deferred payment agreements, see **section 22.14.3**), or
- where they are receiving accommodation provided under S117 for mental health aftercare.

Where top-ups are required from the person whose needs are being met or a third party, the person paying will need to sign an agreement that they are able and willing to pay the difference between the Council's usual rate and the accommodation's actual fees (see following).

Social worker/ Care manager:

- Provide the person paying the 'top-up' with information and advice. Explain that failure to keep up 'top-up' payments may result in the resident having to move to other accommodation, and a rise in the accommodation's fees will not automatically be shared equally between Council and the person paying.
- Advise them to obtain independent financial information and advice.

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- Check that the home is not making a separate 'top-up' agreement with the resident.
- Ensure that the person paying the 'top-up' signs a written 'top-up' agreement which specifies:
  - the additional amount to be paid
  - the amount specified for the accommodation in the person's personal budget
  - the frequency of the payments
  - to whom the payments are to be made
  - provisions for reviewing the agreement
  - a statement on the consequences of ceasing to make payments
  - a statement on the effect of any increases in charges that a provider may make
  - a statement on the effect of any changes in the financial circumstances of the person paying the 'top-up'.

The Council will not seek top-up contributions from the person whose needs are being met or a third party in cases where the Council itself decides to offer someone a place in more expensive accommodation in order to meet assessed needs, or for other reasons. Where care homes are in-borough and the Council has specific agreements on costs, these will be separately considered.

If the rate is above the set fee limits and the person whose needs are being met or a third party is not able to 'top-up', in extenuating circumstances the placement may be approved by the Service Manager, Assessment Services.

22.12 When an appropriate placement has been identified

The care home manager should visit the person to carry out the home's assessment to ensure the home can meet the person's needs.

Social worker/ Care manager:

- Advise the provider manager of the person's care and support needs, any relevant and/or current safeguarding issues and any formal complaints under investigation.
- Arrange for the person and/or relatives to visit the accommodation if possible. Check that the placement will meet the person's needs.
- Discuss with the person and the provider what possessions they can bring with them to the home to support their wellbeing. This may include photos and ornaments that are important to them as well as the basic necessities such as clothing and toiletries.
- Check with the provider whether the person can bring/get a pet if they wish.

Please Note: A person must not be admitted into residential or nursing accommodation without a signed Service User Agreement.

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22.13 Placement confirmed

Social worker/ Care manager:

- Agree admission date and inform Brokerage.
- Ensure transport arrangements are made to take the person to the accommodation on the admission day.
- Ensure arrangements are made to take person's possessions and clothes, and to mark clothing on admission, if needed.

On Frameworki:

- Complete Placement Care Plan.
- Complete a Service User Agreement. The service user agreement sets out the funding arrangements for the placements, including NHS contribution.
- *RBKC only:* Attach Financial Assessment consent.
- Notify Placement Brokerage of any changes to service.
- Set date of Placement Review.

Manager: Check and approve service agreement and Placement Care Plan.

For details of requesting placements on Frameworki, see "**Placement process" in Fwi Guidance**.

Placement Brokerage:

- Confirm fees.
- Ensure that a Service User Agreement is in place.
- Confirm start date of placement with social worker/ care manager: either directly or via case note with alert.

Social worker/ Care manager:

- Send Service User Agreement to the provider for signature before admission, and also send them a copy of the Placement Care Plan.
- Once Service User Agreement is complete with all signatories distribute copies to:
    - provider of nursing or residential care
    - the individual receiving care and support and their carer (if appropriate)

The Placement Care Plan forms the basis of our expectations of the care and support the provider will give to the person and is the foundation for future review and monitoring. It is a key document and is referred to in our contract with providers.

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Include relevant details in the Placement Care Plan so that the care home can provide the personalised care and support the person needs to improve their quality of life: this is particularly important for people who have dementia. Examples might include:

- **The person needs to walk around at 3.30, as this is when they used to collect their children from school.**
- **The person wishes to rise at 5 a.m., as this is when they used to go to work.**
- **The person has behaviour triggers, such as being touched, or someone being physically too close to them so that they will hit out. This information can help workers to predict behaviours and diffuse them before they have the opportunity to escalate.**
- **The person responds to animals, dolls, old typewriters or musical instruments. This can lead to people feeling more fulfilled and encourages more productive conversations and interactions.**

22.14 Treatment of Property

Social worker/ Care manager: This section outlines how a person's property will be treated if they go into residential or nursing accommodation. It is important for you to understand this information in order to be able to explain it to the adult and/or their carer if applicable.

22.14.1 12-week disregard of property

The Care Act 2014 requires the value of a property to be disregarded for 12 weeks from the date of a permanent placement in residential or nursing care.

This primarily benefits those who have low income and capital below £23,250 but have a property to sell. If the property owner has high levels of income or capital above £23,250 they are still required to pay the full cost or be considered as self-funding.

A key aim of the charging framework is to prevent people being forced to sell their home at a time of crisis. The regulations under the Care Act 2014 therefore create space for people to make decisions as to how to meet their contribution to the cost of their eligible care needs. A local authority must therefore disregard the value of a person's main or only home when the value of their non-housing assets is below the upper capital limit for 12 weeks in the following circumstances:

a) when they first enter a care home as a permanent resident, or

b) when a property disregard other than the 12-week property disregard unexpectedly ends because the qualifying relative has died or moved into a care home.

Please Note: In WCC and RBKC, respite care is always chargeable to the adult regardless of length of stay. In LBHF, respite care is not charged for.

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Social worker/ Care manager/ Financial assessment officer:

- Advise the resident or whoever is dealing with their finances that the property will be disregarded for the first 12 weeks following admission and for this period they will be asked to contribute based on their income and their capital over £14,250.
- Advise them to consult a solicitor and an independent financial advisor about their options after 12 weeks.

Financial assessment officer:

- Arrange for a representative from the Financial Assessment Service to attend joint meetings with the resident or family members wherever possible.
- Clarify whether a deferred payments agreement can be offered.

Financial Assessment Service:

- Arrange for a charge to be placed on the property to protect any advance of care fees agreed and enable them to be recovered from any future sale.
- Monitor the cost of the advance and maintain statistics so that these costs can be recovered.
- Provide the resident with financial assessments showing contribution required for first 12 weeks and full cost thereafter.

22.14.2 Should the property be disregarded completely?

The Financial Assessment Service uses the Care Act 2014 rules to decide whether a property should be taken into account at all in the assessment for charging.

In the following circumstances the value of the person's *main or only* home must be disregarded:

a. Where the person is receiving care in a setting that is not a care home

b. If the person's stay in a care home is temporary and they:

   i) intend to return to that property and that property is still available to them, or

   ii) are taking reasonable steps to dispose of the property in order to acquire another more suitable property to return to.

c. Where the person no longer occupies the property but it is occupied in part or whole as their main or only home by any of the people listed below, the mandatory disregard only applies where the property has been continuously occupied since before the person went into a care home (for discretionary disregards see below):

   i. the person's partner, former partner or civil partner, except where they are estranged

   ii. a lone parent who is the person's estranged or divorced partner

   iii. a relative as defined in paragraph 35 of the person or member of the person's family who is:

      - aged 60 or over, or
      - is a child of the resident aged under 18, or

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- is incapacitated.

For more details, see **section 45.3.2**.

A local authority may also use its discretion to apply a property disregard in other circumstances.

Even if the property is included in the assessment of resources, it will be disregarded for the first 12 weeks following permanent admission to a care home.

22.14.3 Universal deferred payment scheme

Under the Care Act[13], local authorities are required to provide advances of care home fees to prevent the need for properties to be sold immediately. These are known as deferred payment agreements (DPAs). By entering into a deferred payment agreement, a person can 'defer' or delay paying the costs of their care and support until a later date.

A deferral can last until death. However, many people choose to use a deferred payment agreement as a 'bridging loan' to give them time and flexibility to sell their home when they choose to do so. This is entirely up to the individual to decide.

The regulations[14] specify that someone is eligible for and so must be offered a deferred payment agreement if they meet all three of the following criteria at the point of applying for a deferred payment agreement:

- anyone whose needs are to be met by the provision of care in a care home. This is determined when someone is assessed as having eligible needs which the local authority decides should be met through a care home placement. This should comply with choice of accommodation regulations and care and support planning guidance and so take reasonable account of a person's preferences, and
- anyone who has less than (or equal to) £23,250 in assets excluding the value of their home (that is, in savings and other non-housing assets), and
- anyone whose home is not disregarded for the purposes of the financial assessment under Section 17 of the Act; for example, it is not occupied by a spouse or dependent relative as defined in regulations on charging for care and support (that is, someone whose home is taken into account in the local authority financial assessment and so might need to be sold) (see **section 22.14.2**).

In addition, the person:

- doesn't want to sell their home, or is unable to sell their home quickly enough to pay for their care, and
- can provide adequate security for the debt deferred against the property, for example, a Land Registry charge on the property.

[13] Sections 34-36 of the Care Act 2014
[14] The Care and Support (Deferred Payment Agreements) Regulations 2014

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Deferred payment agreements are often made during a time that is demanding for a person and their loved ones – a period when they are making a transition into a care home. Carers and families often assist people in making decisions about their care and how they pay for it.

Financial Assessment Service: Advise whether the criteria are met for the resident to be offered a deferred payments agreement. Offer advice about the payment of care home fees, but it may also be helpful for the person to seek independent financial advice.

Financial assessment manager: Refer the case to corporate Legal Services for a charge to be placed on the property once the debt accrues after 12 weeks.

Financial Assessment Service: Ask the person to sign a DPA form. In RBKC and WCC, there is a one-off charge to cover administration, legal and Land Registry costs, and an annual charge of £100 for running the scheme in. However, there is no one-off charge or annual fee in LBHF.

When the agreement is in place, the person will be loaned the funds to pay their care home costs which would have been met from the sale of their property. The Council will recover the full amount of the loan together with interest accrued when the property is sold or when the person leaves the care home. Interest is charged on the deferred amount to cover the cost of lending and the risk associated with the lending.

Please Note: In all cases where a person owns a property consult the Group Finance Financial Assessment Manager.

22.14.4 People who do not have mental capacity to decide about their property arrangements

If the person does not have the mental capacity to make a decision about their own property arrangements such decisions can be made on their behalf if they already have a Deputy or Enduring/ Lasting Power of Attorney acting for them. (See **Section 37 LASTING POWERS OF ATTORNEY AND CERTIFICATE-PROVIDERS** and **section 36.7.1 The Court of Protection**.)

If the person is not ready to be discharged from hospital and a relative has already applied it may be possible for a Deputy to be appointed before the person needs to leave hospital.

Applications can take a minimum of three months. The Court of Protection could agree to release funds to pay the provider while the application is processed. If the provider accepts these arrangements it would not be necessary for the local authority to arrange a contract.

22.14.5 Protection of Property

If an individual is being discharged direct from hospital to residential or nursing accommodation, arrange for Client Affairs to carry out Protection of Property duties, including making arrangements for any pets (see **Section 25 PUBLIC HEALTH FUNERALS AND PROTECTION OF PROPERTY**).

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22.15 Housing Benefits

Housing Benefits can be continued for up to 13 weeks when someone goes into residential or nursing care on a trial basis to pay for the rent on their property, but it ceases to be payable when the stay becomes permanent. As a result, people can find that having given notice on their tenancy, they have to pay rent in full for the notice period because the Housing Benefit has already been stopped.

The Financial Assessment Service recommends notifying Housing Benefits with a very clear description of the situation but requesting that HB be paid until the end of the notice period. Notification can be given in writing in the following form of words or similar:

> *"Please note that Mrs. A entered XX Residential Home on 10.1.13, initially on a trial basis.*
>
> *As a result of a review meeting on 10.2.13, she has decided to stay permanently. She is therefore giving notice on her tenancy which will expire 10.3.13.*
>
> *Please continue to pay HB up to 10.3.13."*

Whenever possible the letter should be signed by the person themselves. If you are unsure whether the person has mental capacity to make this decision then carry out a mental capacity assessment. If you assess they do not have capacity, then arrange to make a best interests decision. (See **Section 35 CONSENT AND CAPACITY** and **Section 36 BEST INTERESTS**.)

22.16 Admission

Social worker/ Care manager: On admission of the person:

- Check that the person has arrived safely at the residential or nursing accommodation.
- Check that staff at the accommodation have started an inventory of possessions and that the person has clothes and that their clothes are marked or tagged. If appropriate take photographs of possessions.
- Arrange to review the placement approximately six weeks after placement starts. Agree the review date.
- Send the **Placements Pre-review Questionnaire** to the provider manager and ask them to complete it and send it to you in advance of the review. The questionnaire helps to shape and inform the review, and also provides information to Contracts and Brokerage in ensuring the placement remains value for money.
- Invite a Financial Assessment Officer to the first review if necessary.
- If the person has a learning disability, notify CQC and the relevant NHS and Local Authority that a placement has been made in their area; that is, that you have placed a person with a pre-existing health need.

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If the person is in receipt of Attendance Allowance, this stops after four weeks; similarly the care component of Disability Living Allowance also stops (unless they are self-funding), so ensure that the Benefits Agency is informed of the placement. Check where the mobility component of the DLA is going and how it is being used.

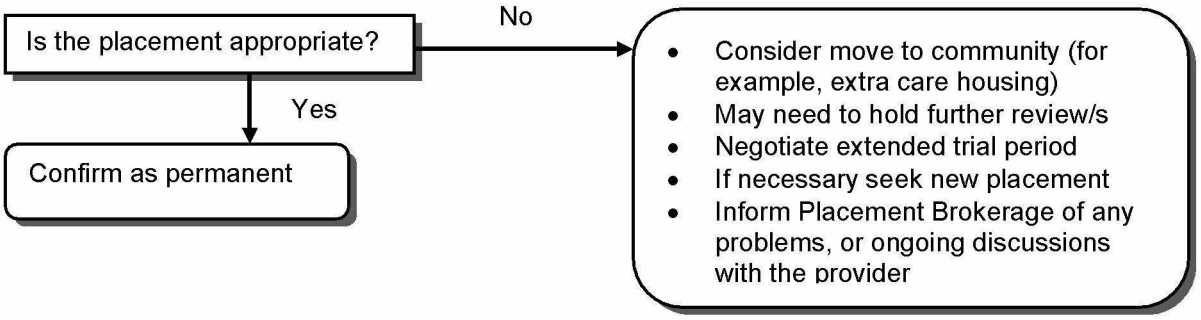
22.17 People placed out of borough

Note that under the Care Act, the principle is that a person placed out of borough is deemed to be ordinarily resident in the area of the placing authority and does not acquire 'ordinary residence' in the second or 'host' authority. The placing authority retains responsibility for meeting the person's needs.

22.18 Initial review(s)

Social worker/ Care manager:

- Monitor the placement for the initial four to six weeks (trial period) through phone calls, talking to family, visit/s to home as appropriate to ensure that the person settles in and that their care needs are being satisfactorily met.
- Hold a formal review at about six weeks from the start of the placement:



Involve the provider manager/care staff, a Financial Assessment Officer, the person, their family/friends, an advocate where indicated, and any others involved in their care. Use any pertinent issues arising from the completed pre-review questionnaire as the starting point. Check whether the placement is meeting the person's needs and their outcomes are being met. At the review, confirm the placement as permanent if appropriate. If the resident is having difficulty coping with the transition, or is unhappy in the accommodation, you may need to negotiate an extended trial period or seek an alternative placement or move to the community. If the resident lacks capacity to decide whether to stay at the placement and is unsettled, consider the use of guardianship or whether the home needs to apply for authorisation to deprive the person of their liberty under Deprivation of Liberty Safeguards (see **Section 38 DEPRIVATION OF LIBERTY SAFEGUARDS**).

Holding the first review at about six weeks allows for a further review to be held if necessary before the end of the 13-week period during which housing benefit can be paid on a person's rented property where relevant (see **section 22.15**).

When the placement has been confirmed as permanent:

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- Provide relative/representative contact details of Financial Assessment Service and of the home for invoices and correspondence.
- Notify the Department of Work and Pensions (DWP) to inform them that the person has entered into residential/ nursing care.
- Where applicable, check that Housing Benefit and Council Tax Benefit have been notified of the person's move to residential care.
- Check the situation on tenancy where applicable. The person can give up their tenancy themselves if they have capacity to do so. If they don't, an attorney or deputy over their property and financial affairs can give up a tenancy. If they don't have an attorney or deputy, an application can be made to the Court of Protection for an order that a named person can give up their tenancy, or the landlord can go to court to ask to evict them, or a best interests decision can be made. See **section 36.7.1 The Court of Protection**.
- Check that the person's accommodation has been cleared.
- Finalise paying utility bills.
- Ensure any appropriate community care is stopped, for example, homecare, meals.

- Note clearly on Frameworki who is managing the person's finances if the person lacks capacity, and check that the person is receiving their personal allowance.
- Note whether there is a will in place and record funeral arrangements if known.
- Check that a statement about the person's wishes about whether to resuscitate is in place.
- If there are concerns about the person's mental health, or the home is finding it difficult to meet their mental health needs, make a referral to the relevant mental health team and ask for their specialist input. The mental health team can carry out a mental health assessment and a risk assessment, and may be able to support the placement with behaviour programmes, training for staff and appropriate medication.

Record all actions relating to these matters with the date each organisation was notified, name of the person spoken to, the telephone number called, and attach any relevant letters or emails. This will help managers check that everything that needs to be done has been carried out.

Social worker/ Care manager:

- Ensure the provider's care plan correlates with the Placement Care Plan on Frameworki.
- Ensure the provider and the person and carer have copies of the Placement Care Plan.
- If it is a nursing placement, ensure the provider has a copy of the Continuing Care Decision Support Tool.
- Check with your line manager that all procedures have been followed.

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Steps on Frameworki – see **"Placement process" in Fwi Guidance**.

- Record the review on the Placement Review on Frameworki. Include an overview of the person, their situation, what led to a placement being considered and their history, not just a written record of what was discussed at the review on the day. This provides information to the worker who will be conducting the next annual review as they will have no prior knowledge of the situation or person.
- If necessary, update the Placement Care Plan and Service User Agreement and notify Placement Brokerage of any change to service.
- Set date of next Placement Review.
- If completing your involvement and transferring the Placement to the Placement Reviewing team, complete a case summary in case notes outlining your involvement. This should include a synopsis of primary health needs, precise details about arrangements for management of the customer's financial affairs including how they will access their personal allowance, MCA/DOLS issues and any other significant information, if this is not already included in the care plan.
- Update the front of the person's record. End all services in PB purchasing episode must be ended including the PB itself as this is no longer required: put in place a non-PB purchasing episode for the placement.
- Ensure that all notes / references / relationships / warnings / placement contact details / GP details are relevant and up to date. Please check with the home and person as to which GP is involved and record this accurately.
- End carer reviews as they do not apply once a person is in residential/ nursing care.
- Record the full contact details of family or friends – addresses, telephone numbers and email addresses where relevant.

Manager: Check and approve Placement Review. Discuss and reach agreement on transfer with Reviewing manager.

Social worker/ Care Manager: Upon agreement of transfer, send a letter to the person, family/carer and home informing them of the transfer and the contact details of the Placement Reviewing team. (A template letter is available with all necessary information to use – see Tri B net and Placement Review Team.)

22.19 Transfer to Placement Reviewing Team

Social worker/ Care manager: Ensure all tasks on the Transfer Checklist (see below) have been completed, and transfer the responsibility for ongoing monitoring and review to the Placement Reviewing Team once all major outstanding issues have been resolved.

A transfer to the Placement Reviewing Team can only be accepted if all necessary work has been completed to the required standard. This could be as soon as after the 6 week review, as long as all the paperwork is completed. If there any issues which need case work up until 9 months of the start of the placement, then the work

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is moved back to the transferring social work team to complete. The placement is transferred back to the Reviewing team when all work is done.

Team Manager: Discuss any issues arising with the Reviewing Team manager to assist achieving a prompt successful transfer.

If there is a need to complete several reviews in short timescales or to move a person quickly from a home due to an emergency or concerns, then the community teams will need to assist with this in order to keep people safe and well.

Transfer Checklist of process and documents

- **Core assessment**
- **Health Needs Assessment completed and ratified at Panel and home are being paid FNC**
- **Panel approval**
- **Pre Review Questionnaire completed**
- **Placement Care Plan and Review**
- **MCA and BI decision-making evident**
- **Financial Assessment completed, money is managed formally where needed through appointeeship/ Court of Protection**
- **Person receiving Personal Allowance**
- **Service User Agreement completed and signed**
- **Home receiving individual's contribution and third party top up where applicable**
- **Fwi workflow all completed**
- **Brokerage have loaded placement and home is being paid**
- **Information about 12-week property disregard given to all involved parties where applicable**
- **Tenancy given up/property put up for sale**
- **DWP have been informed of person's permanent admission to residential care and all appropriate benefits have ceased being paid.**

22.19.1 Allocations in Placement Reviewing team

Reviewing Manager: Allocate each new person in a placement who is transferred to the team. Use resources efficiently, so that a worker can review more than one person in a given home or geographic area, particularly when going outside the borough. Ensure worker and organisation relationships are updated on Frameworki.

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22.19.2 Annual placement reviews

All placements will be reviewed on at least an annual basis to meet statutory requirements.

Reviewing Placement Officer:

- Carry out the review. Record the review on Frameworki.
- Provide a copy of the review to the individual and the Home Manager. Record reasons if the document cannot be shared with the individual – for example, factors such as brain injury or dementia.
- Bring forward the review if there are changes in need (increase or decrease), safeguarding issues, or customer choice – for example, wanting to change placement.
- If there is a need for an unannounced visit, record the visit and any action taken.
- If the person's health has changed from the last review and it appears they may meet the criteria for CHC funding or need a move from residential care to nursing care, complete a CHC Checklist and send to the relevant Continuing Care Team, who have 28 days to complete a new health needs assessment. (See **Section 29 CONTINUING HEALTHCARE** for more details.)

The Health Needs Assessor will carry out a Health Needs Review annually to ensure that they are still eligible for either CHC funding or FNC.

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23 PANEL

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

23.1 Purpose

Each borough has a Panel to examine more complex cases. The Panels are ***(check names)***:

LBHF: Complex Needs Panel

RBKC: Best Outcomes Panel

WCC: Residential and Nursing Care Panel

The purpose of the Panel in each borough is to ensure that the most appropriate outcomes are achieved for adults with eligible care and support needs, making the best use of resources available within the borough, and to provide appropriate governance arrangements for the borough in line with the Care Act.

23.2 Membership

The Panel includes nominated leads from each team. Other staff may be invited to attend a particular meeting where necessary and in agreement with the Head of Service.

The Panel normally meets in person. In exceptional circumstances, where there are other over-riding priorities, the Panel meeting may be held virtually using video or phone conferencing facilities, or via email.

23.3 Scope of Panel

The Panel examines cases where:

- Extra care sheltered housing tenancies are being considered
- Residential or nursing home placements are being considered
- Emergency placements have already been made where necessary
- Complex packages costing more than £500 per week are being proposed
- There are concerns and the case requires discussion and agreement on the direction of travel (how such cases are dealt with in terms of time and place depends on the requirements of each borough).

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23.4 Submitting cases to Panel

Practitioner:

- Discuss and agree case with your manager before submitting to Panel.
- Share with the Service Manager/ Head of Service before Panel.
- Complete Panel checklist and send with relevant documentation to the Panel inbox.

LBHF: ***??*** Submit cases by 12 noon on Wednesday, before the following Monday's Panel.

RBKC: **BestOutcomesPanel@rbkc.gov.uk** Submit cases by 4.00 pm on Friday, before the following Thursday's Panel.

WCC: **placementspaneladults@westminster.gov.uk** Submit cases by 12 noon on Thursday, before the Panel on the same day at 2.00 pm.

Please Note: The Panel is unlikely to agree recommendations for the case if up-to-date assessments or appropriate mental capacity assessments have not been completed.

23.5 Recording

Panel Chair:

- Record the conclusions of the discussion at the time the case is discussed (real time) on a case note in Frameworki. Include the specific recommendations of the Panel and the reasoning behind the recommendations. This record is important not only for the practitioner but also for audit purposes.
- Send alerts to the practitioner/social worker and to brokerage and other care professionals involved in the case in real time.
- Where cases are discussed outside of Panel, attach the relevant documentation to the case in Frameworki.

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24 REVIEWING CARE AND SUPPORT

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

24.1 The purpose of review

The Care Act specifies that plans must be kept under review generally.

Adult Social Care are required to carry out face-to-face reviews of persons at least annually.

This section describes guidelines for a reviewer carrying out the annual review of care and support.

The purpose of a review is to look back at the effectiveness of a care or support plan over a period of time, to gauge the extent to which it has met the needs of the person and achieved their desired outcomes, and to identify changes in need and to adapt the care and support plan accordingly. For those persons with direct payments, it is also to ensure that the money is being used appropriately.

The review process should be:

- person-centred
- outcome-focused
- accessible and proportionate to the needs to be met

The process must involve the person needing care and the carer where feasible.

Reviews can be:

- Planned – the first review is usually within 6-8 weeks and may be "light touch" to check whether arrangements are working well; thereafter, reviews are arranged every 12 months
- Unscheduled – including requested by adult or carer – see **section 24.4.3**.

If a person's needs have changed significantly, this may lead to a re-assessment.

24.2 Arranging the review

Reviewer:

- The review may take the form of a face-to-face meeting, a network meeting or an informal series of meetings or telephone calls over a short period of time. Choose the method appropriate to the particular case. Ordinarily visit the person at the point of review in order to assess adequately whether their needs have changed.

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If this has not been done, record the reason and ensure it is approved by your manager.

- Consult all those involved in the support plan, where relevant, including main contacts, advocates and service providers.
- If an advocate is not already involved, consider whether an advocate is required. See **section 3.3.1**. For out-of-borough placements, if an independent advocate is required, contact the local authority where the placement is located geographically for details of their local commissioned advocacy organisation, and arrange for someone from that organisation to be the independent advocate.
- Inform the person/ carer/ advocate of the timing and arrangements of the review.

24.3 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

24.4 Timescales for reviews

24.4.1 Council-commissioned services

Reviewer:

- If the person has chosen (or, if they lack capacity to make this choice, where it is in their best interests – see **Section 35 CONSENT AND CAPACITY** and **Section 36 BEST INTERESTS**) to have their support arranged by the Council and has a care and support plan, then hold a first 'light-touch' review of the plan within six weeks of the services being put in place or of the person being admitted to a residential or nursing home.
- You must hold the second review for each individual at a point determined by the complexity and risk of the case, but certainly within 12 months.
- Thereafter, you must arrange reviews at least every 12 months.

24.4.2 Direct payments

Reviewer:

- If the person has chosen to manage their personal budget themselves or has a suitable person managing it for them, then check with the person after six weeks that the direct payment arrangements are working properly, and make any necessary adjustments.
- You must hold the first review of direct payments after six months.
- Thereafter, you must arrange reviews at least every 12 months.

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The aim is to synchronise reviews of direct payments and of care and support plans.

24.4.3 Unplanned reviews

Reviewer: Discuss with your manager bringing forward a review as part of the overall work in a case when:

- there is evidence of significant change in need of the person
- requested by a person or carer or advocate
- there is a change in circumstances of person or carer in a way which might affect the efficacy, appropriateness or content of the plan.

Manager: Consider a request for a review from a person/carer/advocate and judge the merits of conducting one. The expectation is that the review will be performed (unless you consider the plan to be sufficient, or the request frivolous, or a complaint). You must involve the person/ carer/ others in considering the request.

Where you decide not to carry out the review immediately, set out the reasons in a format accessible to the person, and inform them when the next review will take place.

24.5 Components of a review

During a review, work with the person (and carer where appropriate) to:

- evaluate the extent to which desired outcomes set out in the support plan have been achieved, and identify reasons for success or failure
- check whether the person's circumstances and/or care and support or support needs changed and if they have, to re-assess the needs and issues of the person (see **section 24.7**)
- determine whether the person continues to be eligible for care and support
- check whether the person has new outcomes they want to meet
- evaluate what is working in the plan, what is not working, and what might need to change to achieve better outcomes
- check whether the personal budget is still meeting the sufficiency test, and whether the current method of managing it is still the best one for what they want to achieve
- examine how the person is managing their personal budget, where they have chosen to do so, and ensure that any direct payments are being used appropriately
- evaluate the quality and cost of the services provided, including whether the person is satisfied with them
- look at whether the person is paying their care charge (if applicable) and how this may be affecting their support package. If they are paying for disability-related expenditure then ensure they are supported to make an appeal if applicable

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- see whether there are any changes in the person's informal and community support networks which might impact negatively or positively on the plan
- confirm or amend the current support plan, or plan to close the case if applicable
- ascertain whether the person/ carer/ independent advocate are satisfied with the plan.

For those services users who have direct payments, see also **section 24.6**.

Always take the last assessment/review record to a review and check whether the information is still correct. If it remains the same and there are no changes then the budget will be the same as the previous budget and the care and support plan the same.

If the person's needs have changed significantly, go to **section 24.7**,

Record the review on Frameworki and create/complete an updated care and support plan.

For details of the steps on Frameworki, see **3B Purchasing in Frameworki** (guidance updated July 2015).

Manager: Approve revised care and support plan.

If the person's needs have changed significantly, go to **section 24.7**.

24.6 Review of Direct Payments

See **section 15.15 Reviewing direct payments**.

24.7 If needs have changed significantly

Reviewer: If the person's needs have changed significantly, reassess the person's needs and appraise the person's eligibility for assistance (see **Section 9 ASSESSMENTS**).

Essentially the process is now the same as that described in the Assessment and Support Planning sections. If the individual is eligible, determine a new indicative personal budget, discuss with the individual, carer and advocate if there is one, set new desired outcomes, and adjust the care and support plan accordingly – as described in the assessment and support planning procedures. Support the person and carer to self plan where appropriate. Incorporate the current needs and the new care arrangements into a revised care and support plan and give copies to the person/carer with the review report. Set the date of the next planned review.

Where the person has been receiving services for some time but whose needs have reduced or which no longer meet the eligibility criteria, arrange a reduction or ending of service provision as sensitively as possibly. Such a reduction or removal of services for persons should only arise where the review identifies that their needs no longer call for the provision of those services. Make sure the person understands as

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fully as they are able what is happening and what the consequences will be. During a review you may also identify needs which require increased service provision by either health or social care.

Start new Review care and support plan episode on Frameworki and complete core assessment, personal budget and care and support plan.

Manager: Approve assessment, personal budget and care and support plan.

24.8 OT Reviews

The OT Service monitor individuals who:

- have complex items of equipment which require servicing six monthly or yearly (for example electrically operated load bearing equipment, hoists, mattress elevators, bath lifts, riser recliner chairs)
- have Community Alarm Service provided via Preventative Technology Grant (PTG) or via a direct referral from the OT Service
- have complex or progressive disabilities.

Reviewer: Complete the Monitoring review either over the phone for low level risk cases or via a home visit with a member of the MDT such as Physio or District Nurse as appropriate.

Use the Proforma available for bath lift monitoring and for completing Monitoring reviews.

24.9 Reviews of care home or nursing home placements

See **section 22.17**.

24.10 Review of placements under Deprivation of Liberty Safeguards (DoLS)

See **section 38.15**.

24.11 Reviews of carers' support plans

See **section 11.23**.

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25 PUBLIC HEALTH FUNERALS AND PROTECTION OF PROPERTY

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

25.1 Public Health funerals

The relevant Council arranges a funeral for a service user only if:

- No funeral arrangements have been made,
- No relatives of the deceased can be found, or
- There is no-one willing or able to arrange a funeral.

The Client Affairs Team arranges for the body to be cremated unless their religion forbids cremation or the person expressed a wish to be buried. If the person's faith is known, then the Team arranges for a religious representative to conduct the service in accordance with that faith.

The Client Affairs Team will visit the home address of the deceased to search for details of next of kin, funeral wishes and financial details.

The Council will seek to recover the cost of the funeral, plus an administrative charge for making these arrangements from the estate of the deceased.

If a person dies in an NHS hospital managed by an NHS Hospital Trust, the Bereavement Officer of that hospital may assume responsibly for the funeral, if

- no relatives can be traced, or
- relatives are unable to afford the cost themselves.

Criteria for referral

- The person died within the boundaries of the relevant borough whether a resident or not.
- The person died in the Casualty (A&E) Department of a hospital within the relevant borough. As the person was not considered to be admitted to hospital, responsibility for arranging the funeral falls to the local authority and not to the hospital.
- The person died in a property situated within the relevant borough.

Please Note: the Council is not responsible for meeting the cost of any funeral already carried out and does not give financial support to family or friends seeking help to arrange a funeral. The Council's funeral contractor is able to give advice on

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claiming funds from the DWP to assist with the cost of a funeral, and will assist in completion of the appropriate claim forms. Address any queries about meeting funeral costs to the Client Affairs Team.

25.2 Protecting property and assets

If a person becomes ill and has no relatives or friends able or willing to make the necessary arrangements, Client Affairs Team will protect their property.

Under the Care Act 2014, it is the duty of the Local Authority to provide temporary protection for a service user's moveable property when admitted to hospital or admitted to a care home. This includes arrangements for re-homing pets or putting them in kennels, securing premises, removing cash, bank books and other small valuable items for safekeeping, and making arrangements for public services to be turned off.

The Council's duty to act ceases when the person is discharged from hospital or a care home. The care manager should notify the Client Affairs Team once a discharge date is known, so that arrangements for the return of the service user's property can be made.

The Council's duty to protect moveable property applies during the lifetime of the person. This section does not apply to a person whose death had occurred before action has commenced. The Council charges the service user to recover any reasonable expenses incurred.

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PART D – MANAGING CASES

26 CASES INTRODUCTION TO MANAGING COMPLEX

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

Sections 51, 52 and 53 have been developed to assist staff in managing complex cases effectively where the risk of harm is likely without effective intervention, including situations where the person:

- self-neglects
- hoards
- lives in squalid conditions and is hard to engage
- makes an unwise/risky decision
- refuses to engage with appropriate services
- experiences tension or conflict with carer or family network who make decisions on behalf of the person without their consent – for example, refusal of services
- has a complex health and social care and support package which is at risk of breaking down

or where the case involves legal casework or financial management – for example, appointeeship or deputyship.

The process is only to be followed when there is no allegation or suspicion of abuse or neglect. In such cases follow the safeguarding adults procedures (see **Section 34 SAFEGUARDING**).

Such cases always involve at least one home visit, and the assessment process may take longer than usual.

They may also require multi-disciplinary working. Consider information sharing guidelines carefully (see **section 3.4 Confidentiality and Information Sharing**).

Social worker/ Care manager: Always discuss such complex cases with your line manager.

For some types of complex cases, there are specific policies and procedures in place:

See **Section 27** for additional guidelines on self-neglect and hoarding.

For additional guidelines about working with a person refusing care and support, see **Section 28**.

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In general, working with a complex case may require referring to a range of policies and procedures. Your task is to work with other relevant and involved professionals to develop a coherent plan to meet the person's needs.

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

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27 SELF-NEGLECT, HOARDING, UNSAFE ENVIRONMENT

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

27.1 Introduction

Managing the balance between protecting adults at risk from self-neglect and/or hoarding behaviour against their right to self-determination is a serious challenge for services. Working with people who are difficult to engage can be exceptionally time-consuming and stressful for all concerned. A failure to engage with people who are not looking after themselves, whether they have mental capacity or not, can have serious implications for the health and wellbeing of the person concerned and can put neighbours, family and animals at risk of harm from fire, gas and water leaks and infestation. It can also cause reputational damage to the local authority or health agencies involved. See **section 45.2 Duty of care**.

Self-neglect is:

- Persistent inattention to personal hygiene and/or environment
- Repeated refusal of some/all indicated services which can reasonably be expected to improve quality of life
- Self endangerment through the manifestation of unsafe behaviours

Compulsive hoarding is a specific type of behaviour marked by acquiring and failing to dispose of a large number of items that would appear to have little or no value to others, severe cluttering of the person's home so that it is no longer able to function as a viable living space, and significant distress or impairment of work or social life.

Hoarding and self-neglect behaviours are not the same and do not always present together. Moreover, hoarding does not always result in verminous or dirty homes that are a risk to health and need to be deep cleaned. However, there are often similarities in terms of needs such as isolation of the individual and their lack of engagement with services which can present a challenge to practitioners where there is ongoing and significant risk of harm.

This section offers guidance to operational staff and managers on how the needs or presenting problems of difficult to engage adults who hoard or self-neglect should be addressed. It recommends multi-agency partnership working to assess the risks and to determine the most favourable approach for achieving engagement with the adult, in conjunction with a care and support plan for delivering the agreed goals and achieving the best outcomes.

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The lead coordinating agency for managing cases of self-neglect or hoarding is Adult Social Care, or the relevant mental health trust where mental health is the main presenting need of the adult at risk.

See also **Section 10 RISK** and **Section 26 INTRODUCTION TO MANAGING COMPLEX CASES**

27.2 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

27.2.1 Mental capacity

If indicated, undertake an assessment of the vulnerable person's mental capacity to choose and manage their home, clearly recording the process and outcome of the assessment. Even if a person is accepting help, they may lack capacity to maintain their accommodation and a decision regarding their residence will need to be made in their best interests. (See **Section 35 CONSENT AND CAPACITY** and **Section 36 BEST INTERESTS**.)

27.2.2 Consent and information sharing

Social worker/ Care manager: Always consider the adult's wishes, and seek to obtain their consent to share information with other professionals as necessary. Explain what information may be shared with other people or organisations. However, if the person does not give consent, you may share information if you consider it necessary to prevent or reduce risk of harm or death. See **section 3.4 Confidentiality and Information Sharing** for further guidance.

27.3 Safeguarding

Self-neglect on the part of an adult at risk will not usually lead to the initiation of safeguarding adult procedures unless the situation involves a significant act of commission or omission by someone else with responsibility for the adult's care. However, the same principles that apply to safeguarding will apply to self-neglect or hoarding cases

27.3.1 If there are children or other vulnerable adults living in the home

Social worker/ Care manager: If you consider that children are at risk from the level of clutter/ cleanliness of the property or that they may be being neglected in any other way then discuss the case with Children and Families services. They will respond under the Pan London Child Protection Policy and Procedures.

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If the child is caring for the adult in any way, consider Young Carers services.

You may also need to use Adult Safeguarding procedures f there are other vulnerable or dependent adult living with the person who are put at risk by the behaviour of the person hoarding or self-neglecting. (See **Section 34 SAFEGUARDING**.)

27.4 Carers

Social worker/ Care manager: In situations where a carer is supporting someone who self-neglects or has hoarding behaviour or indeed lives with the person you must consider whether to carry out a carer's assessment, if it appears that the carer may have any level of needs for support. See **Section 11 CARERS**.

27.5 General Guidance

Social worker/ Care manager: If you encounter or receive a referral about an adult who hoards or neglects themselves and/or their environment, seek support and guidance from your line manager.

Note that the key to supporting people with addressing their hoarding is to build a working relationship with the person, and this may take considerable time and several visits.

Keep records of individual and team discussions and decisions in line with recording policy. (See **Section 40 RECORDING**.)

Social worker/ Care manager:

- Undertake a full core assessment for an adult unknown to Adult Social Care (see **Section 9 ASSESSMENTS**) or either a review or reassessment for adults known to services. In your assessment, take into account all aspects of health, social care and welfare. Has there been a change in the person's behaviour? Or a significant life event?

  In cases of serious hoarding, arrange to carry out a joint assessment with another appropriate professional (for example, mental health practitioner), or your manager if necessary. This will enable reaching a joint opinion on the severity and impact of the hoarding and contribute to a more effective management plan. It is important to see the person within their home environment if there is any suggestion/ evidence of hoarding/ self-neglect.

- Complete a risk assessment taking into account the following factors: (see **Section 10 RISK .**)
  - Physical and psychological impact
  - Mental health
  - Cognitive impairment
  - Activities of daily living
  - Previous history, behaviour patterns, and any recent deterioration
  - Environment

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- Nutrition
- Social network
- Engagement with health service
- Risks of intervention.

- Complete the hoarding assessment tool/ clutter rating index if hoarding is apparent.
- Involve the London Fire Brigade where there is a fire risk. The Fire Brigade is often a main partner in such cases.
- In cases where hoarding is severe and there are risks to the adult's health from filthy or verminous premises, or their living conditions are becoming a nuisance to neighbours or affecting their enjoyment of their property, seek advice from Environmental Health (EH) and arrange for joint working to take place.
- Consider all other relevant professionals and interested parties, such as Health (including GP, district nurse, podiatry, dietetics), voluntary agencies, Housing/ social housing landlords, Environmental Health, Substance Use and Social Inclusion Teams, Mental Health teams, and family and friends if appropriate.
- Engage in full multi-disciplinary partnership working in order to achieve the best outcomes for the adult concerned. Focus on person-centred engagement and risk management. It is recommended that a multi-disciplinary network meeting is convened in all cases where risk of self-neglect and/or hoarding is a concern.
- In very serious cases, and following attempted engagement and at least one network meeting with relevant professionals, it may be helpful to refer the case to the relevant borough Self-Neglect and Hoarding Panel.

- Upload all documents form multi-agency meetings to Frameworki. Complete the Self Neglect and Hoarding Frameworki episodes.

For detailed procedures, refer to the hoarding protocol for your borough:

LBHF: Hoarding Case Management and Panel Process

RBKC: Self-Neglect and Hoarding Protocol 2014

SNAHP Operating Procedures

SNAHP Attendance sheet and confidentiality statement

SNAHP case worker report template

SNAHP referral form

SNAHP risk assessment tool

WCC: Supporting adults with hoarding and self-neglect behaviours: a co-ordinated approach – step by step best practice guide – protocol 2015

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28 PEOPLE REFUSING CARE AND SUPPORT

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

28.1 Introduction

This section lays out the duties and powers of Councils in relation to people refusing care.

The Care Act 2014 establishes the Council's duty to carry out an assessment where a person appears to have care and support needs. (See **Section 45 LEGISLATIVE FRAMEWORK**.)

A person may refuse an assessment or the offer of care and support. This in itself does not discharge the Council's duties to assess for care and support or provide them.

28.2 Key considerations

Consider at every stage: wellbeing (see section 3.1), personalisation (see section 3.2), and the following key considerations (see section 3.3):

Information & advice, participation support and advocacy	Mental Capacity Act principles	Prevention/ reduction/ delay of development of needs	Safeguarding

28.3 Carers

Social worker/ Care manager: In situations where a carer is supporting someone who refuses care and support or indeed lives with the person, you must offer to carry out a carer's assessment, if it appears that the carer may have any level of needs for support. See **Section 11 CARERS**.

28.4 Consent and information sharing

Social worker/ Care manager: Always consider the adult's wishes, and seek to obtain their consent to share information with other professionals as necessary. Explain what information may be shared with other people or organisations. However, if the person does not give consent, you may share information if you

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consider it necessary to prevent or reduce risk of harm or death. See **section 3.4 Confidentiality and Information Sharing** for further guidance.

28.5 Process

Social worker/ Care manager: Assume that the person has capacity to make the decision to refuse care and support, and support the person to make an informed choice if possible. You must assess the refusal and do all you can to address any issues that underlie it. This may take several visits. However, where you are concerned that the person may lack capacity to make the decision to refuse an assessment or to refuse the specific service offered, carry out and record a mental capacity assessment. A thorough capacity assessment is central to how you proceed **and what powers you can use to make improvements to their situation. Consider the** person's executive and problem-solving abilities, and reference it in your recording. Record the results of the assessment whether the person has capacity or not, as you may later need to use it as evidence of the decision. (See **Section 35 CONSENT AND CAPACITY.**) Given the nature of the people to whom the Council has a duty, there will be a higher incidence of people who have difficulty making some of their decisions regarding care than in the general population.

28.5.1 For individuals assessed as having mental capacity to refuse the support offered

If it is clearly established that the person does have the mental capacity to refuse the service and is not incapacitated in their decision-making by some other cause and that there are absolutely no ways of delivering the service which are acceptable to the person, then ultimately the individual does have the right to refuse and the Council's duty is discharged.

Social worker/ Care manager: Complete as full a core assessment as possible with the known information. Fully record a formal decision to this effect with the reasons and evidence fully addressed.

If the risk is high, keep the situation under regular review and re-test the person's mental capacity over time.

28.5.2 For individuals assessed as not having mental capacity to refuse the support offered

Where it is established that the person does not have the capacity to make an informed choice to refuse an assessment or a specific care and support service, then make a decision in their best interests as to whether they should have an assessment or receive the specific care and support service on offer. See **Section 36 BEST INTERESTS**.

Each mental capacity assessment should be decision-specific. So it may be that the person has capacity to make some decisions about their lifestyle choices, but not others. Be clear what the decision is that the person needs to take; for example, to accept or refuse a specific type of support offered. Hold a Best Interests meeting with all relevant professionals, and any family/ interested parties. If there are no family members involved, or it is thought that they would not act in the person's best

interests, and the decision relates to a change to where the person is living, then consult an IMCA. (See **Section 36 BEST INTERESTS**.)

Consider whether it is in the person's best interests to have a care and support package implemented to ensure that their welfare is checked on at appropriate intervals. Consider whether a care and support package can be built on by engaging the person regularly and building up trust so that care and support can be provided as required.

28.6 Powers available to provide care and support when the person has refused a service

The Council has powers available to it to assist it in meeting its duties to assess for and arrange care and support. These include the following but they are not exhaustive.

28.6.1 Mental Capacity Act

The Mental Capacity Act 2005 sets out how the Council makes a decision about what is in the person's best interests, if the person lacks the mental capacity to make the decision to refuse a particular service. This includes taking into account the person's wish to refuse the service and all the relevant factors, including the risk to the person of the service not being provided and the emotional distress of their wishes being overridden. (See **Section 35 CONSENT AND CAPACITY** and **Section 36 BEST INTERESTS**.)

28.6.2 Mental Health Act

The Mental Health Act 1983 Section 115(1) allows an AMHP *"at all reasonable times (to) enter and inspect any premises in which a mentally disturbed patient is living if he has reasonable cause to believe the patient is not under proper care".*

Section 135(1) of the Mental Health Act allows the Council to apply for a police warrant to remove a person to a place of safety, if they are believed to be suffering from a mental disorder and they are living alone and are unable to care for themselves or they are being neglected or ill-treated. The place of safety is usually a borough-based Section 136 suite, but in exceptional cases can be a residential care home, with the home's prior agreement.

Practitioner: If you are considering using these powers under the Mental Health Act, you must consult with a senior manager.

In such a case:

Approved Mental Health Practitioner (AMHP):

- If using a residential care home as a place of safety, determine the least restrictive way of achieving the person's best interests. If appropriate, this may involve applying for a Deprivation of Liberty Safeguards authorisation or guardianship (see **section 28.6.3**) to provide the person with a place in an appropriate care home on an ongoing basis. (See **Section 38 DEPRIVATION OF LIBERTY SAFEGUARDS**.)

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- It is unlikely that restraint would be necessary and proportionate in someone's own home but it is possible: in which case, make an application to the Court of Protection. The Court of Protection has wide ranging powers to make decisions on behalf of people who are unable to make specific decisions about their personal health, welfare or finance. (See **section 36.7.1 The Court of Protection**.) Pending the Court hearing the Council may do what it considers necessary if it prevents a serious deterioration in the person's condition.

Failure to discharge the Council's duties and to make best use of the powers available to do so will result in the Council having failed to provide care and protection for those vulnerable residents of the three boroughs to whom the Councils owe a duty.

28.6.3 Power to receive into Guardianship

Section 7 of the Mental Health Act 1983 allows the Council to receive an adult into its guardianship on the application of an AMHP, with the recommendation of two medical practitioners, if the person is suffering from a mental disorder of a nature or degree which warrants reception into guardianship and it is necessary for their welfare or to protect other people. The powers of the guardian are to require access to where they are living and to require them to attend places such as day centres. A degree of compliance is needed from the person to make it workable.

28.6.4 The inherent jurisdiction of the High Court

It is a fundamental part of common law that a superior court, such as the High Court, has the power to hear anything brought before it unless there is another place where the matter can be decided. This is known as the inherent jurisdiction of the court. The High Court has the jurisdiction to review any decision taken by a council and has far greater powers than a council to protect vulnerable people. If there is no other recourse, then vulnerable people have the right to the protection of the Court.

28.7 Responsibilities of Council officers in integrated teams

All Council officers must comply with the Council's duties to assess the need for care and support and to arrange care and support having due regard to the assessment. Where officers are carrying out these duties within integrated teams, they are doing so for the Council and must therefore comply with the Council's duties.

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29 CONTINUING HEALTHCARE

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

29.1 Introduction

NHS Continuing Healthcare refers to a package of ongoing healthcare and care and support that is arranged and funded solely by the NHS, or where a S75 is in place, where an individual has been assessed as having a primary health need as set out in The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. Such care is provided to people aged 18 or over, to meet needs which have arisen as a result of disability, accident or illness. Eligibility for NHS continuing healthcare places no limits on the settings in which the package of support can be offered or on the type of service delivery.[15]

'Primary health need' is not defined in primary legislation, although the NHS Standing Rules set out that a person should be considered to have a primary health need when the nursing or other health services they require, when considered as a whole are:

> *"where that person is, or is to be accommodated in a care home, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide: or*
>
> *of a nature beyond which a social services authority whose primary responsibility is to provide social services is expected to provide".*

An individual has a primary health need if having taken account of all their needs, following completion of the Decision Support Tool, the main aspects or majority of the care they need is focused on addressing and/or preventing health needs.

Four characteristics of need, namely 'nature', 'intensity', 'complexity' and 'unpredictability' may help to determine where the 'quality' or 'quantity' of care required is beyond the limit of a local authority's responsibilities.[16]

ASC Assessor: Refer to these four characteristics in your assessment.

Where an individual is eligible for NHS Continuing Healthcare (CHC), it is the responsibility of the NHS body to provide appropriate services to meet those needs.

[15] Annex H5 of "Care and Support Statutory Guidance, DH, 2014
[16] Ref: DH: The national framework for NHS Continuing Healthcare and NHS funded Nursing Care – revised November 2012, Part 2 Guidance, para 3.3

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However, this does not prevent a local authority from providing further services, as it sees fit.

Continuing healthcare can be provided in a nursing home or in a person's own home, depending on their choice, needs and risks. If a nursing care placement is being considered, a continuing care assessment must take place.

In addition, a carer who provides (or intends to provide) care for another adult and it appears that the carer may have any level of needs for support has a right to have their needs as a carer assessed in the same way as carers of adults supported through Adult Social Care. (See **Section 11 CARERS**.)

29.2 Assessment for NHS Continuing Healthcare

ASC Assessor:

- For older adults in hospital who are identified as possibly eligible for NHS CHC, discuss with the discharge team and request that they undertake a health needs assessment.
- In the case of dispute, complete a CHC Checklist together with the Health assessor to assist in the decision-making for the need for a full assessment. If a full health needs assessment is to be completed by the health assessor, complete an ASC core assessment in parallel.
- For younger adults in hospital who are identified as possibly eligible for NHS CHC, discuss with the Community Continuing Care Team. They will undertake the health needs assessment in hospital or in a rehabilitation facility. Also carry out an ASC core assessment.
- If the adult is in the community, complete the CHC checklist and ASC core assessment and fax/email it to the CHC team.
- If further clarification on the process is needed, phone the Continuing Care Team on [redacted]

29.2.1 Older adult/ adult with physical disabilities

Upon receipt of the checklist, the Continuing Care Team (CCG) arranges for an assessment. The assessment process should be completed within 28 days.

If the checklist does not support the need for a full health needs assessment the Continuing Care Team arranges for a letter to be sent to the person/family advising them.

If the checklist indicates that a full health needs assessment is required then the Continuing Care Team undertake the assessment.

The Checklist gives a score to each of the domains from A – C.

A full Decision Support Tool (DST) is required if there are two As; one A and 4 Bs; 5 Bs; or A in one of the domains that can be scored Priority on the DST.

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If the Checklist gives lower marking then the person is not eligible for a full health needs assessment; however, the information can be used to establish eligibility for Free Nursing Care (FNC): a separate assessment is no longer required. The Checklist must be signed off by ASC as well as the HNA, and sent to Panel for ratification.

If the Checklist indicates it is required, the Heath Needs Assessor completes health needs assessment and a DST.

If the person's needs are relatively high, the Health Needs Assessor often completes the health needs assessment and DST without doing the Checklist first.

For a case to be presented at the Continuing Health Care Panel the following documents are required:

- a health needs assessment completed by a Health Needs Assessor (confusingly, both are often referred to as HNA), and
- a core assessment, completed by a social worker/ care manager,
- the DST needs (not the scoring).

Other members of the multi-disciplinary team may be asked for specialist assessments if appropriate.

29.2.2 Adults with learning disabilities

For people with learning disabilities the process is the same as for older adults except that in almost all cases the checklist, adult social care needs assessment, the health needs assessment and the decision support tool are all undertaken within the the multi-disciplinary learning disability team.

Where a person with learning disabilities is seen by another service the checklist must be sent to the local LD service rather than the Continuing Care Team.

Please Note: The majority of cases for people with learning disabilities are young people in transition from children's services to adult services. In such cases, the assessment for continuing healthcare is carried out when the young person is aged 17.

29.2.3 Out of Borough placements

ASC Assessor:

- For reviews of people placed out of borough, consider continuing health care at every review and where appropriate complete a CHC checklist. If the checklist indicates a full CHC assessment, make a referral to the local CCG.
- Undertake a full reassessment of the person's needs. Make every effort to meet the local health needs assessor to complete the decision support tool together.

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29.3 Decision Support Tool and Eligibility

The next step is to determine eligibility for continuing healthcare using the Decision Support Tool (DST). The purpose of the DST is to support the application of the National Framework and to inform consistency in decision making.

The DST is scored by the multi-disciplinary team (MDT), never by one person alone; two people of different disciplines can constitute the MDT. For example, the MDT can comprise the Health Needs Assessor, the ASC team leader (usually from the same team as the social worker) and other professionals as appropriate.

MDT:

- Score the individual's needs in relation to 12 care domains, each of which is broken down into a number of levels. Under each domain, identify which level description most closely matches the individual's needs. Apply weightings as No need, Low need, High, Severe and Priority.

  The 12 domains and the highest weighting options are:

  - Behaviour – Priority
  - Cognition – Severe
  - Psychological and emotional needs – High
  - Communication – High
  - Mobility – Severe
  - Continence – High
  - Skin and tissue viability – Severe*
  - Breathing – Priority
  - Drug therapies – Priority
  - Altered states of consciousness – Priority but not severe
  - Other significant health needs – Severe

  * Tissue Viability grade 3 and above is an automatic safeguarding concern. This is an allegation of neglect if there is no clear care and support plan with clear health involvement. There are current policies and procedures in place.

  Within these levels, take into account two factors:

  Unpredictability/Intensity, and Complexity/Intensity.

  A person is eligible for CHC funding if they have a 'primary health need'. A recommendation of eligibility would be expected in the following situations:

  - A level of priority in any one of the four domains that carry this level;
  - A total of two or more incidences of identified severe needs across all care domains, where there is one domain recorded as severe, together with needs in a number of other domains, or a number of domains with high and/or moderate needs.

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The scores are used as an ***indication*** of level of need but do not definitively identify eligibility one way or the other. In all cases, take into account[17]:

- the overall need
- the interaction between needs in different care domains
- the four areas of nature, intensity, complexity and unpredictability and the interplay between them, and
- the evidence from risk assessments

Using all this information, come to a recommendation of whether the person is eligible for NHS continuing healthcare.

- At the end, complete a summary sheet providing an overview of the level chosen and a summary of the person's needs, with a recommendation about eligibility or ineligibility.

29.4 Continuing Care Panels

Assessor: Send all the papers, including the core assessment, to the relevant Continuing Care Panel:

CHC Older Adults Panel meets weekly. HNA sends the papers.

CHC Younger Physically Disabled Adults Panel meets monthly. HNA sends the papers.

CHC Learning Disabilities Panel meets monthly. Assessor sends the papers. Inform the borough's representative on this Panel beforehand of any adult being presented. (See also **Continuing Care Panel Policy (Learning Disability) Panel Protocols & Terms of Reference (London Borough of Hammersmith & Fulham, Royal Borough of Kensington & Chelsea and Westminster City Council and North West London Commissioning Support Unit**).

CHC Out of Borough panels will have different arrangements: you can obtain the details from the local CCG.

However, if the decision will affect a hospital discharge, any Panel can be asked for an 'out of Panel' decision to expedite matters.

The purpose of the Panels is to review/ratify decisions to ensure consistency and equity of decision making by the multi-disciplinary teams. The Panel can ask the multi-disciplinary team to reconsider their decision, or to provide further information to evidence their decision, but it is not their role to make or overturn decisions.

Panel Administrator: Send the results of the Panel discussion to the professionals involved.

[17]Ref: DH: The national framework for NHS Continuing Healthcare and NHS funded Nursing Care – revised November 2012, Part 1, paras 77-85

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29.5 After NHS CHC eligibility is determined

Health team or Panel administrator: Once the Panel decision is made, send a letter to the person formally informing them of the outcome, and of their right to request a review of the decision if they are not satisfied.

Continuing care team: Review eligibility after three months, and then annually.

If NHS continuing healthcare is agreed, then the Health team takes responsibility for making the necessary arrangements.

If, following an assessment, a person is not found to be eligible for NHS CHC, the NHS may still have a responsibility to contribute to that person's health needs – either by directly commissioning services or by part funding the package of support. Where a package of support is commissioned or funded by both an LA and a CCG, this is a joint package of care.

If continuing care is not agreed, the assessment still stands for agreement to Free Nursing Care (FNC) – also called Registered Nursing Care Component (RNCC). This no longer needs a separate assessment.

Social worker/ care manager:

- If NHS continuing care funding is agreed and the adult moves to an NHS-funded nursing home, complete any social care tasks and close the case on Frameworki without reviewing it. See **Section 29 CONTINUING HEALTHCARE**.
- If NHS continuing care funding is not agreed, then follow the procedures for arranging care and support, including making a placement in a care home where appropriate. See **Section 14 SUPPORT PLANNING** and **Section 22 RESIDENTIAL AND NURSING PLACEMENTS**.
- If NHS funding is agreed and the adult is returning home or is at home with a care package, then it is essential:
  - For joint teams or where there is a section 75 agreement, to inform the relevant Home Care Management Team/finance team immediately to change the budget code. The case will remain open to the team but with the CCG funding, or
  - In RBKC, transfer case responsibility to the continuing care social worker, or
  - In LBHF and WCC, close the case once the case has been transferred to the Continuing Care team.

Please Note: For the avoidance of doubt it is the responsibility of social workers/ Care managers to make the relevant adjustments to Frameworki. This is not the role of the CHC Panel Administrators.

29.6 Occupational therapy

Social worker/ care manager: Where a person meets continuing healthcare criteria, but it appears that there is a need for specialist Adult Social Care

occupational therapy (ASCOT) assessment – for example, if the individual has a need for assessment for major adaptations – then consider a referral to ASCOT as ASCOT are the key professionals with the knowledge and skill to complete these assessments.

29.7 Fast track process

If a person is terminally ill they may be eligible for continuing care funding through a quicker process called fast track CHC decision. It is only appropriate to consider this if the person had a very poor prognosis, a couple of months or less, and/or a rapidly deteriorating condition with symptom control issues.

The key medical/nursing professional completes the fast track form which is faxed to the CHC team for a decision to be made wherever possible on the same day.

Social worker/ care manager:

- If continuing care funding is agreed, the adult may move to a nursing home.
- Ensure all work is complete. This may include but is not limited to ensuring that any tenancies are ended in line with procedures, financial arrangements are in place, family and relatives are informed, and carers assessments completed.
- When all tasks are completed, close your involvement in the case on Frameworki. Case responsibility transfers to the Continuing Care Team. Do not close the case if there is ongoing activity on the case, such as appointeeship, deputyship, ongoing carers support, tenancy in extra care sheltered housing. See **Section 33 ENDING YOUR INVOLVEMENT AND CLOSING CASES** for more details.
- If the person receives care and support at home, the casework responsibility is as listed in **section 29.5** for a care package in the community.

29.8 Personal Health Budgets (PHBs)

A Personal Health Budget is an allocation of NHS money to a person with identified health needs to enable them to purchase the services they think will improve certain aspects of their health and wellbeing. People now accessing a personal health budget are those receiving NHS continuing healthcare.

The aim is to give people with long term conditions and disabilities greater choice and control over the healthcare and support they receive.

The individual develops a care plan with their clinician, setting out their personal health and wellbeing needs, the health outcomes they want to achieve, the amount of money in the budget and how it will be spent.

Like personal budgets, the PHB can be taken in different ways – as a direct payment, or a managed account where the local authority will manage the process, including an assessment for a PHB, but will recharge the CCG for this service.

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The five essential features of a personal health budget, as specified by the Department of Health, are that the individual:

- can choose the health and wellbeing outcomes they want to achieve, in agreement with a healthcare professional
- know how much money they have for their healthcare and support
- be enabled to create their own care plan, with support if they want to
- be able to choose how their budget is held and managed, including the right to ask for a direct payment
- be able to spend the money in ways and at times that make sense to them, as agreed in their care plan.[18]

29.9 Disputes

There is a local disputes resolution process to resolve cases where there is a dispute between the local authority and CCGs about eligibility for NHS CHC, about the apportionment of funding in joint funded care and support packages, or about the operation of refunds guidance.

29.10 Further guidance

The following link is to Department of Health section on continuing care which sets out the framework and has examples of all the tools:

www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

For details about continuing care home care packages on Frameworki, see "**Continuing care home care packages" in Fwi Guidance**.

[18]Ref: NHS – Personal Health Budgets Guide – How to get good results – key learning from the evaluation, DH

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30 FOOD AND FINANCIAL SUPPORT

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

30.1 Provision of emergency food by voucher

Foodbanks give food to families in crisis. The registered Foodbank distributor holds vouchers. Identified professionals can issue food vouchers which are given direct to an individual or family in crisis. On receipt of a voucher the person takes it to the relevant Foodbank Centre, and exchanges the voucher for a supply of food items (enough for three days). Food is donated by churches, individuals, groups or charities and by the public (often in 'supermarket collections'). This is a project that involves the whole community.

In addition to giving food, Foodbanks can also offer a cup of coffee and a friendly chat, 'help in finding help' by directing clients towards debt counsellors, and advocacy.

30.1.1 Managing vouchers

Vouchers are issued against a unique reference number so they can be tracked to ensure vouchers are not duplicated. Vouchers are given to boroughs in sets of 10. Vouchers need to be stored securely, as the food represented on each voucher is valuable. **There is no charge for the food,** but it is given on the understanding that it is not resold.

The Foodbank has been established to provide *short term, emergency food to an individual or family in crisis while a long-term strategy is developed.* Normally enough food for three days (one voucher) should be sufficient to cover the immediate crisis, while the normal support agencies arrange to meet the individual's or family's needs.

Social worker/ Care manager: You can issue a food voucher to an individual or family in crisis, whilst you put together an urgent care and support plan. In the event that this takes a little longer than three days, then you can issue up to two more vouchers. If the crisis is still not resolved or re-occurs, contact the Foodbank to discuss extending cover for a longer period whilst problems are resolved.

A note of warning: it has become clear that some clients have attempted to obtain vouchers from various sources.

It is important for auditing, accounting and statistical processes that *all sections of the voucher* are completed. They are treated in strictest confidence and no individual's details will be divulged to anyone without their explicit consent. Complete

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the 'Nature of Crisis' box by ticking the appropriate box or adding a brief explanation of their situation.

30.2 Borough Foodbank schemes

30.2.1 WCC: Westminster Foodbank

Westminster Foodbank
Westminster Chapel, Buckingham Gate,
London, SW1E 6BS

Opening hours: Monday, 2-4pm; Thursdays, 11-1pm

30.2.2 RBKC: Foodbank Distribution Centre

Food is provided either in Emergency Food Boxes (EFBs), or as bagged food from the Foodbank Distribution Centre. The food includes cereals, milk, fruit juice, soup, pasta, meat, fish, pudding and vegetables, providing balanced and nutritional meals. The Foodbank Distribution Centre stocks all the food items issued in an EFB as well as some additional items which are not practical to put in the standard four-person boxes. Examples are household items, baby food, tin openers and extra treats or snacks (when these items are available).

When the client is given food they are given a degree of choice – for example, vegetarian food. There is also the option of giving extra food to larger families.

The Foodbank Distribution Centre
St Lukes, Redcliffe Gardens
London SW10 9HF

Opening hours: Tuesday, 12.00 pm -3.00 pm, Friday, 2.00 – 5.00 pm

If you have any queries or wish to discuss this further, please contact the Foodbank at foodbank@williamwilberforcetrust.org or [redacted]

30.2.3 LBHF: Hammersmith & Fulham Foodbank

Fulham Distribution Centre
Christ Church Fulham
67 Studdridge Street
Fulham SW6 3TD

Opening hours: Tuesdays: 10.30 am – 1.00 pm; Fridays: 2.00 pm – 4.30 pm

Shepherds Bush Distribution Centre
St Simons
Rockley Road
Shepherds Bush W14 0DA

Opening hours: Thursdays: 1.00 pm – 3.00 pm.

Clients may be seen outside of these times in Fulham, *by pre-arranged appointment only*,.

For more info, please contact the office by emailing admin@hffb.org or calling [redacted]

30.2.4 The Trussell Trust

All three foodbanks are part of a nationwide network of foodbanks overseen and supported by the Trussel Trust. The Trust is registered with the Data Protection Agency, and complies with the regulations regarding the holding of client information on a database. Each member of the Foodbank Centre staff has signed a Trussell Trust Confidentiality Agreement.

30.3 Budgeting Loans

Community Care Grants and Crisis loans were abolished from 1 April 2013. These schemes are not being directly replaced However, other elements of the Social Fund such as Budgeting Loans – providing interest free cash loans – are still in existence and a person can still make a claim for assistance by contacting Job Centre Plus on 0845 6060 234.

30.4 Local Support Payments

If a person is not entitled to a Budgeting Loan, the Council may be able to help where there has been an emergency or disaster such as a fire, or flood: This assistance is called Local Support Payments. Local Support Payment can also be awarded where someone needs assistance to remain or settle in the community. However, the Council will not issue cash: instead, we will provide refurbished/ used furniture and white goods and in exceptional circumstances, and/or gift cards to be exchanged for food and clothing.

30.4.1 Qualifying Criteria

To qualify for a Local Support Payment, a person:

- must not have had more than two awards from LSP in the last 12 months, and
- must be on a qualifying benefit, or about to claim one within 6 weeks if leaving an establishment, and
- must live in one of the boroughs, or have been housed outside that borough by that Borough, and
- must have less than £1000 in savings, or £3000 for pension age, and
  - have a serious risk to their own, or family's health or safety, or
  - require essential goods and furniture to establish themselves, or to remain, in the community.

30.4.2 Qualifying Benefits

- Income Support
- Income-related Employment and Support Allowance
- Income-based Jobseeker's Allowance

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- Pension Credit
- DLA/PIP/Attendance Allowance
- Universal Credit

30.4.3 Local Support Payments Queries

The Local Support Payments claim line number is [redacted]

You can also access the service on-line on behalf of your client.

If your client is from Kensington and Chelsea, the link is here:
http://www.rbkc.gov.uk/adviceandbenefits/localsupportpayments.aspx

If your client is from Westminster or Hammersmith & Fulham, then you can access the on-line service for Westminster or Hammersmith & Fulham via Kensington and Chelsea's website here:
http://www.rbkc.gov.uk/adviceandbenefits/localsupportpayments.aspx

30.5 Other financial support options

Assessor:

- Consult the People First website to find contact details of charities which may be able to help people in need of financial support.
- In cases of urgent high risk, check with your manager about other options at their discretion.

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31 TRANSITION

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

To be added

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32 RETAIL MODEL FOR SIMPLE AIDS TO DAILY LIVING – PROCEDURE FOR PRESCRIBERS

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

32.1 Introduction

Transforming Community Equipment Services (TCES) was launched by the Department of Health in 2006. This is a new national retail model that aims to move the provision of some Community Equipment from the current loan-based system to a prescription system, similar to medications and glasses. The model was piloted in the North West of England (2007) and has since been introduced in other parts of the country and rolled out across most London Boroughs, including our partners in the three boroughs.

Community Equipment includes both Simple Aids to Daily Living (SADLs) and Complex Aids to Daily Living (CADLs). Simple Aids to Daily Living (SADLS), for example, walking frame, raised toilet seat, and bathing equipment are typically high-volume, low-cost items less than £100. Complex Aids to Daily Living (CADLs), for example, riser recliner chair, and mobile hoist are high-cost, low-volume items over £100 and often require servicing.

The Retail Model is for SADLs only. Complex equipment will continue to be issued by Medequip under the Loan system.

The Retail Model will only change how equipment is provided. It will not change the referral or assessment process eligibility criteria for the provision of community equipment. Equipment will still be provided free of charge to eligible adults.

The Model benefits both adults who have eligible care and support needs and residents who may not have eligible needs for or wish to have an assessment for community equipment. By increasing the availability of equipment on the high street, it normalises the process of purchasing such items. Individuals have the option to choose when to redeem the prescription (within specified timeframe) and which accredited retailer to use. They can also choose to pay extra towards equipment (of the same specification) that is more to their taste – this is known as '*topping up* ', rather than only being able to accept the current item issued by Medequip. Residents wishing to privately purchase community equipment have a list of Accredited Retailers available to them, knowing that these retailers are able to give advice and supply them with simple equipment. Retailers are also aware of when to direct residents to the Council for an assessment if their needs appear to be complex.

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32.2 What can be issued on Prescription – RBKC Catalogue

The Retail Model is for **Simple Aids to Daily Living (SADLs)** only. All complex items that require ongoing monitoring or servicing, such as bathlifts, hoists and riser recliners, are still provided by Medequip.

Other low cost items are not available on the National catalogue, so cannot be issued on prescription. This includes items such as toe washers, dressing sticks and some sensory items. These items still need to be issued by Medequip at present. Any item included on your prescription that is not available on the National catalogue or the local catalogue will not be issued by the retailer.

RBKC: The local catalogue can be found **here.**

The National Catalogue is managed by ADL Smartcare. They agree which items can be included on the catalogue, based on information submitted by local authorities. They then decide on a generic specification for each item stating the function of the equipment and features such as dimensions, materials used and safe working limits. There will be an agreed Tariff Code that must be used to order the item, and a set Tariff Cost that determines how much the retailer will be paid by the Council for the item.

Prescriber: You can find the National Catalogue **here.** As the specifications are generic, retailers can choose their own suppliers. This means that the individual may not receive the same brand you are currently familiar with Medequip issuing. You also need to ensure that the generic specification is suitable for your client, for example, there may be a lower safe working limit than the current brand provided by Medequip.

The items that you are able to issue will not change; for example, if you currently do not provide mobility equipment, you should not provide this on prescription.

Some items have been removed from the catalogue and can no longer be issued either on prescription or by Medequip. These items are:

- Non-slip bath mat
- Non-slip shower mat
- Ring-pull tin opener
- Twist-top jar opener (cone type)
- Electric tin opener

Direct individuals who require these items to purchase them privately. These items are readily available from both our accredited retailers and a number of other local retailers on the high street, and so will not be supplied by Adult Social Care. This includes replacement of worn items previously issued.

32.3 When to use Medequip and peripheral stores

When simple items only from the local catalogue are being prescribed, equipment **must** be issued on a prescription. The only exception to this is when the equipment is **urgent** and there is no possibility of it being redeemed at a retailer soon enough,

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for example, a person who has no access to any toilet facilities and requires a commode that day, or where equipment is **essential** for discharge and the individual and/or their carer cannot redeem the prescription in time.

Where both simple **and** complex/non-prescription items, known as a 'mixed pack' are being issued, then all the equipment is to be issued by Medequip. This saves the person having to both visit a retailer and have a delivery from Medequip. It also is more cost effective as it avoids the Council paying both a prescription fee and the Medequip delivery charges.

Prescriber: Use peripheral stores stock for **assessment** only; that is, use items for assessment/ demonstration in the person's home, but then issue a long-term provision. The exception to this is for urgent needs where it is essential for same day provision. If an item is issued from the peripheral store, then it must be ordered from Medequip in the same way it is now. Items that are not available on prescription can still be issued from peripheral stores.

32.4 Criteria for delivery and fitting of equipment

The adult/patient is required to make arrangements to **redeem and collect** their own equipment. Delivery will only be included on a prescription where it can be demonstrated that the following criteria are met:

32.4.1 Criteria for Delivery:

- The adult is unable to visit the retailer in person AND they have no carer, family member or friend who is able to visit the retailer for them
- OR The adult has a carer able to visit the retailer but they cannot redeem the prescription within required timescales; for example, the person is due for discharge on Wednesday, but the family will not be visiting until the weekend and equipment is required for discharge
- OR Due to the number of items or size of items prescribed it would be unreasonable to expect the person or carer to collect the equipment, considering their method of transport; for example, perch stool, bed leaver, bathboard and toilet frame recommended for an adult who relies on public transport.

32.4.2 Criteria for Fitting

Fitting refers to equipment that must be fitted and adjusted, but is not permanent, for example, fitting a bathboard or bed lever. It does not include setting items to height; for example, walking sticks and perch stools. It does not include permanently fixing items; for example, grab rails.

For most equipment provided by prescription, it is expected that the adult or their carer will be able to unpack and fit most products. In some cases the prescriber will follow up the equipment and may assist with fitting of equipment.

Fitting can be prescribed when:

- The equipment requires specific and detailed fitting and neither the client NOR their carer will be able to safely carry out the instructions

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- OR The equipment would be too difficult for the adult or carer to fit due to moving and handling issues; for example, chair raisers.

Prescriber: Discuss with the person at the time of providing the prescription how they will be able to redeem it. This discussion can include their support networks and/or transport options available to them. Consider how they currently access the community and do their shopping or if they have a support network who assists. Use of Taxi cards and DLA Mobility component can be considered as part of this discussion.

If the person wishes to make private arrangements with the retailer for delivery and does not meet the criteria above they will be required to make any payments required. They can also select a mobile retailer who may be able to visit them at home at no extra charge.

Use the **Assessment of adult/patient: checklist for delivery and fitting of equipment** as a guide to assist in the decision making process.

Prescriber: If there are any concerns about BOTH adult/patient responsibility and representative responsibility then prescribe delivery and/or fit of equipment OR consider use of Medequip.

32.5 How to prescribe minor adaptations

Prescriber: Some minor adaptations currently provided by Medequip can be issued on prescription for adults who are owner occupiers or privately rent their property. See the catalogue for the full list of rails available. Items such as mopstick rails cannot be issued on prescription.

Any adaptations that require planning permission must be completed through Medequip.

Adults who live in Tenant Management Organisation (TMO) or Housing Association properties cannot have a prescription for minor adaptations, as it is the responsibility of the landlord to provide and install these items.

For adults who privately rent their property, you must have written landlord consent on file **before** issuing the prescription.

When issuing the prescription, select **Deliver and Install** options as the retailer will deliver the rail at the time of installation. Adults are not to collect rails and arrange their own fitting.

Advise the person to select one of our mobile accredited retailers who are approved for adaptations, such as Redlands Healthcare and Adaptations. Our other retailers have chosen not to offer this service and so adults will not be able to redeem their prescription with them. Where both adaptations and equipment are prescribed, the adult must have **all** items redeemed by one retailer.

It is essential that you provide sufficient information for the retailer to be able to install the adaptation correctly. This information can be included on the Additional

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Information part of the prescription form but **must** also be included when you complete the prescription on Equipment for You. It is essential that accurate measurements are provided to prevent the retailer needing to visit more than once.

32.6 How to complete paper prescription form

There are two parts to the prescription. Part one, a paper form, is completed by the prescriber and issued to the adult so they are aware of what equipment/services are being prescribed and for ease for the retailer. Part two: the prescriber completes the online component on Equipment for You as this is essential for the retailer to be able to redeem a prescription and receive payment.

Prescriber:

- Complete the **Community Equipment Prescription** form (a PDF form) at the time you visit the adult. You can also complete it later if necessary and then send it by post; for example, when you are unsure of suitable equipment provision and need to discuss it with your supervisor, or you agree a replacement for a broken piece of equipment on a phone call.

- Complete **all** fields on the paper form. It is especially important to ensure the adult's date of birth on the paper form matches details recorded on 'Equipment for You' as this is a key search field for retailers to locate the prescription on the system. Include contact details so the retailer can contact you with any concerns or discrepancies about the equipment/services ordered, for example, if delivery has been selected on the paper form, but not on the electronic prescription. A sample completed form can be found here: **Community Equipment Prescription (sample form)**.

- For each item include the Tariff Code **and** the name/description of the equipment; for example, BA01, 4-slatted bathboard, 26".

- For each item tick if Delivery, Fit or Installation are required (see above for criteria), ensure that the adult is aware if you are not prescribing these services and why. They can choose to make a private arrangement with the retailer to deliver and fit items if they wish, but will be liable for any costs incurred.

- Additional Information – use this for any additional information that you feel will be helpful to the retailer**,** or the adult. Examples include where to fit a bed lever, height required for a perch stool or how high a chair is to be raised and the type of chair. This information must also be included on Equipment for You when you raise the prescription.

If the adult loses their prescription, they can still redeem the item. If they go to any accredited retailer and show some proof of identity, the retailer will be able to locate their prescription on Equipment for You and redeem the items. They will not have access to any information included in 'Additional Information' so it is important this is included on Equipment for You where relevant.

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- Give the paper prescription form to the adult as soon as possible. If you are not able to provide it at the time you see them, for example, you need to consider what equipment to issue, then send it to them by post.

- Provide the adult with the information leaflet titled "Community Equipment, Redeeming your prescription and useful information".

- Complete the online prescription form on Equipment for You as soon as possible, or no later than 24 hours after the paper form has been issued. For instructions on completing the online component of the prescription, see section below on **To complete the online prescription.**

32.7 Information leaflets

RBKC and WCC only:

Give the 'Community Equipment: Redeeming your prescription and useful information' leaflet to all adults with their prescription. It includes information about their prescription, what happens when they redeem it and where our accredited retailers are located.

The leaflet is also available on People First for adults to **download** if they wish.

A signposting leaflet titled 'Simple Aids to Daily Living, Equipment to help in your day-to-day life' has also been produced for residents who may wish to purchase equipment privately without approaching the Council for an assessment, or who may not meet our criteria for an assessment or equipment provision. This has been distributed to GP surgeries, libraries and other locations. It is also available on People First for information and for individuals to **download** here.

32.8 Obtaining equipment

Prescriber: When introducing the model to your clients, they may expect that equipment will be delivered to them, free of charge, by Medequip. This may be because they have previously had equipment provided this way, or know someone who has. Explain that some equipment will now be provided by prescription and that part of our assessment will include how they are able to redeem this prescription.

Once they have the equipment, it is on permanent loan and does not need to be returned to Medequip when no longer required. Individuals can dispose of the equipment how they choose and guidance is included in the information leaflet.

It is important that the person understands that they now have some responsibility for obtaining the equipment before the prescription expires. They also have the benefit of being able to see the equipment before they take it home, possibly choosing an alternative model for a 'top up' that they prefer – for example, a raised toilet seat with a lid. Individuals also have the choice to redeem none or part of their prescription if they do not wish to have all items prescribed.

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Before prescribing delivery of the items, explore with the person any other options they may have such as family, neighbours, or taxi cards that will enable them to collect the equipment themselves.

Make the person aware that they will have 30 days in which to redeem their prescription. After this time, they will not be able to redeem their prescription they will need to contact you to discuss their needs.

32.9 Accredited retailers

Prescriptions can only be redeemed at accredited retailers. Individuals can select any Accredited Retailer in the UK to redeem their prescription, although it is expected that most people will choose a retailer within borough or close by. Only retailers who are authorised by the Council to access the individual borough's Contract on the Equipment for You portal will be able to process the electronic prescription. This includes all accredited retailers within the borough and some from other boroughs. All other accredited retailers will rely on the paper prescription only, and will submit invoices for payment on a monthly basis.

Retailers must meet National Accreditation Standards that have been set by the Department of Health. The Council cannot alter these standards, but local 'Best Practice' Guidelines will be issued to all our local accredited retailers.

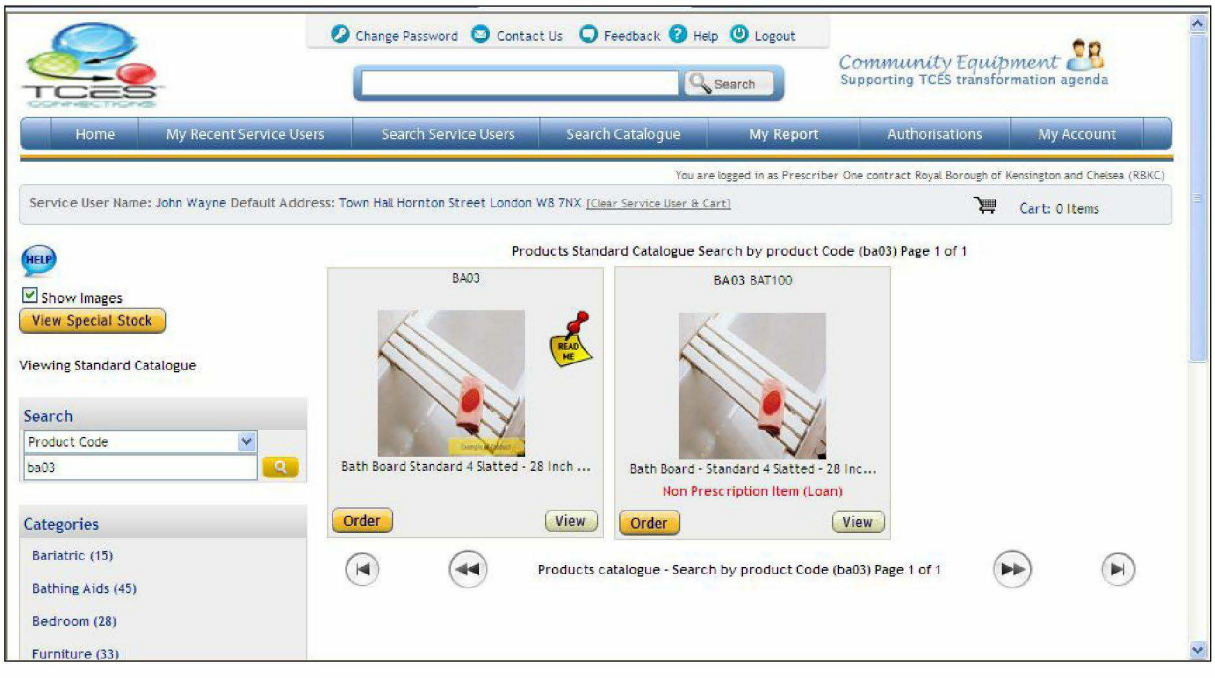
All accredited retailers have received product training prior to becoming accredited. The initial equipment training has been provided by the OT service, with assistance from Physiotherapy (Community Rehabilitation Service). Ongoing training is the responsibility of each retailer.

Retailers can apply to the Council at any time to become accredited. The most up to date list of accredited retailers can be found **??.**

32.10 How to raise a prescription on Equipment for You

Prescriber:

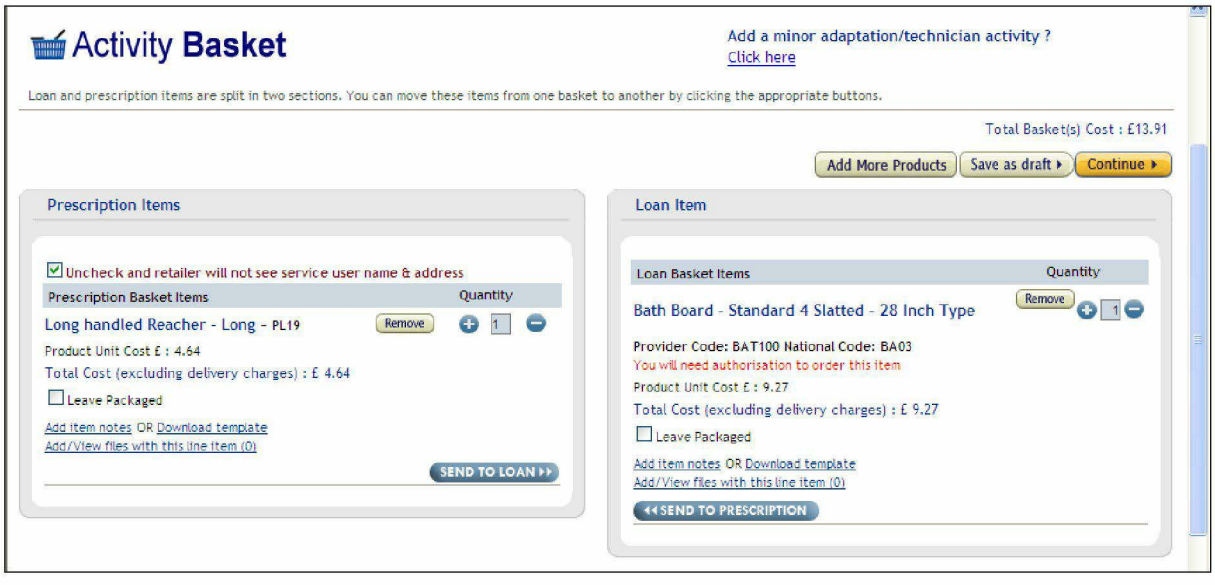
- Log on to Equipment for You as you currently do.
- Search for your client and commence the order as you do now (see the Help section on Equipment for You for more guidance if necessary).
- When you search the catalogue you will see that prescription items are available both on Retail (Prescription) with a yellow watermark and Loan (Medequip) with red text.
- Select Order for the Retail item you wish to order (on the Left, with yellow watermark).
- When you have all the items you need, select Proceed to Checkout.



Your Activity Basket will now show the items you have selected to order on prescription:

Prescription items will always appear on the left hand side of the screen. Loan items that are to be provided by Medequip will appear on the right hand side.

If you have items in both baskets you may have made a mistake:



If all items are to be issued on prescription, select 'Send to Prescription' on the right hand side. All items will then appear on the Prescription basket on the left.

If it is a mixed package and some non-prescription items are being ordered, everything should be provided by Medequip. Select 'Send to Loan' on the left hand side to send items to Loan basket.

Continue through the order until you reach Order Options:

This screen allows you to select additional services.

If the person is eligible, you can select Delivery for local area only, to have all items delivered. Delivery for Out of Area is not permitted.

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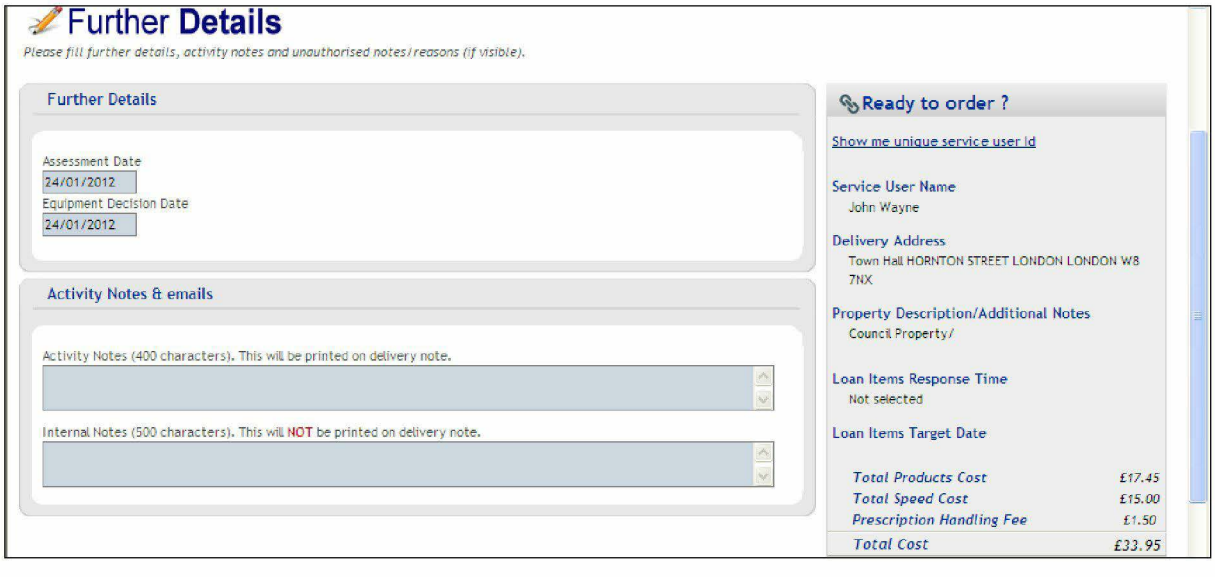
You will then have the option to select Fit/Assemble for individual items if appropriate. Only select this for items that require the retailer to fit.



This page allows you to enter further instructions.

Include any special instructions regarding minor adaptations and fitting of equipment here.

When you have completed all steps, select Place Order.

The prescription will then have been raised. You will no longer be able to alter the prescription, so any changes will require the prescription to be cancelled and a new one to be raised.

Once the prescription has been raised, the person has 30 days in which to redeem their prescription.

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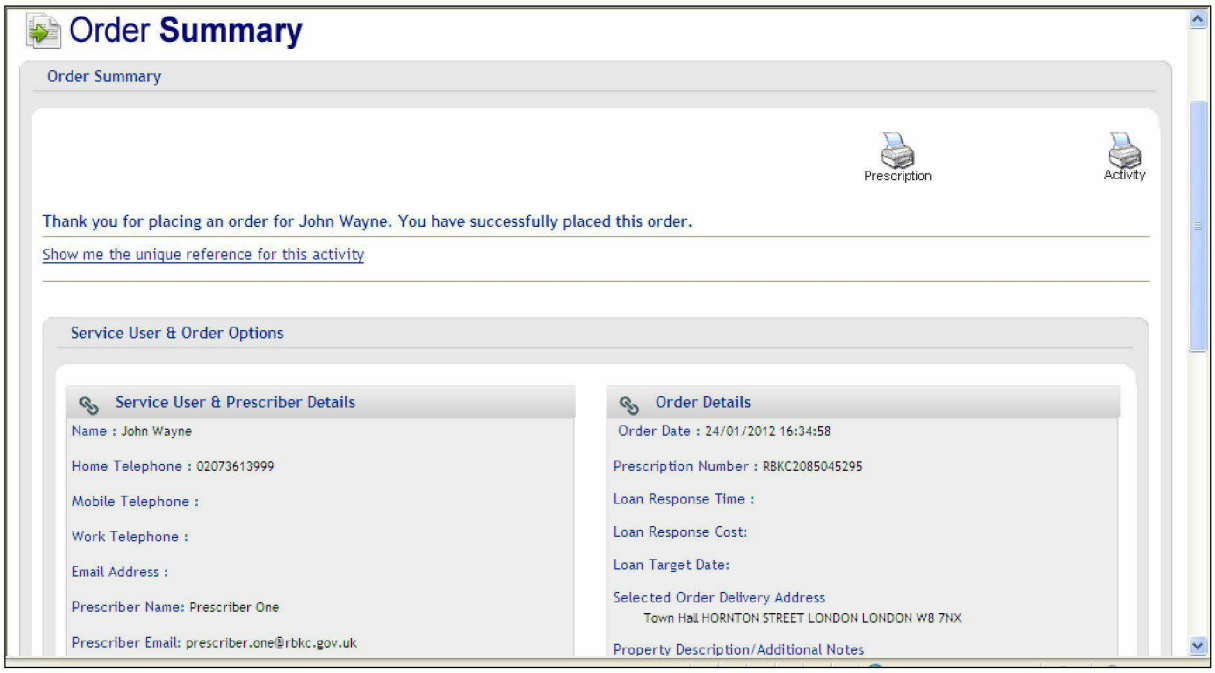


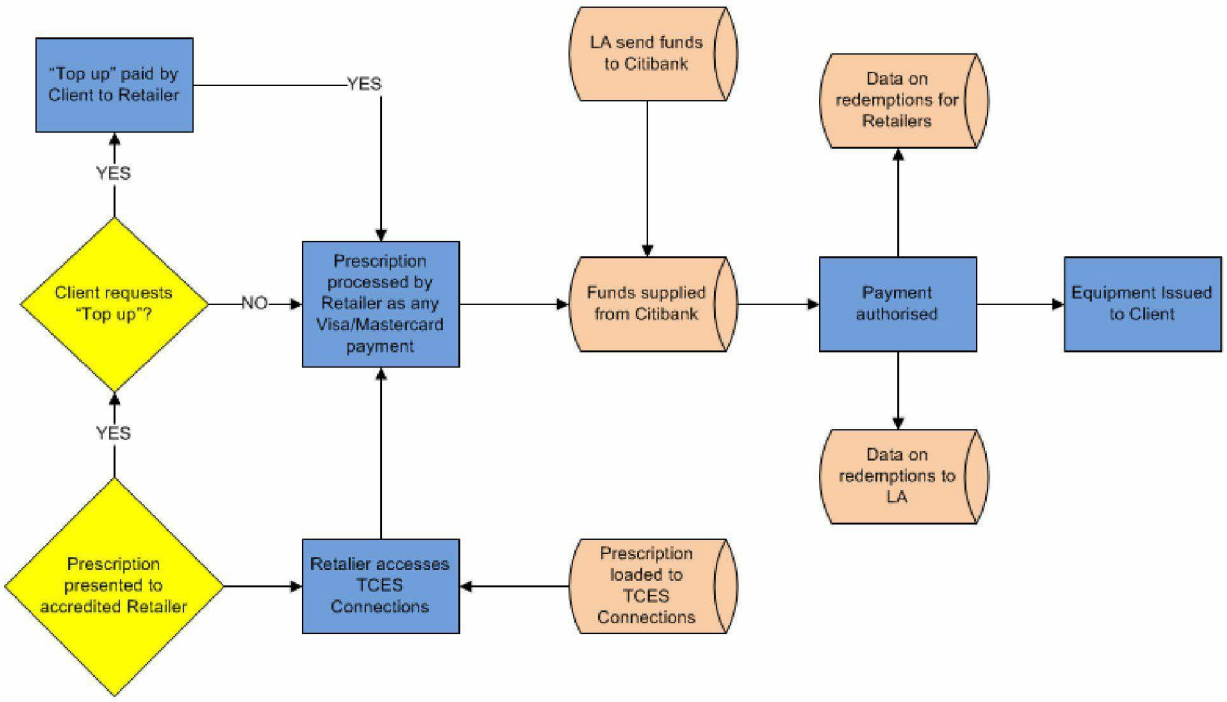
32.11 Reporting and Authorisation

Prescriber: You can order the same items on prescription that you can order from Medequip under the loan model. Anything not on your stock list will need to be authorised by an approved authorising manager prior to the paper prescription being given to the individual.

Senior management: Use the Reports function on Equipment for You to monitor levels of equipment provision, including how many items are issued on prescription, how many are issued via Medequip instead, and how often Delivery is prescribed.

If high levels of items continue to be issued via Medequip, or delivery is used routinely, then the ability for prescribers to make those orders will be restricted. Authorisation will then be needed to order any SADLs from Medequip, or to include Delivery and Fit on a prescription.

32.12 Summary of Payment Process for Retailers



The Council have chosen to use a pre-paid solution offered by Citibank to pay retailers. This is linked to the Equipment for You prescription, so no action is required by the prescriber.

When the person presents their prescription, the retailer will locate the prescription on Equipment for You using the individual's surname name, postcode and date of birth to verify the equipment/services requested. Once all items are issued and services completed, that is, delivery/fit/installation, the retailer completes the processing on Equipment for You to generate a 10 digit Visa card number. The retailer prefixes this with a unique 6 digit number and enters the 16 digits into their chip and pin machine. They are then paid within 3-5 days. Any top up costs, or private delivery arrangements, will be paid by the adult directly to the retailer. Retailers who do not have access to a chip and pin machine will submit a monthly invoice to the Council's finance team to receive payment.

As the online prescription allows the retailer to issue the equipment and be paid, it is essential that this is completed as soon as possible after issuing the paper prescription, and within 24 hours/next working day in all cases in line with ASC Recording Standards. (See **Section 40 RECORDING**.)

Retailers who do not have access to the Council's contract on Equipment for You and/or and chip and pin machine will need to contact the Council's finance team to discuss payment and invoicing.

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32.13 Prescriber Frequently Asked Questions

Where does the duty of care lie between issuing and redemption of the prescription (that is, you have identified a need that is not being met: who is responsible if client has an accident in the interim)?

It is the person's decision **if, when** (within a 30 day prescription redemption period) and **where** (accredited retailers only) they or their representative redeem the prescription.

The *duty of care* centres on the prescriber's assessment of the person's ability to redeem the prescription at an accredited retailer. This can be either face to face, via telephone or using a mobile service that will operate in the borough. If the person cannot manage, a representative can redeem on their behalf – similar to a prescription for medication

Staff will also have to decide if an individual **needs** *delivery* or a *delivery and fit service* and they can prescribe this if the criteria for these services are met. Written criteria are available for staff to use to assist with decision making.

Will rehab clients who may progress through a variety of items be issued with prescriptions for all items?

If a client requires *simple aids to daily living* they will be issued with a prescription for these items.

If someone requires a *mixed pack of equipment* – that is *simple and complex equipment* it can be ordered from Medequip.

How will prescriptions be generated: will we need to complete both a paper and an electronic prescription?

The prescriber will complete a paper version of a prescription. The prescription will be given to the person with an information leaflet including a map of *accredited* retailers. The prescription information will also need to be raised on 'Equipment for You' within 24 hours.

If the person loses their paper prescription, they can still visit an accredited retailer with proof of ID to redeem their prescription.

What will the delivery criteria be?

Delivery and fit criteria are included in the procedure (see sections 32.4.1 and 32.4.2).

When can peripheral stores/Mediquip be used?

Peripheral stores should **only** be used for essential **and** urgent equipment and assessment products.

Medequip can be used for specials, mixed packs (as outlined above), all complex equipment and equipment not available via the retail model.

What happens if an item issued isn't suitable; for example, the generic item isn't quite as expected/suitable, or the prescriber orders an unsuitable item?

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If the prescriber has ordered an incorrect item they will need to reissue another prescription for the appropriate product. If the item cannot be returned (for example, toilet equipment) then the person can dispose of the unwanted item.

If the retailer has issued a product that does not meet the generic specification they will need to replace that item with the correct item.

Who is responsible if the equipment isn't fitted correctly and something goes wrong

As with any incident/accident a thorough investigation of events would need to be carried out. In general if the retailer fits the product incorrectly and it is proven that this was the cause of the accident then it is the retailer who is responsible for fixing it.

Safe fitting of equipment and risks/safety considerations will be included in the retailer training.

Prescribers must also ensure they give retailers any relevant and accurate information; for example, height of walking stick, bed lever to be fitted to right/left side of bed etc.

Will minor adaptations be included?

Yes – see local retail catalogue for list of items to be included.

There will be two *accredited* retailers who adults can contact to ***install*** minor adaptations; for example, grab rail/s. These organisations have experience and insurance cover for this type of work.

Only owner occupiers and tenants in privately rented accommodation (with landlord approval) can have minor adaptations provided on prescription.

Will items be removed from the current catalogue?

It has been agreed that 5 items will be removed from the current catalogue as follows:

- Electric tin opener
- Shower mat
- Bath mat
- Twist top jar opener
- Ring pull tin opener

Can we ask retailers to sell and fit ferrules?

Yes, they are included in the local retail catalogue so retailers will be able to supply either on prescription or for private purchase.

Who does the adult contact if the equipment breaks or is faulty?

If the item is under warranty and develops a fault, the person should contact the retailer directly, who will arrange for a replacement. Outside of warranty, the person should contact SSL or their allocated OT/SW to request a new prescription. They may need a reassessment of their needs before a new prescription is issued.

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33 ENDING YOUR INVOLVEMENT AND CLOSING CASES

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

When all the needs identified on the care or support plan or action plan have been successfully met, and/or where no service is required, and/or when the adult no longer meets the eligibility criteria, then involvement may be closed. A decision to close involvement will usually (but not always) follow a review.

Note: A practitioner can end their involvement when the support/services provided by their team are ended, but the case will stay open overall if there are any other teams/practitioners involved. A case will only fully close when all workers cease their involvement and there are no services being provided. So before proceeding with a decision (outcome) to close a case, check whether any services are current and whether any other teams are still involved.

33.1 Closing worker involvement but not closing the whole case

Practitioner:

- Complete Review episode on Frameworki.
- Inform other professionals, for example GPs, district nurses, Housing Department and Benefit Agencies, highlighting any risks.
- If you are ending your involvement but the case remains open because other support/ services continue to be provided and/or other workers are involved, then choose as Outcome – "No Further Action and other workflow continues". If you are also closing allocation to your team, make sure that the case is allocated to a/the team to which it is still open.
- You must ensure that there is a current workflow/ future episode: cases should not be left with no workflows.

For details of ending an existing care package or service, see **3B Purchasing in Frameworki**.

33.2 Closing case following death of adult

Practitioner:

- Give consideration to any surviving partners in terms of further support services.

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- Try to find any relatives where necessary.
- Make arrangements for any pets.
- Contact Client Affairs Team for property protection and burial or cremation arrangements where necessary (see **Section 25 PUBLIC HEALTH FUNERALS AND PROTECTION OF PROPERTY**).

- Check with Client Affairs Team for any outstanding issues.
- Add date of death to Frameworki.
- Close all packages of care or placements: end all purchasing episodes.
- End all personal and professional relationships.
- Remove 'classes' as service user.
- Ensure any carers listed are also closed and personal relationship amended/ ended.
- Arrange collection of any maintained equipment (such as hoists, bath lifts).
- Arrange collection of CAS equipment.

Where Client Affairs is still involved with the case:

- LBHF: Close the case to your team and send the case to Client Affairs on Frameworki.
- WCC and RBKC: Do not close the case, but agree with your manager where it is allocated until Client Affairs have completed their work.

If Client Affairs is not/ no longer involved with the case, and no other service is still involved, then close the case as described in **section 33.3** below.

33.3 Closing case when person is still alive

Practitioner:

- Inform other professionals, for example GPs, district nurses, Housing Department and Benefit Agencies, highlighting any risks if appropriate.
- Return loaned equipment to the relevant department where appropriate: ***Please Note:*** OT equipment is loaned on a permanent basis for adults with a permanent disability and so should not be returned when the case is closed. The equipment should only be returned when it is no longer needed (for example, when the adult dies or the needs change).

If the adult is to move out of area:

- Contact the appropriate local authority to inform them of the move, and send them a copy of their assessment and care and support plan.
- Give advice to the adult about seeking support in their new location.
- Close the case as below once they have moved.

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33.4 Closing the case on Frameworki

- Check that there are no other open services/workflow on Frameworki. If there are, you will be able to create a Close Case (Adults) episode, but you will not be able to start it.
- Select an outcome of "Close Case (Adults)" from episode where the decision to close has been made (for example, Review).
- Start this episode – you will be presented with details of current services and/or workflow if it exists, and will not be able to proceed until these are ended.
- Select the appropriate file retention criterion (usually 6 years for adults, but 20 years if there has been Mental Health activity, and 1 year if there have been no services, no safeguarding etc.).
- Complete closing summary – this is mandatory, but you can refer the reader to rationale for closure if recorded elsewhere (for example, review form). It is not mandatory to send task to your manager; only do this where they have not already approved the decision to close the case made at the previous episode.
- Complete case closure episode.

For details about how to close a case on Frameworki, together with a case closure checklist, see **Closing cases** and **Case closure checklist Fwi Guidance.**

Manager:

- Check that all necessary actions have been carried out.
- Check and approve the decision to close – whether recorded in preceding episode, or within closing summary.

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PART E – SAFEGUARDING/MCA/DOLS

34 SAFEGUARDING

34.1 People to whom safeguarding duties apply

The Care Act 2014 replaces the 'No Secrets' guidance. The procedures in this section are based on the Care Act and the **'London Multi-Agency Safeguarding Policy and Procedures', Dec 2015**.

Specific adult safeguarding duties apply to any adult who:

- has needs for care and support (whether or not the local authority or anyone else is meeting any of those needs), and
- is experiencing, or at risk of, abuse or neglect, and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

Safeguarding duties also apply to people who pay for their own care and support services.

There are no eligibility criteria for adult safeguarding services. If an adult who has care and support needs and who is at risk of being abused or neglected cannot keep themselves safe from abuse or neglect because of their care and support needs, then the local authority's safeguarding duty applies. The safeguarding duty applies whether or not the person's care and support needs have a significant impact on their wellbeing, and whether or not the needs are being met by the local authority or anyone else. Note that if the adult at risk is able to protect themselves, despite having care and support needs, then a safeguarding response may not be appropriate.

Where someone is 18 or over but is still receiving Children's Services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25 (see also **Section 31**). Where appropriate, involve children's safeguarding colleagues as well as any relevant partners (for example, the police or NHS) or other persons relevant to the case.

Local authority statutory adult safeguarding duties apply equally to those adults with care and support needs, regardless of whether those needs are being met, regardless of whether the adult lacks capacity or not, and regardless of setting, other than prisons and approved premises where prison governors and National Offender Management Service (NOMS) respectively have responsibility.

SCIE has useful additional resources to address particular questions and dilemmas – see **"Adult safeguarding practice questions"**.

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34.2 What safeguarding is

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's **wellbeing** is promoted, including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. (See also **Section 3.1**.) This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

When abuse does take place, it needs to be dealt with swiftly, effectively and in ways which are proportionate to the issues and where the adult in need of protection stays in as much control of the decision-making as possible.

The **aims of adult safeguarding** are:

- To stop abuse or neglect wherever possible
- To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- To safeguard adults in a way that supports them in making choices and having control about how they want to live
- To promote an approach that concentrates on improving life for the adults concerned
- To raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- To provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult, and
- To address what has caused the abuse or neglect.

All staff:

- You must understand your role and responsibilities in regard to adult safeguarding policy and procedures.
- In whatever your setting and role, you are in the front line in preventing harm or abuse occurring and in taking action where concerns arise. You have a duty to report in a timely way any concerns or suspicions that an adult at risk is being, or is at risk of being abused.
- When abuse does take place, work with the adult at risk to establish what being safe means to them and how that can be best achieved.

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34.3 Principles – Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a shift in culture and practice in response to what is now known about what makes safeguarding more or less effective from the perspective of the person being safeguarded. MSP means that safeguarding:

- is person-led
- engages the person from the start, throughout and at the end to address their needs
- is outcome-focused, and
- is based upon a community approach from all partners and providers.

It is about engaging the person in a series of conversations about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Practitioner: In order to support the adult through this process, arrange, where necessary, for an independent advocate to support and represent an adult who is the subject of a safeguarding enquiry or a safeguarding adults review. See also **section 34.7**.

ADASS[19] suggests that examples of the kind of outcomes that people might want are:

- **to be and to feel safer**
- **to maintain a key relationship**
- **to get new friends**
- **to have help to recover**
- **to have access to justice or an apology, or to know that disciplinary or other action has been taken**
- **to know that this won't happen to anyone else**
- **to maintain control over the situation**
- **to be involved in making decisions**
- **to have exercised choice**
- **to be able to protect self in the future**
- **to know where to get help.**

This is not an exhaustive list.

The following are not outcomes in this sense, but rather conclusions or service responses:

- **harm or abuse is substantiated/ unsubstantiated**
- **the person is receiving increased monitoring or care.**

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[19] ADASS/LGA: "Making Safeguarding Personal: Guide 2014"

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See also the Local Government Association's **Making Safeguarding Personal toolkit**.

Six key principles underpin all adult safeguarding work:

- **Empowerment** - Adults are encouraged to make their own decisions and are provided with support and information.

  "I am consulted about the outcomes I want from the safeguarding process and these directly inform what happens."

- **Prevention** – Strategies are developed to prevent abuse and neglect that promote resilience and self-determination.

  "I am provided with easily understood information about what abuse is, how to recognise the signs and what I can do to seek help."

- **Proportionality** – A proportionate and least intrusive response is made, balanced with the level of risk.

  "I am confident that the professionals will work in my interest and only get involved as much as needed."

- **Protection** – Adults are offered ways to protect themselves, and there is a co-ordinated response to adults at risk.

  "I am provided with help and support to report abuse. I am supported to take part in the safeguarding process to the extent to which I want and to which I am able."

- **Partnership** – Local solutions are provided through services working together within their communities.

  "I am confident that information will be appropriately shared in a way that takes into account its personal and sensitive nature. I am confident that agencies will work together to find the most effective responses for my own situation."

- **Accountability** – There is accountability and transparency in delivering a safeguarding response.

  "I am clear about the roles and responsibilities of all those involved in the solution to the problem."

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34.4 Roles and responsibilities of agencies

34.4.1 External agencies

Under the Care Act, the local authority ***must*** cooperate with each relevant partner, and those partners ***must*** also cooperate with the local authority, in investigating and addressing concerns of abuse[20].

34.4.2 Local authority

Local authorities have the lead role in coordinating the multi-agency approach to safeguard adults at risk. This includes the coordination of the application of this policy and procedures, coordination of activity between organisations, review of practice, facilitation of joint training, dissemination of information and monitoring and review of progress within the local authority area.

In addition to that strategic coordinating role, the local authority Adult Social Care department, joint health and social care teams and mental health teams also have responsibility for coordinating the action taken by organisations in response to concerns that an adult at risk is being or is at risk of being abused or neglected.

34.5 Abuse

Abuse or neglect can take many forms. Always consider the circumstances of the individual case. The criteria in **section 34.1** must be met before the issue is considered as a safeguarding concern. Abuse may be:

- a single act or repeated acts
- an act of neglect or a failure to act
- multiple acts; for example, an adult at risk may be neglected and also be financially abused.

Abuse is about the misuse of power and control that one person has over another. Where there is dependency, there is a possibility of abuse or neglect unless adequate safeguards are put in place.

Intent is not an issue at the point of deciding whether an act or a failure to act is abuse; it is the impact of the act on the person and the harm or risk of harm to that individual. Abuse can take place in settings such as the person's own home, day or residential centres, supported housing, educational establishments, or in nursing homes, clinics or hospitals.

A number of abusive acts are crimes and the police must be informed. See **section 34.14**.

The Care Act 2014 gives an illustrative list of the sort of behaviour which could give rise to a safeguarding concern: it is not intended to be an exhaustive list.

- Physical abuse – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions

[20] Sections 6 and 7 of the Care Act 2014

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- Domestic abuse and domestic violence – including psychological, physical, sexual, financial, emotional abuse; so called 'honour'-based violence
- Sexual abuse – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting
- Psychological abuse – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks
- Financial or material abuse – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits
- Modern slavery – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment (see also **section 34.19**)
- Discriminatory abuse – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion
- Organisational abuse – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, or in relation to care provided in the person's own home. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation
- Neglect and acts of omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

Self-neglect – covering a wide range of behaviour such as neglecting to care for one's personal hygiene, health or surroundings, and includes behaviour such as hoarding – is addressed in **Section 27**. Self-neglect may not prompt an enquiry under Section 42 of the Act. Make an assessment on a case by case basis.

Financial abuse is the main form of abuse recorded by the Office of the Public Guardian both amongst adults and children at risk. Financial abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is very often likely to be financial abuse occurring.

Potential indicators of financial abuse include:

- **change in living conditions**
- **lack of heating, clothing or food**
- **inability to pay bills/unexplained shortage of money**

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- **unexplained withdrawals from an account**
- **unexplained loss/misplacement of financial documents**
- **the recent addition of authorised signers on a client or donor's signature card**
- **sudden or unexpected changes in a will or other financial documents**

This is not an exhaustive list, nor does the presence of such an indicator prove that there is actual financial abuse occurring. However, they do indicate that it is worth checking further.

Internet scams, postal scams and doorstep crime are more often than not, targeted at adults at risk and all are forms of financial abuse. These scans and crimes can seriously affect the health, including mental health, of an adult at risk.

Where the abuse is perpetrated by someone who has the authority to manage an adult's money, inform the relevant body - for example, the Office of the Public Guardian for deputies or attorneys and Department for Work and Pensions (DWP) in relation to appointees.

34.6 Carers and safeguarding[21]

Circumstances in which a carer (for example, a family member or friend) could be involved in a situation that may require a safeguarding response include:

- A carer may witness or speak up about abuse or neglect
- A carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with, or
- A carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others.

Assessor: In such cases, in your assessment, consider the wellbeing of both the adult at risk and the carer. Explore the individuals' circumstances and consider whether it would be possible to provide information or support that prevents abuse or neglect from occurring – for example, by providing training to the carer about the condition that the adult they care for has or to support them to care more safely. Where that is necessary make arrangements for providing it. Check whether the carer has mental health needs, and if so, whether they are known to Mental Health services. See also **Section 11** for more information on carers assessments and support plans.

If a carer speaks up about abuse or neglect, it is essential that you listen to them and where appropriate undertake a safeguarding enquiry.

In some circumstances the carer may need to have independent representation or advocacy; in others, a carer may benefit from having such support if they are under great stress. Consider whether other agencies should be involved; in some circumstances where a criminal offence is suspected this may include alerting the

[21] See also ADASS "Carers and Safeguarding Adults – working together to improve outcomes", 2011

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police, or in others the primary healthcare services may need to be involved in monitoring.

Involve carer(s) in safeguarding enquiries if the adult they care for gives consent, unless there are specific reasons not to do so (for example, that the carer is involved in causing abuse or neglect).

34.7 Safeguarding and advocacy

Practitioner: Throughout the safeguarding process, you must give the person as much information as they require about the steps involved, and support them to participate in the process. Arrange, where necessary, for an independent advocate to support and represent an adult who is the subject of a safeguarding enquiry or a safeguarding adults review. Where an independent advocate has already been arranged under s67 of the Care Act or under the Mental Capacity Act 2005 then, unless inappropriate, arrange to use the same advocate.

Section 3.3.1 sets out the role of an advocate and the circumstances where a person has a right to independent advocacy – where they are deemed to have substantial difficulty in being fully involved in all aspects of safeguarding and do not have an appropriate family or friends who are able and willing to support them and/or represent them.

Typically an advocate would support the person during a safeguarding process to[22]:

- understand the concerns that have been identified and communicate their views on these
- understand the safeguarding process and how they can be involved
- weigh up pros and cons to consenting to the enquiry and support them to communicate their wishes
- understand who and how the enquiry will be undertaken
- support them to identify and communicate their views about the enquiry
- support them to identify and communicate their views about ways to keep them safe
- understand written information about them – for example, strategy plan, protection plan, meeting minutes
- raise any concerns they may have about the process.

Where the person has been deemed to lack capacity, the advocate would also undertake the following:

- Access a copy of the safeguarding concern form and ensure they have a good understanding of the concern
- Access a copy of the capacity assessment and raise any questions, where appropriate
- Identify the person's views and wishes about any protective measures and the investigation, and support safeguarding professionals to consider them

[22] Care Act Guidance, 2014, "7.49 In terms of safeguarding there are some particular important issues for advocates to address…"

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- Support safeguarding professionals to ensure all decisions are in line with principles of the Mental Capacity Act – for example, least restrictive
- Attend all meetings, access minutes and key documents – ensuring they understand all aspects of the safeguarding process and raise any concerns they have.

See also **section 3.3.1** for more information on advocacy and the difference between independent advocates and IMCAs.

34.8 Consent and capacity

All decisions taken in the adult safeguarding process must also comply with the Mental Capacity Act. An allegation of abuse or neglect of an adult at risk who may have difficulty making one or more decisions about their own safety will always give rise to action under the adult safeguarding process and any decision made about someone who lacks capacity to make it themselves must be made in their best interests in line with the Mental Capacity Act and Mental Capacity Act *Code of Practice*.

The capacity of the adult at risk to give their informed consent to a concern being raised and to consent to action being taken under these procedures is a significant but not the only factor in deciding what action to take.

Assessor: Assume that the person has the capacity to make the necessary decisions unless there is evidence to the contrary. However, where there is concern that the adult at risk may not have capacity to make one or more relevant decisions, carry out and record on Frameworki a mental capacity assessment. It is important that you offer them appropriate support to make each decision they can make as soon as possible. In the context of adult safeguarding, the vulnerability of the adult at risk is related to whether they have difficulty making and exercising their own informed choices free from duress, pressure or undue influence of any sort, and whether they are able to protect themselves from abuse, neglect and exploitation. It is therefore important to note that people with capacity can also be vulnerable.

Capacity assessment may be a lengthy process, as the person is supported gradually to understand as much as possible about the options being explored. For further details about capacity assessment, see **Section 35 CONSENT AND CAPACITY**.

You do not need to wait until the capacity assessment is finalised to refer to an IMCA. However, you do need to provide a capacity assessment in order to instruct the IMCA fully. Instruct an IMCA where protective measures are being put in place that have an impact on the life of the adult at risk, even if they have family, friends and carers available to consult (see **sections 3.3.1** and **36.4**). Record on Frameworki.

The test of capacity in this case is to find out whether the adult at risk has the capacity to make specific informed decisions:

- about whether an enquiry should be undertaken in response to a concern

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- about each action which may be taken under multi-agency policy and procedures
- about a decision affecting their own safety, including an understanding of longer-term harm as well as immediate effects and an understanding of the impact of their level of ability to take action to protect themselves from future harm
- about sharing information.

Assessor: Record on Frameworki whether the adult at risk consents to proceeding with the safeguarding enquiry, or whether they lack capacity to consent. Always record the result of a mental capacity assessment, including when you assess that the adult does have capacity, as this evidence may be required later in the process. Record clearly if you are proceeding without consent, and give the reason for doing so, such as that it is in the wider public interest or a serious crime has been committed (see also **section 34.12.5**).

The consent questions for safeguarding in the 'Adult Wishes and Consent – Safeguarding' document in Frameworki are as follows:

1. Does the Adult agree to an enquiry into the allegations made?

2. Does the Adult agree to sharing information with others professionals as part of the enquiry?

3. Does the Adult agree to sharing information with other people (such as family members, advocates)?

4. Does the Adult agree to providing a statement to Police (where relevant)?

5. Does the Adult wish to attend or participate in any of the safeguarding meetings?

6. Does the Adult wish to contribute to an assessment of any risks they may face? This includes how these risks may be reduced so that they feel safer.

If you assess that the adult at risk does not have capacity to make the necessary informed decisions, then make a best interests determination based on the evidence available – see **Section 36**.

If you have concerns about the actions of an attorney acting under a registered Enduring Power of Attorney (EPA) or Lasting Power of Attorney (LPA), or a Deputy appointed by the Court of Protection, contact the Office of the Public Guardian (OPG). The OPG can investigate the actions of a Deputy or Attorney and can also refer concerns to other relevant agencies.

34.9 Information sharing

Adults have a general right to independence, choice and self-determination including control over information about themselves. In the context of adult safeguarding these rights can be overridden in certain circumstances (see **section 34.12.5**). Emergency or life-threatening situations may warrant the sharing of relevant information with the relevant emergency services without consent.

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The law does not prevent the sharing of sensitive, personal information **within** organisations. If the information is confidential, but there is a safeguarding concern, sharing it may be justified.

The law does not prevent the sharing of sensitive, personal information **between** organisations where the public interest served outweighs the public interest served by protecting confidentiality – for example, where a serious crime may be prevented.

The Data Protection Act enables the lawful sharing of information. See also **section 3.4**.

Organisations need to share safeguarding information with the right people at the right time to:

- prevent death or serious harm
- coordinate effective and efficient responses
- enable early interventions to prevent the escalation of risk
- prevent abuse and neglect that may increase the need for care and support
- maintain and improve good practice in safeguarding adults
- reveal patterns of abuse that were previously undetected
- identify low level concerns that may identify people at risk of abuse
- help people to access the right kind of support to reduce risk and promote wellbeing
- help identify people who may pose a risk to others, and where possible, work to reduce offending behaviour
- reduce organisational risk and protect reputation.

Practitioner:

- It is good practice to try to gain the person's consent to share information. However, if you do need to share information without consent (for example, if it is necessary to prevent serious harm or it is in the public interest – see **section 34.12.5**), in most cases inform the person and their family of what personal information will be shared and why. **Do not regard the refusal of consent as necessarily precluding the sharing of confidential information.** See also **section 34.8**.
- There are some circumstances where you should not seek consent or inform the person or their family that information will be shared – for example, if doing so would increase risk of serious harm to the adult at risk, or hamper the prevention or investigation of a serious crime, or lead to an unjustified delay in making enquiries about allegations of serious harm to an adult.
- Consider also the risk of sharing information. In some cases, such as domestic violence or hate crime, it is possible that sharing information could increase the risk to the individual. Work jointly with safeguarding partners to provide advice, support and protection to the individual in order to minimise the possibility of worsening the relationship or triggering retribution from the abuser. In terms of sharing information with the police, see also **section 34.14**.

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- Do not share information with the adult at risk, their carer, advocate, attorney or deputy which:
    - is highly confidential and needs not to be in the public domain (for example, intelligence about possible terrorism under PREVENT)
    - may contravene the rights of a third party – for example, a member of staff under investigation.
- Carefully consider what information can be shared with the person causing harm.
- Check with your manager if you have any doubts or concerns about sharing information or issues about confidentiality.

- Always record your decision, and what information was shared with whom.

See also **SCIE's Guidance on "Adult Safeguarding: sharing information"**.

34.10 Ill treatment and wilful neglect

The police will determine whether there should be criminal investigations of ill treatment and wilful neglect. There are a number of possible offences which may apply, including the specific offences mentioned below:

Section 44 Mental Capacity Act 2005 makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity.

Section 127 Mental Health Act 1983 creates an offence in relation to staff employed in hospitals or mental health nursing homes where there is ill-treatment or wilful neglect.

Sections 20 to 25 of the Criminal Justice and Courts Act 2015 makes it a statutory criminal offence for an individual to ill-treat or wilfully to neglect an individual for whom they have a duty of care. For organisations, the offence focuses on the way their activities are managed and organised, and whether an incident amounts to a gross breach of a relevant duty of care owed to the patient.

34.11 Process

The Care Act requires that each local authority ***must*** make enquiries or cause others to do so if it believes an adult is experiencing or is at risk of abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect and if so by whom.

The London Multi-Agency Policy and Procedures set out a four stage process for handling safeguarding enquiries. The stages are:

Stage 1 – Concerns

Stage 2 – Enquiry

Stage 3 – Safeguarding Plan and Review

Stage 4 – Closing the Enquiry

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Templates for all the safeguarding forms can be found in **Safeguarding Adults Templates**.

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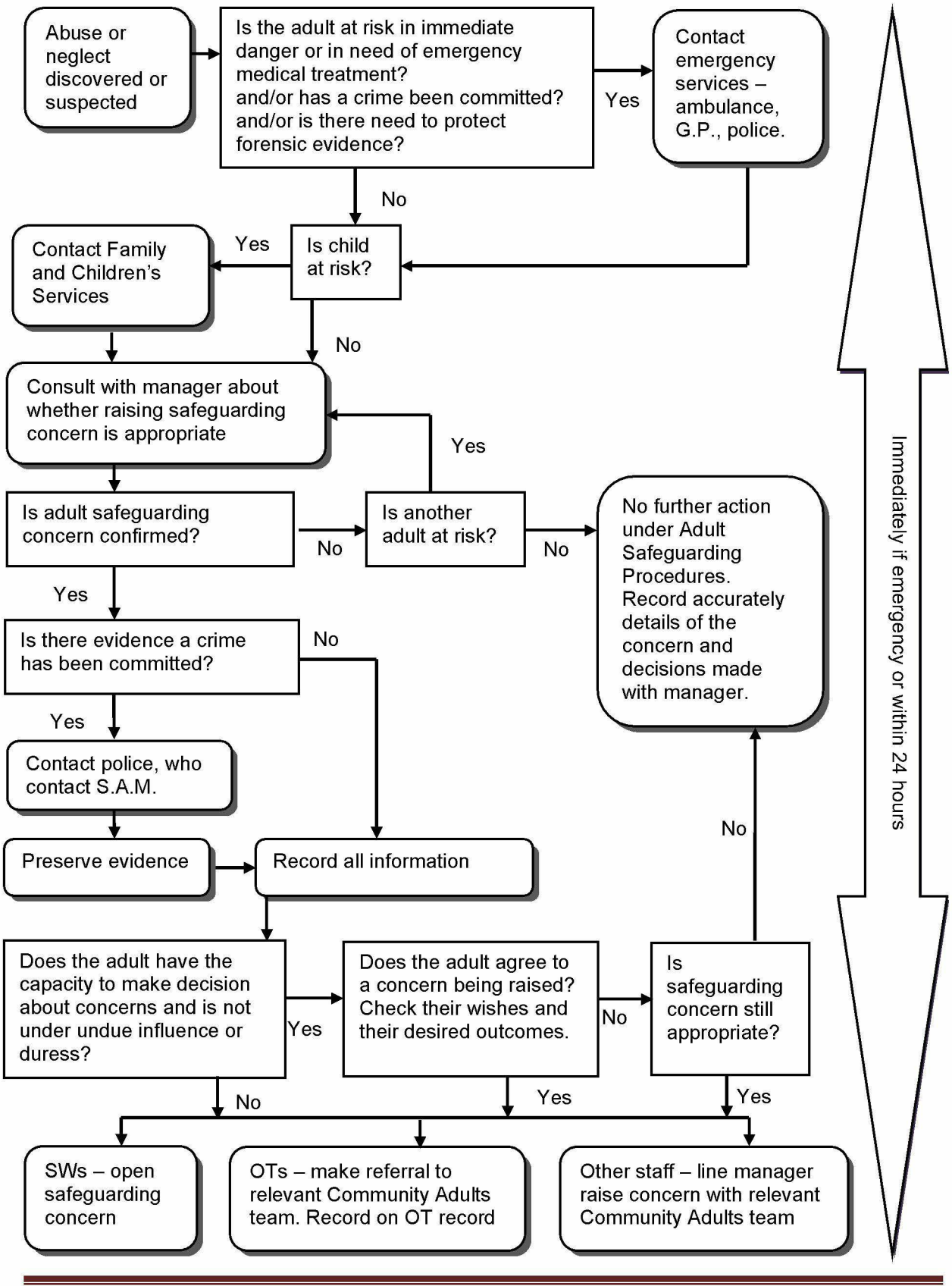
34.12 Stage One: Concerns

***Timescale**: Immediately if an emergency but within one day in other cases.*

34.12.1 Flow chart: raising a concern



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34.12.2 Purpose

The purpose of raising a concern is to protect an adult who has needs for care and support and who is at risk or may be at risk of abuse. An adult safeguarding 'Concern' is when anyone raises a concern about possible abuse or neglect within their organisation or within the community.

This section applies to all staff. All staff from any service or setting who have contact with adults at risk have a responsibility to be aware of issues of abuse, neglect or exploitation. (*Please Note:* This includes personal assistants paid for from direct payments or personal budgets.)

All staff:

- Your first priority should always be to ensure the safety and protection of the adult at risk.
- You have a *duty to act* in a timely manner on any concern or suspicion that an adult who is vulnerable is being or is at risk of being abused, neglected or exploited and to ensure that the situation is assessed and investigated.

34.12.3 What is a concern?

An adult safeguarding concern is any concern about an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs), and
- is experiencing, or at risk of, abuse or neglect, and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

A concern may be:

- a direct disclosure by the adult at risk
- a concern raised by staff or volunteers, others using the service, a carer or a member of the public
- an observation of the behaviour of the adult at risk, of the behaviour of another person(s) towards the adult at risk or of one person towards another.

Factors to consider when raising a concern:

- **How vulnerable is the adult at risk? What personal, environmental and social factors contribute to this?**
- **What is the nature and extent of the abuse or neglect?**
- **Is the abuse or neglect a real or potential crime?**
- **How long has it been happening? Is it a one-off incident or a pattern of repeated actions?**
- **What impact is this having on the individual? What physical and/or psychological harm is being caused? What are the immediate and likely longer-term effects of the abuse or neglect on their independence and well-being?**

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- **What impact is the abuse or neglect having on others?**
- **What is the risk of repeated or increasingly serious acts involving the person causing the harm?**
- **Is a child (under 18 years) at risk?**

34.12.4 Responsibilities of the person raising the concern

Practitioner:

1. Make an evaluation of the risk and take steps to ensure that the adult is in no immediate danger.
2. Arrange any medical treatment. (Note that offences of a sexual nature will require expert advice from the police.)
3. If a crime is in progress or life is at risk, dial emergency services – 999.
4. Encourage and support the adult to report the matter to the police if a crime is suspected and not an emergency situation.
5. Take steps to preserve any physical evidence if a crime may have been committed, and preserve evidence through recording.
6. Ensure that other people are not in danger.
7. Where possible, inform your line manager immediately of any concerns or disclosures. If you are concerned that your line manager has abused an adult at risk, you must inform a senior manager in your organisation, or another Community Adults team manager.
8. Record accurately the information received, risk evaluation and all actions. Keep any contemporaneous notes. See also **section 34.13.9 Recording.**

Responding to a person making a disclosure

- **Speak in a private and safe place.**
- **Assure them that you are taking them seriously.**
- **Listen carefully to what they are telling you, stay calm, and get as clear a picture of the basic facts as you can, but avoid asking too many questions at this stage. Do not be judgmental or jump to conclusions.**
- **Ask them what they would like to happen and what they would like you to do. If there are concerns about their capacity to make these decisions, follow Mental Capacity act procedures – see section 34.8.**
- **Do not give promises of complete confidentiality. Explain that you have a duty to tell your manager or other designated person, and that their concerns may be shared with others who could have a part to play in protecting them.**
- **Explain how the person will be involved and kept informed.**
- **Explain that you will support them to make decisions to keep themselves safe from further abuse or neglect. Put in place any necessary care and support arrangements.**

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- **If they have specific communication needs, provide support and information in a way that is most appropriate to them. Decide whether an advocate may be required (see section 34.7).**

34.12.5 Making a decision to share information or intervene without consent

Practitioner: Normally, you reach agreement with the adult at risk whether to intervene and the reasons, unless discussing it with them would jeopardise their safety or the safety of others.

If you assess the adult at risk as not having capacity to make a decision about their own safety or to consent to sharing information or agreeing to intervention, follow safeguarding procedures in their best interests if appropriate in accordance with the provisions set out in the Mental Capacity Act 2005 (see **section 34.8**).

The key issue in deciding whether to undertake a Section 42 enquiry is whether an adult is experiencing or is at risk of abuse or neglect. An enquiry will establish whether any action needs to be taken to prevent or stop abuse or neglect and by whom.

If there is an overriding public interest or vital interest or if gaining consent would put the adult at further risk, you must raise a concern.

Public interest – a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

Vital interest is a term used in the Data Protection Act 1998 to permit sharing of information where it is critical to prevent serious harm or distress or in life-threatening situations.

This would include situations where:

- other people or children could be at risk from the person causing harm
- it is necessary to prevent crime
- there is a high risk to the health and safety of the adult at risk
- the person lacks capacity to consent.

Record on the safeguarding documentation in Frameworki any decisions about sharing information with other professionals and/or with lay people (for example, family members) and your reasons (see also **section 34.9**). Also record whether the adult at risk consents to providing a statement to the police (where relevant).

34.12.6 Making a decision not to intervene

Practitioner: If the adult at risk has capacity and does not consent to information being shared or an intervention being made and there are no public or vital interest considerations (see above, **section 34.12.5**), give them information about where to get help if they change their mind or if the abuse or neglect continues and they

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subsequently want support to promote their safety. Assure yourself that the decision to withhold consent is not made under undue influence, coercion or intimidation.

Make a record of the concern, the adult at risk's decision and of the decision not to intervene, with reasons. Document your assessment as far as possible. Keep in contact with the person concerned, and carry out an assessment if the adult at risk changes their mind and ask you to do so.

34.12.7 Considering the person alleged to have caused harm

Practitioner: Do not discuss the concern with the person alleged to have caused harm, unless the immediate welfare of the vulnerable adult makes this unavoidable.

34.12.8 Responsibilities of the line manager

Manager: Once the concern has been raised with you as the line manager by a member of your staff, you must decide without delay on the most appropriate course of action.

1. Clarify that the adult at risk is safe, that their views have been clearly sought and recorded and that they are aware what action will be taken.
2. Address any gaps.
3. Check that issues of consent and mental capacity have been addressed.
4. In the event that a person's wishes are being overridden, check that this is appropriate and that the adult understands why.
5. Contact Children Services if a child or young person is also at risk.
6. If the person allegedly causing the harm is also an adult at risk, arrange appropriate care and support.
7. Make sure action is taken to safeguard other people.
8. Take any action in line with disciplinary procedures, including whether it is appropriate to suspend staff or move them to alternative duties.
9. If a criminal offence has occurred or may occur, contact the police force where the crime has occurred or may occur.
10. Preserve forensic evidence and consider a referral to specialist services.
11. Consider whether to alert a senior manager about the case so that they can decide whether it should be put forward for a Safeguarding Adults Review under section 44 of the Care Act (SAR). (See **section 34.24**.)

12. Record the information received and all actions and decisions on Frameworki.

You are responsible for:

- supporting any member of staff or volunteer who raised the concern
- enabling and supporting relevant staff to play an active part in the adult safeguarding process
- ensuring that any staff delivering a service to the adult at risk are kept up to date on a need-to-know basis and do not take actions that may prejudice the enquiry.

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34.12.9 Emergency duty teams (EDTs) and out-of-hours services

Emergency duty officers in the EDT: If a concern is raised with the EDT which indicates an immediate or urgent risk, take any immediate steps necessary to protect the adult at risk including arranging emergency medical treatment, contacting the police and taking any other action to ensure that the adult at risk is safe.

If you are responding to an emergency, be aware that other adults may also be at risk.

You are not responsible for an adult safeguarding enquiry but it may be necessary to interview the alleged victim where:

- the allegation is serious, that is, life-threatening or likely to result in serious injury (in which case action would be coordinated with the police to ensure that any evidence is preserved)
- the concern is unclear and consent needs to be sought as well as what the adult wants to happen next
- there is a need to interview the adult at risk to ensure they can be safeguarded against further abuse if necessary.

Whether or not any immediate action is necessary, record the facts concerning the alleged abuse or neglect and pass all relevant information to the duty team in the appropriate Community Adults team on the next working day. If the case is already allocated, notify the allocated worker.

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34.13 Stage Two: Enquiry

***Timescale**:*

Initial conversation – same day concern received if not already taken place

Planning meetings – within 5 working days

Enquiry actions – target time within 20 working days

Agreeing outcomes – within 5 working days of enquiry report.

34.13.1 Purpose

This stage is about responding to a concern raised about possible abuse or neglect of an adult at risk. Under Section 42 of the Care Act 2014, when the Local Authority becomes aware of a concern(s) as outlined above (**section 34.12.1**), it must make or arrange whatever enquiries it thinks necessary in order to establish whether any action should be taken to prevent or stop abuse or neglect, and if so, what action and by whom.

34.13.2 Enquiry Officer and S.A.M.

An **enquiry officer** is responsible for undertaking actions under adult safeguarding. In some instances there is a lead Enquiry Officer supported by other staff also acting as enquiry officers, where there are complex issues or additional skills and expertise is required. The lead Enquiry Officer will retain responsibility for undertaking and co-ordinating actions under a Section 42 enquiry. Enquiry Officers (including leads) may be from any agency involved.

The **Safeguarding Adult Manager** (S.A.M.) is the manager who manages, makes decisions, provides guidance and has oversight of safeguarding concerns that are referred to the Local Authority, or through the Mental Health Trust where there are agreements in place. The S.A.M. is a team manager or team leader in Adult Social Care or the Central and North West London Mental Health Trust, West London Mental Health Trust or designated substance misuse services

34.13.3 Receiving the Concern – deciding how to proceed

The team receiving the concern decides very early on who is the best person/organisation to lead on the enquiry under Section 42 and who will be the Safeguarding Adults manager (S.A.M.).

The information received may be sufficiently comprehensive that it is clear that immediate risks are being managed, and that the criteria are met for a formal Section 42 enquiry. In other cases some additional information gathering may be needed to establish fully that the three steps are met, as set out in **section 34.12.3** above. Take into account all relevant information through a multi-agency approach wherever possible, including the views of the adult taking into consideration mental capacity and consent.

The degree of involvement of the Local Authority will vary from case to case, but at a minimum must involve decision making about how the enquiry will be carried out, oversight of the enquiry, decision making at the conclusion of the enquiry about what

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actions are required, ensuring data collection is carried out, and quality assurance of the enquiry.

S.A.M.: Decide how the enquiry will be progressed. Decide who will be the Enquiry Officer(s). Decide whether there needs to be a Lead Enquiry Officer to coordinate the work, if there are several enquiries to be carried out.

34.13.4 Conversations with the adult at risk, and providing adequate support

In the majority of cases, unless it is unsafe to do so each enquiry will start with a conversation with the adult at risk.

S.A.M.: Find out whether conversations with the adult at risk have taken place and whether they are sufficient. Decide who is best placed to carry out the enquiry. In some case, this may be the staff/organisation who knows the person best – for example, housing officer, GP, community nurse. But remember that the local authority retains responsibility for making sure that the enquiry happens and is acted upon.

Enquiry Officer: Throughout the process, you must give the person as much information as they require about the steps involved in the safeguarding process, and support them to participate in the process.

If the adult at risk has capacity to make all of the decisions about their safety, seek an interview with them. Have regard to the safeguarding principles – making safeguarding personal (see **section 34.3**).

- Make sure that the adult at risk is safe.
- Identify whether any communications help is required (for example, translated questions or interpreter).
- Remove as much as possible any barriers to the adult at risk participating in their own risk assessment and safeguarding planning. If the adult has capacity but they are likely to have 'substantial difficulty' in being involved or contributing to the process, agree an 'appropriate person' to facilitate involvement or consider a referral to an independent advocate to represent and support the adult (see also **section 34.7**). Record on the Safeguarding documentation in Frameworki.
- Check the consent and capacity of the adult at risk to make relevant decisions by understanding the management of risk, what a safeguarding enquiry is, and how they might protect themselves. See also **section 34.8**.
- Check whether the adult at risk is aware of the safeguarding concern and whether they perceive it as a concern and want action and/or support.
- Check whether there is suspicion that a crime has been committed and depending on the circumstances either consult with the police or make a direct third party report to the police if not already done, taking into account the wishes of the adult needing protection. See also **section 34.9 Information sharing** and the Guidance note in **section 34.13.6 Deciding to undertake a Section 42 enquiry without consent**.
- Gather the adult at risk's wishes and desired outcomes. Support the adult to think in terms of realistic outcomes.

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- Carry out a risk assessment with them to find out if they understand the risk and what help they may need to support them to reduce the risk if that is what they want.
- Identify the strengths of the adult at risk and of their support network towards reducing the risks.
- Reassure the individual that they will be involved and supported in all relevant decisions and actions that are taken to protect them.

- Record all actions and conversations.

Handle enquiries in a sensitive way to ensure minimal distress to the adult at risk. It is critical in this particularly sensitive area (whether an enquiry or a Safeguarding Adults Review – see section 34.24) that the adult at risk is supported in what may feel a daunting process which may lead to some very difficult decisions. An individual who is thought to have been abused or neglected may be so demoralised, frightened, embarrassed or upset that independent advocacy provided under Section 68 to help them to be involved will be crucial (see section 34.7).

Where appropriate, also seek interviews with relative, friend, carer, IMCA or advocate.

Where there is concern that the adult at risk may not have capacity to make one or more relevant decisions, see **section 34.7**.

If you establish that the adult at risk lacks capacity to make one or more decisions about proposed protective measures, give feedback to them and anyone who is acting in their best interests, for example, their attorney or court appointed deputy, unless they are implicated in the safeguarding concern.

Enquiry Officer:

- Report the matter to the police where a crime is committed or suspected (see **section 34.14.**)
- Provide feedback to the person raising the concern.

- Start an Adult Safeguarding Concern episode.
- Complete the **Safeguarding Concern document**; select recommended outcome.
- Send a task to the S.A.M. to confirm information and agree next steps.

34.13.5 Planning further enquiry

S.A.M.: Review the safeguarding documentation and agree next steps. Decide whether actions so far have completed the enquiry. If not, decide whether to proceed without consent if necessary. If there is a need for further enquiry, plan the enquiry and agree how it will be carried out and coordinated.

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Agree how to manage the risk to prevent further abuse or neglect, to keep the risk at a level acceptable to the person, or to support the individual to continue in the risky situation if that is their choice and they have the capacity to make that decision.

Discussions between relevant participants may take place on the telephone, or if the situation is more complex, in a multi-agency planning meeting. The views and/or involvement of the adult will play an important part of this planning phase. Never put action on hold, owing to the logistics of arranging meetings. Proportionality should be the guiding principle.

Enquiries can range from straightforward single agency interventions to complex multi-agency pieces of work, depending on the nature of the safeguarding concern, the outcomes the adult at risk wants, and the best way to reduce risk.

Where there is more than one enquiry:

Lead Enquiry Officer: Coordinate the work to avoid delays, to ensure that people are interviewed once, and to bring the information together.

There are many types of enquiry, each of which will be led by the appropriate organisation[23].

Other processes, including police investigations and HR processes, can continue alongside the safeguarding adult enquiry.

There needs to be a judgment as to the nature of the enquiry based on the following factors:

- **the incident itself (whether it is abuse or neglect)**
- **the impact on the adult**
- **the severity of the incident**
- **whether the person allegedly caused the harm is a member of staff or volunteer**
- **whether it is an alleged crime**
- **the vulnerability of the adult including whether they have capacity to make decisions about the safeguarding process, risk assessment and protection planning**
- **whether it is a repeat incident**
- **the risk of repeated or increasingly serious acts of abuse or neglect**
- **the risk to the adult and other vulnerable adults**

The information on the concern needs unpicking and fact clarified. On initial reading it may not meet the threshold, but consider the following:

- **If it is a care setting, is the establishment managing incidents appropriately?**
- **Are staff 'accepting' incidents between patients because it is a mental health setting?**
- **Incidents do and will occur but we need to be careful that they are limited. People have the right to live in safe environments.**

[23] See London Multi-Agency Safeguarding Policy and Procedures, p78 for list6 of types of enquiries and who might lead.

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- **A common theme in the learning from Serious Case Reviews has been that information about poor and dangerous services was not collated or linked with other information so that intervention might have taken place before serious harm or death occurred. Is there potential for this to be the case for this incident?**
- **For those incidents not converted into a safeguarding enquiry the organisation should be proactive in looking at how it analyses its incident reporting and mapping patterns of concerns. Does this happen?**

34.13.6 Deciding to undertake a Section 42 enquiry without consent

In the following situations, undertake a Section 42 enquiry even if the adult at risk does not want any action taken:

- The adult at risk may not have the capacity to make decisions about their own safety but this does not mean that they cannot be supported in making a decision.
- The abuse or neglect has occurred on property owned or managed by an organisation with a responsibility to provide care.
- The person causing the harm is:
  - a member of staff
  - a volunteer(s)
  - someone who only has contact with the adult at risk because they both use the service.
- Other people are at risk from the person causing harm and they are also adults at risk.
- The risk of harm to the adult at risk is high.

In such a case, inform the adult at risk of the decision, the reason for the decision and reassure them that no actions will be taken which affect them personally without supporting them through the process. (See also **section 34.13.4 Conversations with the adult at risk**.)

Carefully consider any intervention in family or personal relationships. While abusive relationships never contribute to the wellbeing of an adult, interventions which remove all contact with family members may also be experienced as abusive interventions and risk breaching the adult's right to family life if not justified or proportionate. Safeguarding needs to recognise that the right to safety needs to be balanced with other rights, such as rights to liberty and autonomy, and rights to family life. Make sure that if you are considering curtailing contact with a particular individual, there is a clear lawful framework for the decision.

There are a number of additional courses of action to take in particular circumstances under the general umbrella of safeguarding in which partnership working may be required:

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- Refer to MARAC if the concern indicates a high risk of domestic violence (see **section 34.17**).
- Refer to local borough-specific arrangements if the adult at risk is a victim of hate crime harassment or if the adult at risk is experiencing anti-social behaviour and requires support.
- Refer to Channel Case Panel via Prevent Officer if the concern indicates a vulnerability to radicalisation (see **section 34.20**).

34.13.7 Deciding when not to undertake a Section 42 enquiry

S.A.M.: You may decide not to undertake a Section 42 enquiry when there is enough information to decide that:

- the situation does not involve abuse, neglect or exploitation, in which case another service may be appropriate
- the adult at risk is not an adult who is covered by these procedures. They can then be signposted to other services or resources
- the adult has care and support needs and a level of abuse or neglect has occurred, but a full Section 42 enquiry is not a proportionate response
- the adult at risk has the capacity to make an informed choice about their own safety, there are no public interest or vital interest considerations and they choose to live in a situation in which there is risk or potential risk: this may be for example where it is a personal matter and an enquiry may cause family disharmony
- you are satisfied that their ability to make an informed decision is not being undermined by the harm they are experiencing and is not affected by intimidation, misuse of authority or undue influence, pressure or exploitation if they decline assistance.

Do not exclude concerns regarding adults with so-called 'low level needs' where there are risks that the harm to the person puts their independence and well-being at risk and leads to a deterioration in their ability to protect themselves. Remember that the section 42 duty applies to adults who have care and support needs but may not meet eligibility criteria. Such adults include:

- adults with low-level mental health problems/borderline personality disorder
- older people living independently in the community
- adults with low-level learning disabilities
- adults with substance misuse problems
- adults self-directing their care
- adults who are care leavers.

In cases which are not 'Safeguarding' but involve adults at risk who may be hard to engage, see **Section 27** and **Section 28** to identify alternative action that may be necessary.

If you decide not to carry out further enquiries, record the decision with the reasons.

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Inform the person raising the concern of the decision in a timely way, and the reasons for it, and give information about any alternative services, if this does not breach the adult's confidentiality.

34.13.8 Feeding back to the adult at risk

Designate the most appropriate person to feed back to the adult at risk. This will often be the staff member raising the concern or their line manager. Where the person does not have capacity, they should still be included in the process. Arrange for feedback to be given to the person acting in their best interests – for example, their carer, attorney or court appointed deputy.

34.13.9 Recording

Enquiry Officer/ S.A.M.: Record the process in the Safeguarding episode in Frameworki and incorporate all records relevant to the enquiry.

Throughout the safeguarding enquiry, keep detailed factual records. This includes the date and circumstances in which conversations and interviews are held and of any decisions taken.

If the person alleged to have caused the abuse or neglect is an individual known to Adult Social Care, then include in his/her records the information about his/her involvement in an safeguarding adult enquiry, including the outcome of the enquiry. If an assessment is made that the individual still poses a threat to other persons, include this assessment in any information passed onto service providers.

If more than one person is involved, ensure that any reference to the other individuals involved is anonymised.

34.13.10 Enquiry Report

Enquiry Officer (Lead if more than one):

- Collate all the information collected into a single comprehensive enquiry report. Ensure that the report is concise, factual and accurate. The report should cover:
  - the views of the adult at risk
  - whether outcomes were achieved
  - whether any further action is required and if so by whom
  - who supported the adult and if this is an ongoing requirement.
- Append any investigation (for example, disciplinary investigation) to the enquiry report.
- Review the risk assessment and adjust any safeguarding plan accordingly.
- Ensure any recommendations are taken forward.

S.A.M.:

- Check that the enquiry report is of a satisfactory standard: ensure that the report is evidence-based, and that there is sufficient corroboration to draw conclusions. If another organisation has led on the enquiry, decide whether a further enquiry should be undertaken by the Local Authority. The exception to this is where there

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is a criminal investigation and in this case consider whether any other enquiry is needed that will not compromise action taken by the police.

- Share the enquiry report with the other professionals involved and with the adult at risk and their family, advocate, attorney or deputy, except where this may increase the risk of serious harm, where the information is highly confidential, or where it may contravene the rights of a third party, as described in **section 34.9**. In such exceptional cases, summarise and share the relevant facts from the sections of the report concerned rather than the whole of those sections.
- In consultation with the adult at risk and other parties involved in the enquiry, decide whether:
  - the adult has needs for care and support
  - they were experiencing or at risk of abuse or neglect
  - they were unable to protect themselves
  - further action should be taken to protect the adult from abuse or neglect.
- Ask the adult at risk to evaluate:
  - to what extent the desired outcomes were met
  - to what extent they feel safer.

The important factor is the impact of actions on the adult at risk.

Recovery & Resilience

Adults who have experienced abuse and neglect may need to build up their resilience. This a process whereby people use their own strengths and abilities to overcome what has happened, learn from the experience and have an awareness that may prevent a recurrence, or at the least, enable people to recognise the signs and risks of abuse and neglect, and know who and how to contact for help.

Resilience is supported by recovery actions, which includes adults identifying actions that they would like to see to prevent the same situation arising. The process of resilience is evidenced by:

- **the ability to make realistic plans and being capable of taking the steps necessary to follow through with them**
- **a positive perception of the situation and confidence in the adult at risk's own strengths and abilities**
- **an increase in the person's communication and problem-solving skills.**

Resilience processes that either promote wellbeing or protect against risk factors, benefit individuals and increase their capacity for recovery. This can be done through individual coping strategies assisted by:

- **strong personal networks and communities**
- **social policies that make resilience more likely to occur**

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- **handovers/referrals to other services - for example, care management, or psychological services to assist building up resilience**
- **restorative practice**

S.A.M.: If no further safeguarding action is required and there are alternative ways of supporting adults where they may be needed then close down the adult safeguarding process. Close the episode on Frameworki. (See **section 34.16**.)

34.13.11 Person alleged to be responsible for abuse or neglect

Where appropriate, the police will consider whether action may include a prosecution.

S.A.M.: When a complaint or allegation has been made against a member of staff, including people employed by the adult, ensure that the employer makes them aware of their rights under employment legislation and any internal disciplinary procedures. Where appropriate, report the staff member to the relevant professional body, such as the General Medical Council, the Nursing and Midwifery Council or the Health and Care Professions Council.

Consider whether a referral needs to be made to the Disclosure and Barring Services which helps employers prevent unsuitable people working with vulnerable groups. Where appropriate, request a copy of the acknowledgement letter from the DBS to the service provider on receipt of the referral. The employer or Regulated Activity Provider has a duty to make a referral in such a case, but if the service provider unreasonably refuses to make a referral, or there is an unreasonable delay, then the DBS referral can be made by the S.A.M. in consultation with the Safeguarding Adults Team under the Local Authority's power to make a report. (See **here for more information and guidance**.)

Check whether staff were provided with the right training, supervision and support. Whilst this does not condone deliberate intentions of abuse, consider prevention strategies to reduce the risk of it occurring again to the adult at risk or other people.

Where the person who is alleged to have carried out the abuse has their own care and support needs and is unable to understand the significance of questions put to them or their replies, assure them of their right to the support of an 'appropriate' adult if they are questioned in relation to a suspected crime by the police under the Police and Criminal Evidence Act 1984 (PACE). Victims of crime and witnesses may also require the support of an 'intermediary' adult. Where required, arrange for an assessment of their care and support needs.

Where the person who is alleged to have carried out the abuse or neglect themselves has mental health needs, check whether they are known to Mental Health services.

Where the person who is alleged to have carried out the abuse or neglect is preventing you seeing the adult at risk on their own, consider this a cause for concern, and discuss with your manager how to proceed. Consider legal options.

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Where the person who is alleged to have carried out the abuse or neglect also has a caring role, see also **section 34.6 Carers and safeguarding**.

34.14 Referrals to the police

34.14.1 Introduction

You will have reached this section if you are considering contacting or making a referral to the police when responding to an adult safeguarding concern. Always refer to the police when a serious crime has been committed. If in doubt, discuss with the police whether a referral is appropriate. If the crime is not serious and there are no repeat incidents which may indicate a pattern, and there is no wider public interest involved, then take into account the wishes of the adult at risk, exploring with them any reasons they may have for not making a referral to the police.

34.14.2 Emergency cases

In all cases where an urgent police response is required, access this response by dialling 999. Whilst it is undesirable that non-emergency cases are referred via this method, always take into consideration the preservation of the life and wellbeing of the adult at risk. In cases of uncertainty the immediacy of the risk and the need for police attendance should inform the decision making. In particular where:

- the crime / incident is happening now
- the offender is still present or nearby
- someone saw the crime / incident being committed
- evidence has been left at the scene

strongly consider dialing 999.

Where police have attended a particular incident, a crime report (CRIS) should be completed by police and there will be no additional need to submit a referral to police.

34.14.3 Non-emergency cases requiring immediate police attention

Police should always attend all allegations of assault, serious sexual offences or domestic violence or any other crime, for example, burglary, where it would be necessary for police to conduct an initial investigation to establish whether a crime has been committed and to preserve life/evidence and identify witness/suspects.

These actions are necessary to ensure the preservation of evidence: in particular, in assault cases it will be important to secure evidence relating to:

- injuries which have not been treated or documented by a medical practitioner, and
- where the physical effects of the assault are likely to be short-lived and evidence will be lost if police do not attend.

Ring 101 and a CAD (Computer Aided Dispatch) number will be given which should be quoted with the date of notification e.g. CAD 3002 of 12/08/09 in any subsequent enquiry. Inform the Safeguarding Adults Lead to escalate if there are concerns to

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process. See also **section 6.11 Police Referrals: Vulnerable Adults Coming to Notice (VACN) (Merlin) reports**.

34.14.4 Local Protocols

RBKC: **Protocol for Referrals to Police**

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34.15 Stage Three: Safeguarding Plan and Review

***Timescale**:*

Safeguarding Plan - Within 5 working days from receipt/distribution of the enquiry report.

Review – not more than 3 months after plan agree, but dependent on risk

34.15.1 Purpose

The purpose of this stage is to consider the information from the enquiry report, to re-assess risk, to agree and implement an adult safeguarding plan and to review the process and case outcomes.

In most cases there will be a natural transition between deciding what actions are needed and the end of the enquiry, into formalising what these actions are and who will be responsible for each action - this is the adult safeguarding plan.

An adult safeguarding plan is not a care and support plan, and it will focus on care provision only in relation to the aspects that safeguard against abuse or neglect, or which offer a therapeutic or recovery based resolution. In many cases the provision of care and support may be important in addressing the risk of abuse or neglect, but where this is the intention the adult safeguarding plan must be specific as to how this intervention will achieve this outcome.

Adult safeguarding plans should be person-centred and outcome-focused, and should be made with the full participation of the adult at risk.

34.15.2 What to do

S.A.M.: In conversation with the other agencies, the adult at risk and their carer/advocate/attorney/deputy as appropriate:

1. Consider the information contained in the enquiry report.
2. Re-assess risk.
3. Consider what legal or statutory action or redress is required.
4. Agree the adult safeguarding plan.
5. Identify the lead professional who will monitor and review the plan, and when this will happen. In some circumstances it may be appropriate for safeguarding plans to be monitored through ongoing care management responsibilities. In other situations a specific safeguarding review may be required.
6. Close the safeguarding process, if required. Close the episode on Frameworki. (See **section 34.16**.)

The Safeguarding Plan should set out:

- what steps are to be taken to assure the future safety of the adult at risk
- the provision of any support, treatment or therapy, including on-going advocacy

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- any modifications needed in the way services are provided (for example, same gender care or placement; appointment of an OPG deputy)
- how best to support the adult through any action they may want to take to seek justice or redress
- any on-going risk management strategy as appropriate.

The plan should outline the roles and responsibilities of all individuals and agencies involved.

Identified lead practitioner: Monitor the plan on an on-going basis, within agreed timescales.

34.15.3 Review of the enquiry (optional)

S.A.M.: Where appropriate, arrange a review. The purpose of the review is:

- to evaluate the effectiveness of the adult safeguarding plan
- to evaluate whether the plan is meeting/achieving outcomes
- to evaluate risk.

- Ensure that the review of the adult safeguarding plan, and decisions about the plan, are communicated and agreed with the adult at risk. Following the review process, it may be determined that:
  - the adult safeguarding plan is no longer required; or
  - the adult safeguarding plan needs to continue.
- Agree and make any changes or revisions to the plan.
- Set new review timescales (if needed) and identify the lead professional who will continue monitoring and reviewing; ***or***
- Instigate a new adult safeguarding Section 42 Enquiry if necessary. If the decision is that further enquiries would be a disproportionate response to new or changed risks, agree to continue further review and monitoring.

34.15.4 Frameworki Process

Practitioner:

- Complete relevant documentation in the Adult Safeguarding Enquiry episode, and complete and upload any further external document(s) relevant to the Enquiry or Safeguarding plan.
- Send a task to the S.A.M./your line manager.

Manager: Review the safeguarding documentation and agree next steps.

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34.16 Stage Four: Closing the Enquiry

***Timescale**: The adult safeguarding process may be closed at any stage.*

34.16.1 Purpose

To complete and sign-off the adult safeguarding process.

34.16.2 What to do

Please Note: For institutional abuse and complex/ high risk interventions, case closure must be agreed by S.A.M.'s line manager.

S.A.M.:

Inform all relevant parties of the decision to close the safeguarding case. Advise them on how and who to contact with agreement on how matters will be followed up with the adult at risk if there are further concerns. It is good practice where a care management assessment, Care Programme Approach (CPA) assessment or review, reassessment of care and support, health review, placement review or any other pre-booked review is due to take place following the safeguarding enquiry, for a standard check to be made that there has been no recurrence of concerns.

Ensure all necessary actions have been taken:

1. Agree closure with the adult at risk.
2. Refer for assessment and support where required.
3. Provide advice and Information.
4. Update and inform all organisations involved in the enquiry.
5. Give feedback to the person raising the concern.
6. Take action with the person alleged to have caused harm.
7. Take action to support other adults with care and support needs.
8. Refer children and young people to Children's Services (if necessary).
9. Note outcomes and ask adult at risk to evaluate them.
10. Consider whether a SAR is required.
11. Identify any lessons to be learnt.
12. Make sure that all recording is up to date. Note the reason for case closure and the views of the adult at risk.

The adult safeguarding process may be closed but other processes may continue - for example, a disciplinary or professional body investigation. These processes may take some time. Where there are outstanding criminal investigations and pending court actions, the adult safeguarding process can also be closed providing that the adult is safeguarded. Decide how to monitor the effect of these processes on the adult at risk

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All closures no matter at what stage are subject to an evaluation of outcomes by the adult at risk. If the adult at risk disagrees with the decision to close the safeguarding process, fully explore their reasons and offer alternatives.

34.16.3 Frameworki Process

- Complete Safeguarding End of Process form in whichever episode marks the conclusion of the safeguarding process.

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34.17 Domestic violence/ domestic abuse

Adults at risk may be the victims of domestic violence or be affected by it occurring within their household. This can have serious effects on a person's physical and mental wellbeing. It is important to consider the additional barriers that adults at risk may face, including barriers to leaving the abusive situation, for example, disability or illness which makes them dependant on the alleged person causing harm, financial insecurity, or lack of knowledge of available resources.

In 2013, the Home Office announced changes to the definition of domestic abuse. It is an *"incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse... by someone who is or has been an intimate partner or family member regardless of gender or sexuality"*. It includes psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence; Female Genital Mutilation; forced marriage. The age range is now 16 and above.

If you believe that an adult at risk is being abused, consider the abuse in terms of whether domestic violence is occurring. For example, instead of deeming the case of a man who threatens to hit his mother unless she provides money in terms of physical and financial abuse only, this needs be considered in terms of domestic violence. In this case, link the mother's support and protection plan to multi-agency support services to ensure improved outcomes, such as specialist domestic violence support services.

Carefully consider any intervention in family or personal relationships. While abusive relationships never contribute to the wellbeing of an adult, interventions which remove all contact with family members may also be experienced as abusive interventions and risk breaching the adult's right to family life if not justified or proportionate. Safeguarding needs to recognise that the right to safety needs to be balanced with other rights, such as rights to liberty and autonomy, and rights to family life. Make sure that if you are considering curtailing contact with a particular individual, there is a clear lawful framework for the decision.

Practitioner: At the point of concern take steps to support the adult at risk so that they are able to protect themselves from further abuse. When contacting the adult at risk, consider the safest way to make this contact; this may be via the GP, another health service, or educational services if they have children. You may wish to seek advice from a specialist agency or support the adult at risk in doing so.

Do not:

- inform the person alleged to have caused harm that a safeguarding concern has been raised
- approach members of the family or the community unless the person expressly asks you to do so
- attempt to be a mediator.

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Risk assess the adult at risk during the initial assessment. Decide whether to contact or to make a referral to the police in high risk cases (see **section 34.14**).

The planning meeting reviews the risk assessment and protection plan, including linking into other appropriate services. Take into account the capacity of the adult at risk to take part in the adult safeguarding process and their safeguarding plan. Consider whether a referral is required to the Multi-Agency Risk Assessment Conference (MARAC) if this is a high risk case, using the **CAADA-DASH risk assessment and referral**. The MARAC is a multi-agency forum for the sharing of information on high risk domestic violence cases. Refer according to local borough arrangements:

LBHF and RBKC: The MARAC is coordinated by Standing Together Against Domestic Violence, tel - [redacted]

WCC: Send referrals to **marac@westminster.gov.uk**.

34.18 Forced Marriage

There is a clear distinction between a forced and arranged marriage. In arranged marriages, the families of both spouses take a leading role in arranging the marriage but the choice whether or not to accept the arrangement remains with the prospective spouses. In forced marriages, one or both spouses do not (or in the case of some adults at risk, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure or violence.

Practitioner: Treat all concerns of a potential forced marriage or an adult at risk already in a forced marriage, as an adult safeguarding concern. See Forced Marriage (Civil Protection) Act 2007 in **Section 45.4**. Moreover, the Anti-Social Behaviour, Crime and Policing Act 2014 makes it a criminal offence to force someone to marry.

When considering the validity of a marriage, particularly a marriage that took place overseas, seek specialist legal advice. However, do not assume that a marriage is invalid because it was forced: this will most often not be the case.

Remember the 'one chance' rule. Professionals may only have one chance to speak to a potential victim and thus they may only have one chance to save a life. If the victim is allowed to walk out of the door without support, that one chance might be wasted.

Do not:

- send the person away
- approach members of the family or the community unless the person expressly asks you to do so
- attempt to be a mediator.

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Follow the best practice steps:

- Explain all the options to the person.
- Recognise and respect their wishes.
- See them immediately in a secure and private place where the conversation cannot be overheard.
- See them on their own – even if they attend with others.
- Explain to the person about information sharing (see **section 34.9**).
- Establish a way of contacting them discreetly in the future.
- Obtain full details to pass on to the appropriate team.
- Consider the need for immediate protection and placement away from the family.

Follow the steps in these adult safeguarding procedures, giving particular attention to the following:

  - putting in place an immediate interim adult safeguarding plan
  - giving the adult at risk, where possible, the choice of the race and gender of the specialist who deals with their case
  - if necessary, ensuring records of any injuries and arranging a medical examination
  - giving the adult at risk personal safety advice
  - developing a safety plan in case the adult at risk is seen during meetings, that is, prepare another reason why you are meeting
  - establishing whether there is a family history of forced marriage, that is, siblings forced to marry. Other indicators may include domestic violence, self-harm, family disputes, unreasonable restrictions (for example, withdrawal from education or "house arrest") or missing persons within the family
  - advising the adult at risk not to travel overseas and discuss the difficulties they may face
  - keeping information from case files and database files strictly confidential and preferably restricting it to named members of staff only
  - referring the adult at risk, with their consent, to appropriate local and national support groups, counselling services and women's groups that have a history of working with survivors of domestic abuse and forced marriage
  - encouraging the adult at risk to access an appropriate, trustworthy advocacy service which can act on their behalf.

For further advice at any stage in a case, you can contact the Government's Forced Marriage Unit who can offer information and advice on the range of tools available to combat forced marriage, including legal remedies, overseas assistance and advice on how to approach victims. They can be contacted on [redacted] (Mon-Fri 9.00 – 17.00) email **fmu@fco.gov.uk**. See also the **Foreign and Commonwealth Office's "Multi-agency practice guidelines: Handling cases of Forced Marriage"**.

34.19 Human trafficking

Human trafficking is a global crime which affects individuals and businesses worldwide. Victims are trafficked all over the world for little or no money – including to and within the UK. They can be forced to work in the sex trade, domestic service, forced labour, criminal activity, or have their organs removed to be sold.

There is no typical victim and some victims do not understand they have been exploited and are entitled to help and support. Victims are often trafficked to a foreign country where they cannot speak the language, have their travel and identity documents removed and are told that if they try to attempt an escape, they or their families will be harmed.

The early identification of victims of human trafficking is key to ending the abuse they suffer and to providing the assistance necessary.

Key indicators of trafficking include[24]:

- **Is the person in possession of their own passport, identification or travel documents? Are these documents in possession of someone else?**
- **Does the person act as if they were instructed or coached by someone else? Do they allow others to speak for them when spoken to directly?**
- **Was the person recruited for one purpose and forced to engage in some other job? Have transport costs been paid for by facilitators, whom they must pay back through working or providing services?**
- **Does the person receive little or no payment for their work? Is someone else in control of their earnings?**
- **Does the victim have freedom of movement? Are they dropped off and collected from work?**
- **Is the person withdrawn or do they appear frightened?**
- **Has the person or their family been threatened with harm if they attempt to escape?**
- **Is the person under the impression they are bonded by debt, or in a situation of dependence?**
- **Has the person been physically or emotionally harmed or deprived of food, water, sleep, medical care or other life necessities?**
- **Can the person freely contact friends or family? Do they have limited social interaction or contact with people outside their immediate environment.**

This list is not exhaustive. A person may display a number of the trafficking indicators set out above but they may not necessarily be a victim of trafficking.

[24] Home Office practical guidance on human trafficking

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There is a national framework to assist in formal identification and help to coordinate the referral of victims to appropriate services; this is called the National Referral Mechanism. The UK Human Trafficking Centre takes referrals of adults and children identified as being the victims of trafficking. The Centre now comes under the Serious and Organised Crime Agency (SOCA).

The police are the lead agency in managing responses to adults who are the victims of human trafficking.

Under the Council of Europe Convention, identified victims of human trafficking are entitled to minimum levels of support. Councils have a duty to provide assistance to trafficked children in their area; adult victims who are foreign nationals may not have recourse to public funds but Local Authority assistance can be provided on a discretionary basis. Victim support cannot be limited to physical services such as accommodation and schooling; the victim's psychological needs must be addressed from the initial point of contact between the victim and the Local Authority.

Practitioner: If you suspect that someone may be a victim of human trafficking, follow the normal procedure for raising a concern (see **section 34.12**). If you think that someone is in immediate danger call 999. The Metropolitan Police with Stop the Traffik have a 24 hour hotline for victims to call or to report suspected trafficking. The number is [redacted].

Call The Salvation Army 24-hour confidential Referral Helpline on [redacted] anytime of the day or night to refer a potential adult victim of trafficking or to receive advice.

If the victim is a child, refer to Children's Services: the situation is dealt with under the London Child Protection Procedures.

If an identified victim of human trafficking is also an adult at risk, the response is coordinated under the adult safeguarding process. This involves organisations which have a role to play in dealing with victims of human trafficking such as the police, health providers, immigration officials and other relevant support services including those in the voluntary sector. The adult at risk should receive the support and advice they need and be safely repatriated if this is the future plan.

Not all victims may want to be rescued and there may be instances where reporting a suspected trafficking case puts the potential victim at risk.

See also the **Home Office practical guidance on human trafficking**.

34.20 Radicalisation

Radicalisation is comparable to other forms of exploitation, such as grooming and Child Sexual Exploitation. The aim of radicalisation is to attract people to their reasoning, inspire new recruits and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause. This may be direct through a relationship, or through social media.

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There are a number of factors that may make the individual susceptible to exploitation by violent extremists. None of these factors should be considered in isolation but in conjunction with the particular circumstances of the individual. An **assessment can be found here**.

PREVENT is part of the Government's counter-terrorism strategy CONTEST and aims to provide support and re-direction to vulnerable individuals at risk of being groomed into terrorist activity before any crimes are committed.

The Counter-Terrorism and Security Act 2015 requires specified authorities, in the exercise of their functions to have due regard to the need to prevent people being drawn into terrorism. The support available for individuals at risk of being radicalised is called CHANNEL.

Practitioner: If you suspect that someone may be susceptible to exploitation into violent extremism, then contact the Professional Standards and Safeguarding Team for advice. They are the lead for the Channel process, and will take the case to the Channel Panel.

The **Channel Panel** is a multi-agency panel chaired by the Local Authority. The role of the multi-agency panel is to develop an appropriate support package to safeguard individuals at risk of being drawn into terrorism. The purpose of the panel is:

- to assess the nature and extent of that risk; and
- to develop the most appropriate support plan for the individuals concerned.

The panel is responsible for managing the safeguarding risk which is in line with other multi-agency panels where risk is managed, such as the Multi-Agency Public Protection Arrangements (MAPPA). Local safeguarding structures have a role to play for those eligible for adult safeguarding.

34.21 Death of an adult at risk

S.A.M.: If an adult at risk dies, raise any cases currently being progressed under adult safeguarding procedures or where it is suspected that the harm, abuse or neglect of an adult at risk has caused or contributed to their death with the police and the Coroner. This includes the following:

- Advise the Coroner at the earliest opportunity of any serious incident which may result in death. This information will be used by the coroner and their staff in the event of the death to make investigation, post mortem and inquest decisions at the time required.
- Report any death to the Coroner immediately the death is known:
    - where contributory abuse or neglect is suspected, particularly if it involves domestic violence or services in the statutory, independent or voluntary sector
    - which occurs during an adult safeguarding process
    - which occurs immediately after an adult safeguarding process has been completed within the last 30 days.

This will enable the coroner and their staff to make investigation, post mortem and inquest decisions.

- Notify the coroner:
  - when a Large Scale Enquiry is started
  - of services where it is identified there appears to be a high death rate.

  This will enable the coroner to be aware of providers and/or services about which there are significant concerns: they will then know if further enquires are required should a death from that provider or service comes to their attention.

There is a duty to share information with the Coroner from the adult safeguarding process and enquiry.

All of the above relates to self-funding individuals, individuals funded by Adult Social Care and continuing healthcare-funded individuals.

The Safeguarding Adults Executive Board considers whether to conduct a Safeguarding Adults Review in these cases.

34.22 Domestic homicides

Section 9 of the Domestic Violence, Crime and Victims Act 2004 creates an expectation for Local Authority Community Safety Partnerships (CSP) to undertake a multi-agency Domestic Homicide Review (DHR) into the deaths of people aged 18 or over resulting, or appearing to result, from violence, abuse or neglect by a current or former partner, a relative or a member of the same household.

34.23 Safeguarding Adults Board

Under the Care Act 2014, each local authority must set up a Safeguarding Adults Board (SAB). The main objective of a SAB is to assure itself that local safeguarding arrangements are in place, and partners act to help and protect adults in its area who meet the criteria set out in **section 34.1**. In the three boroughs, the Board is known as the Safeguarding Adults Executive Board (SAEB).

The SAEB has a strategic role that is greater than the sum of the operational duties of the core partners. It oversees and leads adult safeguarding across the locality and considers a range of matters that contribute to the prevention of abuse and neglect.

The SAEB has three core duties:

- It must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan must be developed with involvement of the local community, the local Healthwatch, and partners.
- It must publish an annual report detailing what the SAEB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action.

- It must conduct any Safeguarding Adults Review. See **section 34.24**.

34.24 Safeguarding Adults Review (SAR)

The SAEB must arrange a SAR under section 44 of the Care Act when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The SAEB must also arrange a SAR if an adult in its area has not died, but the SAEB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. The SAEB is free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Practitioner: Therefore, make senior managers aware of serious abuse or negflect so that they can consider whether to carry out a SAR.

The SAEB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

See SAR procedures for more details.

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35 CONSENT AND CAPACITY

35.1 Introduction – the Mental Capacity Act

Section 35 and **Section 36** set out the guidelines for assessing a person's capacity to make a decision; and if they do not have capacity, how a best interests decision can be made on their behalf. These guidelines are within the framework specified by:

- the Mental Capacity Act (MCA) 2005 which covers decisions for people aged 16 and over in England and Wales: the Mental Capacity Act puts into legislation previous best practice and case law; and
- the MCA Code of Practice to guide those acting in connection with someone's care or treatment. The Code provides detailed guidance on supporting someone to make a decision, assessing their capacity to do so, how to decide what is in someone's best interests when they lack capacity to make their own decision and other areas of the Act, including Lasting Powers of Attorney. Staff have a duty to have regard to the Code, that is, refer to it and follow it unless there is a good reason not to.

35.2 Consent

It is important to be clear about when the person has a choice. Adult Social Care make the final decision about what the person's eligible needs are and what directly-commissioned services would meet those needs, or whether the personal budget support plan would meet the person's needs. Once Adult Social Care offers any type of support, the person has a choice (if they are able to make one) about whether to accept that support or not.

Consent needs to be sought for each type of support offered.

Consent is the voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

If a person lacks the capacity to consent to an intervention, including medical treatment, no one can give or withhold consent on their behalf, unless there is a Health and Welfare Lasting Power of Attorney in place or a court deputy has been appointed with the relevant decision-making power, or the Court of Protection has issued a direction.

Someone can be considered as lacking capacity only in relation to a specific decision, if they are unable to make the decision at the time when the decision needs to be taken.

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35.3 Supported decision-making

In order to make an informed choice, the person needs to be given full information. The person offering the intervention needs to be very clear what information the person needs to be given in order to make an informed choice. This includes exactly what the decision is, what the possible alternatives are (including the status quo) and what the pros and cons are for that person of each alternative. If an alternative includes risks to the person, it is important to be clear about which risks are established facts and which risks are based on perception. Think about what the simplest way is of explaining the information to that person (including a combination of verbal, written and pictorial information, if appropriate) and what is the least they need to know (the key pieces of information). See the person at a time of a day when they are at their best, with people who know them well if they are happy with this. See Chapter 3 of the Mental Capacity Act Code of Practice for more details on supporting someone to make their own decision. The information needs to include the reasonably foreseeable consequences of deciding one way or another, or failing to make a decision.

Whoever is offering to arrange or carry out the intervention needs to support the person to make an informed choice if possible.

The first three principles of the Mental Capacity Act are as follows:

- *"A person must be assumed to have capacity unless it is established that he/she lacks capacity."* No matter who the person or what the decision, the starting point is that the person has the ability to make their own decision.

- *"A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success."* The fact that someone is unable to take a decision on their own does not mean that they lack capacity to make the decision. The person working with them needs to provide as much support as possible to help them to make an informed choice. This includes considering whether the person would like support from someone they trust or an advocate (see **section 36.4** for information on IMCAs). The process of supporting the person to make their own decision (if possible) could take some time and involve several visits, for example, if the person needs to be taken to different residential options in order to understand what it would be like living there.

- *"A person is not to be treated as unable to make a decision merely because he makes an unwise decision."* If someone is able to make an informed choice to do so, it is their right to refuse any intervention, no matter how serious the potential consequences.

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35.4 Who assesses capacity?

The worker who is offering to arrange or provide the support will normally assess the person's capacity to consent (as well as supporting them to consent if they possibly can).

For each intervention proposed by a worker in an assessment team, a separate mental capacity assessment needs to be carried out if there is any doubt about the person's capacity to consent. Support can be sought from team members, champions and the Mental Capacity Act Lead or the Deprivation of Liberty Safeguards Manager. Specialist support may be needed in some circumstances, for example, from psychiatry, psychology or speech and language therapy.

Workers in provider services need to assess capacity if in doubt when care and support planning. Support staff need to be involved in care and support planning but the Mental Capacity Act Code of Practice states:

"6.25 Decisions about a person's care or treatment are often made by a multi-disciplinary team (a team of professionals with different skills that contribute to a person's care), by drawing up a care and support plan for the person. The preparation of a care and support plan should always include an assessment of the person's capacity to consent to the actions covered by the care and support plan, and confirm that those actions are agreed to be in the person's best interests. Healthcare and social care staff may then be able to assume that any actions they take under the care and support plan are in the person's best interests, and therefore receive protection from liability under Section 5. But a person's capacity and best interests must still be reviewed regularly."

35.5 Assessing capacity to make the decision

Assessing a person's capacity to make the decision is integral to the process of supporting the person to make their own decision. That is, as part of your discussion with the person, be mindful of whether there is any impairment/disturbance in the functioning of their mind or brain, and if so, whether this may stop them from being able to make the decision.

If there is doubt about the person's ability to make the decision, or it is important to establish that they do have capacity (for example, if others may think their decision is not 'wise'), record this capacity assessment using the Mental Capacity Assessment form in the Mental Capacity Assessment episode on Frameworki. Each capacity assessment relates to a specific decision.

For details of the steps on Frameworki, see **Fwi Mental Capacity Assessments Guidance.**

Each capacity assessment relates to a specific decision: assess THIS person's capacity to make THIS decision at THIS time.

Blanket statements which indicate that a person lacks capacity to make all decisions about their care (unless the person is unconscious) or statements that assume that

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someone lacks capacity on the basis of a diagnosis or condition of age or other factor are all unlawful under the Mental Capacity Act.

The capacity assessment is described below. See Chapter 4 of the Mental Capacity Act Code of Practice for more details.

- Is there an impairment of, or a disturbance in the functioning of, the person's mind or brain?

  This could be permanent, for example, dementia or a learning disability, or temporary, for example, being drunk or in shock. It could fluctuate, for example, mental health problems. There does not need to be a formal diagnosis but you need to be sure that something is affecting the way the person's mind is working.

  If there is no reasonable evidence for an impairment or disturbance of the functioning of the mind or brain, the person cannot be deemed to lack capacity under the Mental Capacity Act: in which case end the capacity assessment.

- If there is evidence for an impairment or disturbance under the first stage, does this stop them being able to make the decision? The person will be unable to make the decision if the impairment or disturbance is stopping them from doing any one of the following four things. Each of these are on the balance of probabilities – for example, is it more likely than not that they can understand all of the information relevant to the decision?

  1. Understand the information relevant to the decision (see **section 35.3** Supported decision-making and Chapter 3 of the Code of Practice for more information on which information is relevant to the decision).

     There is no need for the person to know or remember any of the information before it is explained to them (even if it has been explained to them on a previous occasion). They need to be able to understand each key piece of information in order to have capacity to make the decision. When recording on the mental capacity assessment form, describe the conversations that you have had with the person and any feedback from other professionals and what has led you to your conclusion; for example, how you explained a key piece of information and why you think the person was not able to understand it. Make sure you link this to the person's impairment or disturbance of the functioning of their mind or brain.

     Do not use the term "insight" when assessing someone's capacity. The Mental Capacity Act does not refer to "insight" but to the ability to "understand" and "use and weigh" information.

     If they cannot understand the information relevant to the decision, they lack capacity to make the decision and there is no need to go on to the following stages.

     If they can understand the information relevant to the decision, they need to be able to:

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2. Retain that information.

   They only need to be able to retain the information long enough to use it. It does not matter if they could not remember the information prior to the discussion or remember it afterwards, but they do need to be able to keep all the key pieces of information in their mind at one time, in order to be able to weigh them up.

   If they cannot retain the information relevant to the decision long enough to reach a decision, they lack capacity to make the decision and there is no need to go on to the following stages.

   If they can understand the information relevant to the decision and retain it long enough to make the decision, they need to be able to:

3. Use or weigh that information as part of the process of making the decision.

   This is against their own priorities or value base. They have the right to choose an unwise course of action if they have capacity to make the decision. If they disagree with your view of the weight that should be attached to particular risks associated with the different options that does not necessarily mean that they lack capacity. Different individuals (who have capacity) may give different weight to different factors.

   They do not have the capacity to make the decision if extraneous information stops them making a decision, or if they do not have the reasoning skills to use the information, even though they understand it. Make sure you explain how this is due to the impairment of or disturbance in the functioning of the person's mind or brain.

4. Communicate their decision.

   The Mental Capacity Act Code of Practice makes it clear that someone will not be able to communicate a decision only if they have no means of communicating whatsoever, whether verbal or non-verbal.

Because of the presumption of capacity, the person does not have to 'prove' that they have capacity to make the decision. If, on the balance of probability, they are not able to do one of the four elements because of the impairment or disturbance of their mind, then they lack capacity to make the decision. If the person does have capacity to make the decision, record the assessment and end the assessment process. A person with capacity can withhold consent for any or no reason. They can also take a decision that others may consider 'unwise'.

Manager: Sign off the assessment.

If the person is assessed to lack capacity to make a particular decision, someone else will decide what is in their best interests:

- If an applicable Power of Attorney has been registered with the Office of the Public Guardian, then the attorney(s) is the decision-maker – see **Section 37 LASTING POWERS OF ATTORNEY AND CERTIFICATE-PROVIDERS**.

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- The person may be eligible for support from an IMCA. The capacity assessment does not need to have been completed to make the referral – see **section 36.4**.
- The decision would need to be taken in the Best Interests of the individual – see **Section 36**.
- For some major decisions, or where this is a dispute that cannot be resolved, an application may need to be made to the Court of Protection – see **section 36.7.1**.

35.6 Review

It is important to review capacity regularly, as someone's capacity to make the decision can change.

Capacity should always be reviewed:

- whenever a care and support plan is being developed or reviewed
- at other relevant stages of the care and support planning process.

Particular care needs to be taken when it is known that a person's capacity is subject to fluctuations, and care and support plans and case recording should reflect this fact. Remember that the best interests checklist includes considering whether the person will regain capacity to make the decision in question and, if so, whether it is in the person's best interests for the decision not to be made until they have capacity to make it themselves.

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36 BEST INTERESTS

36.1 Introduction

See **section 35.1 Introduction.**

You will have reached this section if you have undertaken an assessment which has determined that the person does not have the capacity to make the required decision at this point in time (see **Section 35**.)

When we make a decision for ourselves, we are normally choosing between two or more options. We are trying to decide what is the best course of action for us, given what we know about the current situation, what the future is likely to be and what we want. The decision we make will probably be a 'best guess' as to what will give us the best outcome, after weighing up the pros and cons of the options. Some of these choices may be heavily influenced by our attitudes, values and beliefs, by our emotional state, or by the views of other people who are important in our lives.

The Mental Capacity Act puts into legislation previous best practice and case law.

The fourth principle of the Mental Capacity Act is that:

> *"An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests."* This is regardless of who the decision-maker is (for example, family carer or paid care worker) and regardless of the decision to be made (for example, what to wear or where to live). The only exceptions are listed in **section 36.9**.

36.2 Who is the decision-maker?

For most day-to-day actions or decisions, the decision-maker will be the carer most directly involved with the person at the time.

If the decision involves whether or not to accept proposed care, the social care worker proposing the care and support plan will be the decision-maker (subject to approval of the care and support plan by their line manager).

Where the decision involves the provision of medical treatment, the decision-maker will be the doctor or other healthcare professional responsible for carrying out the particular treatment or procedure.

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If a Health and Welfare Lasting Powers of Attorney has been made and registered then the attorney will be the decision-maker, unless the person specifically excluded this decision (see Section 37.)

If this is the case then it is up to the Attorney to decide how to go about making the best interests decision. They have to comply with the Mental Capacity Act so they will need to carry out a similar exercise to the one described below. They may find it helpful if the care manager facilitates the process by compiling information on best interests, or holding a best interests meeting as described below. But you need to be clear who is the decision-maker in any given situation.

If you conclude that the Attorney has made a decision that is not in the person's best interests and is putting them at risk, try to resolve this with the Attorney, for example, by encouraging them to attend or hold a best interests meeting. If you are still concerned once their decision is finalised, raise a Safeguarding concern and make a referral to the Office of the Public Guardian. An Attorney's decision can only be over-turned by the Court of Protection and an application to Court (by the Office of the Public Guardian) might be an outcome of the Safeguarding investigation.

If the Court has appointed a deputy, the deputy will be the decision-maker if the decision is within the scope of their authority.

36.3 How does the decision-maker decide what is in the person's best interests?

The 'Principles to follow' and 'Steps to take' are together known as the statutory checklist, from the Act. You need to apply the principles in your practice.

Therefore, if you are the decision-maker and you need to make a best interests decision, consider the person's current and future interests, weigh them up and decide which course of action is, on balance, the best course of action for that person.

***Principles to follow*:**

- Consider whether the person will regain capacity and, if so, whether the decision can be put off until then. This includes considering whether the person has fluctuating capacity or will develop skills that will lead to them gaining capacity to make this decision for themselves in the future. A short-term decision may need to be made if the person may be able to make a long-term decision for themselves in the future, or the decision may be able to be put off altogether.
- If the decision concerns life-sustaining treatment, don't be motivated by a desire to bring about the person's death.

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- Avoid discriminating against the person by making an assumption about what would be in their best interests (for example, assuming that adults with learning difficulties are better off not living with their parents).

Take the following steps and have a reasonable belief that the decision you make is in the person's best interests.

The steps also apply to attorneys appointed under a Lasting Power of Attorney and court-appointed Deputies.

***Steps to take*:**

- Consider all the circumstances of which you are aware and which it would be reasonable for you to regard as relevant.
- Permit and encourage the person to participate in the decision (you will have tried to help them to make the decision for themselves and now need to continue to keep them involved in and informed about the decision-making process).
- Consider (as far as is reasonably ascertainable – this means considering all possible information in the time available) the person's:
    - past and present wishes and feelings (these may have been expressed verbally, through behaviour, emotional responses or habits or in writing. It is important to be sure that other people have not influenced the person's views – an advocate could help the person to express their views)
    - beliefs and values that would influence their decision if they had capacity to take it; for example, religious, cultural, moral or political: the person may have previously set out their beliefs and values in a written statement
    - the other factors the person would be likely to consider if they could do so; for example, the effect of the decision on other people, obligations to dependants, the duties of a responsible citizen.

  Seek the views of the people listed in the bullet point below about the person's wishes, feelings, beliefs, values and factors they would consider.
- Bear in mind that you are not trying to take the choice that you think the person would have made. You are taking their views into account as a very important factor in making the best interests decision. However, if the person has made a written statement of wishes and your decision does not follow this, you need to specifically record the reasons for this.
- Take into account, if it is practical and appropriate to consult them, the views of the following people on what is in the person's best interests. In weighing up these views, consider how long the contributor has known the person and what their relationship is (including any conflicts):
    - anyone named by the person to be consulted
    - anyone engaged in caring for the person (this includes paid carers)
    - anyone interested in the person's welfare (this includes involved family, friends and neighbours – there is no hierarchy of importance in the Mental Capacity Act and no concept of next-of-kin)
    - any attorney appointed under a Lasting Power of Attorney or a court-appointed Deputy.

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36.3.1 Balance sheet' principle

In taking best interests decisions in court, judges have often used the 'balance sheet' principle, drawing up a list of the emotional, medical, social and welfare benefits and disadvantages (including the likelihood of each benefit or disadvantage occurring) of the proposed alternatives. It may be helpful to work through the statutory checklist to try to ensure you do not miss any of the relevant factors. See the two examples in **section 36.11**.

36.3.2 Least restrictive principle

Before the decision is made, check whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Where deprivation of liberty is involved, see **Section 38**.

36.3.3 Other factors to consider

Do not make the decision based on what you would want to do if you were the person lacking capacity to take that decision.

What is in the person's best interests may change over time so it is important to regularly review their best interests.

The decision could benefit someone else, as long as it is also in the person's best interests.

36.4 When to refer for an IMCA

Anyone who may lack capacity to consent to certain major decisions, and who does not have someone to support or represent them, must be referred to an Independent Mental Capacity Advocate (IMCA). These decisions are:

- permanent or long term changes of accommodation – this means if the accommodation will be provided for 8 weeks or more (mandatory referral)
- if a person is 'accommodated' in hospital for 28 days or more (mandatory referral)
- serious medical treatment (mandatory referral)
- protective measures as part of an Safeguarding Adults investigation (discretionary referral)
- reviews of care (discretionary referral).

The capacity assessment does not need to be finalised to instruct the IMCA. If someone may lack capacity to make the decision in question, the IMCA needs to be appointed sooner rather than later, so that the IMCA can support the person to express their wishes and feelings and weigh up the options. Once the capacity assessment is finalised, the IMCA will continue to work with the person if they do lack capacity to make the decision.

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If the person already has a Care Act advocate, the IMCA referral should be sent to the Care Act advocacy organisation, so that the same advocate can fulfil the IMCA role if possible.

A referral may be made for an IMCA to be involved if the decision in question does not fit the above criteria in the following circumstances:

- If there is a dispute about what is in an adult's best interests in relation to serious medical treatment, a change of accommodation or an accommodation review
- An accommodation review following a Deprivation of Liberty Safeguards assessment which has concluded that the deprivation of liberty is not in the person's best interests and therefore the care and support plan needs to be changed. See **Section 38**.

Any referral for additional advocacy must be made through the MCA Lead or the DoLS Manager.

Once instructed, the IMCA has the right to examine and copy any records the person holding records regards as relevant to the decision.

The IMCA supports and represents the person who lacks capacity to take the decision in question. But remember that the IMCA is not the decision-maker.

Refer to the **Joint North-West London Boroughs and Lambeth policy on instructing Independent Mental Capacity Advocates (IMCAs) under the Mental Capacity Act 2005** on instructing IMCAs in order to identify the need for an IMCA and refer in a timely manner.

36.5 Recording

It is important to record the following information:

- how the decision about the person's best interests was reached
- if the person has made a written statement and your decision does not follow this, you need to specifically record the reasons for this
- what the reasons were for reaching the decision
- who was consulted to help work out best interests (and why any of the involved people were not consulted)
- what particular factors were taken into account.

The Mental Capacity Assessment form has a section for recording the best interests decision-making process.

36.6 Best interests meetings

Hold a best interests meeting when you want formal support from the multi-disciplinary team to make the decision; or when there is an unresolved dispute between the decision-maker and family members or other professionals.

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The meetings should be chaired by a senior or team manager in the decision-maker's team.

36.6.1 Role of the chair

Before the meeting

Confirm that a capacity assessment has been carried out and the person does lack the capacity to make the relevant decision.

Be clear what decision or decisions need to be made and when. Ensure that they are not decisions that cannot be made by anyone else on the person's behalf (see **section 36.9**) or a decision about serious medical treatment that needs to be brought before the Court of Protection.

Ensure that all the relevant people are invited to the meeting, and if they cannot attend, that they are asked to provide information to be shared at the meeting. Relevant people include the person responsible for implementing the decision, key staff who currently care for the person, any involved family members or friends and (if they have been appointed) anyone named by the person as someone to be consulted and any attorney or deputy. (The attorney or deputy may or may not be the decision-maker for this specific decision.)

It is important to consider whether being invited to attend the best interests meeting would be beneficial to the person, if it would help them to participate in the decision about them, and share their views.

Ensure that there is someone available to take notes of the meeting, who is different from the chair. Ideally a minute-taker, who is not involved in providing information at the meeting, should attend.

During the meeting – agenda template

- Introductions: Let people introduce themselves, and set out the ground rules.
- Purpose of Meeting: Outline the decision or decisions to be made. Set out the aim of the meeting, that it is to reach a shared decision as to what is in the person's best interests (which means the decision should not be made on the basis of what the participants feel the person would have wanted or what they would do if they were in the person's shoes). It is probably unhelpful to ask the participants at this stage for their views on the person's best interests as this might reinforce the participants' current opinions and make it harder for them to consider new information and others' opinions. The purpose of the meeting is not for any participant to persuade another of their viewpoint.
- Review the requirements of the statutory checklist:
    - Do not discriminate against the person by making an assumption about what is in their best interests
    - Consider whether they will gain capacity to make the decision
    - Help them to take part in the decision as much as they can

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  - Consider their past and present wishes and feelings, their beliefs and any factors they would take into account
  - Consider all relevant circumstances
  - Consider the views of those who know them well, including family and those working with them.

- Invite the participants to share their views on whether the person will gain capacity to make the decision.

- Invite the participants in turn to share information about the person's past and present wishes and feelings, beliefs and factors they would take into account. Discuss how to involve them in the decision.

- Invite the participants in turn to share their views about the pros and cons of the different options. It is helpful to record these on a flip chart as risks and benefits of the alternatives under the headings of emotional, medical, social and welfare. Consider the benefits and disadvantages in terms of likelihood and impact: a disadvantage may be certain to happen, but not have much impact on the person, whereas a particular benefit may only be likely to happen, but would have an important impact on the person. See examples in **section 36.11**.

- Open up the discussion to enable the participants to pull the information together and weigh it up. Encourage all present to participate and do not allow anyone to dominate.

- Summarise the information and factors to be considered.

- It may be appropriate at this point to ask each participant what they consider, on the balance of probability, the best interests decision should be and why. Aim to reach agreement. If the decision-maker cannot reach agreement with the other participants, explain and record the reasons for this at the meeting. Decide whether a second meeting is required or further information needs to be sought.

- Make the participants aware of the means they have to challenge the decision.

- After the meeting review and distribute the minutes.

36.7 Disputes, Mediation and the Court of Protection

An advocate may be able to help settle a disagreement simply by presenting a person's feelings to their family, carers or professionals.

Mediation can help to settle a dispute informally.

If family, friends, carers or an IMCA disagree with the decision-maker's best interests decision, they can follow the usual local complaints procedure.

36.7.1 The Court of Protection

Best interests decisions that are disputed or that are in relation to serious/major issues need to be referred to the Court of Protection for resolution.

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Certain major decisions about a person's social care, serious healthcare issues and some major medical treatments need to be made by the Court.

Decision-Maker:

If there is a major disagreement regarding a serious decision, for example, where someone should live, consider with your line manager the appropriateness of making an application to the Court of Protection via Legal Services.

Consider carefully whether the options being considered will affect the person's relationships with their friends and family. For example, one member of a marriage or established partnership may be assessed as requiring residential care, but the other member will remain in the community. You need to comply with the Human Rights Act 1998 and respect the person's right to privacy and family life under Article 8 of the European Convention on Human Rights.

Any interference with someone's Article 8 rights must be a necessary and proportionate means of achieving one of the objectives specified in the Article. In most cases this is to protect their health. Article 8 issues are likely to be particularly relevant when the person or a member of their family is objecting to the proposed intervention. In these cases, discuss the issues with your line manager and also seek advice from the Professional Standards and Safeguarding Team and/or Legal as appropriate. It may be necessary to ask the Court of Protection to rule on the human rights issues.

The Legal Services Department only accept instructions from nominated officers, who are called Instructing Officers. If the line manager thinks an application to the Court of Protection may be appropriate, they should discuss the case with the relevant Instructing Officer. If the Instructing Officer decides to instruct the Legal Services Department to apply to the Court of Protection, the allocated Lawyer will seek full instructions from the decision-maker and proceed to apply to the Court for permission to start proceedings.

The person themselves (with support) may apply to the Court, in most cases without permission.

The Court can make a declaration as to whether the person has capacity in relation to the decision in question; and which of the available options is in the person's best interests. If someone suspects that a person who lacks capacity to make a decision to protect themselves is at risk of harm or abuse from a named individual, the Court could make an order preventing that individual from contacting the person.

If someone suspects that a person who lacks capacity to make a decision to protect themselves is at risk of harm or abuse from a named individual, the Court could make an order preventing that individual from contacting the person.

36.8 Property and Financial Affairs decisions

Assessor: Whenever possible, encourage individuals to arrange and register a Lasting Power of Attorney whilst they have capacity to do so, in order to make sure there is someone they trust to make decisions on their behalf when they no longer

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have capacity to make such decisions themselves. (See **Section 37 LASTING POWERS OF ATTORNEY AND CERTIFICATE-PROVIDERS**.)

If a person lacks capacity to make some decisions about their property and (financial) affairs, Client Affairs may manage their finances for them if they have no family who are willing and suitable to take this on.

If the person has no savings that need to be accessed and their only income is state benefits, Client Affairs can apply to the Department of Work and Pensions for appointeeship. Although appointees are not covered by the Mental Capacity Act, they are expected to act in the person's best interests.

If the person has savings or other income that needs to be accessed, Client Affairs can apply to the Court of Protection. This could be for a one-off decision, where savings are below £16,000, to be appointed as deputy or (if the person's property needs to be sold) to request the Court to appoint a court-nominated deputy (normally a local solicitor). In general, permission to apply to Court is not needed for property and affairs applications.

Decision-maker:

- Follow the principles of the Mental Capacity Act before referring to Client Affairs. This means: help the person gain understanding of their own affairs, carry out a capacity assessment and (if the person lacks capacity in relation to some of their financial affairs) decide whether it is in the person's best interests that the local authority manage their affairs.
- If you decide that it is in the person's best interests to do so, complete a referral form, and send to the Client Affairs Team, along with any financial information available.
- If an application to the Court of Protection for deputyship is required, complete **Form COP3**.
- Where little is known of the person's finances, carry out a joint visit with the Client Affairs worker to the individual's home to gather the necessary information.

Please Note: The Client Affairs Team can act for a person only where the individual concerned remains open to care management.

36.9 Reviewing best interests

What is in a person's best interests may well change over time. This means that even where similar actions need to be taken repeatedly in connection with the person's care or treatment, the person's best interests should be regularly reviewed.

36.10 Appendix 1 – Exceptions

Decisions that cannot be made under the Mental Capacity Act 2005. No one (including the Court of Protection) can make a decision on another's behalf about:

- consenting to marriage or a civil partnership

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- consenting to have sexual relations
- consenting to a decree of divorce being granted on the basis of two years' separation
- consenting to a dissolution order being made in relation to a civil partnership on the basis of two years' separation
- consenting to a child's being placed for adoption by an adoption agency
- consenting to the making of an adoption order
- discharging parental responsibilities in matters not relating to a child's property
- giving a consent under the Human Fertilisation and Embryology Act 1990 (c.37)
- voting at an election for any public office or at a referendum.

Treatment under Part IV of the Mental Health Act 1983

Medical treatment for mental disorder of a person who is under Part IV of the Mental Health Act 1983 is not covered by the Mental Capacity Act 2005.

Research

There are extra rules relating to carrying out research with people who lack capacity to consent to the research.

36.11 Appendix 2 – Examples

Example 1

Mr C is [redacted] years old. He has a [redacted] and lives with his [redacted]. His father is dead, and he has three siblings who have little contact with him or his [redacted]. He came to the attention of Social Services when neighbours complained to the Council about the rubbish in the garden. Social Services had been aware of Mr C in the past but he had not been in receipt of any services for nearly 20 years.

Mrs C (his [redacted]) was unwilling to let social workers into the house. When they did manage to gain entry, they were concerned about the state of the house, about Mrs C's [redacted] and about the care that Mr C was receiving. The house was dirty, and Mrs C seemed to be very [redacted]. She had not seen a doctor. Mr C was not well cared for – his clothes were dirty and he appeared not have had a bath for some time. There was very little food in the house, and what there was consisted mainly of fizzy drinks and biscuits.

The social workers tried to discuss Mr C's care with his [redacted] However, she was not willing to do this. They tried to do this on a number of occasions, and each time Mrs C refused to discuss it. She also refused to see her GP in relation to her [redacted]

Social Services assessed that Mr C did not have [redacted] to decide where to live, so they would decide in his best interests. They convened a best interests meeting, attended by the social worker, the social work team manager, Mr C's [redacted] her solicitor, a representative of the Local Authority's legal department and Mr C's GP. At the meeting, the following 'balance sheet' was drawn up:

Benefits of moving away from home	Disadvantages of moving away from home
Medical Mr C would benefit from improved diet and healthier lifestyle	Medical He might lose his appetite and stop eating, as this had happened once before, many years' ago

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Emotional Mr C might be able to make friends He would be less dependent on his [redacted]	Emotional Mr C would be distressed if removed from his mother's care He might become very anxious, which might have an impact on his behaviour
Welfare/Social He would be living in good quality accommodation He would be cared for by skilled staff He would be treated more as an adult He would have a more sociable life He would be able to engaged in more adult activities He could still see his mother He would be able to make more choices for himself	Welfare/Social Mrs C is strongly opposed to Mr C moving away from home Although Mr C was not able to express a view about where he wanted to live, he appeared to become anxious if his mother wasn't in the room He would be removed from his familiar routines His behaviour might become challenging He might not like the people he lived with He might find it too pressurising to engage in new activities and not enjoy it

No agreement could be reached and the decision was made to refer the case to the Court of Protection.

Working through the statutory checklist for *Example 1*:

Will the person regain capacity? If so, can the decision be put off until that time?

The degree of Mr C's learning disability made it very unlikely that he would gain capacity to make this decision in the future.

Does the decision concern life-sustaining treatment? If so, do not be motivated by a desire to bring about the person's death.

The decision was not related to life-sustaining treatment.

Avoid discriminating against the person by making the decision merely on the basis of his age or appearance, or a condition of his, or an aspect of his, behaviour which might lead others to make unjustified assumptions about what might be in his best interests.

The decision must not be based on an assumption that, for example, adults with learning disabilities should be supported to move away from their families.

Consider all the relevant circumstances.

These include the pros and cons for Mr C of remaining at home or moving away from home.

Permit and encourage the person to participate in the decision.

The psychologist who had assessed Mr C had used a range of methods to make communication more accessible. Mr C had been unable to express a view as to where he should live or who with. He was, however, able to say something about what he currently enjoyed and what he didn't like.

Consider the person's past and present wishes and feelings (in particular, any written statement).

Mr C had not written down his wishes or preferences. He was not able to express his wishes. He appeared to become anxious when asked to interact with strangers if his mother was not in the room.

Consider the beliefs and values that would influence the person's decision if they had the capacity to take it.

Mr C had never expressed any beliefs or values.

Consider the other factors the person would be likely to consider if they could do so.

His mother stated that Mr C would consider her and would want to stay with her.

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Consider the views of anyone named by the person to be consulted (as to what would be in the person's best interests and for information about the person's wishes, feelings, beliefs etc.).

Mr C had not named anyone to be consulted.

Consider the views of anyone engaged in caring for the person.

The social worker needed to seek the views of the GP.

Consider the views of anyone interested in the person's welfare.

Mr C's [redacted] had the right to be consulted.

Consider the views of an attorney or a court-appointed deputy.

Mr C had not made a power of attorney and no deputy had been appointed.

Example 2

Miss K is an [redacted]-year-old retired head teacher who lives alone, with no living relatives. She attends a day centre five days a week. She cooks light meals for herself and is independent in self-care; a cleaner comes three times a week.

She was [redacted] when she was found after 12 hours by her cleaner lying on the bathroom floor. She refused to use a [redacted] on the ward stating that she would stick to using a single [redacted] even though this was seen to make her gait poor and increase risk of falls when she moved from sitting to standing, or made sudden moves. In [redacted] she refused to undergo formal cognitive testing but she was observed to have [redacted] and to be [redacted] in time and place. A CT scan showed [redacted].

The team (in the care of the Elderly ward in the general hospital) was concerned about her going back home where there were stairs (and a stair lift was not feasible). She refused a care alarm and additional care support, stating that she could manage without these. She stated that she was ready to die. She could move to a ground floor flat or to residential home but she refused to consider either. The social worker (with the support of other team members) assessed that she [redacted] to make the decision as to whether she could go back to live in her home as she was not able to understand the risks explained to her and could not weigh up the different alternatives. The social worker had to decide whether or not it was in her best interests to return home, involving all those engaged in caring for her.

Staff at the day centre felt strongly that she could make her own decisions, but her cleaner was concerned about the risk of further falls which might leave her [redacted] The social worker referred Miss K to an IMCA.

A best interests meeting was held, with the social worker, the keyworker from the day centre, the cleaner, the OT, the lead nurse and the IMCA attending. The following 'balance sheet' was drawn up:

Benefits of returning home	Disadvantages of returning home
Medical Miss K might show improvements in her memory, as she would have familiar things around her She might gain capacity to make decisions for herself A return to her familiar environment might reduce her general decline, which could also reduce risk of death following an unwanted move	Medical Miss K might suffer from serious falls, and any injury that might follow It was also possible that she might die if she fell and was not discovered in time Her diet and hygiene might be compromised if she were reluctant to allow further help in the house
Emotional Miss K might feel calmer, as she would not have to deal with so many other people Her wishes would be followed She would feel more in control – she has always	Emotional She might become more fearful of falling and isolate herself She could become depressed and is would not be noticed easily Miss K periodically asks when she can go

been very independent She would have her memories around her Miss K previously believed that you should cope on your own and never seek help from the state	home but doesn't seem distressed when told she can't yet go

Welfare/Social She would be able to maintain some independence for longer The home carer and day centre staff could continue to check up on her	Welfare/Social She may have a reduced quality of life as she would not be able to leave the house without help

The decision was made that Miss K would return home with monitoring and review.

Working through the statutory checklist for *Example 2*:

Will the person regain capacity? If so, can the decision be put off until that time?

Miss K currently [redacted] to make the decision. The results of the CT scan suggested that the deterioration was significant. The care team felt it unlikely that Miss K would gain [redacted] to make this decision, even if she were in more familiar surroundings.

Does the decision concern life-sustaining treatment? If so, do not be motivated by a desire to bring about the person's death.

This decision was not in relation to life-sustaining treatment.

Avoid discriminating against the person by making the decision merely on the basis of his age or appearance, or a condition of his, or an aspect of his, behaviour which might lead others to make unjustified assumptions about what might be in his best interests.

The decision should not be based on an assumption that, because Miss K is old, frail and apparently cognitively impaired, she will be better off in residential care.

Consider all the relevant circumstances.

These include the pros and cons of Miss K returning home.

Permit and encourage the person to participate in the decision.

Miss K's [redacted] used written and pictorial materials to try and help her retain and understand the options.

Consider the person's past and present wishes and feelings (in particular, any written statement).

Miss K had not made any written statement, but had expressed her views very clearly to her key worker and to staff at the day centre she attended. She did not want to leave her home – she was ready to die, and wanted to die in her own home, with her familiar things about her. Whilst in hospital, she would periodically ask about when she was going home, but did not seem distressed when told that she could not go yet.

Consider the beliefs and values that would influence the person's decision if they had the capacity to take it.

Miss K had a strong self-identity as an autonomous person who was used to making difficult decisions on her own. Miss K had also always been fiercely independent, and was ashamed to ask the 'state' for help. She had managed by herself for her entire adult life, and this was important to her. She had worked hard to become a Head Teacher, and had said that being dependent was a sign of weakness.

Consider the other factors the person would be likely to consider if they could do so.

No other factors were identified.

Consider the views of anyone named by the person to be consulted (as to what would be in the person's best interests and for information about the person's wishes, feelings, beliefs etc.).

Miss K had not named anyone to be consulted.

Consider the views of anyone engaged in caring for the person.

The social worker needed to consult Miss K's [redacted] day centre staff, Miss K's cleaner and the OT. Her GP knew her well and should also be involved.

Consider the views of anyone interested in the person's welfare.

As Miss K had no family or friends and the decision was to do with whether or not she should go home, the social worker instructed an IMCA.

Consider the views of an attorney or a court-appointed deputy.

Miss K had not made a power of attorney. No deputy had been appointed.

37 LASTING POWERS OF ATTORNEY AND CERTIFICATE-PROVIDERS

37.1 Introduction

This section is designed to explain about Lasting Powers of Attorney (LPA) for assessors working with individuals who either already have or are considering completing an LPA. The section also discusses advance decisions and written statements.

37.2 Types of Lasting Powers of Attorney

There are two different types of LPA: Property and financial affairs; Health and welfare.

These two types are completely separate: the forms are separate, they have to be registered separately and the powers are different. They both have to be registered before they can be used. The person has to complete the standard form, which can be downloaded from the **Government website** or ordered from them by ringing 0300 456 0300. There is a registration fee of £110 per form; this can be reduced or waived if the person is on a low income or receives certain benefits.

There are two important points to remember about both types of LPA. The first is that the person must have the capacity to make the decision to appoint an Attorney at the time, and the second is that this is the person's decision. Someone else (for example, a family member who wants to be their attorney) may have suggested the LPA and may even have filled it in, but the person must make their own decision about it.

The person completing the power of attorney form is known as the *donor*.

Attorneys have to follow the Code of Practice and are therefore not making decisions in isolation.

Attorneys can only make decisions on someone's behalf that the person themselves could have made if they had capacity. So, if the local authority decides that the person is ineligible for a service, or a doctor decides not to offer a particular treatment, the attorney cannot insist on it but can follow the normal routes to appeal the decision.

37.3 Property and financial affairs

- There is no legal way of someone accessing the person's bank account if the person lacks capacity to make one or more of their financial decisions without them either being an attorney, a deputy or an appointee.

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- An appointee is appointed by the Department of Work and Pensions and is responsible for applying for, receiving and spending benefits on the person's behalf. The prospective appointee applies directly to the DWP and this process is not under the Mental Capacity Act. Appointees cannot sign or give up tenancies.

- Carers can spend money on behalf of someone who lacks capacity to purchase necessary goods and services.

- However, if someone has savings or income other than benefits, the only legal way someone else can access their bank account if they lack capacity to give them permission is if they are an attorney or a deputy appointed by the Court of Protection. The person appoints an attorney; someone else applies to be their deputy. It is cheaper (£110 compared to £400) and quicker to register an LPA with the Office of the Public Guardian than to apply to the Court of Protection to be appointed a deputy. The choice about appointing an attorney is therefore about whether the person thinks they will have any difficulties making any of their financial decisions and, if so, whether they want to plan ahead to ensure that their money can be accessed by trusted family member(s) or friend(s) legally and quickly.

- Client Affairs will not agree to act as a person's attorney. If the person has no friends or relations they would like to appoint as attorney they can choose to appoint a solicitor. Websites such as Solicitors for the Elderly have information on solicitors who will carry out this role. See **section 36.7.1** about when Client Affairs will request appointeeship or deputyship (if the person has not appointed an attorney).

- The way the form is laid out, the person will normally be giving the attorney(s) the power to make a financial decision even if they have capacity to make it. They can choose to state in the 'restrictions and conditions' box (p6 of LPA form) that they only want the attorney(s) to make a decision if they lack capacity to make it themselves.

- The way the form is laid out, the attorney(s) will normally be able to make any decision about the person's property and financial affairs. This will include all their money and shares (and any other types of investments). This will also include any property that they own or lease, including being able to buy or sell a property, or sign or give up a tenancy. The person can choose to exclude any particular type of decision in the 'restrictions and conditions' box (p6 of LPA form).

- If the person is appointing more than one attorney, they need to choose whether they want the attorneys to make all decisions together, make decisions on their own (although each attorney needs to follow the Code of Practice and so should be consulting the other attorney if they're available at the time) or make some decisions on their own and some together (the person might want the attorneys to make major decisions together, like selling their property or ending their tenancy).

- 'Guidance to your attorneys' (p6 of LPA form) – this can act as a written statement (see **section 37.10** below).

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37.4 Health and welfare

- For the vast majority of health and welfare decisions, if the person lacks capacity to make the decision themselves, the person offering the care or treatment (or proposing to make the arrangements, for example, for a move to a care home), can make a decision in the person's best interests without extra legal authority.

- When there is an unresolvable dispute, particularly between family members and the Local Authority, if there is no attorney or deputy over health and welfare, no party has more right than any other to make a decision in the person's best interests. The Local Authority may need to take the matter to the Court of Protection for resolution.

- In previous years, the Court of Protection has turned down the majority of applications for deputies over health and welfare decisions and appointed very few health and welfare deputies; the Act only enables the Court to appoint a deputy if absolutely necessary. This means that, if someone has not appointed an attorney over their health and welfare, it is very unlikely that the Court will ever appoint a health and welfare deputy. Instead the Court has usually preferred to make orders regarding the person's best interests as and when they are needed. Therefore, making a health and welfare decision for a person who lacks the capacity to do so will usually be possible without appointing a health and welfare attorney. However, it is very important for the person to decide whether they would like whoever is caring for them or working with them to make the decision in question if they can't make it (for example, paid carer about what they wear or what they eat, district nurse about changing their leg dressing, social worker about where they live, surgeon about whether they have an operation), or whether they would like to give this power to a specific person or several people. It is important that individuals understand that family members cannot make decisions about care or treatment being offered by professionals unless they are appointed attorneys. People often believe that being someone's 'next of kin' gives them the power to make decisions on their behalf. This is not correct. The Mental Capacity Act does not mention 'next of kin'.

- The health and welfare attorney(s) can only make a decision if the person lacks capacity to make it. They have the power to consent to or refuse the care or treatment being offered to the person as if they were them, but they have to follow the Code of Practice and therefore are not making the decision arbitrarily or in isolation (see **Section 36 BEST INTERESTS** for information on how they should reach their decision in the person's best interests). The professional cannot override the attorney's decision if they disagree with it but they can raise a Safeguarding concern if they think the attorney isn't acting in the person's best interests and refer to the Office of the Public Guardian. Ultimately, the Office of the Public Guardian can apply to the Court of Protection to challenge the attorney.

- The way the form is laid out, the attorney will be able to make any decision about the person's social care or healthcare (if they lack capacity to make it) unless they specifically exclude anything (in the 'restrictions and conditions' box, on p7

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of LPA form). The person has to choose (p6 of LPA form) whether they want the attorney(s) to give or refuse consent to life-sustaining treatment.

- If the person is appointing more than one attorney, they need to choose whether they want the attorneys to make all decisions together, make decisions on their own (although each attorney needs to follow the Code of Practice and so should be consulting the other attorney if they're available at the time) or make some decisions on their own and some together (the person might want the attorneys to make major decisions together, like moving accommodation).

- 'Guidance to your attorneys' (p7 of LPA form) – this can act as a written statement (see section below).

37.5 Assisting person to decide whether to have a lasting power of attorney

Chapter 1 in the current guidance booklet ("Do you want a lasting power of attorney?") does not emphasise the fact that capacity is decision-specific. The 'information you must read' on p2 of the LPAs is clearer. The person might not understand the information in this format but might understand it if it is explained in a different way.

The Code of Practice (at 3.9), says, *"Try not to give more detail than the person needs – this might confuse them. In some cases, a simple, broad explanation will be enough. But it must not miss out important information."*

For each form, there is listed below suggested simple information that the person needs in order to make an informed choice. There are also suggested questions in the guidance notes. It is important to think how best the person would understand the information (this could be a combination of verbal and written information).

37.5.1 Suggested information to provide to person for them to decide whether to complete a property and financial affairs LPA

- The decision is who manages your finances.
- This form is a legal document. Completing this form gives the person or people named as attorney the power to make your financial decisions. This includes how to spend your money and whether to sell your property. There are examples at 7.36 of the Code of Practice of the sorts of decisions covered.
- If you don't write anything extra on the form, they will be able to make all of your financial decisions. If you want to, you can tell them not to make certain decisions. You do this by writing the decisions you don't want them to make in Box 5.
- If you don't write anything about it on the form, they will be able to make a decision even if you can make it yourself. If you want to, you can say that they are only allowed to make a decision if you aren't able to make it. You do this by writing in Box 5 something along the lines of, 'You must only make a decision if I lack capacity to make it.'
- We are discussing this because your (for example) nephew thought it would be a good idea if he were your attorney. However, this is your decision. It is entirely up to you whether you want him to make your financial decisions. If you don't fill in this form, he won't be able to make your

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financial decisions. If you do fill in the form, you can change your mind at any time if you still have the capacity to make that decision. You may wish to appoint someone else in their place.

- You should only complete this form if you trust the attorney(s) and think they will make good financial decisions. They might not make the decision you would have made, but they have to follow a checklist and decide in your best interests. You can write in Box 6 about what's really important to you; they will have to follow this unless there's a good reason not to – see written statements below.
- If you don't trust the proposed attorney, you could choose someone else, for example, a solicitor.
- If you don't complete the form and you have difficulty making financial decisions in future, someone will need to apply to Court to be your deputy. This may or may not be a concern to you.

37.5.2 Suggested information to provide to person for them to decide whether to complete a health and welfare LPA

- Normally, if you can't make your own decision about care or treatment, the person providing the care or treatment will decide in your best interests. So, a nurse would decide whether you have a flu jab or a social worker might decide whether you move to a care home. There are examples in 7.21 of the Code of Practice of the sorts of decisions covered.
- A family member wouldn't be able to overrule a professional's decision.
- If you would prefer someone close to you to make this sort of decision instead of the professionals, you need to complete this form.
- This form is a legal document. Completing this form gives the person or people named as attorney the power to make each decision about your social care or healthcare that you can't make. If you can make your own decision, it is still yours to make and no one can make it for you.
- If you don't write anything about it on the form, they will be able to make each social care or healthcare decision you can't make. It you want to, you can tell them not to make certain decisions. You do this by writing the decisions you don't want them to make in Box 6.
- You have to decide whether you want your attorney(s) to decide on life or death treatment. If you tick, 'no', the doctor looking after you will make this decision.
- We are discussing this because your (for example) nephew thought it would be a good idea if he were your attorney. However, this is your decision. It is entirely up to you whether you want him to make the social care and healthcare decisions you can't make. If you don't fill in this form, he won't be able to make those decisions. If you do fill in the form, you can change your mind at any point.
- You should only complete this form if you trust the attorney(s) and think they will make good decisions. They might not make the decision you would have made but they have to follow a checklist and decide in your best interests. You can write in Box 7 about what's really important to you; they will have to follow this unless there's a good reason not to – see written statements below.
- If you don't trust the proposed attorney, do not complete this form.
- If you don't complete the form and you have difficulty making some of your social care or healthcare decisions in the future, whoever is caring for you will support you to make a decision and, if you can't make it, they will be able to make it in your best interests. This may not be a relative or next of kin.

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37.6 Checking whether someone is an attorney

If a family member or friend tells you that they are attorney or deputy over the person's health and welfare decisions, ask the attorney or deputy to show you their official documentation. An attorney should have a Lasting Power of Attorney (LPA) form stamped on each page by the Office of the Public Guardian. The LPA will list any restrictions on their decision-making powers. A deputy should have a deputyship order, stamped by the Office of the Public Guardian, which will list the decision-making powers the deputy has been given. If they cannot produce their form, search the Office of the Public Guardian registers (unless the decision cannot be delayed) by completing the form available on the **Government website**. No fee is payable.

37.7 Enduring Powers of Attorney

Enduring Powers of Attorney were made before the MCA. All existing EPA continue to be made effective under the same basis as they were made. EPA apply to property and affairs decisions. They need to be registered at the point when the person is assessed as lacking capacity to make some of their financial decisions.

37.8 Social Workers as Certificate Providers

There is agreement that Adult Social Care social workers/care managers can act as certificate providers if they are an MCA Champion and have completed the relevant training and with agreement from their line manager. Others should check with their line manager.

The certificate provider is confirming that they believe the person understands what they are consenting to on the LPA form, and that they have not been put under pressure to give this consent.

The certificate provider is not carrying out a capacity assessment but is certifying that the person understands the purpose and scope of the LPA. However, the Office of the Public Guardian guidance talks about the certificate provider's opinion about the person's capacity to create the LPA and it is good practice to arrange to carry out a full capacity assessment if there is any doubt.

There is no space in Part B to record your reasoning, so please attach your reasoning to Mental Capacity Assessment.

Please Note: **The LPA forms were simplified on 1st October 2009. The previous forms required the certificate-provider to confirm that they have discussed the contents of the LPA with the person when the attorney was not present and on their own (unless there was a good reason someone else needed to be present; for example, an interpreter). Although there is no longer a requirement to discuss the LPA with the person on their own or without the attorney, this is good practice and should be done unless there is a good reason not to.**

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It is important that you are sure that the person is entirely happy with creating the LPA. If you are in any doubt, you should not sign it and should consider a Safeguarding concern.

Procedural points about Part B (certificate to confirm understanding)

- Part B is the same on both types of LPA.
- Before completing Part B, you need to re-read the guidance at the beginning of the LPA (in the 'information you must read' box on p2) and the separate guidance in the booklet '**Guidance for people who want to make a lasting power of attorney for health and welfare'** (Guidance for certificate providers, p30-34; this is the same guidance as in the property and financial affairs booklet on p29-33).
- Statement of personal knowledge or relevant professional skills – cross through the first box. In the Guidance booklet a registered healthcare professional or a registered social worker is deemed to have the relevant professional skills. Example of what to write in the box: "I am a registered social worker and have worked with adults with dementia for x years. I have been the person's social worker for x weeks/months/years. I have discussed this LPA with him/her in detail, on his/her own (or, if with someone else, reason for this), on x occasions."
- Over the page, in the 'address and postcode' box, please provide the name of the team you work in and the type of team it is, the name of the organisation, and its address and postcode; for example, Adults South Social Work Team, Royal Borough of Kensington & Chelsea, Chelsea Old Town Hall, 165-181 King's Road, London, SW3 5EE. Do not use your personal home address.
- ***Please Note:*** The manager or any employee of the care home where the person lives cannot be a certificate-provider.
- 'About people to be told' (p8, property and financial affairs; p9, health and welfare) – the person can choose people to be informed when the form is sent to the Office of the Public Guardian to be registered. If they don't choose anyone to be notified, or have no one who can be notified, they need to have two certificate-providers. The GP may be able to be the second certificate-provider.
- It takes 8 to 10 weeks for the Office of the Public Guardian to register a Lasting Power of Attorney.

37.9 Advance decisions

Social workers need to know about advance decisions and be able to explain the concept to individuals. Encourage individuals to discuss a possible advance decision with a healthcare professional, for example, community matron or GP. This is particularly important if they have a long-term condition, so that they can talk through the possible consequences of not accepting treatment.

Chapter 9 in the Mental Capacity Act Code of Practice provides a detailed overview of advance decisions. There is a summary at the beginning of the chapter:

- An advance decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.

- An advance decision to refuse treatment must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity: healthcare professionals must follow the decision.

- Healthcare professionals will be protected from liability if they:
    - stop or withhold treatment because they reasonably believe that an advance decision exists, and that it is valid and applicable
    - treat a person because, having taken all practical and appropriate steps to find out if the person has made an advance decision to refuse treatment, they do not know or are not satisfied that a valid and applicable advance decision exists.

- People can only make an advance decision under the Act if they are 18 or over and have the capacity to make the decision. They must say what treatment they want to refuse, and they can cancel their decision – or part of it – at any time.

- If the advance decision refuses life-sustaining treatment, it must:
    - be in writing (it can be written by someone else or recorded in healthcare notes)
    - be signed and witnessed, and
    - state clearly that the decision applies even if life is at risk.

- To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out whether the person:
    - has done anything that clearly goes against their advance decision
    - has withdrawn their decision
    - has subsequently conferred the power to make that decision on an attorney, or
    - would have changed their decision if they had known more about the current circumstances.

- Sometimes healthcare professionals will conclude that an advance decision does not exist, is not valid and/or applicable – but that it is an expression of the person's wishes. The healthcare professional must then consider what is set out in the advance decision as an expression of previous wishes when working out the person's best interests (see **Section 36 BEST INTERESTS**).

- Some healthcare professionals may disagree in principle with patients' decisions to refuse life-sustaining treatment. They do not have to act against their beliefs. But they must not simply abandon patients or act in a way that that affects their care.

- Advance decisions to refuse treatment for mental disorder may not apply if the person who made the advance decision is or is liable to be detained under the Mental Health Act 1983.

CNWL have a specific policy on advance decisions and written statements, designed to support staff and persons with mental health problems, mainly in planning for times when their mental health deteriorates.

The NHS End of Life Care programme has produced a short guide called 'Planning for your future care', which includes a section on advance decisions.

There is no legal document to be used to record an advance decision but there is a proforma at Appendix 1 in the NHS End of Life Care programme advance decisions guide for health and social care professionals. It is a good idea to encourage patients to explain on the form the reasons behind their advance decision(s) as this will help professionals to have more confidence about their validity at the time the treatment is being proposed.

37.10 Written statements of persons

Written statements by persons can be of considerable benefit to a best interests decision-maker. There are benefits to both persons and staff. They give persons the opportunity to express their likes and dislikes and to be able to influence their future care at a time when they may have difficulty making some of their own decisions and may also have difficulty expressing their likes and dislikes.

The Code of Practice explains that, when a decision-maker (whether an attorney or not) is working through the best interests checklist in s4 of the Act:

'*5.42.* Section 4(6)(a) places special emphasis on written statements the person might have made before losing capacity. These could provide a lot of information about a person's wishes. For example, these statements could include information about the type of medical treatment they would want in the case of future illness, where they would prefer to live, or how they wish to be cared for.

5.43. The decision-maker should consider written statements carefully. If their decision does not follow something a person has put in writing, they must record the reasons why. They should be able to justify their reasons if someone challenges their decision.

There is no prescribed legal format to be used to record a written statement and each individual will want to record different things, but there is a suggested **Person Written Statement proforma**.

Alternatively, a statement can simply be written down and signed by the person.

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38 DEPRIVATION OF LIBERTY SAFEGUARDS

38.1 Introduction

This section explains deprivation of liberty and the Deprivation of Liberty Safeguards (DoLS) and in particular sets out procedures for managing DoLS for a person in a care home, in hospital, in supported living or in their own home.

The Deprivation of Liberty Safeguards (DoLS) came into force in England and Wales under amendments to the Mental Capacity Act (MCA) 2005. The safeguards are intended:

- to protect people who lack capacity to agree to stay in a care home or hospital from being detained when this is not in their best interests
- to prevent arbitrary detention, and
- to give people and their representatives rights of appeal and to ensure that the deprivation is reviewed and monitored.

The Deprivation of Liberty Safeguards apply only to people in Registered Care Homes registered under the Care Standards Act 2000 and to people in hospitals. The Care Home or Hospital is known as the 'managing authority' because it has to manage the deprivation of liberty once it has been authorised.

If it is in the person's best interests to be deprived of their liberty in the care home or hospital, the managing authority must apply for authorisation by the 'supervisory body', which is the Local Authority. A person must not be deprived of their liberty unless an authorisation has been given by the supervisory body, or, in urgent cases, the managing authority have given themselves an urgent authorisation and sought authorisation from the supervisory body.

If it is not in the person's best interests to be deprived of their liberty in the care home or hospital the decision can be challenged in the Court of Protection.

The Deprivation of Liberty Safeguards apply only to people 18 or over, who have a mental disorder as defined by the Mental Health Act 1983 and who lack the capacity, as defined by the Mental Capacity Act 2005, to decide whether to stay in the care home or hospital to receive the care and/or treatment they need.

The majority of people who require the protection of the MCA DoLS are those people with more severe learning disabilities, older people with any of the range of dementias or people with neurological conditions such as brain injuries.

The MCA DoLS provide that deprivation of liberty:

- should be avoided whenever possible
- should only be authorised in cases where it is in the relevant person's best interests and the only way to keep them safe

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- should be for as short a time as possible
- should be only for a particular treatment plan or course of action.

38.2 What is deprivation of liberty?

The Supreme Court have outlined an acid test to work out whether someone is deprived of their liberty:

> ***If the person lacks capacity to consent to staying in the accommodation to receive the care or treatment they need, they are deprived of their liberty if they are under continuous supervision and control and are not free to leave.***

The Supreme Court ruled that the following factors are not relevant to whether or not someone is deprived of their liberty:

- the person's compliance or happiness or lack of objection (the issue is about how staff would react if the person did try to leave or if relatives/ friends asked to remove them permanently)
- the suitability or relative normality of the placement (after comparing the person's circumstances with another person of similar age and condition), or
- the reason or purpose leading to a particular placement

though of course all these factors are still relevant to whether or not the situation is in the person's best interests, and should be authorised.

The Supreme Court held that although the Deprivation of Liberty Safeguards legislation currently applies only to care home and hospitals, nevertheless a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This includes a placement in a supported living arrangement in the community. Where there is, or is likely to be, a deprivation of liberty in such placements, it must be authorised by the Court of Protection (see also **section 38.11.1** below).

The Law Society has issued comprehensive guidance on the law relating to the deprivation of liberty safeguards. The guidance was commissioned by the Department of Health and aims to help solicitors and frontline health and social care professionals identify when a deprivation of liberty may be occurring in a number of health and care settings. It uses case scenarios to explain the law following the landmark judgment of the Supreme Court in the case of Cheshire West (2014). Quick reference sheets also highlight relevant liberty restricting factors and key questions for practitioners relating to each individual setting. To read this document, please visit the **Law Society website**.

38.3 When can someone be deprived of their liberty?

The MCA DoLS set out clear guidelines on when someone can be deprived of their liberty.

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1. It must be to provide a specific treatment or care and support plan that is in the person's best interests.

2. Doctors or care professionals must be satisfied that there is no suitable alternative care and support plan that would not deprive the person of their liberty.

3. The managing authority (the hospital or care home where the person is staying) must apply to its supervisory body (the local authority responsible for the hospital or care home) for authorisation to begin the care and support plan.

4. The supervisory body must conduct six assessments to confirm that deprivation of liberty is lawful and appropriate:

- Age assessment: to check whether the person is aged 18 or over (assessed by DoLS Best Interests Assessor)
- No refusals assessment: to ensure that the proposed treatment does not conflict with a valid decision already made by an attorney or deputy on the person's behalf, or with a decision made in advance by the relevant person themselves (assessed by DoLS Best Interests Assessor)
- Mental capacity assessment: to confirm whether the person being deprived of liberty lacks capacity to consent to being in the care home or hospital for care or treatment (assessed by DoLS Best Interests Assessor or Mental Health Assessor)
- Mental health assessment: to check whether the person being deprived of liberty is suffering from a mental disorder within the meaning of the Mental Health Act 1983 (assessed by Mental Health Assessor)
- Eligibility assessment: to confirm whether the person is eligible to be deprived of liberty under the MCA DoLS (assessed by Mental Health Assessor or BIA who must be approved under the MHA)
- Best interests assessment (assessed by DoLS Best Interests Assessor): firstly to establish whether the proposed care and support plan would deprive the person of their liberty, and secondly to confirm whether it is:
    - in the best interests of the person to be subject to the authorisation
    - necessary in order to prevent them from coming to harm
    - a proportionate response to the likelihood of them suffering harm and the seriousness of that harm.

If the answer is Yes to all six assessments, then an authorisation will be granted to deprive the person of their liberty in the relevant care home or hospital.

The assessment process must be completed within 21 calendar days of receiving the request.

If it is necessary to deprive the person of liberty before the assessment process can be completed, the managing authority can give itself an Urgent Authorisation. This can be for up to 7 days and must be accompanied by an application for standard authorisation if not already done. An Urgent Authorisation can be extended only by

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the supervisory body after communicating with the managing authority and only on one occasion for up to a further 7 calendar days.

38.4 Care home placements

This guidance outlines the process for care managers/ social workers to follow when planning and reviewing care home placements for individuals who may lack capacity to consent to the placement. This includes respite placements. All work with adults who may lack capacity to make a decision must follow the provisions of the Mental Capacity Act and the Code of Practice. See **Section 34.1** on Consent and Mental Capacity. In addition all work with adults who are being deprived of their liberty in hospitals or care homes should comply with the Deprivation of Liberty Safeguards Code of Practice.

See **section 38.18** for a flow-chart summary of this process.

38.5 Capacity assessment

Care manager/ Social worker: If there is doubt about the person's capacity to decide whether to consent to the proposed care home placement, carry out a capacity assessment. (See **Section 35 CONSENT AND CAPACITY** for details of how to do this.) The person may want the support of a family member, friend or another professional during the capacity assessment. Record your assessment and your reasons for it on the Mental Capacity Assessment form.

If the person does have capacity to decide on the care home placement, they choose between the available options. This must include the actual care home(s) identified. For example, they can choose to face more risk through staying at home with a care package which you think does not fully meet their needs, rather than accepting the offer of 24-hour care in a care home. If the person has capacity to make this decision and does decide they would like to move to or accept respite at the care home, you need to apply to the relevant panel.

Just because the person agrees with your decision or that of the care team, does not necessarily mean that they have capacity to make that decision.

38.6 Best interests decision

Care manager/ Social worker: If the person lacks capacity to decide to consent to the proposed care home placement, a best interests decision needs to be made on their behalf. Remember that if the proposed move is for more than 28 days and the person has no family or friends willing and appropriate to support them, then an IMCA **must** be instructed. See **section 38.14**.

Check on the Mental Capacity Assessment form whether the person has an attorney or deputy whose decision-making powers include deciding where the person lives (see **Section 37**). See **section 37.6** for how to check whether someone is an attorney. See **section 38.9** if there is an attorney or deputy involved.

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If there is no attorney or deputy with the power to decide where the person lives or stays, you as the care manager need to make the decision in the person's best interests (with agreement from the relevant panel). Record your decision and the reasons for it on the Mental Capacity Assessment form.

See **Section 36** for 'Principles to follow' and 'Steps to take' in Best Interests decisions.

38.7 Care and support planning – consideration of restraint

Care manager/ Social worker: As part of the care and support planning and risk assessment process, consider whether it is likely there will need to be any type of restraint used.

Restraint is either:

- using, or threatening to use, force to make someone do something they are resisting, or
- restricting the person's freedom of movement, whether they are resisting or not.

For each type of restraint being considered:

- Is it likely the person will lack capacity to decide about the matter in question?
- Is the proposed action in the person's best interests?
- Is the proposed restraint in order to prevent harm to the person themselves?
- Is the proposed restraint proportionate to the likelihood of the harm occurring and the seriousness of the harm if it did occur?
- Is the proposed restraint necessary or is there a less restrictive way of keeping the person safe?

More guidance can be found in 6.40-6.48 of the Mental Capacity Act Code of Practice.

38.8 Use of the Mental Health Act

If the person is objecting to moving to the care home, the use of guardianship may be appropriate. The person would need to be suffering from a mental disorder as defined by the Mental Health Act 1983. This means that a person with a learning disability is only eligible for guardianship if they are considered as exhibiting abnormally aggressive or seriously irresponsible conduct.

The person would need to have a Mental Health Act assessment to be considered for guardianship. If the Approved Mental Health Practitioner (AMHP) and approved doctors view guardianship as appropriate, the AMHP puts in the application to the Executive Director, Adult Social Care who then becomes the person's guardian. Amongst other powers, the guardian can specify where the person should live and has the power to transport the person to that place and return them if they leave (but not stop them from leaving). Guardianship therefore does not permit a person to be deprived of their liberty in the place where they are required to reside. In practice, the

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exercise of the functions of the guardian is delegated to the care manager/ social worker.

This may be a good option if the person cannot be persuaded to move.

It is possible for a guardianship order and a DoLS authorisation to apply to the same person, provided that there is no conflict between them. A DoLS authorisation cannot be given if it would conflict with an existing guardianship order. These issues are addressed by the "eligibility assessment" for DoLS.

38.9 Attorney or deputy involved

This part of the guidance applies if the person has an attorney or Court-appointed deputy whose powers include deciding where the person lives or stays.

Care manager/ Social worker: When you have assessed that the person lacks capacity to consent to the proposed care home placement, ask the attorney or deputy to decide between the available options.

The attorney or deputy must follow all the principles of the Mental Capacity Act, including being sure that all possible support has been provided to the person to enable them to make their own decision if possible. The attorney or deputy must be satisfied that the person lacks capacity to make this decision themselves before they can make it for them, as they are only able to make any welfare decision if the person lacks capacity to make it themselves.

The attorney or deputy will need to follow the best interests process laid out in the Mental Capacity Act, in a similar way to if the care manager were making the best interests decision. It is not simply what they think is best for the person but they must take the person's views into account and the views of others, including the care manager/ social worker. The attorney or deputy should be able to explain how they have followed the Mental Capacity Act and its Code of Practice in reaching their decision.

If the attorney or deputy does not agree to the care home placement or to the type of care and support plan being proposed, you cannot go ahead with the placement. If you assess that the person will be left at an unacceptably high level of risk and therefore that the attorney or deputy does not appear to be acting in their best interests, ask for a best interests meeting to resolve the disagreement (see **section 36.6**). If you remain concerned that the attorney or deputy is not acting in the person's best interests, or there is an urgent need to protect the person, raise a Safeguarding concern (see **section 34.12**). The Safeguarding response might include making an application to the Court of Protection for a best interests decision. The attorney or deputy usually has to be informed that an application is being made to the Court.

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38.10 Consideration of deprivation of liberty

Care manager/ Social worker:

- Is the placement likely to deprive the person of their liberty? Consider the acid test – see **section 38.2**. If in doubt seek guidance from your manager or the DoLS Manager or MCA Lead.
- If you conclude that the proposed care arrangements do not amount to deprivation of liberty, apply to the relevant panel for authorisation of the placement. The Panel cannot **determine** whether deprivation of liberty is likely to take place, or whether it is justified. This can only be determined via the DoLS assessment process. If you are concerned about possible deprivation of liberty then you should seek advice from the MCA/DoLS lead in parallel with the Panel process.
- Once Panel have agreed an appropriate level of care, discuss the likely deprivation of liberty with the proposed care home manager (unless there is an attorney or deputy who is making the arrangements themselves). It is the care home manager's legal duty to request a DoLS authorisation if they think this is necessary but it is likely that your discussion will help them to consider whether they can provide the appropriate care and support without depriving the person of their liberty, or whether an authorisation request is necessary.

38.11 Deprivation of liberty likely to be necessary

38.11.1 Domestic settings

The Deprivation of Liberty Safeguards apply only in hospitals and registered care homes. If the proposed placement is likely to deprive the person of their liberty but is not in a registered care home, but in a domestic setting (for example, supported living) where the State is responsible for imposing such arrangements, the relevant panel will need to consider whether an application to the Court of Protection is necessary or whether there is any way in which care can be provided to avoid deprivation of liberty. A person can be deprived of their liberty outside a hospital or care home only if authorised by the Court of Protection.

38.11.2 Care Home settings

If the proposed placement (long-term or short-term) is in a registered care home, the relevant panel will need to decide on what is appropriate provision to meet the person's assessed needs. This should involve consideration of whether there is any way of meeting their needs which would avoid depriving them of their liberty. If the panel feel that the likely deprivation of liberty is necessary, then they will need to decide on an appropriate type of placement and appropriate funding level.

Care manager/ Social worker:

- Once the relevant panel has agreed to a care home placement, identify an appropriate care home.
- Do not finalise the capacity assessment and best interests decision until you have discussed the specific placement(s) with the person.

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- Discuss with the care home manager your own assessment that it is likely to be necessary and appropriate for the care and support plan to involve deprivation of liberty.

If no placement can be found at the agreed fee level, the relevant panel will need to review the care and support plan and funding level and agree on the appropriate next step.

If the care home manager assesses that they can meet the person's needs and are able to offer them a place within the fee level agreed by the panel, it is the care home manager's legal duty to request an authorisation from the Local Authority if they think that the care they will be providing will amount to deprivation of liberty.

Care manager/ Social worker: If the care home manager does not think that the care they will be providing will amount to deprivation of liberty and therefore does not intend to request an authorisation, feed this back to the DoLS Manager or DoLS Coordinator so that they can discuss this with the care home manager. The DoLS Manager will feed back to you. If no authorisation is to be applied for, you can go ahead with making the arrangements for the placement.

If the care home manager is planning to request an authorisation, the person should not be moved until the DoLS assessments have been completed, unless the person needs to move urgently to avoid risk of major harm (in which case the care home manager will issue an urgent authorisation once the person has moved in order to deprive them of their liberty until the DoLS assessments have been completed). Inform the DoLS Coordinator that the care home manager is planning to request an authorisation so that they can expect the request. Also inform anyone who urgently needs to know that DoLS assessments are to be carried out, for example, the hospital discharge team.

The DoLS Coordinator will let you know who will be carrying out the assessments and the date by which the assessments need to be completed. The care home manager will have informed close family or friends that they have made a referral. The Best Interests Assessor will consult you as part of the assessment process. The DoLS Coordinator will feed back the result of the assessments to both the care home manager and to you.

A DoLS authorisation cannot be granted if an attorney or deputy (with the appropriate powers) objects to it. If this happens you should try to convene a best interests meeting to resolve the disagreement (see **section 36.6**). If the attorney or deputy continues to object then the only way to deprive the person of their liberty in the proposed care home in their best interests is to obtain an order from the Court of Protection.

38.11.3 Hospitals

If the relevant person is in hospital whilst the panel process is in progress then there is a risk that any delay may lead to them being deprived of their liberty pending confirmation of placement. If you feel this may be happening, speak to your manager and the DoLS Manager or MCA Lead for advice.

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Care manager/ Social worker: If you are working with someone in hospital and you are concerned that they are being deprived of their liberty, inform the consultant in charge of the person's care and the hospital's Safeguarding lead. The hospital is the managing authority so they make a DoLS application if needed.

If the hospital does not reduce the level of restriction or make a DoLS application within a reasonable time then liaise with the MCA/DoLS lead and raise a Safeguarding concern if necessary.

38.12 DoLS authorisation given

If the authorisation has been given, there may be some conditions attached. These will relate to the deprivation of liberty. The conditions will normally have been recommended by the Best Interests Assessor. For example, the Best Interests Assessor may have assessed that deprivation of liberty is in the person's best interests but that the current proposed care and support plan is too restrictive. They may have recommended a condition relating to the person's cultural or social needs. They may also have recommended that changes can be made to the person's care and support plan over the course of the authorisation to avoid deprivation of liberty in future.

Once the appropriate senior manager has signed off the authorisation, any conditions attached are mandatory for the care home to follow. The Best Interests Assessor will already have discussed the proposed conditions with the care home manager.

Care manager/ Social worker: Revise the care and support plan to incorporate the conditions. If the care home manager is asking for an increase in fees to implement the conditions you may need to refer back to the relevant panel. If the panel consider that another placement could be found at lower cost, they need to bear in mind that the new care home would need to apply for another authorisation. Consider whether any move to a new placement would be in the person's best interests.

38.13 DoLS authorisation not given

Care manager/ Social worker: If the proposed care has been assessed as not amounting to deprivation of liberty, then you can go ahead with making arrangements for the placement.

If the proposed care does amount to deprivation of liberty but the authorisation has not been given, the care and support plan must be amended to avoid deprivation of liberty. Refer back to the relevant panel for a decision on how care can be commissioned in circumstances that do not amount to deprivation of liberty. This may involve increased resources.

Produce and implement a revised care and support plan, following the best interests process (see **Section 36 BEST INTERESTS**). If the person is already a resident in the care home, the care home will need to implement a less restrictive care and support plan. If there are any unreasonable delays on this, open a Safeguarding concern (see **section 34.12**) and inform the DoLS Manager or DoLS Coordinator,

who will inform the Care Quality Commission. An application to the Court of Protection may also be needed.

An unauthorised DoL should be rectified urgently and certainly within 7 calendar days.

38.14 The role of the Independent Mental Capacity Advocate

If there is no appropriate family member or friend who is able to keep in regular contact to support the person during the assessment process, an Independent Mental Capacity Advocate (IMCA) must be appointed by the supervisory body. The IMCA is an independent person with relevant experience and training who supports the resident in relation to the DoLS assessment process, including making submissions to the people carrying out the assessments, challenging decisions on behalf of the person they are representing, raising issues of concern with the care home, requesting a review, and applying to the Court of Protection if necessary.

If authorisation is given, someone must be appointed as the Relevant Person's Representative (RPR), but an IMCA is always instructed to support the person and their unpaid representative. The role of the IMCA at this point is to advise and support the person and their representative on the DoLS process and their rights to approach the Court of Protection for rulings on any DoLS authorisation.

38.15 Placement review

Team Manager: Set the review frequency. This is recommended to be not less than six-monthly (following the initial review) for all placements.

Care manager/ Social worker: Inform the person deprived of their liberty, their RPR, the IMCA if one is involved, and the care home that a review is to be carried out. Review the restraints as part of the review process, including whether there are now any less restrictive options that would be in the person's best interests. If there are any changes in circumstances, for example, if the care regime is unlikely now to amount to deprivation of liberty, discuss this with the care home manager and ask them to consider requesting a review.

The DoLS Team then consider the change in circumstances and request DoLS review assessments if appropriate. The assessor is likely to consult with you as part of their review.

As part of your review, consider whether any conditions attached to the authorisation have been implemented by the care home.

Discuss with the care home as part of your review the visits from the Relevant Person's Representative (RPR) and whether these are frequent enough to support the person adequately. The IMCA may have a role in supporting that person during the review. Note that a DoLS review can also be requested at any time by the person deprived of their liberty, their RPR or an IMCA.

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When the authorisation is near its expiry date, there is no automatic review. The care home manager would need to request a new authorisation to start when the current one expires. A full set of DoLS assessments would then be carried out again. If your review is taking place within two months of the expiry of the authorisation, discuss with the care home whether another authorisation will need to be requested to start when the current authorisation finishes.

Record the above information on your review documentation. Inform all concerned parties of the results of the review.

Contact the DoLS Coordinator to let them know that you have completed a review and where the review is recorded.

The DoLS Manager considers any DoLS issues recorded on the review documentation and liaises with you and the care home manager as appropriate.

38.16 Placement review (no DoLS authorisation in place)

Care manager/ Social worker: Review any restraints as part of the review process, including whether there are now any less restrictive options that would be in the person's best interests. If you consider that the care now amounts to deprivation of liberty or is likely to in the near future, discuss this with the care home manager and aim to reach agreement on whether the care home manager needs to request an authorisation.

If the care home manager comes to the conclusion that deprivation of liberty is not occurring but you disagree, feed this back to the DoLS Manager or DoLS Coordinator and consider requesting an assessment yourself of whether an unauthorised deprivation of liberty is occurring. Discuss your concerns with the person themselves, their representative, and any attorney/deputy/IMCA.

38.17 Death of person

If a person dies when they are subject to DoLS, then the managing authority informs the coroner.

Care manager/ Social worker: Make sure that this is done. Update Frameworki accordingly. See also **section 33.2** for details.

38.18 Flow Chart of the Process

See below.

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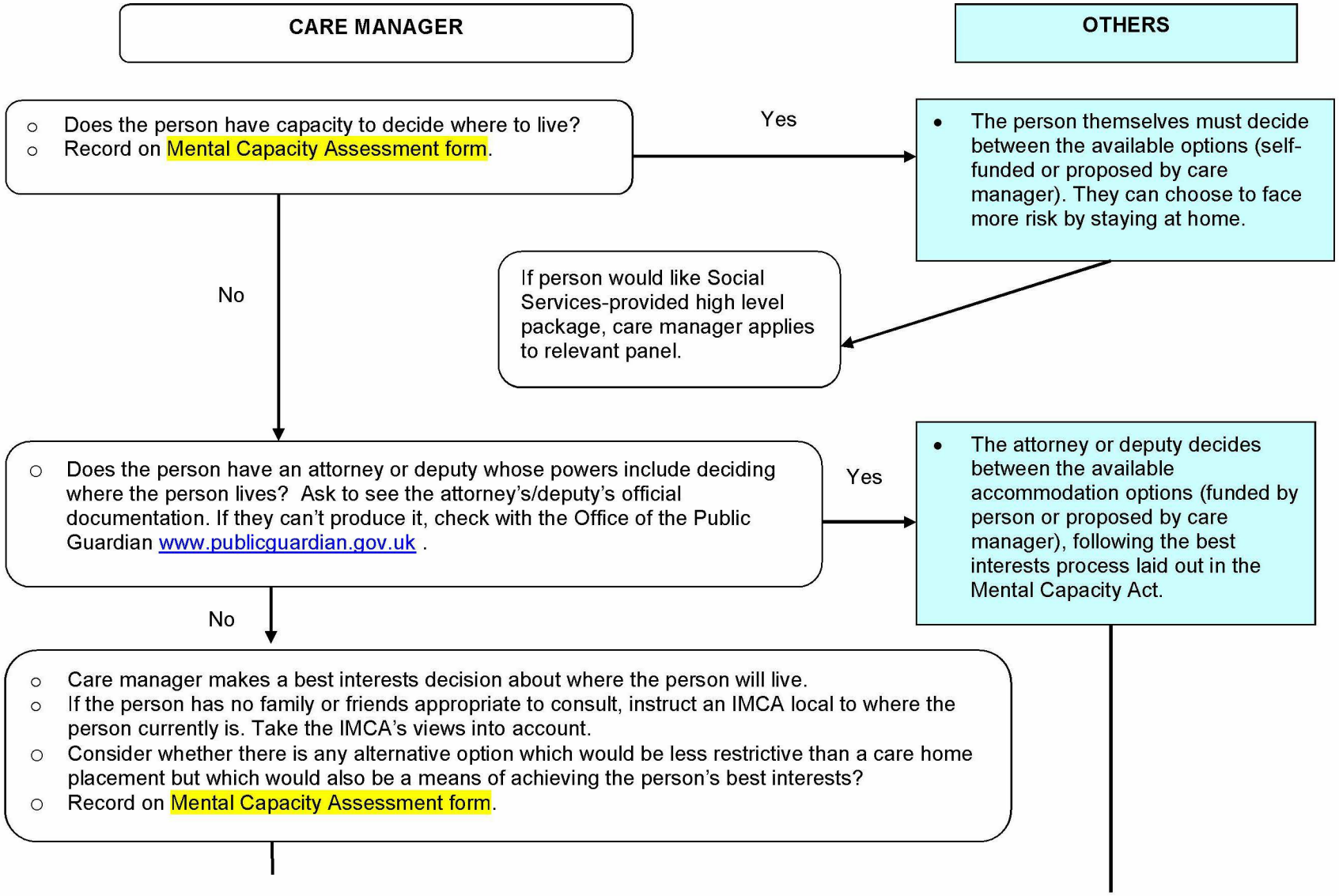

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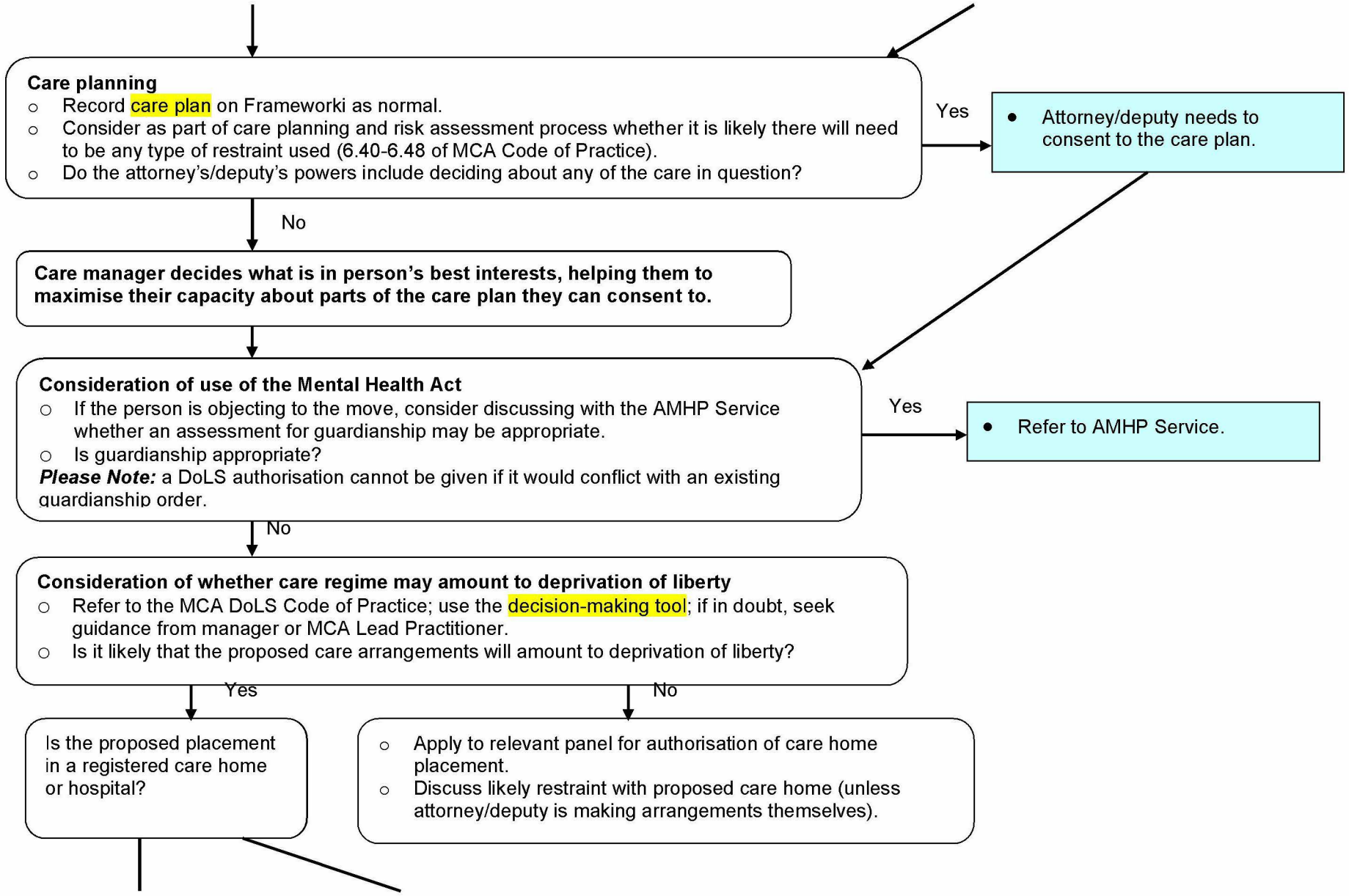

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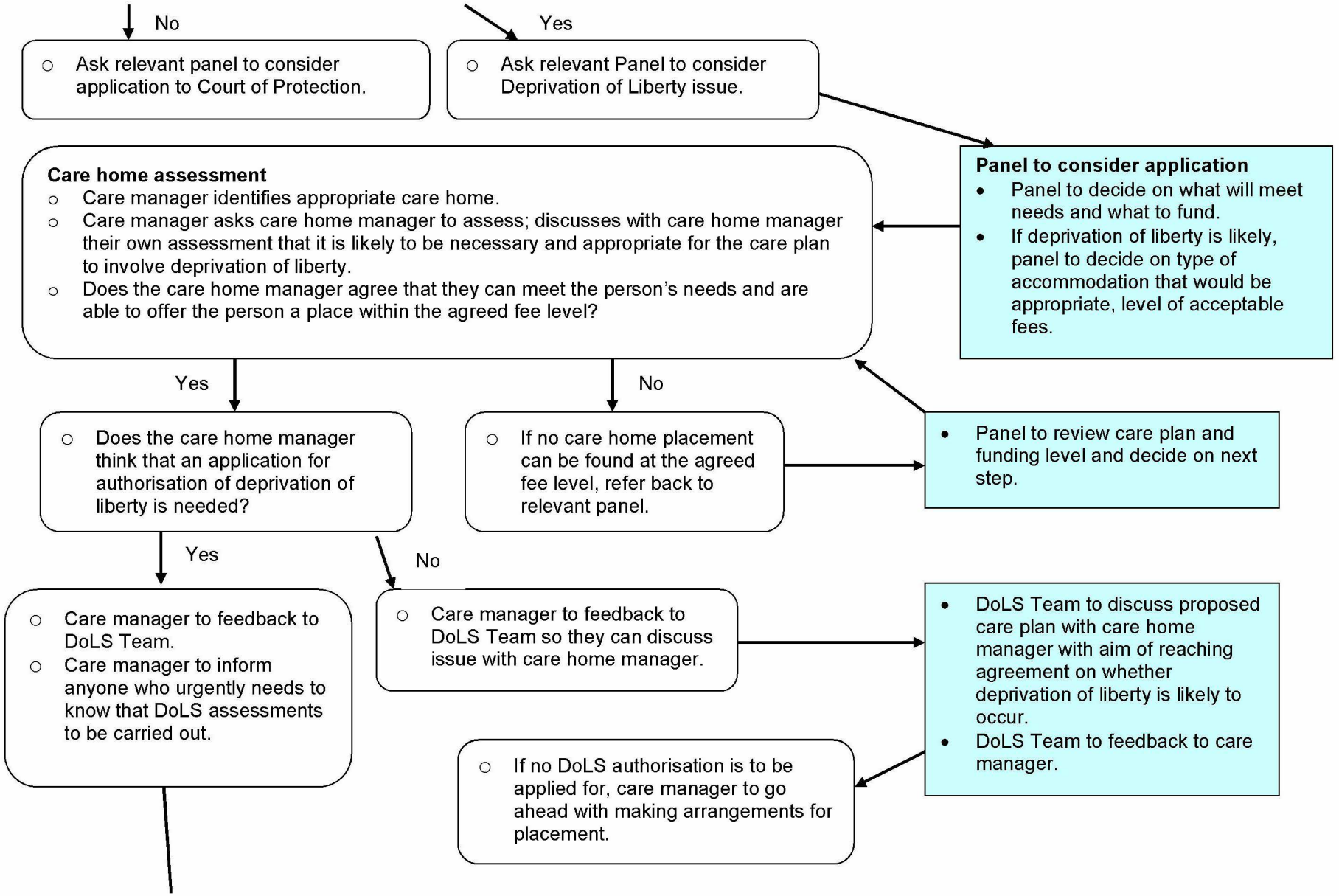

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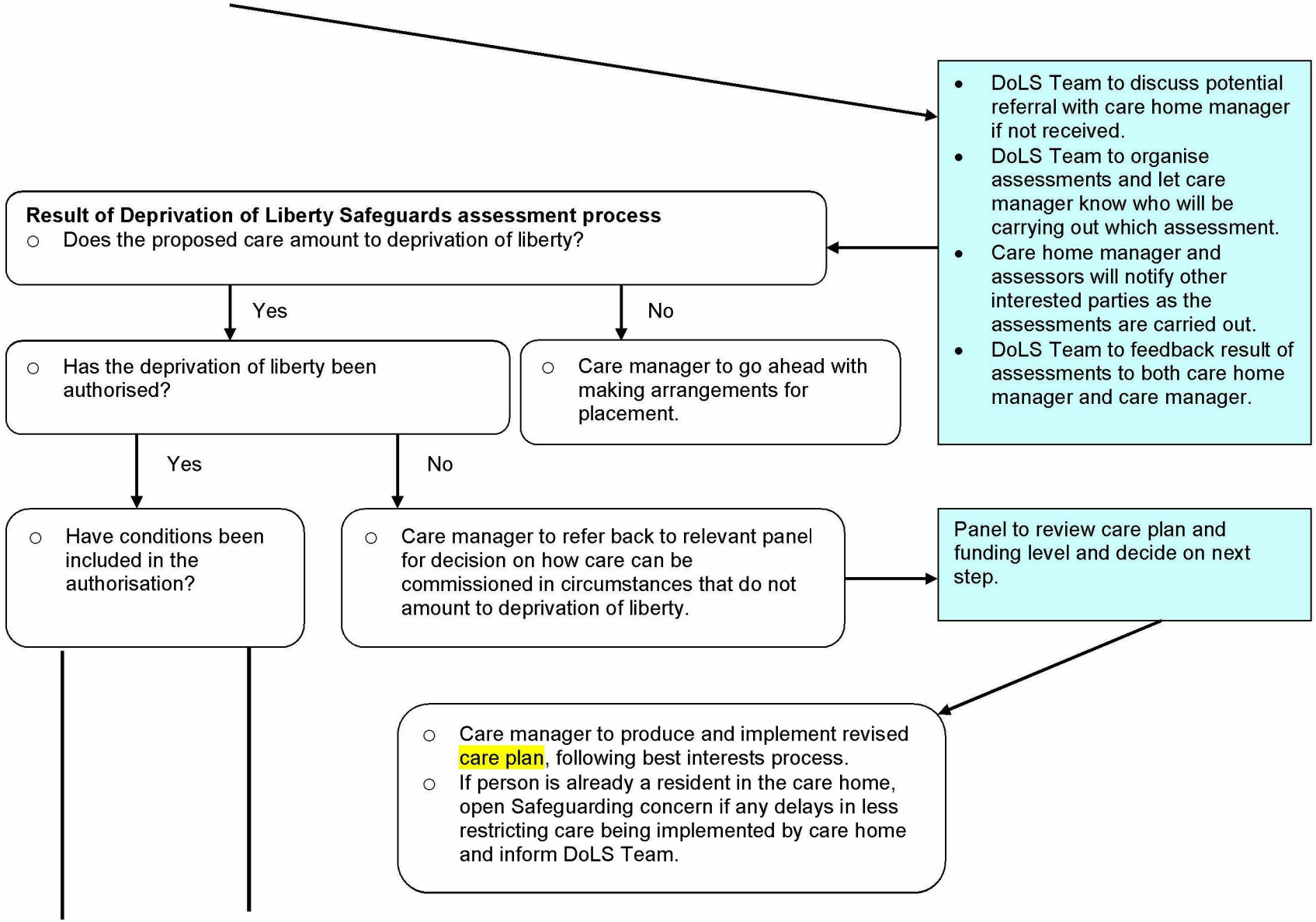

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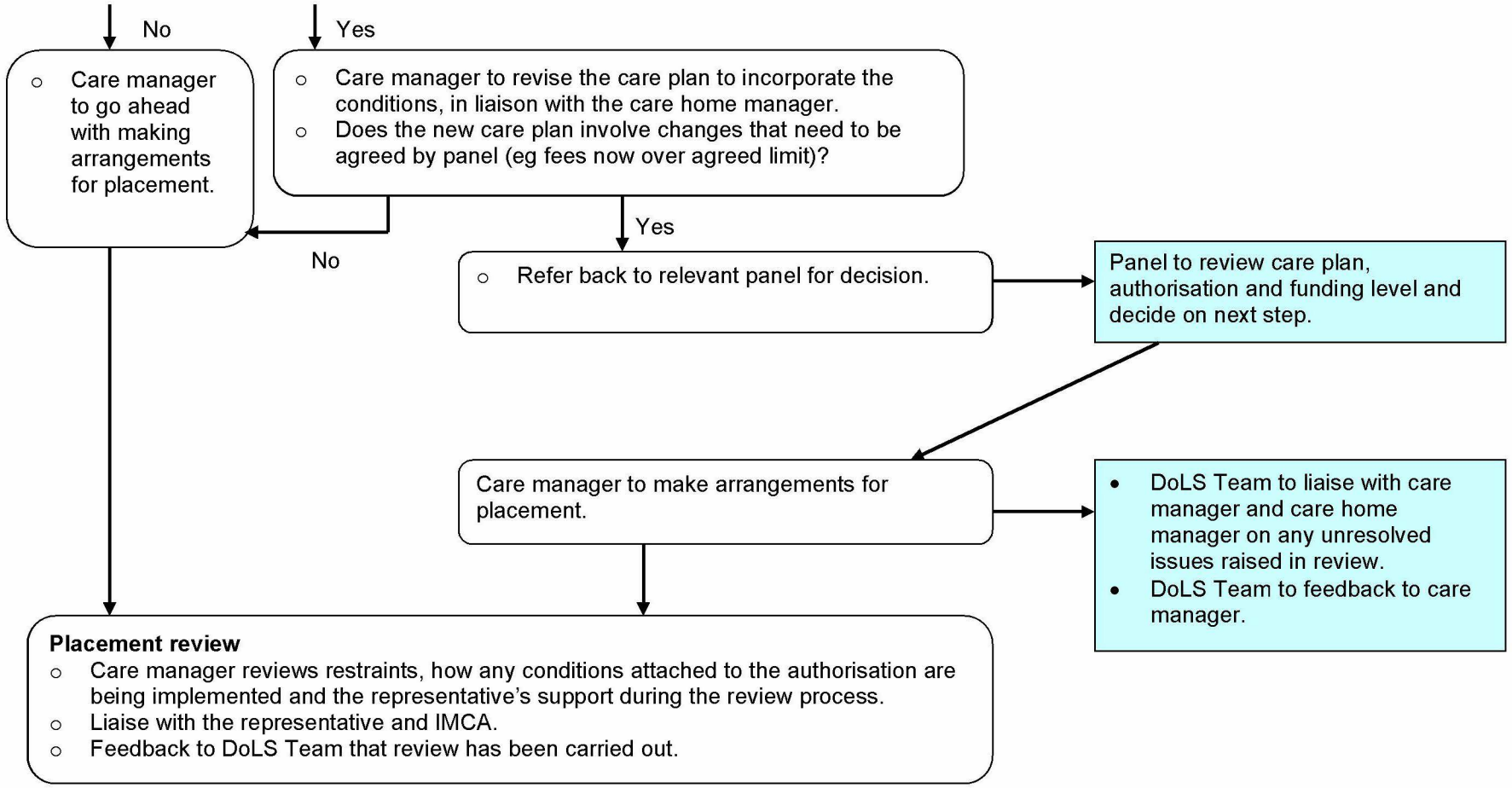

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PART F – GENERAL AND REFERENCE

39 APPEALS AND COMPLAINTS

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

39.1 Purpose

Adult Social Care is keen to know the views of adults and their carers about the services they receive: adults and carers are encouraged to access the appeals and complaints procedures so that they can make representations about the actions, decisions or failings of the department.

The three boroughs' Customer Feedback Team is responsible for managing the complaints procedure and assisting staff and members of the public in the process.

39.2 Appeals

A new appeals process to challenge decisions made by the Local Authority will be introduced in April 2016. Once the government guidance has been issued a shared services process will be developed during 2015/16.

Until then the following process should be used to respond to dissatisfied individuals.

Manager: If the outcome of an assessment is appealed directly to the service, offer the individual a reassessment by a new worker, usually from the same service. However, the person may request that the assessment be undertaken by someone outside of the service. Check such a request with senior management.

Second Assessor: Following the second assessment, send a letter to the person, with a copy of the assessment, explaining in detail the outcome of the assessment. Within this letter inform the person that they have the right to make a statutory complaint via the complaints process if they are dissatisfied with any aspect of the service they (or the person they care for) has received. Include with your letter a copy of the complaints form for the Local Authority in question. See **section 39.5** for links.

A complaint from a person who is either:

- dissatisfied either with the process of assessment and/or the worker and the impact on the outcome of the assessment, or
- satisfied with the outcome of the assessment but is dissatisfied either with the process of assessment and/or the worker,

is considered a statutory complaint.

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Manager: Follow the relevant borough's complaint procedures (see below). In either case, as part of this complaint investigation, you may offer a reassessment.

Second Assessor: Following the second assessment, send a letter to the person, with a copy of the assessment, explaining in detail the outcome of the assessment and the response to the complaint. Within this letter advise the person about their right to escalate their complaint to the Local Government Ombudsman.

39.3 Complaints

Anyone receiving a social care service from Adult Social Care can make a complaint, as can anyone affected by an action, decision or omission by Adult Social Care. Adult Social Care will also accept a complaint from those acting on behalf of such an individual. However, it will be necessary for the department to ensure that the person or organisation representing the person's views is entitled to do so.

The Customer Feedback Team is responsible for managing the complaints procedure and overseeing the complaints process.

A complaint may arise because of many things relating to statutory social services functions. Complaints may relate to the following:

- an unwelcome or disputed decision
- concern about the quality or appropriateness of a service
- delay in decision making or provision of services
- delivery or non-delivery of services including the complaints procedures
- quantity, frequency, change or cost of a service
- attitude or behaviour of staff
- application of eligibility and assessment criteria
- the impact on an individual of the application of the policy
- assessment, care management and review
- wrong, misleading or lack of information given.

As this is not an exhaustive list, if you are unsure, please contact the Customer Feedback Team.

The complaints procedure does not apply when:

- the person making a complaint does not meet the requirements of 'who may complain', and is not acting on behalf of such an individual
- the complaint is not about the actions or decisions of Adult Social Care or of anybody acting on its behalf
- the same complaint is being or has been investigated by a local commissioner (LGO)
- the complaint is unclear, or may be termed frivolous or vexatious

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- the complaint is made orally and is resolved to the complainant's satisfaction no later than the next working day
- a complaint has already been fully investigated under previous regulations or the current one
- it is a matter which should be dealt with under other procedures.

Where the complainant has stated in writing that they intend to take legal proceedings in relation to the subject of the complaint, the complaints process will cease for the duration of the legal proceedings.

If at any point during the investigation matters are raised which indicate the need for a safeguarding adults investigation, these matters will be investigated separately and the complaints process will be frozen whilst it is ongoing. The complainant will have the choice to raise a complaint once the safeguarding investigation is complete.

A complainant may withdraw their complaint at any time, either verbally or in writing.

39.4 Praise and comments

Pass all compliments to the Customer Feedback Team to be recorded. These are acknowledged by the Customer Feedback Team. Copies of the letters and the response letters will be sent to relevant staff and managers for their information. Pass any comments or suggestions to the Customer Feedback Team so that they can be recorded and passed onto the relevant service manager for action.

39.5 Complaints procedures

Complaints and Critical Incidents site

LBHF site

RBKC site – see **"RBKC Procedures for handling complaints about Adult Social Care Services"**, Jan 2013

WCC site – see **"Adults Social Complaints Care Policy & Procedure"**, April 2013

39.6 Safeguarding adults

See three borough **"Safeguarding and Complaints – Protocol for handling complaints that may have safeguarding concerns"**, Jan 2015.

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40 RECORDING

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

40.1 Introduction

Record keeping is an integral aspect of the service and our duty of care, and is a written reflection of the type and quality of intervention. Practitioners should ensure that their recording shows a clear, accurate and up-to-date record of our contacts concerning individuals.

Recording has crucial consequences. The contents can be challenged by adults/carers and they can be used as evidence in a Court of law and scrutinised when a complaint is made. They provide a record of actions agreed and put into place. Records are legal documents. The requirements outlined apply to all records, whether adult in need of care and support or carer.

It is important to consider recording in the context of thinking about professional practice issues. The Care Act demands a person centred approach and as full an involvement of the person as is possible, with an emphasis on the person's strengths, alongside their difficulties and concerns. This is particularly important, given that recording in the core documents, is more of a joint activity, with the sharing of documents and the individual's signature confirming the accuracy of the assessment/care/support plan/other record.

The key points underpin all written accounts regarding the care/support delivered to individuals.

This policy is intended for use by all practitioners and their managers and covers Frameworki, documents in shared drives, emails and notebooks.

For the purpose of recording requirements including supervision, these apply across the three boroughs. However other aspects, including Freedom of Information Requests, remain a separate council authority for the purposes of the Act. Therefore, this policy needs to be read alongside individual borough process instructions/ documents, Information Sharing Agreements and Protocols – **Information Governance**, **Data Protection Policy** and **Information Security**.

40.2 Purpose of recording

- To provide the person with a full and accurate account of their care/support needs

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- To provide a written account of the assessment, support plan and review, of decisions made and actions taken
- To enable managers and staff to know what is happening in a practitioner's absence
- To evidence that a task has been achieved
- To communicate information between practitioners
- To communicate to other organisations/agencies and to service providers
- To demonstrate liability and accountability
- To demonstrate to a manager the individual worker's activity with an individual
- To demonstrate professional competence
- To present cases to any Panel, given that decisions are made on the strength of the record
- To enable managers to monitor the standard and quality of work
- To facilitate audit
- To ensure continuity particularly when a subsequent worker becomes involved
- To support supervision, allowing the manager to see what has been completed and achieved and how
- To demonstrate that policies and local procedures have been followed
- To provide statistical information
- To evidence that the practice of meeting statutory regulations has been adhered to and that, where it has not, there is clear evidence to support this.

40.3 What to record:

- A record and chronology of ongoing intervention.
- Telephone calls should include the full name and number of the person contacted and a brief description of the conversation/message.
- Documents uploaded onto FWi such as letters, emails, reports and external forms should be referenced in the Case Notes. See **section 40.7**.
- The record must include a concise analysis of the situation, using your professional judgement, and leading to a recommendation/conclusion.

40.4 How to record

The written word – principles

- Be clear, concise and accurate.[25]
- Use short paragraphs and make use of headings and bullet points.

[25] Crystal Mark for plain English – www.plainenglish.co.uk/services/crystal-mark.html

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- Use a good standard of written English.
- Use short sentences.
- Cover one theme per paragraph.
- Use good grammar.
- Make sure that tenses are correct and consistent.
- Include direct quotes where possible.
- Make sure that spelling is correct: always use 'spell check'.
- When using an abbreviation or initial in an official form or document, ensure it is spelt out in full the first time with the abbreviation in brackets: thereafter, the abbreviation can be used. Use abbreviations in notebooks/diaries to avoid subject identification.
- Avoid repetitive copy and pasting.

40.5 Where records should be recorded

- The majority of recording should be made within the Frameworki (FWi) work flow of episodes *which contain document templates for completion.*
- FWi covers all main document/'event' recording requirements – referrals, various assessments/reviews, support plans, mental capacity assessments. Reportable information can then be extracted from what has been recorded on these documents.
- All required safeguarding documents are contained in the relevant episodes in FWi apart from the Confidentiality Statement Sheet which needs to be signed and uploaded when any meetings are held. Upload documentation supplied by external agencies as a part of the safeguarding process into the relevant episodes.
- Upload the Deprivation of Liberty documents Word docs to FWi on completion.
- There will occasionally be other situations where a report/meeting/minutes might be recorded outside FWi and then uploaded. In these instances, it will be necessary to follow the guidance set out in the **Three Borough Privacy Impact Assessment document**.

  A privacy impact assessment (PIA) is a simple, risk based mechanism to help identify the potential level of risk when undertaking a project involving the use of personal data. It is required at the point where any process, programme or project brief is being created that must be risk assessed using a PIA. The PIA must be undertaken at the point a business case is being devised, prior to the Project Initiation phase. This ensures the risks are fully understood and can be integrated when assessing the viability of the project, as the costs of mitigating the risks may be too great.
- Record assessments, support planning visits and reviews on the appropriate assessment/review forms.
- Also record them in the Case Notes in terms of date, location and reason for visit, to allow a worker/other worker to easily see continuity on a case when viewing the Case Notes.

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- Use case notes to record information which falls outside the main/statutory workflow and needs to be documented.

40.6 Warnings

Warnings are a Note in Frameworki, set up using a "Type of Note" of "Warning", and is displayed at the top of the screen in red. Other notes are displayed on the bottom right of the screen.

Warnings should:

- Be factual and evidenced
- Point to further information where available
- Be reviewed periodically.

Warnings are not only added to a person's records. They can be added to any person record on the system.[26]

40.7 Appending Case Notes

A case note is a good function to use when there are multiple case note entries over a short period (a day or two) all related to the same issue. An appended case note means there is only one 'Title' in the list of case notes and all the appended case notes can be seen under this one title.

However it is not advisable to append a case note that was entered more than a week ago, even if it relates to the same issue, although this is less of an issue in a case with very few case notes. In these instances, enter a separate case note so it is easy for all workers to find and a clear timeline of events can be established. Where this new case note corrects or overrules an earlier case note, then clearly say so and make a reference to the relevant case note(s).

Upload email correspondence into the document section of the case file with a brief case note stating who it is to and from and the date of the email. Do not cut and paste into the Case Notes. Upload the email in its entirety. *Do not insert non relevant information into an email containing adult/carer information.* Send all email correspondence containing sensitive personal information using a secure email network, such as N3, or encrypted using Egress Switch.

Scan or upload external reports/correspondence as Word docs, depending on how they are received. Dispose of original documents in the confidential waste rather than shredding them, *apart* from any legal documents, for example, Court of Protection and European Court documents, which must be retained in a secured locked cupboard.

The completion of reportable fields required for Government purposes within FWi docs is obligatory. All of the reportable fields have yet to be made

[26] There is also a link to these pages through the Tools menu in Frameworki.

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mandatory on FWi. However, staff should be routinely recording this information for statutory reporting, performance management, budget planning etc.

40.8 Lost Information

Record details if information is lost in the person's Case Notes. All staff need to be aware that lost information can incur fines on the department.

All staff must take responsibility and exercise care when carrying information in both paper format and on devices, for example, a laptop, in public places. When it becomes known that some information has become lost, either through a system error, or staff making a recording of a meeting outside their normal workplace, report that loss to the relevant Information Management Team as a potential security/information protection incident and to the team manager at the point of discovery. The staff member must check their own Borough's process and requirements, and to report the loss, as applicable, to the individual concerned.

40.9 Recording different types of information

All recording should be completed as soon as possible and no later than three working days of an event having taken place, or in line with the professional's Code of Conduct, whichever is less.

40.9.1 Recording needs and outcomes

The core assessment and other assessment forms used require a record of a person's presenting needs, that is, the needs that present themselves, *regardless of whether and how those needs are being currently met.* A record then needs to be made of the person's outcomes, that is, what they hope to achieve. This is the end result and is not a record of the intervention, which is the means to the end. Given the holistic approach to assessment and support planning, it is important to record all of a person's outcomes but to separate those which relate to adult social care from those which do not. The assessment and review and support planning sections have a full description of outcomes. (See **sections 11.9** and **14.5**.)

40.9.2 Recording Supervision sessions

Decisions and actions need to be recorded by the supervisor and agreed promptly, in line with agreed standards – see para X. Recording should be clear and factual and any decisions made/actions required clearly documented. Individual case discussions must be recorded, in the Case Notes, under the case note type "Record of Supervision Discussion". Both parties need to have a record of the supervision session. The Supervision policy (see **Section 43**) has an example of a supervision template.

Where notes are not typed up and agreed at the end of the session, the agreement via a returned email with the supervision notes is acceptable.

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40.10 Substantiating the Eligibility Decision

Under the national minimum eligibility threshold and the need to consider the significant impact on a person's wellbeing of their being unable to achieve outcomes (two or more for an adult in need of care and support, any number for a carer), this will require providing evidence to substantiate the eligibility decision and this must be recorded in the assessment.

In safeguarding situations, the Care Act guidance states that, whenever a complaint or allegation of abuse is made, all agencies should keep clear and accurate records and each agency should identify procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action taken. In addition the guidance states that all agencies should identify arrangements, consistent with principles and rules of fairness, confidentiality and data protection for making records available to those adults affected by, and subject to, an enquiry.[27] When abuse or neglect is raised managers need to look for past incidents, concerns, risks and patterns. We know that in many situations, abuse and neglect arise from a range of incidents over a period of time. In the case of providers registered with the Care Quality Commission (CQC), records of these should be available to service commissioners and the CQC so they can take the necessary action. Staff should be given clear direction as to what information should be recorded and in what format. The guidance gives examples of questions to consider.

The Guidance also states that agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information, based on the welfare of the adult or of other potentially affected adults. Any agreement should be consistent with the principles set out in the Caldicott Review 2013 ensuring that:

- Information will only be shared on a 'need to know' basis when it is in the interests of the adult
- Confidentiality must not be confused with secrecy
- Informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement, and
- It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.[28]

40.11 Evidence

Evidence is key to substantiating your analysis, professional judgement, determination of eligibility, risk assessment and your decisions/conclusions.

There are different types of evidence, as follows:

[27] Care Act 2014 Guidance, paras 14.150 and 14.153
[28] Care Act 2014 Guidance, paras 14.157

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- Testimony – what the person says, which must be recorded as such. This can be verbatim, a summary of what was said or a mixture, provided you state which. Once recorded, check with the person that what is recorded is an accurate reflection of what was reported.
- Your direct observation – what you observe during your interaction with the person
- Verifiable factual information – these are hard undisputed facts, for example, a date of birth, who attended a visit.
- Written reports, for example, from an OT or hospital consultant.

Treat the following evidence with some caution and take care to provide the necessary details:

- Understandings are statements about how things appear and are assumed to be true but must not be considered as facts.
- Hearsay is third party information and should not be considered as fact. The source needs to be clearly identified.
- Opinions, judgements and recommendations. The basis and reasoning for the opinion must be given with supporting information.
- Expert opinion – an opinion expressed by someone of expert status whose opinion seems beyond question and becomes accepted as fact.[29]

Be particularly cautious about recording unsubstantiated diagnoses, for example, dementia, or unsubstantiated risks, for example, risk of falls. In giving your own opinion, state: "In my professional opinion…"

Facts are observable, sustainable and undisputable. Examples are:

- There were 15 people at the case conference.
- The conference took place on the 4th April 2014.
- There were three chairs in the person's bedroom.

If the record is an expression of an *opinion,* it needs to state this and be clearly attributed to the person stating the opinion. If an expert opinion, state who the author is. The following examples are all opinions:

- S was dressed inappropriately.
- The house was very dirty but tidy.
- M was very optimistic on my visit today.

The Guidance chapter on safeguarding also highlights the need to differentiate between fact and opinion.[30]

[29] Section adapted from "It's all in the record – meeting the challenge of open recording", O'Rourke & Grant, Russell House Publishing (2005)
[30] Care Act 2014 Guidance, para 14.87

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40.12 Quality Assurance

Regular case audits will be carried out, covering the following areas:

1. Recording to be adequate, relevant and non excessive
2. Avoidance of jargon
3. Records to be grammatically correct, with accurate spelling and literacy
4. Demonstration of the person's strengths and abilities
5. Evidence of accurate recording of fact/opinion, analysis of the situation and professional judgement
6. Recording in a non discriminatory manner
7. Evidence of the completion of training on information security and data protection within one month of starting work in the Borough
8. Evidence that the case file is up to date
9. Evidence of the completed risk assessment as part of the core assessment
10. Evidence of safeguarding considerations
11. Evidence of mental capacity considerations
12. Evidence that any relevant email or relevant correspondence is uploaded as a PDF file into documents on FWi
13. Recording has been completed within the specified timescales
14. Evidence that the assessment/support plan/review has been given to the person

40.13 Relevant legislation

See **section 45.4** for Legislative Framework.

Freedom of Information Act 2005

Data Protection Act 1998

40.14 Subject Access

Staff must adhere to their local access to file policy – access via Information Governance. In LBHF, a WPR for information held in shares, business applications (such as FWi) and the email archive is needed and approved by the IMT. The officers concerned should be notified as per the H&F IS policy: and email and electronic files security policy.

Enabling individuals to find out what personal data an organisation holds on them, why it is held and who it is disclosed to, is fundamental to good information-handling practice. The DPA gives individuals the right to require an organisation to do this. This right is commonly known as subject access and must relate to a living individual.

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The three boroughs "Your records: your rights" leaflet states the following:

"What information is an individual entitled to?

Your Rights

Under the Data Protection Act, you are entitled to:

- A copy of the information we hold on you
- Not tell us why you would like to see it
- Full and accurate records of the care we provide to you
- Have discussed with you what we plan to record about you
- Be asked your permission when we want to share your information with others
- Choose someone to make decisions about your care on your behalf if you are not able to do so (called a 'lasting power of attorney').

What you can see

We usually share with you what we record about you, including whenever we assess your needs or provide services. If you ask us, we will also let others see your care record.

If we do hold information about you we will:

- Give you a description of it
- Tell you why we are holding it
- Explain to you who it could be shared with, and
- Let you have a copy of the information if we are able to do so

What you cannot see

Under the Data Production Act we cannot share with you any parts of your record/information held about you which contain:

- Confidential information about other people (unless their explicit consent has been obtained)
- Information a care professional thinks will cause serious harm to you or someone else's physical or mental well-being
- Information we hold from third parties that we don't have permission to share.

This applies to both paper and electronic records about you.[31]

What is the time limit for responding?

In most cases a subject access request must be responded to promptly and in any event, within 40 calendar days of receiving it."

[31] Trib **Your records: your rights**, available on Tribnet

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Refer to Appendix A (**section 40.18**) for how case files need to be prepared for both living and deceased people.

40.14.1 Exemptions

The exemption under social work records details the following:

Special rules apply where providing subject access to information about social services and related activities would be likely to prejudice the carrying out of social work by causing serious harm to the physical or mental health or condition of the requester or any other person. These rules are set out in the Data Protection (Subject Access Modification) (Social Work) Order 2000 (SI 2000/415). Their effect is to exempt personal data processed for these purposes from subject access to the extent that its disclosure would be likely to cause such harm.

A further exemption from subject access to social work records applies when a Subject Access Request (SAR) is made by a third party who has a right to make the request on behalf of the individual, such as the parent of a child or someone appointed to manage the affairs of an individual who lacks capacity. In these circumstances, personal data is exempt from subject access if the individual has made clear they do not want it disclosed to that third party.[32]

40.15 Security

All security, confidentiality and information sharing principles apply to electronic recording systems as well as paper systems. Mobile phones and personal digital assistants (PDAs) effectively act as mini-computers, and are subject to similar security threats and vulnerabilities, particularly when the internet, or email communication, is involved.

Your employer is responsible for providing secure devices that are usable in real-life situations, and for agreeing and implementing effective and practical policies to cover the use and transfer of personal information, by whatever means. Electronic devices used for recording personal information are covered by stringent security requirements. Personal devices should not store any sensitive personal information but provide secure access to the council network; all mobile council devices should be encrypted; all emails containing sensitive personal information should be sent by a secure email network or encrypted using Egress Swith.

Independent practitioners need to keep information secure in line with the **Information Controller's policies**, both on computers and/or mobile phones/PDAs. Their security software and systems must meet business and personal information protection requirements. Computers, mobile phone/PDA may be used for both work and personal use but access to the council network must be via a secure way, for example, Lynx. The DPA requires that information is only kept for specified purposes, so personal information should not be available alongside personal information accessed when not working.

[32] **ICO Subject Access guidance – Exemptions**

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40.16 Retention of Records

There are statutory requirements governing the periods of time records have to be maintained, as detailed below.

Needs assessment	Recommend 3 years after cessation of service	To be in writing Section 12(3)	Statutory	Care Act 2014 Chapter 23 Section 9, 13
Carer's assessment	Recommend 3 years after cessation of service	To be in writing Section 12(4)	Statutory	Care Act 2014 Chapter 23 Section 10, 13
Financial assessment	Recommend 3 years after cessation of service Audit may require current year plus 6 years	To be in writing Section 17(6)	Statutory	Care Act 2014 Chapter 23 Section 17
Care and Support Plan Support Plan (carer) including Personal Budget	Recommend 3 years after cessation of service	To be in writing	Statutory	Care Act 2014 Chapter 23 Section 25 Section 26 See also SI 2014 No 1652 for personal budget
Register of sight impaired adults, disabled adults	To be kept up to date	None specified	Statutory	Care Act 2014 Chapter 23 Section 25 Section 77
Learning disability	7 years after death or cessation of service subject to Service Manager's decision that matter is unlikely to recur	Paper	Corporate	In view of increased litigation some authorities are retaining for 25 years but be aware of the requirements of the Data Protection Act and the Freedom of Information Act
Mental Health	20 years after treatment, 10 years after death or cessation of service	Paper	Corporate	Mental Health Act 1985 In view of increased litigation some

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	subject to Service Manager's decision that matter is unlikely to recur			authorities are retaining for 25 years but be aware of the requirements of the Data Protection Act and the Freedom of Information Act

For details of all document retention periods, including Complaints Procedures and Lasting Power of Attorney, refer to the **Batchelor's Retention Schedule** used by the three boroughs

40.17 Recording Standards

40.17.1 National

The Health and Care Professions Council (HCPC), which covers all health and social care professions, state the following in the Standards of Proficiency:

> *"Making and keeping records is an essential part of providing care or services and you must keep records for everyone you treat or for whom you provide services. You must complete all records promptly."*[33]

The College of Occupational Therapy (COT) Standard on record keeping states: *"You have an obligation to keep care records that are fit for purpose and to process them according to legislation."*[34]

Nursing Standards The recording standard states: *"Keep clear and accurate records relevant to your practice."*[35]

40.17.2 Local standards

Do:

- Store all personal data securely, for example, in a locked cabinet and secure the key
- Securely dispose of all electronic personal data: for example, do not just delete items, ensure your desktop recycling bin is emptied regularly
- Delete information when it is no longer required
- Securely dispose of all paper based personal data using the confidential waste service
- Carry a locked briefcase or bag when transporting any data outside of the office
- Only share data when you are allowed to do so by law
- For sending and receiving sensitive personal information use a secure email network, such as GCSX, CJSM or Egress Switch

[33] **HCPC: Codes of Conduct, Performance and Ethics, 2012**
[34] More information is available from the current College of Occupational Therapists' ***Professional standards for occupational therapy practice***. COT Standards , 2011
[35] **The Code for nurses and midwives 2015**

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- Send paper records containing restricted data using enhanced postal services for example, Royal Mail Recorded or Special Delivery
- Create your computer passwords using the password complexity rules, outlined in the Information Security Policy[36]
- Report any data loss or theft including mobile devices such as USB sticks and laptops to your manager immediately
- Always 'lock' the desktop on your computer when leaving the desk
- Clear away personal data from your desk when you are not using it.

Do Not:

- Leave papers containing personal data lying on your desk unattended
- Store large quantities of personal data on the desktop or on the C drive of your computer
- Put any paper-based personal data in the normal waste or recycling boxes
- Store personal data on mobile devices such as laptops, Blackberrys or USB sticks without written approval from your line manager or the Caldicott Guardian
- Disclose your computer password to anyone or write it down on a piece of paper
- Send sensitive and protectively marked information outside the council using regular email
- Leave notebooks/diaries unsupervised.

40.18 Appendix A: Preparation of case files for a living person

Identify where the information may be: for example, paper files, in hospital files, in the Complaints Department, finance and Frameworki.
In Frameworki, check case notes and uploaded documents, for example, assessment and reviews, front sheet, episodes and notes.

When printing from Case Notes, print one page at a time to ensure consistency of quality.

Frameworki documents contained in episodes that are uncompleted do not appear in the chronological list of documents in the person's record (although externally uploaded documents do). Therefore, FWi documents in uncompleted episodes must be retrieved by going into the episode in which they are contained (until such time that the episode has been completed

For any third party information held on Frameworki, any request to release should be made in line with **Access to Files policy**. Add reference number, request closure date and lead officer. Redact all third party information unless consent has been obtained.

[36] H & F Information Security Policy

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Make three copies of every paper document – a complete one for retaining by the Borough, a redacted one retained by the Borough, and one for giving to the person. This is to ensure clarity over what has been sent and what has been held back. Information should be redacted in line with local policy. The paper file should have separate chapters on case notes, documents and documents from any other departments. Where possible, print off the front index.

Find out from the person which part/s of the file they are requesting.

40.18.1 What to do when receiving a subject access request in respect of a deceased person's files

Individuals are entitled to make subject access requests for their personal information in accordance with the DPA.

However, when a request is received from a relative in respect of a deceased person's files, then that request is to be treated as a request under the Freedom of Information Act 2000 ("FOI"), whether or not the request refers to the FOI, the reason being that the information requested does not relate to a living individual. Under the FOI provisions the request is to be complied with within 20 working days of receiving the request and forwarded to the team for logging and handling.

The presumption is that if the relative can satisfy the Borough that they either are the personal representative of the deceased or have the consent of the personal representative of the deceased then they are entitled to such copy documentation as the deceased would have been entitled to in their lifetime under the DPA subject access provisions.

There are three potential categories of personal representative:

(i) an executor appointed in a will – proof of being an executor being an office copy of the Grant of Probate which the executor will obtain from the Registry of Births, Marriages and Deaths

(ii) an administrator appointed under the rules which apply on intestacy where the deceased died without leaving a valid will – proof of being an administrator being an office copy of the Grant of Letters of Administration which the administrator will obtain from the Registry of Births, Marriages and Deaths

(iii) an administrator where the deceased left a will appointing an executor but where the executor predeceased the adult or is unwilling to act – proof of being an administrator being an office copy of the Grant of Letters of Administration with Will Annexed which the administrator will obtain from the Registry of Births, Marriages and Deaths

If the relative is a personal representative then they need to provide an office copy of one of the documents referred to above at (i) to (iii). If they say they have the consent of the personal representative then the personal representative needs to provide the office copy and their written consent to the disclosure.

If the relative is neither a personal representative nor has the consent of the personal representative then they are not entitled to the copy documentation as a result of the exemption under s41 FOI.

Where there is more than one person administering the will, the information goes to both parties or is agreed with them as to which one should receive it. Where there is more than one will, and the will is being contested, legal advice should be sought.

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41 LONE WORKING

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

To be added.

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42 MANAGING YOUR WORKLOAD

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

In order to deliver quality services, in a timely manner, you will need to manage your workload effectively. Doing so will also help to keep additional stress levels within your job to a minimum. There are various forms of support available to assist you to achieve high standards of intervention with adults, to follow procedures, and to record within agreed timescales.

42.1 Training

A range of general/practice focused courses are available via the Student Centre for practitioners. Check what is available under the different categories – especially to see generic courses such as Time Management and Managing Stress and Wellbeing.

42.2 Time management

Time Management Tips

- Maintain a to-do-list and make it a habit/regular task to update it continually. Include urgent and non-urgent items.
- Allocate your time. Include an estimated time-frame for each action point and the date by which the task must be completed.
- Plan your work – use your diary to schedule your tasks, not just visits and meetings.
- Set and respect deadlines. Although we tend to get a lot done when we're under pressure, it is a lot less stressful and considerably more professional to establish and stick to an action plan.
- Use your time wisely – consider accessing your email only at certain times of the day. If possible, never touch the same piece of paper or email twice. Do not open your mail unless you have time to read it and take action on it.
- Get organised – organise your desk, your hard-copy and computer files and your email folders so you can find things easily.
- Stay on task – add new work to your to-do-list but finish what you were working on first.

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- **Avoid disruptions – Don't hesitate to tell colleagues when you are too busy to chat.**

42.3 Supervision

You should expect to meet with your line manager for supervision every two to six weeks depending on your job and individual requirements; in general, the frequency will be every four weeks. You will have an appraisal with your line manager every 12 months, with a six-monthly review. You are encouraged to raise questions/concerns about how you are managing your workload within these sessions – and obviously your manager may also raise this if they perceive a problem. (See **Section 43**.) You and your supervisor sign a Supervision Agreement and keep a written Supervision Record.

If you are struggling with your workload to the point where you are significantly concerned about either your ability to provide the required standard of service, or your own well-being, you should not wait for supervision but raise this with your line manager as soon as possible.

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43 SUPERVISION

43.1 Introduction

Adult Social Care across the three boroughs sees regular and effective supervision as an essential element in staff management and development, and ultimately in ensuring a high quality service is delivered to residents across the three boroughs.

The functions of supervision include casework discussion, line management, learning and development, caseload management and performance management.

The vision for Shared Services is to deliver great local services through quality, innovation and leadership.

This vision is delivered for its residents through the following values:

Being

- Responsive
- Innovative
- Collaborative
- Enterprising

The core value is serving the public. Staff are expected to demonstrate these values through their day to day work and are committed to embedding them into everything they do. Managers are also expected to demonstrate that they are managing their service well and providing leadership to their staff. The performance appraisal process enables all staff to demonstrate this commitment. The behaviours outlined in the statement of Values and Behaviours are examples of what the three Boroughs expect to see. All staff, at all levels, will be assessed using this framework.[37]

43.2 Scope

This policy applies to the supervision of all practitioners, qualified and unqualified, including social workers and Occupational Therapists.

Given the evidence that supervision is associated with job satisfaction and protects against stress, practitioners should insist that good supervision is provided by their employers. The emotionally charged nature of the work places particular kinds of demands on people working in the field which need to be contained by the organisation. This means moving beyond a focus on task and prescription, and providing opportunities for reflective supervision. [38]

[37] Performance Appraisal Guidance for all Staff and Managers in the three boroughs, Version 1, March, 2013

[38] SCIE Research Briefing 43 Effective Supervision in Social Work and Social Care, 2012

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Supervision provides a form of accountability between the employer and employee on behalf of the public. It is a tool for monitoring the quantity and quality of work being done.[39] This includes the duty of employees to keep the line manager informed of all matters of a complex or contentious nature.

43.3 Types of Supervision

This policy focuses on one-to-one supervision. These are planned meetings, comprising the supervisor and supervisee. They will include discussion about practice issues, professional development and performance.

Other forms of supervision do take place and should be considered in individual teams.

A. Peer supervision

This is where colleagues supervise each other and is usually a discussion on specific cases. Any decisions made should be recorded on the case record as informal supervision.

B. Group supervision

This can occur, for example, in a home care team, where a supervisor will supervise a number of staff in a group and this will cover discussion of specific cases and how the group work together as a team. Group supervision complements, rather than replaces, one-to-one supervision. It can provide a valuable means of sharing practices, prompting debate and promoting learning.

C. Informal/Ad Hoc supervision

This occurs in between planned supervision meetings when guidance/advice is required. Any decisions reached must be recorded on the individual's case records.

D. Professional supervision/Case supervision

This occurs on a one-to-one basis, to enable and support quality practice and is for professionals who are using their professional qualification in their role. A key aspect is the review and reflection on practice issues. It includes looking at the outcomes of the work and maximising the opportunities for wider learning. Attendance at other forums which are social work practice related could also be considered – for example, safeguarding forums, hoarding forum, domestic violence briefing.

43.4 Appraisal

Appraisal is an annual event which takes a longer term view of an employee and their performance and professional development. Supervision sessions can inform the appraisal discussion. The appraisal identifies objectives to be worked towards during the following year, and how these are going to be met. The Personal Development Plan (PDP) will come out of the appraisal process. The appraisal identifies objectives for the following year and the support required in meeting them.

[39] Social Work Reform Board, Standards for Employers and Supervision Framework, 2012

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43.5 Functions of Supervision

The four areas which follow will all be covered in the audit process.

A. Casework discussion, caseload management and evidence of non-discriminatory practice

- Critically reflective practice – an opportunity to reflect on a piece of work and discuss what happened, how the practice relates to knowledge, skills and values, what could have been done differently, and what has been learned for future practice. These reflections can be taken from direct work with adults/carers, meetings or managing complaints and/or adult safeguarding cases
- Discussion and feedback from observations
- Looking at the impact of the work on the supervisee
- Professional boundaries
- Quality of the decision making
- Acknowledgement of good practice
- Content and quality of recording [40]
- Review of case numbers and types of cases
- Decision making and case planning
- Feedback on specific cases, actions, changes in needs/support required, Direct Payments management concerns

  Please Note: Every allocated case must be discussed at least once every three months in detail.
- All safeguarding cases must be discussed and the supervisor updated on progress
- Risk Management and the promotion of positive risk taking.[41] Managers should be challenging practitioners on risk decisions which have not supported positive risk taking

B. Line Management

- Demonstration of adherence to policies/procedures/local protocols. It is essential that managers use supervision sessions, alongside team meetings and other group forums, to test practitioners' understanding and adherence to policies. This can be done by asking specific questions, for example, "In substantiating Mr X's eligible needs – what was your evidence to support a significant impact on him being unable to achieve specified outcomes?" Quizzes can also be used, with questions being specifically designed to test aspects within a particular policy. This links into performance management.

[40] See **Section 40 RECORDING**
[41] See **Section 10 RISK**

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- Performance – clear feedback from supervisor of any issues, how they will be addressed and in what timescale
- Conduct issues – to include issue/s to be addressed, how and in what timescale
- Information sharing
- Sickness leave
- Annual leave/Flexi time/TOIL

C. Learning and Development

- Evaluating recent learning and development activities and how the learning has been transferred to practice
- Progressing towards objectives set in appraisal
- Reviewing Continuing Professional Development – have learning journals or CPD folders been kept up to date?
- Identifying and exploring any learning and development needs to find the best kinds of opportunities for the supervisee
- Working towards practice and career development
- Maintaining professional registration
- Review of PDP nd evidence of non-discriminatory practice
  - Identification of any learning and development needs and how these might be addressed
  - How recent learning has been absorbed into practice
  - Progress towards the objectives set in the appraisal should be regularly reviewed in supervision

D. Performance Management

Performance issues, as indicated in Line Management above – should be identified during supervision. These include praising work well done, encouraging innovative ideas, promoting good practice and identifying talent and also addressing performance concerns leading to performance management.

43.6 Social Work Standards

The Social Work Reform Board introduced in 2012, as part of its programme of reform, a set of standards for employers of social workers in all settings. The standards will enable social workers to practice effectively and confidently. The standards include one about supervision, as follows:

Standard – Ensure that social workers have regular and appropriate social work supervision

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Reflective practice is key to effective social work and high quality regular supervision should be an integral part of social work practice. All organisations employing social workers should make a positive, unambiguous commitment to a strong culture of supervision, reflective practice and adaptive learning. Supervision should be based on a rigorous understanding of the key elements of effective social work supervision, as well as the research and evidence which underpins good social work practice. Supervision should challenge practitioners to reflect critically on their cases and should foster an inquisitive approach to social work.

All employers should:

- Ensure that social work supervision is not treated as an isolated activity by incorporating it into the organisation's social work accountability framework
- Promote continuous learning and knowledge sharing through which social workers are encouraged to draw out learning points by reflecting on their own cases in light of the experiences of peers
- Provide regular supervision training for social work supervisors
- Assign explicit responsibility for the oversight of appropriate supervision and for issues that arise during supervision
- Provide additional professional supervision by a registered social worker for practitioners whose line manager is not a social worker
- Ensure that supervision takes place at least weekly for the first six weeks of employment of a newly qualified social worker, at least fortnightly for the duration of the first six months, and a minimum of monthly supervision thereafter
- Ensure that supervision sessions last at least an hour and a half of uninterrupted time
- Monitor actual frequency and quality of supervision against clear statements about what is expected.[42]

43.7 College of Occupational Therapy Standards

The College of Occupational Therapy standards describe a level of practice that the British Association of Occupational Therapists (BAOT) expects its members to abide by, and believe all occupational therapists should follow.

These standards are:

- To ensure a high quality occupational therapy service to adults
- To encourage and enable the supervisee to learn and develop new, improved working practice
- To help the supervisee gain an overview of his/her work and so acquire fresh insights into his/her practices
- To provide an opportunity for the supervisee to share work experiences

[42] The Social Work Reform Board **Standards for Employers and Supervision Framework**, 2012

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- To demonstrate to the supervisee, his/her value to the service and his/her contribution to overall management policies
- To develop rapport and understanding between staff
- To provide a forum for support, encouragement, praise & constructive criticism
- To assist with time management and organisation of workload
- To tackle issues associated with pressures and stress in the workplace
- To enable professional development, continuing education and training
- To provide for staff, personal needs and growth.[43]

43.8 Roles and Responsibilities

Managers/Supervisors are expected to provide regular supervision meetings:

- Based on a signed supervision agreement for each of their supervisees
- Booked well in advance and only changed in exceptional circumstances
- Well-structured, with both parties bringing agenda items and with supervisees being notified in advance of anything specific they need to prepare or bring along. The sessions allow both parties to contribute to the agenda.
- Provided in an appropriate setting and free of interruptions
- Inclusive of the roles and functions outlined in the job profile
- Focused on organisational priorities and target setting for performance reviews
- Incorporating professional development discussions based on the **professional capabilities framework** (see **section 43.10**) and/or professional standards
- Reflective of the emotional impact of work to ensure safe practice and the wellbeing of the supervisee
- Focused on the evidence base for assessment, support planning and decision making
- Targeted to identify and address training and development needs to support effective practice
- Appraisal objectives are regularly reviewed
- Opportunities are made to support critical reflection
- Supervision should allow for the acknowledgement of good practice and the challenging of poor practice and performance
- Inclusions to individual case records should be made at or immediately following the sessions

[43] **The College of Occupational Therapy Standards**, 2011

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- A minimum of one observed practice per year is undertaken and feedback provided – this can form part or all of one supervision session
- Accurately and appropriately recorded, agreed by both parties and copied to the individual without delay

Supervisees are expected to:

- Sign and adhere to the supervision agreement
- Prepare for each supervision meeting by reviewing notes from the previous meeting and thinking about the items they want to raise and discuss
- Notify the supervisor, in good time, of any agenda items which require preparation in advance of the session
- Adopt a reflective approach and be prepared to critically analyse their own practice, and the impact on individuals and the organisation
- Openly share thoughts and ideas, and accept the influence of others to find solutions to issues and reach sound professional judgments
- Be ready to identify professional development needs, plan and undertake training and other development activities, as agreed with their supervisor
- Be aware of professional standards, organisational priorities, policies and procedures and how these relate to the supervisee's own performance
- Check and agree the supervision notes and follow through and complete any agreed actions against timescales

43.9 Supervision Records

All supervision and supervisees should sign a **Supervision agreement** at the start of their supervision contract. This should be reviewed on a six monthly basis. Supervisors should refer to a **Checklist** to assist the agenda and to ensure all relevant topics are covered. All recording should be made on a **Supervision template**.

43.10 Professional Capabilities Framework (PCF)

The **Professional Capabilities Framework** (PCF) is the overarching professional standards framework for social workers. The PCF is divided into nine domains. There are nine levels, from entry through to the strategic social work level. The framework defines the expectations for practice, including the management of issues such as complexity, risk and decision making. The PCF is similar to other professions that have their own set of standards and is owned by The College of Social Work.

PCF is used to assess practice and update capabilities of newly qualified social workers as part of the Assessed and Supported Year in Employment (AYSE). It provides a framework for all social workers to identify ongoing learning needs and to develop practice.

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43.11 Standards of Frequency

Registered social workers should be supervised by registered social workers and have a minimum of monthly one to one supervision meetings with a yearly minimum of 10 sessions.

All newly qualified staff should have supervision every week for the first six weeks of their employment, at least fortnightly for the duration of the first six months and a minimum of monthly supervision thereafter.

For newly appointed staff completing their probationary period, supervision should take place fortnightly to assess their suitability for permanent employment.

Part time staff should receive supervision on a monthly basis, allowing discretion to reduce the time to reflect the worker's caseload.

Agency and temporary staff should receive the same frequency of supervision as permanent staff.

Where a member of staff or the supervisor is on leave or sick or on training for any length of time, it may not be possible to maintain monthly frequency. In this case, both parties must agree to meet at the next earliest opportunity and must ensure that the yearly minimum is maintained.

43.12 Who supervises?

A worker's immediate line manager is responsible for providing supervision. Social workers who are not managed by a registered social worker need to have additional professional supervision.

43.13 Location

The location should be in a quiet room, away from any disruptions and where confidentiality can be maintained.

43.14 Preparation

Both parties need to come to the session with feedback on agreed actions from the last session and a written agenda items for the session.

43.15 Recording

Decisions and actions need to be recorded by the supervisor and agreed promptly. Recording should be clear and factual and any decisions made/actions required clearly documented. Individual outcomes relating to specific cases must be recorded, in the case notes, under the heading (in bold) of Supervision Notes. Both parties need to have a record of the supervision session.

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Where notes are not typed up and agreed at the end of the session, the agreement sent via a returned email with the supervision notes is acceptable.

43.16 Monitoring

An annual audit should take place to monitor actual frequency and quality of supervision against clear statements about what is expected.

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44 CRITICAL INCIDENT

44.1 Introduction

Adult Social Care must demonstrate accountability for effective governance. When a critical incident occurs, the Borough has a responsibility to ensure there is a systematic process in place to review the incident immediately and internally and to ensure steps are taken to minimise the chance of a similar event re-occurring.

A Critical Incident is:

- the unexpected or preventable death of a person, other than from natural causes
- a serious assault or abuse of an adult in need of care and support, staff member or member of the public
- serious harm or injury to an adult/carer staff member or member of the public

and where, in all instances, *there is reason to believe a service failure has been a contributory factor.*

A Critical Incident Review is an internal initial review, commissioned in all incidences of harm, where there is reason to believe an Adult Social Care failure may have been a contributory factor.

The nominated senior member of staff has overall responsibility for reviewing Critical Incidents.

44.1.1 Safeguarding Adult Review

A Critical Incident is different from a **Safeguarding Adult Review** (SCR) which is a multi-agency review of a serious incident and may *follow* a Critical Incident Review.

Safeguarding Adult Reviews are commissioned to examine the ways in which local professionals and agencies worked together to safeguard a vulnerable adult or take place following harm or death of a vulnerable adult where there are concerns about agencies' actions or engagement.[44] [45]

The Care Act 2014 re-affirms the preventative agenda and that Safeguarding Adults Boards must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

[44] Jill Manthorpe and Stephen Martineau, What Can and Cannot Be Learned from Serious Case Reviews of the Care and Treatment of Adults with Learning Disabilities in England? Messages for Social Workers, 2013
[45] SCIE Pan London Safeguarding policy, 2011

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a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, *and* –

b) condition 1 or 2 is met.

(2) Condition 1 is met if:

a) the adult has died, *and* –

c) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if:

a) the adult is still alive, *and* –

b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.[46]

44.2 Purposes

The purposes of a **Critical Incident Review** are to:

- Establish whether there has been a service failure
- Establish whether or not there is a causal link between any service failure and harm to the person using services, or a staff member or where the council has been brought into disrepute
- Support managers in identifying and understanding what the service failure was and in taking action to improve services so as to prevent an incident re-occurring.

44.3 Process

44.3.1 Responsibilities

If a critical incident is identified by a staff member, it should be reported to the line manager immediately.

Manager:

- Control the situation and ensure the safety and welfare of all concerned.

Once under control, consider the severity of the incident, using the definitions above, and inform the Director of Operations by telephone, where you believe a critical incident has occurred. This must be followed up by email on the day of the incident, using the attached Critical Incident Referral form.

Where the Director of Operations considers the incident to be a Critical Incident, they need to alert the Executive Director and the lead member, as appropriate, and a decision reached as to whether the critical incident meets the criteria for a review.

[46] Care Act 2014, Section 44

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44.3.2 Other Considerations

Manager:

- Inform the police if a crime is suspected.
- If the critical incident results from the abuse or neglect of an adult at risk, raise a safeguarding concern and follow the Safeguarding procedure (see **Section 34 SAFEGUARDING**). A Critical Incident Review will not prevent or interfere with any safeguarding procedures progressing in the usual way.[47] A Critical Incident Review may support the safeguarding review but will not replace or restrict it in any way.
- Some incidents need to be reported to the Care Quality Commission (CQC), the Health and Safety Executive (HSE) and/or other organisations and managers' responsibilities for reporting these are detailed in Appendix B – **section 44.7**.

44.3.3 The Critical Incident Review

Manager:

- Once you have reported the incident, gather witness statements from any staff members present. These will be paper copies. If the incident involves an adult/carer, ensure the case file records are up to date and all relevant individual information is available for a review.

Where a need for disciplinary action is highlighted, this will be dealt with separately and will not form part of the Critical Incident Review. Issues which could lead to disciplinary action include:

Criminal or malicious activities
Serious professional misconduct
Failure to comply with Health and Safety procedures
Failure to comply with Adult Social Care policies and procedures
Deliberate falsification of records
Serious negligence

The Director of Operations, in conjunction with a senior member of staff, nominated by the Director of Operations, will appoint a manager (who is independent of the particular service) to conduct the review, with additional staff support, if considered necessary. The review will be overseen by the nominated senior member of staff. *For the purposes of this Protocol, the appointed person will be referred to as the reviewer.*

44.3.4 Conducting the review

(i) Securing files and evidence

Steps need to be taken to ensure that all electronic information is not lost, mislaid, destroyed or tampered with, by:

- Checking the electronic database to establish whether the person is/was known and to identify involved professionals

[47] Refer to SCIE Pan London Safeguarding policy, 2011 (to be revised shortly in line with Care Act, 2014 requirements)

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- Limiting access to all electronic records to those directly involved in the review.

Access to file records may be additionally agreed to allow management staff/senior workers to continue any ongoing casework required.

Files and/or documents should not be entrusted to the postal service and must be delivered in person or by courier.

Documents containing confidential material must not be sent externally by email, in the absence of a secure network in which to exchange information unless password protected.

(ii) Consultation and Consent

Where appropriate, the nominated senior member of staff or the reviewer will notify the adult in need of care and support and/or their carer to advise them that a review is taking place, and to explain the purpose of it.

(iii) Receiving information and reports

The nominated senior member of staff and the reviewer will consider the information and reports provided by any managers and staff involved.

(iv) Staff interviews

Where staff or others are interviewed by the reviewer, a written record of the interviews will be made and shared with the relevant interviewee/s.

(v) Evaluation of evidence

The reviewer will complete the **Critical Incident Report Form**.

S/he will consider the evidence gathered, with the nominated senior member of staff, or a delegated representative, and reach a conclusion about whether a service failure has occurred and whether or not this has had a causal effect on the person.

(vi) Action Plan

The **Action Plan** will be determined and drawn up by the Director of Operations, Head of Service, relevant senior manager, nominated senior member of staff and the reviewer. Clear recommendations, responsibilities for carrying them out and timescales for completion, and intended outcomes, should be stipulated. Action Plan:

The Director of Operations is responsible for ensuring that the Action Plan is delivered. The Director, Head of Service, relevant senior manager, nominated senior member of staff and reviewer will decide who the report should be made available to and who should be informed of the outcome of the review, by what means and by whom. They will also decide the process for debriefing staff and, where appropriate, adults/carers.

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44.4 Performance Standards

The line manager reporting the Critical Incident must:

- Take immediate responsibility for the management of the Critical Incident as soon as they have been informed
- Ensure the safety and welfare of all concerned
- Inform the Director of Operations and the nominated senior member of staff immediately by telephone and follow this up by an email on the day of the incident
- Complete a **Critical Incident Referral form** and send it to the Director of Operations and the nominated senior member of staff on the day of the incident
- Report to any external agencies, as required, for example, the police, CQC and/or HSE
- Carry out an initial review and obtain written witness statements
- Provide support to staff and ensure there is an opportunity for debriefing and access to support/counselling, if required
- Ensure appropriate support to adult in need of care and support and/or family members and an explanation as to what will occur next

The Director of Operations and the nominated senior member of staff:

- Decide on the appropriate response and whether a Critical Incident Review is required.
- Appoint the allocated reviewer, and other staff, if required.
- Arrange for any media management, as required.
- Liaise with any partner organisations, as required.
- Include the Critical Incident report on the ALTT agenda.
- Provide a briefing to the Communications Manager and that Borough's Director of Law.
- Alert the lead member, as appropriate.

Reviewer:

- Agree the terms of reference and the timescale with the Director of Operations and the nominated senior member of staff.
- Review the incident, following the Conducting the Review section above.
- Complete a **Critical Incident Report Form**, within the agreed timescale.
- Present the completed report to the Director of Operations and the nominated senior member of staff

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44.5 Outcomes

- The nominated senior member of staff to ensure that the learning points are carried forward departmentally.
- All incidents are reported, with their findings, on a quarterly basis, to the Adult Social Care Safeguarding Executive Board and the Adults Operational Board.
- The Adult Social Care Safeguarding Executive Board will decide if a Serious Case Review is required.
- Refer findings into The Adult Social Care Safeguarding Adults Case and Serious Case Review group.
- Provide feedback to the adult in need of care and support and/or carer/s.

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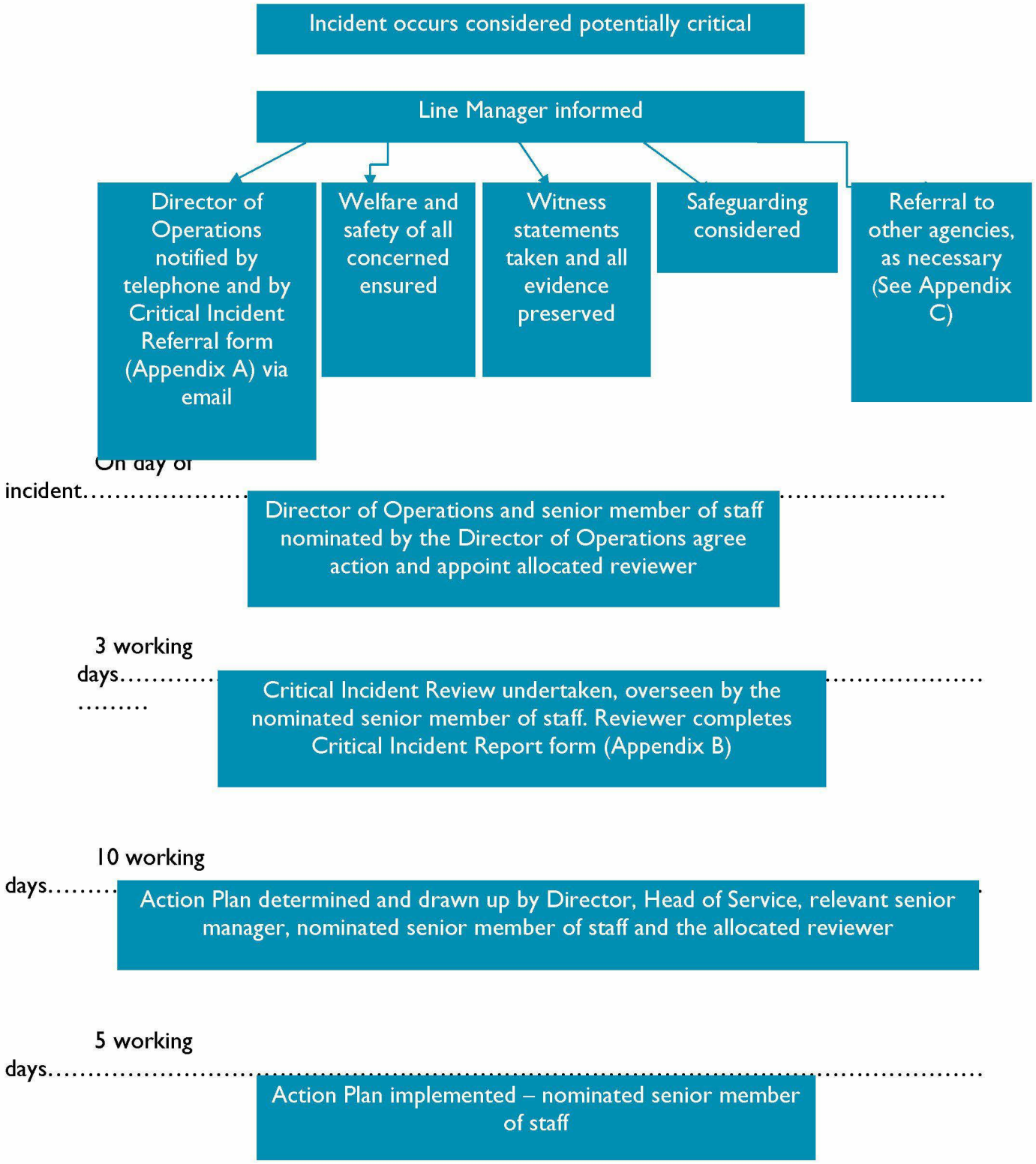
44.6 Process



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44.7 Appendix B: Organisations to whom adverse incidents must be reported

There are a number of organisations outside of Adult Social Care to whom certain adverse incidents must be reported. This list is not exhaustive.

Cause	Further Description	Report to these Agencies	Who reports
Unexpected death of person	Preventable death or sudden death	CQC Police Care Manager and consider: HSE http://www.riddor.gov.uk/	Registered Manager Service Manager
Work related death/injury		HSE http://www.riddor.gov.uk/ Police Refer to Appendix C (**section 44.8**) for more details	Registered Manager Line Manager
Serious Incidents in Healthcare		National Reporting and Learning System (NRLS) CQC	Executive Director (with board level experience for risk and patient safety) Registered Manager
Adult Safe-guarding Protection	Death or injury to an adult at risk where abuse or neglect is suspected to be a factor – where an adult at risk has suffered harm as a result of staff failing to follow agreed procedures or acceptable practice – when an adult at risk has suffered significant injuries suspected to be as a result of abuse	Care Manager Safeguarding team CQC Police	Team/Unit Manager
Homicide by someone under care of mental health services		Police, National Reporting and Learning System (NRLS) CQC Ref follow guidance in the National Patient Safety Agency Independent investigation of serious patient safety incidents in MH services, Feb 08	Executive Director (with board level experience for risk and patient safety) Registered Manager

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Cause	Further Description	Report to these Agencies	Who reports
Serious patient safety incidents in mental health services		Police CQC National Reporting and Learning System (NRLS) Ref follow guidance in the National Patient Safety Agency Independent investigation of serious patient safety incidents in MH services, Feb 08	Senior Manager or clinician to undertake review Appropriate Senior Manager
Medical Equipment Failure	Any serious harm to staff or adult/carer involving medical equipment whether due to human error or due to equipment found to be or suspected of being faulty or to have failed e.g. hoist collapsing, defibrillator failing.	Health and Safety Executive **www.hse.gov.uk** Medicines & Healthcare products Regulatory Agency **www.mhra.gov.uk** Refer to Appendix C (**section 44.8**) for more details	Nurse Advisor Health and Safety team
Acts of Violence		Police	Manager
Child Protection		Children's Services	Team/Unit Manager

44.8 Appendix C: RIDDOR and MHRA Regulations

44.8.1 RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

Types of Reportable Incidents

The death of any person

All deaths to workers and non-workers, with the exception of suicides, must be reported if they arise from a work-related accident, including an act of physical violence to a worker.

Specified injuries to workers

The list of 'specified injuries' in RIDDOR 2013 replaces the previous list of 'major injuries' in RIDDOR 1995. Specified injuries are (regulation 4):

- Fractures, other than to fingers, thumbs and toes
- Amputations
- Any injury likely to lead to permanent loss of sight or reduction in sight

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- Any crush injury to the head or torso causing damage to the brain or internal organs
- Serious burns (including scalding) which:
  - covers more than 10% of the body
  - causes significant damage to the eyes, respiratory system or other vital organs
  - any scalping requiring hospital treatment
- Any loss of consciousness caused by head injury or asphyxia
- Any other injury arising from working in an enclosed space which:
  - leads to hypothermia or heat-induced illness
  - requires resuscitation or admittance to hospital for more than 24 hours

44.8.2 MHRA – Regulating Medicines and Medical Devices Reporting Adverse Incidents involving Medical Devices.

This section gives all the relevant information on reporting adverse incidents involving medical devices, including details on the updated online reporting system.

Report online

Clinicians, healthcare or social care workers

Patients or members of the public

Manufacturers, authorised representatives, suppliers or distributors (link to MORE)

What is a medical device?

Medical devices and equipment are items used for the diagnosis and/or treatment of disease, for monitoring patients, and as assistive technology. This does **not** include general workshop equipment such as power or machine tools, or general purpose laboratory equipment or aids for daily living. See European Commission guidance **MEDDEV 2.1/1**.

What is an adverse incident?

An adverse incident is an event that causes, or has the potential to cause, unexpected or unwanted effects involving the safety of device users (including patients) or other persons.

For example:

- a patient, adult, carer or professional is injured as a result of a medical device failure or its misuse
- a patient's treatment is interrupted or compromised by a medical device failure

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- a misdiagnosis due to a medical device failure leads to inappropriate treatment
- a patient's health deteriorates due to medical device failure.

Causes may include: design; poor user instructions or training; inappropriate modifications; inadequate maintenance; and unsuitable storage and use conditions.

Why report?

The information from adverse incident reports can help identify faults with medical devices and may prevent similar incidents happening again.

Who should report?

Anyone may submit an adverse incident report to the MHRA – clinicians, healthcare workers, carers, patients and members of the public. Reports may need to be submitted via, or copied to, medical device liaison officers and/or patient safety managers.

What should be reported?

Any adverse incident involving a medical device should be reported to the MHRA. Some apparently minor incidents may have greater significance when aggregated with other similar reports.

When should an incident report be made?

All incidents should be reported to the MHRA as soon as possible. Serious cases should be reported by the fastest means possible. Initial incident reports should contain as much relevant detail as is immediately available, but should not be delayed for the sake of gathering additional information.

How do I report an incident?

Preferably by using the online forms (links above). However, you can also send a report by be email or post. Report forms may be downloaded/printed from the website.

Transfer of Patient Safety Function to the NHS Commissioning Board Special Health Authority.

Patient Safety Incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded health care.

The key functions and expertise for patient safety, developed by the National Patient Safety Agency (NPSA), were transferred to the NHS Commissioning Board Special Health Authority (the Board Authority) in 2012. This ensures that patient safety is at the heart of the NHS and builds on the learning and expertise developed by the NPSA, driving patient safety improvement.

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The Board Authority will harness the power of the National Reporting and Learning System (NRLS), the world's most comprehensive database of patient safety information, to identify and tackle important patient safety issues at their root cause. The NRLS does not investigate individual reports but does record public concerns and uses this information to improve safety.

Healthcare organisations should continue to report patient safety incidents to the **NRLS**. Working across sectors, the NHS Commissioning Board Authority will utilise patient safety incident data to analyse risk, drive learning and improve patient safety.

The **Patient Safety website** continues to offer key information, guidance, tools and alerts.

The NHS Serious Incidents Framework, March 2013, is an update to the 2010 National Framework for reporting and learning from Serious Incidents Requiring Investigation, and reflects the new commissioning arrangements. In June 2005, the Department of Health issued new guidance on the independent investigations of serious patient safety incidents in mental health settings. The guidance aimed to help ensure a consistent approach to investigations across the health service and to raise standards.

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45 LEGISLATIVE FRAMEWORK

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

45.1 Legal Context

Local authorities are bound by duties and powers. A **duty** is used to describe responsibilities that legislation makes obligatory, as in 'shall', 'will', 'must'. A **power** is used to describe actions that legislation provides permission to carry out, as in 'may' and 'can'. Where 'you should' or an instruction is used, it is intended to set a clear expectation, but not to create a legal requirement.

45.2 Duty of care

'Duty of Care' can be summarised as "*the obligation to exercise a level of care towards an individual, as is reasonable in all circumstances, by taking into account the potential harm that may reasonably be caused to that individual or his property*". Any failure in the duty of care that results in harm could lead to a claim of negligence and consequent damages.

The duty of care to a person may exist from the moment they are identified for assessment, a task or a service.

The Standard of Care is the test which will be applied in respect to what actions (or omissions) a practitioner took within such a situation. Consequently:

- Always act in the best interest of individuals and others.
- Consider a person's situation with regard to what actions need to be taken to prevent harm occurring, and the potential for harm from any proposed intervention.
- Only act within competence.
- When assessing risks, you must take all reasonable steps to ensure the person's health, safety and wellbeing are balanced with the impact this will have upon the person's quality of life and their capacity to make such decisions for themselves.
- Have regard to the duty not to cause, or fail to prevent, physical or psychological injury.

Therefore, document key decisions and your rationale as these may be subject to later challenge.

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45.3 The Care Act 2014

Following an extensive consultation process the Care Bill received Royal Assent on 15th May 2014. The purpose of the Act is to reform the existing care and support system.

The Care Act 2014 builds on recent reviews and reforms, replacing numerous previous laws, to provide a coherent approach to adult social care in England. Part One of the Act (and its Statutory Guidance) consolidates and modernises the framework of care and support law; it set out new duties for local authorities and partners, and new rights for adults and carers. There are more than 20 sets of regulations supporting the Act, which give more detail on critical requirements, such as assessment processes.

The key elements are:

Wellbeing – The new statutory principle of individual wellbeing underpins the Act, and is the driving force behind care and support.

Prevention – Local authorities (and their partners in health, housing, welfare and employment services) must now take steps to prevent, reduce or delay the need for care and support for all local people (including carers' support needs).

Information and advice – The Act places a duty on local authorities to ensure that information and advice on care and support is available to all as and when they need it. This includes information on how to access independent financial advice, regardless of whether or not a person has eligible support needs.

Independent advocacy must be arranged if a person would experience 'substantial difficulty' in participating in, their assessment and/or the preparation of their care and support plan, and there is no other person who is an appropriate representative.

Carers – The Act recognises carers' vital input and aims to help them maintain their caring role, if they are willing and able to do so, which of course will often help the people they care for to postpone or delay the need for more formal services.

Personalisation – The Act embeds in legislation people's rights to choice, personalised care and support plans, and personal budgets.

Integration – Local authorities must carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services.

Cooperation – There is a general duty to cooperate between the local authority and other organisations which have functions relevant to care and support. This includes a duty on the local authority itself to ensure cooperation between its adult care and support, housing, public health and children's services.

Transitions – The Act requires Children's Services and Adult Services to work together to achieve seamless transitions for young people moving to Adult Social Care services. They must assess a child, young carer or child's carer before they (or

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the child they care for) turn(s) 18, in order to help them plan whether they are likely to have needs once they (or the child they care for) turn(s) 18, and if it will be of 'significant benefit'.

Diverse care markets – Local authorities must promote diversity and quality in the market of care providers so that there are enough high-quality services for people to choose from. Local authorities must also step in to ensure that no vulnerable person is left without the care they need if their service closes due to business failure.

Safeguarding – There is a new statutory framework for safeguarding co-ordination, including the duty for the local authority to carry out enquiries or cause others to where it suspects that an adult is at risk of abuse or neglect past or present and to provide any services specified in a subsequent protection plan regardless of their eligibility status. The local authority must set up a Safeguarding Adults Board on a statutory footing.

Assessment and eligibility – Anybody, including a carer, who appears to need care or support is entitled to an assessment, which must focus on outcomes important to the individual. Any needs currently being met by a carer should still be included in the assessment. The local authority must then apply a national eligibility threshold – set out in Care and Support (Eligibility Criteria) Regulations 2014 – to determine whether the individual has eligible needs.

Duty to meet needs – The local authority must meet eligible needs for care and support not being met by a carer for a person who is ordinarily resident in their area. The local authority must also meet a carer's needs for support if the carer has assessed eligible needs and the person they care for is ordinarily resident in the local authority's area.

Charging and financial assessment – If the type of care being considered is chargeable, then the local authority must carry out a financial assessment to determine how much the person will pay towards the cost of meeting their need for care and support. From April 2015, all councils must offer deferred payments and from 2020, all people with eligible needs will have a care account to set out the notional costs accumulated to date towards their cap on care costs.

Care and support planning – A local authority must help a person decide how their eligible needs will be met through the preparation of a care and support plan, or support plan for carers, and keep it under review generally.

Personal budgets and direct payments – The person's care and support plan or carer's support plan will contain a personal budget which identifies the cost of their care and support. Where a person, including a carer, has a personal budget, they can have a direct payment if certain conditions are met and arrange their own care and support. From 2020, self-funders with eligible needs will have an independent personal budget (IPB) to record the notional cost of meeting their eligible needs.

Continuity – When an individual, and potentially their carer, notifies a local authority they intend to move from one local authority area to another, the second authority must continue to provide services based on the care and support plan provided by the first authority until it has undertaken its own assessment.

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Note that there are a few other provisions which complete the legal framework of the Act, for example:

- changes to ordinary residence – establishing where a person lives and how that affects the responsibilities of local authorities (Sections 39-41) (see **section 45.3.1**)
- cross border placements – the ability to make care home placements in different countries of the UK (Section 39)
- the extension of the Human Rights Act to cover people receiving care and support from a regulated provider that is arranged by their council, whether in a residential setting or at home; however, this provision will not apply to people arranging or paying directly for their own care (Section 73)
- after care services provided under Section 117 of the Mental Health Act 1983 are to meet a need arising from or related to the mental disorder of the person concerned, in order to reduce the likelihood of a deterioration in the person's mental disorder and, accordingly reducing their risk of requiring admission to hospital for treatment (Section 75/S4)
- where it appears that adults in prison or approved premises have needs for care and support, they should have their needs assessed by the local authority and where they meet eligibility criteria, have services provided by the local authority (Section 76)
- a requirement to hold registers of blind and partially sighted people (Section 77)
- delegation of functions – a legal right for councils to contract out mainstream social work functions related to assessment, resource allocation and care and support planning if they so choose (Section 79).

Summary: The Care Act consolidates good practice in statute as well as bringing in new reforms. It should embed and extend personalisation in social care as well as increasing the focus on wellbeing and prevention. It should also enable local authorities and partners to have a wider focus on the whole population in need of care, rather than just those with eligible needs and/or who are state-funded.

Most of the changes take effect from April 2015. However, the major reforms to the way that social care is funded – including the care cap and care account – will not come into operation until 2020.

The legislation which it is planned will be replaced by Orders under the Care Act – either in whole or in part – includes:

- National Assistance Act 1948, which established the Welfare State
- Health Services and Pubic Health Act 1968, which gave local authorities a power to arrange services to promote the welfare of older people
- Local Authority Social Services Act 1970
- Chronically Sick and Disabled Persons Act 1970 (but only repealed for adults), which introduced major reforms, providing entitlement to community services
- Health and Social Services and Social Security Adjudications Act 1983

- Disabled Persons (Services, Consultation and Representation) Act 1986
- NHS and Community Care Act 1990, which ensured that adults had the opportunity to have a needs led assessment and all options for living at home and as independently as possible in the community were exhausted before considering residential or nursing home care
- Carers (Recognition and Services) Act 1995, which required Councils to take account of the sustainability of the caring role when deciding what community care services it is necessary to provide
- Community Care (Direct Payments Act) 1996, which included new powers to make direct payments
- Health and Social Care Act 2001, which extended direct payments for social services users and provided a fairer system of funding for long-term care including measures to reduce the need to sell one's home on entering residential care
- Community Care (Delayed Discharges etc.) Act 2003
- Carers (Equal Opportunities) Act 2004, which extended carers' rights to assessment of their need
- National Health Services Act 2006, which allowed money to be pooled between health bodies and health-related Local Authority services, functions to be delegated and resources and management structures to be integrated

The Act will also revoke secondary legislation and cancel the following statutory guidance:

- Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care (2010)
- Fairer Charging Policies for Home Care and other non-residential Social Services (2013) and LAC (2001)32
- Charging for residential accommodation guidance (CRAG) (2014)
- Guidance on direct payments for community care, services for carers and children's services (2009)
- The Personal Care at Home Act 2010 and Charging for Reablement (LAC (2010)6)
- Identifying the ordinary residence of people in need of community care services (2013)
- Transforming Adult Social Care (LAC (2009)1)
- Guidance on National Assistance Act 1948 (Choice of Accommodation) Directions 1992 and National Assistance (Residential Accommodation) (Additional Payments) Regulations 2001 (LAC (2004)20)
- The Community Care (Delayed Discharges etc.) Act 2003: guidance for implementation (LAC (2003)21)
- Fair Access to Care Services (FACS): guidance on eligibility criteria for adult social care (2002)
- Carers and people with parental responsibility for disabled children (2001)
- No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (2000)
- Caring for people: community care in the next decade and beyond (1990)

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45.3.1 Ordinary Residence

See **section 3.5**.

45.3.2 Property disregards

In the following circumstances the value of the person's *main or only* home must be disregarded:

a. Where the person is receiving care in a setting that is not a care home

b. If the person's stay in a care home is temporary and they:
   - intend to return to that property and that property is still available to them, or
   - are taking reasonable steps to dispose of the property in order to acquire another more suitable property to return to.

c. Where the person no longer occupies the property but it is occupied in part or whole as their main or only home by any of the people listed below, the mandatory disregard only applies where the property has been continuously occupied since before the person went into a care home (for discretionary disregards see below):
   - the person's partner, former partner or civil partner, except where they are estranged
   - a lone parent who is the person's estranged or divorced partner
   - a relative as defined in paragraph 35 of the person or member of the person's family who is:
     - aged 60 or over, or
     - is a child of the resident aged under 18, or
     - is incapacitated.

For the purposes of the disregard a relative is defined as including any of the following:

a. Parent (including an adoptive parent)
b. Parent-in-law
c. Son (including an adoptive son)
d. Son-in-law
e. Daughter (including an adoptive daughter)
f. Daughter-in-law
g. Step-parent
h. Step-son
i. Step-daughter
j. Brother
k. Sister
l. Grandparent
m. Grandchild
n. Uncle
o. Aunt
p. Nephew
q. Niece
r. The spouse, civil partner or unmarried partner of a to k inclusive.

A member of the person's family is defined as someone who is living with the qualifying relative as part of an unmarried couple, married to or in a civil partnership.

For the purposes of the disregard the meaning of 'incapacitated' is not closely defined. However, it will be reasonable to conclude that a relative is incapacitated if either of the following conditions applies:

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a. the relative is receiving one (or more) of the following benefits: incapacity benefit, severe disablement allowance, disability living allowance, personal independence payments, armed forces independence payments, attendance allowance, constant attendance allowance, or a similar benefit; or

b. the relative does not receive any disability related benefit but their degree of incapacity is equivalent to that required to qualify for such a benefit. Medical or other evidence may be needed before a decision is reached.

For the purpose of the property disregard, the meaning of 'occupy' is not closely defined. In most cases it will be obvious whether or not the property is occupied by a qualifying relative as their main or only home. However, there will be some cases where this may not be clear and the local authority should undertake a factual inquiry weighing up all relevant factors in order to reach a decision. An emotional attachment to the property alone is not sufficient for the disregard to apply.

Circumstances where it may be unclear might include where a qualifying relative has to live elsewhere for the purposes of their employment, for example a member of the armed services or the diplomatic service. Whilst they live elsewhere in order to undertake their employment, the property remains their main or only home. Another example may be someone serving a prison sentence. It would not be reasonable to regard the prison as the person's main or only home and they may well intend to return to the property in question at the end of their sentence. In such circumstances the local authority may wish to consider the qualifying relative's length of sentence and the likelihood of them returning to the property. Essentially the qualifying relative is occupying the property but is not physically present.

45.4 Other relevant legislation

Health and Safety Act 1974 – There is a legal duty placed on all employers to ensure, as far as is reasonably practicable, the health, safety and welfare at work of all employees. In addition, there is a duty to protect the health and safety of other people who might be affected, such as people who use services. The Health and Safety Executive endorses a sensible approach to risk, so that health and safety legislation does not prevent reasonable activity.

National Health Service Act 1977 – Schedule 8 identifies the power to provide support for people with alcohol and drug problems.

The Mental Health Act 1983 – If a user of Adult Social Care is exhibiting a high risk of harm to self or others this may mean, but not necessarily, that the MH Act applies. There has to be evidence that the risk behaviour is generated by a mental disorder, as defined in Section 1 of the Mental Health Act[48]. S1 states also that dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the Act. Referrals to AMHP duty for MHA assessments have to be made with these S1 definitions and the Purpose Principle of the MH Act in mind, which

[48] Richard Jones, Mental Health Act Manual, 15th edition p.18-19. This states that: *Mental disorder is defined as 'any disorder or disability of the mind'. A person with a learning disability "shall not be considered by reason of that disability to be 'suffering from mental disorder'…unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part".*

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states that: *"Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm."* (Mental Health Act Code of Practice, p.5.)

Public Health (Control of Disease) Act 1984 ***Section 46*** – places a statutory duty on the Local Authority to arrange for the burial or cremation of the body of any person who has died or been found dead in their area, in any case where it appears to the authority that no suitable arrangements for the disposal of the body have been or are being made other than by the authority.

Disability Discrimination Act 1995 (DDA) – makes it unlawful to discriminate against people in respect of their disabilities in relation to employment, the provision of goods and services, education and transport.
The meaning of Disability, within the Act is: *"Subject to the provisions of Schedule 1, a person has a disability for the purposes of this Act if he has a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities."*
There are further definitions more specifically broken down and categorised within the Act, and further amendments and inclusions have been made within the Disability Discrimination Act 2005. The U.K. Disability Discrimination Act is no longer in use. From 1 October 2010, the Equality Act replaced most of the Disability Discrimination Act (DDA). However, the Disability Equality Duty in the DDA continues to apply.

Human Rights Act 1998 – There is a duty on all public authorities and bodies carrying out functions of a public nature, not to act incompatibly with rights protected under the European Convention of Human Rights (ECHR), and this can extend to a positive duty to protect rights. In this context, where a public authority has, or ought to have, knowledge of an interference with a person's Convention right under a particular article, there is a duty upon them to address the situation as to its propriety and lawfulness. This duty does not apply to private bodies, such as private care homes, when they are not exercising functions of a public nature. When considering risk and the plans for the management of risk, compliance with Articles 5 and 8 of the ECHR, in particular may need careful consideration. Article 5 protects the person from the arbitrary deprivation of their liberty whilst Article 8 concerns the right to respect for private and family life, home and correspondence. Neither are an absolute right and any interference with them must be necessary and proportionate and in accordance with the law.

The **Data Protection Act 1998** (DPA) – establishes a framework of rights and duties which are designed to safeguard personal data. An organisation which collects or holds information about an identifiable living individual or uses, discloses, retains or destroys that information is likely to be processing personal data.

Most of the Act does not apply to domestic use, for example, keeping a personal address book. Anyone holding personal data (information) for other purposes is legally obliged to comply with this Act, subject to some exemptions. The Act defines eight data **protection principles**.

The Data Protection Principles

Everyone responsible for using or processing data (information) has to follow the data protection principles and make sure the information is:

- used fairly and lawfully
- used for limited, specifically stated purposes
- used in a way that is adequate, relevant and not excessive
- accurate
- kept for no longer than is absolutely necessary
- handled according to people's data protection rights
- kept safe and secure
- not transferred outside the UK without adequate protection

Stronger legal controls are required for sensitive personal data (information), such as[49]:

- the racial or ethnic origin of the person
- political opinions
- religious beliefs or other beliefs of a similar nature
- membership of a trade union
- physical or mental health or condition
- sexual life
- the commission or alleged commission of any offence, or
- any proceedings for any offence committed or alleged to have been committed by the person, the disposal of such proceedings or the sentence of any court in such proceedings.

An example of a stronger control is the encryption of emails and mobile devices.

The Conditions for Processing

These are set out in Schedules 2 and 3 of the Data Protection Act. Unless a relevant exemption applies, at least one of the following conditions must be met whenever personal data is processed (see **Data Protection Principles**):

- The individual whom the personal data is about has consented to the processing.
- The processing is necessary in relation to a contract which the individual has entered into; or because the individual has asked for something to be done so they can enter into a contract.
- The processing is necessary because of a legal obligation (except an obligation imposed by a contract).
- The processing is necessary to protect the individual's 'vital interests'. This condition only applies in cases of life or death, such as where an individual's medical history is disclosed to a hospital's A&E department treating them after a serious road accident.
- The processing is necessary for administering justice, or for exercising statutory, governmental, or other public functions.
- The processing is in accordance with the 'legitimate interests' condition.

[49] Information Commissioner's Office (ICO) guidance

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Health Act 1999 – introduced closer partnership initiatives that aim to improve health and reduce health inequalities by working with a community to address the root causes of ill-health and health inequalities.

Care Standards Act 2000 Care Standards Act 2000 (CSA) – provides for the administration of a variety of care institutions, including children's homes, independent hospitals, nursing homes and residential care homes. The CSA, which was enacted in April 2002, replaces the Registered Homes Act 1984 and parts of the Children Act 1989, which pertain to the care or the accommodation of children. The aim of the legislation is to reform the law relating to the inspection and regulation of various care institutions.

Freedom of Information Act 2000 (FOIA)

The main principle behind freedom of information legislation is that people have a right to know about the activities of public authorities, unless there is a good reason for them not to. This is sometimes described as a presumption or assumption in favour of disclosure. The Act is also sometimes described as purpose and applicant blind.

This means that:

- Everybody has a right to access official information. Disclosure of information should be the default – in other words, information should be kept private only when there is a good reason and it is permitted by the Act.
- An applicant (requester) does not need to give the organisation a reason for wanting the information. On the contrary, the organisation must justify refusing them information.
- The organisation must treat all requests for information equally, except under some circumstances relating to vexatious requests and personal data (information). The information someone can get under the Act should not be affected by who they are.
- All requesters should be treated equally, whether they are journalists, local residents, public authority employees, or foreign researchers; and therefore the organisation should only disclose information under the Act if it would disclose it to anyone else who asked. In other words, the organisation should consider any information it releases under the Act as if it were being released to the world at large.

This does not prevent an organisation voluntarily giving information to certain people outside the provisions of the Act with the appropriate management approval.

Recorded information includes printed documents, computer files, letters, emails, photographs, and sound or video recordings.

The Act does not give people access to their own personal information (that is, information about themselves) such as their health records or credit reference file.

The DPA/FOIA give individuals the right to access information, not necessarily the actual records, files or documents.

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Domestic Violence, Crime and Victims Act 2004 – creates an expectation for Local Authority Community Safety Partnerships (CSP) to undertake a multi-agency review following a domestic violence homicide.

The Mental Capacity Act 2005 and the associated Code of Practice provides a statutory framework for how to support people who have difficulty in decision making to make a decision for themselves, how to assess their capacity to do so and how to make a decision in their best interests if they lack capacity to make their own decision.

The Act sets out five principles which must be adhered to when working with people who have difficulty in decision making. Local Authorities are expected to follow these principles carefully during assessment and support planning. See **Section 35 CONSENT AND CAPACITY** and **Section 36 BEST INTERESTS** for discussion of these five principles.

Local Authorities must ensure that a person has support from an Independent Mental Capacity Advocate (IMCA) if they lack capacity to decide on a long-term accommodation move and the person has no family or friends to consult. Local Authorities should also consider where the use of Independent Mental Capacity Advocates (IMCAs) and other advocates – such as dementia advocates or learning disability advocates – might be appropriate to ensure that as far as possible people are supported to be involved in the decision making process if they lack capacity to decide on a protective measure in the Safeguarding Adults process.

If there are concerns about a person's liberty, attention should be given to a deprivation and the Deprivation of Liberty Safeguards with its associated Code of Practice should be considered, bearing in mind the positive duty arising from Article 5. In all cases, the practitioner should follow any local policy/procedure and guidelines on supported decision making. In the event of complex or contentious cases or where a dispute arises, for instance with relatives, the line manager needs to be involved and legal advice obtained. In addition, as required, practitioners need to consult the existing policies on the Court of Protection, Lasting Powers of Attorney and written statements.

The Act also enables people to plan for a time when they may have difficulty decision making.

Disability Discrimination Act 2005 – see Disability Discrimination Act 1995

Equalities Act 2006 – created a duty on public authorities to promote equality of opportunity between men and women, and to prohibit sex discrimination in the exercise of public functions.

Safeguarding Vulnerable Groups Act 2006 establishes the legal basis for the Independent Safeguarding Authority who manages the two lists of people barred from working with children and/or vulnerable adults. The Act also places a statutory duty on all those working with vulnerable groups to register and undergo an advanced vetting process with criminal sanctions for non-compliance.

Mental Health Act 2007 amends the Mental Health Act 1983 and the Mental Capacity Act 2005 by the inclusion of the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards protect the human rights of those who need to be

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detained in a care home or hospital for their own safety. Most of the Act was implemented on 3 November 2008. It introduces significant changes relating to: community treatment; redefining professional roles; defining the 'nearest relative'; defining mental disorder; the criteria for involuntary commitment; Mental Health Review Tribunal (MHRT); and the use of Electroconvulsive Therapy.

Forced Marriage (Civil Protection) Act 2007 was brought into effect to provide civil remedies for those being threatened, or in, forced marriages. The central piece of the Act is the forced marriage order, in which a person threatened with forced marriage can apply to the court for the order. This Act provides for three types of applicant who may apply for a forced marriage protection order. They are the victim, anyone on their behalf with the permission of the court and a relevant third party. A relevant third party may apply on behalf of a victim and does not require the leave of the court. The Lord Chancellor has specified that, once designated, Local Authorities will be able to act as a relevant third party. The court can decide provisions that would be appropriate to prevent the forced marriage from taking place or to protect a victim of forced marriage from its effects. This may include aspects such as confiscation of passport or restricting contact with the victim. The order can extend to prevent any other person who aids, abets or encourages the forced marriage. A person who violates a force marriage order is subject to contempt of court proceedings and may be arrested.

Although there is no specific criminal offence of 'forcing someone to marry' within England and Wales, criminal offences may nevertheless be committed. Perpetrators – usually parents or family members – could be prosecuted for offences including threatening behaviour, assault, kidnap, abduction, theft (of passport), threats to kill, imprisonment and murder. Sexual intercourse without consent is rape, regardless of whether this occurs within a marriage or not. Compelling or facilitating adults at risk who do not have capacity into sexual activity that they could not consent to, is an offence under the **Sexual Offences Act 2003**.

Adults can seek an order for protection from harassment or molestation. Some forced marriages will be legally valid until they are annulled or the court grants a divorce. Others will not be legally valid but may also need to be annulled. There are strict legal requirements that govern whether a marriage is valid under UK law and the rules for recognising a marriage vary depending in which country the marriage took place.

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 requires local authorities to:

- publicise their complaints procedure(s)
- acknowledge receipt of complaints and offer to discuss the matter within three working days
- deal efficiently with complaints and investigate them properly and appropriately; provide a written response to the complainant, outlining how the issue has been resolved, action taken and provision of information that the complainant can now approach the Local Government Ombudsman, should they remain dissatisfied
- provide assistance to the complainant to access the complaints procedure and to understand how it works
- ensure there is a designated manager for complaints

- ensure that there is a senior officer responsible for the complaints policy and learning from complaints
- produce an annual report, stating numbers of complaints received, matters raised, findings and action taken or to be taken to improve service delivery. It must also contain the number of cases referred to the Ombudsman
- ensure that if a complaint involves two or more organisations, the complainant should get a single, coordinated response.

Equality Act 2010 – replaces the previous public sector equality duties – for race, disability and gender. It covers the following characteristics:

age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation and marriage and civil partnership.

The Act has three aims. It requires public bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and people who do not share it, and
- foster good relations between people who share a protected characteristic and people who do not share it.

The Health and Social Care Act 2012 consisted of a plan for the reorganisation of the NHS and elements of adult social care. This included abolition of the primary care trusts and their replacement with Clinical Commissioning Groups (CCGs) and the creation of local authority-based public health duties via new health and wellbeing boards.

45.5 Transition

Various aspects of the transition process from childhood to adult life are covered in particular by both the Care Act 2014 (see **section 45.3**) and the Children and Families Act 2014 amongst other legislation.

The Children Act 2004 – provided the legal underpinning to 'Every Child Matters' introduced new legislation to improve the child protection system.

The Children and Families Act 2014 – Each council is required to publish a 'Local Offer' which includes a full listing of all services available for children and young people aged 0–25 with special educational needs and/or disabilities and their parents. It includes:

- listing of provision both in and out of school
- services and support provided by the private and voluntary sectors as well as the Council and the National Health Service
- information about the arrangements for identifying and assessing children and young people's special educational needs and for requesting an Education, Health and Care (EHC) assessment
- information on how to raise concerns about services

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- information to help parents and young people navigate around the new Special Educational Needs (SEN) arrangements.

Current statements of SEN and Learning Difficulty Assessments will be replaced with an EHC plan during 2014-16.

An important principle of the new Act is to ensure that parents and young people themselves are fully involved at every stage.

Each school publishes their own school offer for children with special educational needs and disabilities. The purpose of the local offer is to improve choice for families by providing a comprehensive guide to information and support.

A joint assessment is designed to ensure that parents and young people only have to 'tell their story' once and that assessment focuses on the outcomes that children and young people wish to achieve together with identifying the support needed to do this. All new assessments now follow the single assessment process.

45.5.1 The Children and Families Act and the Care Act side by side

What the law says:

Outcomes and Wellbeing	
Children and Families Act	**Care Act**
Outcome focus.	Outcome focus.
Preparing for Adulthood outcomes from Year 9 – including: ➢ Employment ➢ Health ➢ Independent living ➢ Friends, relationships and community participation. Focus on choice and control over support for young people and their families. Focus on the importance of wellbeing – the involvement of parents and young people in decision making.	Duty to promote wellbeing, including: a) Control by the individual over day to day life (including over care and support, or support, provided to the individual and the way in which it is provided) b) Participation in work, education, training or recreation c) Social and economic factors d) Domestic, family and personal relationships e) Suitability of living accommodation f) The individual's contribution to society.
Must have regard to the wellbeing duty in the Care Act when providing support to parent carers.	Care and support works to actively promote people's wellbeing and independence, rather than waiting for people to reach a crisis point.
Duty to ensure integration of services across education, where it promotes the wellbeing or improves the special educational provision that is available.	Duty to provide or arrange for the provision of services, health and care, in particular facilities or resources that contribute towards preventing or delaying the development of care and support needs.
	When promoting individual wellbeing the local authority must have regard to

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	the importance of achieving a balance between the individual's wellbeing and that of any friends or relatives who are involved in caring for the individual.

Assessment and Planning	
Children and Families Act	**Care Act**
Single, co-ordinated assessment process.	Duty to carry out an assessment for young people over 18.
Single Education, Health and Care plan for young people with SEN, which can potentially continue up to the age 25. Emphasis on person-centred practice.	Duty to produce a Care and Support plan for anyone over 18 where eligible needs are identified. Duty to carry out a Child's Needs Assessment (CNA) if there are likely to be care and support needs post-18.
Children and young people are engaged, empowered and supported to participate in planning for their future.	Duty to carry out a CNA at a time when it is of significant benefit to the young person's preparation for adulthood.
Focus on preparation for adulthood from Year 9 at the latest.	CNA can be requested by young people or parents at any age.
Duty to assess a parent carer or young carer if it appears they may have needs for support, or if they request an assessment, where the local authority is satisfied that they may provide or arrange for the provision of services under section 17 of the Children Act 1989.	Adult Need's Assessments carried out for individuals over the age of 18 must include a Personal Budget. Duty to carry out a Child's Carer's Needs Assessment where there is 'likely need' for support post-18 and when it is of 'significant benefit'.
Parent carers' needs assessment must have regard to: ➢ the wellbeing of the parent carer ➢ the need to safeguard and promote the welfare of the disabled child cared for, and any other child for whom the parent carer has parental responsibility.	A Carer's Assessment must include an assessment of: ➢ whether the carer is able, and is likely to continue to be able, to provide care and whether the carer is willing to do so; ➢ the outcomes that the carer wishes to achieve in day-to-day life ➢ whether, and if so to what extent, the provision of support could contribute to the achievement of outcomes.
Young carers' needs assessment must have regard to: ➢ the extent to which the young carer is participating in or wishes to participate in education, training or recreation, and ➢ the extent to which the young carer works or wishes to work.	

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45.6 Housing Legislation

Local Government and Housing Act 1989 (DFG) – amended by the Housing, Grants, Construction and Regeneration Act 1996 (see below)

Housing, Grants, Construction and Regeneration Act 1996 – revised Local Government and Housing Act 1989 and is the current housing adaptations legislation.

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46 GLOSSARY

Note: If printed, this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line versions.

Abuse – Violation of an individual's human or civil rights by any other person or persons. Any or all types of abuse may be perpetrated as the result of deliberate intent, negligence or ignorance. Different types of abuse include physical; neglect/acts of omission; financial/ material; psychological; sexual; institutional; discriminatory; self harm/abuse; racial; or any combination of these or other factors. Abuse also has a number of specific legal definitions contained in various acts of parliament.

Accessible Transport Services (ATS) handles requests for Parking Badges (Blue and Purple), Freedom Passes, Taxicards, and Personalised Parking Bays for disabled people (of all ages) within statutory guidelines.

Activities of Daily Living (ADL) – Tasks that people carry out to look after their home, themselves, and their participation in work, social and leisure activities.

Acute Care – Short-term medical treatment, usually in a hospital, for patients with an acute illness or injury or recovering from surgery.

Adult – any person aged 18 years or over.

An **adult at risk** is a person over 18 years of age who is or may be in need of care and support services by reason of mental health, age or illness, and who is or may be unable to take care of themselves, or protect themselves against significant harm or exploitation.

Adult Social Care – Care and support for adults who need extra help to manage their lives and be independent, including older people, people with a disability or long-term illness, people with mental health problems, and carers.

Advocacy – Any action or service which: supports, encourages or helps to represent individuals; helps them to understand and communicate their views, needs or rights.

A&E – Accident and Emergency

Agency – Any vetted organisation contracted by the Council to provide home care services to its residents commissioned directly by purchasers employed in the Council.

Appointee – Some people need help with claiming benefit because they are unable to manage their own affairs. This could be because they do not have the mental

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capacity to make the decision or they are severely disabled. If so, another person – called an appointee – can be given the legal right to act for them.

Appropriate individual – Someone who facilitates a person's involvement with the key care and support planning (or safeguarding) processes, if that person has substantial difficulty in being involved.

Approved Mental Health Professional (AMHP) – An appropriately qualified and competent professional with specialist training in mental health who is approved under the Mental Health Act 1983 and acts independently but on behalf of the Local Authority. AMHPs are responsible for assessing mental health persons and making decisions relating to their detention and treatment under the Mental Health Act 1983. Professionals qualified to train as AMHPs include social workers, psychiatric nurses, clinical psychologists and occupational therapists.

Assessment – The process whereby the care and support needs of an adult or support needs of a carer are identified alongside their impact on independence, daily functioning and quality of life so that appropriate care, health or other support can be planned. It aims to identify and explore the many aspects of a person's needs and identify their desired outcomes. It should be proportionate, self-contained and time-limited. Where support might be required from more than one agency, multi-agency assessments may be undertaken.

Assistive Technology (AT) – Technology or equipment used by a person to enable or promote her/him to live independently. It allows people to perform tasks which they would otherwise be unable to do, or increases the ease or safety with which the task can be performed. Telecare is an example of Assistive Technology.

ASWs – **Approved Social Workers** – See **Approved Mental Health Professional** (AMHP) above.

Assistant Social Workers are non-social-work-qualified staff who can assess less complex social care needs**.**

ATS – see **Accessible Transport Services**

Attorney and Deputy – An Attorney is someone who the person appoints by completing a legally binding Lasting Power of Attorney document (LPA). There are two types of LPA. One is over the person's property and financial affairs and gives the attorney the right to make property and financial decisions (including signing or giving up a tenancy), normally even when the person has capacity to make their own decision. The other is over health and welfare and gives the attorney the power to make a health or welfare decision if the person lacks capacity to make it themselves. The **Mental Capacity Act 2005** gives the **Court of Protection** the authority to appoint a person (a **Deputy**) to make decisions about someone's financial affairs, or (in exceptional circumstances) their health and welfare, if they lack capacity to make one or more of their own financial or welfare decisions, and have not made a Lasting Power of Attorney.

Authorised person – Someone who agrees to manage a direct payment for a person who lacks capacity, and meets the specified conditions.

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BAME – black, Asian and minority ethnic

A **Best interests decision** is a decision made on behalf of someone who does not have the mental capacity to make their own decision about a particular course of action at a particular time and which is taken to give the optimal outcome for the person concerned.

BME – black and minority ethnic

Broker / Brokerage – An individual or organisation that can help a person arrange the support they need. Brokerage can be done by the Council, a voluntary organisation, a private company or an individual such as a family member or friend.

Budget Allocation – see **Personal Budget**.

Capacity to consent – Whether a person can make a decision to agree to (or refuse) a treatment, or course of action affecting them. This involves the ability to sufficiently understand and retain information about their condition. Capacity applies to each decision and is not a one-off judgment. The Mental Capacity Act offers guidance on this and assumes a person has capacity unless proven otherwise.

Capital limits – Determines the extent to which a person with eligible needs could be charged for care and support in relation to their savings and other forms of assets. See upper and lower capital limits. Between the upper and lower capital limits means tested support is available.

Care account – From 2020 everyone with assessed eligible needs will be entitled to a care account, which will keep track of what a person has accrued towards the cap on care costs.

Care and support – The mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent, including older people, people with a disability or long-term illness, people with mental health problems, and carers. It could include residential care, home care, personal assistants, day services, or the provision of aids and adaptations.

Care and support plan – A written plan after a person has had an assessment, setting out what their care and support needs are, how they will be met, and what support they will receive.

Care cap – A limit on the eligible care costs which a person pays over their lifetime. From 2020 this will be set at £72,000 for those over retirement age. How a person progresses towards the cap will be based on what the cost of meeting their assessed eligible needs would be to the local authority.

Care Funding Calculator (CFC) – a tool to support local councils, health trusts and other public bodies across England and Wales to deliver care services efficiently. It has a similar purpose to a price comparison website, but for social care services. It is used by social care practitioners and people who commission social care services to understand the cost of a person's care package. The practitioner inputs the person's daily support needs into the calculator, and based on a range of market costs, it

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works out a cost range, from which the local authrolity can negotiate a fair price for the package.

Care Home – see **Residential care**.

Care pathway – An individual's route from first contact with a service to the last contact.

Care Programme Approach (CPA) – The name for the assessment and care planning process in mental health services. Care planning meetings involving the person are called CPA meetings.

Care Quality Commission (CQC) – The health and social care regulator for England. CQC looks at the 'joined up picture' of health and social care and promotes the rights and interests of people who use the services. It is an independent body which bases its actions on high quality evidence. Its work brings together independent regulation of health, mental health and adult social care.

Carer refers to a person who is unpaid and often a relative or friend who supports a person with care and support needs, either full-time or part-time who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability. A **young carer** is someone who is under the age of 18 and may be looking after his/her parents, brother or sister, grandparent or other relative who needs support. Paid workers, including personal assistants, whose job title may be 'carer', are usually called 'care workers' or 'support workers'.

Carer's assessment – Identifies support needs and outcomes that the carer wishes to achieve in their day-to-day life, whether those needs are eligible for support from the local authority, and how provision of support may assist the carer in achieving their desired outcomes.

Carers' Services are provided to support carers in their caring role and to give them a life outside of caring, for example, by supporting them to keep their job, have a hobby or relax and take time out from their caring role. Sometimes, so that the carer may pursue a life outside of their caring role, it is necessary to provide replacement care for the person whom the carer supports. It is important to remember that replacement care services are chargeable services to the person who receives care.

Care worker – Somebody who under formal arrangements provides support or who looks after a person who needs help because of their age, physical or mental illness, or disability. This would usually include someone paid or employed to carry out that role, or someone who is a volunteer.

CAS – see **Community Alarm Service**.

Chargeable Services – Adult social care services that the Council is allowed to charge for by government legislation. Government legislation may specify whether local authorities are allowed to charge for a service, and if so, how much they are allowed to charge.

Child or young person – Anyone under the age of 18 years.

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Child or young person in transition – Anyone who is likely to have needs for adult care and support after turning 18.

Choice of accommodation – Where a person is receiving local authority support and the care and support planning process has identified their needs are best met in a specific type of accommodation, this provision provides the person with a choice of where they live. It is not a choice between different types of support, for example, a care home or shared lives, but between different providers of the same type.

Clinical Commissioning Groups (CCGs) – Groups of GP Practices that are responsible for commissioning most health and care services for patients. They are responsible for implementing the commissioning roles as set out in the Health and Social Care Act 2012.

Commissioning – The process by which organisations assess the needs of their local population for care and support services, determining what element of this needs to be arranged by the organisation, then designing, delivering, monitoring and evaluating those services to ensure appropriate outcomes.

Community Alarm Service (CAS) – Electronic Alarms (sometimes referred to as Telecare) installed in persons' homes, which are connected to the alarm service staff. The alarms are to be used by persons in an emergency. CAS can hold keys for people who have nobody else to act as key-holders for them.

Complaint – People have a right to complain about a service where they think they have been unfairly treated, or have received unsatisfactory services.

Concern is a concern that an adult at risk is or may be a victim of abuse or neglect. A concern may be a result of a disclosure, an incident, or other signs or indicators.

Consent is the voluntary and continuing permission of the person to the intervention based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it.

Consultation provides an opportunity for people to express their views and opinions about a service area in a constructive manner.

Continuing care is care that is provided over an extended period of time to an individual aged over 18 to meet their physical or mental health needs which have arisen as a result of disability, accident or illness. They may require services from NHS bodies and/or local authorities. Both NHS bodies and local authorities therefore have a responsibility to ensure that the assessment of eligibility for, and provision of, continuing care, takes place in a timely and consistent fashion. Where an individual is eligible for NHS **Continuing Healthcare** (CHC), it is the responsibility of the NHS body to provide appropriate services to meet those needs. It is awarded depending on whether a person's primary need is a health need. It can be provided in a range of settings, including an NHS hospital, a care home or someone's own home. However, this does not prevent a Local Authority from providing further services, as it sees fit.

Continuity of care – Arrangements in place which ensure any health, care and support arrangement/ intervention is carried out in such a way as to ensure the least

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disruption to the adult/patient. This term is often used when considering the impact certain service interfaces can have on a care pathway.

Co-production – The process of designing public services together with people, not just for people.

Court of Protection – Specialist Court for issues relating to people who lack capacity to make a decision on the matter in question. The Court can make a decision or appoint a Deputy (see **Deputy**) in the person's best interests.

CQC – see **Care Quality Commission**

Day Opportunities help individuals to make the most of their day. In the past, giving adult with eligible needs the chance to socialise and engage in arranged activities would probably have been provided through day centres. However, many individuals have said they prefer to make use of mainstream resources and opportunities so that now support planning helps them to choose how they wish to spend their day and give them the necessary support to achieve this.

Deferred payment agreement (DPA) – People entering residential care can defer paying for their care costs, meaning that they should not have to sell their home during their lifetime. A deferred payment agreement enables a local authority to reclaim care costs through the sale of the person's property (or other security) at a later date.

Delayed Transfer of Care is an experience of an inpatient in hospital who is ready to move onto the next stage of their care journey/ pathway but is prevented due to wider health and care system delays.

Deputy – The Mental Capacity Act 2005 gives the Court of Protection the authority to appoint a person (a **Deputy**) to make decisions about someone's financial affairs, or (in exceptional circumstances) their health and welfare, if they lack capacity to make one or more of their own financial or welfare decisions, and have not made a Lasting Power of Attorney.

Deprivation of liberty – Restriction of a person's liberty to the extent that they may be deprived of their liberty, when the provisions of the Mental Capacity Act 2005 must be applied.

Deprivation of Liberty Safeguards ensure that the human rights are met for those who cannot consent to being in a care home or hospital for their own safety in circumstances which may amount to deprivation of liberty.

DFG – Disabled Facilities Grant

DH – Department of Health

Direct Payments are cash payments made directly to eligible individuals who choose to make their own care arrangements, rather than receiving services provided by the local authority. Direct Payments are one way individuals can choose to manage a personal budget. They provide greater choice and control.

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Disability – The Disability Discrimination Acts (1995 and 2005) define a disabled person as 'someone who has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities'. Groups of people with disabilities include people with mental health issues, those with physical limitations and those with learning disabilities. The social model of disability starts from a different perspective. It is not concerned with how 'bad' a person's impairment is. Instead it establishes that everyone is equal and demonstrates that it is society which restricts their opportunities and erects barriers that prevent disabled people from participating fully.

Disposable income allowance – In a deferred payment agreement, the amount of income a local authority must leave the deferred payment holder with (unless the deferred payment holder decides to retain less than the allowance).

Discretionary Services are services which local authorities are not required to provide by law. They are also sometimes referred to as non-statutory services.

Disregard – In a financial assessment, income and capital must be disregarded (ignored) in certain circumstances.

Diversity – The concept of diversity encompasses acceptance and respect. It means understanding that each individual is unique, and recognises individual differences. These can be along the dimensions of race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies.

DLA – Disability Living Allowance

DoLS – see **Deprivation of Liberty Safeguards**

Domiciliary Care (also known as Home Care) can help people with personal care and some of the practical household tasks that help them to stay at home and be as independent as possible.

DWP – Department of Work and Pensions

Education, Health and Care plan (EHC) – Based on an assessment of the child's needs in education, health and care, an EHC plan will replace a statement of Special Educational Needs (SEN) from September 2014.

EDSW – Emergency Duty Social Worker.

EDT – Emergency Duty Team. The Out-of-Hours social worker and manager covering from 5.00 pm to 9.00 am on weekdays and all Saturday, Sunday and Bank Holidays.

Eligible needs – Needs for care and support which result in an adult being unable to achieve specified outcomes and as a consequence there is or is likely to be a significant impact on the person's wellbeing.

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Eligibility Criteria – The Care and Support (Eligibility Criteria) Regulations 2014 set out the national criteria for eligibility for adult social care for both adults with care and support needs and for carers.

An **enquiry** is a one off interaction between a member of staff and a member of the public or a professional from another organisation, usually involving a request for information, and which does not lead to further action from Adult Social Care.

See also **safeguarding enquiry**

EPA – Enduring power of attorney; apply to decisions about property and affairs. Now replaced by **Lasting Power of Attorney**, but all existing EPAs continue to be made effective under the same basis as they were made.

Equity limit – The maximum equity available in a deferred payment agreement from a person's chosen form of security.

Extra Care Housing is housing designed with the needs of frailer older people in mind and with varying levels of care and support available on site. People who live in such housing have their own self-contained homes, their own front doors and a legal right to occupy the property.

Failed Visit – Where the purpose of the visit is not achieved because although the staff member knows that the person is there, the person refuses access and/or the service or family member or carer gives an explanation as to the person's whereabouts. This includes planned or agreed visits by the care manager or other essential service providers.

Fair Access to Care Services (FACS) were guidelines on how councils should determine whether a person was eligible for adult social care services. They have been superseded by the Care and Support (Eligibility Criteria) Regulations 2014 which set out the criteria for eligibility for both adults/carers.

Fairer Charging refers to Government guidelines on how local authorities charge for non-residential care services.

Fairer Contributions refers to the guidelines/process used by the Council to ensure that individuals only pay what they can afford to pay for non-residential care services.

A **Financial Assessment** is the process which the Council undertakes to determine the level of contribution the individual needs to make to their personal budget (if any).

Financial information and advice – A broad spectrum of services whose purpose is to help people plan, prepare and pay for their care costs.

FP – Freedom Pass

Funded Nursing Care (FNC) is the portion of care provided to people in a care home or nursing home which is assessed as requiring qualified nursing support.

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A **Full Cost Payer** is a person who has had an assessment and has been deemed to be eligible for services, but at full cost. Compare with **self-funder**.

GP – General Practitioner

Health and Wellbeing Board – The forum where key leaders from the health and care system work together to improve the health and wellbeing outcomes of their local population and reduce health inequalities.

Here to Help is the Royal Borough of Kensington & Chelsea's first point of call for telephone enquiries.

HIV – Human Immuno-deficiency Virus

Home Care – see Domiciliary Care.

The **Home Treatment Team** is a crisis team for older adults, which is aimed at supporting older adults with complex mental health problems in a crisis in the community and to prevent admission to mental health hospital where possible.

HSWT – Hospital Social Work Team

I&A – Information and Assessment

IMCAs (independent mental capacity advocates) – Workers whom services provide to ensure an additional safeguard for people who are subject to the Mental Capacity Act. They are specialist advocates who are trained to work within the framework of the Act. IMCAs are a legal safeguard for people who lack the capacity to make a decision about where they live or about serious medical treatment and have no family or friends the decision-maker can consult. IMCAs can also be instructed in Safeguarding cases even if family and friends are involved.

Independent advocate – Someone appointed by the local authority to support and represent a person who has substantial difficulty in being involved with the key care and support planning (or safeguarding) processes, where no appropriate individual is able to do so.

Independent Sector – Includes both private and voluntary social care providers, who may be contracted to provide services on behalf of statutory agencies.

Indicative Personal Budget – see **Personal Budget**.

Individual service fund (ISF) – Third-party provider arranges care and support on a person's behalf in line with their wishes.

Information and advice – Knowledge and facts regarding care and support, and helping a person to identify choices and/or providing a recommendation regarding a course of action in relation to care and support.

Informed consent is consent to treatment or care where a person has been given enough objective, evidence-based information to be able to make their own decision, and the person has the capacity to make that decision.

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Integration – Involves joined up, coordinated health and social care that is planned and organised around the needs and preferences of the individual, their carer and family. This may also involve working with other services, for example, housing.

Intermediate Care – A generic term that covers a wide range of services which help prevent unnecessary admission to hospital, or which help facilitate early discharge.

Joint health and wellbeing strategy – A plan, based on evidence from the Joint Strategic Needs Assessment, which sets out how they will address health and wellbeing needs/ outcomes of the local population.

Joint strategic needs assessment (JSNA) – A process which identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness.

Key Worker – A person responsible for working closely with people who use services to ensure the coordination of their care and support plan and act as the main contact for everyone involved.

Lack of capacity – As defined in the Mental Capacity Act 2005 as: *"a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.."*

A **Lasting Power of Attorney** (**LPA**) – An Attorney is someone who the person appoints via completing a legally binding Lasting Power of Attorney document (LPA). There are two types of LPA. One is over the person's property and financial affairs and gives the attorney the right to make property and financial decisions (including signing or giving up a tenancy), normally even when the person has capacity to make their own decision. The other is over health and welfare and gives the attorney the power to make a health or welfare decision if the person lacks capacity to make it themselves. The **Mental Capacity Act 2005** gives the **Court of Protection** the authority to appoint a person (a **Deputy**) to make decisions about someone's financial affairs, or (in exceptional circumstances) their health and welfare, if they lack capacity to make one or more of their own financial or welfare decisions, and have not made a Lasting Power of Attorney.

LD – see **Learning Disability**

Lead Professional (sometimes referred to as a key worker) – Coordinates the transition process. They act as a single point of contact for a child and their family when a range of services are involved and an integrated response is required.

Learning Disability – For someone to be defined as having a **learning disability**, there needs to be a *"significant reduced ability to understand new or complex information, to learn new skills with a reduced ability to cope independently and which started before adulthood with a lasting effect on development"*.[50]

[50] Department of Health, Valuing People (2001)

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Legal mortgage charge – An entry on the Land Registry against a person's property which indicates that the property has been used to secure a deferred payment agreement.

A caller has a **legitimate interest** if they are a professional involved in the care of the named person, or if they care for the named person, or if they are a friend or relative with concerns about the named person.

LGBT is an acronym used to refer collectively to lesbian, gay, bisexual and transgender people.

Market oversight – A regime to oversee the financial stability of the most hard-to-replace care providers and to ensure people's care is not interrupted if any of these providers fail.

Market shaping – Local Authorities with their partners are expected to have an understanding of demand and supply for well-being, health and social care services. They are expected to intervene accordingly to ensure the right services are in situ for the specified population.

MDT – see **Multi-disciplinary team**.

Means-tested Contributions are based on a calculation which determines how much individuals pay towards the costs of their social care services. This calculation is based on the information provided in the Financial Assessment and the total is determined by looking at a person's financial circumstances, (for example, what income they have, if they have any assets such as their own home).

Mental capacity is the ability to make a decision about a particular matter at the time the decision needs to be made. See **Section 35 CONSENT AND CAPACITY**.

Mental health – The World Health Organization defines mental health as *"a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"*. It was previously stated that there was no 'official' definition of mental health. There are different types of mental health problems, some of which are common, such as depression and anxiety disorders, and some not so common, such as schizophrenia and bipolar disorder.

MH – Moving and Handling

Minimum income guarantee – When an adult contributes towards their care and support they must still be left with a certain amount of money for themselves after the local authority has charged them. The minimum income guarantee is the minimum amount of income a person must be left with after charging in all settings except a care home. The amounts are set out in regulations and are based on income support, plus any relevant premiums plus 25%.

Multi-disciplinary team – A team of people with different roles or functions within the same organisation or across sectors; for example, doctors, social workers and therapists.

Multi-disciplinary working describes the joint working of people with different roles or functions within the same organisation or across sectors; for example, doctors, social workers and therapists.

National eligibility threshold – the level at which a person's needs for care and support, or for support in the case of a carer, reach the point where the local authority must ensure they are met.

NFA – No Further Action is required.

Next of Kin (NOK) – Nearest relative or person appointed by the individual.

Nominated person – Someone who agrees to manage a direct payment on behalf of the person with care needs.

Non-chargeable Services – adult social care services which the council is not allowed to charge for by government legislation. Also see **Chargeable Services**.

Non-statutory services – See **Discretionary Services**.

No Reply – Where there is no access or contact with the person at a planned or agreed visit. This includes planned or agreed visits by the care manager or other essential service providers.

Open case – A case currently being worked on by Adult Social Care.

Ordinary residence – Identifies where responsibility lies between authorities for the funding and/or provision of care for people aged 18 and over who are assessed as needing social care services.

Occupational Therapist (**OT)** – Professional whose specialist training equips them to work with people with a physical disability, learning disability/difficulty or mental health needs. They help people learn new skills or recover lost skills, and may arrange for special equipment or adaptations to accommodation.

OTA – occupational therapy assistant

Outcomes are aspects of quality of life which contribute to a person's wellbeing.

PA – see **Personal Assistant**

Partnership – A joint working arrangement where the partners: are otherwise independent bodies; agree to co-operate to achieve a common goal; create a new organisational structure or process to achieve this goal; plan and implement a joint programme; share information, risks and rewards.

The **Person Index (PI)** is the RBKC central index holding basic details of individuals and others known to adults' and children's social care. It holds their core demographic data, i.e. name, address, date of birth, etc. It also holds a complete allocation history across adults' and children's services for a person, but it does not hold any confidential case information. It sits on top of our other systems.

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Personal Assistant (PA) is a person employed to help someone with their daily social care in a way that is right for them. Using their **Personal Budgets**, a person can employ a Personal Assistant to provide support like: cooking, cleaning, help with personal care like washing and using the toilet, driving or help with getting around, medical tasks, shopping, banking or paying bills.

A **Personal Budget** is the amount of money (if any) that the Council determines is necessary to cover the cost of services to meet the person's needs and to help achieve the person's desired outcomes. People can take their Personal Budget as a direct payment (choosing themselves how their care needs are met and by whom), ask the Council to commission the services on their behalf, or elect to have some combination of the two.

The **indicative personal budget** is the amount calculated to meet the needs identified in the assessment; the **agreed personal budget** is the amount agreed to fund the agreed support plan.

Personal Expenses Allowance – When an adult contributes towards the cost of their care and support they must still be left with a certain amount of money for themselves after the local authority has charged them. The PEA is the minimum amount of income a person must be left with in a care home. The amount is set out in regulations.

Personal Independence Payment (PIP) – A new benefit that replaces the DLA.

Personalisation covers the whole process of giving more choice and control to individuals through the use of personalised budgets. It is support that fits around the person rather than a person having to fit around the support that is available.

Person-centred approach – Seeks to involve the person and ensure they can engage as fully as possible. The local authority must take a person-centred approach throughout the assessment and care and support planning processes, and in all other contact with the person (such as a review of their care and support package).

PIP – see **Personal Independence Payment**

Pooled budget – An arrangement where two or more partners make financial contributions to a single fund to achieve specified and mutually agreed aims. It is a single budget, managed by a single host with a formal partnership or joint funding agreement that sets out aims, accountabilities and responsibilities.

Power of Attorney (POA) – see **Lasting Power of Attorney**.

Pre-screener is a form used by the Community Team for People with a Learning Disability to respond quickly to a referral.

Preventative service – An early intervention or activity that supports a person to retain or regain their skills or confidence: a service that prevents a need for care and support occurring, reduces an existing need or delays further deterioration.

Principal Social Workers – Previously called senior practitioners

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Proportionality – Taking a sensible and flexible approach that is to a level of detail necessary to understand the person's needs.

Provider of Care Services – An independent or statutory organisation that may provide a whole range of care services.

Public interest – A decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

Purchaser of Care Services may be the Local Authority or individuals with their own private financial means or direct payments who purchase care services for others or themselves.

Reablement is the process of helping a person regain confidence and the ability to carry out activities of daily living and self-care for themselves, in order to restore or improve their level of independence and reduce the need for long-term support, following a crisis in their lives (for example, being in hospital). Reablement is usually an intervention of up to six weeks, but can be longer in certain circumstances – for example, for 12 weeks following a stroke. Reablement is free of charge for the first six weeks to all those who are eligible for adult social care.

Referral to Adult Social Care – A request for action from Adult Social Care on behalf of a specific person who has social care needs who is either not known to the department or whose case has been closed, which is accepted by a member of staff as requiring further action. A referral can be made by anyone, either for themselves or on behalf of another person. A referral can be made by phone by letter, in person, or by email. Giving general advice is not a referral. An agreed transfer of responsibility for a case from one team in Adult Social Care to another is not a referral.

Rehabilitation Work is done to assist someone regain skills they may have lost through illness or disability. It helps them re-learn to do things they could previously do for themselves.

Residential accommodation may take the form of either a nursing or a care home that provides 24-hour care to individuals who have been assessed as no longer being able to be supported at home. Residential accommodation can be either long or short stay.

Resource Allocation System (RAS) is a system by which a Council may determine an up-front indicative allocation of money which it determines may be required to meet the person's needs before support planning takes place. This amount may be adjusted following the development of the support plan.

Respite Services are services giving carers a break from their caring responsibilities by providing short term care to the cared-for-person in their own home or in a residential setting.

A **Review** is an examination of an individual's needs and services contained in their outcomes focussed support plan undertaken at regular intervals at or by a predetermined date. It is a reassessment of the person's needs together with a

systematic evaluation of the extent to which the support plan is meeting the stated objectives, whether the desired outcomes have been achieved and whether the plan needs to be adapted to respond to changes in needs or circumstances or service criteria. A review can take many forms, including face-to-face, by post, or by telephone.

Risk Assessment is the assessment of a person's health, their safety, wellbeing and their ability to manage essential daily routines and the impact this has on the individual, their carers and staff.

Safeguarding Adults is the process of ensuring that an adult (or adults) are not being, or are not at risk of being abused, neglected or exploited. Although the Local Authority takes the lead on adult safeguarding, the responsibility for safeguarding adults lies with every agency.

Safeguarding Adults Board (**SAB)** oversees local policy and practice for safeguarding adults at risk.

A **safeguarding enquiry** is the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under Section 42, right through to a much more formal multi-agency plan or course of action.

Self-directed support is the mechanism and framework through which greater choice and control for the person is being delivered. It is a process led as far as possible by the person with social care needs and their family and friends, working in partnership with professionals.

A **Self-funder** is a person who has sufficient funds to organise and pay for their own care. Some people choose to organise their own care because they prefer not to be financially assessed.

Service-led approach is an approach which tends to fit the needs of individuals into already existing services, whereas under the Care Act, support planning should focus on meeting a person's needs and delivering agreed outcomes.

Signposting – Pointing people in the direction of information that they should find useful.

Social Care – Any form of support or help given to someone to assist them in taking their place in society.

Social Care Coordinators are non-social-work-qualified staff who are able to assess less complex social care needs.

Social Services Line (SSL) – The main contact point for Adult Social Care in RBKC. It deals with calls for social services and it is open during office hours only.

Social Workers help protect vulnerable adults and children from abuse and help people to live more successfully within their local communities by helping them find

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solutions to their problems. To succeed, social workers must work not only with people who use services, but also with their families, neighbours and friends as well as with other organisations such as the police, the NHS and schools. The title 'social worker' has been protected by law in England since 1 April 2005 and all social workers are required to maintain registration on the Social Care Register.

SSL – see **Social Services Line**

Stakeholders – People or organisations, which have an interest in a proposed development or idea.

Strengths-based approach – Focuses on the person's strengths and abilities. This means thinking positively about people with needs for care and support, and also engaging the community to reduce isolation and bring those with needs for care and support more closely into community networks. The strengths-based approach is about reducing dependency and challenging the 'prescription culture' but is also, crucially, about protecting the person's independence, resilience, choice and wellbeing.

Substantial difficulty – The Care Act defines four areas in any one of which a person might have substantial difficulty in being involved in the care and support planning, or safeguarding, processes. This includes substantial difficulty in understanding relevant information, retaining that information, using or weighing that information, and communicating the individual's views, wishes or feelings (whether by talking, using sign language or any other means).

A '**suitable person**' to receive direct payments on an adult's behalf is:

- a 'representative' – someone is a representative if they are an attorney or deputy
- a 'surrogate' – someone is a surrogate if they are an attorney or deputy whose powers include decisions about securing the provision of community care services
- someone else if a surrogate (if there is one) agrees and if the responsible authority considers them to be a suitable person. The LA would also have to consult others and be sure the suitable person would act in the individual's best interests and is capable of managing the direct payment and that it is appropriate for them to do so, before the duty to provide a direct payment would arise.

A **Support Plan** lays out in detail how a carer's personal budget will be used to support them to continue in their caring role.

Supported decision making – An individual may lack capacity to request an assessment or lack capacity to express their needs. The local authority must in these situations carry out supported decision making, supporting the adult to be as involved as possible in the assessment, and must carry out a capacity assessment and take "best interests" decisions.

Supported Self Assessment – Individuals will be able to have as much say in their assessment and support planning as they are able. Some may be able to complete a

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self assessment entirely by themselves, or with help from others, and some people may want social care staff to support them to complete it.

Tariff income – A means to work out what a person can afford to contribute from their assets between the lower and upper capital limits. It assumes that for every £250 worth of assets the person has above the lower capital limit they can afford to pay £1 per week towards the cost of their care and support.

Telecare is equipment, which helps to keep people safe in their own homes, using sensors such as fall detectors and personal pendants linked to a monitoring and response centre. See also **Community Alarm Service**.

Top-up fee – Payment for additional costs of residential care over and above what the local authority will pay for so that the individual can secure the care and support of their choice.

A **transfer** is an agreed shift in responsibility for a case from one team in Adult Social Care to another (such a move is not to be termed a referral).

Transition describes the process of moving from childhood into adult life. If children receiving Children's Services are likely to have care and support needs when they are 18, they will need to make a transition to Adults' Services.

A **trusted assessor** is an assessor who is able to carry out both assessments within their professional training and assessments for which they have been skilled for low level needs outside their professional area – for example, social workers or assistant social workers who have been trained to assess for simple equipment, or OTs who have been trained to assess for social care needs.

Universal services – Services, such as transport, leisure, health and education that should be available to everyone in a local area and are not dependent on assessment or eligibility.

User Involvement – Working in a way to ensure individuals have a say in their care and support or about a service as a whole – for example, setting up user groups to get their views on how services are developed in the future.

User-led services are services which are designed and managed by people who receive services.

Virtual wards – Use the systems and staffing of a hospital ward, but without the physical building; they provide preventative care for people with long-term health conditions in their own homes and reduce the need for hospital admissions.

Vital interest – A term used in the Data Protection Act 1998 to permit sharing of information where it is critical to prevent serious harm or distress or in life-threatening situations.

Wellbeing – A broad concept underlying the Care Act, which is described as relating to the following areas in particular: personal dignity (including treatment of the individual with respect); physical and mental health and emotional wellbeing; protection from abuse and neglect; control by the individual over day-to-day life

(including over care and support provided and the way it is provided); participation in work, education, training or recreation; social and economic wellbeing; domestic, family and personal relationships; suitability of living accommodation; the individual's contribution to society.

Young carer – see **Carer**

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