Leicester
City Council

Supported Assessment Questionnaire
Staff Guidance

July 2015

Written by

FOREWORD

The demand for social care is increasing as people's needs are becoming more complex and challenging and expectations are rising. As resources are pressured, assessments can become focused on managing access to existing services. For a sustainable future, we need to use high quality assessments to help people find solutions to their problems, enabling them to become active participants in their care rather than passive recipients.

The Care Act 2014 has brought into effect some key legislative changes in the way that Local Authorities carry out their assessments and it was recognised that the assessment tool would need to change in order to assist staff and customers to embed these changes into practice.

The Self-Assessment Questionnaire (SAQ) has been amended to ensure that it is Care Act compliant. This guidance replaces that issued in January 2013

A Care Act Compliance Group was set up, comprising staff representatives from care management, commissioning and finance, to develop the SAQ so that it continues to be a tool that works in practice for individuals needing support and for assessors. The revised SAQ reflects legislative changes but also takes account of previous feedback from staff and customers.

Adult Social Care (ASC) is experiencing a period of unprecedented financial austerity and a change in legislation that will impact on service users and carers. The challenges that result from these changes make it paramount that the assessment process is properly focused, robust, accurately reflects need and that eligibility criteria is applied consistently and fairly across all areas.

The legal imperative to meet assessed eligible needs and the commitment to the Personalisation agenda remains unchanged, but there is a clear expectation on all Councils that needs are met in the most cost effective way. This is everyone's responsibility and at times will undoubtedly present uncomfortable challenges. However, if we are clear with service users that assessed eligible need will continue to be met, and if we are transparent and open about our processes, this should alleviate some of the concern

An accurate Resource Allocation System (RAS) is dependent upon a thorough assessment of need and the proposed changes to the SAQ, along with a consistent management approach to agreeing eligibility decisions, will result in customers receiving a fair outcome. It will also help ASC to ensure that we continue to have the resources required to meet all eligible needs in the future.

Ruth Lake – Director of Adult Social Care and Safeguarding

SECTION 1
Key Changes to the SAQ

1.1 Advocacy

The Care Act brings in a legal requirement to ensure that where a person has substantial difficulty in understanding the process an advocate is considered. This applies at any time throughout the assessment process, from initial contact to support planning and review.
Substantial difficulty relates to:-

- Understanding the information provided
- Retaining the information
- Using or weighing up the information as part of the process of being involved
- Communicating their views, wishes or feelings.

If a person has difficulty in any of these areas a worker must find someone "appropriate and independent" to support and represent the person. This may be a friend or family member, if they are willing and able to do so, and felt to be appropriate by the person and the Local Authority. Where there is no one deemed appropriate, an independent advocate must be appointed by The Local Authority.

1.2 Provision of Information

The Care Act requires that the Local Authority provide people with information and advice regarding the assessment process and all available services within the area they live. Where appropriate, and if desired, people should have a list of assessment questions available to them before the assessment visit so that they are able to prepare.

1.3 Supported Self-Assessment

A person who has capacity must be offered a supported self-assessment. Where able, the person may complete their own assessment and send this back. At this point the worker must ensure that the assessment is an accurate and complete reflection of the person's needs and outcomes. The right for a person to send through their own completed assessment in no way changes the duty of the Local Authority to determine eligibility.

It is essential that all the information is verified through contact with other professionals involved in a person's care and any informal support. A consent form must be sent to the person with the assessment and returned signed so that this follow up work can be completed.

Following contact with other professionals, a follow up visit must always be carried out to discuss the assessment with the person and agree eligibility.

This visit is not to recomplete the whole assessment but to ensure that the information is correct and the person fully understands the outcomes and eligibility decision.

If a person would like a supported self-assessment, it is important to agree timescales for this to be returned. As a guide, it is considered reasonable for a timescale of up to

4 weeks to be given. If these timescales are not met a follow up contact needs to be made. It is essential that a case is not closed due to unreturned assessments.
It is also important that the person knows that they can change their mind and request an assessment visit once they receive the assessment if they choose.

1.4 Specialist Assessments and MDT

There is a requirement that all assessments are carried out by staff qualified to do so. For example, when completing an assessment for a person with a diagnosis of Autism, it is important to have an understanding of how the condition affects the person. It is expected that a specialist will be involved to inform the assessment when required, this may be the GP or a Community Nurse actively involved in the person's life.
It is expected that assessments are proportionate and evidence based and other professionals should be involved in any assessments taking place where appropriate.
Carrying out an assessment for a deafblind person is a specialist area and a referral through to the specialist assessor should be made to complete this task.

1.5 Frequencies

The wording of the responses, including frequencies, is representative and therefore needs to genuinely reflect the underlying need. It is essential that the assessment process is undertaken robustly with an accurate recording of need. Manipulating the responses in the SAQ with the intention of maximising the amount of the indicative RAS leaves the Council exposed to legal challenge and will compromise the integrity of reviews of the SAQ / RAS. When Managers authorise an assessment and sign off a Support Plan they are confirming that the assessment reflects need accurately and that the support plan appropriately meets the outcomes identified within the assessment.

1.6 Fluctuating Needs

Responding appropriately to service users who have fluctuating needs has always presented challenges to assessment processes and effective support provision irrespective of the assessment tool. The management of fluctuating needs ultimately involves the application of professional judgement and there is not a "one size fits all" solution.

In most instances, fluctuating needs are the result of changes associated with chronic, enduring or degenerative medical conditions. In view of this it is essential that the assessment includes evidence of discussion with involved health practitioners e.g. GPs, CPNs, Community Matrons etc. It is also important to involve paid/unpaid carers who can contribute valuable information and to ensure that the completed assessment accurately reflects health and social care needs.

The gathering of information during the assessment will be underpinned by the need to understand the following 3 parameters, to enable the assessor to get as accurate a picture as possible of a person's overall needs:

- frequency with which the variation in need arises
- duration of the changes in need
- predictability of the changes in need.

It is not appropriate to base the assessment of needs solely on a service user's 'bad day' or solely on a 'good day'. Either of the following two methods can be adopted to help ensure that a person's fluctuating needs are appropriately assessed:

1) Averaging Out the Level of Need on a Single Assessment

The frequency with which support is required and the number of hours of support that are required can be averaged out over a relevant period, to enable the appropriate response to be selected.

2) Multiple Assessments & Support Plans

Where a person's needs fluctuate on a predictable basis, for example where needs are lower during term time, two separate assessments could be undertaken. This would result in 2 separate RAS allocations and support plans.

Only one support plan can be activated on the Liquid Logic system at one time, support plans are also used to pay the provider and it is therefore essential that only one support plan is open at any one time. There will therefore be a need to close a support plan and open the applicable support plan at the appropriate time. The information can be brought forward from previous support plans.

The SAQ will need to clearly evidence in the Supporting Information, the reasons why that level of support has been selected.

It may be necessary for a person with fluctuating needs to have more frequent reassessments. The four week review will be crucial to ensure the Personal Budget is adequate to meet the assessed eligible needs. There is also a convincing argument to be made about undertaking timely reviews on these cases to ensure that the level of Personal Budget continues to be appropriate.

1.7 Wellbeing and Prevention Principle

The Care Act introduces a legal requirement to promote the wellbeing of people throughout the assessment process. This principle has been considered throughout the SAQ and ensures that people's wellbeing is taken into account. It is essential that all needs are considered, whether eligible or not, and that outcome focused assessments are completed. In practice, it is important to ensure whilst completing the assessment that people are asked what outcome they hope to achieve and that this is recorded. Options need to be considered as to how these outcomes can be best achieved through preventative measures, e.g. information and advice, signposting, referral through to community support groups or informal carers as well as considering areas of assistive technology that could prevent a deterioration in need. It is essential that prevention is considered at all stages of the assessment to promote the independence and wellbeing of the person and also reducing the risk that an ineligible need will become an eligible adult social care need.

1.8 Identification of Eligible and Ineligible Needs

A short section of narrative is included at the top of each question to help clarify its scope. Any lists of typical needs included within these sections are not intended to be exhaustive, but rather to act as an initial prompt and for guidance.

If eligible social care needs are identified in the SAQ, then the support plan must show how these needs and associated outcomes are going to be met. The level of need should be accurately recorded and not elevated within the assessment above that which is genuinely the case (for whatever reason e.g. to generate a bigger RAS), and nor should any eligible social care needs remain unmet once identified.

With the introduction of The Care Act it is also essential that any need, whether eligible for Adult Social Care support or not is identified and an outcome recorded. Where a person has only ineligible needs identified it is a requirement that information and advice is provided and recorded as an outcome. Where both eligible and ineligible needs are identified it is essential that all needs are identified on the person's Support Plan and outcomes are recorded for all ineligible and eligible needs.

The Care Act promotes and encourages a flexible and creative approach to assessment, considering outcome focused support and ensuring that the wellbeing of people is considered throughout the process. As well as giving choice and control to customers, outcomes must correlate to all needs identified within the SAQ regardless of the eligibility. It is important to remain clear about the identification of eligible social care needs, rather than wants and aspirations and to manage expectations of customers, carers and other professionals in an open and transparent manner.

Where there is a difference of opinion between the customer and worker, this should be recorded, but it is important to note that it is the worker view that prevails.

Assessors and those involved in support planning and brokerage need to be mindful of this and in signing off support plans, Team Leaders will be confirming that the support plan appropriately meets the needs and outcomes identified.

It is essential that the assessment clearly identifies a person's needs without any support from a carer and reflects separately what support they get so that if there was a crisis involving any informal care it would be clear what a person's needs were without the need for a re-assessment to be completed.

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 it should be recorded where this is the case.

1.9 Risk

Assessment of risk is a central part of Adult Social Care interventions. Within this context, positive risk taking should be employed. Risk can only ever be minimised, never completely eliminated, and provided due process has been followed in terms of a robust assessment (to include capacity / best interest assessments where indicated), "anticipatory" or "what if" support provision, not based on evidenced need, must be carefully considered in terms of eligibility. When identifying the level of support that is required, the focus should center on reducing risk factors to an acceptable level, rather than endeavouring to eliminate all risk. It might be that a level of risk remains, but that this is not sufficient to represent an eligible need. Usage of Assistive Technology and signposting to community support should be considered in all instances to manage risk.

1.10 Eligibility

The SAQ has a single box for an overall eligibility decision, rather than a separate one for each of the domains. It is important to be clear that eligibility is the result of professional judgement, based on a thorough assessment of need and not the product of the RAS calculator.

The SAQ and RAS are often referred to as one, and it is important to separate the two. Whilst the RAS is an important tool in the development of someone's Personal Budget, it is the responses and information in the SAQ that determine eligibility. If the assessment is robustly completed, the RAS is more likely to generate an accurate indicative budget.

1.11 Service Users Declining Support

If a service user declines an element of support following the completion of an assessment that identifies eligible needs, then managerial advice should be sought relating to risk and vulnerability. The assessment should remain as it is. However, if only partial support is to be provided, the RAS will have over-allocated. In these circumstances, there is a clear expectation that the support will be arranged for less than the indicative RAS. Clear recording will be required in these circumstances to evidence the decision making rationale.

SECTION 2
Specific Question Guidance

2.1 Question 1 – Autonomy

- This question is not about whether a person actually makes decisions or not, but rather about the ability of the individual to do so, and the level of support they need to be able to do this independently. For example, a service user's relative may make decisions on their behalf, but this does not mean that the individual necessarily requires support in decision making. A service user might *prefer* for another to make decisions on their behalf, but would be fully able to do so themselves. In these instances, the assessment should indicate that the person does not need any support with making decisions.

- Consideration should be given to the completion of a Mental Capacity Assessment to assist and support the conclusions and recommendations where there is concern relating to specific decision making.

- It is important to distinguish between day-to-day decisions rather than 'important' decisions. It is acknowledged that this is a subjective professional judgement and as such it is important to link to risks and impacts that will help to determine eligibility.

- Adequate supporting information should be included to inform and assist in eligibility decisions.

- There is an expectation that risks and their impact are identified within the supporting Information free text box.

2.2 Question 2 – Support With Personal Care

- It is important to pay particular attention to the frequencies when undertaking the assessment, as the point's allocation for each response has been developed based on the stated frequency.

- Reablement and/or Occupational Therapy assessment, as well as Assistive Technology, should be routinely considered in terms of maximising independence and limiting the need for on-going support provision.

- If support is required 3 or 4 times a day, it is important to consider whether it is appropriate for Community Health Services to be involved in the care provision, or whether a CHC Checklist needs to be completed.

- It is essential that outcomes the person wants to achieve is recorded and that all needs are recorded in the summary, these would include both eligible and ineligible needs.

2.3 Question 3 – Support With Practical Domestic Tasks

- If the SAQ identifies that a person has a need for support with practical domestic tasks, but *either* the service user already has arrangements in place, *or* could reasonably be expected to make such arrangements for meeting these needs, provided due consideration is given to the service user's means, the service user should ordinarily be assessed as getting enough of the support needed.

- If the SAQ identifies an eligible need requiring the provision of support, there is an expectation that a number of domestic tasks should be carried out at the same time, thus reducing the need for multiple calls per week, and this should be discussed with the service user at the point of completing the assessment.

- In all but exceptional circumstances, service users should not require routine domestic support (comprising shopping, pension collection,) more than once a week, totalling 1-2 hours. It should be noted that this is a guide only and it is acknowledged that there will always be exceptions which will need to be discussed with a manager.

- The need for support with washing up dishes, laundry, essential cleaning and putting bins out should be considered alongside the need for support with meal preparation or personal care rather than as a practical / domestic task.

- It is important to remember that if an eligible social care need is identified within the SAQ, there is a duty to meet that need. There is a need to manage expectations and historical practice around this area and distinguish between a need and want. There is also a need to ensure that all community resources and informal support networks have been utilised before commissioning a service to meet that need.

2.4 Question 4 – Meals & Nutrition

- When considering eligibility for support with meals and nutrition, if the service user already has arrangements in place, *or* could reasonably be expected to make such arrangements for meeting these needs, provided due consideration is given to the service user's means, they should ordinarily be assessed as getting enough of the support needed. This should include discussion with the service user about the options to obtain meals from within the local community.

- The support required to prepare main meals, snacks and drinks is separate from the support required to actually eat food and to drink.

- There is an assumption that if a service user is receiving support with meals and nutrition then assistance is likely to be required with washing up dishes and an allocation for this is contained within the meal preparation part of this question.

- A person who 'always needs support to get a hot meal, drinks and snacks' is one who is unable to reheat a pre-cooked/ready meal in a microwave or cooker, or who is unable to meet the requirement for meals in other ways, such as obtaining a meal from within the local community.

- The response "I occasionally need support" relates to individuals who have fluctuating needs, where the person does not consistently need support. This may also apply where a person is more able in the morning to manage independently but becomes less able as they become more tired and their condition deteriorates.

- Assistive technology, equipment and informal support networks to meet these needs must have been ruled out before the need is identified on the assessment.

- The response 'always need support with eating and drinking' should be used for individuals who need to be fed, and in these instances it is a requirement to complete a CHC checklist to rule out a primary health need. Prompting and encouragement may involve a small amount of feeding, but to a large extent the expectation is that the person would principally feed themselves.

- As with the note on preparing main meals, in most cases, a service user is likely to always require support/prompting or require no support to eat and drink. The response "I occasionally need support" relates to individuals who have fluctuating needs, where the person does not consistently need support. It is not anticipated that many service users will fall into this category.

2.5 Question 5 – Friends & Social Involvement

- The introductory paragraph to this section includes examples of ways in which a person's social inclusion needs may be met.

- Professional judgement needs to be applied in terms of what is "reasonable" and there should not be an expectation that Adult Social Care will be responsible for all aspects of a person's social inclusion. The identified need should relate to risks and the impacts of those risks. The impact to the person's well-being and the outcome they wish to achieve should also be considered and recorded.

- It is an important part of the assessment process to consider universal services and local community resources and how these might contribute to meeting social inclusion needs.

- The SAQ should identify all outcomes that the person wishes to achieve but distinguish between eligible and ineligible needs. It is essential that wants and aspirations are not used to identify eligible social care needs.

2.6 Question 6 – Access to Voluntary or Paid Work, Education & Learning

- When identifying the amount of support that is being provided by others (including friends and family) consideration also needs to be given as to whether educational establishments or the employer provides, or might provide, support not funded by ASC, and include this within the level of support provided by others.

- This question is not about a person's aspiration to undertake work or learning (although this should be recorded and service user outcomes recorded as encouragement and information and advice to signpost may be required). The assessment should also identify where on-going support is required and work/learning is being undertaken or where this will start imminently.

- Where a person has clearly different needs during different times of the year (e.g. term-time and non-term time), then either 2 separate assessments can be undertaken or the average weekly number of hours can be calculated and used on a single assessment. For example, if 7 hours of support per week are required during term time (representing, for example, 38 weeks of the year) and 0 hours support are required during non-term time (representing 14 weeks of the year), then this would equal an average of 5.1 hours per week over the course of a year. The appropriate response would therefore be "I need support for between 4 and 7 hours per week". The length of term time included above is only indicative, and may need to be adjusted in each case.

2.7 Question 7 – Transport

- The need for transport should only be identified in the SAQ where a service user is unable to travel independently, having taken account of the extent to which needs are already being met, or could reasonably be met independently of ASC. The ability of friends and family to meet needs should be thoroughly explored as part of the assessment, as should voluntary driver options and the independent arranging of a taxi by the service user, provided due consideration is given to their individual circumstances.

- It is important to remember that ASC will only fund transport relating to an assessed eligible social care need. If a service user does not have an assessed need for social inclusion, ASC will not ordinarily be responsible for their transport needs. However, there are always exceptions to the rule and any such cases should be considered on a case-by-case basis.

- ASC should not be providing transport for medical appointments, Health Day Support or other non-eligible transport related needs.

- If a person is in receipt of DLA Mobility Component, then it is appropriate to *consider* whether this could be used to fund the transport need. However, this cannot be assumed, or applied as a blanket policy, as it may be that there are

other demands upon the DLA, which if not taken into account could result in the Council being in breach of s.2(1)(d) CSDPA 1970. Case-by- case decision making is required here, with legal advice being sought, where required.

- Specialised vehicles, such as those with a tail lift, would only be appropriate once all other options have been exhausted and require authorisation at Head of Service level.

- The need for an escort relates to service users who require another person (other than the driver) with them whilst travelling, predominantly as a result of risky behaviour whilst travelling or serious health conditions that pose an unpredictable risk, and should not be used purely when requiring support to get into / out of transport.

- Occasional or anticipatory transport requirements should be considered as they arise and not included as an on-going need.

2.8 Question 8 – Being a Parent or Family Carer

- This question relates to caring responsibilities for children within the service user's family unit. The question does not relate to support for older or disabled family members. If it is considered that community care needs exist, a separate assessment of need should be completed for the family member and the service user themselves may be entitled to a Carer's Assessment.

- This is a challenging area, as it is often difficult to separate out the needs relating to adults and children. There is no "one size fits all" approach and it will often be necessary to liaise and negotiate with Children's Services to reach agreement on a way forward.

- It is important to manage expectations in this area and the narrative at the start of the question should assist with this. Staff also need to be mindful about potential child welfare concerns and respond to these appropriately.

- Where the need for support in being a parent varies throughout the year (e.g. during term time and non-term time) then the number of hours of support required should be averaged. For example, if 7 hours of support per week are required during non-term time (representing 14 weeks of the year) and 0 hours support are required during term time (representing 38 weeks of the year), then this would equal an average of 1.9 hours per week over the course of a year. The appropriate response would therefore be "I need support for up to 4 hours per week". The length of term time included above is only indicative, and may need to be adjusted in each case.

2.9 Question 9 – Staying Safe From Harm

- This question relies heavily on professional judgement. In terms of general guidance, although frequency is important, it is the level of risk and associated impacts that will be the main factor to consider when completing this section.

- Adequate Supporting information should be included to inform and assist in eligibility decisions.

2.10 Question 10 – Prevention

- This question is critical in ensuring that the person's circumstances and needs are considered and any risks of deterioration are identified and preventative measures are considered.
- In order to prevent the need for Adult Social Care services, maximise a person's independence and promote their well-being being creative when thinking about prevention is critical.
- Preventative measures may include referring to health services for ongoing support, providing information about community and voluntary services, referral through to organisations for housing or benefit advice or providing assistive technology.
- It is essential that advice is given to people, where possible, of any actions that they can take independently to prevent any deterioration in their circumstances.

2.11 Question 11 – Quality of Life Question

- It is essential that Councils are able to collect information about outcomes for service users in order to ensure a quality of service and improved outcomes for people. This information is gathered by asking how people currently feel their Quality of Life has improved based on the support, or services that they have received from the Local Authority. This support may be signposting or reablement and does not purely mean providing a commissioned service.

2.12 Question 12 – Existing Carer Support

- This question focusses on whether or not the carer can continue to provide the current level of support relating to each of the 9 main questions within the SAQ. Looking at each domain separately enables a more accurate resource allocation to be generated.

- The responses to this question impact significantly on the indicative Resource Allocation and it is crucial that this is completed accurately, taking into account the revised focus of the question.

- It is necessary to ensure that any carer under 18 is identified and therefore this question is mandatory.

2.13 Contingency Section

- It is essential when completing an assessment that contingency plans are considered in case the current arrangements for providing support are unable to continue.

- It is important that Carers and Adults with support needs have information on where to access support and that they consider the level of risk and vulnerability if the arrangements were to break down; if the Carer was unable to continue for any reason, e.g. health.

- A contingency plan should be clearly recorded in the assessment. A contingency plan should highlight high risk areas for the cared for person and how this would be managed in the absence of informal support networks. Some of the questions that need to be considered and recorded are;
  - Can the cared for person raise an alarm if they need support?
  - Does the cared for person have other people visiting them to identify if there are any sudden changes in their care?
  - Does the Carer have other people around them who can is aware of their caring role and access support for the cared for person if the Carer is unable to

2.14 Decision and Summary

Under the Care Act it is essential that where a person is not eligible for support any outcomes they identified during the assessment are still recorded and information is provided about support in the community.

Where a person is eligible for support, the support plan will enable both eligible and ineligible needs to be recorded as well as any information provided. However if there are no eligible needs the ineligible needs can be provided on the assessment and sent out to the person.