

Devon Social Services Directorate

Care Management - A Differentiated Approach

1. Introduction and Purpose

1.1 General

The primary purpose of this policy framework and practice guidance is as follows:

- ◆ To describe the key principles of the differentiated approach to Care Management and the key policy changes.
- ◆ To describe the new Care Management process and the practice principles.
- ◆ To describe the new model of Care Management.
- ◆ To describe the method of delivering the new approach.

This is set within the Government's policy and legislative requirements and the Directorate's policies and planning framework for Community Care and Children and Families Services.

This policy will be refined and developed over time reflecting the changing national agenda and practice experience.

1.2 The Case for Revision

The need for a revision of Devon Social Services' approach to Care Management developed from the findings of national and local research, Department of Health Guidance and consultation with users, carers and staff groups.

The "*Cornerstone of Care*" report found that most SSDs did not differentiate levels of Care Management sufficiently and had major problems in managing the volume of work.

"SSDs should differentiate between the co-ordinating and intensive types of Care Management. They should ensure the latter is limited to those who need it." Cornerstone of Care, Department of Health 1997.

At a local level, an extensive audit of Care Management arrangements and performance was undertaken in 1996 by the Devon Social Services Performance Review Team. Key findings from the audit included the following:

- ◆ The sharp increase in demand for services had resulted in Districts experiencing difficulty in meeting agreed targets and quality standards.
- ◆ The Directorate's approach, whereby all service users had a named care manager, did not adequately differentiate between high volume, relatively straight forward work and the lower volume, more complex and intensive work. Effective targeting of Care Management intervention was not being achieved.
- ◆ There was some evidence of user dissatisfaction with Devon's approach to Care Management, in particular, lengthening delays and waiting lists. User groups reported wanting more opportunities to exercise control over their care packages.
- ◆ There was some staff dissatisfaction as the tension between increasing levels of demand and meeting performance targets increased.

1.3 Summary of New Model

The new model of Care Management challenges traditional ideas, such as the notions that all service users require a named allocated worker and that all assessments or reviews must be undertaken face to face.

The policy describes a differentiated approach to Care Management in which there will be three new categories of Care Management support:

Personal Care Management	For those people who are assessed as needing a named allocated worker to support the safe and effective co-ordination and implementation of their Care Plans.
Care Co-ordination	For those people who are assessed as needing the intermittent support of the Help Desk service in managing their care needs and services.
Self Care Management	For people who are assessed as being able to manage their own care needs and services.

There will also be a differentiated approach to assessment, Care Planning and review processes.

The method of delivering the new model of Care Management will be through the development of new Help Desk and Personal Care Management service teams for both Children & Families Services and Community Care Services within each locality.

The Help Desk will be the public face of the Directorate. It will provide the initial point of contact for the public and other agencies in each locality, in terms of information, advice and assessment. In addition, it will be the ongoing point of contact for people being supported through Care Co-ordination and Self Care Management.

The Personal Care Management service will provide ongoing case management support to people who have been assessed as requiring a named allocated worker to ensure the safe and effective, co-ordination and implementation of their Care Plan. Also, in Community Care only, this service will undertake all Level 3 assessments.

1.4 Summary of Key Policy Changes

The key policy changes are:

- ◆ Not all service users require a named allocated worker.
- ◆ Everyone in receipt of on-going services organised by Devon Social Services requires a Care Plan.
- ◆ Different levels of assessment, Care Planning and reviews which reflect the complexity of the situation.
- ◆ The active involvement of service users and carers in the Care Management process.
- ◆ Carers may have a separate or joint (with cared for person) assessment of their needs.
- ◆ Collaboration with other agencies in the Care Management process.
- ◆ Accredited providers may be commissioned to undertake Care Management activity within agreed and defined circumstances.
- ◆ Accredited providers will have access to key information derived from the Care Management process.

1.5 Key Principles of the Differentiated Approach to Care Management

The overarching principle is that people can be supported in different ways according to their level of needs and risk.

The following principles underpin the differentiated approach:

- ◆ Ensuring **equality of opportunity and access** for service users and carers.
- ◆ **Working in partnership** with users and carers in a way that is respectful and open and takes account of their ethnic, religious and cultural needs.
- ◆ **Recognising and building on the strengths of users and carers**, and supporting them to resolve their needs themselves wherever possible and appropriate.
- ◆ The **provision of quality information and advice** to enable people to make informed choices about the resolution of their care needs.
- ◆ A **needs based approach**, the level of intervention and involvement being based on the service user's and carer's needs and identified risks.
- ◆ **A model which is transferable to a multi-agency/multi-disciplinary approach.**
- ◆ An **evidence based approach** that places emphasis on measuring the outcome of interventions.
- ◆ **Effective use of resources.**
- ◆ A **dynamic process** enabling service users to move between the three pathways of Care Management, for example, from Personal Care Management to Care Co-ordination to Self Care Management.
- ◆ **Continuous improvement**, evaluation and audit of Care Management processes.
- ◆ **All information will be treated in a confidential manner, taking account of our partner agencies confidentiality procedures.**

1.6 Who is the Policy For?

The policy is for all commissioning and provider staff within the Directorate, including support staff, who are involved with the Care Management processes. Staff in partner agencies and independent providers will need to be familiar with the changes described in this guidance.

2. The Care Management Process

2.1 Introduction

The following section describes the stages of the Care Management process and the practice principles that support this. For the purpose of this document, some of the Care Management stages have been integrated to reflect the practice process.

The differentiated approach is underpinned by a recognition that Care Management is a process that promotes and facilitates good practice. It must not be seen as a bureaucratic or administrative system.

2.2 Information, Contacts and Referrals

Description:

Information The provision of high quality and accessible information is a key feature of the new differentiated approach to Care Management. The Directorate is currently developing its information strategy to reflect the importance of information as a preventative tool.

The two following definitions are provided to describe the parameters of the initial points of contact with the Directorate.

Contacts *Those people who make contact with the Directorate who are not eligible for, or require, an assessment of their needs. They may be people seeking advice or information or require re-direction to another service.*

Such contacts will be recorded on a contact sheet, but this will not include people who call in to pick up a leaflet or who are redirected by reception.

Referrals *Those people whom at the point of contact present as being eligible for an assessment of their needs.*

Referrals will be recorded on a referral form, which incorporates a Level 1 screening assessment.

Practice Principles – Referrals:

The following principles underpin referral taking:

- ◆ Referrals are normally taken by a designated referral co-ordinator.
- ◆ Referral information will be collected in a structured format and will be recorded in a clear and concise way.
- ◆ Core referral information must be sufficient to inform a judgement about what action should follow.
- ◆ Such information will not normally be requested more than once.
- ◆ Referrals will be responded to in a timely manner and in accordance with the Care Management quality standards.
- ◆ The referring person will be advised of the outcome of the referral in accordance with Care Management quality standards.

2.2 Assessment**Description:**

Assessment and re-assessments are the process of gathering information for determining a person's needs and eligibility for services. There will be different levels of assessment dependent on presenting levels of need and risk.

Assessments and re-assessments may be simple, complex, specialist or multi-disciplinary.

"The assessment function should be as simple, speedy and informal as possible. This means that procedures should be based on the principle of what is the least that it is necessary to know, to understand the needs being presented and to justify the investment of public resources." (Care Management and Assessment – Department of Health 1991.)

If circumstances change before the scheduled review date then a re-assessment of need must be undertaken (see Section 2.4, page 8).

Practice Principles - Assessments:

The following principles underpin assessment practice:

- ◆ A seamless process, not a single, one-off event.
- ◆ Clear statements for users/carers about what information is required and why.

- ◆ Service users and carers will normally be actively involved and their views must be evidenced.
- ◆ Providers and other agencies may contribute to, or be commissioned to undertake, assessments.
- ◆ The type of Care Management will be determined by the assessment outcome.
- ◆ A supervisor will always determine the assessment outcome based on the practitioner's recommendation.
- ◆ A named, allocated worker with appropriate skills, from either the Help Desk or Personal Care Management service team, will undertake all assessments beyond the initial screening stage as follows:
 - Community Care: Level 2 – Help Desk service
 Level 3 – Personal Care Management service
 - Children & Families: All Core Assessments – Help Desk service
- ◆ Assessments are needs led and holistic, the level, scope and format based on the service users/carers needs and risks presented. Negotiation with service user/carers should take place where considered to be appropriate. (See Appendix A and Appendix C).
- ◆ **A copy of the assessment /assessment summary will normally be given to service users, carers, service providers and other involved agencies.**

Criteria:

See Appendix A (Community Care) and Appendix B (Children & Families).

2.3 Care Planning

Description:

A Care Plan is based on a service user's assessed needs and describes how these needs will be met. There will be different Care Plan formats dependent on levels of need and risk.

A Care Plan identifies needs, specifies desired outcomes (for example, what a Care Plan is to achieve) and describes actions and services required.

Practice Principles - Care Planning:

The following principles underpin care-planning practice:

- ◆ All people who are receiving continuing services organised by Devon Social Services will have a Care Plan.
- ◆ The complexity of need and the level of risks will determine the scope and format of the Care Plan.
- ◆ Service users and carers will normally be actively involved and their views must be evidenced.
- ◆ Providers and other agencies may contribute to, or be commissioned to write, Care Plans.
- ◆ Care Plans for people in the categories of Care Co-ordination and Self Care Management will be co-ordinated through the Help Desk service, and may be monitored and reviewed either by the Help Desk service, other agencies or service provider staff.
- ◆ Care Plans for people in the Personal Care Management service will be monitored by the named, allocated worker.
- ◆ **A copy of the Care Plan will normally be given to service users, carers, service providers and other involved agencies.**

2.4 Reviews

Description:

Reviews are a re-examination of a service user's needs, whether desired outcomes have been achieved and an evaluation of the appropriateness of services.

They are undertaken at, or by, a predetermined date. There are different types of reviews dependent on levels of need and risks.

If circumstances change before the scheduled review date then a re-assessment of need must be undertaken. Minor variations to care packages can be agreed without review activity.

Practice Principles - Reviews:

The following principles underpin review practice:

- ◆ The level, scope and format of reviews will be set down in the Care Plan and determined by the category of Care Management, levels of needs and risks. Negotiation with service users and carers should take place where considered to be appropriate. (See Appendix C.)
- ◆ Service users and carers will normally be actively involved and their views must be evidenced.
- ◆ Providers and other agency staff may contribute to, or be commissioned to undertake, reviews.
- ◆ Reviews for people in Care Co-ordination and Self Care Management will be undertaken by the nominated worker within the Help Desk service. These reviews may be face to face, telephone or written reviews.
- ◆ Reviews for people within the Personal Care Management service will be undertaken by the named, allocated worker and will be face to face.
- ◆ Reviews will be at least once a year (or more frequently if required by legislation, Devon Social Services policy or quality standards).
- ◆ Following reviews, if the indicators for Care Co-ordination or Self Care Management are met, service users in Personal Care Management will be transferred to the Help Desk service for monitoring and review.
- ◆ If reviews of people in Care Co-ordination or Self Care Management identify significant changes then a re-assessment of needs will take place.
- ◆ **A copy of the review outcome will normally be given to service users, carers, service providers and involved other agencies.**

Criteria:

See Appendix C.

3. The New Model of Care Management

3.1 Introduction

The following section describes the new Care Management pathways of Care Co-ordination, Self Care Management and Personal Care Management. It sets out the criteria for these categories and examples of when they may be used.

The new model of Care Management challenges traditional ideas, such as the notions that all service users require a named, allocated worker and that all assessments or reviews must be undertaken face to face.

It recognises the potential ability of users and carers to take responsibility for managing their care, dependent on the level and complexity of their needs.

It gives priority to the provision of information as a preventative resource.

The judgement about which level of Care Management is required will be based on the assessment outcome and the criteria for the new categories of Care Management. (See Appendix D.)

3.2 Care Co-ordination (CC)

Description:

Care Co-ordination is used when people are assessed as needing the intermittent support of the Help Desk service to manage their care needs and services. It provides a co-ordinating and reviewing function for service users, carers, providers and other agencies.

It is important to recognise that Care Co-ordination can be undertaken on a time limited or long term basis to reflect changing needs over time.

Principles:

- ◆ There is no named allocated worker. Any contact regarding Care Plans and changes in needs will initially take place with the Help Desk service.
- ◆ Service providers will monitor Care Plans and liaise with the Help Desk service as required.
- ◆ Reviews/re-assessments may be face to face, telephone or written, dependent on needs.
- ◆ Following review, individuals may move from Care Co-ordination to either Personal Care Management or Self Care Management, or exit from Care Management.
- ◆ Any changes required to a Care Plan must be within agreed parameters.

Note: All nursing home placements must be reviewed face to face.

Further guidance will be given in the light of revisions to the eligibility criteria and following the High Court judgement.

Criteria:

Care Co-ordination could happen when:

- ◆ A person does not need their own named, allocated worker.
- ◆ A person is not undertaking their own Care Management.
- ◆ A person does need some contact with Social Services to monitor and review their Care Plan and help with managing services.
- ◆ The person has a Care Plan that they, their carer and appropriate Social Services staff are satisfied with.
- ◆ Needs are clearly defined and may be either simple or complex.
- ◆ There is a predictable or planned situation.
- ◆ Risks are identified and can be managed within the Care Plan.
- ◆ There is no requirement for the provision of casework intervention by commissioning staff.

Examples of Care Co-ordination:

- | | |
|--------------------------------|--|
| Children & Families | Family in receipt of family support services via a family centre. Care Plan identifies that monitoring will be undertaken by the provider. No requirement for casework intervention by a social worker. |
| Community Care | Person settled in a residential home on a long stay basis. Care Plan identifies that monitoring will be undertaken by the service user, their family and the provider. No requirement for casework intervention. |

3.2 Self Care Management (SCM)

Description:

Self Care Management is specifically designed to enable people to manage their own, or a relative's, care needs and services with the Help Desk service offering support when requested to do so.

Whilst some people in Self Care Management will be in receipt of direct payments, this is not a pre-requisite for this form of Care Management.

Equally, direct payments may be available to people in Care Co-ordination or Personal Care Management. Policy development is continuing in this area and further guidance will be given.

It is important to recognise that Self Care Management can be undertaken on a time limited or a long-term basis to reflect changing needs over time.

Principles:

- ◆ There is no named allocated worker.
- ◆ Service users and carers manage their own Care Plans within agreed parameters, including minor variations to the plan.
- ◆ Reviews/re-assessments may be face to face, telephone or written dependent on needs. (See Appendix C.)
- ◆ Following review, individuals may move from Self Care Management to either Personal Care Management or Care Co-ordination, or exit from Care Management.

Criteria:

Self Care Management could happen when:

- ◆ The person has a Care Plan that they, their carers and appropriate Social Services staff are satisfied with.
- ◆ The person wants to manage their own Care Plan and Social Services agrees they are capable of this.
- ◆ Needs are clearly defined and may be either simple or complex.
- ◆ Needs are within the context of a planned and predictable situation.
- ◆ Risks are identified and can be managed through the Care Plan.
- ◆ There is no requirement for the provision of casework intervention by commissioning staff.

Examples of Self Care Management:

Children & Families	Child with a disability in receipt of ongoing respite care, it is agreed that parents are willing and able to manage their child's care within agreed parameters. Providers will undertake a monitoring role. No requirement for a casework intervention.
Community Care	Person with a disability in receipt of day, domiciliary and respite care, where it is agreed they are able and willing to manage their own Care Plan within agreed parameters. Providers, service users/carers will undertake a monitoring role.

3.3 Personal Care Management (PCM)

Description:

Personal Care Management is for people whose care needs are such that they require the ongoing involvement of a named, allocated worker to ensure the safe and effective co-ordination and implementation of their Care Plan. This may include the provision of a casework service by commissioning staff and/or situations where there is statutory involvement.

It is important to recognise that Personal Care Management can be undertaken on a time limited or long term basis, to reflect changing needs over time.

Principles:

- ◆ People in Personal Care Management will have **a named, allocated worker** from the Personal Care Management service.
- ◆ Contact and casework with service users should be purposeful, solution focused and task centred with clearly defined outcomes set within the Care Plan.
- ◆ Reviews/re-assessments will be face to face.
- ◆ Following reviews, individuals may move from Personal Care Management to either Self-Care Management or Care Co-ordination, or exit from Care Management.

Criteria:

Personal Care Management could happen when:

- ◆ The person's circumstances are changing a lot.
- ◆ The person appears vulnerable or unsafe.
- ◆ Risks are ill defined, unknown or unstable.

- ◆ Needs are complex and/or difficult to predict.
- ◆ There is a requirement for ongoing casework intervention by commissioning staff.

Note: Personal Care Management must be undertaken when one or more of the following are present:

- ◆ The person is the subject of a legal order requiring a named, allocated worker.
- ◆ The needs affect personal safety or the safety of others.
- ◆ Needs are complex and difficult to predict.
- ◆ People subject to the Care Programme approach model of support and supervision.
- ◆ Children not subject to a legal order, for example, accommodated or on the Child Protection Register.

Examples of Personal Care Management:

Children & Families

Looked After children where statutory supervision and reviewing is required.

Community Care

Service user who has an identified mental illness and who requires ongoing support and supervision as part of a multi-agency care programme approach.

4. The Method of Delivering a Differentiated Approach to Care Management

4.1 Introduction

The new model of Care Management developed by the Devon Social Services Directorate will be delivered by the creation of Help Desk and Personal Care Management service teams, for both Children and Families and Community Care Services, within each locality. It should be emphasised that these services do not equate to the traditional intake and long term models of working, as reflected in the descriptions below.

The overarching principles for both Help Desk and Personal Care Management services are the active involvement of people in the Care Management process; listening to them in order to understand their needs and wherever possible helping people to help themselves.

What can people expect from the new Help Desk and Personal Care Management Services?

- ◆ Consistent and equal responses across all localities.
- ◆ Information and advice that is understandable, accurate and accessible.
- ◆ One point of contact with the Directorate in each locality.
- ◆ A prompt and timely response with clear explanations of what will happen next and when.
- ◆ Least intrusive but effective approaches to assessment and the management of Social Care Services.
- ◆ Easy and prompt access to services for people who are eligible.
- ◆ Partnership working with users and carers in an open and honest way that maximises their involvement in the process.
- ◆ Personal details relevant to a user/carers situation will only need to be given once.
- ◆ A named, allocated worker when required, and a clearly defined point of contact for all others.
- ◆ A range of options and choices relevant to their particular circumstances.
- ◆ The need for personal information will be explained.
- ◆ All personal details will be treated in a confidential manner.

4.2 Help Desk Service

Description:

The Help Desk will be the public face of the Directorate. It will provide the initial point of contact for the public and other agencies in each locality. In addition, it will be the ongoing point of contact for people being supported through Care Co-ordination and Self Care Management.

The Help Desk is not a generic service. Each District will have a Help Desk for Children and Families Services and for Community Care Services. The differences for each service area are highlighted below. The principle difference between the two Help Desk services is the scope and timescales of assessments undertaken.

Scope of the Help Desk:

Children & Families The Help Desk currently offers the full range of services described above, to all children in need, whether they have a disability, are in need of protection, looking after or family support services.

Community Care The Help Desk currently offers the full range of services described above, to people who are elderly, physically disabled, learning disabled, or have a sensory impairment. It provides a signposting service only for people who have mental health needs.

The role of specialist services, for example, learning disability and sensory services, is currently being evaluated to inform the future shape of providing services at the initial point of contact.

Help Desks will be staffed by a group of people with a wide skill mix to do the following:

- ◆ Give information.
- ◆ Give advice.
- ◆ Give help, for example, signposting.

Where a person requires further support, Help Desks will also do the following as required:

Children & Families	Community Care
Take referrals.	Take referrals.
Undertake an initial assessment of need.	Undertake an initial assessment of need.
Named allocated workers will undertake a Core Assessment as per policy guidance.	Named allocated workers will undertake a Level 2 assessment of need as per policy guidance.
Develop Care Plans and arrange services.	Develop Care Plans and arrange services.
Undertake financial assessment.	Undertake financial assessment.
The Help Desk manager will determine the assessment outcome based on the practitioner's recommendation.	The Help Desk manager will decide on the transfer of cases requiring a Level 3 assessment to Personal Care Management service.
Identify type of Care Management required, e.g. Personal Care Management, Care Co-ordination, Self Care Management.	Identify type of Care Management required, e.g. Personal Care Management, Care Co-ordination, Self Care Management.

In addition, the following may be required:

- ◆ Referral for specialist assessment, including carer assessment as necessary.
- ◆ Convene child protection conference.
- ◆ Referral for Mental Health Act assessment.

Help Desk support for people who require ongoing services:

Help Desks will provide intermittent support to people whose Care Plan can be managed through Care Co-ordination. The Help Desk will also offer support, as requested, by people who are undertaking Self Care Management. This will be in the form of:

- ◆ Monitoring Care Plans.
- ◆ Reviewing Care Plans as per policy guidance.
- ◆ Adjusting Care Plans in conjunction with users/carers, within agreed parameters.

Cases requiring such support will come from assessments undertaken by either Help Desk or Personal Care Management services, or from reviews within the Personal Care Management service where the criteria for ongoing Personal Care Management is no longer met.

Practice Principles:

Priorities and Timescales for Assessment

- | | |
|--------------------------------|---|
| Children & Families | <ul style="list-style-type: none">◆ Completion of initial assessment within seven working days.◆ All referrals requiring a core assessment (and Care Plan) will be allocated to an appropriately skilled, nominated worker for completion within six weeks and up to a maximum of eight weeks (in keeping with the national framework for assessment).◆ No referral requiring a core assessment will be held on a waiting list.◆ Where a core assessment identifies a case as requiring Personal Care Management, it must be transferred no later than eight weeks from the date of referral. |
| Community Care | <ul style="list-style-type: none">◆ All referrals requiring Level 2 or 3 assessments will be allocated to an appropriately skilled, nominated worker for completion.◆ As per current priorities and timescales set down in the Directorate's quality standards (which are under review, with a draft to be published in September 1999.) |

Timescales for Reviews:

Children & Families and Community Care

- ◆ Reviews will be held in accordance with statutory requirements and/or policy guidance.
- ◆ For Care Co-ordinated and Self Care Managed cases, reviews will be undertaken at least annually.
- ◆ Reviews undertaken by post should be completed within three weeks of commencement.

4.3 Personal Care Management Service

Description:

The Personal Care Management service will provide ongoing case management support to service users who have been assessed as requiring a named, allocated worker to ensure the safe and effective co-ordination and implementation of their Care Plan. This may involve the direct provision of a casework service.

In addition, in Community Care only, all Level 3 assessments will be undertaken by this service. The Personal Care Management service is not a generic service. Each District will have a Personal Care Management service for Children & Families and Community Care Services. The differences for each service area are highlighted below. The principle difference between the two services is that in Community Care the Level 3 assessment will be undertaken within Personal Care Management Service.

The Personal Care Management service will be staffed by people with the appropriate skills and experience to do the following:

Community Care:

Assessment/ Care Planning

- ◆ Receive the case from the Help Desk.
- ◆ All Level 3 assessments.
- ◆ Development of Care Plans.
- ◆ Arrange services and other support.
- ◆ Organise specialist assessments if necessary.
- ◆ Arrange or undertake carer assessments.
- ◆ Recommend type of Care Management, for example, Personal Care Management, Care Co-ordination, Self Care Management. Where Self Care Management or Care Co-ordination, arrange transfer to Help Desk. If Personal Care Management, retain in the Personal Care Management service.

Ongoing Case Management

- ◆ Implement and co-ordinate the Care Plan.
- ◆ Undertake ongoing assessment or re-assessment work as required or identified in the Care Plan.
- ◆ Provide a direct casework service as part of the Care Plan.

- ◆ Monitor and review the Care Plan, and recommend the most appropriate type of ongoing Care Management, or case closure.

Children & Families Services:

- ◆ Receive the case from the Help Desk.
- ◆ Implement and co-ordinate the Care Plan.
- ◆ Amend the Care Plan as necessary.
- ◆ Arrange services and other support.
- ◆ Undertake ongoing assessment work as required or identified in the Care Plan.
- ◆ Organise specialist or carer assessments if necessary.
- ◆ Provide a direct casework service as part of the Care Plan.
- ◆ Monitor and review the Care Plan and recommend the most appropriate type of ongoing Care Management or case closure. If review outcome is Care Co-ordination or Self Care Management, transfer to Help Desk. If Personal Care Management, retain in Personal Care Management service.

Note: Personal Care Management will be the only service in which waiting lists will be permitted pending allocation. Waiting lists may only be used when:

- ◆ **The case has been fully assessed; and**
- ◆ **The level of quantified risk is sufficiently low to indicate it is safe to hold in this way.**

Management of waiting lists will be the responsibility of the supervisor of the Personal Care Management service.

Appendix A The Differentiated Levels of Assessment – Community Care

Level	Name	Intended Usage	Criteria for Assessment	Format
1	Screening	<ul style="list-style-type: none"> ◆ Assessments are undertaken by Help Desk staff often referral co-ordinators. ◆ To gather information in order to determine level of need and risk, and whether further assessment is required, including specialist assessment. ◆ To provide info/advice about how needs which fall outside eligibility and prioritisation categories may be met. ◆ To determine eligibility for access to low level/single services. These services may be short term or on-going e.g. meals, simple disability equipment. 	<p>Access to Information, Advice or Services:</p> <ul style="list-style-type: none"> ◆ Stable situation. ◆ Needs clearly defined, straightforward, require no further checking. ◆ Individual has clear view of what is required and why. ◆ Agreement on needs and how they can best be met. ◆ Risks easily identifiable and can be reduced without further. ◆ Assessment. <p>Access to further Assessment:</p> <p>Referral information suggests the criteria for Level 2 or 3 assessment are met (as below).</p>	SSI Referral Form
2	Moderate	<ul style="list-style-type: none"> ◆ Assessments are undertaken by named, allocated worker. ◆ The Assessment format should be used flexibly in accordance with complexity of need + the referred person's wishes and circumstances. ◆ The assessment, scope & format are negotiated with the referred person by named, allocated worker. ◆ It is a user led questionnaire style approach that can be done face to face, by telephone or by post. ◆ To assess in order to access a wide range of services and/or ◆ Specialist provision across a combination of services, e.g. domiciliary care, day care, disability equipment, rehab services, adaptations, planned respite. ◆ To identify areas of risk or potential risks. 	<ul style="list-style-type: none"> ◆ The Level 1 assessment indicates needs require further clarification + definition. ◆ The Level 1 assessment indicates risks are set at a moderate level but require further definition and identification. ◆ Where a person is permanently and substantially disabled under disability legislation at least a Level 2 assessment should be offered. ◆ Where a carer requests an assessment of their own needs the cared for person must be offered at least a Level 2 assessment. 	Care Needs Assessment

Appendix A (Cont.)

Level	Name	Intended Usage	Criteria for Assessment	Format
3	Complex	<ul style="list-style-type: none"> ◆ To assess in order to access a complex combination of services and/or specialist provision, e.g. residential/nursing accommodation, major adaptations, multiple domiciliary services, shared care, respite. ◆ To assess rehabilitation potential of people with complex needs. ◆ To identify areas of risk or potential risks. ◆ Assessments will normally have a multi-agency/disciplinary approach. ◆ Practitioner assessment following allocation. This will be face to face. ◆ The assessment format should be used flexibly in accordance with the complexity of needs, the joint agency requirements and the user's wishes and circumstances. ◆ All nursing and residential home assessments. 	<ul style="list-style-type: none"> ◆ Level 1 assessment indicates needs are complex and/or ill-defined. ◆ The situation is not easily predictable and/or the person's circumstances are changing a lot. ◆ Level 1 assessment indicates risks are difficult to define and identify. ◆ Legal and policy requirements to be met, e.g. Vulnerable adult requirements, CPA. ◆ Where a change of home environment is being considered. 	<p>Shared Assessment Schedule (Joint Agency)</p> <p>CPA Joint Agency Forms</p>

Appendix B The Differentiated Levels of Assessment – Children & Families

Name	Intended Usage	Criteria for Assessment
Screening Assessment	<ul style="list-style-type: none"> ◆ Assessments are undertaken by Help Desk Staff, normally referral co-ordinators. ◆ To gather information in order to determine level of need and risk, and whether further assessment is required, including specialist assessment. ◆ To provide info/advice about how needs which fall outside eligibility and prioritisation categories may be met. ◆ To determine eligibility for access to low level/single services. These services may be one off or short-term e.g. Section 17 payments, holiday play-schemes. 	<p>Access to Information, Advice or Services:</p> <ul style="list-style-type: none"> ◆ Stable situation. ◆ Needs clearly defined, straightforward, require no further checking. ◆ Individual has clear view of what is required and why. ◆ Agreement on needs and how they can best be met. ◆ Risks easily identifiable and can be reduced without further assessment. ◆ Likely response is low level. <p>Access to further Assessment:</p> <p>Referral information suggests the criteria for core assessment are met as below.</p>
Core Assessment	<ul style="list-style-type: none"> ◆ For assessing all situations where children have been defined as being in need as per the definition in S17 Children Act 1989. ◆ Assessment is practitioner led following allocation and will be face to face. ◆ To identify areas of risk or potential risk. ◆ To assess in order to access a wide range of services, e.g. family support, foster/residential care, child protection. ◆ Assessments will normally have a multi-agency approach. ◆ This assessment format should be used flexibly in accordance with complexity of need presented. 	<ul style="list-style-type: none"> ◆ Screening assessment indicate needs require further clarification and definition. ◆ Screening assessment suggests risks require further definition/identification. ◆ Legal and policy requirements to be met, e.g. Child Protection, Children in Need. ◆ Where a change of home environment is being considered. ◆ Where a carer requests an assessment of their own needs.

Appendix C

Indicators for Different Types of Assessment or Review – Community Care and Children & Families

Face to Face Assessment/Review	Telephone or Questionnaire Assessment/Review
<ul style="list-style-type: none"> ◆ At service user request with reason. ◆ Person is unable to communicate effectively by 'phone or in writing. ◆ The person is/appears vulnerable. ◆ Criteria for Personal Care Management are met, i.e. fluctuating situation, needs difficult to predict, and risks hard to identify and manage. ◆ Where there is a complex combination of services/disciplines involved, e.g. reablement. ◆ Legal Order/Statutory involvement or policy requirement for named, allocated worker. ◆ Complex financial issues outstanding. ◆ Telephone or questionnaire review notes significant changes in need. ◆ Where there is disagreement about the Care Plan. ◆ Care Plan indicates need for a face to face review, e.g. when reviewing changes in mood or functional abilities. ◆ Where service user no longer appears to meet eligibility for services. 	<ul style="list-style-type: none"> ◆ Where service user request this type of assessment/review, unless there are contra-indicators ◆ Care Plan indicates this type of review. ◆ Person is able to communicate effectively by 'phone or in writing. ◆ Where there is agreement about the Care Plan. ◆ Criteria for Self Care Management, Care Co-ordination are met, i.e. needs are likely to be simple but within the context of a stable or predictable situation. ◆ Criteria for Personal Care Management are not met. ◆ No legal order requiring named, allocated worker. ◆ No outstanding financial issues. ◆ Where service user appears to meet eligibility for services.

Appendix C

Indicators for Different Types of Assessment or Review – Community Care and Children & Families (Cont.)

In Addition for Residential and Nursing Home Reviews	
<ul style="list-style-type: none">◆ All end of trial reviews.◆ Resident has no regular contact with family/friends, i.e. at least four weekly, or family/friends unable to advocate for service user.◆ All Nursing Home reviews.	

Appendix D The Criteria for the New Categories of Care Management

Criteria for Personal Care Management	Criteria for Care Co-ordination	Criteria for Self Care Management
<p>Personal Care Management could happen when:</p> <ul style="list-style-type: none"> ◆ The person's circumstances are changing a lot. ◆ The person appears vulnerable. ◆ Risks are ill defined, unknown or unstable. ◆ Needs are complex and/or difficult to predict. ◆ There is a requirement for ongoing casework intervention by commissioning staff. ◆ Personal Care Management must be undertaken when one or more of the following are present: <ul style="list-style-type: none"> • The person is the subject of a legal order requiring a named, allocated worker. • The needs affect personal safety or the safety of others. • Needs are complex and difficult to predict. • People subject to a care programme approach. • Children not subject to a legal order e.g. accommodated or on the child protection register. 	<p>Care Co-ordination could happen when:</p> <ul style="list-style-type: none"> ◆ A person does not need a named, allocated worker. ◆ A person is not managing their own Care Plan. ◆ A person does need some contact with Social Services to monitor and review their Care Plan and help with managing services. ◆ The person has a Care Plan that they, their carer and Social Services are satisfied with. ◆ Needs are clearly defined and may be either simple or complex. ◆ There is a predictable or planned situation. ◆ Risks are identified and can be managed within the Care Plan. ◆ There is no requirement for the provision of casework intervention by commissioning staff. 	<p>Self Care Management could happen when:</p> <ul style="list-style-type: none"> ◆ The person has a Care Plan that they and Social Services are satisfied with. ◆ The person wants to manage their own Care Plan and Social Services agrees they are capable of this. ◆ Needs are clearly defined and may be either simple or complex. ◆ Needs are within the context of a planned and predictable situation. ◆ Risks are identified and can be managed through the Care Plan. ◆ There is no requirement for the provision of casework intervention by commissioning staff.

